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Basic Psychoanalytic Concepts: IV. Counter-Transference

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In previous papers in this series we have discussed two concepts which have been used in connection with aspects of the relationship between the patient and his doctor. These were the *treatment alliance* (Sandler, Holder and Dare, 1970) and *transference* (Sandler, Dare and Holder, 1970). Although these two clinical concepts originated within the psychoanalytic treatment situation they are capable of extension outside it. Both relate to and emphasize processes occurring within the patient and tend to stress one side of the relationship only. Even the concept of treatment alliance, although nominally appearing to include the roles of both patient and doctor, has tended to be regarded from the point of view of processes and attitudes in the patient; the aspect of the therapist's attitudes, feelings and professional stance have to a large extent been omitted. However, in recent years more attention has been paid in psychoanalytic and other writings to the relation of the doctor towards his patient. Just as the term 'transference' is often used loosely as a synonym for the totality of the patient's relation to his therapist, so is the term 'counter-transference' often used in a general sense (both within psychoanalysis and outside it) to describe the whole of the therapist's feelings and attitudes towards his patient, and even to describe facets of normal, non-therapeutic relationships (Kemper, 1966). Such a usage is very different from what was originally intended, and as a consequence confusion has arisen about the precise meaning of the term. It is the purpose of this paper to examine the concept in the light of its origins and development within psychoanalysis and to comment briefly on some possibilities of its extension outside the psychoanalytic treatment setting.

The term was first used by Freud in discussing the future prospects of psychoanalysis (1910a). He said of the psychoanalyst: 'We have become aware of the 'counter-transference', which arises in him as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it . . . no psycho-analyst goes further than his own complexes and internal resistances permit . . .'. In the same year, in a letter to his colleague Ferenczi, whom he had analysed, he apologized for his failure to overcome counter-transference feelings which had interfered with the analytic work (1910b).

Freud later developed the theme that the analyst should aim to show the patient as little as possible of his own personal life, and he warned analysts against discussing their own experiences and shortcomings with their patients. 'The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him.' He pointed to the danger of falling into 'the temptation of projecting outwards some of the peculiarities of his own personality' (1912).

Just as transference was, early on, seen by Freud as an obstruction to the patient's flow of free associations, so counter-transference was consistently regarded as an obstruction to the freedom of the analyst's understanding of the patient. In this context, Freud regarded the analyst's mind as an 'instrument' (1913), its effective functioning in the analytic situation being impeded by counter-transference. Freud did not take the step (which he took in regard to transference) of regarding counter-transference as a useful tool in psychoanalytic work.

It should be emphasized that for Freud the fact that the psychoanalyst has feelings towards his patients, or conflicts aroused by his patients, did not in itself constitute counter-transference. He did not advocate that the analyst should turn into a 'mirror', but rather that he should aim to *function* like a mirror in the analytic

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situation, reflecting (through his interpretations) the meaning of the material brought by the patient, including the patient's transference distortions. Counter-transference was seen as a sort of 'resistance' in the psycho-analyst towards his patient, a resistance due to the arousal of unconscious conflicts by what the patient said, did or represented to the analyst. The analyst might, through self-scrutiny, become aware of the existence of such conflicts in himself, and this was an indication for him to make every effort to recognize their nature and to eliminate their adverse consequences. In Freud's view, the conflicts were not in themselves counter-transference but could give rise to it.

Freud repeatedly stressed the limitations imposed on the analytic work by the analyst's psychological blind spots (1912, 1915, 1931, 1937). He advocated initially (1910a) a continuous self-analysis for the analyst, but he soon took the view that this was difficult because of the analyst's own resistances to self-understanding and recommended that the analyst should undergo an analysis himself ('training analysis') in order to gain insight and to overcome the psychological deficiencies created by unresolved unconscious conflicts (1912). Later, believing even this to be inadequate, he suggested that analysts be re-analysed about every five years (1937).*

It is clear that Freud included in counter-transference more than the analyst's transference (in the sense in which he used the term) to his patient. While it was true that a patient might come to represent a figure of the analyst's past, counter-transference might arise simply because of the analyst's inability to deal appropriately with those aspects of the patient's communications and behaviour which impinged on inner problems of his own. Thus if a psychoanalyst had not resolved problems connected with his own aggression, for example, he might need to placate his patient whenever he detected aggressive feelings or thoughts towards him in the patient. Similarly, if the analyst was threatened by his own unconscious homosexual feelings, he might be unable to detect any homosexual implications in the patient's material; or, indeed, he might react with undue irritation to homosexual thoughts or wishes in the patient, might side-track the patient on to another topic, etc. The 'counter' in counter-transference may thus indicate a reaction in the analyst which implies a *parallel* to the patient's transferences (as in 'counterpart') as well as being a reaction to them (as in 'counteract'). The etymology of the term has been discussed by Greenson (1967).

There have been a number of different lines of development in the psychoanalytic literature on counter-transference since Freud. Several authors have maintained that the term should be employed in the exact sense in which it was first used, i.e. that it should be limited to those unresolved conflicts and problems that are aroused in the psychoanalyst during the course of his work with the patient and consequently hinder the analyst's effectiveness (Stern, 1924; Fliess, 1953). Winnicott (1960) describes the counter-transference as the analyst's 'neurotic features *which spoil the professional attitude* and disturb the course of the analytic process as determined by the patient'. Others, while adhering more or less to the original concept, have emphasized that the origin of counter-transference hindrances lies predominantly in the therapist's transference towards the patient (A. Reich, 1951; Gitelson, 1952; Hoffer, 1956; Tower, 1956). For example, A. Reich remarks that the analyst '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.' She goes on to say '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 the past feelings and wishes are projected . . . this is counter-transference in the proper sense' (1951).

Unfortunately, the views of those authors who regard counter-transference as being the outcome of the analyst's own transference to the patient are often rendered obscure by their

* A recommendation which has not been commonly implemented.

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failure to indicate the exact sense in which they make use of the concept of transference (cf. Sandler, Dare and Holder, 1970). Some appear to relate counter-transference to Freud's original concept of transference, while others equate it with all aspects of relationships (e.g. English and Pearson, 1937). In line with this latter usage, M. Balint, in one of the earliest papers on counter-transference (1933), equated it with the analyst's own transference to his patient, and later (M. Balint and A. Balint, 1939) broadened the use of the term to include anything (even the disposition of the cushions on the couch) which reveals the personality of the analyst. In a later paper (1949) M. Balint uses the term counter-transference unambiguously to describe the totality of the analyst's attitudes and behaviour towards his patient. For Balint, unlike Freud, counter-transference has come to include the professional attitude of the analyst towards his patient.

A major development in psychoanalytic writings on counter-transference occurred when it began to be seen as a phenomenon of importance in helping the analyst to understand the hidden meaning of material brought by the patient. The essential idea put forward is that the analyst has elements of understanding and appreciation of the processes occurring in his patient not immediately conscious to him, and that these elements can be discovered by the analyst if he monitors his own mental associations while listening to his patient. This is an idea which is implicit in descriptions by Freud of the value of the analyst's neutral or 'free-floating' attention (1909, 1912), but the first explicit statement of the positive value of counter-transference was made by Heimann (1950, 1960), and has been extended by others (e.g. Little, 1951, 1960). Heimann begins by regarding counter-transference as covering all the feelings which the analyst experiences towards his patient. The analyst has to be able to '*sustain* the feelings which are stirred up in him, as opposed to discharging them (as does the patient), in order to *subordinate* them to the analytic task in which he functions as the patient's mirror reflection.' Her 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 "counter-transference" ' (1950). She maintains that the analyst must use his emotional response to the patient—his counter-transference—as a key to the understanding of the patient. In other words, an analyst may become aware of rising emotionally-tinged reactions to a patient which cannot immediately be linked with the surface content of the patient's associations, but which nevertheless indicate the existence of a role which is being unconsciously forced on to the analyst by the patient. The analyst's awareness of his own responses can thus provide an additional avenue of insight into the patient's unconscious mental processes. It is of some interest that this extension of the concept of counter-transference is similar to Freud's change in his view of the function of transference, first regarded only as a hindrance but later seen as an asset to therapy.

As with other psychoanalytic concepts, the attribution of additional meaning to the term 'counter-transference' has led to a loss of precision in its use. While there can be little doubt that the whole of the therapist's feelings towards his patient must be a subject of interest to those investigating the doctor-patient relationship in a variety of situations, it can be questioned whether the extension of the counter-transference concept to cover *all* the feelings experienced towards a patient is useful.

Most of the psychoanalytic literature on counter-transference appears to reflect adherence to one or other or both of the two main views described above, i.e. that counter-transference is either an obstacle to the analytic work or that it is a valuable tool. The problems arising from this have been recognized in the psychoanalytic literature (e.g. Orr, 1954). Kernberg, in a review of the writings on counter-transference (1965), has pointed out that the broadening of the term to include all emotional responses in the analyst is confusing and causes the term to lose all specific meaning. However, he also cites criticisms of the earlier view which may obscure the importance of counter-transference by implying that it is something 'wrong'. This may encourage a 'phobic' attitude in the analyst towards his own emo-

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tional reactions, and thus limit his understanding of the patient. He points out, in accord with views expressed by others (e.g. Winnicott, 1949) that the full use of the analyst's emotional response can be considered to be of particular importance in the treatment of patients with profound personality disorders and other very disturbed or psychotic patients. Hoffer (1956) has attempted to deal with some of the confusion connected with the term by distinguishing between the analyst's transference to his patient and his counter-transference, but he idiosyncratically relates the analyst's transference to his humanity and appreciation of the patient's realistic needs, and the counter-transference to the analyst's intrapsychic reactions, including his limitations in comprehending the patient's material.

A persistent theme in the psychoanalytic literature is that counter-transference phenomena are essential concomitants of psychoanalytic treatment. One of the clearest statements in this connection was made by Sharpe (1947): 'To say that . . . an analyst will still have complexes, blind spots, limitations is only to say he remains a human being. When he ceases to be an ordinary human being he ceases to be a good analyst.' She adds: 'Counter-transference is often spoken of as if it implied a love-attitude. The counter-transference that is likely to cause trouble is the unconscious one on the analyst's side, whether it be an infantile negative or positive one or both in alternation . . . We deceive ourselves if we think we have no counter-transference. It is its nature that matters.' Similarly, A. Reich (1951) points out that 'counter-transference is a necessary prerequisite of analysis. If it does not exist, the necessary talent and interest is lacking.' A similar view is put forward by Spitz (1956) and Little (1960); the latter says: 'without unconscious counter-transference there would be neither empathy nor analysis itself.' Money-Kyrle (1956) refers to empathy as the 'normal' counter-transference.

We can see that the concept of counter-transference has been broadened over the years to include a number of different meanings, thus inevitably diminishing the precision with which it was originally used. In present usage the following main elements can be discerned. (Some of these have been listed by Little, 1951.)

1. 'Resistances' in the analyst due to the activation of inner conflicts in him. These disturb his understanding and conduct of the analysis, producing 'blind spots' (Freud, 1910a, 1912).

2. The 'transferences' of the analyst to his patient. Here the patient becomes a present-day substitute for an important figure in the childhood of the analyst (e.g. A. Reich, 1951, 1960).

3. The disturbance of communication between analyst and patient due to anxiety aroused in the analyst in the patient-analyst relationship (Cohen, 1952).

4. Personality characteristics of the analyst which are reflected in his work and which may or may not lead to difficulties in his therapy (e.g. M. Balint and A. Balint, 1939); or the whole of the analyst's conscious and unconscious attitudes to his patients (e.g. Balint, 1949; Kemper, 1966).

5. Specific limitations in the psychoanalyst brought out *by particular patients*; also the specific reaction of the analyst to his patient's transference (e.g. Gitelson, 1952).

6. The normal emotional response of the analyst to his patient. This can be an important therapeutic tool (Heimann, 1950, 1960; Little, 1951) and a basis for empathy and understanding (Heimann, 1950, 1960; Money-Kyrle, 1956).

Undoubtedly the restriction of the clinical concept of counter-transference to the analyst's transference to his patient provides us with too narrow a definition, and one which is too closely tied to the particular meaning attributed to transference (Sandler, Dare and Holder, 1970). The broadening of the concept to include all of the analyst's conscious or unconscious attitudes, and even all his personality traits, renders the term practically meaningless. On the other hand, it would seem appropriate to take into account the useful extension of the concept to include those aspects of the analyst's emotional responses to his patient which do not lead to 'resistances' or 'blind spots' in the analyst, but which may be employed by him as a means of gaining insight (through an

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examination of his own mental reactions) into the meaning of the patient's communications and behaviour.

It would follow from this that the most useful view of counter-transference might be to take it as referring to the specific emotional responses aroused in the analyst by the specific qualities of his patient. This would exclude *general* features of the analyst's personality and internal psychological structure (which would colour or affect his work with all his patients) and would imply:

1. That there are 'normal' counter-transference responses in the analyst, and that these exist throughout the analysis.

2. That counter-transference can lead to difficulties in, or inappropriate handling of the analysis. This will occur if the analyst fails to become aware of aspects of his counter-transference reactions to the patient.

3. That constant scrutiny by the analyst of variations in his counter-transference feelings and attitudes towards the patient can lead to increased insight into processes occurring in the patient.

The concept of counter-transference can readily be extended outside psychoanalytic treatment, and awareness of the counter-transference can be regarded as a useful element in any doctor-patient or therapist-patient relationship. It follows that it can be of potential value for the clinician to monitor his reactions to his patients, and this can be extended to include the monitoring by the clinician of the reaction of other members of the staff of a therapeutic institution. For example, Main (1957) has described a group of patients who evoke a particular type of response in the medical and nursing staff of a psychiatric hospital. He suggests that this reaction, although it may be related to the internal problems and conflicts stimulated in the staff by such patients, is also the manifestation of an area of psychopathology in the patients themselves. The observation of counter-transference reactions may also be of diagnostic importance. Hill (1956) has commented that a feeling of irritation in the doctor can suggest a diagnosis of hysteria in the patient.

It seems legitimate to conclude that counter-transference is of use in the consideration and conceptualization of doctor-patient interaction in a variety of clinical situations, and the concept is capable of substantial extension outside the psychoanalytic setting in which it arose.

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