3 Countertransference

3.1 Countertransference: The Cinderella in Psychoanalysis

Freud viewed countertransference, even when he first discovered it (1910d), as connected with the patient's transference in a dynamic way. It "arises in him [the physician] as a result of the patient's influence on his unconscious feelings" (Freud 1910d, p. 144). Freud emphasizes that "no psychoanalyst goes further than his own complexes and internal resistances permit" (1910d, p. 145). Thus it is necessary for the analyst to undergo a training analysis in order to be freed of his "blind spots."

Because Freud's recommendations about treatment techniques — expressed in striking metaphors such as to reflect like a "mirror" and to act like an "emotionless surgeon" — were taken literally, countertransference retained a negative meaning for decades. Freud had to place great value on "psychoanalytic purification" (1912e, p.116) both because of his concern about the dangers that misuse might pose to the psychoanalytic method, and for scientific reasons. The fact that the analyst's "personal equation" (Freud 1926e, p.220) would still remain even after the influence of countertransference had been mastered (i.e., ideally, eliminated) was regretfully accepted as inevitable. Freud was able to comfort himself with the fact that the personal equation[1] cannot be eliminated from observations even in astronomy, where it was discovered. However, he hoped that training analysis would lead to such a far-reaching balancing of the personal equation that satisfactory agreement would one day be achieved among analysts (Freud 1926e, p.220).

These reasons were decisive factors in the very different histories of the concepts of transference and countertransference. It was not until much later that their separate paths merged in the realization that "we are dealing with a system of relations in which each factor is a function of the other" (Loch 1965a, p. 15). Neyraut came to a similar conclusion in his study *Le transfert* (1974). Kemper (1969) spoke of transference and countertransference being a "functional unity." Earlier, Fliess (1953) had gone as far as to view some transference phenomena as reactions to the analyst's countertransference. Their interaction was also emphasized by Moeller (1977).

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1 ' Freud knew of the concept's origin in astronomy. The famous case that led to the discovery of personal equation concerned the astronomers Maskelyne and Kinnebrook. Maskelyne, the director of an observatory, dismissed his assistant in 1796 because the latter always observed the passage of stars more than half a second later than he did. He could not imagine that an equally attentive observer using the same method would register systematically different times. It was not until 26 years later that Bessel recognized this possibility, thus solving the discrepancy and leading to Kinnebrook's later rehabilitation. As Russell et al. wrote in 1945, "This personal equation is an extremely troublesome error, because it varies with the observer's physical condition and also with the nature and brightness of the object."

While transference changed within a short time from a major obstacle to the most powerful resource in treatment, countertransference retained its negative image for almost 40 years. It contradicted the time-honored scientific ideal which Freud was committed to and which was important to him both out of personal conviction and for the sake of his controversial method's reputation. In the history of science the analogy with the mirror can be found as early as Sir Francis Bacon's theory of idols (1960 [1620]), where it also was associated with the notion of objectivity, namely that true nature becomes apparent after cleaning the observing, reflecting mirror and eliminating all subjective elements. This led to the demand that countertransference, i.e., the mirror's blind spots and other blemishes, be eliminated. The demand that neurotic conflicts, and especially their manifestations toward the patient in countertransference, be overcome developed into a downright phobic attitude on the part of analysts toward their own feelings.

Freud addresses his recommendations in particular to the young and ambitious psychoanalyst who starts off to cure with true psychoanalysis and not with treatment by suggestion. He also warns him against employing too much of his own individuality although the temptation is certainly great.

> It might be expected that it would be quite allowable and indeed useful, with a view to overcoming the patient's existing resistances, for the doctor to afford him a glimpse of his own mental defects and conflicts and, by giving him intimate information about his own life, enable him to put himself on an equal footing. One confidence deserves another, and anyone who demands intimacy from someone else must be prepared to give it in return.
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> But in psychoanalytic relations things often happen differently from what the psychology of consciousness might lead us to expect. Experience does not speak in favor of an affective technique of this kind. Nor is it hard to see that it involves a departure from psychoanalytic principles and verges upon treatment by suggestion. It may induce the patient to bring forward sooner and with less difficulty things he already knows but would otherwise have kept back for a time through conventional resistances. But this technique achieves nothing towards the uncovering of what is unconscious to the patient. It makes him even more incapable of overcoming his deeper resistances and in severer cases it invariably fails by encouraging the patient to be insatiable: he would like to reverse the situation, and finds the analysis of the doctor more interesting than his own. The resolution of the transference, too one of the main tasks of the treatment is made more difficult by an intimate attitude on the doctor's part, so that any gain there may be at the beginning is more than outweighed at the end. I have no hesitation, therefore, in condemning this kind of technique as incorrect. The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him. In practice, it is true, there is nothing to be said against a psychotherapist combining a certain amount of analysis with some suggestive influence in order to achieve a perceptible result in a shorter time — as is necessary, for instance, in institutions. But one has a right to insist that he himself should be in no doubt about what he is doing and should know that his method is not that of true psychoanalysis. (Freud 1912e, pp. 117-118)

The difference between what the psychotherapist and the psychoanalyst may do, or between psychotherapy and psychoanalysis, is as relevant today as it has ever been, and differences can be most easily clarified by using rules. The entire complex surrounding influence became associated with countertransference, creating a formidable practical and theoretical problem. The fear of countertransference is thus not only a personal matter; the analyst's professional responsibility requires him to avoid the unfavorable influences which countertransference came to embody. Countertransference was the Cinderella of psychoanalytic technique, and its other qualities did not become apparent until it too had become a princess. To be sure, there was a preconscious premonition of its hidden qualities long before it gained official recognition, but the whispers

could not make themselves heard. Thus the transformation seemed to take place overnight. The admiration now paid to the "new" countertransference creates the impression that many psychoanalysts immediately felt liberated, just as they did after Kohut's brilliant rehabilitation of narcissism. The strength of the phobic avoidance can be recognized in the fact that it was not until 30-40 years after Freud's discovery of countertransference (1910d, p. 144) that the subject was put in a new perspective in publications by A. and M. Balint (1939), Berman (1949), Winnicott (1949), A. Reich (1951), Cohen (1952), Gitelson (1952), and Little (1951). In hindsight, Heimann's original contribution on the subject (1950) was later seen as marking a turning point; we will discuss this publication in detail below.

The history of this concept (Orr 1954; Tower 1956) shows that there were a few forerunners to the above-mentioned publications from the 1950s. The obscurity of the positive aspects of countertransference can be demonstrated by referring to an article by Deutsch, missing from Orr's otherwise comprehensive study. Deutsch published her influential considerations on the relationship between countertransference and empathy in 1926; this line of work was continued by Racker in 1968. The title of Deutsch's article was "Occult Phenomena in Psychoanalysis" — no wonder these ideas remained in obscurity! The publications by Ferenczi (1950 [1919]), Stern (1924), Ferenczi and Rank (1924), W. Reich (1933), and A. Balint (1936) also did not have any significant influence.

Fenichel (1941) recognized relatively early that the fear of countertransference could bring the analyst to suppress every natural human emotion in his reactions toward the patient. Patients who had previously been in treatment with another analyst had often expressed surprise at his (Fenichel's) freedom and naturalness. They had believed that an analyst was somebody special and that he was not permitted to be human, although just the opposite impression should be dominant. The patient should always be able to depend on his analyst's humanity (Fenichel 1941, p.74). Berman (1949) also emphasizes that the negative evaluation of countertransference had led to rigid, antitherapeutic attitudes. The optimal emotional climate is described, for him, by clinical anecdotes which demonstrate the great therapeutic importance of an analyst's caring and genuine, sincere interest; however, this side of the psychoanalytic process, to which the examples of many reputable analysts have contributed, is handed down primarily in a personal and informal way.

This verbally transmitted wealth of experience did not bear fruit because Freud's rules were ritualized. Yet since the burdens particular to our profession do not change from generation to generation, it is not surprising that this has been a prominent topic in the history of psychoanalysis and has been discussed at all the important symposia held by the International Psychoanalytical Association on psychoanalytic technique for the past half century. The disputes about Freud's suggestions on technique, impressively exemplified by the mirror analogy, emotional coldness, neutrality, and incognito, are repeated regularly because every psychoanalyst is exposed over and over again to the diverse disturbances of a complex situation. Thus a high value is placed on all solutions which promise

to be reliable and easy to use. Understandable as it is, however, that novices in particular follow Freud word for word, this should not be viewed as an inevitable repetition compulsion confronting every generation of psychoanalysts in the recourse to the literal meaning of his words instead of to their historical meaning.

The further clarification of the foundations of therapy contributed to putting countertransference in a new light. The fact that numerous authors worked in the same direction simultaneously but independently demonstrates that the time was ripe for fundamental changes.

M. Balint and Tarachow (1950) reported that psychoanalytic technique was entering a new phase of development. The main concern had previously been the analysis of transference, i.e., the patient's contribution to the analytic process. In the phase beginning at that time the analyst's role, especially with regard to his countertransference, moved to the center of practical interest.

For the following reasons we will treat the articles by Heimann (1950,1960) as exemplary in this connection.

1. Her initial presentation (1950) marks the turning point to a *comprehensive* understanding of countertransference as encompassing *all* the analyst's feelings toward the patient.
2. Heimann emphasized more than any other author the positive value of countertransference as an essential diagnostic aid and even as an instrument for psychoanalytic research. She also attributed the creation of countertransference to the *patient.*
3. Thus the countertransference feelings were in a certain sense depersonalized. Admittedly, they originate within the analyst, but as *products of the patient.* The more completely the analyst opens himself to countertransference, the more useful it is as a diagnostic aid. Heimann traced the *origin* of countertransference back to the patient and initially explained it as projective identification in the Kleinian sense.
4. Heimann initiated the comprehensive conception of countertransference, but after 1950 made numerous critical comments on "misunderstandings." She was stimulated to further clarify her position in discussions which took place in Heidelberg and Frankfurt within the framework of the studies on the interpretive process initiated by Thomä (1967b); this led to her publications on the analyst's cognitive process (Heimann 1969,1977). Although she finally so distanced herself from the thesis that countertransference is the patient's creation that she expressed amazement at having ever made such an assertion (in a private conversation with B. and H. Thomä on August 3, 1980), this idea had long taken on a life of its own.

We believe it correct to mention such personal recollections here, because most analysts go through a learning process which is full of conflicts and which becomes more and more difficult with the increasing duration of training analyses. Heimann is a typical example. It was not until one of her last publications that she argued for the therapeutic use of countertransference without appealing to projective identification and independently of Klein's theories.

Special maieutic skill was required to free this Cinderella of the negative

connotations Freud attached to it from the very beginning. Conceptual changes lead to profound professional and personal conflicts among analysts, which can be lessened if an interpretive connection to Freud can be made plausible. Heimann had good reason to handle countertransference with kid gloves. Today we know (King 1983) that she was urgently advised by Hoffer and Klein not to present her paper "On Countertransference" (1950) at the International Psychoanalytic Congress in Zurich. It is understandable that she used the usual ploy, saying in effect, "Actually, Freud also viewed the matter in a similar way or always acted in this way in his practice; he was simply misunderstood." In this way she diplomatically pointed to "misreadings" which Freud's views on countertransference and his mirror and surgeon analogies had led to. Nerenz (1983) has recently gone even further and asserted that Freud has been misunderstood because of a "legend" in which his comprehensive understanding of countertransference has been reinterpreted and assigned its generally accepted negative connotation.

Yet, of course, even Ferenczi, back in 1918, had spoken of the analyst's resistance to countertransference. Ferenczi described three phases of countertransference. In the first phase the analyst succeeds in gaining "control of everything in his actions and speech, and also in his feelings, that might give occasion for any complications." In the second phase he then sinks into "resistance against the countertransference" and is in danger of becoming far too harsh and rejecting; this would postpone the establishment of transference or even make it completely impossible to achieve. "It is only after overcoming this stage that one perhaps reaches the third, namely, that of the control of the countertransference" (Ferenczi 1950 [1919], p.188). In the same publication Ferenczi accurately described the optimal attitude of the analyst as "constant oscillation between the free play of fantasy and critical scrutiny" (p. 189). The reader will be surprised to find that Ferenczi, of all people, after acknowledging the role of intuition, continued: "On the other hand, the doctor must subject the material submitted by himself and the patient to a logical scrutiny, and in his dealings and communications may only let himself be guided exclusively by the result of this mental effort" (p. 189).

With hindsight it is understandable that even Ferenczi's descriptions of the three phases of mastering countertransference failed to decrease the excessive anxiety which he described as the incorrect attitude. The analyst's acquired ability to control his own feelings and the exaggeration of this ability in resistance to countertransference cannot be altered by the vague observation that this is not the correct attitude. That is to say, if a strict control of feelings is introduced as the first learning experience, then it should come as no surprise that the result is "excessive anxiety" which is retained even when it should be discarded. In any case, Ferenczi's description of countertransference has had only minimal positive influence on its use. Psychoanalysts followed Freud's suggestions about technique very literally.

3.2 Countertransference in Its New Guise

There is no better description of the transformation of Cinderella into a radiant beauty than Heimann's following sentence, with its profound implications and consequences: "The analyst's countertransference is not only part and parcel of the analytic relationship, but it is the patient's *creation,* it is part of the patient's personality" (1950, p. 83). If countertransference had until then been regarded as a (more or less) strong neurotic reaction by the analyst to the patient's transference neurosis that was to be avoided as far as possible, now it became part and parcel of the analytic relationship and, later, "comprehensive" countertransference (Kernberg 1965). For Heimann, countertransference includes all the feelings the analyst experiences toward the patient. Her thesis is that

> the analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's countertransference is an instrument of research into the patient's unconscious .... It has not been sufficiently stressed that it is a relationship between two persons. What distinguishes this relationship from others is not the presence of feelings in one partner, the patient, and their absence in the other, the analyst, but above all the degree of the feelings experienced and the use made of them, these factors being interdependent. (Heimann 1950, p.81)

It is essential that the analyst, in contrast to the patient, does not abreact the feelings released in him. They are subordinated to the task of analysis, in which the analyst functions as a mirror for the patient.

> The analyst along with this freely working attention needs a freely roused emotional sensibility so as to follow the patient's emotional movements and unconscious fantasies. Our 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 is the most dynamic way in which his patient's voice reaches him. In the comparison of feelings roused in himself with his patient's associations and behavior, the analyst possesses a most valuable means of checking whether he has understood or failed to understand his patient. (Heimann 1950, p.82)

Since Heimann herself later considerably narrowed her conception of countertransference and wanted to have its area of applicability tested by reliable criteria, we can conclude our discussion of this theme. In psychoanalysis theories not only serve to solve substantive problems, but are embedded in a genealogy or tradition. With the new theory of countertransference, Heimann was very probably attempting to reconcile the conflicting positions of her teachers Reik and Klein. Through his countertransference the analyst hears with Reik's "third ear," and the patient's creation allegedly reaches him via the mechanisms described by Klein.

In the theory espoused by Klein and her school, the analyst's capacity for empathy is dependent on his recognition of the projective and introjective identification processes which underly the psychopathology and which proceed unconsciously in the patient. The following reasons are given for this.

Paranoid-schizoid and depressive positions are viewed as necessary dispositions of general and, under additional conditions, specific psychopathology. The transitions from "normal" to "pathologic" are gradual and smooth. Because of the assumed innate polarity of instincts and the secondary significance of experience, everyone is subject to the development of both positions (as

unconscious "psychotic core") and to their effects on projective and introjective identifications.

> The fixation point of the psychotic illnesses lies in the paranoid-schizoid position and at the beginning of the depressive position .... If the depressive position has been reached and at least partially worked through, the difficulties encountered in the later development of the individual are not of a psychotic, but of a neurotic nature. (Segal 1964, p.61)

Since the depressive position is unconsciously retained, the neurosis inevitably becomes a universal phenomenon. Because of the general presence of these positions, the psychoanalytic process proceeds evenly according to the dominance of one or the other position insofar as the analyst acts as a *perfect mirror* and promotes the development of the transference neurosis in the sense of the unfolding of projective and introjective identification. These two processes determine the kind of object relationship to internal and external objects, for both patient and analyst.

The analyst's capacity for empathy is explained formally and substantively by the two aspects of identification (Segal 1964). Empathy in its metaphoric representation as a receiver is equated with countertransference (Rosenfeld 1955, p. 193). Through self-perception the analyst becomes able to trace a certain feeling back to the patient's projection. Thus Bion concludes the presentation of one vignette with the following words: "It will be noted that my interpretation depends on the use of Melanie Klein's theory of projective identification, first to illuminate my countertransference, and then to frame the interpretation which I gave the patient" (Bion 1955, p. 224). Money-Kyrle described the smooth, "normal course" of transference and countertransference as a fairly rapid oscillation between introjection and projection:

> As the patient speaks, the analyst will, as it were, become introjectively identified with him, and having understood him inside, will reproject him and interpret. But what I think the analyst is most aware of is the projective phase that is to say, the phase in which the patient is the representative of a former immature or ill part of himself, including his damaged objects, which he can now understand and therefore treat by interpretation, in the external world. (Money-Kyrle 1956, p.361)

Grinberg (1979) describes the analyst's unconscious answers to the patient's projections as "projective counteridentification."

The substantive and formal connection of empathy to the processes of projective and introjective identification renders only those analysts who have "worked through" the paranoid-schizoid and the depressive positions personally and psychoanalytically fully capable of cognition. In the Kleinian theory of object relationships, unconscious fantasies — as products of instincts — are neglected relative to real persons from one's environment with regard to the constitution of the object in both its form and content (see Guntrip 1961 p.230; 1968, p.415; 1971, pp.54-66). According to this, the analyst fulfills his task best when he acts as an impersonal mirror or neutral interpreter (Segal 1964). The Kleinian psychoanalyst ties his purely interpretive technique to a position of maximum neutrality. In terms of the metaphor, the mirror does not have any more blind spots insofar as the analyst has achieved the most profound insights into his own

projective and introjective identifications. The Kleinian school can legitimately continue to claim to be able to employ a purely psychoanalytic technique even for patients other psychoanalysts view as requiring variations or modifications of technique.

From a scientific point of view it is distressing that the family ties within psychoanalysis lead to the development of new ideas only by means of a process of bracketing out well-justified criticism. For example, Heimann had neglected Grotjahn's (1950) criticism of Reik's ideas as well as Bibring's (1947) and Glover's (1945) criticism of Klein's teachings. Nevertheless, the liberating effect generated by the decisiveness with which Heimann described countertransference as the patient's creation cannot be valued highly enough. Ten years later Heimann had to straighten out some misunderstandings; "some" trainees had begun to make interpretations according to "feeling," quoting her article in support. When Heimann expressed criticism, the trainees claimed to be following her new conceptualization of countertransference and did not appear inclined to test interpretations on the actual events in the analysis (Heimann 1960). While Heimann had achieved her "main objective...to lay the ghost of the 'unfeeling,' inhuman analyst, and to show the operational significance of the countertransference" (Heimann 1960, p. 10), it is nonetheless necessary for this banishment to be repeated in every generation since the ghost reappears again. Without a doubt this is easier today because a distinguished analyst has set a precedent. Yet other questions remain to be answered, questions which were not posed in Freud's theory of countertransference because they seemed inapplicable in his approach.

3.3 Consequences and Problems of the Comprehensive Conception

The road to the integration of countertransference seems to be paved with misunderstandings which not only arise in trainees and which are not only caused by the failure to test interpretations based on countertransference in the analytic situation, as criticized by Heimann. The new understanding of countertransference had implications for basic problems of psychoanalytic technique and consequently led to various attempts to develop answers. At question is nothing less than the analyst's own cognitive process, i.e., the complex in which his therapeutic actions and especially his particular interpretations originate and are founded. The implication of appealing to interpretations based on feeling (as described above) without being concerned about their verification in the analytic situation and about real events is that their justification, i.e., their validity, is eo ipso presumed from the beginning. If countertransference is accorded the status of the central perceptive function, there is more than a remote danger that a reliable power of judgement will be attributed to it.

The concept of countertransference as transformed by Heimann seems to have entered into a close relationship with "evenly suspended attention" (see Sect. 7.3). Yet how can we go from unprejudiced listening to reliable knowledge that

our own physical sensations, feelings, fantasies, and rational considerations correspond to the patient's unconscious processes, whether through reciprocity or through complementarity? The fact that Heimann raised countertransference to the level of a research instrument provided support for the naive idea that clarifying the origin of the analyst's fantasies would in itself ensure reliable and valid conclusions with regard to the patient's unconscious processes. However, how does it happen that Heimann's "countertransference" and Kohut's "empathy," closely related tools which cannot conceal their descent from Reik's third ear, arrive at completely different statements about a patient's unconscious? We will concern ourselves with the origin and foundation of interpretations, a topic largely neglected in psychoanalysis, in Chap. 10. Reiss (1983) has presented a thorough study of the problems which have to be solved in an attempt to grasp the interactional origin of empathy.

The huge difference between, on the one hand, the assertion that countertransference is the core of the analytic relationship and the patient's creation and, on the other, the proof of this assertion has hardly been tackled. Heimann's thesis, which goes far beyond merely laying the ghost and far beyond rehabilitating countertransference (including its hypothetical explanatory basis in projective identification), is instead treated as if it were already well founded, especially with regard to very specific thoughts and fantasies which the analyst has in individual cases. We summarize our own investigations of the *genesis* of analysts' fantasies and of their *foundation* in the transformation into interpretations, including the controls in the analytic situation demanded by Heimann, in Sect. 3.5. If countertransference is used as an instrument of perception, we are dealing in part with the solution to the problem Heimann referred to as "control" in the therapeutic situation. This control, in the sense of checking, is all the more necessary because it is easy for the analyst to "fall into the temptation of projecting outwards some of the peculiarities of his own personality, which he has dimly perceived, into the field of science, as a theory having universal validity" (Freud 1912e, p. 117) or to attribute these peculiarities to the patient instead of to himself. Exactly because psychoanalysis attempts to make full use of subjectivity, as Loch (1965a) rightly emphasized, it is essential for analysts to be conscious of subjectivity in order to be able to discuss a personal theory intersubjectively. This requires that countertransference be distinguished from the analyst's personal theory; discussion can clarify which theoretical assumptions actually influence treatment.

The comprehensive concept of countertransference appears to have especially the following theoretical and practical consequences. Without disturbing the still valid demand that the blind spots of countertransference in Freud's sense be overcome, the comprehensive concept led to the creation of links to Freud's receiver model of psychoanalytic perception (see Sect. 7.3). The comprehensive concept revived a tradition Reik had especially fostered. A secondary aspect of this tradition is the related idea that empathic perception from unconscious to unconscious does not recognize any further foundation whereby a particularly "psychoanalytic" understanding of truth is claimed. It should be noted that cultivation of this tradition in psychoanalysis is not limited to any particular

school.

The attempt by psychoanalysts of the Kleinian school to reduce the psychoanalyst's patient-related fantasies to a few typical mechanisms and thus to provide an explanation for his empathy can also be viewed as another consequence of the comprehensive view of countertransference.

Heimann believed that the patient's unconscious partially expresses itself in countertransference. This view remained for her tied to the one-to-one relationship in analysis. The idea that one's own sensations might correspond to and be initiated by the other person's was soon transported into the field of applied psychoanalysis. There it spread like wildfire, because applied psychoanalysis makes it very difficult to exercise the controls demanded by Heimann. Today it is especially popular to view the fantasies of participants at technical seminars as reflections of a patient's unconscious. The more ideas the participants have and the more convincing the moderator is in discerning a common theme in the multitude of perspectives, the more productive these seminars are. They familiarize the participants with fantasies and unconscious wishes hidden behind the manifest phenomena. The joint fantasizing about a patient thus fulfills a primary didactic function, which somehow can also provide benefits for treatment. This "somehow" is of course the crux of the problem, because testable theses are posed only very rarely and because there is usually no feedback on the further development of the case being discussed. More exact clinical verification is probably completely impossible because an infinite number of variations of the themes can be imagined.

Thus we are faced with a dilemma. On the one hand it is instructive when there is much speculating and fantasizing at casuistic seminars, on the other it is often at an immense distance from the absent patient's problems and their unconscious motivation. Opinions differ on this dilemma. It is only possible to take unadulterated pleasure in fantasizing until the question is raised as to the nature of the relationship of the participants' associations to the absent patient's unconscious thoughts. We have stressed the patient's absence as a reminder that the seminar participants have only secondhand information available about him and that this information includes only what the treating analyst has reported. They look through a telescope whose lens system has produced numerous refractions of the characteristics of the object. Our analogy makes it clear that it is impossible to trace the path of the light without exact knowledge of the individual systems. In order at least to learn as much as possible about the treating analyst's approach, the custom of taking protocols of treatment sessions was initiated at the psychosomatic clinic at the University of Heidelberg in the 1960s; this permitted good insight into verbal exchanges (Thomä and Houben 1967; Thomä 1967). Klüwer also bases his investigations into the relationship between transference and countertransference in seminar discussions on detailed treatment protocols. The primary topics discussed in treatment influence the participants' dispositions and judgements. Sessions which are depressive stimulate different reactions than those in which the patient lets the analyst participate in his successes and seeks his approval. To this extent the seminar group is a sounding board. Yet how far is this analogy valid? Klüwer asserts that in seminar groups "phenomena of the

transference-countertransference relationship extend into the group via the protocols and direct statements in the discussion; there they can be grasped by the groups more quickly than by the attending analyst" (Klüwer 1983, p. 134). This assertion is supported by an assumption which itself first has to be proved, in other words, a *petitio principii* Klüwer in addition states "that as a matter of principle all the phenomena considered are interpreted strictly on the *patient* and not on the attending analyst" (Klüwer 1983, p. 134). This procedure certainly ensures harmony in the seminar and relieves the reporting therapist, who apparently does not speak on his own behalf. The patient's voice is heard through that of the analyst.

The critical comment of a seminar participant might, for example, be traced back to the patient who had first put his aggression into the analyst. The patient's aggression reaches the seminar by means of the analyst's unnoticed countertransference, where it can be grasped after being amplified by the sounding board. This schematic description makes it clear that perceptiveness bordering on telepathy would be necessary in order to leap over the many unclarified transformations and get back to the origin of the phenomena of transference and countertransference. Yet the sounding board can do just that! Every instrument of the polyphonous orchestra has its own resonance. Every seminar participant in his own way amplifies the patient's tone. It somehow happens that one resonance appears to have more to do with the patient than the others, and there are always some so far from him that they have practically nothing to do with him. Thus there are some things which have nothing to do with the patient. Yet who in the group knows this? Either the conductor, first violinist, or a distinguished soloist ensures that the resonance is somehow harmonious. Specific group dynamic processes take place which are very distant from the patient. It is not uncommon for the theory of projective identification to give ideas produced by resonance the semblance of scientific validity, where in fact only telepathic powers would suffice to bridge the many gaps in information. These critical comments restrict the didactic value of this seminar style considerably because such seminars promote belief in authority rather than scientific thinking.

The idea that the seminar is a sounding board has spread, especially in Germany, via Balint groups. While Balint himself also related the ideas of the members to the patients for didactic reasons when leading a case seminar, as a conductor he intervened in the resonance in an unobtrusive manner and adopted what appeared practicable to him. Countertransference mysticism held no fascination for him; it thrives above all in Germany and is just as foreign to the pragmatic "English" school as it is to the "British" object relations theorists (Sutherland 1980). The use of countertransference by de M'Uzan (1977, pp. 164-181) is also bound strictly to the analytic situation and to whether the patient can link the analyst's interpretations to his own experience. According to de M'Uzan, intensifying the analyst's sensitiveness for the analysand's unconscious processes sometimes makes the following process possible: In an altered state of consciousness, comparable with slight depersonalization but paradoxically also with increased attentiveness, and without a rationally recognizable connection to

the material being studied, the analyst perceives in words and images fragments of the analysand's thoughts which had never been conscious or which had been repressed. After an interpretation has been made, these contents are supplemented, and thus confirmed, by the analysand in the same session or later with associations or dreams.

The analyst must, of course, distinguish the conflicts triggered in him by the patient from his own unconscious conflicts. According to de M'Uzan one indication that conscious contents have been triggered by the patient is that the analyst registers unusual phenomena in subsequent self-observation, including stronger object devotion to the analysand together with a disturbance of his own sense of identity. Exact descriptions of this process in which the patient's association as it were confirms the countertransference — or not — could contribute to demystifying the concept. This psychic activity, which is not peculiar to either being awake, dreaming, or sleeping, is called "paradoxical thinking" *(pensée paradoxale)* by de M'Uzan (1977). It occurs in an instant when the psychic state of the analyst has become largely identical to that of the analysand. This paradoxical thinking is considered to originate in the zone between the unconscious and the preconscious because of the patient's partly incomprehensible and fragmentary speech.

The comprehensive concept of countertransference finally became so broad that it encompassed everything; it became identical with the analyst's entire psychic reality. McLaughlin (1981) therefore suggested abandoning the concept after it had become so inflated as to merge into psychic reality. However it is just as impossible to eliminate established speech habits, whose meanings are obvious to every analyst, as it is to abolish the phenomena to which they refer. For this reason McLaughlin's suggestion will not find any resonance, although it should be taken seriously at a deeper level. In pychoanalysis concepts not only take on expanded meanings, they are also redefined. Numerous and contradictory definitions are formulated, leading inevitably to confusion. For example, Heimann had to add that there are of course also habitual blind spots not caused by the patient, which thus would not be termed countertransference according to the new nomenclature. Heimann now called this habitual countertransference the analyst's transference. After the redefinition of countertransference, it was not clarified which of the many thoughts and fantasies which constitute the analyst's evenly suspended attention were imposed upon — or, as it is called in jargon, invested in — him by the patient.

Heimann not only laid a ghost and extended or redefined a concept, she created a special new theory (initially in association with Klein's mechanisms of projective and introjective identification); it was not generally recognized, however, that this theory had not yet passed the tests of scientific validity. That countertransference is the patient's creation was presented as a fact. Heimann had thus not been misunderstood at all by trainee psychoanalysts faithful to her theories. It was not until 10 years later that her statement was reclassified as a hypothesis inasmuch as clinical *control* was now urgently advised. During this period Heimann became critical of Klein's theories; her understanding of countertransference also changed accordingly because her belief in the

explanatory power of projective identification had begun to waver. For example, she (Heimann 1956, p.304) long continued to believe in the death instinct and derived disavowal and other resistance mechanisms from it. Those who presume the theory of projective identification to be valid still maintain that all countertransference answers are determined by the patient. Such assertions must, in accordance with Sandler (1976, p.46), be strictly rejected, because they make further clarification apparently superfluous and present a hypothesis as selfevident.

We hope we have clarified why the struggle for better definitions alone cannot resolve the confusion and why the suggestion that a concept be removed from circulation is not very productive. Concepts as such have a subordinate significance, essentially fulfilling a function within a theory and within a school of thought. Shane (1980) showed that the unwitting acceptance of rules of behavior from training and supervisory analysts can function as schoolspecific countertransference. Freud's and Heimann's definitions of countertransference fulfilled functions in different theories of therapeutic interaction and of the analytic processes dependent on it. Everything indicates that the phobic avoidance of feelings suggested by Freud's theory had unfortunate consequences, except in Freud's own treatments — Freud applied his rules flexibly (Cremerius 1981 b; Kanzer and Glenn 1980). It is just as certain that Heimann's innovations in treatment technique changed and reappraised more than a concept. "Making use of our subjectivity means to make it conscious." We agree completely with this demand by Loch (1965a, p. 18), which he supported with the following famous sentence from Freud's letter to Binswanger (1962, p.65): "A person is not free until he recognizes and overcomes each manifestation of his countertransference."

3.4 Concordance and Complementarity of Countertransference

We shall now consider a few attempts to describe typical examples of countertransference. Within the framework of Klein's theory, Racker (1957) distinguished among an analyst's countertransference reactions according to two forms of identification, calling them concordant and complementary. In concordant identification the analyst identifies himself with the corresponding part of the patient's psychic apparatus, ego with ego, superego with superego, and id with id. The analyst thus experiences the feeling in himself in the same way the patient does. The expression "complementary identification," which goes back to Deutsch (1926), describes the analyst's identification with the patient's objects of transference. The analyst then experiences feelings in the same way as the patient's mother or father, while the patient reexperiences feelings like those he had earlier with regard to his parental imagoes. Deutsch spoke out very early in favor of using countertransference:

> I call this procedure the "complementary position" in contrast to identification with the infantile patient. Only together do they form the essence of unconscious countertransference, the utilization and purposive mastering of which belong to the most important tasks of the analyst. This unconscious countertransference is not to be confused with the course-affective conscious relationship to the patient. (Deutsch 1926, p. 423, emphasis added)

Sandler added a role-theoretical supplement to the complementary position by tracing the interaction between patient and analyst back to the intrapsychic role relationship that each tries to impose on the other. "What I want to emphasize is that the role-relationship of the patient ... consists of a role in which he casts himself, and a *complementary* role in which he casts the analyst at that particular time" (Sandler 1976, p.44). Although it is difficult to expand role theory to include intrapsychic and unconscious processes, complementarity comes close to observation and experience according to this view. The analyst deals in a reflective manner with the roles unconsciously attributed to or imposed on him, reaches an understanding about it with the patient, and thus makes it possible for the patient to achieve an altered enactment. The therapeutic process could be described in role theory as a path leading more and more to the actual role that the patient not only plays but would like to be. The roles which are tailor-made for the patient are the ones which come closest to him (to his "true" self). The analyst's complementary function is essential; the reenactment would be more difficult if he refused the complementary role.

With the help of complementarity as a fundamental principle of social interaction, we are now also able to grasp why Ferenczi was able to make the observation reported above as early as 1919 (1950). Namely, the analyst's resistance to countertransference makes it more difficult for transference to be achieved, because an object that acts in a completely impersonal way tends to be repulsive. Equally, it would be a mistake to believe that such an object is especially appropriate to help old imagoes become faithful reflections of reality, and thus to secure their intellectual reconstruction. In role theory and from symbolic interactionism we are also able to derive why the consequences are bound to be similarly fatal if the comprehensive conception of countertransference explains the analyst's experience as a projection of inner objects. For how is someone to find and change himself through communication with some significant other if the analyst claims to be nothing more than what the patient is? This is exactly the case, however, in the strict Kleinian interpretation technique based on the theory of projection and introjection. That such interpretations could nonetheless be therapeutically effective is on an entirely different level. This could, for example, be associated with the fact that speaking about shifting good and bad elements back and forth facilitates identification with human nature in general and with one's own unconscious fantasies in particular.

Melanie Klein and her school deserve our praise for having extended the perceptive capacity of analysts for their countertransference and deepened their insights into the nature of evil in man. However much the patient contributes to the enactment of countertransference, this phenomenon arises in the analyst and he is responsible for it.

In our opinion the therapeutic turning point occurs precisely at the point of reflection on role enactment and role responsiveness. Building role theory into a stage model which goes back to Mead (1913) makes it possible to say that the psychoanalytic situation permits continuous trial action to take place so that both participants can move from the stage to the auditorium quickly and easily and

can thus observe themselves.

Both are virtually on the stage and in the audience at the same time. The patient's self-representation contains expressions of his favored leading role and enigmatic supporting role whose latent meanings are especially important to the analyst. Also in their roles as observers, the patient and the analyst do not remain on the same seats: the scene being enacted on the stage changes with the perspective. The analyst's interpretations contribute to the change in perspective, interrupt the patient's talking or silence, and contain metacommunications, i.e., information about the exchange taking place. Overemphasizing the metacommunicative aspect of the interpretation means failing to recognize that interpretations have the same effect on actors' portrayals as a director's instructions. That the director himself is also on the stage is demonstrated especially by the transference interpretations that add dramatic depth to the dialogue.

There are several objections to this stage model of the psychoanalytic dialogue, as we have extended it following Habermas (t971) and Loewald (1975). In fact, no analogy expresses the psychoanalytic situation properly; all comparisons are flawed. Yet the weaknesses of our analogy do not lie where the reader who takes exception to role theory or to the comparison of treatment for severe mental illnesses with a stage play might suppose. The tears wept there are no less authentic and real than those shed in real life. The transference and countertransference feelings are also authentic. With reference to Freud's profound remarks on the authenticity of transference (1915 a, especially pp. 166170), we would like to emphasize the responsibility of the analyst, who, as the director, is also responsible for his own countertransference. The comprehensive concept makes a virtue out of necessity, i.e., the inevitability of countertransference: the more, the better! In end effect this would mean, for example, the more countertransference, the better. This is an absurd consequence of the countertransference euphoria which in some places has now replaced the earlier evasion of it! Eissler has made the following ironic comment on these excesses:

> Countertransference was clearly defined by Freud as a psychic process in the analyst that is detrimental to the psychoanalytic process. It amounts to no less than a perversion of theory and practice when it is heralded as highly effective in bringing about the patient's cure. Jokingly, I might say that we seem to be not far from the point when candidates will be advised to resume their training analyses, because they do not form countertransferences to their patients. (1963a, p.457)

In the sense of the enlarged stage model we maintain that while the analyst is greatly affected by the patient, he can only fulfill his professional task when, as director and observer in one, he remains conscious of the great effect of his thoughts and actions in the analytic situation. Since, as Freud (1915a, p. 169) emphasized, the analyst also "evokes this love," he is partially responsible for the ideas which the patient forms about authenticity and reality in general and in particular. In terms of the stage model we reach the result that the analytic situation offers the patient a greater degree of freedom than real life does. Freud took the opposite view; he believed that the dependence of transference on

infantile experience and the latter's inevitable repetition limit one's freedom. Although this statement is partially valid, it does not take the fact into account that reenactment and role responsiveness in the analytic situation enlarge the realm of freedom because the possible forms of action enable restrictive templates to be resolved.

Reenactment permits the analyst to exert influence from the outset, which makes it easier for the patient, through therapy, "to acquire the extra piece of mental freedom" which for Freud was the goal of "a strictly regular, undiluted pychoanalysis" (Freud 1915 a, pp. 170, 171).

The stage analogy thus does not founder on authenticity. On the contrary, it is possible to speculate that things on the stage or in a dream are even more authentic because we know that we will escape again. Of course, we also know that pleasure seeks to achieve not only eternity but also reality.

It is precisely the restrictions of the psychoanalytic situation which create a secure realm for the patient to discover the roles that he had previously not been able to *occupy or cathect* adequately. The two meanings of the German *besetzen* are both important. The theory of cathexis concerns the unconscious inner world and its energetic regulation, which is far from being enacted, far from the level of expression. The analogy reaches its limit here, just as in the fact that in psychoanalysis formation and movement are largely restricted to verbal action. The animation of images evoked through countertransference is part of the analyst's cognitive process. Part of the patient's unconscious instinctual desire can be an inner image that an object stimulus fits, in harmony like a key fits a lock. Supplement, correspondence, and agreement characterize certain aspects of an interactional event. Whether the inner stimulus, the instinct, creates the image or the outer object provokes the endopsychic stimulus — we will pass over this age-old problem, to which Kunz (1946 a) dedicated a two-volume study. As Freud showed, the "loose connection" of the instinct with the object constitutes human development.

3.5 Should the Analyst Admit Countertransference?

We will now draw consequences which open new perspectives and bring the difficult problems of handling countertransference closer to a solution. We are referring to the controversial question of whether the analyst should admit his countertransference to the patient. Most analysts reject this proposition, referring to Freud's experiences and the incognito rule he derived from them. However, Winnicott (1949), Little (1951), and Searles (1965, pp. 192-215), in particular, gave examples to justify exceptions. Heimann warned for decades against confirming the patient's realistic perceptions, discovering only late that the analyst's admission of a feeling relating to a patient does not amount to a personal confession and does not burden the patient with the analyst's own personal problems. Upon closer examination it is clear that Freud's recommendations referred to not letting the patient participate in the analyst's personal conflicts, even with well-meaning intentions, because it confuses or burdens the patient and

can keep him from finding his own life style. Heimann also argued in this way until a late study with the pungent title "On the Necessity for the Analyst To Be Natural with His Patient." In a certain therapeutic situation Heimann not only let herself be led by a feeling, but even communicated it. She commented on this as follows:

> The communication of my feelings in violation of the rules appeared to me as something natural. I was somewhat surprised myself and thought more about it later. The description of one's self in another person is a well-known strategy of our patients, a compromise between the desire for frankness and resistance to it, and it is usual to tell this to our parents. I could have done this without mentioning my feelings. Thus I later tried to find formulations omitting my feelings, but I did not like any of the interpretations; they all seemed a little cramped. My self-supervision did not produce anything better. As detailed elsewhere (Heimann 1964),1 am against an analyst communicating his feelings to his patient and giving him an insight into the analyst's private life, because this burdens the patient and distracts from his own problems. While I did not find a better interpretation than that my patient had given, I recognized that the statement that I shudder at a IS-year-old having the mental caliber of a 70-year-old in reality does not disclose anything about my private life, just as my assertion does not that the female patient identified with the girl. (Heimann 1978, pp. 225-226)

It is essential that the communication of a feeling be considered in the sense of complementarity. This is the reason that Heimann can say that she has not revealed anything about her private life. We are concerned with a feeling tied to a situation; this feeling is, so to speak, part of an interaction and makes it clear to the patient what effect he has on the "object." We would like to discuss this aspect on a general level because we are convinced that still another way can then be found to employ countertransference profitably.

All patients find it incomprehensible that analysts apparently cannot be irritated by any affect and that they react to hopelessness with the same equanimity as to contempt and hate. Analysts also appear to maintain their neutrality when confronted with intense transference love. Yet appearances are deceptive, as we knew even before the comprehensive concept of countertransference was formulated. What must the effect be, however, if the analyst indirectly ruins his credibility by putting himself beyond good and evil and indicating to the patient what the patient, based on his unconscious wishes, intends to do with the analyst as the transference object? Part of the usual interpretation strategy is also the intention to show the patient that he really means another object, such as his father, mother, or sibling. Thus the analyst cannot be personally affected! Escaping from this theoretically and therapeutically regrettable situation requires conceding, at least in principle, that the analyst can be affected and moved. Neutrality in the sense of reflective restraint begins after countertransference has been experienced, and makes our professional task possible by creating a distance to the natural physical-sensual complementary reactions which can be triggered by the patient's sexual and aggressive impulses. We therefore consider it vital to let the patient participate in the analyst's reflections, including those about the context and background of interpretations, in order to facilitate his identifications. This permits us to regulate the relationship of closeness and distance to the analyst as the "object." Heimann described this process; we have tried to describe its fundamental significance.