Excerpts from:

Understanding Countertransference:

From Projective Identification to Empathy.

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1989 The Analytic Press.

Examinations of the experience of the psychoanalytic therapist have traditionally fallen under the heading of countertransference and—for those authors who make this distinction—noncountertransference. The clinical processes of empathy and of projective identification also figure prominently in efforts to understand the arousal of identificatory experiences for the therapist. Whereas empathy is typically related to a therapist's skillful functioning, projective identification is commonly associated with countertransference turmoil. In subsequent chapters we develop the argument that the processes of empathy and projective identification, far from being unrelated or even antipathetic, are in fact intimately related in a way that is critical to the fullest possible understanding of countertransference responses to virtually all patients. The strongest and most obvious link between empathy, projective identification, and countertransference is that all three involve the arousal of an identificatory experience—whether transient or enduring—on the part of the therapist.
Our intention here in the present chapter is to trace major historical trends in psychoanalytic approaches to countertransference theory. The historical development of this literature comprises three stages. First, clinicians and theoreticians, struggling with the goal of “scientific objectivity,” had to acknowledge that identificatory experiences for the therapist—even those of a powerful nature—occur with regularity. This acknowledgment made possible subsequent efforts to use the emotional experiences of the therapist constructively within the treatment. The progression has culminated in current attempts to specify the varieties of countertransference experience with increasing clarity.

Advances in psychoanalytic understanding of the identificatory experience of the therapist-in-interaction have frequently come as the result of mutually enriching cross-fertilization between the theoretical developments of empathy, projective identification, and countertransference. This enrichment has occurred despite the frequent involvement of opposing theoretical perspectives within the psychoanalytic community. In his 1965 review of the countertransference literature, Kernberg distinguished between the “classical” and the “totalist” approaches to countertransference. The former restricts the concept of countertransference to the therapist’s unconscious, pathological reactions to the patient that reflect unresolved conflicts that need to be overcome in order for the therapist to work well with the patient. In contrast, the totalist approach broadens the concept to include the therapist’s total response to the patient—conscious and unconscious, “real” and neurotically “distorted.” The totalist camp argues further that the usual distinction between the therapist’s so-called realistic perceptions and his neurotic perceptions is fallacious, since perceptions virtually always involve elements of past and present reality. The classicist views countertransference as a pathological impediment to be overcome; the totalist views it as a potentially useful tool for understanding the patient. As will become clear, the disagreement is partly substantive and partly attributable to different definitions of terms.

1910: FREUD’S SEEMINGLY CONTRADICTORY VIEW OF COUNTERTRANSFERENCE

To understand the apparent schism that exists in countertransference theory, we must reexamine Freud’s introduction of the term in 1910:

We have become aware of the “counter-transference,” which arises in the physician as a result of the patient’s influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize his counter-transference in himself and overcome it [p. 144].

The question arises as to what Freud meant by “overcoming” countertransference. Did he mean eliminate the countertransference response, which is to be regarded only as an impediment deriving solely from the analyst’s unresolved conflicts; or did he mean attempt to analyze and understand the experience, thereby reducing its intensity? The first interpretation coincides with the classical view; the second accords with the totalist. In the same paper, Freud prescribed a self-analysis for the analyst, stating that “anyone who fails to produce results in a self-analysis of this kind may at once give up any idea of being able to treat patients by analysis” (p. 145).

Beyond these initial penetrating comments, Freud wrote very little on countertransference. In his 1912 technical paper, he alluded to the subject in the following widely quoted passage:

I cannot advise my colleagues too urgently to model themselves during psychoanalytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible . . . .

The justification for requiring this emotional coldness is that it creates the most advantageous conditions for both parties: for the doctor a desirable protection for his own emotional life and for the patient the largest amount of help we can give him today [p. 115].

Both of the foregoing passages are invoked as support for the classical view. A case can be made, however, that Freud’s writings also contain the seeds for the totalist perspective on countertransference, defined broadly as the therapist’s total response...
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For example, in the two paragraphs that immediately follow the suggestion that the analyst emulates the patient, Freud argued that in attempting to make sense of the patient's material, the analyst must not substitute a "censorship of his own for the patient's," instead, the analyst must strive to "turn his own unconscious like a receptive organ to the therapist's put aside his feelings." But if the doctor is to be in a position to use his unconscious in this way as an instrument in the analysis, he must fulfill one psychological condition to a high degree. He may not tolerate any kind of resistance in himself, which hold back from consciousness what has been perceived and evaluated in his unconscious; he would introduce what he knew has been assimilated by his own mind (p. 110).

Thus it appears that in the space of a few sentences, Freud has supported both sides of the debate. On the one hand, he recognizes the therapeutic model himself after the surgeon is able to achieve emotional coldness. But he also urged the therapist to attend to his perceptions as fully as he is able. In discussing the observation that "Freud is the easiest psychiatrist," (p. 5) saw such contradictions as a consequence of the analyst's being a true "pioneer," the writer to make contradictions himself (p. 117) in the analyst's making self-analysis of the mind in a systematic fashion.

Returning to Freud's (1912) paper, however, we may find a resolution to this apparent contradiction. Immediately following the last passage, he "insisted" that the analyst's self-analysis "must be a completely personal purification through a personal analysis" (p. 5) to test the suggestion for self-analysis to that of actually seeking out an analyst for personal treatment. The analyst's self-analysis may therefore be regarded as purely a personal purification through a personal analysis, which contrasted with the analyst's seeking out an analyst for a personal treatment. The analyst's assumption that an analyst could become purified of contaminating personal issues and could become emotionally good, as a result, is potentially good use of a strong emotional reaction to a patient.
1910–1948: FOUR DECADES OF SILENCE

Apart from the papers already mentioned, Freud went no further in the exploration of countertransference. Not until the late 1940s was the subject taken up in the literature with any depth or substance. Various opinions have been offered to account for the enormous hiatus of nearly 40 years from the introduction of the term until its active exploration in the literature.

Roland (1981) offered two factors to account for this gap. First, psychoanalysis wished to differentiate itself as fully as possible from “unscientific” artistic and literary efforts to probe the human mind, since these approaches tended to emphasize the occult. Second, the absence of countertransference studies reflected the desire for a strictly objective stance on the part of analysts so as not to submit patients to the harsh Victorian morality that prevailed at that time.

We might extend Roland’s observation still further regarding the psychoanalytic reaction to Victorian judgmentalism. By not attending to countertransference, analysts may or may not have spared their patients from having to submit to moralistic expectations. But it appears that they did not direct a similarly accepting attitude toward themselves in the conduct of their own work. That is to say, the prevailing expectation of strict analytic objectivity, departures from which were viewed as essentially pathological and “bad,” in and of itself seems unmistakably harsh and Victorian.

In a very important paper written in 1957, Racker attributed the 40-year neglect of countertransference to a persistence of infantile ideals passed along from one generation of analysts to the next. The training analysis represented the primary vehicle for this legacy, characterized by the analyst’s colluding unconsciously with the analysand’s infantile idealization of him. The training analyst’s failure to handle countertransference more effectively resulted in the candidate’s feeling enormous pressure to live up to similar standards of “perfection” with his own patients, thus perpetuating the “myth of the analytic situation” that analysis is “an interaction between a sick person and healthy one” (p. 308). Racker argued that transference had been much more carefully studied than countertransference for the same reason that the Oedipus complex of the child toward his parents had been much more closely examined than that of the parents toward their child.

If indeed Racker’s argument is valid that the 40-year neglect of countertransference represented a psychoanalytic heritage passed from one generation to the next, it follows that this legacy was set in motion by Freud himself. This conclusion is perfectly consistent with Freud’s relative neglect of the subject in his clinical papers. It is also consistent with Freud’s training and experience in the hard sciences prior to his founding the psychoanalytic movement. Like a surgeon or a laboratory scientist, the “objective” analyst was expected to strive to establish a sterile field for the patient, uncontaminated by the therapist’s personal material.

During those 40 years of virtual inactivity, Freud’s early followers (Ferenczi, 1919; Simmel, 1926) maintained what we (Tansey and Burke, 1985) have previously referred to as the “pollergeist view” of countertransference as something dangerous that needs to be controlled. There are, however, two exceptions during this hiatus that point to the potential usefulness of the therapist’s emotional response to the patient. Both of these contributions are remarkably prescient in anticipating the totalitarian viewpoint.

The first is an exceptionally illuminating paper by Deutsch (1926) in which she introduced but did not fully elaborate the notion that there are two types of identifications involved in the therapist’s experience of the patient. Her regretfully brief comments on countertransference are embedded within a paper that attempts to utilize psychoanalytic insights to shed light on occult processes. In the very first such statement that we know of in the literature, Deutsch argued that countertransference includes not only pathological responses but also the process of unconscious identification with a patient through revival of memory traces from the analyst’s own developmental experiences that are similar to those of the patient. It is this identificatory process that forms the basis of “intuitive empathy.”

Deutsch also pointed out that countertransference is not limited to the analyst’s identification with the patient’s ego—what Racker (1957) much later referred to as “concordant” identifications—but also entailed identification with the patient’s “original objects.” She called this the analyst’s “comple-
mentary attitude” and believed that it arose from the patient’s
directing toward the analyst the same “infantile-libidinous
wishes” that were once directed toward the patient’s parents.
For Deutsch, both types of identification form the basis of intui-
tive empathy.

Virtually everyone who has written on this subject disagrees
with Deutsch’s observation that complementary identifications
are included in the empathic process. The consensus is to con-
sider only the analyst’s identification with the patient’s self as
characteristic of empathy, not the identifications with the
patient’s internalized objects. Nearly 60 years after Deutsch’s pa-
per, we (Tansey and Burke, 1985) independently arrived at the
same conclusion that both forms of identification are to be
considered as trial identifications that potentially may lead to-
ward an empathic outcome. We did this without being aware
that Deutsch had made the same point.

Deutsch went on to specify various forms of countertrans-
ference “short-circuiting” that arise from the analyst’s failure
to utilize and master his acquired identifications. One must
wonder if her extraordinarily insightful comments were com-
pressed into the space of three short pages because she realized
that she was clashing head-on with the one-sided view of
countertransference as strictly pathological that prevailed in
1926.

Whereas Deutsch’s contribution was regrettably brief, Reik
(1937) wrote an entire book on the subject of the therapist’s use
of his affective response to the patient. He took this same book,
etitled Surprise and the Psychoanalyst, essentially in its en-
tirety, modified some of the chapters, and added more than 20
new chapters in his 1948 Listening with the Third Ear. He did
not use the term countertransference in either book, and it is
perhaps largely for this reason that he is not mentioned in any
of the major reviews of the countertransference literature
(Kernberg, 1965; Langs, 1976; Epstein and Feiner, 1979). Ne-
evertheless, we argue that his work holds very special signifi-
cance for countertransference theory since he ardently encour-
gaged the therapist to attend to affective signals emanat-
ing from within as vital sources of information for compre-
hending the patient’s unconscious processes. Although Fliess
(1942) generally receives credit for describing the process of

“trial identification” that underlies the empathic process, Reik
(1937) presented a similar description five years earlier.

The united or conflicting effect of the [patient’s] words, gestures, and
unconscious signals, which point to the existence of certain hidden
impulses and ideas, will certainly not at first stimulate the observing
analyst to psychological comprehension. Their first effect will rather be
to rouse in himself unconsciously impulses and ideas with a like ten-
dency. The unconscious reception of the signals will not at first result
in their interpretation, but in the induction [in the analyst] of the
hidden impulses and emotions that underlie them, [p. 193].

The other person’s impulse, which has unconsciously aroused a
responding impulse in the observer, is seen externally like the image
on the retina. The observation of other people’s suppressed and re-
pressed impulses is only possible by the roundabout way of inner per-
ception. In order to comprehend the unconscious of another person, we
must, at least for a moment, change ourselves into and become that
person [p. 199].

Reik argued against calling this transformation within the
analyst an identification; he suggested instead that it be con-
sidered a “temporary introjection” (p. 199). The communica-
tive process that Reik described goes on unconsciously both for
the patient and for the analyst. It is only by attending to the affective signals coming from within himself that the analyst is
able to fathom their hidden meanings and to bring into his own
consciousness what the patient is unconsciously communicat-
ing about himself through this inductive process. Reik went
into extensive detail, augmented by rich clinical illustrations,
describing how the analyst achieves insight both about the pa-
tient and about himself by paying attention to his own subtle
affective responses to the patient.

In commenting on his work, Annie Reich (1960) maintained
that Reik was not describing the utilization of countertransfer-
ence, which she defined in its narrow and pathological sense,
since the transient introjection of the patient remained con-
trolled and temporary. She stated that Reik was referring to
processes in which “the analyst never loses sight of the patient as a separate being and at no time feels his own identity
changed [which] enables him to remain uninvolved” (p. 391).
Although her position is defensible in reference to Reik’s
(1937) earlier contribution, her claim that Reik was referring to
rather mild emotional reactions, the data analyst's part does not appear to be accurate in reference to his later volume, to which we shall return later.

Building on the work of Reik, Fliess (1942) studied the manner in which the analyst uses his self-experiences with patients to act as the "telephone receiver" (Fliess, 1912) of the patient's unconscious. Comparing the analyst to a "telephone taster," Fliess believed that the optimally functioning analyst properly interpreted the "instructed material" emanating from the patient, experiencing its quality but not its intensity. Referring to Fliess's position that such experiences should properly be labeled temporary projections, Fliess posited that Fliess from a conceptual point of view. Despite terminological differences, Fliess's position appears to entitle the analyst to a "relational/structure" model (Greenberg and Mitchell, 1993). A reconceptualization of the view of the object-relations perspective expanded the view of the object-relations perspective expanded the view of personality development. Especially in the work of Winnicott (1956, 1971), the external, real-life objects with whom the growing infant and child interacted were seen as contributing significantly to the gradual differentiation and integration of the infant's internal self- and object representations in the child's psychic makeup.

In Fliess's conceptualization of empathy, the feelings experienced by the therapist during the trial identification were the patient's feelings. The therapist merely utilized his capacity to transciently "become the subject." This experience was viewed as distinctly different from countertransference to the "induced transference" by the therapist's capacity. Fliess described a case of an uncontrolled surrender to the "induced transference" which produced a more permanent condition, rendering the analyst ineffective as the neutral observer of the analytic process. In a subsequent paper, Fliess (1953) widened the dichotomy between empathy and countertransference still further. Whereas the empathic experience was characterized by the analyst's taking in identifications from the patient, countertransference was characterized by the analyst's taking in identifications from his own traumatic past having nothing at all to do with the patient.
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Other major object relations theorists of this time period, such as Fairbairn (1946) and Balint (1937), were making important contributions. But the work of Melanie Klein (1946, 1955) undoubtedly exerted the greatest impact. Unlike Winnicott, however, Klein remained firmly intrapsychic in her focus. Focusing on the child’s efforts to adapt to and defend against instinctual drives emanating from within, she virtually ignored the impact of real, external objects on the child’s developmental experience. In Klein’s language, an object referred not to an actual, external, real-life figure, but rather to an internalized mental representation of that object. Any resemblance, or lack of it, between the two was of no consequence or interest to Klein. With regard to the clinical setting also, she maintained the same intrapsychic focus on the patient, not attending to countertransference except to comment in passing on its hindrance to treatment.

In 1946, Klein introduced the concept of projective identification as a defense mechanism by which the infant attempts to rid the self of destructive, aggressive impulses by projecting these impulses in fantasy into an internalized object, which in turn is experienced as persecutory. By controlling the object, the infant then feels a sense of control over its own instinctual aggression. The threat is felt to be coming from the outside rather than from the inside. The concept the projective identification has since been used in a variety of different and often confusing ways. As Sandler (1987) has emphasized in an extremely useful and lucid account, Klein was referring to a process that occurs in fantasy only. In Klein’s definition of projective identification, external objects are not regarded as actually being affected interpersonally. Only internal or fantasy objects are influenced. Sandler refers to this usage as “first stage projective identification.”

It remained the task of subsequent object relations theorists to extend the work of Klein both to an exploration of the influence of actual interactions with real objects on the child’s psychological development and to an examination of the therapist’s countertransference as influenced by the patient’s projective identification. As Sandler points out, Heimann (1950), Racker (1968), and Grinberg (1962) used the concept of projective identification to refer to the patient’s actual influence in causing the therapist to identify with either the patient’s internalized self or object representations. Thus, the strictly fantasy activity involved in Klein’s usage of projective identification becomes actualized to some degree in the form of real influence over the therapist’s countertransference status—what Sandler refers to as “second stage projective identification.”

Despite the fact that Klein herself remained staunchly intrapsychic in her theory building, her work contained the seeds of several new and critical advances in clinical theory and practice and helped to set the stage for the totalistic viewpoint. The extension of her work by her followers provided a theoretical underpinning from which to extend the concept of empathy, which had been thought to be characterized only by brief and mild emotional responses, to include much more powerful and often negative responses. As Ogden (1979) pointed out, the development of the concept of projective identification by Klein’s followers shifted from the intrapsychic to the interpersonal arena and, as such, provided a very useful bridge between the two realms. The concept of projective identification also provided the theoretical groundwork for the therapist to make use of strong, and often negative, reactions to a patient. Prior to the development of object relations theory, strong emotional responses were generally regarded not as empathic reflections of the patient’s emotions but as impure impediments indicating pathological countertransference. The majority of the early totalist theorists, including Winnicott (1965), Little (1951), Heimann (1950), and Racker (1957), were heavily influenced by Klein.

Although geographically separate, the interpersonal psychoanalysis movement in America during the 1930s and 1940s shared some common ground with the object relations school. Led by Sullivan (1930, 1931, 1936, 1938, 1940, 1953) and Fromm (1941, 1947, 1955), the emphasis shifted from intrapsychic drives and defenses to the interpersonal and sociocultural realms. Sullivan’s pioneering work on the “interpersonal field theory” combined a respect for intrapsychic forces with a bold new interpretation of psychopathology as a humanly understandable adaptation to a less than optimal environment. Espousing a philosophy that attempted to take the onus away from “mental illness” and preferring instead to speak of
universal “difficulties in living,” he argued that we are all much more simply human than otherwise. Sullivan, unlike Klein, placed central importance on the quality of past interpersonal relationships in the formation of personality and the manner in which interpersonal anxiety is dealt with. Fromm’s view of the impact of societal and cultural forces on individual choice provided an even wider scope of influence on personality development than Sullivan’s.

Interpersonal psychoanalysis diverged from drive theory in two important ways. First, variables other than intrapsychic drives were viewed as important and active determinants of personality development and functioning that required acknowledgment and investigation. Second, rather than considering psychotherapy as occurring in a sterile field uncontaminated by the perspective of the therapist, the interpersonalists viewed treatment as a two-person interaction in which the therapist is both participant and observer. As a “participant-observer,” the therapist influenced and formed part of what was observed. Treatment was no longer considered to be the therapist’s detached, uninvolved observation of the pathological intrapsychic operations of the patient. The therapist’s experience of the patient was valued as an important source of information about the patient and the therapeutic relationship.

In addition to advancements in the theory of empathy, the development of object relations theory, and the growth of interpersonal psychoanalysis, a fourth factor helped to set the stage for the reawakening of countertransference theory beginning in 1948. We are referring to the widening application of psychoanalytic theory and practice to include both children and more disturbed adult clinical populations. Melanie Klein and Anna Freud were the dominant leaders in psychoanalytic work with children, and Sullivan (1931) pioneered in the treatment of psychotic and schizophrenic patients. It was discovered that the psychotherapy of both groups usually exerts a greater emotional impact on the therapist than work with neurotic adult patients. Channels of communication are more often nonverbal and action oriented, with a greater emotional pressure being placed on the therapist for responsivity and affective participation. As a consequence, the emotional reactions of the therapist working with the child or the severely disturbed adult demand greater attention. Such responses, if properly handled can be extremely useful sources of understanding the patient.

1948–1958: THE ERIPTION OF INTEREST IN COUNTERTRANSFERENCE

The period 1948–1958 represents a critical breakthrough for countertransference theory and, as a consequence, for psychoanalytic theory in general. Having incubated in a half-century of clinical work with patients, the idea burst forth in full force from several quarters that the analyst could potentially make very good use of strong emotional reactions to a patient.

Heimann (1950) is widely cited as having made the landmark statement of the totalistic perspective. She described the analytic situation as “a relationship between two persons” (p. 81) characterized by the presence of strong feelings in both partners. She argued that the term countertransference should properly refer to all the feelings that the therapist has for the patient, since the distinction between “realistic” responses and “distorted” responses based on past experiences is a very difficult one to make. She applied the same argument to the term transference. Believing that Freud himself had been misread on countertransference strictly as a source of disturbance, Heimann asserted that the key to utilizing strong emotional reactions was for the analyst to “sustain the feelings which are stirred in him, as opposed to discharging them (as the patient does), in order to subordinate them to the analytic task” (p. 81). She posited that the “analyst’s unconscious understands that of his patient” on a much deeper and more accurate level than the analyst’s conscious reasoning. By attending to “feelings roused in himself with his patient’s associations and behavior,” the analyst is best able to be reached by the “patient’s voice” (p. 82).

Although Heimann’s brief paper is noteworthy for its clarity and usefulness, Reik (1948) had covered much the same territory two years before Heimann’s paper. Nonetheless, throughout the countertransference literature, Reik’s work is consistently overlooked. In addition to the fact that he himself did not use
the actual term countertransference, the general neglect of his work may be attributable to his having been a psychologist who immigrated from Germany to America, where psychoanalysis was still dominated by the medical profession.

In comparison to his earlier efforts, Reik's work in 1948 became considerably bolder. Borrowing from Neitzsche, he stated that an analyst must learn to “listen with the third ear” in order to understand the unconscious of his patient. With language very similar to Heimann's (1950) but in much more elaborate detail, Reik urged analysts to attend very carefully to “inner voices” that signal the analyst's unconscious perceptions about the patient. Impressions that typically might be regarded as insignificant became, for Reik, far more important than the logical, “objective” reasoning processes that had come to dominate the approach of many analysts. Like Heimann, he believed that affective reactions to a patient, whether subtle or gross, were the manifestations of the analyst's unconscious perception, which potentially is far more attuned to the patient than his conscious perception. It is this unconscious perception that must lead the way.

Just as Heimann (1950) emphasized that the analyst must not become “a mechanical brain which can produce interpretations on the basis of a purely intellectual procedure” (p. 81), Reik referred to the analytic “worship of the bitch-goddess objectivity, of pseudo precision, of facts and figures;” (p. 147) and of analysts' fears of writing of their own reactions to patients. He believed that “objectivity” had become confused with inhumaness, and he, too, pointed out that emotions could be aroused without being expressed or acted upon. Though he did not label strong responses as countertransference, Reik (1948) wrote:

What kind of psychoanalyst, some readers will ask, can feel annoyed or impatient? Is this the much-praised calm and the correct scientific attitude of the therapist? Is this the pure mirror that reflects the image of the patient who comes to psychoanalysis with his troubles, symptoms, and complaints? Is this the proper couch-side manner? The question is easily answered. The psychoanalyst is a human being like any other and not a god. There is nothing superhuman about him. In fact, he has to be human. How else could he understand other human beings? ... If he were cold and unfeeling, a “stuffed shirt” as some

According to Reik, human sensitivity in no way contradicts therapeutic objectivity; in a well-functioning analyst, the two peacefully coexist.

Several other papers appeared almost simultaneously that are important to mention. Winnicott (1949) published a paper whose very title, “Hate in the Countertransference,” conveyed a radical position for that time. The paper referred to analytic work with severely disturbed patients and emphasized the need for a treatment to provide protection from abuse, not only for the patient but also for the therapist. Such measures would provide necessary relief for the therapist and reduce the pressure to act on strong and often negative emotional feelings and urges aroused by the patient.

Berman (1949) is cited in an opening footnote to Heimann’s paper because of his similar position, though neither had been aware of the other’s work at the time of writing. Berman’s paper is also noteworthy in that, unlike Heimann, he favored the judicious usage of countertransference disclosure, a technical recommendation that was further supported by Little (1951). Although Little retained the narrow, classical definition of countertransference as a response based on past experience, she managed to do so with a remarkably tolerant view of the analyst as a human being. She believed that countertransference developments were inevitable but could be put to good use. She argued against a “paranoid or phobic attitude” toward countertransference and favored a “lessening of the didactic or authoritarian attitude” in the analyst. Tower (1956) pursued a similar line of thought, suggesting that analysts were more highly resistant to the awareness of countertransference than patients were of transference. In part, she attributed this to the “rigidity and prohibitiveness” of training institutes.

No single author has made more valuable contributions to the countertransference literature than Racker (1953, 1957). In rich clinical detail, he illustrated the manner in which a therapist could be induced by his patient to identify either with the patient’s self, which he termed a concordant identification, or
with the patient’s internalized objects, which, following Deutsch (1926), he termed a complementary identification. He argued that although concordant identifications alone constituted the basis of empathy, both forms of identification should be considered countertransference in its totalistic sense. Referring to the talionoic law, he asserted that every transference situation provokes a corresponding countertransference response. Analogous to the manner in which Freud depicted transference as both the greatest danger and the best tool for analytic work, Racker argued that the induced countertransference response, in addition to being a potentially serious barrier, could also be extremely valuable to the analyst, opening up avenues to understanding the patient that otherwise would simply not exist.

The key, according to Racker, is for the analyst to strive to maintain a “deep and continuous” contact with himself so as to be as aware as possible of his countertransference position in relation to the patient. Through this awareness, the analyst is better able to avoid falling into a blind repetition of the particular vicious circle that constitutes the patient’s primary problem in human relationships. The awareness of countertransference lays the groundwork for the interpretation of the patient’s unconscious efforts to repeat, leading to an interruption of the vicious circle and an opportunity to internalize a more positive outcome with the therapist. This in turn allows for more productive experiences in outside relationships and less pressure to repeat traumatic relationships. Without countertransference awareness, Racker insisted, the analyst was likely doomed to “drown” in his responses to the patient and destructively repeat the patient’s vicious circle. He gave examples of therapists who had begun to succumb to forceful countertransference pressures and yet were eventually able to right themselves through self-awareness, ultimately snatching therapeutic victory from the jaws of defeat.

In opposition to the proliferation of publications espousing the potential usefulness of countertransference, papers began to appear from the so-called classical camp reemphasizing the view that strong emotional reactions by the analyst were to be viewed strictly as a problem. Fliess (1953) was representative of this group. He provided clinical examples in which he concluded that various thoughts and feelings of a therapist had absolutely nothing to do with the patient or the interaction but rather were derived exclusively from the analyst’s intrapsychic conflicts. As such, the material represented pathological interference that the analyst must strive to “abolish.”

Annie Reich (1951, 1960, 1966) is generally regarded as having been the leading proponent of the classical view of countertransference during the early 50s. Building upon the works of Reik, Deutsch, and Fliess, Reich argued that a therapist may indeed learn something about what is going on in the patient’s unconscious through an awareness of what is happening in the therapist’s own mind through the process of empathic identification. She repeatedly emphasized in all of her papers, however, that the identification must be “partial and short-lived.” If, on the contrary, the analyst begins to experience strong emotions, she believed this was evidence of countertransference, which she narrowly defined as the analyst’s unresolved conflicts and concerns that have nothing at all to do with the patient. Emotional intensity, for Reich, became a critical distinguishing factor between useful empathic trial identifications and pathological countertransference. She (1960) specifically attacked Heimann’s (1950) seminal contribution on the grounds that Heimann had not recognized that her perception of the patient in her clinical example had been obscured by what Reich believed were her own feelings, which had nothing to do with the patient. Although the validity of Heimann’s perception of her patient is debatable, Reich nevertheless made the very useful argument that a therapist’s hypotheses concerning a patient, based on emotional responses to the patient, require clinical validation. Without such a validating process, there is no way of knowing with any certainty whether, and to what degree, such hypotheses are correct or not.

Despite the fact that she is described as the leading proponent of the classical view, Reich herself appeared to waver on the position that strong emotional responses to a patient are always pathological. Indeed, in the conclusion of her first paper on the subject (1951) she equivocated rather confusingly by stating, “Countertransference is a necessary prerequisite of analysis. If it does not exist, the necessary talent and interest is lacking” (p. 31). Similarly, in the 1960 paper, she maintained,
"The countertransference as such is not helpful, but the readiness to acknowledge its existence and the ability to overcome it is" (p. 392). Freud too (1910) had used the same verb, "overcome." Once again, it is not clear what was meant by this term. One way in which a strong emotional response may be "overcome" is for the therapist to recognize it as being in some way meaningful. Through understanding the source of the feeling, the feeling itself often becomes much less intense and the temptation to discharge the feeling in action is also reduced. This particular interpretation of overcome tends to lessen the apparent substantive differences between both Reich and Freud in relation to the totalist perspective.

A review of the countertransference literature of this era reveals additional examples of what appear to be terminological rather than substantive differences between the classical and the totalist perspectives. On the totalist side, for example, Racker (1957) explicitly referred to the potential danger of "drowning" in countertransference, Heimann (1950) warned of the dangers of intense emotional responses, and a similar caveat was offered by Little (1951). On the classical side, Reich (1951) herself acknowledged that emotional responses to a patient may be very useful in illuminating the patient's unconscious.

Such instances of agreement do not diminish the differences between the two perspectives, especially regarding the intensity factor. Beyond a certain point, albeit vaguely defined, the classicist argues that an intense response to a patient has passed from the realm of useful trial identification into the realm of pathological countertransference emanating strictly from the analyst's own past history and having nothing to do with the patient. The totalist holds open not the certainty but the possibility that if the therapist is able to pull back and begin to examine the experience of even a strong response, there is the potential to learn something useful about the patient. Whereas the classicist may be too quick to attribute an intense response to the therapist's exclusively private concerns, the totalist runs the risk of too readily concluding that the countertransference response to the patient constitutes a royal road to the patient's unconscious rather than a detour into his own.

How is a therapist to know whether an emotional response to a patient, mild or intense, is a private problem or a useful clue? Clearly the matter rests with a process of clinical validation, an area in which too little has been written. We address this matter in considerable detail in chapter 8.

**THE 1960S: THE SECOND HIATUS IN COUNTERTRANSFEERENCE THEORY**

Following the eruption of papers between 1948 and 1958, the literature on countertransference once again entered an extended period of dormancy. Although literature reviews appeared, there were no major milestones in the countertransference literature until the mid-1970s. Throughout this second hiatus in the development of countertransference theory, several important papers surfaced on the subjects of empathy and projective identification that examined the therapist's experience of the therapeutic interaction. We believe that the further refinements in the concepts of empathy and projective identification provided the groundwork for the second reawakening of interest in countertransference beginning in the mid-1970s.

Schaefer (1959), Kohut (1959), and Greenson (1960) published seminal papers on the subject of empathy that continue to be cited today as major contributions to the literature. Kohut emphasized the important role of empathy as the therapist's mode of observation for scientific inquiry in psychoanalysis. From an ego psychological point of view, Schaefer and Greenson examined the process through which a therapist undergoes an empathic identification that is reflective of the patient's experience. Schaefer defined several aspects of the therapist's ego functioning required for the "controlled regression" that characterizes "generative empathy" and the concomitant "conflict free interplay of projective and introjective mechanisms" (p. 346). Whereas Schaefer sketched a brief outline of the "mechanisms of generative empathy," Greenson built upon Flieiss's (1942) initial efforts and went much further in delineating the sequence of events involved in the empathic process. In his concept of the internalized "working model" that the therapist develops of the patient over time and then utilizes to potentiate the empathic identification, Greenson provided a brilliant insight into the experiential nature of the therapist's
introjective identification with his patient. Both Schafer and Greenson studied the empathic process from a primarily intrapsychic perspective centered on the structural capacities of the therapist’s ego to engage in and manage affective identifications with a patient.

Following the papers by Kohut (1959), Schafer (1959), and Greenson (1960), the empathy literature became virtually inactive for the next decade. At the same time, work on projective identification became more active at this very time. Building upon papers by Bion (1955) and Racker (1957), Grinberg (1962) proposed the term “projective counteridentification” in direct response to the pressure of the patient’s projective identification. Although he included projective identification as an “aspect” of countertransference, he very carefully distinguished projective counteridentification from “countertransference reactions resulting from the analyst’s own emotional attitudes, or from his neurotic remnants, reactivated by the patient’s conflicts” (p. 436).

Grinberg’s contribution lay not only in coining a term to define this special aspect of countertransference, but also in his strong advocacy of projective counteridentification as potentially leading toward a greater (empathic) understanding of the patient: “Projective counter-identification may become a positive element in the analysis, since it clarifies to the analyst some of the patient’s contents and attitudes, and makes possible certain interpretations, whose emergence could not otherwise be explained” (p. 440).

Malin and Grotstein (1966) were the first Americans to make a significant contribution to the understanding of projective identification. They attempted to delineate the manner in which the therapist’s reception of the patient’s projective identification formed “the basis of the therapeutic effect in psychoanalysis” (p. 26). In an examination of the relationship between projection and identification, they took the position that “all identification includes projection, and all projection includes identification” (p. 27). In the first such statement of its kind that we know of, they proposed that projective identification is “a normal, as well as abnormal, way of relating which persists into mature adulthood,” the investigation of which can “enhance our knowledge of identification itself” (p. 27).

Taken together, the papers by Grinberg (1962) and by Malin and Grotstein (1966) advanced the overall exploration of the identification process occurring within the therapist in two important ways. First, because the authors viewed the identification process from the perspective of projective identification, they were able to emphasize the manner in which an identification is interpersonally induced. Rather than conceptualizing identification as a relatively static phenomenon involving exclusively intrapsychic events unfolding within the therapist, identification was defined as the outcome of an interpersonal process involving two participants. Second, contrary to the predominant view in the empathy literature, the analyst’s potentially empathic identification with his patient was no longer portrayed as a comfortable, well-controlled experience. The authors took the position that the identificatory experience was often a very uncomfortable, poorly controlled response to the inductive pressure created by the patient’s projective identification. Such experiences were no longer reflexively ascribed to pathological countertransference.

From 1968 to 1974, the empathy literature once again came to life with several significant contributions. Kohut’s (1968, 1971) landmark work on the treatment of narcissistic character disorders placed the therapist’s empathic ability into a central role in the therapeutic process. While most of his efforts focused on the influence of the therapist’s empathic attitude on the developing idealized or mirror transference, Kohut (1971) cautioned therapists that the experience of being a selfobject is a difficult one indeed:

In order to function properly during the analysis of such personality disorders the analyst must be capable of remaining interested in and attentive to the remobilized psychological structures despite the absence of significant object-instinctual cathexes. Furthermore, he must be capable of accepting the fact that his position (which is in harmony with the specific level of the major fixation) within the patient’s therapeutically activated narcissistic world view is that of an archaic pre-structural object, i.e., specifically, that of a function in the service of the maintenance of the patient’s narcissistic equilibrium [p. 293–294].

Kohut’s (1971, 1977) theory of psychic development and innovative technical recommendations served as a springboard for
the increased interest in the perspective of self psychology and the role of empathy. Later authors (Wolf 1980; Goldberg, 1988) have continued to expand and deepen an understanding of the technical and theoretical aspects of the therapist's maintenance of an empathic attitude during the interaction with the patient, for whom the therapist is "an impersonal function related to the Kingdom of [the patient's] own remobilized narcissistic grandeur and exhibitionism" (Kohut, 1971 p. 288).

Olinick (1969) attempted to integrate the interactional focus of projective identification with the intrapsychic ego analysis characteristic of the empathy literature. He emphasized the therapeutic importance of the containment function that the therapist must serve for the patient's projections; thus the therapist must have a high level of "openness and receptivity." Borrowing from Kris (1952), he described the "ego operations" necessary for the therapist to engage in a therapeutic "regression in the service of the other" (p. 42).

In a follow-up paper, Olinick (1973) further specified the sequential functions of the therapist's "work ego" (Flies, 1942). These functions are the basis for interpretation and for the "regressive experiencing of the regressed other as oneself, and oneself as the other" (p. 148). Olinick suggested that the therapist's reactions to the patient form a continuum (trial identification, counteridentification, overidentification) according to the degree of ego mastery of the experience. His efforts at differentiating a spectrum of possible countertransference responses presaged what we refer to as the "specifist" movement within the countertransference literature during the mid-1970s and the 1980s.

In a very enlightening paper, Beres and Arlow (1974) examined the relationship between empathy and intuition and discussed the role of fantasy activity in the empathic process. Pointing to identification followed by separation as being crucial to the empathic process, they explored the role of signal affect as the therapist's cue to shift from thinking and feeling with the patient to thinking about the patient. Although they did not use the term complementary identification, this is one of the very few papers that accords with Deutch's (1926) position that such identifications, if properly handled, may indeed lead to an empathic outcome:

The affect which the therapist experiences may correspond precisely to the mood which the patient has sought to stimulate in him as, for example, the masochist who tries to evoke criticism and attack. Empathy in such instances consists of recognizing that this is precisely what the patient wishes to provoke in the analyst. The affect experienced is a signal affect alerting the therapist to the patient's motivation and fantasy [p. 35].

In an examination of the dimensions of egocentricism and object centeredness in the identificatory experience of the therapist, Shapiro (1974) specified the "structural and adaptive mechanisms operative in the experience of empathy" (p. 7). Like Olinick's work, the paper anticipated the many papers that were forthcoming in the 1970s and 1980s in the countertransference literature seeking to distinguish between different categories of identification within the therapist.

**THE 1970s AND 1980S: THE SPECIFIST MOVEMENT IN COUNTERTRANSFERENCE THEORY**

Beginning in the 1970s, there has been a second reawakening of strong interest in countertransference that appears to have been stimulated by prior developments in the areas of empathy and projective identification. Although the number of publications on countertransference has increased since about 1974, a review of the literature reveals relatively fewer works dealing primarily with empathy or projective identification, with some notable exceptions (e.g., Buie, 1981; Ogden, 1979, 1982; Grotstein, 1981; Basch, 1983; Schafer, 1983; Sandler, 1987). The overall trend appears to be in the direction of classifying the therapist's identificatory experience as countertransference. Empathy and projective identification increasingly are being conceptualized as aspects of countertransference. In addition, as Epstein and Feiner (1979) have pointed out, fewer and fewer therapists believe that strong emotional reactions to a patient are necessarily pathological, a point of view that reflects an increasingly totalistic view of countertransference. Greenon (1974) is an outstanding example of a prominent classical analyst who shifted unequivocally to the totalistic view of countertransference as potentially useful. Sandler (1976, 1987) and Gill (1983) are also noteworthy in this regard.
The totalist versus classical debate, so hotly waged during the 50s, has clearly subsided in favor of accepting and examining all of the experiences of the therapist as potentially—though not necessarily—useful. A recent and eloquent statement of this position is provided by Gorkin (1987). Questions about whether a therapist should or should not have a given reaction to his patient are less frequently raised. Rather, questions have been aimed at the specific kinds of identifications the therapist has undergone, the manner in which they arose in the therapeutic interaction, and their degree of applicability to the patient's concerns. The predominant view is that the therapist's identificatory experiences fall along a continuum ranging from identification directly reflective of the patient's concerns to those reflective of the therapist's idiosyncratic inclinations. Countertransference has become an all-inclusive term that is more and more frequently applied to the entire continuum.

The ambiguity and confusion that resulted from applying the term countertransference to such a broad range of experiences gave rise to a new breed of investigators whom we refer to as the "specificists." Their aim is to categorize and classify the varieties of identificatory experience for the therapist under the overarching rubric of countertransference. Although their numbers have proliferated in the past 10 to 15 years, Deutsch (1926), as mentioned earlier, appears to have made the first such distinction; she referred to empathic identifications with the patient's ego as opposed to empathic identifications with the patient's objects, which she termed complementary. Other early specificist efforts include Winnicott's (1949) objective versus idiosyncratic countertransference, Reich's (1951) sublimated versus pathological countertransference, and Racker's (1957) direct versus indirect countertransference. Cohen (1952) differentiated three types of countertransference responses arising from situational factors in the analyst's life, from the analyst's neurotic vulnerabilities, and from anxiety generated by the patient that the analyst has "incorporated in some manner." Benedek (1953) distinguished those countertransference responses arising in reaction to the transference of the patient from those stemming from the "analyst's projection of an important person of his past onto the patient" (p. 206). The papers by Olinick (1973) and Shapiro (1974) previously alluded to should also be mentioned in the specificist tradition.

Since the early 1970s, the countertransference specificists have employed what appear to be five dimensions for differentiating types of therapist identifications: the degree of the therapist's consciousness or lack of consciousness of the experience; the degree of the therapist's control over the intensity of the experience; the degree of separateness or differentiation of ego boundaries maintained by the therapist through the different stages of the identificatory process; the type of introjection involved; and the question of whether the identification is with the patient's internalized self-representation (concordant identification) or with the patient's internalized object representation (complementary identification).

These dimensions provide the criteria for attempting to establish, along a continuum, the extent to which the therapist's identificatory experience is a reflection of the patient's internal world and a response to the interactional pressures exerted by the patient. At the opposite end of the continuum are those therapist identifications which may have been stimulated in the presence of the patient but emanate predominantly from the therapist's essentially private concerns. At best, the specificist tradition combines what is most useful from both the totalist and the classical perspectives. The former holds an openness to, and interest in, the potential usefulness of even strong emotional responses; the latter cautions against potential pitfalls and makes an effort to validate hypotheses.

Langs (1976) differentiated five "countertransference constellations" (p. 289), all of which were clearly demarcated from "primarily noncountertransference reactions." To distinguish sympathizing from empathizing, Liberman (1978) delineated six patient styles of communication, each of which elicit particular types of affective responses from the therapist that can be used to understand the patient's unconscious emotions. Chediak (1979) proposed that countertransference represents only one of five possible categories of therapist reactions, which also include intellectual understanding, a general response to the patient, the therapist's transference to the patient,
and empathic identification. In his theory of “the intrapsychic nature of empathy,” Buie (1981) proposed four types of perceptual referents that allow a therapist to complete the “inferential process” of knowing another person’s subjective state: conceptualization, self-experience, resonance, and imaginative intuition.

In a useful specificist paper, Roland (1981) systematically categorized therapist identifications according to the degree of influence exerted by the patient. His five categories of “induced emotional reactions” included: transitory identifications with patients; preconscious associations and imagery; responses to a variety of transference experiences and situations created by the patient; responses that are part and parcel of a transference paradigm; and “countertransference proper,” representing the analyst’s unconscious problematic reactions usually to specific patients and transference situations.

Meissner (1982) formulated a model of transference-countertransference interaction based on a conceptualization of three developmental introjective configurations (aggressive, narcissistic, and erotic) of the borderline patient. He described the manner in which these configurations are reenacted within the therapeutic interaction, and he specified “reciprocal patterns of introjection and counterprojection in the analyst, which serve as the basis of countertransference reactions” (p. 121).

Finally, Lakovics (1983) discussed countertransference in an effort to provide useful guidelines for supervisors. He listed six sources of “total countertransference”: concordant identifications, complementary identifications, interactive reactions, the therapist’s life events, institutional countertransference, and classical countertransference.

**SUMMARY**

As we have attempted to demonstrate in this chapter, there have been a number of key historical developments in the psychoanalytic literature investigating countertransference, empathy, and projective identification as identificatory experiences within the therapist in the therapeutic interaction. The obvious first critical step had to involve acknowledgment that a therapist does indeed experience strong emotional responses with patients without this necessarily indicating emotional problems for the therapist. Given the early emphasis on surgical skill and scientific objectivity, this first step was very long in coming. The recognition of milder and usually positive feelings for a patient, officially sanctioned within mainstream psychoanalysis under the heading of “empathy,” represented an important preliminary achievement leading to the acknowledgment of much more intense and often negative responses. Having recognized that intense responses do indeed exist in emotionally stable therapists, it became possible to examine such responses much more carefully and openly in the literature and at scientific meetings. Thus the door was opened to investigations of the potential usefulness, as well as the possible pitfalls, of such responses. Success in understanding the potential usefulness of countertransference responses, in turn, made further acknowledgment that much easier and that much more widespread. What we have referred to as the specificist movement in studies of countertransference appears to represent the inevitable outcome of such a progression, once set in motion.

In the chapters that follow, our efforts are very much in line with the general trajectory of current countertransference theory. In addition to examining countertransference phenomena from both a totalistic and a specificist perspective, we shall present a schema for analyzing the therapist’s identificatory experiences. In so doing, we offer a theoretical integration of the concepts of empathy, projective identification, and countertransference by demonstrating that these phenomena, often thought to be disparate, are actually elements of one overall sequence through which a therapist can use his emotional responsiveness to achieve an empathic outcome.