

## A BRIEF HISTORY OF THE CONCEPT OF COUNTERTRANSFERENCE

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Freud was very much aware that the analyst's unconscious response to the patient was very important and had the potential to influence the treatment. His idea about how this took place was very different from ours, however, as can be seen by his treatment of the Rat Man, in which he invited him for dinner and gave him a gift (Gottlieb, 1989). He did not consider either of these things as having anything to do with countertransference because they were within his conscious awareness and he defined countertransference as the analyst's unconscious response to the patient and believed that it had the potential to cause difficulty in the treatment. He wrote:

"We have become aware of the 'counter-transference,' which arises in [the physician] as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and over-come it" (Freud, 1910, p. 144-145). At this time, Freud realized that no analyst could go further than his "complexes and resistances" permitted, and recommended self-analysis as the solution. In 1912, he realized that self-analysis was not enough and insisted on a training analysis that was conducted by another analyst. And in 1937, he recommended periodic reanalysis of the analyst. At the same time that Freud was concerned about the countertransference, particularly because of sexual relationships that were taking place between some analysts and their patients, "[i]n a letter to Jones (1909) he

also spoke of the possible advantage that could occur from understanding one's countertransference" (Jacobs, 2002, p. 19).

Slakter (1987) has pointed out that for the next forty years, up to 1950, most analysts followed Freud's lead and defined countertransference as the analyst's transference to the patient that interfered with treatment. Slakter notes that Ferenczi (1919) was an exception, however, in that he included the analyst's emotional reactions to the personality of the patient and called these reactions the "objective countertransference." Slakter also mentions Helene Deutsch (1926) and Ella Freeman Sharpe (1930) as seeing countertransference as having positive aspects that could be helpful to the treatment, in addition to having negative aspects. They continued to define countertransference as the unconscious fantasies of the analyst about the patient's transference, however.

Around 1950, there were a number of papers that articulated a revised view of countertransference that included all the reactions of the analyst to the patient, both conscious and unconscious, and included reactions to the patient's personality in addition to reactions to the patient's transference. Abend (1989) states that most summaries focus on three papers: one written by Winnicott in 1949, one by Paula Heimann in 1950, and one by Margaret Little in 1951.

Winnicott's paper discussed work with borderline and psychotic patients, and he believed that at some point in the treatment some of these patients would need to become aware of the analyst's objective hatred. He and Margaret Little both wrote that at times the analyst's countertransference should be discussed

with the patient. Paula Heimann, on the other hand, did not believe that it was useful to discuss the countertransference with the patient.

Heinrich Racker's papers on countertransference (1953, 1957) have been summarized well by Jaffe (1986). Racker suggested that every transference situation produces a countertransference that is necessary for the full understanding of the patient. The patient becomes cathected on an unconscious level and revives a primitive or infantile object for the analyst, just as the analyst does for the patient. There are two alternative modes of identification of the analyst with the patient. The first mode is a concordant identification. Here the analyst resonates with aspects of the patient that are ego-syntonic for the analyst. Here the positive transference and countertransference are present.

The second mode is a complementary identification, an identification with the patient's internalized objects. Jaffe states that the reason for the analyst's rejection of the patient's position is that the patient's position is anxiety-provoking or depressing for the analyst, and that the role of the superego is predominant here. He gives an example of the anxiety generated by a suicidal patient as a cause of a complementary identification.

Jaffe also describes Racker's distinction between countertransference *reaction*, which may be accessible to the analyst's conscious perception and working through, and a countertransference *position*, which is repressed and can set up a vicious circle that causes unanalyzability.

These papers were controversial at the time and fostered much interesting debate. They were written in England and South America either by Kleinians or

middle school British analysts and did not represent the mainstream thinking of American analysts and ego psychologists. In this country, Freida Fromm-Reichmann (1950), however, took a similar position when she described her work with primarily psychotic patients. She also proposed a broad definition of countertransference but advised against disclosing the countertransference because she saw it as a burden for the patient.

Annie Reich (1960) and a number of other analysts, however, were in favor of staying close to Freud's definition of countertransference as coming from the analyst's unconscious reactions and constituting an interference with the treatment. Annie Reich stated that countertransference "comprises the effects of the analyst's own unconscious needs and conflicts upon his understanding or technique....Conscious responses should be regarded as counter-transference only if they reach an inordinate intensity or are strongly tainted by inappropriate sexual or aggressive feelings, thus revealing themselves to be determined by unconscious infantile strivings" (p. ).

In 1989, Abend believed the majority of analysts had adopted a broad, revised meaning that includes all the reactions the analyst or therapist has to the patient, both conscious and unconscious. A number of analysts, though, including both Abend and Arlow (1987), preferred a version of Freud's narrow definition that includes only the unconscious conflicts of the analyst.

Fifteen years later, Abend (2002) described how he worked with his countertransference: "I believe I experience the influence of my countertransference reactions primarily through their subtly, and often silently

helping to shape my intuitive responses to my patients. They come to my conscious attention and demand explicit inspection only when they are exceptionally strong, or unusually disturbing to me. I realize that other analysts are much more devoted to conscious self-scrutiny as part of their technical approach. I have never been convinced, either by the Kleinians or other devotees of this approach in the use of countertransference, that there are reliable guides to distinguishing the patient's influence on the analyst's emotional responses from those which come primarily from the analyst's own dispositions. This caution supports my inclination to seek confirmatory evidence for my conjectures about what is going on between me and my patients from the pattern of the patient's association, rather than relying more confidently on my own self-observation" (p. 53). Nonetheless, Abend believes that he is more attuned to "subtleties in how I feel when I am with my patients than was true in the early part of my career" (p. 53).

Around this time, other concepts began to take the place of countertransference and emphasize co-created aspects of the treatment. The concept of "role responsiveness" describes the way the patient seeks to actualize the transference in an object relationship with the analyst in the here-and-now, behaving in ways that manipulate the analyst into a reciprocal relationship (Sandler, Dare and Holder, 1973; Sandler, 1987). A complex system of unconscious cues is communicated and the analyst uses "free-floating responsiveness," which Sandler says is a parallel to free-floating attention. The analyst or therapist may only become aware of the role he or she is playing by

observing his or her own behavior, responses and attitudes after they have been carried over into action.

Smith (1990) wants to extend broadly Sandler's idea and he proposes that all transferences are actualized before they are interpreted. They are first enacted in the countertransference, and it is through these enactments that therapists become aware of the transference, and become able to make transference interpretations. Smith observes that these enactments take many forms, ranging from overt acting out to enactments in the content of interventions, feelings, fantasies and formulations.

Schwaber (1992) characterizes countertransference as a retreat from the patient's vantage point. She started out as a selfpsychologist, with her emphasis on empathy, but later branched out with her own way of working, which is very detailed and precise, and she is willing to interpret minute resistances. Her point is that when the analyst is no longer seeing things from the patient's point of view, the countertransference is there and is creating a disturbance in the work.

Jacobs's (1998) work on countertransference enactments focuses on the subtler affective communications. During the 1980's and 1990's, a number of analysts (Basseches, Chused, P. Ellman, Goodman, Helm, McLaughlin, Moskowitz, S.Ellman,) became interested in transference countertransference enactments emphasizing the involvement of both patient and analyst in nonverbal communications of feeling and action. Many of these analysts had a chapter in a book on enactments edited by S. Ellman and Moskowitz (1998).

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Westen and Gabbard (2002b) note that “the broadening of the concept in recent years has raised the question of how to distinguish what might be called ‘unobjectionable’ and ‘objectionable’ countertransference reactions. The former facilitate the process by maintaining the focus on the patient’s dynamics (including dynamics that pull the analyst into enactments that can then be understood, and that do not foreclose the possibility of later analytic work). The latter prevent the patient from bringing important dynamics into the treatment hour in word or deed” (p. 127).

Lachmann (1998) wants to get rid of the term countertransference altogether, as does Fosshage (1995), who emphasizes the totality of the analyst's experience of the analysand. The analyst's experience includes "...theoretical models, organizing patterns, shifting motivations (Lichtenberg, 1989), momentary self-states (Lichtenberg, Lachmann & Fosshage, 1992) and variable listening perspectives" (Fosshage, 1995, p. 380.) Grusky (2002) also notes that the analyst has important experiences of emotional and common-sense understanding of the analysand that do not exactly fit the definitions of countertransference or projective identification.

In summary, the concept of countertransference continues to change, and its usefulness is even being questioned.

