Controversies About the Use of Countertransference in Psychoanalytic Technique*

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No psychoanalyst practicing today, regardless of his theoretical allegiance, would dispute the statement that carefully observing his own emotional responses to patients is absolutely essential to the proper performance of his analytic work. His emotional reactions are no longer merely regarded as potential interferences with optimal analytic functioning, but, on the contrary, as providing uniquely useful analytic data about his patients' emotional lives, as these are manifested in analysis. The information the analyst gains through his attentive self-awareness helps immeasurably in his understanding of the patient's transferences, and therefore it is utilized in formulating his therapeutic interventions. While the foregoing general summary of the situation would probably be received with universal agreement these days, that would certainly not have been the case in Freud's time. Furthermore, and much more significant for our purposes, there is considerable disagreement among analysts of today about how best to understand and employ this aspect of the analyst's highly trained sensitivity.

My plan in this lecture is to trace a schematic history of the evolution of the current view of the place of countertransference in psychoanalysis, because while doing so I can point out the emergence of some fundamental controversies that still influence our thinking in this area. This will enable me to talk about some of the important theoretical and practical differences in respect to the use of countertransference that exist in modern psychoanalytic technique, as it is practiced in various places. I will have to be quite selective in my interpretation of events in order to highlight what I see as the major issues, and later on I will also indicate my personal opinions on what is the best course to follow, among the choices available to today's psychoanalysts. I must add that it will quickly become obvious that there is no true consensus about what constitutes the one most correct theory, or technical posture, in world psychoanalysis nowa-

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days, nor for that matter was there such agreement even in Freud’s time. Like all other analysts elsewhere, you shall have to think through these complex issues, and arrive at your own conclusions about how best to use countertransference in the practice of our difficult profession. I hope that my description of the problem of countertransference, and how I have come to see it, will help you in your own struggles towards achieving a satisfactory position on this challenging, tricky and most essential aspect of the theory of psychoanalytic technique.

To begin with, we recall that Freud said very little about countertransference. His most complete exposition of technique was presented in the technical papers of 1912-1917, while the topographical model was still in place, and it emphasized the analyst’s learning to understand the patient’s unconscious complexes, and then helping the patient to recognize them himself. The analyst’s comprehension of the patient’s unconscious was not thought to be just a matter of straightforward rational cognition, but was instead a question of his capacity for unconscious attunement and recognition, which the analyst then used to formulate interpretations designed to provide the patient with new insight. Remember Freud’s famous analogy of the telephone receiver, from his 1912 paper, “Recommendations to physicians practicing psychoanalysis” in which he compared the analyst’s intuitive skill to the telephone instrument, and says that the analyst “must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient.”(pp.115-116)

Forgive me if I pass over the momentous significance of Freud’s discovery of the phenomena of transference and resistance, and the roles these play in psychoanalytic technique, because to elaborate those fundamentals of psychoanalysis here would take us too far away from the subject of countertransference. Freud, at this early point in his theorizing, did not say much about how the analyst’s unconscious was able to understand that of the patient, but he did realize very early on that the analyst’s countertransferences could possibly limit his ability to recognize what is going on in the patient.(1910). Freud assumed that the analyst’s own analysis succeeds in reducing his resistances and opens him to his own unconscious, thus equipping him, more or less, to clearly see the unconscious of his patients. Much later on in his career, after the revolutionary introduction of the structural hypothesis, and the consequent development of defense analysis as a cornerstone of technique, Freud, although only in passing, commented again about the problem of countertransference. He did so(1937) by suggesting that all analysts probably require a periodic return to personal analysis in order to maintain sufficient freedom within themselves to be able to understand the patients’ unconscious difficulties well enough to analyze them thoroughly.

However, in the years between Freud’s early papers on technique and the later
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ones, profound disagreements about how to do analysis had already made their appearance on the scene. In fact, even before the structural hypothesis replaced the topographic model, Ferenczi led an assault on Freud’s emphasis on insight as the main tool of therapy, a battle which raged throughout the intervening decades, in one form or another, and which still divides analysts today. Ferenczi’s thrust was to stress the patient’s emotional experience in analysis as central to being helped, and he argued against what he thought might be a too intellectual, too didactic treatment, in which insight might remain sterile and limited in its therapeutic impact. His so-called active technique encouraged various maneuvers on the part of the analyst, which, he believed, would promote a good analytic experience for patients. Those suggestions and others like them in the years since, have invariably aroused heated controversy and bitter debate, however, I will limit myself here to underlining Ferenczi’s placing greater emphasis on the patient’s emotional experience in analysis. What is interesting for us to note, as those of you who have heard me speak about supervision will remember, is that the Hungarian school of analysis, of which Ferenczi was a founding member, also laid more stress than did other schools on the psychoanalyst’s emotional experience while doing analysis with his patients! I think it is fair to conclude that what would later erupt into an impassioned and prolonged controversy about the subject of countertransference, and its place in technique, had its origin in these earlier discussions about the role of emotional experience versus that of insight in effective psychoanalysis.

An even more influential theoretical controversy, as far as the question of countertransference is concerned, was that introduced by the work of Melanie Klein and her followers. To put it most succinctly, her formulations about the part she believed is played by introjection, projection, projective identification and internalized object relations in human development, and in the metapsychology of transference itself, gave rise to important new trends in psychoanalytic theory, including the theory of psychoanalytic technique. For our purposes, I will concentrate on the redefinition of the role of countertransference to which her innovations led her followers. In landmark papers Winnicott(1949), Heimann(1950), and Little(1951) explicitly proposed that the analyst’s emotional experience when with each of his patients is, to a great extent, a response to that patient’s emotional life, and, in fact, is actually largely shaped by the patient.

Heimann’s expression of this idea was in these words, “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’.” Then she goes on to say that the
analyst's countertransference is actually, "the patient's creation, it is a part of the patient's personality."

Thus it followed, according to these thinkers, that by paying careful and explicit attention to his own mental state while doing analysis, the analyst is able to understand the psychic activity of his patients in exquisite and accurate detail. A fierce intellectual argument between the followers of Freud and those of Klein soon erupted, and it continued for many years. To greatly oversimplify what was actually a highly complex and many-sided debate, the classical position was to hold on to the concept of countertransference as applying only to emotional aspects of the analyst which interfere with his analytic functioning, as Freud had suggested. It was, however, recognized that countertransference, even in that very restricted definition of it, was more complicated than Freud had appreciated. For example, it would include subtle dimensions of the analyst's personality and character, such as a tendency to be directive, or morally critical, or overly sympathetic with certain types of suffering, and so on. Since the understanding of transference, and of psychopathology, had become more sophisticated with the advent of defense analysis and ego psychology, it was much clearer that analysts' own attitudes and tendencies, like those I have just mentioned as examples, could influence how the analyst works with certain aspects of his patients' problems, and, if extreme enough, could prove to be serious limitations on his ability to analyze them fully.

Meanwhile the Kleinians were joined by other groups in opposition to the classical Freudian position on countertransference. The interpersonal school in the United States, which has become known for its emphasis on patterns of interpersonal relationship, and many North American, European and South American analysts influenced by Kleinian thought who have preferred to think of themselves as object relations theorists, rather than pure Kleinians and so on, all joined in focusing much attention on the analyst's emotional reactions to patients in the analytic situation. More and more, the analyst's emotionality was seen as a source of valuable data about the analysand, and it became, in their opinion, the foundation upon which clinical intuition is built.

In my opinion, it is not very interesting to try to follow all the ways in which various authors of different schools have tried to define different subdivisions of the analyst's emotional reactions to patients in their efforts to clarify and resolve these problems. I would make one exception to this statement, and that is the idea that some of the analyst's responses are simply realistic ones, while others are considered to be countertransference. Many analysts of today still try to maintain this distinction, but in my view, this fails to take into account that the analyst's unconscious is always
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contributing some proportion of his response to any situation in life, including his analytic work, just as is true of all other people. Thus even accurate judgments cannot truly be said to be only realistic, as if no inner predilections lend some color and shape to these situations. Perhaps I can return to that issue later on. For now, from the standpoint of tracing the history of countertransference and technique, it will be more efficient to stay on the main road that theory has followed.

For those of you who share my fascination with understanding the history of concepts in psychoanalysis, it will be quite rewarding to read the work of Heinrich Racker on the subject of countertransference. He was a European who emigrated to Buenos Aires in Argentina, where he had a short but brilliant career which unfortunately was terminated when he died from illness while he was still rather a young man. Over the course of ten years or so in the 1950's, however, he published a series of papers on countertransference which constitute the most remarkable elaboration of the Kleinian position on the topic to be found in the world literature. He even went so far as to suggest that the analyst invariably develops a complex countertransference neurosis in response to each of his patient's transference neuroses, and he presented many clinical examples of the use of countertransference to formulate the nature of the patient's transferences.

Although such radical hypotheses as those of Racker have not convinced the entire psychoanalytic world to think as he did, over the course of years, all analysts, even the most traditional or classical Freidians, have come to accept that the analyst's internal emotional responses to his patients can provide psychoanalytically important information about their psychopathology. Furthermore, the term countertransference has come to be used, more or less universally, to refer to all the analyst's emotional responses to his patients, those which help him in his analytic work as well as those which interfere with it. Although some analysts are more systematic about it than others, none would dispute that analysts are obliged to monitor their personal reactions so as to obtain the benefits that such self-examination can bring to their analytic work. And no one today would suggest that the analyst's emotional reactions are not, in some substantial measure, affected by his analysands' emotionality, particularly their transferences. However, all analysts also acknowledge that the analyst's emotional responses are not entirely a product of the patient's influence, but are also formed by his personal life, that is to say, by his own personality and its ongoing efforts to deal with his private conflicts, as well as his responses to the significant events in his outside life that affect him. How the analyst is able to determine whether what he observes in himself at any specific moment can be trusted to be primarily a result of his patient's influence on him, and not overly contaminated by his own inner sources of
feeling, is not at all a simple question. While analysts of all schools and persuasions agree about that in principle, when it comes to practice they do seem to differ greatly about how much emphasis to place on this problem of validation and reliability. Surprisingly little attention has been paid to this question in the by now substantial literature on countertransference!

I think it is possible that a growing number of contemporary analysts might raise an argument about my last statement. In saying that I have in mind an increasingly popular contemporary emphasis on evaluating the way in which the validity of all analytic observations is determined. I am not certain whether or not the introduction of Self-psychology by Kohut and his followers is responsible for initiating this trend, but Self-psychology does take credit for placing stress on the need for the analysts to take very seriously the patient's perception and interpretation of all he experiences, including his responses to and ways of understanding the analyst. At least some Self psychologists have suggested that the traditional Freudians with whom they differ are often, if not always, not respectful enough of their patients' points of view, and they characterize classical analysts as overly authoritarian in interpreting the meaning of their patients' reactions to their analysts in terms of transference and resistance.

At the present time there are also many analysts, at least in the United States, who have become interested in what they call the intersubjective nature of psychoanalysis. This trend is growing in popularity very rapidly. I cannot say that this important new trend is a direct outgrowth of the Kohut school of Self-psychology, because it is very possible that the issue of re-evaluating the nature and extent of the authority of the analyst in his encounter with patients has emerged as a theoretical challenge among a number of different thinkers more or less independently. Certainly there are leaders of this movement towards a reconsideration of the nature of the analytic relationship who are not Self psychologists, and whose views on the nature and origin of psycho-pathology are centered on Freudian concepts of intrapsychic conflict and/or on object relations theory, rather than the significantly different fundamental propositions of Self-psychology.

What this group of analysts all agree about is placing stress on the subjective nature of the analyst's reactions to patients. The older conception of analysis, with which they disagree strongly, tended to regard the analyst as a consistently neutral presence who could, with fairly reliable objectivity, observe and interpret the patient's perceptions of him as primarily determined by the patient's transference tendencies. Those aspects of the patient's psychology always serve to distort his picture of the analyst, and his reactions to the analyst's interventions. In contrast, the social constructionists, followers of the various interpersonal schools, intersubjective theorists,
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and a number of classical analysts who have changed their approach, believe strongly that the analyst's neutrality and objectivity are not so reliable as had been thought previously. Thus his emotional reactions to patients, while still informative, have to be examined even more carefully than had previously been assumed to be necessary, and they must be measured against the patient's interpretation of things, with more weight being placed on the patient's point of view as having validity, and correspondingly less inclination to interpret it as determined exclusively by transference and resistance. They see the authority of the analyst to interpret what is realistic and what is distorted in the patient's perceptions as much less secure than prior generations of analysts had confidently assumed to be the case. As a result, the whole spectrum of countertransference reactions, in their opinion, has to be utilized with more caution than the Kleinians who promoted its use had done. Paradoxically, some, but by no means all of this large and heterogeneous group of analysts, at the same time practice less cautiously in another aspect of technique. They advocate intentionally revealing to patients more of their subjective countertransference responses to them. Some of these analysts believe that this promotes more honest self-revelation by patients, others of them that it advances the process of validation of the accuracy of the analyst's reactions, and some of them simply assert that an attempt to be non-revealing of the analyst's personal responses in the hope of maintaining a neutral presence for transference projections is futile, and self-deceiving. They think it amounts to a way of covertly fortifying the analyst's authority at the expense of honest and respectful interchange with patients. It is safe to say that these newer conceptual trends, and the changes in technique that they promote, are all highly controversial in the current analytic scene.

This very brief and schematic overview does not fully take into account the thinking on countertransference of contemporary Europeans, or modern trends in Latin America, in fact it hardly does justice to the range of opinion in the North American psychoanalytic literature with which I am most familiar. However, it does set out for your attention many important questions. I would like now to fulfill my promise to express some of my own views about these matters. To make my position clear, I must first tell you that I identify myself as a modern traditionalist! Before you dismiss me as contradicting myself from the outset, let me try to explain what I mean by that. My training at the New York Psychoanalytic Institute was as a classical Freudian analyst in the era of ego psychology and the structural theory, with its retained emphasis on the central role in human psychology of the outcome of childhood instinctual conflicts. My post-graduate development was primarily influenced by the work of Charles Brenner, who has been both a teacher and friend to me, as he has to
two generations of analysts, both at my home institute and elsewhere in the psychoanalytic world. His thinking has continued along the lines of what we have come to call modern conflict theory, one important evolutionary strand that derives directly from Freud’s pioneering discoveries.

We believe that analysts’ adult personalities, like those of all other human beings, are shaped in fundamental ways by their efforts to master the universal, inevitable psychological conflicts over their aggressive and libidinal desires with which all children must struggle. These developmental tasks result, in each individual, in producing a complicated matrix of compromise formations, which deal with the forces of desire and the demands and limitations of the environment, especially in regard to morality. The collective outline of these compromises helps to form the outline of our personalities, along with genetic and biological factors, and the experiences contributed by families and by educational and cultural influences. I must also emphasize that in respect to these important conflicts, the resulting compromise formations persist in a state of dynamic balance, and not in a static, fixed, invariable form.

It follows from this view of human psychology that our work as analysts calls into action a number of these personal compromise formations, which help to determine our reactions to patients, our cognitive and emotional styles, and our sensitivity to the material we attempt to understand and analyze. Our network of personal compromise formations is sometimes, most of the time we hope, favorable to doing good analysis, but some of the time some parts of it are unfavorable, at least in certain respects. I have no difficulty in accepting the predominant modern view that calls all of the analyst’s emotional responses to patients by the collective term countertransference, rather than to try to restrict that label to the strictly unfavorable ones. To my way of thinking, it is more important to keep in mind that the analyst’s own unconscious trends are continuously expressed through this network of personal compromise formations, just as is true for his patients, and all other persons as well. His personal analysis, his psychoanalytic education and training experiences, all give him, we expect, a good grasp of his personal tendencies and susceptibilities, but they do not make him perfect or immune to fluctuations in his own dynamic balance. The analyst’s psychology, and therefore his countertransferences, are affected by inner forces and by the effects of stresses and other events in his personal life, as well as by the way his patients behave towards him in their analyses.

Try to picture in your imagination a constantly shifting balance between the unconscious, irrational aspects of personality, and its more rational, mature dimensions, both in analysts and in their patients, in which the relative degree of irrationality fluctuates at all times. We hope that, in respect to what takes place in analysis at least,
the analyst's responses are, for the most part, and let me stress for the most part, since it can never be completely so, reasonably reliably rational. After all, his patients come to him for help with their neurotic troubles, which, by their very nature, are irrational in structure, and, at least at the start of treatment, the patient is hardly at all able to see his own inner nature clearly or objectively. On top of that, the circumstances under which analytic treatment is conducted deliberately favor the expression of the patient's irrationality, in its historical and its contemporary forms, especially in his relationship to his analyst, that is to say, the transference.

Thus we have established in analysis an intentionally charged emotional situation, one which is necessary in order to learn at first hand about the irrational, unconscious dimension of the problems analysis hopes to ameliorate. I think that these days most analysis would agree that it is the transference dimension of the analysis that provides the best opportunity for experiential depth to enter the analytic treatment. The old argument about intellectual versus experiential factors in analytic treatment is not fully resolved by this hypothesis, since transference can be interpreted to patients whose assimilation of it may be limited to an intellectual understanding without true emotional acceptance. It is also true that a number of contemporary analysts think that the patient's experience of living out with his analyst a relationship characterized by being understood, accepted and dependably cared about has important therapeutic benefits, even if his intellectually insightful comprehension of the meaning of that experience is incomplete. Even though the theoretical problem of the roles of insight and experience will not be easily settled, I think there is no doubt that the transference aspects of analysis do provide the best arena for combining these two dimensions of treatment. However, it is precisely in the area of transference interpretation that the reliability of the analyst's own personality and judgement, or, in other words, the impact of his countertransferences, is most crucial, and most likely to be questionable.

The patient's wishes, fears, perceptions, memories and interpretations of his relationship with his analyst are in part objectively realistic, and in part influenced by his unconscious makeup, and the two are blended together in his transference reactions and attitudes. The patient cannot tell these aspects apart, so he remains convinced at first that what he is consciously aware of is complete, accurate and realistic. It is up to the analyst to help acquaint the patient with the unconscious aspects of his transference experience through his interpretation of the defences, self-punitive trends and wishes the analyst recognizes, but which the patient does not see clearly in himself.

Unfortunately, the analyst's own personal subjectivity, as described above, keeps
him from being at all times a perfectly reliable, objective and accurate observer of the
patients' complex psychology. While the analyst's informed self-awareness, that is his
monitoring of the countertransferences, provides him with extremely important, often
subtle understanding of his patients' transferences, we now realize that the in-
formation the analyst gains this way is not 100% dependable because of his una-
voidable human imperfections and limitations as an instrument of measurement. Here
is the problem of the use of countertransference in psychoanalytic technique reduced
to its most basic terms.

My view is that our progress in clarifying these issues in psychoanalysis is like pro-
gress in many other social and scientific areas. New ideas seek to correct the de-
ciciencies of previous theories, and in so doing, frequently exaggerate the faults of the
past, and become, temporarily at least, too uncritically enthusiastic about the new
direction. I believe that early generations of traditional analysts probably did overes-
timate their ability to see their patients' unconscious accurately, and many were, I
suppose, too authoritarian in the their interpretive style. They might have been to
confident in insisting that patients accept their views of what was taking place, and in
treating all reluctance to accepting their interpretations as manifestations of resistance
in the transference. I think those early analysts probably overestimated how much
their own analyses had corrected their blind spots and other limitations and pre-
judices, as well.

The revolutionary emphasis on self-awareness and the use of the analyst's coun-
tertransference which was introduced by the Kleinians, and is now universally ac-
cepted, has added a great deal of sensitivity to our ability to understand our patients,
and has advanced our understanding of analyst-patient communication and intuition.
What is has not done, however, is address the false assumption of the analyst's in-
falibility in seeing patients' transference distortions. You see, it is just as possible for a
dedicated Kleinian analyst to have excessive confidence in the ideas about his patients'
transferences he gains from systematically using his countertransferences as a guide, as
it is for a classical analyst to overestimate his intuitive grasp. I am certain that my
school of analysis may produce some analysts who are to authoritarian, too sure of
their own opinions, and too inclined to treat their patients' refusal to accept all their
opinions and interpretations as coming from resistance which must be overpowered
by more interpretations. However, I think this is an individual failing affecting certain
analysts, and not a property of the school of thought, whether it be my own theoreti-
cal preference, a Kleinian one, or any other, for that matter.

I am also convinced that all through the history of psychoanalysis there have been
many analysts of all schools who were more aware of their personal fallibility, and
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who conscientiously examined their patients' responses to them and their interpretations for evidence that either confirmed them, or modified them, or proved them incorrect. Be that as is may, it is clear that the current emphasis of empathizing with the patient's point of view, and remaining mindful of the analyst's subjectivity, is attempting to improve our awareness of the fragile, elusive, intersubjective nature of the analytic interchange. It seeks to replace the overconfidence in the analyst's judgement that was often a problem in past generations with an increased respect for the patient's subjective experience in analysis. My own view is that this shift is intellectually useful to all analysts because it keeps us more alert to the problem of evidence and validation of our conjectures and hypotheses about our patients. It also may make us more sensitive clinicians, especially in working with certain types of analytic patients, especially very narcissistic ones, and those who are either overly compliant in nature, or else highly guarded against being influenced by others in any way.

I do believe, though, that this new movement which emphasized the subjectivity of the analyst, can also go too far in the other direction. The analyst and the patient are not equal in their capacity for objectivity about the patient: the analyst's proper authority comes from his training and experience, which are dedicated to the service of the patient in analysis. Even the measuring instruments of the physical sciences have their limits of reliability, but unless they are grossly defective, they are sufficiently accurate to carry out many tasks well. Analysts too, despite their imperfections and limits, if well trained and well analyzed, can do a very good job of understanding their patients' unconscious elements: they are usually much better able to do so than are the patients themselves.

The analyst is subjected to his patients' transference pressures and neurotic resistances, and must be aware that he is also subject to his own subtle personal variability that may limit him at times. Still, he must also be confident enough in himself to use his knowledge, including his knowledge about his countertransferences, to understand his patients, and pursue the truth. He does this sometimes with his patients' help, and sometimes despite his patients' resistances to knowing themselves, and he is obliged to practice his craft with appropriate modesty to counterbalance the necessary confidence. No wonder analysis has been called, "The Impossible Profession!"

To my colleagues among you who are already members of the impossible profession, I say we must always help one another to grow in understanding and, if I may employ a paradoxical statement, do so with confident humility. To those of you who are already students of psychoanalysis, I can assure you that despite the difficulties and uncertainties I have described, this is a career which has proven to me and many others to be endlessly fascinating, in no small part because of its chal-
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inging and changing nature. And to those of you in the audience who are simply interested in psychoanalysis, I hope I have shown you something of its mysteries, its growth and its potential for increasing our understanding of ourselves and others.