On Counter-Transference

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The act of understanding the patient's productions in analysis and the ability to respond to them skilfully is not based solely on logical conclusions. Frequently the analyst can observe that insight into the material comes suddenly as if from somewhere within his own mind. Suddenly the confusing incomprehensible presentations make sense; suddenly the disconnected elements become a Gestalt. Equally suddenly, the analyst gets inner evidence as to what his interpretation should be and how it should be given. This type of understanding impresses one as something which is experienced almost passively; 'it happens'. It is not the result of an active process of thinking, like the solution of a mathematical problem. It seems obvious that this kind of insight into the patient's problem is achieved via the analyst's own unconscious. If is as if a partial and short-lived identification with the patient had taken place. The evidence of what is going on in the patient's unconscious, then, is based on an awareness of what is now going on in the analyst's own mind. But this identification has to be a shortlived one. The analyst has to be able to swing back to his outside position in order to be capable of an objective evaluation of what he has just now felt from within.

Anyhow, the tool for understanding is the analyst's own unconscious. When Freud advises that the analyst should listen with free floating attention, he has exactly this in mind. The material should be absorbed by the analyst's unconscious; there should not be any aim-directed censoring or conscious elimination through the analyst's attempts at rational thinking. This method of listening will guarantee the analyst's ability to remember, in an effortless way, those parts of the patient's previous material which connect with or serve to explain the new elements which are presented.

It is obvious what hazards may arise. If the analyst has some reasons of his own for being preoccupied, for being unable to associate freely, for shrinking back from certain topics, or if he is unable to identify with the patient, or has to identify to such a degree that he cannot put himself again outside the patient—to mention only a few of the possible difficulties—he will be unable to listen in this effortless way, to remember, to understand, to respond correctly.

Furthermore, there are more tasks for the analyst. He has to be the object of the patient's transference. He has to be the screen on to which the patient can project his infantile objects, to whom he can react with infantile emotions and impulses, or with defences against these. The analyst has to remain neutral in order to make this transference possible. He must not respond to the patient's emotion in kind. He must be able to tolerate love and aggression, adulation, temptation, seduction and so on, without being moved, without partiality, prejudice or disgust. It is, indeed, not an easy task to be able, on the one side, to feel oneself so deeply into another person as the analyst has to do in order to understand, and, at the same time, to remain uninvolved. Without having faced his own unconscious, his own ways and means of solving conflicts, that is, without being analysed himself, the analyst would not be able to live up to these difficult requirements.

To be neutral in relationship to the patient, to remain the screen, does not, of course, imply that the analyst has no relationship at all to the patient. We expect him to be interested in the patient, to have a friendly willingness to help him. He may like or dislike the patient. As far as these attitudes are conscious, they have not yet anything to do with counter-transference. If these feelings increase in intensity, we can be fairly certain that the unconscious feelings of the analyst, his own transferences on to the patient, i.e. counter-transferences, are mixed in. Intense dislike is frequently a reaction to not understanding the patient; or it may be based...

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on deeper 'real counter-transference'. Too great, particularly sexualized, interest in the patient can most frequently be understood also as a counter-transference. We shall come back to this point.

A situation in which the analyst really falls in love with the patient is infrequent. In such a situation the analysis becomes impossible, and the patient should be sent to somebody else.

Counter-transference thus comprises the effects of the analyst's own unconscious needs and conflicts on his understanding or technique. In such cases the patient represents for the analyst an object of the past on to whom past feelings and wishes are projected, just as it happens in the patient's transference situation with the analyst. The provoking factor for such an occurrence may be something in the patient's personality or material or something in the analytic situation as such. This is counter-transference in the proper sense.

In a discussion before the psycho-analytic study group in Prague in 1938 between Dr. Otto Fenichel and myself on the topic of counter-transference, which Dr. Fenichel later on used as the basis of a paper entitled 'The Implications of the Didactic Analysis' (mimeographed by the Topeka Institute of Psychoanalysis), the conception of counter-transference was understood in a much wider sense. We included under this heading all expressions of the analyst's using the analysis for acting-out purposes. We speak of acting out whenever the activity of analysing has an unconscious meaning for the analyst. Then his response to the patient, frequently his whole handling of the analytic situation, will be motivated by hidden unconscious tendencies. Though the patients in these cases are frequently not real objects on to whom something is transferred but only the tools by means of which some needs of the analyst, such as to allay anxiety or to master guilt-feelings, are gratified, we have used the term counter-transference. This seemed to us advisable because this type of behaviour is so frequently mixed up and fused with effects of counter-transference proper that it becomes too schematic to keep the two groups apart. The simplest cases in the proper sense of counter-transference are those which occur suddenly, under specific circumstances and with specific patients. These are, so to speak, acute manifestations of counter-transference. I give you a simple example which was related to me recently:

An analyst was ill, suffering pain but being able to continue work with the help of rather large doses of analgesics. One of his patients chose this time to accuse the analyst of neglecting her, of not giving her enough time, and so on. The complaints were brought forth with the nagging persistence of a demanding oral aggressive individual. The analyst became violently annoyed with the patient and had great difficulty in restraining the expression of his anger. What had been going on is fairly obvious. The analyst resented the fact that the patient was able to make these aggressive demands for attention while he, the analyst, was in a situation which would have justified similar demands, but he had to control himself. The unexpressed demands then tie up with deeper material which is irrelevant in this connexion.

The analyst is here in a special situation in which his mental balance is shaken by illness. In this condition, he cannot tolerate the patient who, as a mirror, reflects his own repressed impulses. The counter-transference reaction is based on an identification with the patient. Identifications of this kind belong to the most frequent forms of counter-transference.

Another example: A young analyst, not yet finished with his own training, feels irked by one of his patients and feels a desire to get rid of him. Why? The patient has expressed homosexual tendencies which the analyst is not inclined to face within himself. Here again the patient is the mirror that reflects something that is intolerable.

Counter-transference phenomena are by no means always manifestations of defence against the impulse, as in these last examples, but they may be simple impulse derivatives. I remember the case of a colleague who came for a second analysis because he had a tendency to fall in love with young attractive women patients. The analysis revealed that he was not really interested in these women but in identification with them, he wanted to be made love to by the analyst and in this way to gratify the homosexual transference fantasies which in his first analysis had remained unanalysed.

The sexual interest in the patient which could be called the most simple and direct manifestation of counter-transference is here the result of an identification with the patient. This is most typical. Most of the so-called 'simple' manifestations of that kind are built after that pattern. The patients are not really the objects of deeper drives but they reflect the impulses.
of the analyst as if they were fulfilled. But identification is certainly not the only possible danger. At other times, for instance, one is faced with counter-transference reactions which are provoked by the specific content of the patient's material. For instance: certain material of a patient was understood by an analyst as a representation of the primal scene. Whenever the material was touched upon by the patient the analyst reacted to it with the defence reaction he had developed in the critical situation in his childhood: he became sleepy and had difficulties in concentrating and remembering.

Sometimes the disturbances are of a more general nature, not dependent on any special situation of the analyst or special material. It is the analytic relationship as such and some special aspects of the relationship to patients which cause the analyst to be disturbed by manifestations of counter-transference. For instance, an inclination to accept resistances at face value, a feeling of inabiliy to attack or analyse them, was based, in two cases which I could observe in analysis, on an unconscious identification with the patient, just because he was in the position of a patient. The analyst expressed in that identification a passive masochistic wish (in one case, a homosexual one; in the other case, of a woman analyst, a predominantly masochistic one) to change places with the patient and to be in the passive position. Both were tempted to let themselves be accused and mistreated by the patient. In both cases, to be a patient corresponded to an infantile fantasy.

Such manifestations of counter-transference, of course, do not represent isolated episodes but reflect permanent neurotic difficulties of the analyst. Sometimes the counter-transference difficulties are only one expression of a general character problem of the analyst. For instance, unconscious aggression may cause the analyst to be over-conciliatory, hesitant and unable to be firm when necessary. Unconscious guilt feelings may express themselves in boredom or therapeutic overeagerness. These attitudes naturally represent serious handicaps for the analyst.

Another example of this kind is a paranoid attitude which makes the analyst concentrate on 'motes' in other people's eyes in order not to see the 'beams' in his own. This can degenerate into complete projection of his own contents or may remain within the frame of usefulness and enable the analyst to develop an uncanny sense of smell, so to speak, for these particular contents. He does not invent them in his patients but is able to unearth them, even if they exist only in minimal quantities. Obviously the analytic situation is a fertile field for such behaviour. This mechanism may originally even have created the interest in analysis. Frequently, though, the analytic situation is not the only battleground for these forces, which extend also to other fields of life. This attitude cannot be considered as a pure counter-transference phenomenon in the proper sense any more. It belongs more to the 'acting out' group, which I mentioned earlier, and of which I would like to bring just one example:

An analyst had the need to prove that he was not afraid of the unconscious, not afraid of his own unconscious drives. This led to a compulsion to 'understand' the unconscious intellectually, as if to say: 'Oh, I know and understand all that, I am not scared.' This caused a tendency to preserve a safe distance from the patient's unconscious by helping to keep up an intellectual isolation and induced the analyst to overlook the patient's defence mechanisms like isolations. The aim of this acting out was, of course, to master the analyst's anxiety. Such mechanisms are double-edged. They work only for a certain time and tend to break down when the intensity of anxiety becomes too great. The analyst, being afraid of his breakdown, was frightened by any emotional breakthrough or outburst of anxiety in his patient and avoided anything which could help the patient to reach greater emotional depth. Under such conditions it became important not to identify himself with the patient at all, or, at least, only with the resistances, which then were not recognized as such but were taken at their face value, this again seriously interfering with the analyst's tasks.

The bad relationship of the analyst with his own unconscious may lead to constant doubt of the veracity of the expressions of the unconscious. Such a doubt is sometimes overcompensated by the extraordinary stress which is placed on any bit of unconscious material that can be recognized. Deep interpretations are then given in a compensatory way to overcome the analyst's doubts before the patient is ready for them. In other cases I have seen a fear of interpretations.

I shall refrain from giving any other examples for 'acting out' in order not to overburden
the reader with too many details. But there is one more group that should be mentioned. Here the analyst misuses the analysis to get narcissistic gratifications and assurances for himself.

A specific form of this kind might be called the 'Midas touch'. It is as if whatever the analyst touches was transformed into gold. He is a magic healer. He restores potency and undoes castration. His interpretations are magic gifts. His patients become geniuses just because they are his patients. It is obvious what enormous gratification the analyst can get from such an attitude and how dangerous it is. It easily can lead to unrealistic evaluations of the patients, to inability to observe soberly, to therapeutic overambition and hostility against the patient who fails to give his analyst the narcissistic gratification of becoming cured by him. In general, the slow cumbersome process of analysis makes high demands on the analyst's patience and narcissistic equilibrium. It is obvious how detrimental it may become if this equilibrium is shaky, that is, if the analyst depends on his patients for narcissistic supplies.

Related to this are attitudes which one might call pedagogic ones. The analyst feels tempted to fulfill thwarted infantile desires of patients and thus to teach them that the world is not as terrible as they in their childish ways of thinking assume. Thus anxiety is smoothed over, reassurance is given instead of real analysis of the anxiety. The psychotherapeutic past with which most of our students recently come to analytic training presents us frequently with tendencies of this kind.

I remember the case of a colleague, for instance, who would constantly answer all the questions of a patient relating to the analyst's private affairs. The analyst was unable to let a frustration situation come to a peak, which would have led into the analysis of the childhood situation. Instead, he had to gratify and reassure the patient. It was as if he were saying to the patient: 'I am not treating you as you were treated, that is—mistreated—by your parents'. which means: 'I am not treating you as I was treated by my parents or by my former analyst. I am healing what they damaged.' Sometimes pedagogic attitudes like this may stand under the opposite sign: 'I shall treat you as I was treated. I will do to you what was done to me.' Here something that was originally passively experienced is transformed into something which is actively done to somebody else. This is one of the most effective forms of anxiety mastering.

I shall not continue to enumerate and describe here how the variety of possible disturbances in the activity of analysing is as manifold as the whole psychopathology of neuroses, character disturbances included. In all similar types of behaviour in which the activity of analysing is used in some way for extraneous unconscious purposes, mostly in order to keep up the analyst's inner equilibrium, the patient, as I mentioned before, is not a real object but is only used as a fortuitous tool to solve a conflict situation. Fenichel has coined a specific term to describe this situation: the patient is used as a witness to whom the analyst has to prove, for instance, that he can master the unconscious, or that he has no reason to feel guilty.

Let me stop here and look back. I have given many more examples of the permanent kind than of the acute one. This may be due to the material available to me, which after all was mostly contributed by analysts who came to analysis on account of some difficulty—but I am almost inclined to believe that indeed most counter-transference difficulties are of the permanent type. It is obvious that the acute ones are much easier to deal with than the others. Frequently a bit of self-analysis can reveal what is going on and bring about a complete solution of the conflict. The permanent and more generalized forms are consequences of deeply engrained personality difficulties of the analyst for which there is only one solution: thorough analysis. Freud, in his paper 'Analysis Terminable and Interminable', advises that the analyst after some years of practice should have some more analysis, even when the difficulties he has to struggle with are not as serious as those described. This is something we really should bear in mind.

The two forms of counter-transference manifestations could be compared with incidental hysterical symptoms in contrast to permanent character distortions. The attempt to keep these two types of counter-transference clearly separated is of course schematic. As mentioned before, there are transitions from one form to the other.

It would be impossible to attempt to give a complete description and classification of even the most frequent forms of counter-transference only. This would amount to a survey of the psychopathology of the analyst. We are most
concerned with the effect these psychological mechanisms have on analytic technique. Nearly all the phenomena mentioned will interfere with the analyst's ability to understand, to respond, to handle the patient, to interpret in the right way. But on the other hand, the special talent and the pathologic are usually just two sides of the same; a slight shift in cathexis may transform an unconscious mechanism of the analyst from a living out of his own conflicts into a valuable sublimation. On the other hand, what is the preliminary condition for his psychological interest and skill may degenerate into acting out.

It appears to me highly desirable to reach a closer understanding about the conditions under which these unconscious elements do constitute a foundation for adequate or even outstanding functioning and when they serve to interfere with or at least to complicate the activity of analysing. We said before that the unconscious of the analyst is his tool. The readiness and faculty to use his own unconscious in that way obviously must have some deeper motivation in the analyst's psychological make-up.

The analysis of these deeper motives, which, as we said, are the necessary basis for the analyst's interest, leads us back to the unconscious drives which were sublimated into psychological talent. Sometimes this personal origin of the analyst's interest in his work is clearly discernible even without analysis. I know, for instance, a number of analysts who, after many years of work, are still fascinated by their being entitled to pry into other people's secrets; that is to say, they are voyeurs; they live out their infantile sexual curiosity. Curiosity is seriously considered by many analysts as an essential prerequisite for analysis, but this curiosity has to be of a special nature. It has to be desexualized. If it were still connected with sexual excitement, this would necessarily interfere with the analyst's functioning. It must be, furthermore, removed from the original objects and has to be used for an interest in understanding their psychology and their structure. In this way the whole process is lifted above the original level of conflict.

I give here a piece of case material from the analysis of an analyst that throws some light on the psychologic background of such a sublimation; this may permit a somewhat deeper understanding of the structure of such a sublimation. The example I am choosing comes from a person who was capable and successful and had good therapeutic results. The counter-transference in his case, in spite of the rather pathological origin, was, one might say, tamed and harnessed for the benefit of the work. I shall limit myself to a few important elements.

One of the special gifts of this analyst was his keenness of observation, his ability to grasp little peculiarities of behaviour in his patients and to understand them—correctly—as expressions of an unconscious conflict. He was deeply interested in his work, to the exclusion of extraneous intellectual inclinations.

The genesis of his psychological interest could be reconstructed in analysis as follows: Dr. X. from early childhood was again and again an unwilling witness of violent fights between unhappily married parents, which frightened him and brought forth the wish to reconcile them and to undo whatever damage might have been done in their battles, which were misunderstood by the child as sadistic primal scenes. The father, strong and powerful, but intellectually the mother's inferior, was 'tearing pieces out of mother', as she complained whenever she wished to ward off his affectionate approaches. This left mother, the boy felt, castrated, sick, complaining and, at the same time, overambitious and demanding recompensation for her own deficiencies from her son, who had to become 'magnificent' to fill her narcissistic needs. Too frightened to identify with the father in his sadistic activities, the child rather early identified with the mother and felt passive and castrated like her. A mild attack of poliomyelitis during the height of the Oedipal period served to engrave the mother identification more deeply. He now began to observe his own body as he had been observed anxiously by his mother who had been looking for signs of the illness. Overstress was now laid on any spark of masculinity, strength and perfection to contradict the inner awareness of his passivity and his fear of castration. In a partial regression he now became interested in his anal functions, following his mother here, too, who overanxiously watched his anal productions, willing to give him ample praise when she was satisfied. He now overevaluated himself just as his mother overevaluated him. At that time a peculiar fantasy appeared: he is one with mother as if he and she were one body. He is her most precious part, that is, he is her penis. By being 'magnificent' as she wants him to be, his whole body becomes a big
penis and in this way he undoes her castration. Both together they are complete.

This fantasy remained the basis for his tendency to self-observation, which thenceforward continued to exist. In this self-observation he plays two roles. He is identified with the anxious, castrated mother who watches him and at the same time he exhibits himself in order to gratify her. This narcissistic play now becomes a new source of gratification for himself. He is proud of his keenness of observation, his intelligence and knowledge. His thoughts are his mental products, of which he is as proud as of his anal achievements. In this way he is reconstructing what mother has lost. By self-observation he heals her castration in a magic way.

When he was nine, a little brother, the only other sibling, was born. This was a fulfilment of a desire for a child of his own which had already come to the fore in connection with his anal interests. Now he develops a motherly interest in the baby and succeeds in turning away his interest to a large degree from his own body to the baby and later to other outside objects. The self-observation turns into observation of other people, and thus the original play between him and mother is re-enacted by him in projection on to outside objects and thus becomes unselfish and objective. A necessary preliminary step in the direction of sublimation was made.

Furthermore, another important development can be now noticed. His interest in the little brother becomes a psychological one. He remembers a scene when the little one, not yet two years of age, had a temper tantrum, in his rage biting into the wood of the furniture. The older brother was very concerned about the intensity of emotion in the child and wondered what to do about it. Thus the interest which originally had to do with physical intactness had turned towards emotional experiences.

The psychological interest from now on played an important role in his life. The decision to study medicine and to choose psycho-analysis as his specialty impresses us as a natural development of these interests. Here he can build up a stable sublimation of his peculiar strivings. He can now continue to observe, not himself, but other people. He can unearth their hidden defects and signs of castration and can use the technique of analysis for healing them. He has a special talent for understanding other people's unconscious and their hidden resistance. In the relationship with the patient he relives his original interplay with mother. By curing the patient he himself becomes cured and his mother's castration is undone. The cured patient represents himself as a wonderful phallus that has returned to mother. It is obvious what tremendous narcissistic stress he laid on being a 'good analyst'. In this new position, as a 'magnificent' analyst, he represents his deepest ego-ideal as fulfilled, he is a phallic mother.

On a higher level, the patient also represents his child, his little brother, whom he wants to understand, in order to educate and help him.

The analytic faculties of this analyst are obviously based on an originally rather pathologic and narcissistic self-interest. That he is interested in a patient is based on a projection of this self-interest; but what he observes remains objective and does not represent a projection of inner experiences and fantasies. This faculty for objective observation has to do with the fact that Dr. X., in spite of the at some time unstable boundaries between him and his mother, had had a warm and affectionate relationship with her and was capable of real object libidinal relationships. He sees what is there and not what is within himself, though his motive for seeing and his ability to understand are based primarily upon his preoccupation with the mother's and his own intactness or deficiency; though deep down he wants to be a magic healer he is able to content himself with the slow process of interpreting resistances, removing defences and unearthing the unconscious. Thus one can say that though his need to understand is the result of his highly pathological mother fixation he has succeeded in sublimating these infantile needs into true psychological interest. That he wishes to understand and to heal is motivated by the past. What he understands and how he tries to heal is based on objective reality. This is essential, as it represents the difference between acting out and a true sublimation.

I am aware that in representing this bit of case material I am not being fully successful in really shedding light on the finer prerequisites of this accomplishment. The problem why a sublimation is successful or not depends to a large degree on economic factors, and these are beyond the scope of this discussion. This is a problem, by the way, which is by no means specific for this type of sublimation.

The wish to heal and the psychological interest
could be traced in this material to specific infantile set-ups. I do not feel entitled to assume that the wish to heal is typically based on a similar conflict situation. A further investigation of the origin of the interest in psychology and healing in a more general way would be a challenging problem.

What is of interest for us here is the similarity and the difference of the well-functioning sublimation and the aforementioned types of acting out. Here as well as there deep personal needs are fulfilled. But while in this sublimation the fulfilment is achieved via the route of desexualized psychological insight this transformation has not taken place in the pathological forms of counter-transference.

The double-edged character of such a sublimation is obvious. The intensity of interest, the special faculty of understanding lead to a high quality of work, but any disturbance of psychic equilibrium may bring about a breakdown of the sublimation and the satisfaction of personal needs may become over-important so that the objectivity in the relationship to the patient becomes disturbed.

What I should like to stress is that in this case of undisturbed functioning the psychological interest obviously is based on a very complicated 'counter-transference', which is desexualized and sublimated in character, while in the pathological examples the conflict persisted in its original form and the analytic situation was used either for living out the underlying impulses or defending against them or for proving that no damage has occurred in consequence of them.

Maybe we might come to the following conclusion: Counter-transference is a necessary prerequisite of analysis. If it does not exist, the necessary talent and interest is lacking. But it has to remain shadowy and in the background. This can be compared to the role that attachment to the mother plays in the normal object choice of the adult man. Loving was learned with the mother, certain traits in the adult object may lead back to her—but normally the object can be seen in its real character and responded to as such. A neurotic person takes the object absolutely for his mother or suffers because she is not his mother.

In the normally functioning analyst we find traces of the original unconscious meaning of analysing, while the neurotic one still misunderstands analysis under the influence of his unconscious fantasies and reacts accordingly.