Countertransference
Condensed History and Personal View of Issues With Regressed Patients

L. Bryce Boyer, M.D.

Freud's ambivalently negative attitude toward countertransference discouraged systematic study until some psychoanalysts, predominantly Kleinians, began to treat patients with narcissistic neuroses. Recognizing the need to understand the unconscious and conscious contribution of the analyst to the therapeutic process, Heimann, Rosenfeld, Balint, and Racker pioneered in serious study of countertransference. Racker and Boyer found that unresolved countertransference problems contributed significantly to unfavorable responses to psychoanalysis in seriously disturbed patients. Searles, Giovacchini, Ogden, and Volkan have likewise furthered countertransference research. Following a historical review, the author delineates his personal approach to understanding patients, especially seriously disturbed ones, in terms of the ongoing introjection of patient and analyst of each other's projections. This approach stems from Rosenfeld's initial propositions.

(The Journal of Psychotherapy Practice and Research 1994; 3:122–137)

My training, which began in the 1940s, occurred in an ultraconservative institute where the psychoanalytic treatment of regressed disorders was strongly disapproved and any discussion of countertransference issues involved in their therapy was deemed irrelevant. Countertransference was considered an embarrassing topic, one to be avoided. I doubted Freud's grounds for eschewing psychoanalytic treatment of the narcissistic disorders, noting his ambivalence and contradictions,¹ and I tolerated with discouragement and sometimes despair the open ridicule and contempt of my mentors while I pursued my research in determining the effectiveness, in my hands, of the psychoanalysis of seriously disturbed patients.²⁻¹¹ Doing so inevitably required studying more thoroughly the transference-countertransference interactions in working with such patients. When I suggested that countertransference neuroses or psychoses were a major cause of failure in the treatment of regressed patients, I was treated as an enfant terrible, persona non grata in my institute and society.

The ego psychological literature on the subject was practically nonexistent, although there were some studies¹²⁻¹⁸ from which useful understanding could be gleaned.

Received April 1, 1993; revised June 20, 1993; accepted June 24, 1993. From the Center for the Advanced Study of the Psychoses, San Francisco, California. Address reprint requests to Dr. Boyer, 3021 Telegraph Avenue, Berkeley, CA 94705.

Copyright © 1994 American Psychiatric Press, Inc.
It was not until I was exposed to Kleinian and neo-Kleinian thinking, initially through contacts with Latin Americans and their psychoanalytic literature, that the subject of transference-countertransference became more understandable to me. This new understanding facilitated my psychoanalytic work with patients who had narcissistic disorders.

The past quarter-century has seen tremendous changes in clinicians' attitudes about the types of patients who can be treated with psychoanalysis. In general, that altered attitude has been ascribed to our expanded knowledge of character structure and psychopathology and our increased understanding of early developmental processes and primitive internalized object relations.

The crucial importance of how the therapist uses his own conscious and unconscious responses to the patient, whether psychic or somatic, verbal or nonverbal, has been clearly recognized; this recognition is probably due to the increased use of psychoanalytic psychotherapy for severe characterological, narcissistic, and borderline disorders and psychotic disturbances, as well as psychosomatic and alexithymic disorders.

Today it is generally accepted that action (aside from verbal symbolization) constitutes an important medium through which the analysand indicates specific unconscious meanings to the analyst, as through the actions mediating projective identifications, the "role responsiveness," the "evocation by proxy," and the "enactments." However, it is less well recognized that many of the analyst's most critical transference interpretations are conveyed to the analysand by means of the analyst's interpretative actions that have resulted from his processing, probably predominantly unconsciously, his introjections of the patient's projective identifications.

Similarly, psychoanalysts have changed their view of their own method. According to O'Shaughnessy, many analysts now hold that "instead of being about the patient's intrapsychic dynamics, interpretations should be made about the interaction of patient and analyst at an intrapsychic level" (p. 281; see also Volkan).

Heightened interest in countertransference has paralleled the rapidly expanding use of psychoanalytic therapy for severely regressed individuals, no doubt in large part because treatment of patients with primitive disorders demands heightened understanding of that interaction.

In the Americas, Racker and Boyer independently introduced the notion that unresolved countertransference problems often present the principal impediment to the effective psychoanalytic treatment of severely regressed patients. Their contributions, in conjunction with the work of Giovacchini, Grotstein, Kernberg, Searles, and others, have been central in establishing the conception that the understanding of countertransference in work with deeply regressed patients is of comparable importance to, and inseparable from, the analysis of the transference.

* The first five volumes of The Index of Psychoanalytic Writings list 29 references to studies whose titles include the word countertransference. Those volumes list writings from the origins of psychoanalysis through 1952. Volumes 6 through 9, covering 1953 through 1960, list 61 publications that have the word countertransference in the title. Apart from those citations, such references are almost nonexistent in psychological literature up to 1960. By stark contrast, a brief review of the titles of the psychological and social work literature of Europe and the Americas for the years 1988 through 1991 reveals references in the thousands to publications that include the word countertransference in the title.

** The Latin American, particularly the South American, psychoanalytic literature, unknown to me until the 1960s, has been rich in studies of transference and countertransference involving split-
There is a large literature pertaining to countertransference reactions in the analyses of patients with neurotic disturbances, including a number of reviews. The following section, a brief history of more modern ideas including attitudes toward countertransference and its uses with regressed patients, is to be added to other studies such as those of Boyer, Epstein and Feiner, Etchegoyen, and Scharff. It must be stressed that before the mid-twentieth century, very few contributors disagreed with the view that countertransference was an interference in the analytic procedure. Those such as Ferenczi who communicated their emotional reactions to their patients in word or action were reprimanded severely; see M. Balint (pp. 149–156) and Stärcke.

Freud introduced the term countertransference in the context of disapproval. Although the phenomenon continued to concern him, he never devoted a specific study to it, nor was a theory of countertransference elaborated until much later.

Freud seldom if ever totally renounced any theoretical position he had introduced. For example, he continued in his last works to combine the topographical and the structural theories as explanatory models. We shall see that this holds true with regard to countertransference as well. He never recanted his position that countertransference was an undesirable impediment. In 1912, in a letter written to Ferenczi, Freud implied that his failure to overcome his positive, maternal countertransference had made impossible the interpretation to Ferenczi of a negative transference. Freud may have been joking when in 1937 he spoke of his answer to a patient’s complaint that the mentor had not interpreted the negative transference; Freud replied that if it had not been interpreted, it had not appeared.

Heimann suggested that Freud’s discovery of resistance was based on his countertransference, his feeling that he was meeting a resistant force in the patient. I agree with Grotstein that it is more profitable in therapeutic situations to think of many so-called resistances as communications, not only about the present but about the past, especially in the cases of, for example, psychosomatic problems and alexithymia. I agree also with D. Rosenfeld and Ogden, who hold that in treating severely regressed patients it is the task of the analyst to contain, through the countertransference, a presumed picture of the patient’s infantile past to be revised during treatment and communicated to the patient at appropriate later times.

It is well known that Freud’s clinical failures sometimes were the products of countertransference interferences. Freud introduced the word countertransference when writing technical advice to unanalyzed and largely untrained physicians who were practicing psychoanalysis; doubtless he hoped that the danger of the clinician’s emotional involvement and acting out with the patient could be reduced. He defined countertransference as a function of the analyst, the product of the influence of the patient’s verbal and nonverbal communications on the unconscious of the analyst. Two years later he specifically recommended that therapists undergo training...
analysis; and that the "therapist turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient...so that the doctor's unconscious is able...to reconstruct the patient's unconscious" (pp. 115–116). This position is an example of Freud's ambivalence or a reflection of his dialectical mode of thinking, of which he was largely unconscious. This ambivalence continues to characterize the disagreement between the classic and the totalistic approaches to countertransference. At the same time that Freud insists that the analyst be purified so that he has no blind spots, he says that the analyst's unconscious should be in contact with that of the analysand.

Probably having been influenced by Janet while studying with Charcot, Freud was much interested in the subject of telepathy, publishing on related subjects in 1899, 1904, and 1921. Later, Soon after the appearance of Stekel's 1922 The Telepathic Dream, Freud wrote specifically about telepathy; other publications appeared in 1925 and 1933. In his earliest article on telepathy, Freud wrote,

Psychoanalysts...study occult material only because they hope that this would enable them to eliminate once and for all the creations of the human wish from the realm of material reality. . . . If, in the course of his work, [the psychoanalyst] is on the lookout for occult phenomena, he runs the risk of overlooking everything which is closer at hand. . . . The analyst's self-discipline can protect him against the subjective risk of having his interest absorbed by occult phenomena.

Things are different, however, as regards the objective danger. It is probable that the study of occult phenomena will result in the admission that some of these phenomena are real. . . ." (p. 58)

His attitudes did not change in subsequent articles. Eisenbud, in his survey of Freud's contributions to psychoanalysis and telepathy, summarized Freud's position:

What Freud says, in effect, is: "Distortion of perception is one of the characteristics of mental functioning dominated by unconscious needs. But this distortion is purposeful and occurs along dynamic, deterministic lines. There is no reason to suppose that telepathic perceptions should be free from this universal effect." (p. 9)

The Telepathic Dream was based on Stekel's dreams while working with neurotic patients, dreams that today would be strongly suspected of being associated with countertransference phenomena. However, a footnote to Freud's 1922 article acknowledging his awareness of Stekel's book makes no allusion to countertransference. In all of Freud's communications the question of the validity of extrasensory perception remained open. Oddly, the word countertransference does not appear in any of Freud's communications dealing with telepathy and the occult. One wonders whether Freud thought, perhaps unconsciously, that telepathy constituted some aspect of transference-countertransference interactions. * * *

Surely many other analysts have implied their similar belief, namely that

---

* There seems ample evidence that Freud, at least at times, had disappointing clinical results because of unresolved countertransference problems. May has suggested that Freud's formulations, technique, and style demonstrated in the case history of the Wolf Man were largely products of unanalyzed transference-countertransference phenomena.

** Excerpts of his first two articles and his last three contributions appear in Devereux.

*** It was long common for many Kleinian psychoanalysts, particularly in Latin America, such as Garma and Goldberg, to speak of projective identification as constituting the patient's actual
unconscious communication involves extra-sensory perception." In his summary of the theories of István Hollós, Devereux\textsuperscript{76} writes, "Telepathic incidents became especially numerous during a difficult period in the analyst's life" (p. 200), surely linking them with countertransference, although the word was not used by Hollós or Devereux in this context.

Analysts have long been concerned with the means by which the psychological attributes of one person are assumed by another. Many, following Freud's,\textsuperscript{82} lead, have written about the influence of patients' introjection of analysts' attributes on the transference relationship. Fenichel\textsuperscript{83} was the first to note that analysts' countertransferences are largely determined by the influences on their unconscious conflicts of introjections of patients' attributes—a frequently affirmed observation.\textsuperscript{84-86}

Meltzer\textsuperscript{87} (p. 14) called introjection "the most important and mysterious concept in psycho-analysis" and said we have not yet described the process by which the child's experience of the external object is taken in. Menzies-Lyth\textsuperscript{88} added, "introjection and introject have in no way found in the psychoanalytical literature a place comparable to projection and project" (p. 1). She agrees with Meissner\textsuperscript{89} and countless others in noting that "Projection turns out to be more exciting, more innovative, more illuminating, to our understanding of normal and pathological development" (p. 3). Hinting, perhaps, at a reason that many analysts have been so reluctant to study countertransference, preferring instead to investigate "intuition" and "enactment," Menzies-Lyth suggests that the introjective process has been underinvestigated because of interference from the effects of the patient's selective introjection of the analyst's narcissism. Scharff\textsuperscript{90} would add that the analyst's narcissism may affect what the patient finds available for introjection, suggesting that "the analyst censors the introjective process before and after it occurs, because it is gratifying inside the self" (p. 52).

The study of introjection, which has proceeded from the beginnings of psychoanalysis, has determined that the means by which the analyst and the analysand may introject the other's qualities are legion. In The Psycho-pathology of Everyday Life, Freud\textsuperscript{91} commented on sensory preference in referring to forms of memory, and in Instincts and Their Vicissitudes\textsuperscript{82} he noted that every perceptive mode is related to introjection. In 1917,\textsuperscript{91} he introduced the concept of oral incorporation as a step in identification, as did Abraham\textsuperscript{92} with anal incorporation, affirming the inferences of van Ophuijsen\textsuperscript{93} and Stärcke,\textsuperscript{47} who had written independently of the enema as the infantile prototype of the paranoid's equation of persecutor and feces. Abraham\textsuperscript{92} found epidermal incorporation to correspond to feces-smearing; later Lewin\textsuperscript{94} viewed it to be an equivalent of oral incorporation. Leonard\textsuperscript{95} wrote of visual incorporation. Fenichel\textsuperscript{83} made respiratory incorporation a special study and stated that the respiratory tract has an autonomous erotogenicity. It is common knowledge that every perceptive mode can also be used in the service of projection; Malcolm\textsuperscript{96} wrote of the use of vision for the attempted unification of fragmented internal objects.

---

* This material has been reviewed at great length in Devereux,\textsuperscript{76} where relevant articles by Helene Deutsch, Hirschmann, Röheim, Schilder, Zulliger, and others are reprinted and the Eisenbud-Pederson-Krag-Fodor-Ellis controversy is reviewed, and in Volume 10 of Confrontation: Telepathie,\textsuperscript{81} where several of those articles and more recent contributions by Bergson, Costa de Beauregard, Derrida, Dumas, Farrell, Mignotte, and others are reprinted.
It has long been assumed that countertransferences are determined largely by the analyst's introjection of qualities of the patient that come into contact with the therapist's unresolved infantile conflicts (see Federn,44 Fenichel,97 and Fliess85). In Giovacchini's,35 Ogden's,24 Searle's,56 and Volkan's26 experience and my own,17-19 both the most effective interpretations and the recovery of the most relevant repressed memories are frequently based on information gathered through countertransference reactions, that is, interpreting through the countertransference. Until the past few years, interpreting through the countertransference appears to have been very unusual in the practice of North American analysts. In fact, it may have been limited to the analysts cited above. But it was not uncommon among neo-Kleinians, as illustrated by the case histories selected by Spillius.98,99

There were almost no direct studies of countertransference for approximately forty years following the introduction of the term. To my knowledge, the first to suggest that the analyst's reactions to the patient's productions could be used as helpful data was Hann-Kende,100 who was followed by Strachey101 with his concept of the "mutative interpretation," which was later rediscovered by Kohut.102

Although countertransference was not investigated, curiosity about "intuition" was active, as it is today. Throughout his works, Reik105-105 indicated that if the analyst has a receptive attitude and trusts intuition more than mere reasoning, he will be surprised with a sudden understanding of a message from the analysand's unconscious, an intuitive grasp from unconscious to unconscious, as Freud90,105 indicated previously. When Reik106 mentions countertransference, he views it as a resistance and does not indicate that the analyst's response is nourished by a conflict of his own. Similarly, W. Reich107 refers to his own affective reactions as intuitions. Racker30 would call them countertransferential reactions, and Etchegoyen45 wrote, "the analyst's méter consists in listening to and scrutinizing his countertransference—that is his intuition" (p. 163).

Analysts have sought to understand what constitutes Reik's104 "listening with the third ear," or Isakower's "analyzing instrument." Spiegel98 noted that analyst and analysand operate in similar states of mind (free-floating attention and free association, respectively) and that the resultant conversation is unique to psychoanalysis. Balter et al.109 speak of the analyzing instrument as operating within a subsystem of the ego of the analyst, who "is more likely to perceive connections between words, ideas and images which are the products of the patient's primary process, because his subsystem is in part freed from the constraints of secondary process thinking, reality testing, and so on" (pp. 490-491). They note "the regression in the (ego) subsystem of the analyst is essentially of the same nature as that which obtains in the subsystem of the analysand" (p. 486).

**MELANIE KLEIN'S CONTRIBUTION**

The vast majority of today's authors who write about transference-countertransference interactions use one or another version of Klein's110 concepts of splitting and projective and introjective identification in their attempts to understand the phenomena. This is true whether their dominant orientation

* As does Ogden,111 I use the term projective identification to refer to a wide range of psychological-interpersonal events, including the earliest forms of mother-infant communication (Bion116), fantasied coercive incursions into and occupation of the personality of another person, schizophrenic confusional states (Rosenfeld113), and healthy "empathic sharing" (Pick114).
Although well: stems appreciation infant's not perception of Klein's patient's psychological theories of Kleinian patient's and reactions to the analyst's verbal and nonverbal productions. Obviously, the importance of Bion's extension of Klein's work must be recognized as well: he found projective identification to be not only a defense mechanism, but also an infant's first way of communicating with its objects, and he posited the role of the mother and the analyst as metabolizing containers (see also Winnicott\textsuperscript{116,117}).

As early as 1961, Stone\textsuperscript{118} ascribed to the neo-Kleinian Racker's\textsuperscript{59,92} work a growing appreciation of the countertransference as an affirmative instrument that facilitates perception. In Racker's view, countertransference enhances awareness of the analyst's incipient reactions to the patient and leads to a richer and more subtle understanding of the patient's transference striving. More recent Kleinian contributors to this area of analytic thought include Grinberg\textsuperscript{119-121} Joseph,\textsuperscript{122,125} Meltzer\textsuperscript{124,125} Money-Kyrle,\textsuperscript{126} O'Shaughnessy,\textsuperscript{25} and Segal.\textsuperscript{127}

Through the inclusion of views of countertransference to be discussed below, the psychoanalytic treatment of regressed patients is becoming revolutionized in North America, despite the seemingly adamant opposition of many Hartmann-influenced ego psychologists who also oppose regression to primitive states during treatment.

**Countertransference and Introjection Since Midcentury**

I turn now to the definition of countertransference as it is used here and a history of the development of that view. My concept of transference-countertransference follows Rosenfeld's\textsuperscript{137,138} concept of the constant interplay between analyst and analysand that involves mutual introjection of the other's projective identifications. Regarding countertransference, projective identification functions as a means of communication, of learning from the patient what he cannot think consciously. The analyst seeks to find words to form a bridge between the subjective states of the analyst and the patient while understanding that the space that separates them is the most potentially powerful link between the patient's dissociated states.

Faimberg\textsuperscript{139} argues that what the analysand cannot say through parapraxes, dreams, silences, and symptoms can be heard only from the countertransference position of the analyst. As Bromberg\textsuperscript{140} suggests, when words are found and negotiated, they can become part of the patient's creative effort to symbolize and enunciate in words what he had no

* A similar revolution is gaining impetus among the thinking and field techniques of investigators of personality development. Over 30 years passed between the writing and the publication of Devereux's\textsuperscript{128} landmark *From Anxiety to Method in the Behavioral Sciences* because he introduced the unpopular theme of countertransference distortions into anthropological fieldwork. As had Racker and Boyer into psychoanalytic treatment. Since then, the understanding and even the technique of fieldwork have been heavily influenced by psychoanalytically knowledgeable anthropologists who are taking into account the effects of countertransference (see Crapanzano,\textsuperscript{129} Good et al.,\textsuperscript{130} Kracke,\textsuperscript{131} R. Levine,\textsuperscript{132} S. Levine,\textsuperscript{133} Parsons,\textsuperscript{134} Stein,\textsuperscript{135} and Tobin\textsuperscript{136}).

\textsuperscript{*}}
way of expressing. He finds that the patient is not in need of insight that will correct faulty reality, but, rather, needs a relationship with another person through which words can be found for that which has no verbal language. As he finds words that represent his experience, he "knows himself." E. Balint adds that as the patient knows about mutual experience, he knows about the analyst, too. She holds that in the transference-countertransference relationship, another person is there to enable the patient to put himself together, provided the analyst can use his emotional responses to the patient's communications without countertransference distortion; Ogden would add that with some patients the analyst's interpretive actions are of more use than his words.

A major thread in the development of analytic understanding of the interdependence of transference and countertransference emerged from Winnicott's ideas concerning the interdependence of the subjectivities of mother and infant and the creation of a "third area of experiencing" in the potential space "that exists (but cannot exist) between the baby and the object" (p. 107). Subsequent authors have significantly expanded the understanding of the analytic process as taking place in the "overlap of two areas of playing, that of the patient and that of the therapist" (Winnicott, p. 38; Ogden). Winnicott held there to be "no such thing as an infant (apart from the maternal provision)" (p. 39 fn), and Ogden believes there to be no such thing as an analysand apart from the relationship with the analyst or there to be an analyst apart from his relationship with the analysand. Ogden has developed the concept of the analytic third. He writes,

"The intersubjectivity of the mother-infant is not that of the analyst-analysand (as separate psychological entities) exists in pure form. The intersubjective and the individually subjective each create, negate and preserve the other. In both the relationship of mother and infant and the relationship of analyst and analysand, the task is not to tease apart the elements constituting the relationship in an effort to determine which qualities belong to each individual participating in it; rather, from the point of view of the dialectical interdependence of subject and object, the analytic task involves an effort to describe as fully as one can the specific nature of the interplay of individual subjectivity and intersubjectivity."

The Gaddinis and Boyer have discussed and demonstrated with case examples the emergence of words from the psychesoma during complementary regression of patient and therapist.

It is held here that whatever the analyst experiences during the analytic session constitutes his idiosyncratic introjection of the patient's verbal and nonverbal communications, containing the patient's projections and the analyst's predominantly unconscious reactions to those introjections. In addition, the analyst exists as a part of the analytic third, experiencing and simultaneously observing himself, the analysand, and the analytic third as they interact with one another. We should not be misled into thinking our stay, apparently unrelated thoughts, fantasies, and physical or emotional reactions can be dismissed as idle preoccupations, taking us away from the business at hand, interfering with our free-floating or even hovering attention.

Drowsiness is a reaction of the analyst that has been dismissed often as irrelevant or explainable for "rational" reasons. McLaughlin and others have emphasized its countertransference implications, and Boyer illustrated how sleepiness provided highly important clues to patients' unconscious conflicts.
It is obvious that the analyst's prevailing emotional state and individual conflicts, repressed or otherwise, will determine his degree of openness to the analysand's projections.

The mental set of the analyst is firmly embedded in his life history, which will influence strongly his receptivity. To cite a few examples will suffice. My lifelong experiences with psychotic people have conditioned me to be automatically aware of very early stages of regression as possibly premonitory of psychotic outbreak. Here I note only subtle manifestations, leaving aside such obvious events as slips of the tongue and the insertion into speech or action of false memories or of fantasies momentarily held to be facts. When a person who regularly uses good grammar begins to use pronouns incorrectly, such as saying "to him and I," I become alerted and keep track of possible repetitions and the circumstances in which they occur. Frequently, my eventually calling the analysand's attention to the erroneous use of (for instance) I rather than me leads to his awareness that his incorrect use of I signals a potential profound regression, a speaking from a position in which he had not yet become differentiated into an I and a me (see E. Balint). Similarly, when an analysand begins to use scatological language, I am especially aware of relevant bodily sensations and their potential meanings.

We all know of Freud's holding that some dreams cannot be interpreted on the basis of the patient's associations, yet that the analyst is certain that he understands significant elements. My many years of field research in anthropology and study of folklore and the cross-cultural use of the Rorschach Test have led me, in agreement with Freud, to believe firmly that each symbol has at least one basic meaning, apparently inborn, in addition to whatever additional meanings have been added by learning. My automatic subliminal thought, "female-mother," when a patient began to be preoccupied with the wood of furniture near him in the consultation room, led me to make an interpretation that both relieved my inner tension and lifted him from a deep, sudden psychotic regression (Boy
er, pp. 121-137). Automatically thinking of sibling rivalry when patients begin to talk of tiny animals or insects, or Christmas or Easter, often leads to a quickened introjection and understanding of a projection.

The analyst's involvement in his countertransference may prove distracting at times, especially when his patients succeed each other with only a few minutes' break between. It may be difficult for the analyst to make the internal changes requisite for undistorted perception of the conflicts and emotional states of the second patient who enters the consultation room. This is more true if the patients' characterological structures and the contemporary nature of the transference-countertransference relationships are similar.

For example, two women had suffered similarly severely traumatic infancies and childhoods, and each had undergone frequent catatonic episodes, involving intense withdrawal and obviously psychotic thinking, until they left home to attend school. Subsequently, each withdrew from stressful situations, having similar episodes that might last for days or weeks. Neither had been hospitalized, but both had undergone repeated psychotherapy and psychoanalysis in the care of highly respected training analysts in North America. Neither considered her analyses to have been useful clinically; each had stopped them voluntarily when the analysts would not allow regression in the service of treatment. An extreme example follows. When one of these patients asked her analyst why she was being discouraged from attempting to recover fantasies that had immediately preceded a frightening dissociated state during therapy, the analyst told her that the recovery of the fantasies might lead to her suicide. It was more usual for the analyst to discourage covertly the patient's attempt to regress, usually by asking questions that changed the
subject; it has long been common knowledge that the therapist often seeks to relieve his own anxiety in this way.\textsuperscript{156}

Winnicott\textsuperscript{142} and Ogden\textsuperscript{159-161} have stressed the need for the analyst to allow the existence of potential space in which creativity can occur, and Bion\textsuperscript{162} the need for the analyst to enter into a “reverie” allowing a similar development. I find that my most exhilarating and productive periods in working with regressed patients occur during those unusual occasions when, while in a slight state of reverie, I play Winnicott’s\textsuperscript{149,163} “squiggle game” with the patient. We do not use pencils but instead create our “drawings” verbally through associating to each other’s associations. It is at these times that the thinking of both analysand and analyst most easily and understandably switches without conflict to the simultaneous use of the autistic-contiguous, schizo-paranoid, and depressive modes of generating experience (Ogden\textsuperscript{161}). It is doubtful that such an interchange could take place in a therapeutic endeavor in which the analytic frame had not been consistently maintained; nor would it be likely if the therapist was uncomfortable, presumably because of anxiety concerning his own aggressive or libidinal urges, during the patient’s sometimes psychotic regressions.\textsuperscript{*}

Especially important in this interchange are the distinctive features of the depressive position as “the integration of part objects to form the whole object and the painful recognition by the individual that his feelings of love and hate are directed to the same, whole object. The theme of concern for the object is central to the idea” (Spillius,\textsuperscript{164} p. 4). There is also recognition of the object’s separateness and the intrinsic relationship between the depressive position, symbolic thought, and creativity (Segal\textsuperscript{164-166}).\textsuperscript{**} At such times both analysand and analyst retain sufficient objectivity that a part of their minds can observe the interchange among primitive mental functions. During such a period, one of the female patients mentioned above laughed aloud and said if any other analyst she knew listened in on our conversation, he or she would surely deem us mad.\textsuperscript{***}

For a few months, these two patients’ sessions were consecutive one day each week; their other four hours were at separate times of the day. During that few months’ period, each had bravely regressed to a primitive state during her interviews; this regression both frightened and greatly encouraged each because she deemed it a necessary reliving in the service of her analysis. For several days, each of them had been playing a verbal squiggle game with me. Our interactions created a state that we found to be similar to the potential space of which Winnicott and Ogden wrote, within which creations occur when mother and infant are properly attuned. It is my impression that many analysts become uneasy with the onset of reverie and seek to terminate the state.

One night, after one of the women and I had experienced such an episode, I dreamed

\* I am unable to cite an example because at such times I am quite lost in my interaction with the analysand and cannot keep dependable notes.

\** Although this interchange between the analyst and the analysand can be thought of as freely involving combinations of primary and secondary process thinking,\textsuperscript{167} viewing the interchange in these terms fails to convey the richness implied in Ogden’s three modes of experience.\textsuperscript{161}

\*** Except for the periods of reverie during which the analysand and I play “squiggle,” I am easily able to retain my observing ego while simultaneously interacting with the patient during my altered ego state, and I am able to record detailed process notes during the interview\textsuperscript{168}—a procedure that very rarely disturbs my analysands, even those who are otherwise quite paranoid. My notes include my conscious fantasies and my emotional and physical reactions.
that she and I were Siamese twins, connected solely by our occipital cortices. One of my waking associations was that we had been seeing "eye to eye" and did indeed share visual cortices. For me, these two women had become Siamese twins, connected by my head.

The following day I told the patient my dream, something I had never done with any analysand, only to remember subsequently and secretly that I had in fact had the dream about the other patient.

In this instance, no harm was done. However, on other occasions I have indeed felt foolish and delayed analytic progress when I have unwittingly carried my emotional state and preoccupation with the former transference-countertransference interactions into the successive hour. Such experiences, among others, led me to seek to view each analytic session as if it were a dream, in which the major unresolved transference-countertransference issue of the last or last few sessions composes the "day residue." Accordingly, I assume that every communication of the interview is in some way related to that day residue in the context of the ensuing "dream" and am particularly interested in the symbolic meanings of the opening verbal and/or nonverbal communications. Often, to refresh my memory, I review my notes in advance of the interview, notes that include my own fantasies, emotional experiences, and physical sensations.

Countertransference interpretations can even enable a reactively hostile, frightened patient to begin treatment. A woman was convinced that her characterological disturbance and multiple psychosomatic symptoms, predominantly gastrointestinal, were products of her having been sexually molested during her early childhood, although she had no memory of such an event. She refused to enter psychotherapy with any of a series of analysts whom she consulted after drug therapy had proved ineffective, because none of them would vouchsafe that he believed that her symptomatology was the result of such early molestation. Finally I chose not to deal with her demand at face value but instead depended on my experiencing internal anxiety and gastrointestinal cramping while listening to her litany and observing her tension. I told her that I could not know on the basis of her stated history or my medical and psychiatric knowledge that her belief was accurate, but that I felt certain that she had been severely psychically traumatized while very young on the basis of my emotional and physical reactions to her presentation of her complaints. Relieved and intrigued, she promptly entered psychoanalytic treatment, which was remarkably successful.

Khan\textsuperscript{160,170} conceives of countertransference as an instrument of perception, and McDougall\textsuperscript{61} holds that she articulates her introjections of the patient's preverbal and presymbolic experiences. At times she becomes aware of countertransference disturbances through dreams of her own, as do I.

At midcentury, analysts began suddenly to present and publish studies devoted specifically to countertransference, perhaps beginning with Winnicott's\textsuperscript{7} "Hate in the Countertransference" and followed by contributions such as those of Lacan,\textsuperscript{172} Little,\textsuperscript{173,174} Nacht,\textsuperscript{175} and A. Reich.\textsuperscript{43}

Many psychoanalysts agree that the earliest systematic and valuable work toward developing a theory of countertransference was done by Heimann\textsuperscript{52,176} and Racker,\textsuperscript{29-32} who apparently worked independently, each without knowledge of the other's thinking. The contributions of Rosenfeld\textsuperscript{177} have been overlooked by many. This may be attributable to his not having used the word countertransference in any title until very late in his career\textsuperscript{137} (chap. 12). Although he depicts himself as an orthodox Kleinian, in his earliest publicaton dealing with psychotic states (1947) Rosenfeld\textsuperscript{178} notes his use of countertransference reactions as guides to interpretation. He first uses the word countertransference in 1952\textsuperscript{113} while discussing the difficulties in interpreting to patients with schizophrenia: "Our countertransference is frequently the
only guide" (p. 126). No doubt Rosenfeld wanted to protect his relations with Melanie Klein (his analyst), who was so incensed with Paula Heimann that their previously cordial relationship was terminated when Heimann delivered her 1950 paper at the Zurich conference (DePaola'79). Similarly, Klein was hostile toward Little'78,79 after she advocated the use of countertransference reactions in treatment, as, it has been said, she would be eventually toward Hanna Segal'27 (chap. 6). In the early 1950s Balint'80,82 advocated the analyst's conscious use in therapy of his emotional reactions to patients. Balint's position has also been overlooked generally.

**Summary**

During the past half century, countertransference has come to be seen as a valuable tool in our therapeutic armamentarium, rather than solely as an impediment to psychoanalytic treatment. This change of attitude resulted from psychoanalysts' coming to view their task as interpreting the interactions of both patient and therapist on an intrapsychic level, rather than the patient's intrapsychic dynamics, and understanding those interactions in terms of the constant interplay between analysand and analyst, involving their mutual introjection of the other's projective identifications. An important element in the change in therapists' attitudes regarding the types of patients who should be included as analytic subjects is the increased understanding of the nature of the interaction between therapist and patient during the inevitable regressions in the service of treatment—an understanding that can be usefully interpreted.

Although it is generally believed that Freud originally viewed countertransference solely as an impediment to analysis, he was always ambivalent on this issue. He may have believed there is a relationship between transfence and countertransference and extrasensory perception.

Heimann and Racker are usually credited with having the major roles in the development of a systematic theory of countertransference, and the important work of others, such as Rosenfeld and Balint, has probably been underemphasized.

L. Doty assisted in manuscript preparation. A version of this article was presented at the Center for the Advanced Study of the Psychoses, San Francisco, June 1992, and at the Graduate Seminar, Department of Psychiatry, Alta Bates-Herrick Memorial Hospital, Berkeley, CA, December 1992. It is a companion to a clinically focused article as yet unpublished.

**References**

9. Boyer LB: Thinking of the interview as though it were a dream. Contemporary Psychoanalysis 1988; 24:275-
52. Heimann P: Counter-transference. Int J Psychoanal 1950; 31:81–84
64. Rosenfeld D: The Psychotic Aspects of the Personality. London, Karnac, 1992
69. Freud S: A premonitory dream fulfilled (1899). SE, vol 5
72. Stekel W: Der telepathische Traum. Berlin, Johannes Baumm, 1920
73. Freud S: Dreams and telepathy (1922), SE, vol 18
74. Freud S: The occult significance of dreams (1925). SE, vol 19
82. Freud S: Instincts and Their Vicissitudes (1915). SE, vol 14
90. Freud S: The psychopathology of everyday life (1901). SE, vol 6
91. Freud S: Mourning and melancholia (1917). SE, vol 14
96. Malcolm RR: El espejo: una fantasia sexual pervarsa
153. Freud S: The Interpretation of Dreams (1900). SE, vols 4-5