2

COUNTERTRANSFERENCE AND THE PATIENT'S RESPONSE

I

I will begin with a story:

A patient whose mother had recently died was to give a radio talk on a subject in which he knew his analyst was interested. He gave him the script to read beforehand, and the analyst had the opportunity of hearing the broadcast. The patient felt very unwilling to give it just then, in view of his mother's death, but could not alter the arrangement. The day after the broadcast he arrived for his analysis in a state of anxiety and confusion.

The analyst (who was a very experienced man) interpreted the patient's distress as being due to a fear lest he, the analyst, should be jealous of what had clearly been a success and be wanting to deprive him of it and of its results. The interpretation was accepted, the distress cleared up quite quickly, and the analysis went on.

Two years later (the analysis having ended in the meanwhile) the patient was at a party which he found he could not enjoy, and he realized that it was a week after the anniversary of his mother's death. Suddenly it came to him that what had troubled him at the time of his

broadcast had been a very simple and obvious thing, sadness that his mother was not there to enjoy his success (or even to know about it) and guilt that he had enjoyed it while she was dead. Instead of being able to mourn for her (by canceling the broadcast) he had had to behave as if he denied her death, almost in a manic way. He recognized that the interpretation given, which could be substantially correct, had in fact been the correct one at the time for the analyst, who had actually been jealous of him, and that it was the analyst's unconscious guilt that had led to the giving of an inappropriate interpretation. Its acceptance had come about through the patient's unconscious recognition of its correctness for his analyst and his identification with, or nondifferentiation from, him. Now he could accept it as true for himself in a totally different way, on another level—i.e. that of his jealousy of his father's success with his mother and guilt about himself having a success which represented success with his mother, of which his father would be jealous and want to deprive him. (His father had in fact been jealous of him in his baby relation to his mother. He discovered later still that if left to himself he would probably have broadcast anyway, but for a different reason, and it would have felt quite different.) But the analyst's behavior in giving such an interpretation must be attributed to countertransference.

II

Surprisingly little has been written on countertransference apart from books and papers on technique chiefly meant for students in training. The writers of these all emphasize the same two points—the importance and potential danger of countertransference and the need for thorough analysis of analysts. Much more has been written about transference, and a lot of that would apply equally well to countertransference. I found myself wondering why, and also why different people use the term *countertransference* to mean different things. The term is used to mean any or all of the following:

a. The analyst's unconscious attitude to the patient.
b. Repressed elements, hitherto unanalyzed, in the analyst himself which attach to the patient in the same way as the patient "transfers" to the analyst affects, etc. belonging to his parents or

to the objects of his childhood: i.e. the analyst regards the patient (temporarily and varyingly) as he regarded his own parents.

c. Some specific attitude or mechanism with which the analyst meets the patient's transference.

d. The whole of the analyst's attitudes and behavior toward his patient. This includes all the others, and any conscious attitudes as well.

The question is why it is so undefined or undefinable. Is it that true isolation of countertransference is impossible while the comprehensive idea of it is clumsy and unmanageable? I found four reasons.

1. I would say that unconscious countertransference is something which cannot be observed directly as such, but only in its effects: we might compare the difficulty with that of the physicists who try to define or observe a force which is manifested as light waves, gravity, etc. but which cannot be detected or observed directly.

2. I think part of the difficulty arises from the fact that (considering it metapsychologically) the analyst's total attitude involves his whole psyche, id, and any superego remnants as well as ego (he is also concerned with all these in the patient), and there are no clear boundaries differentiating them.

3. Any analysis (even self-analysis) postulates both an analysand and an analyst: in a sense they are inseparable. And similarly, transference and countertransference are inseparable, something suggested in the fact that what is written about the one can so largely be applied to the other.

4. More important than any of these, I think there is an attitude toward countertransference, i.e. toward one's own feelings and ideas, that is really paranoid or phobic, especially where the feelings are or may be subjective.

In one of his papers on technique Freud pointed out that the progress of psychoanalysis had been held up for more than ten years through fear of interpreting the transference, and the attitude of psychotherapists of other schools to this day is to regard it as highly dangerous and to avoid it. The attitude of most analysts toward countertransference is precisely the same, that it is a known and recognized phenomenon but that it is unnecessary and even dangerous ever to interpret it. In any case, what is unconscious one cannot easily be aware of (if at all), and to try to observe and interpret

something unconscious in oneself is rather like trying to see the back of one's own head—it is a lot easier to see the back of someone else's. The fact of the patient's transference lends itself readily to avoidance by projection and rationalization, both mechanisms being characteristic for paranoia, and the myth of the impersonal, almost inhuman analyst who shows no feelings is consistent with this attitude. I wonder whether failure to make use of countertransference may not be having a precisely similar effect as far as the progress of psychoanalysis is concerned to that of ignoring or neglecting the transference. If we can make the right use of countertransference, may we not find that we have yet another extremely valuable, if not an indispensable, tool?

In writing this chapter, I found it very difficult to know which of the meanings of the term *countertransference* I was using, and I found that I tended to slip from one to another, although at the start I meant to limit it to the repressed, infantile, subjective, irrational feelings, some pleasurable, some painful, which belong to the second of my attempted definitions. This is usually the countertransference which is regarded as the source of difficulties and dangers.

But unconscious elements can be both normal and pathological, and not all repression is pathological any more than all conscious elements are "normal." The whole patient-analyst relationship includes both "normal" and pathological, conscious and unconscious, transference and countertransference, in varying proportions. It will always include something specific to both the individual patient, and the individual analyst. That is, every countertransference is different from every other, as every transference is different, and it varies within itself from day to day, according to variations in both patient and analyst and the outside world.

Repressed countertransference is a product of the unconscious part of the analyst's ego, that part nearest and most closely belonging to the id and least in contact with reality. It follows from this that the repetition compulsion is readily brought to bear on it, but other ego activities besides repression play a part in its development, of which the synthetic or integrative activity is most important. As I see it, countertransference is one of those compromise formations in the making of which the ego shows such surprising skill; it is in this respect essentially of the same order as a neurotic symptom, a perversion, or a sublimation. In it libidinal gratification is partly

forbidden and partly accepted; an element of aggression is woven in with both the gratification and the prohibition, and the distribution of the aggression determines the relative proportions of each. Since countertransference, like transference, is concerned with another person, the mechanisms of projection and introjection are of special importance.

By the time we have paranoia linked with countertransference, we have a mammoth subject to discuss, and to talk about the patient's response may be just nonsense unless we can find some simple way of approach. Many of our difficulties, unfortunately, seem to me to come from trying to oversimplify and from an almost compulsive attempt to separate out conscious from unconscious and repressed unconscious from what is unconscious but not repressed, often with an ignoring of the dynamic aspects of the thing. So once again I would like to say here that although I am talking mainly about the repressed elements in countertransference, I am not limiting myself strictly to this, but am letting it flow over into the other elements in the total relationship. At the risk of being disjointed my "simple approach" is chiefly a matter of talking about a few things and then trying to relate them to the main theme.

Speaking of the dynamic aspects brings us to the question: What is the driving force in any analysis? What is it that urges the patient on to get well? The answer surely is that it is the combined id urges of both patient and analyst, urges which in the case of the analyst have been modified and integrated as a result of his own analysis so that they have become more directed and effective. Successful combination of these urges seems to me to depend on a special kind of identification of the analyst with the patient.

III

Consciously, and surely to a great extent unconsciously too, we all want our patients to get well, and we can identify readily with them in their desire to get well, that is with their ego. But unconsciously we tend to identify also with the patient's superego and id, and thereby with him, in any prohibition on getting well and in his wish to stay ill and dependent, and by so doing we may slow down his recovery. Unconsciously we may exploit a patient's illness for our own purposes, both libidinal and aggressive, and he will quickly respond to this.

A patient who has been in analysis for some considerable time has usually become his analyst's love object. He is the person to whom the analyst wishes to make reparation, and the reparative impulses, even when conscious, may through a partial repression come under the sway of the repetition compulsion: it becomes necessary to make that same patient well over and over again, which in effect means making him ill over and over again in order to have him to make well.

Rightly used, this repetitive process may be progressive, and the "making ill" then takes the necessary and effective form of opening up anxieties which can be interpreted and worked through. But this implies a degree of unconscious willingness on the part of the analyst to allow his patient to get well, to become independent and to leave him. In general we can agree that these are all acceptable to any analyst, but failures of timing of interpretation such as that which I have described, failure in understanding, or any interference with working through, will play into the patient's own fear of getting well, with all that it involves in the way of losing his analyst, and these fears cannot be put right until the patient himself is ready to let the opportunity occur. The repetition compulsion in the patient is here the ally of the analyst, if the analyst is ready not to repeat his former mistake and so once more strengthen the patient's resistances.

This unconscious unwillingness on the analyst's part to let his patient leave him can sometimes take very subtle forms, in which the analysis itself can be used as a rationalization. The demand that a patient should not "act out" in situations outside the analysis may hinder the formation of those very extraanalytic relationships which belong with his recovery and are evidence of his growth and ego development. Transferences to people outside the analysis need not be an actual hindrance to the analytic work if the analyst is willing to use them, but unconsciously he may behave exactly like the parents who, "for the child's own good," interfere with his development by not allowing him to love someone else. The patient of course needs them just as a child needs to form identifications with people outside his home and parents.

These things are so insidious that our perception of them comes slowly, and in our resistance to them we are allying with the patient's superego through our own superego. At the same time, we are showing our own inability to tolerate a splitting either of something in the patient or of the therapeutic process itself; we are demanding to be the only cause of the patient's getting well.

A patient whose analysis is "interminable" then may perhaps be the victim of his analyst's (primary) narcissism as much as of his own, and an apparent negative therapeutic reaction may be the outcome of a counterresistance of the kind I have indicated in my story.

We all know that only a few of several possible interpretations are the important and dynamic ones at any given point in the analysis, but as in my story, the interpretation which is the appropriate one for the patient may be the very one which, for reasons of countertransference and counterresistance, is least available to the analyst at that moment. If the interpretation given is the one that is appropriate for the analyst himself, the patient may, through fear, submissiveness, etc., accept it in precisely the same way as he would accept the "correct" one, with immediate good effect. Only later does it come out that the effect obtained was not the one required, and that the patient's resistance has been thereby strengthened and the analysis prolonged.

IV

It has been said that it is fatal for an analyst to become identified with his patient and that empathy (as distinct from sympathy) and detachment are essential to success in analysis. But the basis of empathy, as of sympathy, is identification, and it is the detachment which makes the difference between them. This detachment comes about partly at least by the use of the ego function of reality testing with the introduction of the factors of time and distance. The analyst necessarily identifies with the patient, but there is for him an interval of time between himself and the experience which for the patient has the quality of immediacy—he knows it for past experience, while to the patient it is a present one. That makes it at that moment the patient's experience, not his, and if the analyst is experiencing it as a present thing, he is interfering with the patient's growth and development. When an experience is the patient's own and not the analyst's, an interval of distance is introduced automatically as well, and it is on the preservation of these intervals of time and distance that successful use of the countertransference may depend. The analyst's identification with the patient needs of course to be an introjective, not a projective, one.

When such an interval of time is introduced, the patient can feel his

experience in its immediacy, free from interference, and let it become past for him too, so that a fresh identification can be made with his analyst. When the interval of distance is introduced, the experience becomes the patient's alone, and he can separate himself off psychically from the analyst. Growth depends on an alternating rhythm of identification and separation brought about in this way by having experiences and knowing them for one's own, in a suitable setting.

To come back to the story with which I began, what happened was that the analyst felt the patient's unconscious, repressed jealousy as his own immediate experience, instead of as a past, remembered, one. The patient was immediately concerned with his mother's death, feeling the necessity to broadcast just then as an interference with his process of mourning, and the pleasure proper to it was transformed into a manic one, as if he denied his mother's death. Only later, after the interpretation, when his mourning had been transferred to the analyst and so become past, could he experience the jealousy situation as an immediate one, and then recognize (as something past and remembered) his analyst's countertransference reaction. His immediate reaction to the analyst's jealousy was a phobic one—displacement by (introjective) identification, and rerepression.

Failures in timing such as this, or failures to recognize transference references, are failures of the ego function of recognizing time and distance. Unconscious mind is timeless and irrational, "What's yours is mine, what's mine is my own." "What's yours is half mine and half the other half's mine, so it's all mine." These are infantile ways of thinking which are used in relation to feelings and experiences as much as to things, and countertransference becomes a hindrance to the patient's growth when the analyst uses them. The analyst becomes the blind man leading the blind, for neither has the use of the necessary two dimensions to know where he is at any given moment. But when the analyst can keep these intervals in his identification with his patient, it becomes possible for the patient to take the step forward of eliminating them again and of going on to the next experience when the process of establishing the interval has to be repeated.

This is one of the major difficulties of the student in training or the analyst who is undergoing further analysis—he is having to deal with things in his patients' analysis which have still the quality of presentness, or immediacy, for him himself, instead of that pastness which is

so important. In these circumstances it may be impossible for him always to keep this time interval, and he has then to defer as full an analysis as the patient might otherwise achieve until he has carried his own analysis further, and wait until a repetition of the material comes.

V

The discussions of Dr. Rosen's work—"Direct Analysis"—brought the subject of countertransference to the surface with a fresh challenge to us to know and understand much more clearly what we are doing. We heard how in the space of a few days or weeks patients who for years had been completely inaccessible had shown remarkable changes which, from some points of view at least, must be regarded as improvement. But what was not originally meant to be in the bargain, they seem to have remained permanently dependent on and attached to the therapist concerned. The description of the way in which the patients were treated and of the results stirred and disturbed most of us profoundly and apparently aroused a good deal of guilt among us, for several members in their contributions to the discussion beat their breasts and cried mea culpa.

I have tried to understand where so much guilt came from, and it seemed to me that a possible explanation of it might lie in the unconscious unwillingness to let patients go. Many seriously ill patients, especially psychotic cases, are not able, either for internal (psychological) reasons or for external (e.g. financial) ones, to go through with a full analysis and bring it to what we regard as a satisfactory conclusion, that is, with sufficient ego development for them to be able to live successfully in real independence of the analyst. In such cases a superficial relationship of dependence is continued (and rightly continued) indefinitely, by means of occasional "maintenance" sessions, the contact being preserved deliberately by the analyst. Such patients we can keep in this way without guilt, and the high proportion of successes in the treatment of these patients, it seems to me, may well depend on that very freedom from guilt.

But over and above this there is perhaps a tendency to identify particularly with the patient's id in psychotic cases generally; in fact it would sometimes be difficult to find the ego to identify with. This will

be a narcissistic identification on the level of the primary love-hate, which nevertheless lends itself readily to a transformation into object-love. The powerful stimulus of the extensively disintegrated personality touches on the most deeply repressed and carefully defended danger spots in the analyst, and correspondingly the most primitive (and incidentally least effective) of his defense mechanisms are called into play. But at the same time a small fragment of the patient's shattered ego may identify with the ego of the therapist (where the therapist's understanding of the patient's fears filters through to him, and he can introject the therapist's ego as a good object). He is then enabled to make a contact with reality through the therapist's contact with it. Such contact is tenuous and easily broken at first, but is capable of being strengthened and extended by a process of increasing introjection of the external world and reprojection of it, with a gradually increasing investment of it with libido derived originally from the therapist.

This contact may never become sufficient for the patient to be able to maintain it entirely alone, and in such a case continued contact with the therapist is essential and will need to vary in frequency according to the patient's changing condition and situation. I would compare the patient's position to that of a drowning man who has been brought to a boat, and while still in the water his hand is placed on the gunwale and held there by his rescuer until he can establish his own hold.

It follows from this perhaps, a truth already recognized, that the more disintegrated the patient the greater is the need for the analyst to be well integrated.

It may be that in those psychotic patients who do not respond to the usual analytic situation in the ordinary way, by developing a transference which can be interpreted and resolved, the countertransference has to do the whole of the work, and in order to find something in the patient with which to make contact, the therapist has to allow his ideas and the libidinal gratifications derived from his work to regress to a quite extraordinary degree. (We may wonder, for instance, about the pleasure an analyst derives from his patients sleeping during their analytic sessions with him.) It has been said that greater therapeutic results are found when a patient is so disturbed that the therapist experiences intense feelings and profound disturbance, and the underlying mechanism for this may be identification with the patient's id.

But these outstanding results are found in the work of two classes of analyst. One consists of beginners who are not afraid to allow their unconscious impulses a considerable degree of freedom because, through lack of experience, like children, they do not know or understand the dangers and do not recognize them. It works out well in quite a high proportion of cases because the positive feelings preponderate. Where it does not the results are mostly not seen or not disclosed—they may even be repressed. We all have our private graveyards, and not every grave has a headstone.

The other class consists of those experienced analysts who have gone through a stage of overcautiousness and have reached the point at which they can trust not only directly to their unconscious impulses as such (because of the modifications resulting from their own analyses) but also to being able at any given moment to bring the countertransference as it stands then into consciousness enough to see at least whether they are advancing or retarding the patient's recovery—in other words to overcome countertransference resistance.

At times the patient himself will help this, for transference and countertransference are not only syntheses by the patient and analyst acting separately but, like the analytic work as a whole, are the result of a joint effort. We often hear of the mirror which the analyst holds up to the patient, but the patient holds one up to the analyst too, and there is a whole series of reflections in each, repetitive in kind and subject to continual modification. The mirror in each case should become progressively clearer as the analysis goes on, for patient and analyst respond to each other in a reverberative kind of way, and increasing clearness in one mirror will bring the need for a corresponding clearing in the other.

The patient's ambivalence leads him both to try to break down the analyst's counterresistances (which can be a frightening thing to do) and also to identify with him in them and so to use them as his own. The question of giving him a "correct" interpretation is then of considerable importance from this point of view.

VI

When such a thing happens as I have quoted in this story, to neutralize the obstructive effect of a mistimed or wrongly empha-

sized interpretation by giving the "correct" interpretation when the occasion arises may not be enough. Not only should the mistake be admitted (and the patient is entitled not only to express his own anger but also to some expression of regret from the analyst for its occurrence, quite as much as for the occurrence of a mistake in the amount of his account or the time of his appointment), but its origin in unconscious countertransference may be explained, unless there is some definite contraindication for so doing, in which case it should be postponed until a suitable time comes, as it surely will. Such explanation may be essential for the further progress of the analysis, and it will have only beneficial results, increasing the patient's confidence in the honesty and goodwill of the analyst, showing him to be human enough to make mistakes and making clear the universality of the phenomenon of transference and the way in which it can arise in any relationship. Only harm can come from the withholding of such an interpretation.

Let me make it clear that I do not mean that I think countertransference interpretations should be unloaded injudiciously or without consideration on the heads of hapless patients, any more than transference interpretations are given without thought today. I mean that they should neither be positively avoided nor perhaps restricted to feelings which are justified or objective, such as those to which Dr. Winnicott refers in his paper "Hate in the Countertransference" (1949). (And of course they *cannot* be given unless something of the countertransference has become conscious.) The subjectivity of the feelings needs to be shown to the patient, though their actual origin need not be gone into (there should not be "confessions"). It should be enough to point out one's own need to analyze them, but above all the important thing is that they should be recognized by both analyst and patient.

In my view a time comes in the course of every analysis when it is essential for the patient to recognize the existence not only of the analyst's subjective feelings: that is, that the analyst must and does develop an unconscious countertransference which he is nevertheless able to deal with in such a way that it does not interfere to any serious extent with the patient's interests, especially the progress of cure. The point at which such recognition comes will of course vary in individual analyses, but it belongs rather to the later stages of analysis than to the earlier ones. Occasionally mistakes in technique or

mistakes such as errors in accounts, etc., make it necessary to refer to unconscious mental processes in the analyst (i.e. to countertransference) at an earlier time than one would choose, but the reference can be a slight one, sufficient only for the purpose of relieving the immediate anxiety. Too much stress on it at an early time would increase anxiety to what might be a really dangerous degree.

So much emphasis is laid on the unconscious fantasies of patients about their analysts that it is often ignored that they really come to know a great deal of truth about them—both actual and psychic. Such knowledge could not be prevented in any case, even if desirable, but patients do not know they have it, and part of the analyst's task is to bring it into consciousness, which may be the very thing to which he has himself the greatest resistance. Analysts often behave unconsciously exactly like the parents who put up a smoke screen and tantalize their children, tempting them to see the very things they forbid their seeing. Not to refer to countertransference is tantamount to denying its existence or forbidding the patient to know or speak about it.

The ever-quoted remedy for countertransference difficulties—deeper and more thorough analysis of the analyst—can at best only be an incomplete one, for some tendency to develop unconscious infantile countertransference is bound to remain. Analysis cannot reach the whole of the unconscious id, and we have only to remember that even the most thoroughly analyzed person still dreams to be reminded of this. Freud's saying "Where id was ego shall be" is an ideal, and like most other ideals is not fully realizable. All that we can really aim at is reaching the point at which the analyst's attitude to his own id impulses is no longer a paranoid one and so is safe from his patients' point of view and remembering besides that this will still vary in him from day to day, according to the stresses and strains to which he is exposed.

To my mind it is this question of a paranoid or phobic attitude toward the analyst's own feelings which constitutes the greatest danger and difficulty in countertransference. The very real fear of being flooded with feeling of any kind, rage, anxiety, love, etc., in relation to one's patient and of being passive to it and at its mercy leads to an unconscious avoidance or denial. Honest recognition of such feeling is essential to the analytic process, and the analysand is

naturally sensitive to any insincerity in his analyst and will inevitably respond to it with hostility. He will identify with the analyst in it (by introjection) as a means of denying his own feelings and will exploit it generally in every way possible, to the detriment of his analysis.

I have shown above that unconscious (and uninterpreted) countertransference may be responsible for the prolonging of analysis. It can equally well be responsible for the premature ending, and I feel that it is again in the final stages that most care is needed to avoid these things. Analysts writing about the final stages of analysis and its termination speak over and over again of the way in which patients reach a certain point and then either slip away and break off the analysis just at the moment when to continue is vital for its ultimate success or else slip again into another of their interminable repetitions, instead of analysing the anxiety situations. Countertransference may perhaps be the deciding factor at this point, and the analyst's willingness to deal with it may be the all-important thing.

I should perhaps add that I am sure that valuable unconscious countertransferences may also very often be responsible for the carrying through to a successful conclusion of analyses which have appeared earlier to be moving toward inevitable failure and also for quite a lot of the postanalytic work carried on by patients when analyses have been terminated prematurely for any reason.

In the later stages of analysis then, when the patient's capacity for objectivity is already increased, the analyst needs especially to be on the lookout for countertransference manifestations and for opportunities to interpret it, whether directly or indirectly, as and when the patient reveals it to him. Without it patients may fail to recognize objectively much of the irrational parental behavior which has been so powerful a factor in the development of the neurosis, for wherever the analyst does behave like the parents and conceals the fact, there is the point at which continued repression of what might otherwise be recognized is inevitable. It brings great relief to a patient to find that irrational behavior on the part of his parents was not intended for him personally, but was already transferred to him from their parents. To find his analyst doing the same kind of thing in minor ways can give conviction to his understanding and make the whole process more tolerable to him than anything else can do.

There will of course be fantasies in every analysis about the

analyst's feelings toward his patient—we know that from the start—and they have to be interpreted like any other fantasies, but beyond these a patient may quite well become aware of real feelings in his analyst even before the analyst himself is fully aware of them. There may be a great struggle against accepting the idea that the analyst can have unconscious countertransference feelings, but when once the patient's ego has accepted it certain ideas and memories which have been inaccessible till then may be brought into consciousness, things which would otherwise have stayed repressed.

I have spoken of the patient revealing the countertransference to the analyst, and I mean this quite literally, though it may sound like the dangerous blood sport of "analyzing the analyst." The "analytic rule" as it is usually worded nowadays is more helpful to us than in its original form. We no longer "require" our patients to tell us everything that is in their minds. On the contrary, we give them permission to do so, and what comes may on occasion be a piece of real countertransference interpretation for the analyst. Should he not be willing to accept it, rerepression with strengthened resistance follows, and consequently interruption or prolonging of the analysis. Together with the different formulation of the analytic rule goes a different way of giving interpretations or comments. In the old days analysts, like parents, said what they liked when they liked, as by right, and patients had to take it. Now, in return for the permission to speak or withhold freely, we ask our patients to allow us to say some things, and allow them too to refuse to accept them. This makes for a greater freedom all round to choose the time for giving interpretations and the form in which they are given, by a lessening of the didactic or authoritarian attitude.

Incidentally, a good many of the transference interpretations which are ordinarily given are capable of extension to demonstrate the possibility of countertransference; for instance, "You feel that I am angry, as your mother was when . . . " can include "I'm not angry as far as I know, but I'll have to find out about it, and if I am, to know why, for there's no real reason for me to be." Such things of course are often said, but they are not always thought of as countertransference interpretations. In my view that is what they are, and their use might well be developed consciously as a means of freeing countertransferences and making them more directly available for use (Searles 1965).

In her paper read at the Zurich Congress Dr. Heimann (1950) has referred to the appearance of some countertransference feelings as a kind of signal comparable to the development of anxiety as a warning of the approach of a traumatic situation. If I have understood her correctly, the disturbance which she describes is surely in fact anxiety, but a secondary anxiety which is justified and objective and brings a greater alertness and awareness of what is happening. She specifically states that in her opinion countertransference interpretations are best avoided.

But anxiety serves first of all another purpose—it is primarily a method of dealing with an actual trauma, however ineffective it may be in this capacity. It can happen that this secondary anxiety with its awareness and watchfulness can mask very effectively anxiety of a more primitive kind. Below the level of consciousness analyst and patient can be sensitive to each other's paranoid fears and persecutory feelings and become so to speak synchronized (or "in phase") in them, so that the analysis itself can be used by both as defense. The analyst may swing over from an introjective identification with the patient to a projective one, with a loss of those intervals of time and distance of which I spoke earlier, while the patient may defend himself by an introjective identification with the analyst, instead of being able to project onto him the persecuting objects.

Resolution of this situation can come about through conscious recognition of the countertransference either by the analyst or by the patient. Failure to recognize it may lead to either premature interruption of the analysis or to prolonging it. In each case there will be rerepression of what might otherwise have become conscious and strengthening of the resistances. Premature interruption is not necessarily fatal to the ultimate success of the analysis, any more than its prolongation is, for the presence of sufficient understanding and some valuable countertransference may make further progress possible, even after termination, by virtue of other introjections already made.

The ideal analyst of course exists only in imagination (whether the patient's or the analyst's), and can only be made actual and living in rare moments. But if the analyst can trust to his own modified id impulses, his own repressions of a valuable kind, and to something positive in his patient as well (presumably something which helped to decide him to undertake the analysis in the first place), then he can

provide enough of that thing which was missing from the patient's early environment and so badly needed—a person who can allow the patient to grow without either interference or overstimulation. Then a benign circle forms in the analytic situation which the patient can use to develop his own basic rhythmic patterns, and on those patterns to build up the more complex rhythms needed to deal with the world of external reality and his own continuously growing inner world.

VII

I have tried to show how patients respond to the unconscious countertransferences of their analysts, and in particular the importance of any paranoid attitude in the analyst to the countertransference itself. Countertransference is a defense mechanism of a synthetic kind, brought about by the analyst's unconscious ego, and is easily brought under the control of the repetition compulsion. But transference and countertransference are still further syntheses in that they are products of the combined unconscious work of patient and analyst. They depend on conditions which are partly internal and partly external to the analytic relationship and vary from week to week, day to day, and even moment to moment with the rapid intrapsychic and extrapsychic changes. Both are essential to psychoanalysis, and countertransference is no more to be feared or avoided than is transference; in fact it *cannot* be avoided, it can only be looked out for, controlled to some extent, and used.

But only insofar as analysis is a true sublimation for the analyst and not a perversion or addiction (as I think it sometimes may be) can we avoid countertransference neurosis. Patches of transitory countertransference neurosis may appear from time to time even in the most skilled, experienced and well-analyzed analysts, and they can be used positively to help patients toward recovery by means of their own transferences. According to the analyst's attitude to countertransference (which is ultimately his attitude to his own id impulses and his own feelings) paranoid anxiety, denial, condemnation, or acceptance, and the degree of his own willingness to allow it to become conscious to his patient as well as to himself, the patient will be encouraged to respond either by exploiting it repetitively or by using it progressively to good purpose.

Interpretation of countertransference along the lines which I have tried to indicate would make much heavier demands on analysts than before, but so did interpretation of transference at the time when it began to be used. Nowadays that is something which is taken for granted, and it has been found to have its compensations in that the analyst's libidinal impulses and creative and reparative wishes find effective gratification in the greater power and success of his work. I believe that similar results might follow a greater use of countertransference if we can find ways of using it, though I must stress the tentativeness with which I am putting forward any of these ideas.