COUNTERTRANSFERENCE.

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I. THEORETICAL CONSIDERATIONS

References to countertransference appeared very early in psychoanalytic literature. Originally, they paid mostly lip service to its existence, with unelaborated statements that, of course, analysts could have transference reactions to their patients. Little else was said, other than to imply that these were dubious reactions and should be controlled, and for analysts to discuss their countertransference reactions in public would be somewhat indecently self-revealing. About ten years ago, a moderate number of articles began to appear. The general overtone of these articles has been of a rather embarrassed sort, as though these were major imperfections in our therapeutic procedures, and of course certain countertransference phenomena are considered reprehensible in the extreme.

The literature on countertransference has recently been excellently reviewed by Douglass Orr. I shall make only cursory comments about this literature because my main purpose is to present some ideas of my own and some detailed case material. Despite wide agreement among analysts about transference, there has been wide disagreement about countertransference. Freud's first reference to it in 1910 was rather forbidding: "We have begun to consider the 'counter-transference' ... arising as a result of the patient's influence on his [the physician's] unconscious feelings, and have nearly come to the point of requiring the physician to recognize and overcome this counter-transference in himself" (9, p. 289).

It is striking that a natural and inevitable phenomenon, so rich in potential for understanding, should have sustained so forbidding a tone toward its existence for forty-five years. I refer to the fact that no analyst has ever been presumed to have been so

perfectly analyzed that he no longer has an unconscious, or is without susceptibility to the stirring up of instinctual impulses and defenses against them. The very phraseology of our training practices belies the mask of the "perfect analyst." We state that the student's personal analysis should "serve as a first-hand experience with the unconscious"; it should gain him "working freedom from his own disturbing emotional patterns"; and it should enable him to continue his self-analysis on his own. At no time is it expected that he will have been perfectly analyzed. In addition, our recommendations for periodic reanalysis of analysts presuppose a large unconscious reservoir of sources for the development of new neurotic responses to emotional pressures from analytic patients upon the analyst's unconscious.

Conflicting conceptions of countertransference have covered a wide range. There were early ideas that it was the analyst's conscious emotional reaction to the patient's transference; attitudes that it covered every conscious or unconscious reaction about the patient, normal or neurotic; mechanistic constructions of the interpersonal relation between patient and analyst into some schematized oedipal picture (20) ; characterological disposition and personal eccentricities of the analyst were included; reactions to the patient as a whole have been considered transferences, and to partial aspects of the patient, countertransferences; anxiety in the analyst has been taken to be the common denominator to all countertransference reactions and every anxiety-producing response in the analyst considered countertransference (7) ; and finally, only sexual impulses toward patients have been regarded as countertransference. Major differences center around "seeing the analyst as a mirror—versus the analyst as a human being" Countertransferences are considered as being simply transferences—and nothing else— versus their not being transferences and being almost anything else.

Other differences center around questions of whether or not to discuss countertransferences with patients; whether countertransferences are always present and therefore reasonably normal; or whether they are always abnormal. "Carry over"4 is mentioned several times as particularly ominous in its implications. Almost invariably there are explicit prohibitions against any erotic countertransference manifestations.

Only once, I believe, is it suggested that unless there are periods or occasions of "carry over, " the analysis will not be successful, and only once, I believe, is it suggested that there may be under normal, and perhaps even useful, circumstances something approaching a countertransference neurosis. Mostly the latter are strenuously criticized.

The forbidding nature of writings on the subject is indicated by the following typical quotes (slightly edited):

- Our countertransference must be healthy.
- It is assumed that the appropriate responses predominate.
- At least some analystical toilet is a part of the analyst's necessary routine..
- Countertransference is the same as transference—it is then immediately obvious that countertransference is undesirable and a hindrance.
- The [countertransference mistake] should be admitted, to allow the patient to express his anger, and he is entitled to some expression of regret from the analyst..
- It is not safe to let even subtle manifestations of the countertransference creep inadvertently into the inter-personal climate. The analyst must recognize and control these reactions.

All of these—and similar attitudes—presuppose an ability in the analyst consciously to control his own unconscious. Such a supposition is in violation of the basic premise of our science—namely, that human beings are possessed of an unconscious which is not subject to conscious control, but which is (fortunately) subject to investigation through the medium of the transference (and presumably also the countertransference) neurosis.

Common evidences of countertransference are given as:

- anxiety in the treatment situation;
- disturbing feelings toward patients;
- stereotypy in feelings or behavior toward patients;
- love and hate responses toward patients;

- erotic preoccupations, especially ideas of falling in love with a patient;
- carry over of affects from the analytic hour;
- dreams about patients and acting-out episodes.

The very recent literature on this subject includes a number of perceptive articles, rich with descriptive material and clinical examples, and with a much less forbidding tone.

I would employ the term countertransference only for those phenomena which are transferences of the analyst to his patient. It is my belief that there are inevitably, naturally, and often desirably, many countertransference developments in every analysis (some evanescent—some sustained), which are a counterpart of the transference phenomena. Interactions (or transactions) between the transferences of the patient and the countertransferences of the analyst, going on at unconscious levels, may be—or perhaps always are—of vital significance for the outcome of the treatment. The intellectual verbalizations, consisting of the communications of the patient, and the interpretive activity of the analyst are the media through which deep underground channels of communication develop between patient and doctor. Interpretations as such do not cure, nor will any analyst ever be remembered primarily for his interpretative brilliance by any patient with whom he has been successful. This is not, however, to depreciate the importance of interpretation in the analytic procedure. Obviously, only through the patient's verbal communications, and the painstaking, dispassionate, interpretative efforts of the analyst is it possible, little by little, so to peel away defenses that those deep insights and communications can be obtained that we know to be the essence of the curative effect of the analytic process.

Transferences and countertransferences are unconscious phenomena, based on the repetition compulsion, are derived from significant experiences, largely of one's own childhood, and are directed toward significant persons in the past emotional life of the individual. Habitual characterological attitudes should not be included as countertransference phenomena, since these will find expression in almost any situation,

and nearly always in virtually the same form. They lack the specificity to a given situation of the countertransference phenomena. The fact that instinct derivatives have been permitted to become ego-syntonic through being incorporated into the character structure makes such attitudes essentially conscious or preconscious in character, in contrast to the transference phenomena, which derive from deep unconscious conflicts, in a given situation at a given time, and in response to a given individual, in which are mobilized old, affectively significant experiences in relation to earlier important figures. Indoctrination of patients, for example, is probably not usually a countertransference phenomenon, but an impulse derivative. Many other things incorrectly discussed as "countertransferences" are simply defects in the analyst's perceptions or experience.

There are many difficulties in presenting countertransference problems for discussion. There is a scarcity of good clinical material which derives substantially from the defensive systems of analysts toward the problem in general. The same resistances toward awareness of countertransference are seen among analysts in higher degree and in more insidious form than they are in patients in their resistances to transference insights. This is for good reason. The practicing analyst is under constant assault and has a precarious position to maintain. He has little motivation to change himself, and if he does develop such motivation, it is usually for personal reasons. The patient comes to the analyst for the purpose of being changed, and he values the procedure only if he feels changes are under way. The analyst, however, becomes anxious when he becomes aware of changes effected by emotional pressures from his patients, and there is no one except himself to push him into facing them.

Aside from the resistances of analysts to countertransference explorations and the time not yet having been ripe, there are simple practical reasons for the scarcity of our information on the subject. During the treatment hour, an analyst habitually forces down fantasy about himself. It does take time to analyze anyone, including oneself, and a busy analyst, spending most of his day with patients, naturally pushes aside much potentially illuminating material about himself which comes into his own mind from time to time. Another factor is that many countertransference phenomena when catapulted into

consciousness create a sort of emergency. Countertransference acting-out episodes, for example, confront the analyst with a situation of surprise necessitating rapid action and good judgment. He must concentrate on keeping the analytic situation in hand, and often the surprise and shock blot out memory of the processes leading up to the incident, probably due to repression out of the discomfort he experiences.

The decision long ago that analysts themselves should be analyzed before they practice analysis was a tremendous departure from any previous form of medical training. The idea of making a doctor into a patient before he can practice as a doctor is itself traumatic. After all one goes through to become an analyst, to have to become aware of the pervasiveness of countertransference phenomena is a threat and a letdown. The importance of analyzing the prospective analyst was recognized early. Carried into action, it was a major factor, probably, in the rapid advancement of our science. For many years, however, this was as far as it could go. In a sense, the preparatory or personal analysis of the future analyst offered some of the protection which the dream offers our patients. They often regard the dream as a foreign body, over which they have no control, remote in time, and something for which they need not have any feeling of guilt. Similarly, the preliminary personal analysis is often regarded by the practicing analyst, remote in time, forced on him, and related to former problems, as having no connection with present operations, about which there may thus be a bolstering of defenses and rationalizations. The analysis (or observations) of the functioning analyst may be a most important future "royal road" toward understanding the treatment process. Analysts doing supervision are in a position to understand and to make such observations.

Group resistances to exploration of the unconscious of the analyst in the treatment situation follow well-known patterns. There is an unexpressed fear of studying the functioning analyst, as though to report any of his responses were to be permissive about reactions of dubious character. In almost every paper written on countertransference, some tribute has been paid to this group rigidity, in the form of moralizing and pious prohibition, despite intelligent and sympathetic discussion of countertransference problems. Virtually every writer on the subject of

countertransference, for example, states unequivocally that no form of erotic reaction to a patient is to be tolerated. This would indicate that temptations in this area are great, and perhaps ubiquitous. This is the one subject about which almost every author is very certain to state his position. Other "countertransference"5 manifestations are not routinely condemned. Therefore, I assume that erotic responses to some extent trouble nearly every analyst. This is an interesting phenomenon and one that calls for investigation. In my experience, virtually all physicians, when they gain enough confidence in their analysts, report erotic feelings and impulses toward their patients, but usually do so with a good deal of fear and conflict. The following story is typical:

A candidate, who had had a partial therapeutic analysis prior to beginning his training, was talking about a very attractive woman patient whose treatment was winding up successfully. The patient had presented a prolonged and irritating resistance of silence. The candidate said: "This was the patient, perhaps, of all my patients, toward whom I have had the most sexual countertransference. I would sit and have sexual fantasies about her during those periods of silence. I used to think that if I ever went into a training analysis, I would never tell about this, because of what Dr. X [the previous analyst] said. When I had told him about it, he had seemed angry and had said [in effect], 'But how can you be interested in such a sick patient—and besides, you have no right to have any such fantasies toward any patient.' I am puzzled because I think I have gotten a lot of insight from my fantasies. I really never thought that I would be able to tell you about this, and I'm damned if I know how I was able to. I wish I knew what you had done to make me feel that it was alright to tell you... Now I remember: once I had had been talking about being 'attracted' to a certain patient. I was being quite guarded and wasn't admitting that the attraction was sexual, only that I was attracted, and you said, 'But how do you know that your feelings toward her may not be really helpful to her?'6 It was this that made it possible for me to talk about my sexual fantasies ... Now I'm beginning to wonder: did your remark really include acceptance of sexual fantasies (i.e., feelings) or did it just refer to being attracted?"

This man was an excellent therapist and there was no acting-out behavior. Nevertheless, this man had an artificial fear of erotic and countertransference responses which was related to what he perceived to be the prohibitive attitude of the group to which he aspired to belong. Essentially he did not have within himself a feeling that there was anything wrong with his having these responses.

In our selection of candidates for training, we are disposed to pay close attention to the libidinal resources of the applicant, on the theory that large amounts of available libido are necessary to tolerate the heavy task of a number of intensive analyses. At the same time, we deride almost every detectable libidinal investment made by an analyst in a patient. There is much that is obscure about

our understanding of the vicissitudes and functions of the analyst's libido in the treatment relationship. I believe this is a large and important topic in itself. It is not enough to talk just about dedication, empathy and rapport, important as these are. I have brought the analyst's libidinal responses into this discussion because they evoke so much countercathexis among analysts; I feel that this countercathexis belongs to the category of rigidity defenses of the analytic group. Suffice it to say that various forms of erotic fantasy and erotic countertransference phenomena of a fantasy and of an affective character are in my experience ubiquitous and presumably normal. Among the conspicuous characteristics of these phenomena are the facts that they are aim-inhibited in the sense of being virtually without impulse toward action, and are in most instances in high degree separated in point of time from erotic transferences of the patient.

Fantasies and feelings toward patients are profuse in all of us, and are now fairly generally accepted especially where they overlap reality based considerations. Almost all the rational and irrational feelings that we can have toward people in our daily lives, we may at times feel toward our patients. Feelings, however, which seem excessive or inappropriate to what the patient appears to be, or to what he is saying, and especially if they are associated with anxiety, undoubtedly have countertransference significance. Dreams about patients are, of course, usually significant and should always be explored for specific countertransference meaning.

I have for a very long time speculated that in many—perhaps every—intensive analytic treatment there develops something in the nature of countertransference structures (perhaps even a "neurosis") which are essential and inevitable counterparts of the transference neurosis. These countertransference structures may be large or small in their quantitative aspects, but in the total picture they may be of considerable significance for the outcome of the treatment. I believe they function somewhat in the manner of a catalytic agent in the treatment process. Their understanding by the analyst may be as important to the final working through of the transference neurosis as is the analyst's intellectual understanding of the transference neurosis itself, perhaps because they are, so to speak, the vehicle for the analyst's emotional understanding of the transference neurosis. Both transference neurosis and countertransference structure seem intimately bound together in a living process and both must be taken continually into account in the work which is psychoanalysis. In fact, I doubt that there is any interpersonal relationship between any two people, and for any purpose whatever, which does not involve, in greater or lesser degree, something in the nature of this living psychological process—interaction at an unconscious and transference level.

We cannot assume that we more than scratch the surface in the preparatory analyses of future analysts in regard to their understanding of themselves and their transference potentials in future analytic work. In addition I am inclined to believe that there are levels of transference which transcend any capacity we now have to gain access to them. There are perhaps even levels of transference to which we will never have access, at any rate by psychological means, because they lie at the borderline between that which is biological and that which is hereditary in us. The phenomenon of falling in love—so little comprehended dynamically—may lie at this borderline.

It is one thing, however, to be able, from experience and training, to formulate consciously the possible occurrence of given countertransference problems. It is another thing to be able to fulfill the cautions with which one charges oneself with 100 per cent efficiency as one goes deeper and deeper into an analytic treatment, week after week, month after month, and year after year, becoming more and more identified with,

interested in, and deeply aware of a patient and his problems. If nothing else, too much attention to possible unfavorable countertransference reactions could lead an analyst to some kind of a fixed defense by virtue of which very significant material could be overlooked. Every analyst of experience knows that as he gets deeper and deeper into an analysis, he somehow or other loses a certain perspective on the total situation.

I would conjecture that the development of countertransference neurotic structures in an analyst over a long period of time might be something like Einstein's theory of relativity. This theory has to do with the fact that light is supposed to travel in a straight line from one point to another, and actually does so in our own little world and with our own short distances of measurement. However, when light travels the gigantic distances known to us in terms of millions of light years, other factors previously never understood or even conceived of enter into the picture; and Einstein proved that over these vast reaches of time and space, there is a drift from the straight line in the beam of light. So, too, the hypothetically perfectly trained and perfectly analyzed analyst should be able to pursue an utterly straight course of avoiding all those countertransference pitfalls which his personal analysis should have taught him to anticipate and to avoid. And, undoubtedly, by and large, he is increasingly able to do so and over considerable periods of time. Ultimately, however, it would appear that even under the most ideal circumstances there are bound to be certain drifts, so to speak, from the utterly straight direction of the analyst's performance and understanding of a case, and it is these very slow almost imperceptible drifts which develop in him in unconscious response to hidden pressures and motivations from his patient, which I think constitute the essence of the development of a countertransference structure in and of itself. It is irrelevant to this thesis that these may be most minor excresences on a very large total structure—the treatment situation. I simply do not believe that any two people, regardless of circumstance, may closet themselves in a room, day after day, month after month, and year after year, without something happening to each of them in respect to the other. Perhaps the development of a major change in the one, which is, after all, the purpose of the therapy, would be impossible without at least some minor change in the other, and it

is probably relatively unimportant whether that minor change in the other is a rational one. It is probably far more important that the minor change in the other, namely, the therapist, be that which is specifically important and necessary to the one for whom we hope to achieve the major change. These changes in the therapist would be compounded in my view from the ego adaptive responses and the unconscious countertransferences of the analyst, interacting upon each other in such a way as to expand his ego integrative powers specifically to cope with the particular patient's transference resistances. It is in the nature of the transference resistances as they are built up by the patient that they should ferret out and hurl themselves against the weakest spots in the therapist's armamentarium.

Focusing in this manner on one small aspect of a long and involved treatment procedure may inadvertently create an impression that I do not at all wish to create—namely, an illusion that the matter under study is felt to be quantitatively of major importance or qualitatively very different from the bulk of our experience. It is the defensiveness of the analytic group about countertransference phenomena which makes it necessary to caution against such misinterpretation. I do not like the term "countertransference neurosis" and would not employ it. It has, however, crept into our literature, and it has some reason for existence through analogy with the term "transference neurosis." However, this latter is perhaps also a misnomer, in view of what actually occurs in an analysis. In general, the transference phenomena are experienced in multiple and varying forms throughout any analytic experience, and by both patient and therapist. A discrete, well-structured, easily describable transference neurosis as such probably seldom occurs, and by the same token even less frequently does a discrete countertransference neurosis develop. The term neurosis is very loosely used in our literature. It is employed as an epithet (with the specificity of the word rheumatism) or a well-defined psychiatric diagnosis, or as a catch-all for any and all of the immaturities, eccentricities, and emotional conflicts of those people who come to us for assistance. It is easy for us to say that their transferences to us comprise another neurosis to be given the test tube treatment, but it is another matter entirely to concede that our own

transferences to them are similar in kind, though—hopefully—microscopic in quantity by comparison.

I reserve for further and future thought understanding of the nature and meaning of countertransference affect, or lack of it, in psychoanalysis. Increasing personal and group maturity should make its contemplation scientifically a little more tolerable. To some extent this has already begun to occur, but it is still most gingerly approached. A paper presented to The Chicago

Psychoanalytic Society four years ago by Adelaide Johnson touched tangentially on this problem and evoked the most massive anxiety and countercathexis in the audience I have observed in many years of psychoanalytic meetings. This reaction seemed all out of proportion to the valid objections which could be raised against the argument of the paper.

If one accepts the premise that countertransferences should be understood as transferences of the analyst, and that they are normal and ubiquitous, countertransference affects have a theoretical raison d'être in the universally accepted dictum that true insight is achieved in analysis of transferences only with accompanying and appropriate releases of affect. The fact that the analytic group, despite its vaunted preliminary personal analyses as a means of removing "blind spots, " should still defend itself strenuously against applying to its own operations the same dynamic interpretations that it systematically applies to its patients' operations is further testimony to the interminability of the analytic process and the strengths of the repressive forces of the ego.

II. CLINICAL MATERIAL

I have selected for discussion countertransference elements from the analyses of four of my own patients, as I have been able to perceive these. In three cases, countertransference affects of fair intensity played a role at times. Two cases were reasonably successful analyses, one perhaps should have been more successful. I believe

my fear of countertransference involvements in this case limited the results. One relatively unsuccessful case was marked by little countertransference affect; an inability to clarify in my own mind my countertransference involvement, if any, and little deep emotional communication between myself and the patient. I wish to emphasize that I believe in general an external observer could not have detected anything out of the ordinary in any one of these analyses.

I have chosen material which I felt demonstrated rather simply some of the points under discussion in Part I. In addition, I chose material which I could be reasonably comfortable about presenting. None of these cases were really painful failures. Also, I selected material from long, fairly "classically" conducted analyses, for reasons which should be obvious. All of the patients seemed to be both analyzeable and to require thorough analysis. I do not believe the experiences I had with these patients are particularly unusual in comparison with many other cases of my own and cases I have supervised with other analysts, except for somewhat striking and above or below average countertransference.

I will begin with an example of a specific countertransference reaction with acting out. Many years ago a patient, referred after a near-psychotic reaction, to an "analysis" with an untrained person was utterly enraged at the referral, because of the frustration of her claims upon the previous therapist. Week after week, and month after month, she raged at me in a vituperative manner, despite my having the greatest of patience with her. I endured a quantity of abuse from her, such as I have never taken from any other patient. At times, I would get irritated with the abuse, but mostly I rather liked the patient, was genuinely interested in helping her and was somewhat surprised at my ability to control my irritation with her. I eventually came to understand that what was for the most part a desirable therapeutic attitude, offered a certain countertransference complication. The following episode brought this problem to my attention.

One beautiful spring day I walked out of my office, twenty minutes before this patient's hour, with my appointment book lying open on my desk. I had a delicious luncheon, alone, which I enjoyed more than usual, and strolled back to the office, in time

for my next appointment, only to be informed that my patient had been there and had left extremely angry. It was obvious that I had forgotten her appointment, unconsciously and purposely, and it suddenly came over me that I was absolutely fed up with her abuse to the point of nonendurance. At this point, I began to be angry at my patient, and between this time and the next time she came in, I was in a substantial rage against her. Part of this rage I related to guilt, and part to some anxiety about how I would handle the next treatment interview, which I expected would surpass all previous abuse, and I was now aware of the fact that I was no longer going to be able to tolerate this abuse. I fantasied (which of course was a hope) that my patient would terminate her treatment with me. At her next appointment, she glared at me and said, in an accusatory manner, "Where were you yesterday?" I said only, "I'm sorry, I forgot." She started to attack me, saying she knew I had been there shortly before, and went on with her customary vituperation. I made no comment, for the most part feeling it was better that I say nothing. This went on for five or ten minutes and abruptly she stopped. There was a dead silence and all of a sudden she started to laugh, saying, "Well, you know, Dr. Tower, really I can't say that I blame you." This was absolutely the first break in this obstinate resistance. Following this episode, the patient was much more cooperative and after one or two short recurrences of the abusiveness, probably to test me, the defense disappeared entirely, and she shortly went into analysis at deep transference levels. At first glance, this seems so unimportant an episode that it hardly warrants description. One would say I was irritated with the patient and missed her hour because of aggression, which of course was true. But the real countertransference problem was not that. Actually, my acting-out behavior was reality-based and brought a resolution to the countertransference problem which was that I had been patient with her too long. This tendency in myself I could trace in detail from certain influences upon me in my earliest childhood. I had gotten into difficulties from this tendency from time to time during my development. I understood this in part, and yet it was not sufficiently resolved in my personality. This prolonged abusive resistance need not have lasted so long, had I been freer to be more aggressive in the face of it. The manner in which I repressed my

aggression and allowed it to accumulate to a point where I was forced to act it out, was not an entirely desirable therapeutic procedure. Thus, a theoretically good therapeutic attitude, namely, that of infinite patience and effort to understand a very troubled patient, was actually in this situation a negative countertransference structure, virtually a short-lived countertransference neurosis, which undoubtedly wasted quite a bit of the patient's time, and but for my sudden resolution of it through acting out might well have gone on for a considerably longer time. I gave this little episode a good deal of thought in subsequent years, and eventually came to understand more of its true significance.

However, it is only recently that I might have questioned whether this countertransference reaction which had such clear negative implications at certain levels in this treatment, might perhaps at other levels have had equally positive implications. This particular disposition of mine might well have facilitated this patient's eventual ability to deal fully and affectively with her most highly defended problem—the passive homoerotic aspect of the transference—for it had been an acute paranoid type reaction that brought her into treatment with me.

In the following material I attempt to trace countertransference developments in two analyses which lend themselves to many comparisons.

This is material from the cases of two men, both successful business men of fairly similar backgrounds, near my own age, both liked me as a person, and I liked both of them as people. Both were intelligent, married and had children; both had long analyses. One analysis was successful in a working through at the very deepest transference levels, of an intense transference neurosis, resulting in great symptomatic improvement, much maturation and increased success. In the second, there was no real working through of a transference neurosis, the analysis was unsatisfactory to me, and I felt insecure about the patient's future. There was symptomatic improvement, and the patient was not too dissatisfied, but I eventually counseled him to seek analysis with someone else, which he did after a considerable resistance.

I was initially more favorably inclined toward the second patient, who seemed highly motivated for treatment, more adequate, and whose psychosexual development seemed more normal. The first and more successful patient, on the other hand, was initially ambivalent, derisively hostile, and created early doubts in me about taking him for treatment.

Both parental marriages had been stable, the fathers being somewhat passive but reasonably successful. Both mothers seemed compulsive, and both patients seemed to have suffered deep developmental defects in relation to the mother, the first, and successful patient, perhaps less so.

The course and content of his analysis suggested mainly regression from oedipal conflict, while this as a dominant feature was by no means as demonstrable in the second case.

Both patients presented severe problems of inhibition of masculine assertiveness with passive homosexual reaction formations. Both had deep, unconscious problems of an oral sadistic, murderous disposition toward a female sibling; both had developed fairly serious neurotic symptomotology in late adolescence, and in both there were schizoid features. Both reacted against homosexual problems by early flight into marriages with aggressive, controlling, narcissistic women. Both wives were attractive, compulsive, disturbed, and so highly defended that neither would consent to treatment, despite the fact that both marriages were stormy. The husbands were devoted, and struggled to keep the marriages going. The wives resented their husbands' treatment and attempted to sabotage it. I had occasion to become acquainted with both wives, although this was not sought by me. I did not experience troublesome negative feelings about either of them, despite their anxiety-ridden efforts to undercut the husbands' treatment.

With both men, I was quite aware of the contributions which they themselves made to the difficulties with their wives, namely, that both were to submissive, too hostile, in a sense too devoted, and both wives were frustrated for lack of sufficient uninhibited masculine assertiveness from their husbands. In both instances, this was extensively interpreted and worked over, but without much change in the picture.

Obviously, this was a problem that could not be satisfactorily worked through without thorough analysis of its deep sources in conflict which each had toward the female sibling, and behind that, the murderous rage toward the mother, as an oral sadistic regression from oedipal conflict. I went through phases of (countertransference?) protectiveness, in both cases; that with the first man was toward the marriage and the wife; with the second it was toward the man himself. Both patients confronted me, in transference material, with suggestions that I was being too protective and as I became conscious of this, I believe I was reasonably able to correct this.

In the first case, the protectiveness was directed toward avoiding secondary disturbance in the wife. She had at one time been thought by a psychiatrist to be psychotic, and I wished, realistically, not to provoke a blowup in her with all of the disruptive effects upon a family that such an episode can have. The protectiveness in the second case was directed toward the patient himself, and on a similar basis. This patient himself had once been thought to be psychotic. There was a Rorschach examination of this patient which, in brief, showed the case to be a deeply set neurosis; analytic treatment was indicated though it could be expected to be very difficult. It was a very productive record, with no schizophrenic material. While energy and drive appeared extremely high, the personality organization was such as to lead to expectation of a boiling over of affects into the world at large. Imagination was limited and there were reduced avenues of escape into an inner life. The symptomotology which brought these patients to treatment was similar: diffuse anxiety with some depression, a strong awareness of massive inhibition, and a certain amount of confusion, particularly regarding sexual roles. Both, thus, would be classed as anxiety neurosis. The more normal psychosexual development of the second case, and my initial more favorable feeling toward him, would suggest theoretically that if my own libidinal organization approached the so-called "normal" and if I were to develop countertransference deviations, these would be more likely to be manifested toward the second patient, rather than the first,

who when he came into treatment presented some not too attractive psychosexual problems. In fact, exactly the reverse proved to be the case.

Both patients presented irritating difficulties in communication: mumbling, halting speech, circumstantiality, repetitiveness, minutiae. There were times in both analyses when I became quite irritated with the communication problem. Only late in the treatment of both, as the infantile neuroses unfolded, did I begin to perceive some of the differences between what appeared to be fairly similar speech difficulties. The communication problem in the first case was a highly structured resistance, with the concealed purpose of destroying my power as an analyst and getting revenge upon me for my attentions to any and all other siblings and all males. The speech blocks in this case concealed biting, sardonic, destructive, object-oriented impulses, and disappeared with the working through in the transference of the deep oral sadistic problem. The communication problems of the second patient appeared to be an extension of the hidden anaclitic character of his ego, were essentially clinging in character and designed to acquire an object rather than to destroy a frustrating one, and were never in any substantial way relieved. Despite my long and conscientious effort to help this man, I do not think that I succeeded in any way commensurate with the amount of time and energy expended by both of us upon the attempt.

At this point, one might say that it has long been known that cases which we classify as transference neuroses, as our first patient would seem to be, are far more accessible to analytic procedures than the narcissistic neuroses, as was apparently the diagnosis of our second patient. Why should one have to bring in considerations of countertransference as a factor in the ultimate success of these treatments? This is all very true and, at the same time, too simple. It was, indeed, a very long time before I could differentiate sharply between these two cases, as I have just done, and it is also after the fact, so to speak. For a long time the first patient appeared to be most narcissistic. Certain delinquencies in this man and his much more severe psychosexual problems pointed this up. Additionally, I am not trying to prove that countertransference neurotic phenomena are the sole, or even major, factors involved in therapeutic progress.

My purpose is to attempt to demonstrate their existence in a far more pervasive and perhaps significant manner than is generally conceded; to offer some evidence that they may be of crucial importance under certain circumstances, and to make some small contribution toward tracing their origins, development and resolution in the course of an analytic treatment.

This brings me to crucial turning points in the analyses of these two men. So far, I have discussed the emotional and practical situations with which I was confronted, and the background material which seems pertinent to a framework in which I might or might not develop some relatively organized countertransference response. Both men presented me with a specific problem, calculated potentially to stir up some countertransference responses of a reasonably normal character, in any female analyst who might be somewhat off guard. I refer to the fact that both these rather nice men were dependently attached to wives who defensively resented and made efforts to undermine the analyses, who were possessive of their husbands, and depreciating of them in a refined kind of way. Both men had much aggression against their wives, of which both were afraid, and had varying forms of overcompensatory behavior in regard to this. Both were therefore bound, sooner or later, to make efforts to play the analyst off against their wives, and both were bound, eventually, to attempt to exploit the analyses in the heterosexual transference, for whatever gratification they might be able to seduce from the analyst. Both were, of course, inevitably bound to succeed or fail, to some extent in terms of the deeper aspects of the resolution of the oedipus conflict in the analyst's own personality. Of all of this I was, of course, theoretically aware from very early in the treatment of both men, and was consistently and reasonably well on guard to watch my own reactions, especially toward the large amount of complaining material brought against the wives. I was equally on guard against letting myself become irritated with the respective wives for their subversive behavior in regard to their husbands' treatment.

The turning point in the first case developed as follows: Toward the end of the second year of this analysis, despite much intellectual knowledge of his difficulties, when

there seemed virtually no improvement in the marital situation, the communication block or in his dependency defense, the patient's wife developed a severe psychosomatic illness. I took careful note of this fact at the time, speculating to myself that this illness might bind her anxiety which seemed so prepsychotic. I wondered if this might not be an out for her, in that she could now abandon her controlling, attacking behavior and lean on her husband more, without too much ego anxiety. I thought this might benefit the marital relation. What I took note of consciously, however, must have remained detached from what already was developing unconsciously in me as the nucleus of a small countertransference reaction toward the total situation. I believe this man's developing transference neurosis was slowly and inexorably pushing me in the direction of actually being to him, in some small measure, the overconcerned and overidentified mother figure (which he felt his wife was not) who, regardless of the merits of the situation, would see things much more in terms of his evaluation of them, and would identify with his hostilities, rather than being the completely dispassionate observer. I believe that, despite my cautions, I had been imperceptibly pushed by his transference pressures into regarding his wife as more of a problem than she had initially appeared to be. At any rate, I failed to observe that she had actually slowly become somewhat less of a problem, for, despite the patient's chronic, exasperating resistance, he was dealing with his domestic situation with more firmness and gentleness. Whether this was concealed from me by the patient, or I, for my own unconscious reasons, was blind to it, is beside the point. Very probably both were true. By this time the ego satisfactions of an improved functioning outside of the treatment were disrupted by strong, unconscious, frustrated libidinal drives in the transference neurosis. These were to make the most of the possession of a truly interested, maternally perceived person out of those transference needs as well as out of whatever unconscious potential I had to offer in the direction of fulfilling them.

This man's mother had, in reality, twice in his life deserted him emotionally at very crucial periods. There was a remoteness between mother and son which I never did fathom, but which inclined me to consider whether this was not a quite detached

mother. Some of the later phases of the analysis of his transference neurosis bore this out, and revealed why it was perhaps of crucial importance for this particular patient that he literally be able to seduce me, to some small extent, into a countertransference deviation toward the side of his hostile dependent defenses against his wife, before he would be able to trust me with his deepest transference neurotic needs of me. These, I believe, are some of the factors which led to my intellectual speculations about the meaning of the wife's psychosomatic illness, remaining detached from the slowly developing countertransference blindness about the wife.

This all came to a head about a year later. I had been getting both uneasy and frustrated with the monotonous masochistic and depressive character of this patient's resistance. I suddenly had a dream which so startled me that it blotted out all recollection of what led up to it. The dream was very simply that I was visiting in this patient's home. Only his wife was there, she seemed glad to have me, and was being most hospitable and gracious. The general tone of the visit was much like that of an afternoon chat of friendly wives, whose husbands were, perhaps, friends or colleagues. The dream vaguely disturbed me.

As I started to think about it, I realized that I had known for some time, but had not taken note of the fact, that the wife was no longer interfering in her husband's treatment. This was due to his better adjustment, to a developing confidence that I was no true threat to her, and a decreasing direct envy of her husband's relationship to me. I also remembered, at this point, that almost a year previously I had speculated about the meaning of the wife's psychosomatic illness and had then largely forgotten it. In other words, I realized that I had unconsciously developed a somewhat fixed attitude of being too afraid of her psychotic potential, and had ignored her improvement. The dream pointed up to me that I had been derelict in identifying with her in the marital situation; that in effect she really did want me to come into her home and would welcome my having a better perspective upon her. The dream said that the wife was much more positively oriented toward me than I had given her credit for during the past year, and that it was time that I look in on the domestic scene from her point of view.

After I had given all of this very careful thought and felt fairly sure of my ground, I went into action. First, I picked up the analysis of the subtle acting out on his part against his wife within the domestic situation, a point which had been neglected for some time. I became very direct in discussing the aggression against his wife through the mechanism of his masochism and his dependent hostility, which we both now understood much better than in the earlier analysis of these problems. Following this, I discussed again and more actively his attempts to play off his wife and myself against each other, and how he had exaggerated and prolonged the bad marital situation for purposes of transference gratification. All of this had been previously extensively worked over, but with insufficient effect. It is, of course, obvious that in my own unconscious some resurgent oedipal conflict in the form of an overdetermined competition with and fear of another woman in a triangular situation lay behind my countertransference response.

Following this active repairing of the holes in the analysis, so to speak, the patient shortly took over the analysis very assertively. From a complaining, low-voltage approach for nearly the three years, he began moving with the greatest directness. He began subjecting me to intense emotional pressures; he himself carried the analysis back into a comprehensive review of his entire development, with new insights into crucial life experiences, and with minute attention to reconstructing the infantile situation. There were new recoveries of early memories, especially of primal scene material and of a peculiarly unexpressed remoteness between the parents.

Following extensive reworking over of the oedipal material—without, however, enough reliving of castration anxiety to make me feel secure about a working through—the patient switched to the deepest oral material. This had been displaced from the sister born when he was about two, to the sister born during the height of the oedipal period. With the opening up of this material the first intense, undefended affect of the entire analysis made its appearance. There was a long period characterized by profound depressive feelings and naked rage, feelings largely confined to the analytic hours. With this outpouring of affect, the patient's block in communication disappeared permanently. Dream and fantasy material in this phase included almost every form of sadistic attack or

indignity conceivable. This was, of course, phallic sadism couched in oral language. During this period the relationship between us was very tense. The quantity of the patient's affect alone would have constituted a severe burden upon any one attempting to deal with it. In addition, he subjected me to the most persistent, minute and discomforting scrutiny, as though tearing me apart—cell by cell. My every move, my every word, was watched so closely that it literally felt to me that if I made even one slightest false move, all would be lost. The threat, however, was not to myself. The affect created in me was more of the following order: if I were to fail to meet this test, he would fall apart, and would never again trust another human being. On several occasions I experienced dreams which directly anticipated oncoming material, as though from my own unconscious came forewarning of what was to come, and fortified me to deal with the massive quantity of his affect when it hit.

During this period, every hour was exhausting and often the feelings engendered in me during the hour would carry over. On several occasions, I began to be worried about the extent of this carry- over. All my disposition to become morbid about this was dispelled rather suddenly and amusingly. I was to go off one afternoon for a vacation, having seen the patient that morning. This had, in itself, stepped up both the sadistic and depressive feelings with which he burdened me. I went off feeling at a very low ebb and on the verge of anger with the whole business. The depression and irritation in me lasted for several hours and then suddenly disappeared completely. Nothing extraneous happened to dispel it, nor did I make any conscious effort to do so. I doubt that I even thought of this patient, except in the most casual way throughout the entire vacation. The fact that this could happen so spontaneously led me to the reassuring conclusion that my disturbing feelings did not of themselves mean that I was getting involved in any quantitatively excessive countertransference problem which might prove to have unfavorable implications, either for him or for myself. It seemed to me only that what had been going on was that my unconscious had somehow finally become sufficiently attuned to his unconscious; that I was able to tolerate the affect connected with his feelings of utter despair, because of affects and attitudes in myself over which I had no

conscious control, but which were appropriate to his needs, in order to work this problem through. As I have thought it over since, to understand what had been going on in myself in response to this patient, it seems compounded of two factors. On the one hand there developed in me, on a transient basis, an amount of masochism sufficient to absorb the sadism which he was now unloading, and which had terrified him throughout his entire life. The other ingredient of my affective response was, I believe, a joining with him and a supporting of him, through identification, in a true unconscious grief reaction. This, I believe, was similar to the "sadness" of affect in the therapist, of which Adelaide Johnson (15) and Michael Balint (3) have written. As he unloaded his sadism, free from fear of loss of control, and of any fear of retaliation, I believe that this man's ego was finally and permanently freed of the binding of this sadism into his superego. The depressive affect had become wholly free of self-depreciation and guilt and had taken on the quality of a true mourning for a lost love object.

Following this, the patient returned to the oedipal situation, and with intense affect. The repressed competition with the father was brought out in the transference in a quite usual way, with fantasies about men in the analyst's life, competition with father surrogates, and real fear derived from competitive impulses toward these men as erotic transference impulses arose toward the analyst. With this final working through of the oedipal material, the patient went on to termination. The improvement and personality changes in this patient have now been sustained for some time, and I have the impression that the wife's difficulties are largely intrinsic only, and are not being contributed to by her husband.

Interestingly, it was only with the development and resolution of my countertransference response to the marital situation, and the breaking through of the patient's resistance against communication, with the outpouring of long stored-up affect, that I began to have feelings of very much liking this man as a person. I do not mean that I had previously disliked him. Precisely here, I believe, lies evidence that in this case the countertransference response had a beneficial effect. I am inclined to think that it was only after this man's unconscious perceived that he had actually forced me into a

countertransference response that he became sufficiently confident of his powers to influence me, and of my willingness, at least in small part, to be influenced or subjugated by him. It was only then that he could finally allow me to penetrate his masochistic defense, and give me access to the deep unconscious sadism so long bound into his superego, for it now became both possible and necessary to turn that sadism upon me. This massive sadism, deriving presumably from an infantile depression, had been re-experienced in the oedipal situation, causing strong regressive admixtures of oral sadism into the phallic sadism of the oedipal conflict. I do not believe that without the experience, perceived by his unconscious, of actually having been able in some small way to bend me affectively to his needs, this man would have succeeded in going into these deepest sources of his neurosis. That he was able so to bend me to his will, simultaneously repaired the wound in his masculine ego, and eliminated his infantile fear of my sadism in the mother transference. It would seem that he had finally achieved an inner confidence that his controls were in fact adequate, and that I in fact trusted them.

Interestingly, his unconscious also perceived that I had changed in my feeling about him. During this period, he made a number of comments about my affection for him, which bore no references to sexual love. They were simple statements of fact. I do not think he ever gave conscious thought to whether I had changed. He never asked for any confirmation, never indicated that he felt not liked previously; these were simple and causal statements of a perception of something, which from his point of view was timeless, incontrovertible and unambivalent. His unconscious had correctly perceived something which had actually developed in me. In fact, I think it is possible that any final successful working through of a deep and thorough analysis involves some development of this sort. That there are many more or less successful analyses, which are nevertheless partial analyses in fact, is well known to all of us. Many, clearly, never should be other than partial. I doubt that there is any thorough working through of a deep transference neurosis, in the strictest sense, which does not involve some form of emotional upheaval in which both patient and analyst are involved. In other words, there is both a transference neurosis and a corresponding countertransference "neurosis" (no matter

how small and temporary) which are both analyzed in the treatment situation, with eventual feelings of a substantially new orientation on the part of both persons toward each other.

I do not know whether the crucial episode which seemed to me to be a turning point in the second case was a sudden perception on my part of the reality that this man was unanalyzable by me, and the real countertransference difficulty was my illusion that I could treat this man. The resistance described earlier had become chronic. Slowly, there were gains which in all honesty I would have to look upon as psychotherapeutic largely. Slowly, I became aware of a subtle smeary overtone in his attitudes toward his wife, and also toward me in the analysis. It lay, however, so nebulously concealed behind the manifest oral sadistic and oral dependent material that somehow I was never able to bring it out into the open where it could be dealt with. Even now I wonder if it were not really some derivative of the fuzziness in this man's ego boundaries. I found myself slowly and increasingly identified with and sympathetic for his wife, related primarily to my perception of this vaguely smeary attitude toward her. I was aware also, step by step, of changes in her attitudes, how her interference gradually slowed down, how she began to cooperate with him about his analysis, and finally turned to me with despair because there were no significant changes for the good in his attitude toward her. This patient made intense protestations of dependent and erotic need for me in a manner in which such material usually appears. From hindsight, I would say the reason I was not moved by this was that it was not structured and was thus interpretively intangible, and that deep down this man did not have a mobilizable strength capable of bending me to his will, as did the first patient. I believe that with his deep anaclitic ego organization, his maximum potential would have been to seduce me into bending him toward my will. Consequently, I must have always felt that these protestations were overcompensatory, not contained, and not truly transference.

The turning point in this case came when he suddenly and unpredictably developed a schizoid depressed state. I had no warning that this was coming, had little material with which to understand it, and before I could evaluate what was happening, he came for a

five o'clock appointment one day, following several days of intense anxiety and obsessive suicidal fantasies. He became severely agitated, the suicidal fantasies suddenly gave way to a violent outburst of murderous feelings, such that I became truly alarmed. I felt he was very close to an ego break and might very well go out the window, or off the fire escape, out of fear of the murderous ideas. The office was deserted, the secretaries having gone home. I announced quickly and calmly that I thought he was far too upset to discuss his problems that evening, would he please go home, take a sedative, try to find distraction and return first thing in the morning when he might feel more calm. The patient followed my request, in a trance-like state, and left. Slowly I was able to pull him out of this acute apparently near-psychotic state. After this episode I never again had confidence in my ability to do anything with this man psychoanalytically, nor did I ever see him again outside of office hours. Eventually I terminated his relationship with me and arranged his treatment with someone else. I felt that perhaps this might be worked through with a male analyst whom he would perceive as a person able to control him. We eventually parted company with mutual good feeling, rather of a surface character. However, out of all this long effort at therapy, I think little in the way of really deep mutual (i.e., nonverbal) communication of feeling ever occurred between us.

If this man was unanalyzable by me—or by a woman—I would conjecture that the reason lay in that the defect in his masculine ego was reparable only by identification and actual incorporation of a masculine ego in a treatment situation with a man, and perhaps only after experiencing an intense passive homoerotic transference. Apparently I could not offer him this, and neither was I able to mobilize any affect in the homoerotic material he did bring. In contrast, the defect in the masculine ego of the first man was apparently actually repaired by a small victory over me in the transference.

In other words, there were built-in controls in his ego, which I unconsciously perceived, and this permitted me without undue anxiety to respond in very small but perhaps crucial measure to this man as woman to man, at the same time that my dominant relation to him was that of physician to patient. Built-in controls appeared absent in the second case, and would have to be acquired by identification and

incorporation before he could live out affectively his underlying sadism, or move me to trust him as woman.

A number of years ago I analyzed a young man who had essentially the same problems and personality structure as the first of the two cases just discussed, and whose analysis reached virtually the same depth with similar mutual affective intensity. This case was not carried through to a fully successful result, and I believe that it should have been. There were further countertransference complications in this case, in that I could never decide whether this was one of those rare cases in which the analyst should actively foster a divorce. In retrospect, I believe two important factors were operative in me. First, my discomfort with the transference- countertransference affect blocked me in a full working through of this problem. Secondly, I was probably intimidated by the pressures of an older and very aggressive analyst, who was treating the wife and who was openly determined that this marriage be successful. I terminated the case prematurely, with all the usual supposedly mutual understandings and rationalizations between us about indications for terminating. The fact that the patient's unconscious correctly perceived what I had unconsciously done to him, and why, was proved by some rage-motivated, fairly serious acting out he did against me afterward, which I understood immediately but which unfortunately did not come to my attention until far too late for me to do anything about it. Fortunately, the young man later obtained further analysis with someone else.

III. SUMMARY AND CONCLUSIONS

An attempt has been made to clarify present conceptions of psychoanalysts about material to bear upon a thesis that these conceptions need simplification and modification, and that countertransference phenomena are inherently dynamically operative in all treatment procedures.

It is emphasized that countertransference is only one of a number of responses of the analyst of equal or greater importance to the treatment situation. (Empathy, rapport,

intuition, intellectual comprehension and ego-adaptive responses are, of course, other very significant elements.)

The treatment situation between patient and analyst at its deepest and nonverbal levels probably follows the prototype of the mother-child symbiosis so sensitively described by Benedek and involves active libidinal exchanges between the two through unconscious nonverbal channels of communication. Thus, broadly speaking, patients do affect their analysts. At these deep levels of interchange the dominant trends of constructive or of destructive use of the treatment situation by the patient are probably derivatives of the earliest relationships to the mother.

In the successful analysis the patient not only brings out in full form his own worst impulses, but perhaps, in addition, accomplishes a similar purpose, in minor form, with reference to the analyst, in part as a testing, in part as a becoming deeply aware of the analyst as a human being with limitations. At the same time, he accomplishes, for the purposes of his own ego strengthening, a capacity to handle the analyst's defects constructively, to forgive him for his aggression, his countertransference acting out, and to establish a mature adequately positive libidinal relationship with him, despite these imperfections.

The term countertransference should be reserved for transferences of the analyst—in the treatment situation—and nothing else. As such, they are syntheses of the analyst's unconscious ego, and together with the patient's transferences, both are products of the combined unconscious work of patient and analyst. They are multiple and varied in their origins and manifestations, and change

from day to day and from patient to patient. They are normal phenomena, taking root in the repetition compulsion. They become "abnormal, " or perhaps better described as interfering, excessive, fixed, or unworkable, on the basis of both qualitative and quantitative factors in their synthesis, as well as the manner in which they impinge on the analytic situation.

An effort has been made to explore the concept and the possible functions of a countertransference "neurosis" as such. There is evidence that structured formations

may occur more consistently than generally supposed and that they may under certain circumstances perform useful functions. This usefulness may be a more or less temporary phenomenon and derive from the source and the character of the structure itself. On the other hand its uncovering, analysis, and resolution by the analyst may be useful to a deeper emotional understanding by the analyst of the transference neurosis.

I believe that in all instances where anything more than the most superficial relationship develops between patient and therapist, and inevitably, in truly deep analytic procedures, there are many countertransference reactions and that something in the nature of a countertransference neurosis develops, which, no mater how small, may be of great significance for the course of the treatment, in the sense of a catalytic agent. By definition, a catalyst is an ordinarily inert substance which in a given milieu is capable of accelerating, or of decelerating, a chemical process. It does not seem too unrealistic to think that there may be similar phenomena at those deep levels of interpersonal relationship which one finds in the psychoanalytic treatment process.

Scientific study of the psychoanalyst's unconscious in the treatment situation should improve our therapeutic efficiency and do much to provide a solid scientific basis upon which to evaluate treatment techniques. Such study would likewise illuminate that which is defensive and acting out upon the therapist's part, and that which is scientifically and demonstrably constructive.

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