to achieve what he (the 'father') had been unable to. He did not incite him directly to 'independent' living—his conscience as an analyst would not allow of that—but, on the other hand, he asked him certain questions. By persuading himself that they were only questions, the analyst satisfied the demands of his professional conscience. Yet the questions led the patient to what the analyst desired, namely, 'independent' living, and in this way the analyst satisfied his desires too. These questions obeyed the same process of formation as neurotic symptoms, being a transaction between the id, ego, and superego. These stimuli to action only lead, as a rule, to apparent changes; though we know it, it seems difficult for us to free ourselves from the 'educator' within us, with all his neurotic impulses and the corresponding ideals. The realization of our relative unconsciousness as regards our own neurotic processes of countertransference should constitute a reason for doubly observing the fulfilment of the rule of abstinence with respect to acting out; and I am referring to acting out not only on the part of the patient but also on the part of the analyst. A cure is to be achieved—as Freud repeatedly stressed—only by overcoming the resistances.

I should like to add a few words about the most immediate practical conclusions that follow from this exposition. There is, in the first place, an evident need to keep watch on the resistances, regarding countertransference and the corresponding problems. Just as in controls, in the publications of case histories, etc., the processes of transference are given due consideration, so also should the essential processes of countertransference be regarded. The need to continue didactic analysis until the candidate has faced up squarely to his own countertransference neurosis has already been stressed by M. Langer (*loc. cit.*) and others. The breakdown of the corresponding resistances in the candidate will then lead to a lessening of his neurotic dependence on his didactic analyst and so favour the introjection of a good object. In the programmes of technical lecture-courses, countertransference should—insofar as this has not been carried out already—receive the attention it deserves.

One last word: Freud once said that his pupils had learnt to bear a part of the truth about themselves. The deepening of our knowledge of countertransference accords with this principle. And I believe we should do well if we learnt to bear this truth about each one of us being also known by some other people.

6

The Meanings and Uses of Countertransference[1]

Freud describes transference as both the greatest danger and the best tool for analytic work. He refers to the work of making the repressed past conscious. Besides these two implied meanings of transference, Freud gives it a third meaning: it is in the transference that the analysand may relive the past under better conditions and in this way rectify pathological decisions and destinies. Likewise three meanings of countertransference may be differentiated. It too may be the greatest danger and at the same time an important tool for understanding, an assistance to the analyst in his function as interpreter. Moreover, it affects the analyst's behaviour; it interferes with his action as object of the patient's re-experience in the new fragment of life that is the analytic situation, in which the patient should meet with greater understanding and objectivity than he found in the reality or fantasy of his childhood.

What have present-day writers to say about the problem of countertransference?[2]

Lorand (1946) writes mainly about the dangers of countertransference for analytic work. He also points out the importance of taking countertransference reactions into account, for they may indicate some important subject to be worked through with the patient. He emphasizes the necessity for the analyst to be always aware of his countertransference, and discusses specific problems such as the conscious desire to heal, the relief analysis may afford the analyst from his own problems, and narcissism and the interference of personal motives in clinical matters. He also emphasizes the fact that these problems of countertransference concern not only the candidate but also the experienced analyst.

Winnicott (1949) is specifically concerned with 'objective and

[1] Read at a meeting of the Argentine Psychoanalytic Association in May 1953. Reprinted from *Psychoanal. Quart.* (1957), 26.

[2] I confine myself in what follows to papers published since 1946. I have referred to earlier literature in Chapter 5 of this volume.

justified hatred' in countertransference, particularly in the treatment of psychotics. He considers how the analyst should manage this emotion: should he, for example, bear his hatred in silence or communicate it to the analysand? Thus Winnicott is concerned with a particular countertransference reaction insofar as it affects the behaviour of the analyst, who is the analysand's object in his re-experience of childhood.

Heimann (1950) deals with countertransference as a tool for understanding the analysand. The 'basic assumption is that the analyst's unconscious understands that of his patient. This rapport on the deep level comes to the surface in the form of feelings which the analyst notices in response to his patient, in his countertransference.' This emotional response of the analyst is frequently closer to the psychological state of the patient than is the analyst's conscious judgement thereof.

Little (1951) discusses countertransference as a disturbance to understanding and interpretation and as it influences the analyst's behaviour with decisive effect upon the patient's re-experience of his childhood. She stresses the analyst's tendency to repeat the behaviour of the patient's parents and to satisfy certain needs of his own, rather than those of the analysand. Little emphasizes that one must admit one's countertransference to the analysand and interpret it, and must do so not only in regard to 'objective' countertransference reactions (Winnicott) but also to 'subjective' ones.

Annie Reich (1951) is chiefly interested in countertransference as a source of disturbances in analysis. She clarifies the concept of countertransference and differentiates two types: 'countertransference in the proper sense' and 'the analyst's using the analysis for acting out purposes'. She investigates the causes of these phenomena, and seeks to understand the conditions that lead to good, excellent, or poor results in analytic activity.

Gitelson (1952) distinguishes between the analyst's 'reactions to the patient as a whole' (the analyst's 'transferences') and the analyst's 'reactions to partial aspects of the patient' (the analyst's 'countertransferences'). He is concerned also with the problems of intrusion of countertransference into the analytic situation, and states that, in general, when such intrusion occurs the countertransference should be dealt with by analyst and patient working together, thus agreeing with Little.

Weigert (1952) favours analysis of countertransference insofar as it intrudes into the analytic situation, and she advises, in advanced stages of treatment, less reserve in the analyst's

behaviour and more spontaneous display of countertransference.

In the last chapter, I discussed countertransference as a danger to analytic work. After analysing the resistances that still seem to impede investigation of countertransference, I attempted to show without reserve how oedipal and preoedipal conflicts as well as paranoid, depressive, manic, and other processes persist in the 'countertransference neurosis' and how they interfere with the analyst's understanding, interpretation, and behaviour. My remarks applied to 'direct' and 'indirect' countertransference.[1]

In another paper (1952), I described the use of countertransference experiences for understanding psychological problems, especially transference problems, of the analysand. In my principal points I agreed with Heimann (1950), and emphasized the following suggestions. (1) Countertransference reactions of great intensity, even pathological ones, should also serve as tools. (2) Countertransference is the expression of the analyst's identification with the internal objects of the analysand, as well as with his id and ego, and may be used as such. (3) Countertransference reactions have specific characteristics (specific contents, anxieties, and mechanisms) from which we may draw conclusions about the specific character of the psychological happenings in the patient.

The present paper is intended to amplify my remarks on countertransference as a tool for understanding the mental processes of the patient (including especially his transference reactions)—their content, their mechanisms, and their intensities. Awareness of countertransference helps one to understand what should be interpreted and when. This paper will also consider the influence of countertransference upon the analyst's behaviour towards the analysand—behaviour that affects decisively the position of the analyst as object of the re-experience of childhood, thus affecting the process of cure.

Let us first consider briefly countertransference in the history of psycho-analysis. We meet with a strange fact and a striking contrast. The discovery by Freud (1910) of countertransference and its great importance in therapeutic work gave rise to the

[1] This differentiation accords in essentials with Annie Reich's two types of countertransference. I would add, however, that also when the analyst uses the analysis for his own acting out (what I have termed 'indirect' countertransference), the analysand represents an object to the analyst (a 'sub-transferred' object), not merely a 'tool'.

institution of training analysis which became the basis and centre of psycho-analytic training. Yet countertransference received little scientific consideration over the next forty years. Only during the last few years has the situation changed, rather suddenly, and countertransference has become a subject examined frequently and with thoroughness. How is one to explain this initial recognition, this neglect, and this recent change? Is there not reason to question the success of training analysis in fulfilling its function if this very problem, the discovery of which led to the creation of training analysis, has had so little scientific elaboration?

These questions are clearly important, and those who have personally witnessed a great part of the development of psycho-analysis in the last forty years have the best right to answer them.[1] I will suggest only one explanation.

The lack of scientific investigation of countertransference must be due to rejection by analysts of their own countertransferences—a rejection that represents unresolved struggles with their own primitive anxiety and guilt. These struggles are closely connected with those infantile ideals that survive because of deficiencies in the personal analysis of just those transference problems that later affect the analyst's countertransference. These deficiencies in the training analysis are in turn partly due to countertransference problems insufficiently solved in the training analyst, as I shall show later. Thus we are in a vicious circle; but we can see where a breach must be made. We must begin by revision of our feelings about our own countertransference and try to overcome our own infantile ideals more thoroughly, accepting more fully the fact that we are still children and neurotics even when we are adults and analysts. Only in this way—by better overcoming our rejection of countertransference—can we achieve the same result in candidates.

The insufficient dissolution of these idealizations and underlying anxieties and guilt-feelings leads to special difficulties when the child becomes an adult and the analysand an analyst, for the analyst unconsciously requires of himself that he be fully identified with these ideals. I think that it is at least partly for this reason that the Oedipus complex of the child towards his parents, and of the patient towards his analyst, has been so much

[1] Michael Balint (1948) considers a similar problem, the scarcity of papers on the system of psycho-analytic training. Investigation of this problem leads him to several interesting remarks on the relationship between training analysts and candidates. (See footnote p. 132.)

more fully considered than that of the parents towards their children and of the analyst towards the analysand. For the same basic reason transference has been dealt with much more than countertransference.

The fact that countertransference conflicts determine the deficiencies in the analysis of transference becomes clear if we recall that transference is the expression of the internal object relations; for understanding of transference will depend on the analyst's capacity to identify himself both with the analysand's impulses and defences, and with his internal objects, and to be conscious of these identifications. This ability in the analyst will in turn depend upon the degree to which he accepts his countertransference, for his countertransference is likewise based on identification with the patient's id and ego and his internal objects. One might also say that transference is the expression of the patient's relations with the fantasied and real countertransference of the analyst. For just as countertransference is the psychological response to the analysand's real and imaginary transferences, so also is transference the response to the analyst's imaginary and real countertransferences. Analysis of the patient's fantasies about countertransference, which in the widest sense constitute the causes and consequences of the transferences, is an essential part of the analysis of the transferences. Perception of the patient's fantasies regarding countertransference will depend in turn upon the degree to which the analyst himself perceives his countertransference processes—on the continuity and depth of his conscious contact with himself.

To summarize, the repression of countertransference (and other pathological fates that it may meet) necessarily leads to deficiencies in the analysis of transference, which in turn lead to the repression and other mishandling of countertransference as soon as the candidate becomes an analyst. It is a heritage from generation to generation, similar to the heritage of idealizations and denials concerning the imagos of the parents, which continue working even when the child becomes a father or mother. The child's mythology is prolonged in the mythology of the analytic situation,[1] the analyst himself being partially subject to it and collaborating unconsciously in its maintenance in the candidate.

Before illustrating these statements, let us briefly consider one of those ideals in its specifically psycho-analytic expression: the

[1] Little (1951) speaks, for instance, of the 'myth of the impersonal analyst'.

ideal of the analyst's objectivity. No one, of course, denies the existence of subjective factors in the analyst and of countertransference in itself; but there seems to exist an important difference between what is generally acknowledged in practice and the real state of affairs. The first distortion of truth in 'the myth of the analytic situation' is that analysis is an interaction between a sick person and a healthy one. The truth is that it is an interaction between two personalities, in both of which the ego is under pressure from the id, the superego, and the external world; each personality has its internal and external dependences, anxieties, and pathological defences; each is also a child with his internal parents; and each of these whole personalities —that of the analysand and that of the analyst—responds to every event of the analytic situation.[1] Besides these similarities between the personalities of analyst and analysand, there also exist differences, and one of these is in 'objectivity'. The analyst's objectivity consists mainly in a certain attitude towards his own subjectivity and countertransference. The neurotic (obsessive) ideal of objectivity leads to repression and blocking of subjectivity and so to the apparent fulfilment of the myth of the 'analyst without anxiety or anger'. The other neurotic extreme is that of 'drowning' in the countertransference. True objectivity is based upon a form of internal division that enables the analyst to make himself (his own countertransference and subjectivity) the object of his continuous observation and analysis. This position also enables him to be relatively 'objective' towards the analysand.

[1] It is important to be aware of this 'equality' because there is otherwise great danger that certain remnants of the 'patriarchal order' will contaminate the analytic situation. The dearth of scientific study of countertransference is an expression of a 'social inequality' in the analyst-analysand society and points to the need for 'social reform'; which can come about only through a greater awareness of countertransference. For as long as we repress, for instance, our wish to dominate the analysand neurotically (and we do wish this in one part of our personality), we cannot free him from his neurotic dependence, and as long as we repress our neurotic dependence upon him (and we do in part depend on him), we cannot free him from the need to dominate us neurotically.

Michael Balint (1948) compares the atmosphere of psycho-analytic training with the initiation ceremonies of primitives and emphasizes the existence of superego 'intropressure' (Ferenczi) which no candidate can easily withstand.

II

The term countertransference has been given various meanings. They may be summarized by the statement that for some authors countertransference includes everything that arises in the analyst as psychological response to the analysand, whereas for others not all this should be called countertransference. Some, for example, prefer to reserve the term for what is infantile in the relationship of the analyst with his analysand, while others make different limitations (A. Reich (1951) and Gitelson (1952)). Hence efforts to differentiate from each other certain of the complex phenomena of countertransference lead to confusion or to unproductive discussions of terminology. Freud invented the term countertransference in evident analogy with transference, which he defined as reimpressions or re-editions of childhood experiences, including greater or lesser modifications of the original experience. Hence one frequently uses the term transference for the totality of the psychological attitude of the analysand towards the analyst. We know, to be sure, that real external qualities of the analytic situation in general and of the analyst in particular have an important influence on the relationship of the analysand with the analyst, but we also know that all these present factors are experienced according to the past and the fantasy—according, that is to say, to a transference predisposition. As determinants of the transference neurosis and, in general, of the psychological situation of the analysand towards the analyst, we have both the transference predisposition and the present real and especially analytic experiences, the transference in its diverse expressions being the result of these two factors.

Analogously, in the analyst there are the countertransference predisposition and the present real, and especially analytic, experiences; and the countertransference is the result. It is precisely this fusion of present and past, the continuous and intimate connexion of reality and fantasy, of external and internal, conscious and unconscious, that demands a concept embracing the totality of the analyst's psychological response, and renders it advisable, at the same time, to keep for this totality of response the accustomed term 'countertransference'. Where it is necessary for greater clarity one might speak of 'total countertransference' and then differentiate and separate within it one aspect or another. One of its aspects consists precisely in *what is transferred* in countertransference; this is the part that originates in

an earlier time and that is especially the infantile and primitive part within total countertransference. Another of these aspects —closely connected with the previous one—is *what is neurotic* in countertransference; its main characteristics are the unreal anxiety and the pathological defences. Under certain circumstances one may also speak of a countertransference neurosis, which I have discussed in the previous chapter.

To clarify better the concept of countertransference, one might start from the question of what happens, in general terms, in the analyst in his relationship with the patient. The first answer might be: everything happens that *can* happen in one personality faced with another. But this says so much that it says hardly anything. We take a step forward by bearing in mind that in the analyst there is a tendency that normally predominates in his relationship with the patient: it is the tendency pertaining to his function of being an analyst, that of understanding what is happening in the patient. Together with this tendency there exist towards the patient virtually all the other possible tendencies, fears, and other feelings that one person may have towards another. The intention to understand creates a certain predisposition, a predisposition to identify oneself with the analysand, which is the basis of comprehension. The analyst may achieve this aim by identifying his ego with the patient's ego or, to put it more clearly although with a certain terminological inexactitude, by identifying each part of his personality with the corresponding psychological part in the patient—his id with the patient's id, his ego with the ego, his superego with the superego, accepting these identifications in his consciousness. But this does not always happen, nor is it all that happens. Apart from these identifications, which might be called *concordant* (or *homologous*) *identifications*, there exist also highly important identifications of the analyst's ego with the patient's internal objects, for example, with the superego. Adapting an expression from Helene Deutsch, they might be called *complementary identifications*.[1] We will consider these two kinds of identification and their destinies later. Here we may add the following notes.

(1) The concordant identification is based on introjection and projection, or, in other terms, on the resonance of the exterior in the interior, on recognition of what belongs to another as one's own ('this part of you is I') and on the equation of what is one's own with what belongs to another ('this part of me is

[1] Helene Deutsch (1926) speaks of the 'complementary attitude' when she refers to the analyst's identifications with the object imagos.

you'). The processes inherent in the complementary identifications are the same, but they refer to the patient's objects. The greater the conflicts between the parts of the analyst's personality, the greater are his difficulties in carrying out the concordant identifications in their entirety.

(2) The complementary identifications are produced by the fact that the patient treats the analyst as an internal (projected) object, and in consequence the analyst feels treated as such; that is, he identifies himself with this object. The complementary identifications are closely connected with the destiny of the concordant identifications: it seems that to the degree to which the analyst fails in the concordant identifications and rejects them certain complementary identifications become intensified. It is clear that rejection of a part or tendency in the analyst himself, —his aggressiveness, for instance—may lead to a rejection of the patient's aggressiveness (whereby this concordant identification fails) and that such a situation leads to a greater complementary identification with the patient's rejecting object, towards which this aggressive impulse is directed.

(3) Current usage applies the term 'countertransference' to the complementary identifications only; that is to say, to those psychological processes in the analyst by which, because he feels treated as, and partially identifies himself with, an internal object of the patient, the patient becomes an internal (projected) object of the analyst. Usually excluded from the concept of countertransference are the concordant identifications—those psychological contents that arise in the analyst by reason of the empathy achieved with the patient and that really reflect and reproduce the latter's psychological contents. Perhaps it would be best to follow this usage, but there are some circumstances that make it unwise to do so. In the first place, some authors include the concordant identifications in the concept of countertransference. One is thus faced with the choice of entering upon a terminological discussion or of accepting the term in this wider sense. I think that for various reasons the wider sense is to be preferred. If one considers that the analyst's concordant identifications (his 'understandings') are a sort of reproduction of his own past processes, especially of his own infancy, and that this reproduction or re-experience is carried out as response to stimuli from the patient, one will be more ready to include the concordant identifications in the concept of countertransference. Moreover, the concordant identifications are closely connected with the complementary ones (and thus with 'countertrans-

ference' in the popular sense), and this fact renders advisable a differentiation but not a total separation of the terms. Finally, it should be borne in mind that the disposition to empathy—that is, to concordant identification—springs largely from the sublimated positive countertransference, which likewise relates empathy with countertransference in the wider sense. All this suggests, then, the acceptance of countertransference as the totality of the analyst's psychological response to the patient. If we accept this broad definition of countertransference, the difference between its two aspects mentioned above must still be defined. On the one hand we have the analyst as subject and the patient as object of knowledge, which in a certain sense annuls the 'object relationship', properly speaking; and there arises in its stead the approximate union or identity between the various parts (experiences, impulses, defences), of the subject and the object. The aggregate of the processes pertaining to that union might be designated, where necessary, 'concordant countertransference'. On the other hand we have an object relationship very like many others, a real 'transference' in which the analyst 'repeats' previous experiences, the patient representing internal objects of the analyst. The aggregate of these experiences, which also exist always and continually, might be termed 'complementary countertransference'.[1]

A brief example may be opportune here. Consider a patient who threatens the analyst with suicide. In such situations there sometimes occurs rejection of the concordant identifications by the analyst and an intensification of his identification with the threatened object. The anxiety that such a threat can cause the analyst may lead to various reactions or defence mechanisms within him—for instance, annoyance with the patient. This—his anxiety and annoyance—would be contents of the 'complementary countertransference'. The perception of his annoyance may, in turn, generate guilt-feelings in the analyst and these lead to desires for reparation and to intensification of the 'concordant' identification and 'concordant' countertransference.

Moreover, these two aspects of 'total countertransference' have their analogy in transference. Sublimated positive transference is the main and indispensable motive force for the patient's work; it does not in itself constitute a technical problem. Transference becomes a 'subject', according to Freud

[1] In view of the close connexion between these two aspects of countertransference, this differentiation is somewhat artificial. Its introduction is justifiable only in the circumstances I have mentioned.

(1912, 1913), mainly when 'it becomes resistance', when, because of resistance, it has become sexual or negative. Analogously, sublimated positive countertransference is the main and indispensable motive force in the analyst's work (disposing him to the continued concordant identification), and countertransference also becomes a technical problem or 'subject' mainly when it becomes sexual or negative. And this occurs (to an intense degree) principally as a resistance—in this case, the analyst's—that is to say, as counterresistance.

This leads to the problem of the dynamics of countertransference. We may already discern that the three factors designated by Freud as determinant in the dynamics of transference (the impulse to repeat infantile clichés of experience, the libidinal need, and resistance) are also decisive for the dynamics of countertransference. I shall return to this later.

III

Every transference situation provokes a countertransference situation, which arises out of the analyst's identification of himself with the analysand's (internal) objects (that is the 'complementary countertransference'). These countertransference situations may be repressed or emotionally blocked but probably they cannot be avoided; certainly they should not be avoided if full understanding is to be achieved. These countertransference reactions are governed by the laws of the general and individual unconscious. Among these the law of talion is especially important. Thus, for example, every positive transference situation is answered by a positive countertransference; to every negative transference there responds, in one part of the analyst, a negative countertransference. It is of great importance that the analyst be conscious of this law, for awareness of it is fundamental to avoid 'drowning' in the countertransference. If he is not aware of it he will not be able to avoid entering into the vicious circle of the analysand's neurosis, which will hinder or even prevent the work of therapy.

A simplified example: if the patient's neurosis centres on a conflict with his introjected father, he will project the latter upon the analyst and treat him as his father; the analyst will feel treated as such—he will feel treated badly—and he will react internally, in a part of his personality, in accordance with the treatment he receives. If he fails to be aware of this reaction, his behaviour will inevitably be affected by it, and he will renew the situations that, to a greater or lesser degree, helped to establish

the analysand's neurosis. Hence it is of the greatest importance that the analyst develop within himself an ego observer of his countertransference reactions, which are, naturally, continuous. Perception of these countertransference reactions will help him to become conscious of the continuous transference situations of the patient and interpret them rather than be unconsciously ruled by these reactions, as not infrequently happens. A well-known example is the 'revengeful silence' of the analyst. If the analyst is unaware of these reactions there is danger that the patient will have to repeat, in his transference experience, the vicious circle brought about by the projection and introjection of 'bad objects' (in reality neurotic ones) and the consequent pathological anxieties and defences; but transference interpretations made possible by the analyst's awareness of his countertransference experience make it possible to open important breaches in this vicious circle.

To return to the previous example: if the analyst is conscious of what the projection of the father-imago upon him provokes in his own countertransference, he can more easily make the patient conscious of this projection and the consequent mechanisms. Interpretation of these mechanisms will show the patient that the present reality is not identical with his inner perceptions (for, if it were, the analyst would not interpret and otherwise act as an analyst); the patient then introjects a reality better than his inner world. This sort of rectification does not take place when the analyst is under the sway of his unconscious countertransference.

Let us consider some applications of these principles. To return to the question of what the analyst does during the session and what happens within him, one might reply, at first thought, that the analyst listens. But this is not completely true: he listens most of the time, or wishes to listen, but is not invariably doing so. Ferenczi (1919) refers to this fact and expresses the opinion that the analyst's distractability is of little importance, for the patient at such moments must certainly be in resistance. Ferenczi's remark sounds like an echo from the era when the analyst was mainly interested in the repressed *impulses*, because now that we attempt to analyse resistance, the patient's manifestations of resistance are as significant as any other of his productions. At any rate, Ferenczi here refers to a countertransference response and deduces from it the analysand's psychological situation. He says '. . . we have unconsciously reacted to the emptiness and futility of the associations just

presented by the withdrawal of conscious excitation'. The situation might be described as one of mutual withdrawal. The analyst's withdrawal is a response to the analysand's withdrawal, which, however, is a response to an imagined or real psychological position of the analyst. If we have withdrawn—if we are not listening but are thinking of something else—we may utilize this event in the service of the analysis like any other information we acquire. And the guilt we may feel over such a withdrawal is just as utilizable analytically as any other countertransference reaction. Ferenczi's next words, 'the danger of the doctor falling asleep . . . is not great because we awake at the first idea that in any way concerns the treatment', are clearly intended to placate this guilt. But better than to allay the analyst's guilt would be to use it to promote the analysis, and indeed so to use the guilt would be the best way of alleviating it. In fact, we encounter here a cardinal problem of the relation between transference and countertransference, and of the therapeutic process in general. For the analyst's withdrawal is only an example of how the unconscious of one person responds to the unconscious of another. This response seems in part to be governed, insofar as we identify ourselves with the unconscious objects of the analysand, by the law of talion; and, insofar as this law unconsciously influences the analyst, there is danger of a vicious circle of reactions between them, for the analysand also responds 'talionically' in his turn, and so on without end.

Looking more closely, we see that the 'talionic response' or 'identification with the aggressor' (the frustrating patient) is a complex process. Such a psychological process in the analyst usually starts with a feeling of displeasure or of some anxiety as a response to this aggression (frustration) and, because of this feeling, the analyst identifies himself with the 'aggressor'. By the term 'aggressor' we must designate not only the patient but also some internal object of the analyst (especially his own superego or an internal persecutor) now projected upon the patient. This identification with the aggressor, or persecutor, causes a feeling of guilt; probably it always does so, although awareness of the guilt may be repressed. For what happens is, on a small scale, a process of melancholia, just as Freud described it: the object has to some degree abandoned us; we identify ourselves with the lost object;[1] and then we accuse the introjected 'bad' object—in

[1] It is a partial abandonment and it is a threat of abandonment. The object that threatens to abandon us and the persecutor are basically the same.

other words, we have guilt-feelings. This may be sensed in Ferenczi's remark quoted above, in which mechanisms are at work designed to protect the analyst against these guilt-feelings: denial of guilt ('the danger is not great') and a certain accusation against the analysand for the 'emptiness' and 'futility' of his associations. In this way a vicious circle—a kind of paranoid ping-pong—has entered into the analytic situation.[1]

Two situations of frequent occurrence illustrate both the complementary and the concordant identifications and the vicious circle these situations may cause.

(1) One transference situation of regular occurrence consists in the patient's seeing in the analyst his own superego. The analyst identifies himself with the id and ego of the patient and with the patient's dependence upon his superego; and he also identifies himself with this same superego—a situation in which the patient places him—and experiences in this way the domination of the superego over the patient's ego. The relation of the ego to the superego is, at bottom, a depressive and paranoid situation; the relation of the superego to the ego is, on the same plane, a manic one insofar as this term may be used to designate the dominating, controlling, and accusing attitude of the superego towards the ego. In this sense we may say, broadly speaking, that to a 'depressive-paranoid' transference in the analysand there corresponds—as regards the complementary identification—a 'manic' countertransference in the analyst. This, in turn, may entail various fears and guilt-feelings, to which I shall refer later.[2]

(2) When the patient, in defence against this situation, identifies himself with the superego, he may place the analyst in the situation of the dependent and incriminated ego. The analyst will not only identify himself with this position of the patient; he will also experience the situation with the content the patient gives it: he will feel subjugated and accused, and may react to some degree with anxiety and guilt. To a 'manic' transference

[1] The process described by Ferenczi has an even deeper meaning. The 'emptiness' and 'futility' of the associations express the empty, futile, dead part of the analysand; they characterize a depressive situation in which the analysand is alone and abandoned by his objects, just as has happened in the analytic situation.

[2] Cesio (1952) demonstrates in a case report the principal countertransference reactions that arose in the course of the psycho-analytic treatment, pointing out especially the analyst's partial identifications with objects of the patient's superego.

situation (of the type called 'mania for reproaching') there corresponds, then—as regards the complementary identification—a 'depressive-paranoid' countertransference situation.

The analyst will normally experience these situations with only a part of his being, leaving another part free to take note of them in a way suitable for the treatment. Perception of such a countertransference situation by the analyst and his understanding of it as a psychological response to a certain transference situation will enable him the better to grasp the transference at the precise moment when it is active. It is precisely these situations and the analyst's behaviour regarding them, and in particular his interpretations of them, that are of decisive importance for the process of therapy, for they are the moments when the vicious circle within which the neurotic habitually moves—by projecting his inner world outside and reintrojecting this same world—is or is not interrupted. Moreover, at these decisive points the vicious circle may be re-enforced by the analyst, if he is unaware of having entered it.

A brief example: an analysand repeats with the analyst his 'neurosis of failure', closing himself up to every interpretation or repressing it at once, reproaching the analyst for the uselessness of the analysis, foreseeing nothing better in the future, continually declaring his complete indifference to everything. The analyst interprets the patient's position towards him, and its origins, in its various aspects. He shows the patient his defence against the danger of becoming too dependent, of being abandoned, or being tricked, or of suffering counter-aggression by the analyst, if he abandons his armour and indifference towards the analyst. He interprets to the patient his projection of bad internal objects and his subsequent sado-masochistic behaviour in the transference; his need of punishment; his triumph and 'masochistic revenge' against the transferred parents; his defence against the 'depressive position' by means of schizoid, paranoid, and manic defences (Melanie Klein); and he interprets the patient's rejection of a bond which in the unconscious has a homosexual significance. But it may happen that all these interpretations, in spite of being directed to the central resistance and connected with the transference situation, suffer the same fate for the same reasons: they fall into the 'whirl in a void' (*Leerlauf*) of the 'neurosis of failure'. Now the decisive moments arrive. The analyst, subdued by the patient's resistance, may begin to feel anxious over the possibility of failure and feel angry with the patient. When this occurs in the analyst, the patient feels it

coming, for his own 'aggressiveness' and other reactions have provoked it; consequently he fears the analyst's anger. If the analyst, threatened by failure, or, to put it more precisely, threatened by his own superego or by his own archaic objects which have found an '*agent provocateur*' in the patient, acts under the influence of these internal objects and of his paranoid and depressive anxieties, the patient again finds himself confronting a reality like that of his real or fantasied childhood experiences and like that of his inner world; and so the vicious circle continues and may even be re-enforced. But if the analyst grasps the importance of this situation, if, through his own anxiety or anger, he comprehends what is happening in the analysand, and if he overcomes, thanks to the new insight, his negative feelings and interprets what has happened in the analysand, being now in this new positive countertransference situation, then he may have made a breach—be it large or small—in the vicious circle (see Example 8 on pp. 156–159 below).

IV

We have considered thus far the relation of transference and countertransference in the analytic process. Now let us look more closely into the phenomena of countertransference. Countertransference experiences may be divided into two classes. One might be designated 'countertransference thoughts'; the other 'countertransference positions'. The example just cited may serve as illustration of this latter class; the essence of this example lies in the fact that the analyst feels anxiety and is angry with the analysand—that is to say, he is in a certain countertransference 'position'. As an example of the other class we may take the following.

At the start of a session an analysand wishes to pay his fees. He gives the analyst a thousand-peso note and asks for change. The analyst happens to have his money in another room and goes out to fetch it, leaving the thousand pesos upon his desk. During the time between leaving and returning, the fantasy occurs to him that the analysand will take back the money and say that the analyst took it away with him. On his return he finds the thousand pesos where he had left it. When the account has been settled, the analysand lies down and tells the analyst that when he was left alone he had fantasies of keeping the money, of kissing the note goodbye, and so on. The analyst's fantasy was based upon what he already knew of the patient, who in previous sessions had expressed a strong disinclination to pay his fees.

The identity of the analyst's fantasy and the patient's fantasy of keeping the money may be explained as springing from a connexion between the two unconsciouses, a connexion that might be regarded as a 'psychological symbiosis' between the two personalities. To the analysand's wish to take money from him (already expressed on previous occasions) the analyst reacts by identifying himself both with this desire and with the object towards which the desire is directed; hence arises his fantasy of being robbed. For these identifications to come about there must evidently exist a potential identity. One may presume that every possible psychological constellation in the patient also exists in the analyst, and the constellation that corresponds to the patient's is brought into play in the analyst. A symbiosis results, and now thoughts occur spontaneously in the analyst corresponding to the psychological constellation in the patient.

In fantasies of the type just described and in the example of the analyst angry with his patient, we are dealing with identifications with the id, with the ego, and with the objects of the analysand; in both cases, then, it is a matter of countertransference reactions. However, there is an important difference between one situation and the other, and this difference seems not to lie only in the emotional intensity. Before elucidating this difference, I should like to emphasize that the countertransference reaction that appears in the last example (the fantasy about the thousand pesos) should also be used as a means to further the analysis. It is, moreover, a typical example of those 'spontaneous thoughts' to which Freud and others refer in advising the analyst to keep his attention 'floating' and in stressing the importance of these thoughts for understanding the patient. The countertransference reactions exemplified by the story of the thousand pesos are characterized by the fact that they threaten no danger to the analyst's objective attitude of observer. Here the danger is rather that the analyst will not pay sufficient attention to these thoughts or will fail to use them for understanding and interpretation. The patient's corresponding ideas are not always conscious, nor are they always communicated as they were in the example cited. But from his own countertransference 'thoughts' and feelings the analyst may guess what is repressed or rejected. It is important to recall once more our usage of the term 'countertransference', for many writers, perhaps the majority, mean by it not these thoughts of the analyst but rather that other class of reactions, the

'countertransference positions'. This is one reason why it is useful to differentiate these two kinds of reaction.

The outstanding difference between the two lies in the degree to which the ego is involved in the experience. In one case the reactions are experienced as thoughts, free associations, or fantasies, with no great emotional intensity and frequently as if they were somewhat foreign to the ego. In the other case, the analyst's ego is involved in the countertransference experience, and the experience is felt by him with great intensity and as true reality, and there is danger of his 'drowning' in this experience. In the former example of the analyst who gets angry because of the analysand's resistances, the analysand is felt as really bad by one part of the analyst ('countertransference position'), although the latter does not express his anger. Now these two kinds of countertransference reaction differ, I believe, because they have different origins. The reaction experienced by the analyst as thought or fantasy arises from the existence of an *analogous situation* in the analysand—that is, from his readiness in perceiving and communicating his inner situation (as happens in the case of the thousand pesos)—whereas the reaction experienced with great intensity, even as reality, by the analyst, arises from *acting out* by the analysand (as in the case of the 'neurosis of failure'). Undoubtedly there is also in the analyst, himself, a factor that helps to determine this difference. The analyst has, it seems, two ways of responding. He may respond to some situations by *perceiving* his reactions, while to others he responds by *acting out* (alloplastically or autoplastically). Which type of response occurs in the analyst depends partly on his own neurosis, on his inclination to anxiety, on his defence mechanisms, and especially on his tendencies to repeat (act out) instead of making conscious. Here we encounter a factor that determines the dynamics of countertransference. It is the one Freud emphasized as determining the special intensity of transference in analysis, and it is also responsible for the special intensity of countertransference.

Let us consider for a moment the dynamics of countertransference. The great intensity of certain countertransference reactions is to be explained by the existence in the analyst of pathological defences against the increase of archaic anxieties and unresolved inner conflicts. Transference, I believe, becomes intense not only because it serves as a resistance to remembering, as Freud says, but also because it serves as a defence against a danger within the transference experience itself. In other

words, the 'transference resistance' is frequently a repetition of defences that must be intensified lest a catastrophe be repeated in transference (Chapter 3). The same is true of countertransference. It is clear that these catastrophes are related to becoming aware of certain aspects of one's own instincts. Take, for instance, the analyst who becomes anxious and inwardly angry over the intense masochism of the analysand within the analytic situation. Such masochism frequently rouses old paranoid and depressive anxieties and guilt-feelings in the analyst, who, faced with the aggression directed by the patient against his own ego, and faced with the effects of this aggression, finds himself in his unconscious confronted anew with his early crimes. It is often just these childhood conflicts of the analyst, with their aggression, that led him into this profession in which he tries to repair the objects of the aggression and to overcome or deny his guilt. Because of the patient's strong masochism, this defence, which consists of the analyst's therapeutic action, fails and the analyst is threatened with the return of the catastrophe, the encounter with the destroyed object. In this way the intensity of the 'negative countertransference' (the anger with the patient) usually increases because of the failure of the countertransference defence (the therapeutic action) and the analyst's subsequent increase of anxiety over a catastrophe in the countertransference experience (the destruction of the object).

This example also illustrates another aspect of the dynamics of countertransference. In Chapter 3, I show that the 'abolition of rejection'[1] in analysis determines the dynamics of transference and, in particular, the intensity of the transference of the 'rejecting' internal objects (in the first place, of the superego). The 'abolition of rejection' begins with the communication of 'spontaneous' thoughts. The analyst, however, makes no such communication to the analysand, and here we have an important difference between his situation and that of the analysand and between the dynamics of transference and those of countertransference. However, this difference is not so great as might be at first supposed, for two reasons: first, because it is not necessary that the free associations be *expressed* for projections and transferences to take place, and second, because the analyst communicates certain associations of a personal nature even

[1] By 'abolition of rejection' I mean adherence by the analysand to the fundamental rule that all his thoughts are to be expressed without selection or rejection.

when he does not seem to do so. These communications begin, one might say, with the plate on the front door that says 'Psychoanalyst' or 'Doctor'. What motive (in terms of the unconscious) would the analyst have for wanting to cure if it were not he who made the patient ill? In this way the patient is already, simply by being a patient, the creditor, the accuser, the 'superego' of the analyst; and the analyst is his debtor.

V

The examples that follow illustrate the various kinds, meanings and uses of countertransference reaction. First I describe situations in which the countertransference is of too little intensity to drag the analyst's ego along with it; next, some situations in which there is an intense countertransference reaction deeply involving the ego; and finally, some examples in which the repression of countertransference prevents comprehension of the analysand's situation at the critical moment.

(1) A woman patient asked the analyst whether it was true that another analyst named N had become separated from his wife and married again. In the associations that followed she referred repeatedly to N's first wife. The idea occurred to the analyst that the patient would also like to know who N's second wife was and that she probably wondered whether the second wife was a patient of N. The analyst further supposed that his patient (considering her present transference situation) was wondering whether her own analyst might not also separate from his wife and marry her. In accordance with this suspicion but taking care not to suggest anything, the analyst asked whether she was thinking anything about N's second wife. The analysand answered, laughing, 'Yes, I was wondering whether she was not one of his patients.' Analysis of the analyst's psychological situation showed that his 'spontaneous thought' was possible because his identification with the patient in her oedipal desires was not blocked by repression, and also because he himself countertransferred his own positive oedipal impulses, accepted by his conscious, upon the patient.

This example shows how, in the analyst's 'spontaneous thoughts'—which enable him to attain a deeper understanding—there intervenes not only the sublimated positive countertransference that permits his identification with the id and the ego of the patient but also the (apparently absent) 'complementary countertransference'—that is, his identification with the internal objects that the patient transfers and the acceptance in

his conscious of his own infantile object relations with the patient.

(2) In the following example the 'spontaneous thoughts', which are manifestly dependent upon the countertransference situation, constitute the guide to understanding.

A woman candidate associated about a scientific meeting at the Psychoanalytic Institute, the first she had attended. While she was associating, it occurred to the analyst that he, unlike most of the other training analysts, did not participate in the discussion. He felt somewhat vexed, thinking that the analysand must have noticed this, and perceiving in himself some fear that she consequently regarded him as inferior. He realized that he would prefer her not to think this and not to mention the occurrence; for this very reason, he pointed out to the analysand that she was rejecting thoughts concerning him in relation to the meeting. The analysand's reaction shows the importance of this interpretation. She exclaimed in surprise: 'Of course, I almost forgot to tell you.' She then produced many associations related to transference which she had previously rejected for reasons corresponding to the countertransference rejection of these same ideas by the analyst. The example showed the importance of observation of countertransference as a technical tool; it also showed a relation between a transference resistance and a countertransference resistance.

(3) On shaking hands at the beginning of the session the analyst, noticing that the patient was depressed, experienced a slight sense of guilt. The analyst at once thought of the last session, in which he frustrated the patient. He knew where the depression came from, even before the patient's associations led him to the same conclusion. Observation of the countertransference ideas, *before* and *after* the sessions, may also be an important guide for the analyst in understanding the patient's analytic situation. For instance, if a feeling of annoyance before entering the consulting-room is a countertransference response to the patient's aggressive or domineering behaviour, the annoyance may enable the analyst to understand beforehand the patient's anxiety which, at the most superficial layer, is fear of the analyst's anger provoked by the patient's behaviour. Another instance occurs in the analyst who, before entering his consulting-room, perceived a feeling of guilt over being late; he realized that he often kept this patient waiting and that it was the patient's pronounced masochistic submission that especially prompted him to this frustrating behaviour. In other words,

the analyst responded to the strong repression of aggression in the patient by doing what he pleased and abusing the patient's neurosis. But this very temptation that the analyst felt and yielded to in his behaviour, and the fleeting guilt-feelings he experienced for this reason, could serve as a guide for him to comprehend the analysand's transference situation.

(4) The following example from analytic literature likewise shows how the countertransference situation makes it possible to understand the patient's analytic situation in a way decisive for the whole subsequent course of the treatment. It is interesting to remark that the author seems unaware that the fortunate understanding is due to an unconscious grasp of the countertransference situation. I refer to the 'case with manifest inferiority feelings' published by Wilhelm Reich (1933). After showing how, for a long period, no interpretation achieved any success or any modification of the patient's analytic situation, Reich writes:

> I then interpreted to him his inferiority feelings towards me; at first this was unsuccessful but after I had persistently shown him his conduct for several days, he presented some communications referring to his tremendous envy not of me but of other men, to whom he also felt inferior. And then there emerged in me, like a lightning flash, the idea that his repeated complaints could mean only this: 'The analysis has no effect upon me—it is no good, the analyst is inferior and impotent and can achieve nothing with me.' The complaints were to be understood partly as triumph and partly as reproaches to the analyst.

If we inquire into the origin of Reich's 'lightning idea', the reply must be, theoretically, that it arose from identification with those impulses in the analysand or from identification with one of his internal objects. The description of the event, however, leaves little room for doubt that the latter, the 'complementary countertransference', was the source of Reich's intuition—that this lightning understanding arose from his own feeling of impotence, defeat, and guilt over the failure of treatment.

(5) Now a case in which repression of the countertransference prevented the analyst from understanding the transference situation, while his later becoming conscious of the countertransference was precisely what brought this understanding.

For several days a patient had suffered from intense anxiety

and stomach-ache. The analyst did not understand the situation until she asked the patient when it first began. He answered that it went back to a moment when he bitterly criticized her for certain behaviour, and added that he had noticed that she had been rather depressed of late. What the patient said hit the nail on the head. The analyst had in truth felt somewhat depressed because of this aggression in the patient. But she had repressed her aggression against the patient that underlay her depression and had repressed awareness that the patient would also think, consciously or unconsciously, of the effect of his criticism. The patient was conscious of this and therefore connected his own anxieties and symptoms with the analyst's depression. In other words, the analyst scotomatized the connexion between the patient's anxiety and pain and the aggression (criticism) perpetrated against her. This scotomatization of the transference situation was due to repression of the countertransference, for the aggression that the patient suspected in the analyst, and to which he responded with anxiety and gastric pains (self-aggression in anticipation), existed not only in his fantasy but also in the analyst's actual countertransference feelings.

The danger of the countertransference being repressed is naturally the greater the more these countertransference reactions are rejected by the ego ideal or the superego. To take, for instance, the case of a patient with an almost complete lack of 'respect' for the analyst: it may happen that the analyst's narcissism is wounded and he reacts inwardly with some degree of annoyance. If he represses this annoyance because it ill accords with the demands of his ego ideal, he deprives himself of an important guide in understanding the patient's transference; for the patient seeks to deny the distance between his internal (idealized) objects and his ego by means of his manic mechanisms, trying to compensate his inferiority feelings by behaviour 'as between equals' (in reality inverting this situation with the idealized objects by identification with them) and defending himself in this way against conflict situations of the greatest importance. In like manner, sexual excitement in the analyst may point to hidden seductive behaviour and erotomanic fantasies in the analysand as well as to the situations underlying these. Repression of such countertransference reactions may prevent access to the appropriate technique. What is advisable, for instance, when the patient exhibits this sort of hypomanic behaviour is not merely analytic 'tolerance' (which may be intensified by guilt-feeling over the countertransference reactions),

but, as the first step, making the patient conscious of the countertransference reactions of his *own* internal objects, such as the superego. For just as the analyst reacted with annoyance to the almost total 'lack of respect' in the patient, so also do the patient's internal objects; for in the patient's behaviour there is aggressiveness against these internal objects which the patient once experienced as superior and as rejecting. In more general terms, I should say that patients with certain hypomanic defences tend to regard their conduct as 'natural' and 'spontaneous' and the analyst as 'tolerant' and 'understanding', repressing at the same time the rejecting and intolerant objects latently projected upon the analyst. If the analyst does not repress his deeper reactions to the analysand's associations and behaviour, they will afford him an excellent guide for showing the patient these same repressed objects of his and the relationship in which he stands towards them.

(6) In analysis we must take into account the *total* countertransference as well as the total transference. I refer, in particular, to the importance of paying attention not only to what has existed and is repeated but also to what has never existed (or has existed only as a hope), that is to say, to the new and specifically analytic factors in the situations of analysand and analyst. Outstanding among these are the real new characteristics of this object (of analyst or of analysand), the patient-doctor situation (the intention to be cured or to cure, to be restored or to restore), and the situation created by psycho-analytic thought and feeling (as, for instance, the situation created by the fundamental rule, that original permission and invitation, the basic expression of a specific atmosphere of tolerance and freedom).

Let us illustrate briefly what is meant by 'total transference'. During a psycho-analytic session, the associations of a man, under treatment by a woman analyst, concerned his relations with women. He told of the frustrations and rejection he had endured, and his inability to form relationships with women of culture. There appeared sadistic and debasing tendencies towards women. It was clear that the patient was transferring his frustrating and rejecting imagos upon the analyst, and from these had arisen his mistrust of her. The patient was actually expressing both his fear of being rejected by the analyst on account of his sadism (deeper: his fear of destroying her and of her retaliation) and, at bottom, his fear of being frustrated by her —a situation that in the distant past gave rise to this sadism. Such an interpretation would be a faithful reflection of the

transference situation properly speaking. But in the total analytic situation there is something more. Evidently the patient needed and was seeking something through the session as such. What was it? What was this specific present factor, what was this prospective aspect, so to speak, of the transference situation? The answer is virtually contained in the interpretation given above: the analysand was seeking to connect himself with an object emotionally and libidinally, the previous sessions having awakened his feelings and somewhat disrupted his armour; indirectly he was asking the analyst whether he might indeed place his trust in her, whether he might surrender himself without running the risk of suffering what he had suffered before. The first interpretation referred to the transference only as a repetition of what had once existed; the latter, more complete, interpretation referred to what has existed and also to what has never existed and was hoped for from the analytic experience.

Now let us study an example that refers to both the total transference and total countertransference situations. The illustration is once again drawn from Wilhelm Reich (1933). The analysis had long centred on the patient's smile, the sole analysable expression, according to Reich, that remained after cessation of all the communications and actions with which he had begun treatment. Among these actions at the start had been some that Reich interpreted as provocations (for instance, a gesture aimed at the analyst's head). It is plain that Reich was guided in this interpretation by what he had felt in countertransference. But what Reich perceived in this way was only a part of what had happened within him; for apart from the fright and annoyance (which, even if only to a slight degree, he must have felt), there was a reaction of his ego to these feelings, a wish to control and dominate them, imposed by his 'analytic conscience'. For Reich had given the analysand to understand that there is a great deal of freedom and tolerance in the analytic situation and it was this spirit of tolerance that made Reich respond to these 'provocations' with nothing but an interpretation. What the analysand aimed at doing was to test whether such tolerance really existed in the analyst. Reich himself later gave him this interpretation, and this interpretation had a far more positive effect than the first. Consideration of the total countertransference situation (the feeling of being provoked, *and* the 'analytic conscience' which determined the fate of this feeling) might have been from the first a guide in apprehending the total transference situation, which consisted in

aggressiveness, in the original mistrust, *and* in the ray of confidence, the new hope which the liberality of the fundamental rule had awakened in him.

(7) I have referred above to the fact that the transference, insofar as it is determined by the infantile situations and archaic objects of the patient, provokes in the unconscious of the analyst infantile situations and an intensified vibration of archaic objects of his own. I wish now to present another example that shows how the analyst, if not conscious of such countertransference responses, may make the patient feel exposed once again to an archaic object (the vicious circle) and how, in spite of his having some understanding of what is happening in the patient, the analyst is prevented from giving an adequate interpretation.

During her first analytic session, a woman patient talked about how hot it was and other matters which to the analyst (a woman candidate) seemed insignificant. She said to the patient that very likely the patient dared not talk about herself. Although the analysand was indeed talking about herself (even when saying how hot it was), the interpretation was, in essence, correct, for it was directed to the central conflict of the moment. But it was badly formulated, and this was so partly because of the countertransference situation. For the analyst's 'you dare not' was a criticism, and it sprang from the analyst's feeling of being frustrated in her desire for the patient to overcome her resistance. If the analyst had not felt this irritation or if she had been conscious of the neurotic nature of her internal reaction of anxiety and annoyance, she would have sought to understand why the patient 'dared not' and would have told her. In that case the lack of courage that the analyst pointed out to the patient would have proved to be a natural response within a dangerous object relationship.

Pursuing the analyst's line of thought and leaving aside other possible interpretations, we may suppose that she would then have said to the analysand that something in the analytic situation (in the relationship between patient and analyst) had caused her fear and made her thoughts turn aside from what meant much to her to what meant little. This interpretation would have differed from the one she gave the patient in two points: first, the interpretation given did not express the object relationship that led to the 'not daring' and, second, it coincided in its formulation with superego judgements, which should be avoided as far as possible.[1] Superego judgement was not avoided

[1] If the interpretations coincide with the analysand's superego judgements, the analyst is confused with the superego, sometimes with good reason. Superego judgements must be shown to the analysand but, as far as possible, should not be stated specifically.

in this case because the analyst was identified in countertransference with the analysand's superego without being conscious of the identification; had she been conscious of it, she would have interpreted, for example, the feared aggression from the superego (projected upon the analyst) and would not have carried it out by means of the interpretation. It appears that the 'interpretation of tendencies' without the consideration of the total object relationship is to be traced, among other causes, to repression by the analyst of one aspect of his countertransference, his identification with the analysand's internal objects.

Later in the same session, the patient, feeling that she was being criticized, censured herself for her habit of speaking rather incoherently. She said her mother often remarked upon it, and then criticized her mother for not listening, as a rule, to what she said. The analyst understood that these statements related to the analytic situation and asked her: 'Why do you think I'm not listening to you?' The patient replied that she was sure the analyst was listening to her.

What has happened? The patient's mistrust has clashed with the analyst's desire for the patient's confidence; therefore the analyst did not analyse the situation. She could not say to the patient, 'No, I will listen to you, trust me', but she suggested it with her question. Once again interference by the uncontrolled countertransference (the desire that the patient should have no resistance) converted good understanding into a deficient interpretation. Such happenings are important, especially if they occur often. And they are likely to do so, for such interpretations spring from a certain state of the analyst and this state is partly unconscious. What makes these happenings so important is the fact that the analysand's unconscious is fully aware of the analyst's unconscious desires. Therefore the patient once again faces an object which, as in this case, wishes to force or lure the patient into rejecting his mistrust and unconsciously seeks to satisfy its own desires or allay its own anxieties rather than to understand and satisfy the therapeutic need of the patient.

All this we infer from the reactions of the patient, who submitted to the analyst's suggestion, telling the analyst that she trusted her and so denying an aspect of her internal reality. She submits to the previous criticism of her cowardice and then,

apparently, 'overcomes' the resistance, while in reality everything is going on unchanged. It cannot be otherwise, for the analysand is aware of the analyst's neurotic wish and her transference is determined by that awareness. To a certain degree, the analysand finds herself once again, in the actual analytic situation, confronting her internal or external infantile reality and to this same degree will repeat her old defences and will have no valid reason for really overcoming her resistances, however much the analyst may try to convince her of her tolerance and understanding. This she will achieve only by offering better interpretations in which her neurosis does not so greatly interfere.

(8) The following more detailed example demonstrates: (*a*) the talion law in the relationship of analyst and analysand; (*b*) how awareness of the countertransference reaction indicates what is happening in the transference and what at the moment is of the greatest significance; (*c*) what interpretation is most suitable for making a breach in the vicious circle; and (*d*) how the later associations show that this end has been achieved, even if only in part—for the same defences return and once again the countertransference points out the interpretation the analysand needs.

We will consider the most important occurrences in one session. An analysand who suffered chiefly from an intense emotional inhibition and from a 'disconnexion' in all his object relationships began the session by saying that he felt completely disconnected from the analyst. He spoke with difficulty as if he were overcoming a great resistance, and always in an unchanging tone of voice which seemed in no way to reflect his instincts and feelings. Yet the countertransference response to the content of his associations (or, rather, of his narrative, for he exercised a rigid control over his ideas) did change from time to time. At a certain point the analyst felt a slight irritation. This was when the patient, a physician, told him how, in conversation with another physician, he sharply criticized analysts for their passivity (they give little and cure little), for their high fees, and for their tendency to dominate their patients. The patient's statements and his behaviour meant several things. It was clear, in the first place, that these accusations, though couched in general terms and with reference to other analysts, were directed against his own analyst; the patient had become the analyst's superego. This situation in the patient represented a defence against his own accusing superego, projected upon

the analyst. It is a form of identification with the internal persecutors that leads to inversion of the feared situation. It is, in other words, a transitory 'mania for reproaching' as defence against a paranoid-depressive situation in which the superego persecutes the patient with reproaches and threatens him with abandonment. Together with this identification with the superego, there occurs projection of a part of the 'bad ego', and of the id, upon the analyst. The passivity (the mere receptiveness, the inability to make reparation), the selfish exploitation, and the domination he ascribes to the analyst are 'bad tendencies' of his own for which he fears reproach and abandonment by the analyst. At a lower stratum, this 'bad ego' consists of 'bad objects' with which the patient had identified himself as a defence against their persecution.

We already see that it would be premature to interpret this deeper situation; the patient will first have to face his 'bad ego': he will have to pass in transference through the paranoid-depressive situation in which he felt threatened by the superego-analyst. But even so we are still unsure of the interpretation to be given, for what the patient said and did has even at the surface still further meanings. The criticism he made to the other physician about analysts had the significance of rebellion, vengeance, and provocation; and, perhaps, of seeking for punishment as well as of finding out how much freedom the analyst allowed, and simultaneously of subjugating and controlling this dangerous object, the analyst.

The analyst's countertransference reaction made clear to the analyst which of all these interpretations was most strongly indicated, for the countertransference reaction was the living response to the transference situation at that moment. The analyst felt (in accordance with the law of talion) a little anxious and angry at the aggression he suffered from the patient, and we may suppose that the patient in his unconscious or conscious fantasy sensed this annoyance in the internal object towards which his protesting behaviour was directed, and that he reacted to this annoyance with anxiety. The 'disconnexion' he spoke of in his first utterance must have been in relation to this anxiety, since it was because of this 'disconnexion' that the analysand perceived no danger and felt no anxiety. By the patient's projection of that internal object the analyst is to the patient a tyrant who demands complete submission and forbids any protest. The transgression of this prohibition (the patient's protest expressed to his friend, the physician) must seem to the analyst

—in the patient's fantasy—to be unfaithfulness, and must be responded to by the analyst with anger and emotional abandonment; we deduce this from the countertransference experience. In order to reconcile the analyst and to win him back, the patient accepted his anger or punishment and suffered from stomach-ache—this he tells in his associations but without connecting the two experiences. His depression on this day was to be explained by this guilt-feeling and, secondarily, by the object loss resulting from his increased 'disconnexion'.

The analyst explained, in his interpretation, the meaning of the 'disconnexion'. In reply the patient said that the previous day he recalled his conversation with that physician and that it did indeed cause him anxiety. After a brief pause he added: 'and just now the thought came to me, well . . . and what am I to do with that?' The analyst perceived that these words once again slightly annoyed him. We can understand why. The patient's first reaction to the interpretation (he reacted by recalling his anxiety over his protest) had brought the analyst nearer to satisfying his desire to remove the patient's detachment. The patient's recollection of his anxiety had been at least one forward step, for he thus admitted a connexion that he usually denied or repressed. But his next words frustrated the analyst once again, for they signified: 'that is of no use to me, nothing has changed'. Once again the countertransference reaction pointed out to the analyst the occurrence of a critical moment in the transference, and that here was the opportunity to interpret. At this moment also, in the patient's unconscious fantasy, must have occurred a reaction of anger from the internal object—just as actually happened in the analyst—to which the interpretation must be aimed. The patient's anxiety must have arisen from just this fantasy. His anxiety—and with it his detachment—could be diminished only by replacing that fantasied anger by an understanding of the patient's need to defend himself through that denial ('well . . . what am I to do with that?'). In reality the analyst, besides feeling annoyed, had understood that the patient had to protest and rebel, close himself up and 'disconnect' himself once again, deny and prevent any influence, because if the analyst should prove to be useful the patient would fall into intense dependence, just because of this usefulness and because the patient would be indebted to him. The interpretation increased this danger, for the patient felt it to be true. Because of the analyst's tyranny—his dominating, exploiting, sadistic character—this dependence had to be prevented.

The analyst by awareness of his countertransference understood the patient's anxiety and interpreted it to him. The following associations showed that this interpretation had also been accurate.

The patient said shortly afterwards that his depression had passed off, and this admission was a sign of progress because the patient was admitting that there was something good about the analyst. The next associations, moreover, permitted a more profound analysis of his transference neurosis, for the patient now revealed a deeper stratum. His underlying dependence became clear. Hitherto the interpretation had been confined to the guilt-feelings and anxiety that accompanied his defences (rebellion, denial, and others) against this very dependence. The associations referred to the fact that a mutual friend of the patient and of the analyst had a few days before told him that the analyst was going away on holiday that night and that this session would therefore be his last. In this way the patient admitted the emotional importance the analyst possessed for him, a thing he had always denied. We understand now also that his protest against analysts had been determined beforehand by the imminent danger of being forsaken by his analyst. When, just before the end of the session, the analyst explained that the information the friend gave him was false, the patient expressed anger with his friend and recalled how the friend had been trying lately to make him jealous of the analyst. Thus does the patient admit his jealousy of the analyst, although he displaces his anger onto the friend who roused his anxiety.

What had happened? And how was it to be explained?

The analyst's expected journey represented, in the unconscious of the patient, abandonment by internal objects necessary to him. This danger was countered by an identification with the aggressor; the threat of aggression (abandonment by the analyst) was countered by aggression (the patient's protest against analysts). His own aggression caused the patient to fear counter-aggression or abandonment by the analyst. This anxiety remained unconscious but the analyst was able to deduce it from the counter-aggression he perceived in his countertransference. If he had not interpreted the patient's transference situation, or if in his interpretation he had included any criticism of the patient's insistent and continuous rejection of the analyst or of his obstinate denial of any bond with the analyst, the patient would have remained in the vicious circle between his basic fear of abandonment and his defensive identification with

the persecutor (with the object that abandons); he would have continued in the vicious circle of his neurosis. But the interpretation, which showed him the analyst's understanding of his conduct and of the underlying anxiety, changed (at least for that moment) the image of the analyst as persecutor. Hence the patient could give up his defensive identification with this image and could admit his dependence (the underlying stratum), his need for the analyst, and his jealousy.

And now once again in this new situation countertransference will show the content and origin of the anxiety that swiftly drives the analysand back to repetition of the defence mechanism he had just abandoned (which may be identification with the persecutor, emotional blocking, or something else). And once again interpretation of this new danger is the only means of breaking the vicious circle. If we consider the nature of the relationship that existed for months before the emotional surrender that occurred in this session, if we consider the paranoid situation that existed in the transference and countertransference (expressed in the patient by his intense characterological resistances and in the analyst by his annoyance), if we consider all this background to the session just described, we understand that the analyst enjoys, in the patient's surrender, a manic triumph, to be followed of course by depressive and paranoid anxieties, compassion towards the patient, desires for reparation, and other sequelae. It is just these guilt-feelings caused in the analyst by his manic feelings that may lead to his failure adequately to interpret the situation. The danger the patient fears is that he will become a helpless victim of the object's (the analyst's) sadism—of that same sadism the analyst senses in his 'manic' satisfaction over dominating and defeating the bad object with which the patient was defensively identified. The perception of this 'manic' countertransference reaction indicates what the present transference situation is and what should be interpreted.

If there were nothing else in the analyst's psychological situation but this manic reaction, the patient would have no alternative but to make use of the same old defence mechanisms that essentially constituted his neurosis. In more general terms, we should have to admit that the negative therapeutic reaction is an adequate transference reaction in the patient to an imagined or real negative countertransference in the analyst (Little, 1951). But even where such a negative countertransference really exists, it is a part only of the analyst's psychological

response. For the law of talion is not the sole determinant of the responses of the unconscious; and, moreover, the conscious also plays a part in the analyst's psychological responses. As to the unconscious, there is of course a tendency to repair, which may even create a disposition to 'return good for evil'. This tendency to repair is in reality a wish to remedy, albeit upon a displaced object, whatever evil one may have thought or done. And as to the conscious, there is, first, the fact that the analyst's own analysis has made his ego stronger than it was before so that the intensities of his anxieties and his further countertransference reactions are usually diminished; second, the analyst has some capacity to observe this countertransference, to 'get out of it', to stand outside and regard it objectively; and third, the analyst's knowledge of psychology also acts within and upon his psychological response. The knowledge, for instance, that behind the negative transference and the resistances lies simply thwarted love, helps the analyst to respond with love to this possibility of loving, to this nucleus in the patient however deeply it be buried beneath hate and fear.

(9) The analyst should avoid, as far as possible, making interpretations in terms that coincide with those of the moral superego.[1] This danger is increased by the unconscious identification of the analyst with the patient's internal objects and, in particular, with his superego. In the example just cited, the patient, in conversation with his friend, criticized the conduct of analysts. In so doing he assumed the role of superego towards an internal object which he projected upon the analyst. The analyst identified himself with this projected object and reacted with unconscious anxiety and with annoyance to the accusation. He inwardly reproached the patient for his conduct and there was danger that something of this reproach (in which the analyst in his turn identified himself with the conduct of the patient as superego) might filter into his interpretation, which would then perpetuate the patient's neurotic vicious circle. But the problem is wider than this. Certain psycho-analytic terminology is likely to re-enforce the patient's confusion of the analyst with the superego. For instance 'narcissism', 'passivity', and 'bribery of the superego' are terms we should not use literally or in paraphrase in treatment without careful reflection, just because they increase the danger that the patient will confuse the imago of the analyst with that of his superego. For greater

[1] Something similar, although not connected with countertransference, is emphasized by Fairbairn (1943).

clarity two situations may be differentiated theoretically. In one, only the patient experiences these or like terms as criticism, because of his conflict between ego and superego, and the analyst is free of this critical feeling. In the other, the analyst also regards certain character traits with moral intolerance; he feels censorious, as if he were indeed a superego. Something of this attitude probably always exists, for the analyst identifies himself with the objects that the patient 'mistreats' (by his 'narcissism', or 'passivity', or 'bribery of the superego'). But even if the analyst had totally solved his own struggles against these same tendencies and hence remained free from countertransference conflict with the corresponding tendencies in the patient, it would be preferable to point out to the patient the several conflicts between his tendencies and his superego, and not run the risk of making it more difficult for the patient to differentiate between the judgement of his own superego and the analyst's comprehension of these same tendencies through the use of a terminology that precisely lends itself to confusing these two positions.

One might object that this confusion between the analyst and the superego neither can nor should be avoided, since it represents an essential part of the analysis of transference (of the externalization of internal situations) and since one cannot attain clarity except through confusion. That is true; this confusion cannot and should not be avoided, but we must remember that the confusion will also have to be resolved and that this will be all the more difficult the more the analyst is really identified in his experience with the analysand's superego and the more these identifications have influenced negatively his interpretations and conduct.

VI

In the examples presented we saw how to certain transference situations there correspond certain countertransference situations, and *vice versa*. To what transference situation does the analyst usually react with a particular countertransference? Study of this question would enable one, in practice, to deduce the transference situations from the countertransference reactions. Next we might ask, to what imago or conduct of the object, to what imagined or real countertransference situation, does the patient respond with a particular transference? Many aspects of these problems have been amply studied by psycho-analysts, but the specific problem of the relation of trans-

ference and countertransference in analysis has received little attention.

The subject is so broad that we can discuss only a few situations and those incompletely, restricting ourselves to certain aspects. We must choose for discussion only the most important countertransference situations, those that most disturb the analyst's task and that clarify important points in the double neurosis, *la névrose à deux*, that arises in the analytic situation—a neurosis usually of very different intensity in the two participants.

(1) What is the significance of countertransference anxiety?

Countertransference anxiety may be described in general and simplified terms as being of depressive or paranoid character.[1] In depressive anxiety the inherent danger consists in having destroyed the analysand or made him ill. This anxiety may arise to a greater degree when the analyst faces the danger that the patient may commit suicide, and to a lesser degree when there is deterioration or danger of deterioration in the patient's state of health. But the patient's simple failure to improve and his suffering and depression may also provoke depressive anxieties in the analyst. These anxieties usually increase the desire to heal the patient.

In referring to paranoid anxieties it is important to differentiate between 'direct' and 'indirect' countertransference (Chapter 5). In direct countertransference the anxieties are caused by danger of an intensification of aggression from the patient himself. In indirect countertransference the anxieties are caused by danger of aggression from third parties onto whom the analyst has made his own chief transferences—for instance, the members of the analytic society, for the future of the analyst's object relationships with the society is in part determined by his professional performance. The feared aggression may take several forms, such as criticism, reproach, hatred, mockery, contempt, or bodily assault. In the unconscious it may be the danger of being killed or castrated or otherwise menaced in an archaic way.

The transference situations of the patient to which the depressive anxieties of the analyst are a response are, above all, those

[1] See Klein (1935, 1950). The terms 'depressive', 'paranoid', and 'manic' are here used simply as descriptive terms. Thus, for example, 'paranoid anxieties' involve all the fantasies of being persecuted, independently of the libidinal phase or of the 'position' described by Klein. The following considerations are closely connected with my observations on psychopathological stratification (1957).

in which the patient, through an increase in frustration[1] (or danger of frustration) and in the aggression that it evokes, turns the aggression against himself. We are dealing, on one plane, with situations in which the patient defends himself against a paranoid fear of retaliation by anticipating this danger, by carrying out himself and against himself part of the aggression feared from the object transferred onto the analyst, and threatening to carry it out still further. In this psychological sense it is really the analyst who attacks and destroys the patient; and the analyst's depressive anxiety corresponds to this psychological reality. In other words, the countertransference depressive anxiety arises, above all, as a response to the patient's 'masochistic defence'—which at the same time represents a revenge ('masochistic revenge')—and as a response to the danger of its continuing. On another plane this turning of the aggression against himself is carried out by the patient because of his own depressive anxieties; he turns it against himself in order to protect himself against re-experiencing the destruction of the objects and to protect these from his own aggression.

The paranoid anxiety in 'direct' countertransference is a reaction to the danger arising from various aggressive attitudes of the patient himself. The analysis of these attitudes shows that they are themselves defences against, or reactions to, certain aggressive imagos; and these reactions and defences are governed by the law of talion or else, analogously to this, by identification with the persecutor. The reproach, contempt, abandonment, bodily assault—all these attitudes of menace or aggression in the patient that give rise to countertransference paranoid anxieties—are responses to (or anticipations of) equivalent attitudes of the transferred object.

The paranoid anxieties in 'indirect' countertransference are of a more complex nature since the danger for the analyst originates in a third party. The patient's transference situations that provoke the aggression of this 'third party' against the analyst may be of various sorts. In most cases, we are dealing with transference situations (masochistic or aggressive) similar to those that provoke the 'direct' countertransference anxieties previously described.

The common denominator of all the various attitudes of

[1] By the term 'frustration' I always refer to the subjective experience and not to the objective facts. This inner experience is determined by a complementary series at one end of which is primary and secondary masochism and at the other end the actual frustrating happenings.

patients that provoke anxiety in the analyst is to be found, I believe, in the mechanism of 'identification with the persecutor'; the experience of being liberated from the persecutor and of triumphing over him, implied in this identification, suggests our designating this mechanism as a manic one. This mechanism may also exist where the manifest picture in the patient is quite the opposite, namely in certain depressive states; for the manic conduct may be directed either towards a projected object or towards an introjected object, it may be carried out alloplastically or autoplastically. The 'identification with the persecutor' may even exist in suicide, inasmuch as this is a 'mockery' of the fantasied or real persecutors, by anticipating the intentions of the persecutors and by one doing to oneself what they wanted to do; this 'mockery' is the manic aspect of suicide. The 'identification with the persecutor' in the patient is, then, a defence against an object felt as sadistic that tends to make the patient the victim of a manic feast; and this defence is carried out either through the introjection of the persecutor in the ego, turning the analyst into the object of the 'manic tendencies', or through the introjection of the persecutor in the superego, taking the ego as the object of its manic trend. Let us illustrate.

An analysand decides to take a pleasure trip to Europe. He experiences this as a victory over the analyst both because he will free himself from the analyst for two months and because he can afford this trip whereas the analyst cannot. He then begins to be anxious lest the analyst seek revenge for the patient's triumph. The patient anticipates this aggression by becoming unwell, developing fever and the first symptoms of influenza. The analyst feels slight anxiety because of this illness and fears, recalling certain previous experiences, a deterioration in the state of health of the patient, who still however continues to come to the sessions. Up to this point, the situation in the transference and countertransference is as follows. The patient is in a manic relation to the analyst, and he has anxieties of preponderantly paranoid type. The analyst senses some irritation over the abandonment and some envy of the patient's great wealth (feelings ascribed by the patient in his paranoid anxieties to the analyst); but at the same time the analyst feels satisfaction at the analysand's real progress which finds expression in the very fact that the trip is possible and that the patient has decided to make it. The analyst perceives a wish in part of his personality to bind the patient to himself and use the patient for

his own needs. In having this wish he resembles the patient's mother, and he is aware that he is in reality identified with the domineering and vindicative object with which the patient identifies him. Hence the patient's illness seems, to the analyst's unconscious, a result of the analyst's own wish, and the analyst therefore experiences depressive (and paranoid) anxieties.

What object-imago leads the patient to this manic situation? It is precisely this same imago of a tyrannical and sadistic mother, to whom the patient's frustrations constitute a manic feast. It is against these 'manic tendencies' in the object that the patient defends himself, first by identification (introjection of the persecutor in the ego, which manifests itself in the manic experience in his decision to take a trip) and then by using a masochistic defence to escape vengeance.

In brief, the analyst's depressive (and paranoid) anxiety is his emotional response to the patient's illness; and the patient's illness is itself a masochistic defence against the object's vindictive persecution. This masochistic defence also contains a manic mechanism in that it derides, controls, and dominates the analyst's aggression. In the stratum underlying this we find the patient in a paranoid situation in face of the vindictive persecution by the analyst—a fantasy which coincides with the analyst's secret irritation. Beneath this paranoid situation, and causing it, is an inverse situation: the patient is enjoying a manic triumph (his liberation from the analyst by going on a trip), but the analyst is in a paranoid situation (he is in danger of being defeated and abandoned). And, finally, beneath this we find a situation in which the patient is subjected to an object-imago that wants to make of him the victim of its aggressive tendencies, but this time not in order to take revenge for intentions or attitudes in the patient, but merely to satisfy its own sadism—an imago that originates directly from the original sufferings of the subject.

In this way, the analyst was able to deduce from each of his countertransference sensations a certain transference situation; the analyst's fear of deterioration in the patient's health enabled him to perceive the patient's need to satisfy the avenger and to control and restrain him, partially inverting (through the illness) the roles of victimizer and victim, thus alleviating his guilt-feeling and causing the analyst to feel some of the guilt. The analyst's irritation over the patient's trip enabled him to see the patient's need to free himself from a dominating and sadistic object, to see the patient's guilt-feelings caused by these tend-

encies, and also to see his fear of the analyst's revenge. By his feeling of triumph the analyst was able to detect the anxiety and depression caused in the patient by his dependence upon this frustrating, yet indispensable, object. And each of these transference situations indicated to the analyst the patient's object-imagos—the fantasied or real countertransference situations that determined the transference situations.

(2) What is the meaning of countertransference aggression?

In the preceding pages, we have seen that the analyst may experience, besides countertransference anxiety, annoyance, rejection, desire for vengeance, hatred, and other emotions. What are the origin and meaning of these emotions?

Countertransference aggression usually arises in the face of frustration (or danger of frustration) of desires which may superficially be differentiated into 'direct' and 'indirect'. Both direct and indirect desires are principally wishes to get libido or affection. The patient is the chief object of direct desires in the analyst, who wishes to be accepted and loved by him. The object of the indirect desires of the analyst may be, for example, other analysts from whom he wishes to get recognition or admiration through his successful work with his patients, using the latter as means to this end (Chapter 5). This aim to get love has, in general terms, two origins: an instinctual origin (the primitive need of union with the object) and an origin of a defensive nature (the need of neutralizing, overcoming, or denying the rejections and other dangers originating from the internal objects, in particular from the superego). The frustrations may be differentiated, descriptively, into those of active type and those of passive type. Among the active frustrations is direct aggression by the patient, his mockery, deceit, and active rejection. To the analyst, active frustration means exposure to a predominantly 'bad' object; the patient may become, for example, the analyst's superego which says to him 'you are bad'. Examples of frustration of passive type are passive rejection, withdrawal, partial abandonment, and other defences against the bond with and dependence on the analyst. These signify frustrations of the analyst's need of union with the object.

In summary, we may say that countertransference aggression usually arises when there is frustration of the analyst's desires that spring from Eros, both those arising from his 'original' instinctive and affective drives and those arising from his need of neutralizing or annulling his own Thanatos (or the action of his internal 'bad objects') directed against the ego or against the

external world. Owing partly to the analyst's own neurosis (and also to certain characteristics of analysis itself) these desires of Eros sometimes acquire the unconscious aim of bringing the patient to a state of dependence. Hence countertransference aggression may be provoked by the rejection of this dependence by the patient who rejects any bond with the analyst and refuses to surrender to him, showing this refusal by silence, denial, secretiveness, repression, blocking, or mockery.

Next we must establish what it is that induces the patient to behave in this way, to frustrate the analyst, to withdraw from him, to attack him. If we know this we shall know what we have to interpret when countertransference aggression arises in us, being able to deduce from the countertransference the transference situation and its cause. This cause is a fantasied countertransference situation, or, more precisely, some actual or feared bad conduct from the projected object. Experience shows that, in somewhat general terms, this bad or threatening conduct of the object is usually an equivalent of the conduct of the patient (to which the analyst has reacted internally with aggression). We also understand why this is so: the patient's conduct springs from that most primitive of reactions, the talion reaction, or from the defence by means of identification with the persecutor or aggressor. In some cases it is quite simple: the analysand withdraws from us, rejects us, abandons us, or derides us when he fears or suffers the same or an equivalent treatment from us. In other cases it is more complex, the immediate identification with the aggressor being replaced by another identification that is less direct. To exemplify: a woman patient, upon learning that the analyst is going on holiday, remains silent a long while; she withdraws, through her silence, as a talion response to the analyst's withdrawal. Deeper analysis shows that the analyst's holiday is, to the patient, equivalent to the primal scene; and this is equivalent to destruction of her as a woman, and her immediate response must be a similar attack against the analyst. This aggressive (castrating) impulse is rejected and the result, her silence, is a compromise between her hostility and its rejection; it is a transformed identification with the persecutor.

To sum up:

(*a*) The countertransference reactions of aggression (or of its equivalent) occur in response to transference situations in which the patient frustrates certain desires of the analyst. These frustrations are equivalent to abandonment or aggression which the patient carries out or with which he threatens the analyst,

and they place the analyst, at first, in a depressive or paranoid situation. The patient's defence is in one aspect equivalent to a manic situation, for he is freeing himself from a persecutor.[1]

(*b*) This transference situation is the defence against certain object-imagos. There may be an object that persecutes the subject sadistically, vindictively, or morally, or an object that the patient defends from his own destructiveness by an attack against his own ego (Racker, 1957); in these, the patient attacks —as Freud and Abraham have shown in the analysis of melancholia and suicide—at the same time the internal object and the external object (the analyst).

(*c*) The analyst who is placed by the alloplastic or autoplastic attacks of the patient in a paranoid or depressive situation sometimes defends himself against these attacks by using the same identification with the aggressor or persecutor as the patient used. Then the analyst virtually becomes the persecutor, and to this the patient (insofar as he presupposes such a reaction from his internal and projected object) responds with anxiety. This anxiety and its origin is nearest to consciousness, and is therefore the first thing to interpret.

(3) Countertransference guilt-feelings are an important source of countertransference anxiety; the analyst fears his 'moral conscience'. Thus, for instance, a serious deterioration in the condition of the patient may cause the analyst to suffer reproach by his own superego, and also cause him to fear punishment. When such guilt-feelings occur, the superego of the analyst is usually projected upon the patient or upon a third person, the analyst being the guilty ego. The accuser is the one who is attacked, the victim of the analyst. The analyst is the accused; he is charged with being the victimizer. It is therefore the analyst who must suffer anxiety over his object, and dependence upon it.

As in other countertransference situations, the analyst's guilt-feeling may have either real causes or fantasied causes, or a mixture of the two. A real cause exists in the analyst who has neurotic negative feelings that exercise some influence over his

[1] This 'mania' may be of 'superego type', as for instance 'mania for reproaching' (identification with the persecuting moral superego) which also occurs in many depressive and masochistic states. It may also be of a 'pre-superego type' (belonging to planes underlying that of moral guilt) as occurs for instance in certain erotomanias, for erotic mockery is identification with the object that castrates by frustrating genitally (Racker, 1957).

behaviour, leading him, for example, to interpret with aggressiveness or to behave in a submissive, seductive, or unnecessarily frustrating way. But guilt-feelings may also arise in the analyst over, for instance, intense submissiveness in the patient even though the analyst had not driven the patient into such conduct by his procedure. Or he may feel guilty when the analysand becomes depressed or ill, although his therepeutic procedure was right and proper according to his own conscience. In such cases, the countertransference guilt-feelings are evoked not by what procedure he has actually used but by his awareness of what he might have done in view of his latent disposition. In other words, the analyst identifies himself in fantasy with a bad internal object of the patient and he feels guilty for what he has provoked in this role—illness, depression, masochism, suffering, failure. The imago of the patient then becomes fused with the analyst's internal objects which the analyst had, in the past, wanted (and perhaps managed) to frustrate, make suffer, dominate, or destroy. Now he wishes to repair them. When this reparation fails, he reacts as if he had hurt them. The true cause of the guilt-feelings is the neurotic, predominantly sado-masochistic tendencies that may reappear in countertransference; the analyst therefore quite rightly entertains certain doubts and uncertainties about his ability to control them completely and to keep them entirely removed from his procedure.

The transference situation to which the analyst is likely to react with guilt-feelings is then, in the first place, a masochistic trend in the patient, which may be either of a 'defensive' (secondary) or of a 'basic' (primary) nature. If it is defensive we know it to be a rejection of sadism by means of its 'turning against the ego'; the principal object-imago that imposes this masochistic defence is a retaliatory imago. If it is basic ('primary masochism') the object-imago is 'simply' sadistic, a reflex of the pains ('frustrations') originally suffered by the patient. The analyst's guilt-feelings refer to his own sadistic tendencies. He may feel as if he himself had provoked the patient's masochism. The patient is subjugated by a 'bad' object so that it seems as if the analyst had satisfied his aggressiveness; now the analyst is exposed in his turn to the accusations of his superego. In short, the superficial situation is that the patient is now the superego, and the analyst the ego who must suffer the accusation; the analyst is in a depressive-paranoid situation, whereas the patient is, from one point of view, in a 'manic' situation (showing, for example, 'mania for reproaching'). But on a deeper plane the

situation is the reverse: the analyst is in a 'manic' situation (acting as a vindictive, dominating, or 'simply' sadistic imago), and the patient is in a depressive-paranoid situation (Racker, 1957).

(4) Besides the anxiety, hatred, and guilt-feelings in countertransference, there are a number of other countertransference situations that may also be decisive points in the course of analytic treatment, both because they may influence the analyst's work and because the analysis of the transference situations that provoke such countertransference situations may represent the central problem of treatment, clarification of which may be indispensable if the analyst is to exert any therapeutic influence upon the patient.

Let us consider briefly only two of these situations. One is the countertransference boredom or somnolence already mentioned which of course assumes great importance only when it occurs often. Boredom and somnolence are usually unconscious talion responses in the analyst to a withdrawal or affective abandonment by the patient. This withdrawal has diverse origins and natures; but it has specific characteristics, for not every kind of withdrawal by the patient produces boredom in the analyst. One of these characteristics seems to be that the patient withdraws without going away, he takes his emotional departure from the analyst while yet remaining with him; there is as a rule no danger of the patient's taking flight. This *partial* withdrawal or abandonment expresses itself superficially in intellectualization (emotional blocking), in increased control, sometimes in monotony in the way of speaking, or in similar devices. The analyst has at these times the sensation of being excluded and of being impotent to guide the course of the sessions. It seems that the analysand tries in this way to avoid a latent and dreaded dependence upon the analyst. This dependence is, at the surface, his dependence upon his moral superego, and at a deeper level it is dependence upon other internal objects which are in part persecutors and in part persecuted. These objects must *not* be projected upon the analyst; the latent and internal relations with them must not be made present and externalized. This danger is avoided through various mechanisms, ranging from 'conscious' control and selection of the patient's communications to depersonalization, and from emotional blocking[1] to total repression of any transference relation; it is this rejection

[1] This emotional blocking and, in particular, the blocking of aggression seems to be the cause of the 'absence of danger' for the analyst (the fact that the analysand does not run away or otherwise jeopardize the

of such dangers and the avoidance and mastery of anxiety by means of these mechanisms that lead to the withdrawal to which the analyst may react with boredom or somnolence.

Countertransference anxiety and guilt-feelings also frequently cause a tendency to countertransference submissiveness, which is important from two points of view: both for its possible influence upon the analyst's understanding, behaviour, and technique, and for what it may teach us about the patient's transference situation. This tendency to submissiveness will lead the analyst to avoid frustrating the patient and will even cause the analyst to pamper him. The analyst's tendency to avoid frustration and tension will express itself in a search for rapid pacification of the transference situations, by prompt 'reduction' of the transference to infantile situations, for example, or by rapid reconstruction of the 'good', 'real' imago of the analyst.[1] The analyst who feels subjugated by the patient feels angry, and the patient, intuitively perceiving this anger, is afraid of his revenge. The transference situation that leads the patient to dominate and subjugate the analyst by a hidden or manifest threat seems analogous to the transference situation that leads the analyst to feel anxious and guilty. The various ways in which the analyst reacts to his anxieties—in one case with an attitude of submission, in another case with inner recrimination—is also related to the transference attitude of the patient. My observations seem to indicate that the greater the disposition to real aggressive *action* in the analysand, the more the analyst tends to submission.

VII

Before closing, let us consider briefly two questions which have yet to be answered. How much confidence should we place in countertransference as a guide to understanding the patient? And how useful or how harmful is it to communicate to the patient a countertransference reaction? As to the first question, I think it certainly a mistake to find in countertransference reactions an oracle, with blind faith to expect of them the pure truth about the psychological situations of the analysand. It is

analysis), which seems to be one of the conditions for occurrence of countertransference boredom.

[1] Wilhelm Reich (1933) stressed the frequent tendency in analysts to avoid negative transference. The countertransference situation just described is one of the situations underlying that tendency.

plain that our unconscious is a very personal 'receiver' and 'transmitter' and we must reckon with frequent distortions of objective reality. But it is also true that our unconscious is nevertheless 'the best we have of its kind'. His own analysis and some analytic experience enables the analyst, as a rule, to be conscious of this personal factor and know his 'personal equation'. According to my experience, the danger of exaggerated faith in the messages of one's own unconscious is, even when they refer to very 'personal' reactions, less than the danger of repressing them and denying them any objective value.

I have sometimes begun a supervisory hour by asking the candidate how he has felt towards the patient that week or what he has experienced during the sessions, and the candidate has answered, for instance, that he was bored, or that he felt anxious because he had the impression that the patient wanted to abandon the analysis. On other occasions I have myself noticed annoyance or anxiety in the candidate relative to the patient. These countertransference responses have at times indicated to me in advance the central problem of the treatment at whatever stage it had reached; and this supposition has usually been verified by detailed analysis of the material presented in the supervisory hour. When these countertransference reactions were very intense they of course referred to unsolved problems in the candidate, and his reactions were distorted echoes of the objective situation. But even without such 'intensity' we must always reckon with certain distortions. One candidate, for instance, reacted for a time with slight annoyance whenever his analysands were much occupied with their childhood. The candidate had the idea that only analysis of transference could further the treatment. In reality he also had a wish that the analysands concern themselves with him. But the candidate was able by analysing this situation quickly to revive his interest in the childhood situations of the analysands, and he could also see that his annoyance, in spite of its neurotic character, had pointed out to him the rejection of certain transference situations in some analysands.

Whatever the analyst experiences emotionally, his reactions always bear some relation to processes in the patient. Even the most neurotic countertransference ideas arise only in response to certain patients and to certain situations of these patients, and they can, in consequence, indicate something about the patients and their situations. To cite one last example: a candidate, at the beginning of a session (and before the analysand, a woman,

had spoken), had the idea that she was about to draw a revolver and shoot at him; he felt an impulse to sit in his chair in a defensive position. He readily recognized the paranoid character of this idea, for the patient was far from likely to behave in such a way. Yet it was soon clear that his reaction was in a certain sense appropriate; the analysand spontaneously remarked that she intended to give him 'a kick in the penis'. On other occasions when the candidate had the same idea, this patient was fantasying that she was the victim of persecution; in this case also the analyst's reaction was, in a way, appropriate, for the patient's fantasy of being persecuted was the consequence and the cause of the patient's sadistic impulses towards the transferred object.

On the other hand, one must critically examine the *deductions* one makes from perception of one's own countertransference. For example, the fact that the analyst feels angry does not simply mean (as is sometimes said) that the patient wishes to make him angry. It may mean rather that the patient has a transference feeling of guilt. What has been said above concerning countertransference aggression is relevant here.

The second question—whether the analyst should or should not 'communicate' or 'interpret' aspects of his countertransference to the analysand—cannot be considered fully here.[1] Much depends, of course, upon what, when, how, to whom, for what purpose, and in what conditions the analyst speaks about his countertransference. It is probable that the purposes sought by communicating the countertransference might often (but not always) be better attained by other means. The principal other means is analysis of the patient's fantasies about the analyst's countertransference (and of the related transferences) sufficient to show the patient the truth (the reality of the countertransferences of his inner and outer objects); and with this must also be analysed the doubts, negations, and other defences against the truth, intuitively perceived, until they have been overcome. But there are also situations in which communication of the countertransference is of value for the subsequent course of the

[1] Alice Balint (1936), Winnicott (1949), and others favour communicating to the patient (and further analysing) certain countertransference situations. Heimann (1950) is among those who oppose doing so. Liberman (1952) describes how, in the treatment of a psychotic woman, communication of the countertransference played a very important part. The analyst freely associated upon unconscious manifestations of countertransference which the patient pointed out to him.

treatment. Without doubt, this aspect of the use of countertransference is of great interest; we need an extensive and detailed study of the inherent problems of communication of countertransference. Much more experience and study of countertransference needs to be recorded.