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Countertransference Past And Present: A Review Of The Concept

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My purpose in this paper is to review the major trends and developments in the evolution of the concept of countertransference. I will do so from my own perspective; that is, from the viewpoint of one American analyst, trained in a classical institute, who has had a long-standing interest in this issue.

Although I will attempt to describe some of the questions and controversies that have surrounded the idea of countertransference as well as the viewpoints of many of those who have written on the subject, I will make no attempt to be all-inclusive. My effort, rather, will be to present an overview of a concept, long in the shadows, that has emerged as one of the issues most actively discussed and debated in psychoanalysis today.

Looking back on the final decades of the twentieth century, in fact, future historians of psychoanalysis may well designate this period the countertransference years; for in this time few concepts in our field have gained as much attention, have been as widely explored and written about, and have been the subject of as much controversy as has the question of countertransference and its role in the analytic process. Certainly in America, but also, to a considerable extent worldwide, countertransference and the closely related issues of inter-subjectivity, enactments, self-analysis and the question of neutrality have taken centre stage as matters with which contemporary analysts are much preoccupied.

One could say, then, of countertransference, that it is a concept whose time has come; or perhaps more accurately, that it is a concept that, like the proverbial groundhog, has emerged into the sunlight when the conditions were right after having previously poked its head into the air, tested the weather, and retreated below ground. The creature who has now appeared, however, is essentially the same one who did the initial reconnoitring; more sprightly and energetic, perhaps, but basically unchanged. What has prompted his re-emergence is not some fundamental alteration in himself. It is a change in the climate, a change in the analytic atmosphere that has made it possible for the familiar face of countertransference to reappear.

A review of the literature on the concept, in other words, makes clear that although relatively little was written about countertransference in the first half of this century, those authors who were interested in the topic raised many of the issues that, today, are being actively discussed and debated in our psychoanalytic societies. The time was not right, however, for a full exploration of the topic of countertransference. It took a change in the intellectual climate, both within and outside of analysis; and, in America, a change in the analytic establishment for this to happen.

This is the first of several articles to appear on the topic of countertransference. They form part of the Journal's new Education Section (edited by Robert Michels with the assistance of Cláudio Eizirik, Alain Gibeault and Richard Rusbridger). Together the articles on countertransference (and later those on other topics) are designed to set out the main issues embraced by a basic concept and at the same time to illustrate how the concept is viewed and understood from the perspective of each of several different psychoanalytic cultures (Michels, 1997, 78:1067–1069).

Writers on countertransference have pointed out that although he was the first to identify and describe the phenomenon, Freud actually had little more to say about it. In fact, while it is true that Freud's comments on countertransference were sparse, what he did say, I believe, is of the greatest importance. His brief remarks on the topic have served as the source and foundation for the two divergent currents that have characterised subsequent thinking and theorising about countertransference. In **1910**, Freud made a profound observation.

'We have noticed', he wrote, 'that no psychoanalyst goes farther than his own complexes and resistances permit, and we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his own observations on his patients …' (pp. 141-2).

This statement speaks to a fundamental issue for all analysts: the limitations that our own neuroses, our own blind spots, and our own character issues impose on our ability to understand, and respond to, communications from another person. Viewing countertransference as unconscious forces arising in the analyst that impede his ability to receive and correctly understand those communications, Freud recognised that unless the analyst can work with himself to overcome those blocks and scotomas that, years later, **McLaughlin (1988)** characterised as our 'hard spots and dumb spots', the analysis will be

severely compromised and, in fact, effectively stalemated by these unrecognised aspects of the analyst's psychology.

While Freud's early emphasis on the importance of self-analysis occurred prior to the establishment of the training analysis as the prime means for helping analysts overcome their neurotic conflicts and the countertransference reactions that spring from them, the idea that, ultimately, every analyst is left to contend with the powerful, and potentially disruptive, unconscious forces unleashed in him or her by the process of analysing remains an insight of fundamental importance. Today with the freer and more spontaneous use of the analyst's subjectivity emphasised by a number of analysts (**Renik, 1993**), Freud's recognition of the enduring nature of countertransference and of the fact that it exists as an ever-present force in analytic work has taken on fresh significance. Under-emphasised by certain contemporary authors, the notion that countertransference not infrequently acts as an impediment to understanding and a block to progress was one that was central to Freud's thinking.

Another observation of Freud's, however, was at the root of the opposite view of countertransference; the idea that countertransference is not only inevitable in analysis, but that as a pathway to understanding the unconscious of the patient it plays an indispensable role in treatment. This view of countertransference, which informs much current thinking, has a long history in analysis, which, in this communication, I will touch on only briefly. Its origins can be traced to Freud's recognition that analysis involves communication between the unconscious of patient and analyst and that the transmission, beneath their surface exchanges, of unconscious messages between the two participants constitutes an essential part of the analytic process. This fundamental insight, conveyed in **Freud's (1912)** advice to the analyst to attune his unconscious to that of the patient as a telephone receiver is attuned to the transmitting apparatus, not only paved the way for the seminal idea, articulated by **Heimann (1950)**, that countertransference contains the unconscious of the patient, but through the choice of metaphor implicitly conveyed the notion that unconscious transmission in analysis is a two-way street.

Freud's efforts, early in the century, were devoted to developing theories of unconscious mental functioning that could explain the clinical pictures that confronted him daily and, as a consequence, he focused primarily on the psychology of the patient. His appreciation, however, of the fact that the unconscious of patient and analyst are in continual contact and that covert messages are continually transmitted between the two participants opened

the way to the idea, now increasingly accepted, that analysis inevitably involves the interplay of two psychologies.

A number of writers (**Tyson, 1986**; **Slakter, 1987**) have pointed out that Freud viewed countertransference solely as an obstacle in analysis and a problem of the analyst's that had to be overcome. He spoke quite directly, they point out, of the importance of the analyst's mastering his countertransference.

There is little doubt that this attitude developed, in large part, in response to the threat to the public image of analysis that stemmed from the behaviour of certain of Freud's colleagues. Ferenczi, Jung and other key figures were engaged in troubling involvements with patients and/or the families of patients, and Freud himself is reported to have confided to Ferenczi that he nearly succumbed to the charms of a female patient. Moreover, Freud remembered well how, in response to Anna O's erotic transference feelings, his old friend, Joseph Breuer, fled the field in panic.

Clearly danger existed, and as the leader of a nascent movement Freud understood that it was necessary for him to take a stand against the inappropriate behaviour that threatened its very existence. Whether he also recognised anything positive in countertransference is uncertain, but there is some evidence that he grasped its potential usefulness. **Tyson (1986)** points out that in a letter to Jung in response to the latter's involvement with Sabina Spielrein, **Freud (1909)** remarked that although they must be dominated, the analyst's sexual and loving feelings for patients can help him develop a thick skin and learn how to displace his affects in a clinically useful way. Thus, he said, such countertransference feelings constitute a ‘blessing in disguise’ (p. 231).

It was **Ferenczi (1919)**, however, who spoke most directly of the inevitability of countertransference and of the idea that it is valuable in understanding the patient. In fact, partly in rebellion against his old mentor, Ferenczi took issue with Freud's notion that countertransference must always be mastered. Efforts to do so, Ferenczi pointed out, may cause the analyst to constrain or inhibit his free-floating mental processes. And such free-ranging processes in the analyst, he believed, are essential elements in analytic listening and in the attainment of empathic understanding.

Appreciating, as few did before him, the central role that countertransference plays in treatment, the critical impact that it can have on the analytic process, and the fact that patients often have an intuitive awareness of the analyst's emotional responses, **Ferenczi (1919)** advocated disclosure of certain of the analyst's subjective experiences. He also experimented with mutual analysis, with the patient, for a time, becoming the analyst's analyst.

In addition to whatever personal motivations led him to undertake this experiment, Ferenczi believed that the analyst could learn much about himself from the patient and that the patient could benefit from understanding how the analysts personality and conflicts have affected his thought processes and the material that emerges in sessions. In different form,

some of these ideas are currently being investigated by colleagues (**Aron, 1991**; **Ehrenberg, 1992**), who are interested in the way in which the covert transmission of unconscious affects and fantasies influences the analytic process.

Radical for their time and perceived by Freud and his circle as potentially dangerous ideas, Ferenczi's views remained for many years outside the mainstream of classical analysis. Regarded for the most part as the product of a creative, but troubled, individual whose personal needs contaminated his thinking, Ferenczi's work was largely ignored by traditional analysts in the US. Rarely were his papers read in the classical American institutes, and when one was assigned, it was usually recommended as a matter of historical interest, rather than as a significant contribution to theory or technique.

In recent years there has been some revival of interest in Ferenczi in the US. A biography of him recently appeared and, not infrequently, his views are cited in papers and presentations. This new interest in Ferenczi stems. I believe,

from several sources. Certain contemporary analysts, interested in the intersubjective and social constructivist views of analysis, find in him a kindred spirit; one who, in their view, was, like themselves, regarded by the reigning powers as an outsider and a non-conformist. It is also true in the US, however, that in response to the shift that has taken place towards greater appreciation of the interactive dimension of analysis and the fluidity and permeability of the transference —countertransference relationship, a number of classically trained analysts have wanted to take a second look at some of Ferenczi's views. Whereas not many years ago his ideas were regarded as little more than rationalised enactments of personally driven beliefs, a number of colleagues today are finding in them an appreciation of the role of meta-communications in analysis and of the interplay between the minds of patient and analyst that was quite remarkable for its time.

Of course not all of Ferenczi's contributions are regarded as having equal value, and, in fact, many analysts of the classical school continue to view his thinking as naïve and misguided. Traditional analysts, who are critical of the so-called contemporary Freudians, not infrequently point out that many of their ideas, far from being original, are simply applications and restatements of Ferenczi's old, well-worn and long-discarded notions.

One of his ideas that not infrequently comes in for severe criticism is a formulation of the analytic process that Ferenczi put forward in **1920**. At that time, he conceived of analysis as essentially a corrective emotional experience, one in which the analyst's sincere and caring interest in his patient provides an opportunity for the reworking and correction of emotional trauma experienced in early childhood. As is well known, the idea of a corrective emotional experience in any form has long been a *bête noir* for traditional analysts. The fact that **Ferenczi (1920)** endorsed this view has been used by certain traditional analysts to discredit not only this idea, but his work in general. Moreover, responding to certain similarities between Ferenczi's thinking and that of contemporary analysts interested in intersubjsctivity and ignoring their equally important differences, these critics regard many of the current developments in analysis simply as repetitions of Ferenczi's mistakes.

Whatever one's view of these matters, however, it is clear that as a pioneer in exploring the interactive nature of countertransference, the way in which transference and countertransference interweave in the analytic process, and the fact that patients often intuitively grasp, and are affected by, covertly transmitted aspects of the analyst's attitudes and feelings, Ferenczi both anticipated and influenced much contemporary thinking.

It was not only Ferenczi, however, who anticipated certain current ideas about countertransference. A number of writers raised issues that, today, are at the forefront of current discussion and debate. **Stern (1924)** spoke of two kinds of countertransference; that stemming from the analyst's personal conflicts, and that arising in response to the patient's transference. It is the latter, Stern said, that is useful in analysis. The former constitutes an obstacle to understanding. To use himself effectively, Stern maintained, the analyst must meet the patient's transference with a transference of his own; that is, his approach must not be too intellectual, not too focused on cognitive understanding. Rather, he must permit his feelings and fantasies to arise and must allow his unconscious to resonate with that of the patient in order to grasp the latter's unconscious communications. This perspective embraces much that was to come later, including **Isakower's (1963a)** notion of the analytic instrument, **Reich's (1951)** concern with the neurotic aspects of countertransference, and **Sandler's (1976)** idea that, optimally, the analyst functions not only with freely hovering attention (**Freud, 1912**), but with free-floating responsiveness.

Deutsch (1926) also spoke of the way in which the analyst receives and utilises the patient's material. The patient's associations, she held, become an inner experience for the analyst. This mode of processing the material,

which gives rise to fantasies and memories on the part of the analyst, is, she claimed, the basis for all intuition and intuitive

empathy. It is not enough, however, Deutsch said, for the analyst to sift the patient's material through his unconscious. He must also process the data intellectually in order to arrive at proper understanding. This view foreshadows the position of **Arlow (1993)** who believes that conscious processing of the data must be added to the analyst's intuition and unconscious mental operations in order for accurate interpretations to be formulated. It also anticipated the current controversy between those who favour the Deutsch-Arlow view and those, like **Renik (1993)** who maintain that, being a continuous unconscious influence in analysis, the analyst's subjectivity is inevitably enacted before it reaches consciousness and can be subjected to the kind of cognitive processes that **Arlow (1993)** describes.

Other authors, too, anticipated current issues in countertransference. By pointing out that the patient's psychosexual conflicts evoke developmentally similar conflicts in the analyst, **Glover (1927)** was touching on an issue that is much discussed today; the way in which the patient's material resonates with and evokes memories of parallel psychological experiences in the analyst (**McLaughlin, 1981**; **Blum, 1980**; **Poland, 1986**; **Jacobs, 1991**; **Levine, 1997**). This issue is currently the subject of neurophysiological research, as well as efforts by analysts to learn how such subjective reactions can best be utilised in the clinical situation. **Glover (1927)** also attempted to distinguish countertransference proper from counter-resistance in the analyst. While few analysts today believe that such distinctions can be meaningfully made, Glover's interest in the analyst's, as well as the patient's, resistance also foreshadowed a matter of current concern; the way in which resistances are mutually constructed by patient and analyst (**Boesky, 1990**; **Hoffman, 1991**).

Strachey (1934) recognised the fact of mutuality in analysis; that is, the interaction of patient and analyst, and he pointed out that the mutative transference interpretation can be effective only when there is an emotional force field (or strong emotional engagement) between patient and analyst. Thus, although he did not refer to countertransference proper, **Strachey (1934)** helped set the stage for the recognition both of the intersubjective aspects of analysis and the fact that the analyst's emotional participation, expressed, in large measure, through his countertransference responses, is an indispensable element in the therapeutic action of analysis.

Low (1935) anticipated the views of **Renik (1993)** by taking issue with Freud's contention that countertransference can and should be mastered. This, she believed, was a fantasy, and she argued, not for the exclusion of the analyst's countertransference reactions, but for their use in analysis. It is through the analyst's subjective experiences, she held, that he or she can arrive at a correct understanding of the patient. This latter aspect of Low's position was elaborated and developed in different forms by the British object-relations school, by the Kleinians, and by a number of contemporary American analysts. Thus the idea that the analyst's subjectivity constitutes a valuable pathway to understanding the unconscious of the patient—the central notion that links contemporary views of countertransference—has a long history in psychoanalysis.

Other issues that are at the forefront of modern thinking also arose in the thirties and forties. **Balint & Balint (1939)** spoke of the question of self-revelation and noted that analysts inevitably reveal much about themselves through their character traits and their ways of working. And they pointed out that patients regularly pick up these cues and, preconsciously, possess a good deal more knowledge about their analysts than may be apparent.

Fliess (1942) used the concept of trial identification, currently an important idea in our understanding of the inner processes of the analyst (**Arlow, 1993**), and **De Forest (1942)** not only underlined the importance of countertransference in shaping the analytic experience,

but, like **Ferenczi (1920)**, advocated its selective disclosure.

Thus, before the Second World War most of the questions concerning countertransference that have preoccupied analysts today were raised for consideration. Despite this fact and its obvious importance as a central element in the analytic process, for some years countertransference held a peripheral place in the house of psychoanalysis: a concept acknowledged to be important but one not further developed or explored. Perhaps this was partly because that Freud wrote comparatively little about countertransference and, after offering his initial insights, essentially dropped the subject. It also seems, however, to be due to the fact that analysis was concerned with other matters. The assimilation and integration of the structural theory, the development and clinical application of ego-psychology, and the efforts to establish psychoanalysis as a general psychology, among other issues, preoccupied the oreticians and clinicians alike.

Several factors changed this picture. Experience in the Second World War put analysts in touch with a wide variety of mental conditions, particularly trauma and its effects on the personality. This led to a greater interest in working with patients outside the realm of the strictly neurotic. And as analysts expanded their practices to include more of the ‘widening scope’ type of patients, they often found themselves experiencing powerful and troubling emotions evoked by the blatant sexuality, the raw aggression, and other primitive affects directed at them by these patients. It soon became evident that contending with countertransference was a major consideration in working with the borderline and psychotic patients that analysts were now attempting to treat.

It was partly as a result of such experience that **Winnicott (1949)** published his well-known paper, 'Hate in the countertransference'. Echoing Ferenczi's contention that some countertransference reactions were objective responses to qualities in the patient and not neurotic in origin, Winnicott not only legitimised countertransference feelings and emphasised the important role that negative countertransferences play in treating disturbed patients, but demonstrated that the evocation of such feelings is a necessary and essential part of the treatment.

This liberating step in the use of countertransference was soon followed by another landmark contribution; a year later, **Heimann (1950)** argued that countertransference was not only inevitable, it was invaluable because it constituted an essential research tool for the analyst. Articulating a position that since then has been the subject of much controversy, **Heimann (1950)** viewed the countertransference as largely the creation of the patient. The analyst's subjective experiences, she believed, were put into him by projections from the patient. Thus what the analyst experiences subjectively can be understood as representing aspects of the patient's mind. This view has had a strong influence on certain conceptions of countertransference, and, in modified form, underlies the assumption of certain colleagues who view the mechanism of projection and, especially, projective identification as constituting the heart of the countertransference experience.

Another influential contribution appeared about the same time. In 1951, Little published a paper in which she explored the complex nature of the transference–countertransference relationship and pointed out that, inevitably it contains a mixture of normal and pathological elements derived from the psychologies of both patient and analyst. Exploring the countertransference in more depth than had been done previously, she showed how conflicting motives in the analyst, including his need for reparations for his or her unconscious aggression, will cause him both to wish to cure the patient and to keep him ill. Several years later, **Little (1957)** followed up this contribution with another in which she focused on the critical role that the analyst's paranoid anxieties and depressive feelings play in treatment, and she maintained that the success of an analysis depended on the satisfactory working through of the analyst's pathology.

Winnicott's (1949) paper and those of **Heimann (1950)** and **Little (1951)** had a substantial influence on the future development of the concept of countertransference, particularly in England, South America and in some European countries. Winnicott's approach, which viewed countertransference as induced by projections of the patient's internal objects, was expanded and elaborated by colleagues of the object-relations school (**Fairbairn, 1952**, **1963**; **Guntrip, 1961**), who, with much sophistication and expertise, explored and mapped this terrain. For them, countertransference became equated with the analyst's total responses, responses which, in large measure, reflected the projected and displaced inner object world of the patient. This view of countertransference is maintained today by many colleagues trained in this tradition and has been the basis for the illuminating contributions of **Bollas (1987)**, **Casement (1985)**, **Sandler (1962)** and many others.

The key papers of Heimann and Little reflected the views of **Melanie Klein (1921–1945)**, whose influence grew rapidly in postwar England. Klein's emphasis on the continued existence in troubled individuals of primitive schizoid-paranoid mechanisms and the pervasive use of projective identification in such patients contained the corollary ideas that the analyst would inevitably experience the impact of those primitive mechanisms and that the understanding and management of his countertransference responses was at the very heart of the treatment. Although modified and expanded today by more complex and subtle notions about the way in which patient and analyst experience each other as well as by innovative and valuable advances in technique, **Joseph (1985)**, **Steiner (1993)**, the Kleinian view of countertransference has its roots in the idea that the analyst's subjective experiences are primarily, though not exclusively, the product of projective identifications, and that it is the impact on him of the patient's projected paranoid-schizoid states of mind that constitutes the most important—and potentially most useful—aspect of countertransference.

Although he did not focus on countertransference as such, **Bion (1967)** emphasised the importance of the analyst's psychology in clinical work. Conceptualising analysis as an undertaking involving the emotional life of two individuals who are engaged in an intense relationship, Bion pointed out that the analyst's attitudes and values are communicated to, and continually influence, the patient and the emerging material. Chief obstacles to effective analytic work, Bion maintained, are the analyst's fantasies of omnipotence, and his tending to cling to theory and to *a priori* knowledge. In this regard, **Bion (1967)** spoke of the need for the analyst to approach each hour without memory or desire, by which he meant unburdened by subjectivity that prejudices his or her ability to hear and to respond to what the patient is seeking to communicate. Bion was also aware of the analyst's need, like that of the patient, to avoid the pain that not infrequently comes with self-knowledge. In his efforts to minimise pain, Bion pointed out, the analyst may focus on material less troubling to himself as well as to the patient and, in that way, enter in a collusion with him. In indirect ways, Bion's views have influenced the thinking of a number of colleagues, particularly in the Kleinian and intersubjective schools, with regard to the persistent effect of the analyst's countertransferences on the analytic process.

In France, **Lacan's (1966)** teaching has been an influential force in shaping conceptualisations of the analytic enterprise.

With regard to countertransference issues, Lacan pointed out that certain attitudes of the analyst can serve to block the unfolding analytic process. Central among these are the analyst's acceptance of the patient's identification with him, his wish for certainty, and his seeking specific responses from the patient; responses that serve as confirmation of the correctness of his interpretations. Lacan also held that if the analyst seeks to be scientific in the sense of searching for evidence either to formulate or confirm interpretations, such an attitude constitutes an interference to analysis. Effective analytic work, he said, requires open-ended exploration of the way in

which the unconscious reveals itself in image, symbol and metaphor. Like **Racker (1968)**, Lacan also pointed out the candidate's wish to please supervisors and teachers and to conform to the prevailing ethos of his analytic institute; attitudes that clearly involve counter-transference responses; and that not infrequently derail the analytic work.

In the US, it has been Kernberg (**1965**, **1976**), perhaps more than any contributor, who, in his writings on countertransference, has sought to integrate competing points of view. Drawing on Kleinian and object-relations perspectives as well as the work of **Jacobson (1964)** on the relationship of self and object, Kernberg has developed a complex and creative view of countertransference that illustrates how the idea of projective identification can be interpreted within an ego-psychological perspective. In addition, he emphasised the idea that unresolved conflicts in the analyst, aroused by the patient's material, constitute an important element in any countertransference response.

Grotstein's (1981) views are more centrally in the Kleinian-Bionian tradition. His writing focuses less on the contribution of the analyst's neurotic conflicts to countertransference and emphasises, rather, the way in which the patient's aggression, envy, competitive strivings and wish to destroy meaning produces powerful affects in the analyst.

Apart from these two major authors, recent work by **Thomas Ogden (1994)**, which I will comment on shortly, and perhaps a small number of other contributors, American views of countertransference are characterised by a different emphasis and, consequently, a different way of conceptualising the issue. Central to this difference are two factors of overriding importance. The first has to do with the history of psychoanalysis in America after the war. The second related issue concerns the influence of ego-psychology, particularly the ideas of conflict and compromise formation, on the thinking of American analysts.

Following the war, and for some three decades thereafter, analysis in America was dominated by the *émigré* analysts from Europe who had close ties to Freud and the circle of early analysts. To them, analysis, as they had learned it from their teachers, was a precious gift to be preserved, protected against dilution, and handed down to the next generation of students. Their anxiety about the possible contamination of analysis, increased by being in an unfamiliar culture (and one that Freud disliked and found alien to his values) caused them to close ranks and to remain essentially unreceptive to ideas other than those of Freud and those colleagues who were clearly in the Freudian camp.

To these analysts, the ideas of Melanie Klein (**1946**, **1952**) seemed to be the product of fantasy and in the Freud–Klein controversy of the fifties, they lined up solidly on the side of Anna Freud. To them, as to many of the English Freudians, Klein's ideas about the infant's mental states seemed so speculative, so unsubstantiated, and so little capable of proof, that for many years they were not given serious consideration. With few exceptions, Klein was not taught in the curriculum of American institutes and it is only in recent years that there has been greater receptivity to Kleinian ideas and a desire on the part of students to study and understand them.

As for the object-relations perspective, this was regarded as a rather superficial approach, one that sacrificed in-depth understanding of the drives and that underplayed the importance of infantile sexuality. As a consequence, few American students were exposed in any systematic way to the thinking of Winnicott, Fairbairn, Guntrip, or other major contributors of the object-relations school. As a result, for some years many American analysts had only a passing knowledge of the views of these English colleagues and the ways in which they conceptualised the meaning and uses of countertransference.

When, in the early fifties, Heimann and Little published their papers on countertransference, their ideas, clearly influenced by Klein, set off an alarm signal among many Freudians. Instead of countertransference being seen, as

Freud viewed it, as an impediment to correct understanding, the concept, as they saw it, was now being elevated to an exalted place by these British analysts and held up as the key to understanding the patient's inner world. Dedicated to the idea that the patient's conflicts could only be approached through careful analysis of ego defences and that countertransference represented the stirring of potentially troubling unconscious conflicts in the analyst, the Freudians in this country strongly opposed these new ideas.

Speaking from the standpoint of classical analysis, Annie Reich responded to the challenge posed by her English colleagues. In a series of papers (1951, 1960, 1966), she clarified the view of countertransference that prevailed among traditional analysts. Acknowledging that countertransference is not only inevitable in analysis but is a necessary ingredient if the analysis is to be emotionally engaged in the work, she reiterated Freud's view that it must be mastered. Countertransference, she said, is not a royal road to the unconscious. Rather, it represents the arousal of conflicts in the analyst that have the effect of interfering with his or her ability to hear and to respond to the patient's communications.

Describing a variety of countertransference responses, **Reich (1951)** illustrated the way in which long-standing character traits, as well as more immediate countertransference reactions, are not infrequently played out in treatment.

The influence of Reich's papers in America was enormous. For close to two decades the view of countertransference that she held was accepted by traditional analysts in this country. And when the issue was discussed at all in their institutes—by no means a regular occurrence—it was Reich's position that most often was endorsed.

Largely because **Reich's (1951)** paper solidified the view that countertransference is a problem—more or less severe, depending on the circumstances—that has to be attended to, either through self-examination or further analysis, for some years in this country, a curtain of silence descended on the topic. Since the very word, countertransference, now carried a certain stigma—presumably good analysts had little troubling countertransference and could deal effectively with the little that they had—students were afraid to acknowledge its existence in their case presentations and clinical reports. At the New York Psychoanalytic Institute, typical I believe of the situation that existed in most classical institutes, discussions of countertransference, either in clinical conferences or presentations, were rare. In courses on technique, the issue was touched on but not explored in any depth, (the work of **Heimann, [1950]**, **Little [1951]** and their predecessors was largely neglected), and if, in supervision, a piece of countertransference behaviour was noted, most often the candidate was advised to take the matter up with his analyst.

The general silence and embarrassment that surrounded the entire question of countertransference at that time extended to the literature. In the late fifties and sixties few articles on countertransference appeared and, scientifically, the topic seemed to be a dead issue.

There were exceptions to this general trend, however, and in that period, several American analysts made noteworthy contributions to the question of countertransference. Most influential of these was **Otto Isakower (1963a)** whose notion of the analytic instrument as belonging to both patient and analyst and as being composed of the temporarily fused unconscious of each, was a highly creative idea that both anticipated later studies concerning unconscious communication and its transmission in analysis (**Reiser, 1997**; **Dahl et al., 1988**) and raised questions about technique that are being actively debated today.

Isakower (1963b) stressed the importance of the role of regression in analysis. To communicate effectively, he said, the minds of patient and analyst must be in a state of temporary regression, a condition that is facilitated by the use of the couch, by free association, and by the analyst's stance of expectant silence and evenly hovering attention. Only when these conditions are met, he said, can the instrument operate

so that the images, fantasies and memories that arise in the analyst's mind as he listens be meaningfully related to the patient's unconscious.

In contemporary discussions of the issue, Isakower's insight concerning the critical role that regression plays in the positive and creative use of countertransference is often overlooked. Few authors, either in America or abroad, address this important question, which remains an aspect of countertransference that, as yet, has been insufficiently explored.

Several other authors, too, had useful things to say about countertransference. **Fromm-Reichmann (1950)** echoed **Winnicott's (1949)** view that countertransference plays an essential role in work with seriously disturbed patients, and she emphasised that the analyst brings his total being, his past as well as his present, to the treatment.

Tower (1956), writing in a vein similar to **Little (1951)**, underscored the interactive nature of the transference–countertransference amalgam and suggested that, in parallel with the transference neurosis, a countertransference neurosis also develops. Thus she conceived of analysis as a dual process, with the unconscious of patient and analyst in continual interaction and the resolution of the transference depending on the analyst's ability to recognise, and to work through, his countertransference neurosis.

Benedek (1953) carried forward the observation made by **Ferenczi (1919)** and the **Balints (1939)** that patients have an intuitive awareness of the analyst's attitudes and feelings and she maintained that the latter's personality plays a key role in all that happens in treatment.

Gitelson (**1952**, **1962**), reflecting the influence of Reich's paper and the position of traditionalists in the sixties, became

increasingly conservative in his view of countertransference. In an early paper, **Gitelson (1952)** saw a valuable role for countertransference in the analytic process. He even favoured its selective disclosure to patients as a technique that could advance the analytic process. Ten years later, however, Gitelson took a different stand. Countertransference, he said then, has a very limited place in treatment. Change, he maintained, occurs primarily through the interpretation of defence, not through the influence of the analyst's personality or, as some colleagues held, through the interaction of the unconscious of patient and analyst.

Like Fromm-Reichman, **Searles (1975)** was influenced by the interpersonal school and his work focused on the patient's experiences *vis-à-vis* the analyst. And like **Benedek (1953)**, he noted that patients intuit much about their analysts. In not a few cases, however, he added, the patient, like a child wishing to help a distressed parent, seeks to heal the analyst. And unless he becomes aware of this process and can effectively interpret it, the analyst may collude with the patient, leading to a situation in which the patient becomes entrapped in a neurotic interaction that compromises his autonomy and ability to achieve separation from the parent–analyst.

While valuable in themselves, these various contributions did not stimulate strong interest in the issue of countertransference an America. Nor did they affect the view that, far from being useful, countertransference was a problem to be dealt with personally—and privately—by each analyst; a view that held sway in the US for more than two decades.

The situation was quite different elsewhere. Under the impact of **Klein's (1921–45)** ideas and object-relations theory, both of which put a good deal of emphasis on the analyst's subjectivity as a way of accessing the unconscious of the patient, colleagues abroad—especially in England—were far more comfortable with, and knowledgeable about, countertransference than their American counterparts. In fact, the use of countertransference as a way of understanding the inner world of the patient became a regular feature of analytic work both in England and in those countries that were strongly influenced by Kleinian thought.

Chief among these were the Latin American countries. In fact, it was an Argentinian analyst, Heinrich Racker (**1958**, **1968**) who, in pioneering work, opened up many previously

unexplored dimensions of countertransference. Making useful distinctions between various types of countertransference responses, Racker showed how certain of these reactions resulted from the analyst's identification with the patient's internal objects, while others developed as consequence of his identification with the patient's drives or ego states. The latter phenomena he termed concordant identifications, while the former were named complementary ones. Racker also distinguished between direct and indirect countertransference reactions. Direct reactions are those which are stimulated by the patient. Indirect countertransference responses arise as more complex phenomena. They represent the analyst's emotional reactions to supervisors, teachers, colleagues or other significant individuals who exert an influence on his way of perceiving and working with his patient. Racker also recognised that the analyst may be influenced in important ways by his reactions to individuals in the patient's world about whom he hears and who evoke memories and fantasies in him. A male analyst, for instance, may develop feelings of rivalry *vis-à-vis* the spouse of a female patient and in subtle, or not so subtle, ways in which this reactivation of his oedipal conflicts may unconsciously influence his perception of the patient. A similar situation may arise when pre-oedipal conflicts are stimulated in the analyst by the patient's interaction with mothering figures in his life. Racker's recognition of these indirect, but important, dimensions of countertransference opened the way to further exploration and investigation of the phenomena and to the appreciation of the fact that countertransference is a highly complex reaction that condenses and expresses wishes, fantasies, memories, defences and superego prohibitions in a multi-determined way.

Racker's innovative study was influential in two respects. It stimulated interest in countertransference as a phenomenon whose effect on the analytic process was clearly profound, and it set the stage for the development of the view currently held by **Hoffman (1991)**, Stolorow et al. (**1983**, **1992**) and others in the US; that the analytic process entails not only the uncovering of unconscious fantasies and beliefs, but the creation of new psychic realities.

Another South American, **Leon Grinberg (1957)**, extended the Kleinian view of countertransference. He pointed out that, in response to the patient's projective identifications, the analyst reacts with projective identifications of his own. Unlike other Kleinians who, in large measure, viewed countertransference as representing the projected inner world of the patient, **Grinberg (1957)** emphasised the mutual nature of the projections that take place in intense transference–countertransference reactions. In doing so, he took a step towards broadening the Kleinian view of countertransference and underlined the fact, now increasingly accepted, that countertransference inevitably contains a mixture of elements emanating from both sides of the couch.

It was in the mid- to late seventies that things began to change in America. All at once, as though a dam had broken, a flood of papers on countertransference and related topics began to appear in American journals. Suddenly it became a topic

of interest to American analysts and one that, increasingly, became the focus of discussion and debate.

Although seemingly abrupt, this change had been in the making for some time and was the result of a number of interweaving factors. Perhaps the most important of these was the shift in power, influence and control that had gradually taken place on the American analytic scene.

As the influence of the older European analysts diminished with the passage of time, analysts in America became increasingly exposed to ideas outside the Freudian canon. The work of Racker, the English object-relations school, and the Kleinians became more familiar and stimulated interest in the analyst's subjectivity and the way in which it reflected aspects of the patient's inner world. There was greater contact, too, with colleagues in America who were trained in the interpersonal and cultural schools and whose exposure to **Sullivan (1953)**, **Thompson (1964)**, **Fromm-Reichmann (1950)**

and **Horney (1939)** gave them an understanding of the interactional and intersubjective aspects of analysis that were little emphasised in classical training.

The work of **Kohut (1971)**, too, although much criticised by classical analysts, illuminated an important and commonly experienced countertransference difficulty; that involved in working with highly narcissistic individuals. Kohut's work also demonstrated that empathy—in his view the key element in the analytic instrument—is dependent on the analyst's ability to employ vicarious introspection. He emphasised, in other words, the importance of the analyst utilising his subjectivity, including his countertransference reactions, as a means of understanding the unconscious communications of the patient. Thus, indirectly, Kohut emphasised the indispensable role that countertransference plays in analytic work and, over the years, as aspects of Kohut's thinking became more widely accepted and integrated into the main body of analytic thought, so, gradually, did his view concerning the essential role played in analysis by the analyst's ability to utilise self-reflection and self-monitoring functions in his work.

Equally important, however, was the fact that in the new analytic climate colleagues felt freer to explore their countertransference reactions, to write about them, and to share them with colleagues. In their institutes, at meetings, and amongst themselves, analysts began to talk more openly about their emotional reactions to patients and to explore the effect that such responses had on the analytic work.

The fact, too, that in allied fields, especially in literature and philosophy, the older positivist views had given way to a new relativism, with emphasis on deconstruction, reader-response criticism and the like, influenced contemporary thinking about psychoanalysis. No longer was the analyst seen as the sole possessor of the truth about the patient's psychology that he conveys through interpretation. Increasingly, the patient was viewed, rather, as a partner in the analytic journey whose insights and intuitions are to be respected, and analysis as a project in which, working together and utilising their own subjective experiences, patient and analyst uncover core unconscious fantasies and construct what **Spence (1982)** has spoken of as narrative truth. Analysts, too, began to reexamine long-held ideas and discovered, not surprisingly, that some of their prized theories and established ways of working contain unacknowledged countertransference responses to their teachers and training analysts.

In this new climate, there appeared the work of a number of authors who helped stimulate interest in countertransference and such related issues as enactments, intersubjectivity and self-analysis. Important contributors at this time—to name just a few—were **Gill (1982)**, **Poland (1986)**, **Schwaber (1983)**, **McLaughlin (1981)**, **Gardner (1983)**, **Boesky (1990)**, **Chused (1991)**, **Stolorow (1983)**, Ogden (1986) and **Renik (1993)**.

Gill's influence was central. His focus on the analysis of transference, or as he described it, the patient's experience of the analyst, was a major stimulus to the examination, not only of the transference proper, but of the influence that the analyst's subjective reactions had on the patient's perceptions and the material that was linked to those perceptions.

Schwaber's papers (**1983**, **1992**) helped sensitise analysts to the subtleties of the listening process and to the way in which their theories, values, pre-set assumptions and idiosyncratic reactions to aspects of the patient's personality prejudice the way they listen and respond to their patients.

Poland's work (**1986**, **1988**) focused on the way in which patient and analyst operate as a dyad, each a separate individual, but linked through the resonance between their unconscious mental processes. It is because such a dyadic relationship exists, he said—and solely because of its existence—that the analyst can understand the meaning of the patient's associations. Poland's view has much in common with **Isakower's (1963a)** idea that in analytic hours the unconscious of patient and analyst

form a temporary unit that allows for communication to take place between them.

In a series of seminal papers, McLaughlin (**1975**, **1981**, **1988**) illustrated the way in which the lives of patient and analyst often intertwine (**Blum, 1980**) and how subtle enactments of aspects of both of their histories influences the analytic process.

In an original and thought-provoking book, **Gardner (1983)** described the workings of his mind in analytic hours and, in some detail, illustrated how the memories, and imaginations that surfaced as he listened, were meaningfully linked to the patient's material.

Boesky (1996) has shown convincingly that countertransference enactments are not only inevitable in analytic work, but that they contribute in important ways to the therapeutic action of analysis. While it is essential for such enactments to be analysed, he said, the effectiveness of treatment often depends on the actualisation of certain countertransference responses. Only through this means, he pointed out, can patients gain meaningful understanding of their impact on the analyst and the way in which the transference–countertransference interaction illuminates aspects of their own history.

Chused's (1991) work has been instrumental in developing and clarifying the role of enactments in both child and adult analysis. Like **Boesky (1990)**, she sees enactments as inevitable and potentially useful in illuminating the transference–countertransference relationship. She insists, however, that it is important for the analyst to monitor herself and to make every effort to catch herself in the process of carrying out an enactment. Through such self-reflection, the analyst may be able both to curtail behaviour that is potentially damaging to patients and to gain insight into those communications of the patient that has evoked them.

In his publications, Stolorow (**1983**, **1992**), along with his co-workers, has been at the forefront of efforts to conceptualise the analytic process as an intersubjective one. Taking issue with the traditional view of analysis as essentially a one-person psychology, Stolorow has argued that the subjective worlds of both patient and analyst are mobilised in analysis, that they are in continuous communication, and that both exert an ongoing influence on all that transpires in the analytic process. These ideas, although often criticised by traditional analysts as too much focused on object relations and as not taking the drives and infantile sexuality into account, have been influential in helping to shape certain current views of analysis.

Highly creative, Ogden's (1983, 1997) work has contributed an interesting perspective to thinking about countertransference. Drawing on the Kleinian concept of projective identification, he has focused on the analyst's reveries as a valuable source of information about the patient's inner world. He has also developed the concept of the analytic third (Ogden, 1994), the term he uses to designate those ideas, beliefs and imaginations jointly created and shared by patient and analyst. This shared set of ideas has psychic reality for each and affects the perceptions and thinking of both. Similar to **Baranger's (1993)** notion of the analytic field, an idea that embraces fantasies and beliefs jointly constructed by patient and analyst, the concept of the analytic third is an original and creative one that focuses on a dimension of the analytic situation that has yet to be fully explored.

Ogden (1994) has also shown convincingly how actions on the part of the analyst, often carried out unconsciously, function as interpretations and are received by the patient as such.

Schafer (1959) has demonstrated how, over time, the analyst builds up a picture of the patient and the patient's inner world that inevitably mixes and fuses with aspects of the analyst's history. The picture that he constructs aids the analyst in creating a narrative that helps the patient organise and understand his psychological experiences.

In recent years, **Schafer's (1997)** lucid explanations of the work of the new Kleinians, such as **Joseph (1985)**, **Steiner (1993)**,

Feldman (1993), and **Spillius (1993)**, has been instrumental in familiarising American analysts with the thinking of these writers. Their emphasis on the importance of the here-and-now interaction of patient and analyst, on the use of the analyst's subjectivity (especially as it relates to the impact of the patient's projective identification on the analyst) and on investigation of the patient's fantasies about the analyst, have had a growing impact on technique among many American colleagues.

A key figure in the current discussions and debates concerning countertransference and the role of the analyst's subjectivity is Owen Renik. Few authors in recent times have aroused as much controversy as has Renik, who, during the past several years, has taken issue with many of the concepts that traditional analysis has long held sacrosanct.

Questioning the validity of such concepts as neutrality, abstinence and objectivity, Renik (1993a, **1995**) maintains that the analyst's subjectivity is an inherent and irreducible part of the analytic process. As such, it exerts a continual influence on that process. Given this reality, Renik argues, the concept of countertransference really has no meaning. The analyst's subjectivity infuses the treatment, making the notion of countertransference redundant.

Enacted unconsciously in all that the analyst thinks and does, including behaviour that he may believe to be neutral and/or objective, the subjectivity of the analyst, Renik says, cannot be identified or controlled prior to its being enacted. Inevitably it will be lived out by the analyst in ways both obvious and subtle. Rather than attempt the unrealisable task of monitoring and controlling his subjectivity, the analyst, Renik believes, is better advised to make it part of the analytic work. The analyst's enactments, in other words, he maintains, must be brought into the analysis, discussed, and their impact on the patient and the analytic work thoroughly understood.

Renik also believes that it is important for the analyst to share certain of his ideas, opinions and perceptions with patients so that they can be openly discussed in treatment. Arguing that analysts simply deceive themselves when they contend that their attitudes, values and beliefs are not communicated to patients, Renik maintains that quite the opposite is true. Whether he likes it or not, the analyst's subjectivity is transmitted to the patient in many ways and on many levels in treatment. Since this is so, Renik says, it is far better for the analyst to bring his views into the open so the patient can evaluate them and assess the impact that they have had on him.

Renik's views have been vigorously disputed by many of his colleagues who believe that in his challenge to classical analysis he has thrown out much that is valuable, that has stood the test of time, and that, in fact, constitutes the core of the method. Renik's iconoclastic ideas, however, have had the undeniably useful effect of stimulating active discussion and debate about the nature of the analytic process and about which ideas and methods in the classical tradition are worth preserving and which should now be discarded.

Although Renik's challenge to the idea of countertransference is a strong and persistent one, he is not the only one who has questioned the usefulness of the term. Some years ago, **McLaughlin (1981)** took a similar stand. Contending that countertransference has become a term so loosely and imprecisely used today that it has lost much of its value, McLaughlin proposed that we eliminate it altogether and speak of the analyst's transferences. While quite logical and potentially clarifying, this suggestion has not been widely adapted.

It seems, in fact, that countertransference is a term that is here to stay. Like its counterpart, transference, it is an established part of our lexicon, and, although interpretations of it differ—it is understood in a broad, totalistic way by some colleagues, more narrowly by others—it is generally agreed that the term refers to those emotional reactions in the analyst that are evoked by aspects of the patient, including his transference. In its emphasis on response to the patient, countertransference differs from the broader term, the analyst's subjectivity, which may include aspects of the

analyst's psychology (such as his reactions to pain from a physical injury) which, although they may influence and be influenced by the patient's material, arise independently of them.

Even as generally understood, however, there is much about the concept of countertransference that remains unsettled and problematic. Is it true, for instance, as some colleagues maintain, that countertransference can be understood primarily, if not exclusively, as consisting of projected aspects of the patient's internal world? Is projective identification the main mechanism through which countertransference comes into existence? And is it true that countertransference contains primarily projected aspects of those early mental states designated by **Klein (1946)** as the schizoid-paranoid position?

It would seem, too, that although modified today, certain notions of countertransference retain **Heimann's (1950)** idea that a direct channel exists between the unconscious of patient and analyst. In this view, the analyst's inner experiences are products of the patient's mind as projected into the mind of the analyst.

Explicitly, or by implication, some formulations of projective identification endorse this view. Others, however, hold that the patient's projections, no matter how evocative or compelling they may be, are not represented in the analyst's mind in any simple or straightforward way. Increasingly, colleagues of various persuasions are recognising that countertransference, like other aspects of mental functioning, is a complex entity that contains elements derived from the patient's projections, the analyst's psychology, including aspects of his personality and history, and the here-and-now transference–countertransference relationship. In this view, countertransference, like transference itself, is a creation fashioned out of components that shift and change in response to the developing analytic process and changes in the psychology of the analyst.

This view, which draws heavily on the notion of compromise formation and the principle of multiple functioning, is one that underlies much of the thinking about the analytic process in America today. Brenner (**1983**, **1985**), who has been its foremost exponent and explicator, has persuasively discussed the concept of countertransference in these terms.

Another area of controversy concerns the uses of countertransference and the extent to which the analyst can monitor or control it. Renik's view, as noted previously, is that the analyst's subjective reactions, including his more specific countertransference responses, are inevitably enacted in sessions before they can be consciously apprehended or understood. The idea that, through self-reflection, the analyst can control his countertransference reactions is, he says, a fiction.

In contrast, there is the viewpoint of **Jacob Arlow (1993)**, who represents the position long held by classical analysts.

Self-reflection, on the part of the analyst, Arlow maintains, is one of his essential functions. Valuable as they are, he points out, the analyst's intuition and other subjective experiences can provide no more than a clue to what is transpiring in the mind of the patient. The analyst's inner reactions must be monitored and subjected to a cognitive process in which his subjectivity is matched against the evidence provided by the patient's associations. Arlow stresses the importance of utilising image and metaphor, associative links between thoughts, and the contiguity of associations, to obtain the objective evidence needed to confirm and amplify the analyst's intuitions.

Another issue being widely discussed and debated in the US concerns the question of psychological truth and whether, in analysis, it is discovered or created. Authors such as **Poland (1988)**, **Chused (1991)** and **Boesky (1990)** hold that while the analyst's countertransference responses often prove useful in helping him gain access to unconscious conflicts in the patient, such reactions do not alter these conflicts. They are, rather, part of the internal world that the patient brings to treatment, and it is the recognition and resolution of such long-standing conflicts that is the central task of analytic work.

Quite different is the position of **Irwin Hoffman (1991)**, whose view of analysis he has labelled a social-constructivist one. Hoffman, like Renik, believes that the analyst's subjectivity is an ever-present force that influences all that happens in analysis. Going beyond Renik, however, Hoffman contends that the analyst's subjective responses not only affect the emerging material, but help create a new psychic reality for the patient. Forged out of the transference–countertransference amalgam, this new reality substitutes and replaces the neurotic compromise formations that are part of the patient's inner world and have been at the root of his troubles. As one can imagine, Hoffman's views, and the idea of analysis that they represent, have been a source of much controversy in America. They extend and expand on the ideas articulated by **Spence (1982)** and **Schafer (1976)**, who view analytic work as developing narrative, rather than historical truth.

Increasingly discussed and debated, too, is the question of self-disclosure on the part of the analyst and its role in the analytic situation. Until quite recently a taboo, self-disclosure in its many forms has now become a subject of exploration and experimentation.

Arguing that patients perceive much more about their analysts than is apparent in their verbalisations, **Aron (1991)** believes that active questioning on the part of the analyst about such perceptions opens up previously untapped areas in analytic work and, like Renik, he believes that there is a place, at times, in treatment for a frank and open statement of the analyst's opinions and beliefs. Revealing themselves in this way, these colleagues maintain, does not contaminate the transference, but simply makes explicit what was transmitted in covert and indirect ways.

Other colleagues, too, have begun to explore the possible uses of selective self-disclosure. One of the most articulate of these is **Christopher Bollas (1987)**, who has argued persuasively that judicious sharing with patients of aspects of the analyst's countertransference responses may open a pathway to certain split-off aspects of their self and object representations that would not be otherwise be accessible.

Ehrenberg (1995), **Davies (1994)** and **Miletic (1998)**, among others, also support the use of self-disclosure in specific and limited circumstances to enhance the patient's understanding of his projections and long-standing beliefs; and through neurophysiological and clinical studies, **Reiser (1997)** has demonstrated that memory banks in the analyst are activated by the patient's material. When he is well-attuned to the patient, Reiser maintains, the analyst's memories are meaningfully related to the patient's associations. For Reiser, these findings support Isakower's idea that sharing certain of his inner responses with patients can advance the analytic process.

An interesting area in which the analyst's use of his countertransference is held to be central to understanding and progress in treatment concerns the analysis of patients who have suffered severe psychological trauma in the early years of life. As **McDougall (1979)** in France and **Mitrani (1995)** in the US have shown, such patients are unable to verbalise feelings, and their associations therefore do not provide access to these traumatic experiences. It is only through the analyst's subjective responses as they arise in sessions that he is able to gain access to the troubled inner world of the patient. Such studies, along with Reiser's investigations and the clinical research of such colleagues as **Dahl et al. (1988)** and **Waldron (1997)**, who are studying the exchanges of patient and analysts in tape-recorded analyses, have verified the essential role played by countertransference in elucidating certain long-buried, and not easily decipherable, aspects of the patient's psychology.

It is clear, then, that the study of countertransference and its uses in treatment is an area that is being actively pursued on a number of fronts today. Over the last twenty years investigations of countertransference and the larger issue of the mind of the analyst at work have expanded our understanding of the analytic process, the importance of the

analyst's subjectivity in that process, and the relationship of the intersubjective aspects of analysis to the intrapsychic world of the patient. In short, in the last two decades of this century analysts have begun a fruitful exploration of an observation made years ago by Freud: that communication between the unconscious of patient and analyst is a central feature of the analytic situation.

As I have noted in this review, this exploration has raised many unanswered questions, has sparked a number of controversies, and in the US has contributed to the tensions and divisions between classical analysts, intersubjectivists, and those who seek to integrate these two perspectives.

There is no question, however, that the explorations of countertransference and related issues that have been carried out by a number of colleagues over the past two decades have had a significant impact on contemporary views of the analytic process. In large measure because of this work, the idea of psychoanalysis as a two-person psychology (as well as a one-person psychology) has gained wide acceptance and countertransference is no longer viewed primarily as an obstacle to treatment. It is seen, rather, as a complex entity containing the analyst's subjective responses fused and mixed with projected aspects of the patient's inner world. Arising from the interplay of patient and analyst, countertransference, like other aspects of mental functioning, can best be viewed as a compromise formation. A creation forged out of the interplay of patient and analyst, it is an integral and inherent part of the analytic situation; and, as the work described above amply demonstrates, countertransference not only exerts a continuous influence on the analytic process, but constitutes an invaluable pathway for the investigation of that process.

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