Two

Countertransference

THE CONCEPT OF COUNTERTRANSFERENCE

Two contrasting approaches in regard to the concept of countertransference could be described. Let us call the first approach the "classical" one, and define its concept of countertransference as the unconscious reaction of the psychoanalyst to the patient's transference. This approach stays close to the use of the term as first proposed by Freud (8) and to his recommendation that the analyst overcome his countertransference (9). This approach also tends to view neurotic conflicts of the analyst as the main origin of the countertransference.

Let us call the second approach the "totalistic" one; here countertransference is viewed as the total emotional reaction of the psychoanalyst to the patient in the treatment situation. This school of thought believes that the analyst's conscious and unconscious reactions to the patient in the treatment situation are reactions to the patient's reality as well as to his transference, and also to the analyst's own reality needs as well as to his neurotic needs. This second approach also implies that these emotional reactions of the analyst are intimately fused, and that although countertransference should certainly be resolved, it is useful in gaining more understanding of the patient. In short, this approach uses a broader definition of countertransference and advocates a more active technical use

of it. Some radical proponents of this approach discuss, under certain circumstances, the effect of the countertransference with the patients as part of the analytic work.

Reich (32, 33), Glover (15), Fliess (6), and to some extent Gitelson (14), are the main exponents of the "classical" approach. Among the main exponents of the "totalistic" approach are Cohen (2), Fromm-Reichmann (11), Heimann (16), Racker (31), Weigert (43), Winnicott (45, 46) and to some extent Thompson (41). Little's (23, 24) definition of countertransference is closer to the "classical" approach, but her use of it is closer to the "radical" wing of the "totalistic" approach. She has been the most important proponent of the use of countertransference as material to be communicated to the patient. Menninger (26) and Orr (29) occupy an intermediate position.

The classical approach's main criticism of the totalistic approach is that the broadening of the term countertransference to include all emotional phenomena in the therapist is confusing and makes the term countertransference lose all specific meaning. The classical approach implies that the broadening of the concept of countertransference tends to exaggerate the importance of the analyst's emotional reaction, with a detrimental shift away from the position of neutrality in which the analyst should ideally remain. Adherents of the classical approach also point out the danger of an excessive intervention of the analyst's personality when his emotional reaction is put so much in the foreground. On the other hand, Reich (33) points out that adherents of the totalistic approach tend to do the classical position injustice when stating that the analyst's neutrality implies detached coolness and lack of humanity on the part of the analyst. Freud (10) states quite clearly that neutrality does not mean loss of spontaneity and of the natural warmth of the analyst, and that "listless indifference" on the analyst's part may in itself bring about resistences in the patient.

The totalistic orientation's main criticisms of the classical approach are the following: (i) The restricted definition of countertransference tends to obscure its importance by the implication that countertransference is something basically

"wrong." Thus, this criticism continues, a phobic attitude of the analyst toward his emotional reaction is fostered, limiting his understanding of the analytic situation. (ii) The fusion of influences of the patient's transference and his reality on the one hand and of the therapist's past and present reality on the other gives much important information about the nonverbal communication between patient and analyst, which tends to get lost when the efforts center on eliminating the analyst's emotional reaction rather than focusing on it and on its sources. When the analyst feels that his emotional reaction is an important technical instrument for understanding and helping the patient, the analyst feels freer to face his positive and negative emotions evoked in the transference situation, has less need to block these reactions, and can utilize them for his analytic work. (iii) An important group of patients—those presenting severe character disorders and those with borderline and psychotic levels of organization who nonetheless seem able to benefit from analytically oriented psychotherapy—tend, by their intense, premature, and rapidly fluctuating transference, to evoke intensive countertransference reactions in the therapist which may at times give the most meaningful understanding of what is central in the patient's chaotic expression (19).

I want to develop further some of the positions of the totalistic approach. Not only the patient's transference but also his reality (both in the analytic situation and in his extra-analytic life) may elicit strong emotional reactions in the analyst which are actually quite justified. Winnicott (45) points out that there exists an "objective countertransference," that is, natural reactions of the analyst to rather extreme manifestations of the patient's behavior toward him. Also, as Fromm-Reichmann (11) mentions, there are aspects of the therapist's reaction to the patient which are determined by the therapist's special professional nature since he does not work in a vacuum but represents a professional standard, status, and group. These are reality aspects of the therapist in his work with any patient.

Racker (30) refers to what he calls "indirect countertransference," that is, the therapist's emotional reaction to third persons somehow involved in the treatment program. Tower

(42) analyzes the influence of the analyst's own training analyst in his therapeutic dealings.

Gitelson (14) also considers all these reality aspects as part of countertransference reactions, but different in type from what he calls the "transference reactions" of the analyst. He states that transference reactions of the analyst are his "total" reactions to the patient's personality which tend to appear especially at the beginning of treatment and may even disqualify the analyst from continuing his work with that patient. Countertransference reactions, in contrast, Gitelson continues, are of a partial type, fluctuating, changing according to the nature of the material that the patient presents. Yet, as Cohen (2) points out, these "total" reactions to the patient's personality are present during the whole course of the analysis and not at all limited to the initial period, and implicitly cannot be differentiated from countertransference reactions in Gitelson's terms. Heimann (18) formulates a critique similar to Cohen's. Thompson (41) states that the boundary between the analyst's normal reaction to the patient and his reaction based on his own problems is difficult to evaluate.

A totalistic concept of countertransference does justice to the conception of the analytic situation as an interaction process in which past and present of both participants, as well as their mutual reactions to their past and present, fuse into a unique emotional position involving both of them. Sullivan (39, 40) makes this concept of interpersonal interaction process a cornerstone of his theories; Menninger (26) specifically underlines it in its connection with countertransference.

Most examples of countertransference in the literature refer to emotional reactions of the analyst which usually are conscious, with the unconscious aspects appearing as transitory "blind spots" in the therapist which he later overcomes by bringing his emotional reaction out into the open. One might say, of course, that only the initial, unconscious "blind spot" is countertransference, but this would not do justice to the fact that very often the problem for the therapist is not so much to find out one aspect of his feeling of which he might not have been aware but rather how to deal with the very strong emotions which he experiences and which influence the

treatment. Menninger (26) states that "the manifestations of the countertransference may be conscious although the intrapsychic conditions resulting in its appearance may be unconscious." This has relevance for the management of countertransference, in that it implies the possibility of the analyst's understanding of the function of his countertransference reaction in the concrete analytic interaction, although the part of its origin stemming from his own past may remain concealed from him. Although the analyst may not be able to discover the past roots of a certain countertransference position, he may still become aware not only of the intensity and meaning of his emotional reaction but also to what extent this reaction is determined by the reality of both patient and analyst, and thus delimit the participation of the analyst's own past.

Reich (32, 33) separates "permanent countertransference" reactions from "acute countertransference" reactions, referring to the former as due to character disorder of the analyst, and the latter as determined by the different transference manifestations of the patient. She feels that permanent countertransference reactions are more difficult to deal with and ideally would require more analysis of the analyst. Yet, even countertransference reactions which reflect predominantly unresolved character problems of the therapist are intimately connected with the analytic interaction with the patient. Through the mechanism of emphatic regression in the analyst, certain conflicts of the patient may reactivate similar conflicts of the analyst's past; this regression may also reactivate previously abandoned, old character defenses of the analyst. Also, when strong negative countertransference reactions extend over a long period of time, whatever their origin, the analyst may revert to former neurotic patterns in his interaction with a particular patient which had been given up in his contact with other patients and in his life outside the analytic hours. The analyst, so to speak, becomes his worst in his relationship with a certain patient. Operating with a restricted concept of countertransference, it is tempting to write the whole reaction off as a character problem of the analyst and not consider

sufficiently the specific way in which the patient provokes this reaction in the analyst.

One can describe a continuum of countertransference reactions ranging from that related to the symptomatic neuroses on one extreme to psychotic reactions at the other, a continuum in which the different reality and transference components of both patient and therapist vary in a significant way. As we proceed from the "neurotic pole" of the continuum toward the "psychotic pole," transference manifestations become increasingly predominant in the patient's contribution to the countertransference reaction of the therapist, displacing the importance of those countertransference aspects which arise from the therapist's past. When dealing with borderline or severely regressed patients, as contrasted to those presenting symptomatic neuroses and many character disorders, the therapist tends to experience rather soon in the treatment intensive emotional reactions having more to do with the patient's premature, intense and chaotic transference, and with the therapist's capacity to withstand psychological stress and anxiety, than with any particular, specific problem of the therapist's past. In other words, given reasonably well-adjusted therapists, all hypothetically dealing with the same severely regressed and disorganized patient, their countertransference reactions will be somewhat similar, reflecting the patient's problems much more than any specific problem of the analyst's past. Little (23) states that the more disintegrated the patient the greater is the need for the analyst to be well integrated, and that with psychotic patients, countertransference may have to do the whole of the work, with the underlying mechanism probably being identification with the patient's id. Will's (44) observations point in the same direction.

Thus, countertransference becomes an important diagnostic tool, giving information on the degree of regression in the patient and the predominant emotional attitude of the patient toward the therapist and the changes occurring in this attitude. The more intense and premature the therapist's emotional reaction to the patient, the more threatening it becomes to the therapist's neutrality, and the more it has a quickly changing, fluctuating, and chaotic nature—the more we

can think the therapist is in the presence of severe regression in the patient. At the other extreme of the continuum, working with patients suffering from symptomatic neuroses and not too severe character disorders, such intensive emotional reactions of the therapist occur only temporarily, after a "build-up" over a period of time (generally past the initial period of treatment), and are of a much less threatening nature in so far as the stability and neutrality of the analyst are concerned.

REGRESSION AND IDENTIFICATION IN THE COUNTERTRANSFERENCE

Fliess (5) states that the analyst's attitude is based on empathy, which in turn depends on a "transient trial identification" with the patient. Spitz (38) states that this process of trial identification may be considered a form of regression in the service of the ego. In a later article, Fliess (6) describes the transient trial identification when a major degree of regression in the countertransference occurs. Such regression motivates what Fliess calls "counteridentification" in the analyst, that is, an excessive and more permanent identification with the patient, involving a duplication in the analyst of some constituent identification of the patient. Counteridentification, he says, interferes permanently and severely with the analyst's work. Reich (33) elaborates on Fliess's concept, and states that countertransference is exactly what is implied in the failure of the transient trial identification and in the appearance of "counteridentification." She says that one consequence of this failure is the return of impulses following the Talion principle, the analyst now tending to return love for love and hate for hate, or to "get stuck" in an identification which gives him narcissistic gratification.

What Fliess considers a constituent identification in the therapist and a duplication of the equivalent constituent identification of the patient is related to what Erikson (3, 4) might call an early identity of the ego, that is, a precipitate of identifications involving very early object relationships. The danger of "getting stuck" in such a "constituent identification" has to do with the fact that it involves a repressed or dissociated

early identity containing painful or traumatic interpersonal experiences that the ego could not integrate at the time when these early identifications occurred. This dissociated early ego identity also contains the derivatives of pregenital aggressive impulses, the identifications involved being of a very hostile nature because of the activation, projection, and reintrojection of these aggressive impulses in early interactions. Finally, this ego identity also involves archaic defensive operations of the ego, among which the mechanism of projective identification as described by Klein (20, 21), Heimann (17), and Rosenfeld (34, 35) seems to me to be of special interest.

I suggest in Chapter 1 projective identification may be considered an early form of the mechanism of projection. In terms of structural aspects of the ego, projective identification differs from projection in that the impulse projected onto an external object does not appear as something alien and distant from the ego because the connection of the self with that projected impulse still continues, and thus the self "empathizes" with the object. The anxiety which provoked the projection of the impulse onto an object in the first place now becomes fear of that object, accompanied by the need to control the object in order to prevent it from attacking the self when under the influence of that impulse. A consequence or parallel development of the operation of the mechanism of projective identification is the blurring of the limits between the self and the object (a loss of ego boundaries), since part of the projected impulse is still recognized within the ego, and thus self and object fuse in a rather chaotic way.

When very early conflictual object relationships become manifest in the transference, as frequently is the case in severe character disorders and more disorganized patients, the therapist is involved in a process of empathic regression in order to continue his emotional contact with the patient. At some point of regression, the therapist's own early identifications may become reactivated, together with the mechanism of projective identification. The therapist is now faced by several dangers from within: (i) the reappearance of anxiety connected with early impulses, especially those of an aggressive nature which now are directed toward the patient; (ii) a certain loss of

his ego boundaries in the interaction with that particular patient; and (iii) the strong temptation to control his patient in consonance with an identification of him with an object of the analyst's own past.

Fliess and Reich point out the dangers of such developments in the countertransference. Yet, the emotional experience of the analyst at that point can also be useful. It may provide information of the kind of fear the patient is undergoing at that time and of the fantasies connected with it, because this process in the analyst has come about by "duplicating" a process in the patient. Also, when the therapist is able to face the awareness of his own aggressive impulses without feeling too threatened by them, this may provide the basis for a most helpful transmission of emotional security to the patient.

Fortunately, there are important compensatory mechanisms operating in the analyst. Some aspects of his ego remain intact, while others are involved in the empathic regression to the point where projective identifications occur as part of the activation of a "constituent identification" in him. What remains functioning at a mature level in the analyst is the main part of his ego, including his advanced ego identity and the adaptive and cognitive structures connected with it. Projective identification involves loss of ego boundaries in the analyst only in the sector of his interaction with the patient, and in compensation special stress is exerted on his more advanced ego functions which normally keep the ego boundaries well delimited.

Even with severely regressed patients, the therapist may have lost his "analytic objectivity" during the hour, but after leaving the sessions or a few hours later slowly regains his equilibrium. A process of working through occurs in the therapist by which the stable, adaptive and cognitive structures formed around his later and more mature ego identity act, one might say, in a supportive way toward the part of his ego in which primitive identifications, defense mechanisms, and impulses have been activated and where ego boundaries have become fluid. When this process fails, the analyst gradually loses his capacity to "snap out" of the countertransference

position created by a certain patient. Over a period of days or weeks or months, the analyst finds himself more and more involved in a permanent emotional distortion in regard to that patient. Some symptoms of this "fixed" countertransference position are, other than those general symptoms of countertransference reaction as mentioned in the literature (2, 15, 24, 26, 46), the development of suspiciousness in connection with that particular patient, even paranoid fantasies about unexpected attacks from him and the form that these might take; a broadening of the inner reaction to that particular patient so that other people are involved in emotional reactions of the therapist which have to do with the relationship with that particular patient; and finally, the development of a kind of "microparanoid" reaction in the analyst. What has happened is that the working through within the analyst's ego has failed, mainly because the patient has successfully managed to destroy the more stable and mature ego identity of the analyst in their relationship, and the analyst is duplicating the patient's emotional position, without ego control.

We have to keep in mind that the analyst experiences a regression in the service of the ego, in order to keep in touch with the patient, and not as a reaction to the onslaught of the patient's behavior. The very tolerance and neutrality toward the patient, which is part of the analyst's efforts to keep in emotional touch with him, may reinforce the danger of the analyst's being unprotected in facing the inappropriate, especially aggressive behavior of borderline patients. In fact, some analysts especially interested in working with severely regressed patients unwillingly become the passive victims of the patient's behavior because so much of the analyst's efforts are absorbed by the struggle with his inner emotional reactions triggered off by that patient.

Ego identity depends on the continuity and confirmation of the self concept, and this holds true also for the analyst in his relationship with any patient. In the particular interaction with a patient who threatens the analyst both by inducing an important countertransference regression and by his behavior, this confirmation does not take place. The analyst's identity is continuously undermined and finally the very forces—the

structures of his mature ego identity—which otherwise would compensate for his regression in the service of the ego are no longer available. From a practical point of view, this consideration underlines the importance of some external structure as part of the analytic work with severely regressed patients, a certain limit to what the patients can do and will be permitted to do, a limit to which the analyst must then firmly and unwaiveringly adhere, direct indications to the patient that certain behavior is not permitted in the hour, increased structure through hospitalization, or other adjunctive treatment devices.

Racker (31) further develops the utilization of countertransference reactions of the analyst to obtain information about the inner emotional constellation of the patient, classifying the identifications that take place in the countertransference reaction in two types: "concordant identification" and "complementary identification." "Concordant identification," according to Racker, is an identification of the analyst with the corresponding part of the patient's psychic apparatus: ego with ego, superego with superego. Under the influence of concordant identification, the analyst experiences in himself the central emotion that the patient is experiencing at the same time, and, Racker states, one might consider empathy as a direct expression of concordant identification.

"Complementary identification" (a concept first expressed by Helene Deutsch) refers to the identification of the analyst with the transference objects of the patient. In that position, the analyst experiences the emotion that the patient is putting into his transference object, while the patient himself is experiencing the emotion which he had experienced in the past in his interaction with that particular parental image. For instance, the analyst may identify with a superego function connected with a stern, prohibitive father image, feeling critical and tempted to control the patient in some particular way, while the patient may be experiencing fear, submission, or rebelliousness connected with his relationship to his father. Racker states that the analyst fluctuates between these two kinds of countertransference identifications.

It is precisely at the level of regression in which projective

identification in the analyst occurs where the maximal development of complementary identification takes place. And, as stated, while the analyst is struggling with the upsurge of primitive impulses in himself and the tendency to control the patient as part of his efforts to control these impulses, he also thus reproduces the early relationship with a significant parental image of the patient. Thus a highly meaningful and specific situation is brought about which, when understood and worked through, may provide a cornerstone of the analytic work with that particular patient. Under these circumstances, the analyst may bring about fundamental changes in the ego structure of the patient through the corrective experience implied in the analytic situation. In contrast, the greatest danger confronting the analytic situation at this point is the threat of a traumatic repetition of the early frustrating childhood experience of the patient in the analytic situation. What the analyst does when he becomes unable to "snap out" of his countertransference bind is to re-establish the vicious circle of the patient's interaction with the parental image.

SOME CHRONIC COUNTERTRANSFERENCE FIXATIONS

The reappearance of the previous neurotic character structure of the analyst, which had been generally abandoned but which becomes reactivated strongly in his dealings with a particular patient, has already been mentioned. Its reappearance frequently acquires a peculiar form, so that the analyst's particular pathology becomes molded in the therapeutic interaction and resembles the patient's own personality structure or complements it in such a way that the patient and therapist seem "prematched" to each other. This kind of chronic countertransference bind is, of course, very harmful to both participants. What happens in these circumstances is that the neurotic character defenses of the analyst are his safest defense against rather primitive anxieties that tend to emerge in his countertransference, and the peculiar complementary character formation that he establishes with

the patient is the product of the mutual influence of projective identification in both of them.

With borderline and psychotic reactions, or at times of very deep regression in all kinds of patients in analytic treatment, conflicts around pregenital aggression have been found to occupy a central position (12, 13, 20, 22, 24, 36, 46). Throughout the literature, the examples of the most serious countertransference disturbances and difficulties in handling it are those involving this kind of severe, archaic aggression in the patient, expressed typically by the therapist's emotional reaction to the patients who always seem to have to bite the hand that feeds them. Wherever one stands in regard to the controversy about whether there exists a death instinct or whether aggression is secondary to frustration, there is sufficient evidence that there is a strong predisposition in the psychic apparatus to turn aggression against the self. Aggression and aggression against the self are fused in the patient's efforts to destroy the analyst's capacity to help him, and both elements are also present in the analyst's emotional response to this situation.

In very simple terms, the experience of giving something good and receiving something bad in return, and the impossibility of correcting such experience through the usual means of dealing with reality, is a dramatic part of the analyst's work. It resembles that other basic experience in which building up of what Erikson calls "basic trust" fails, or what Melanie Klein calls the "securing of the good inner object" fails. It is as if in his relationship with that particular patient, the analyst would have to lose confidence in the forces that could neutralize aggression; this in turn reactivates the analyst's masochism. Money-Kyrle (28) points out how the patient's aggression feeds into the superego functions of the analyst, provoking in him paranoid fears or depressive guilt.

In dealing with borderline personality organization, dedicated therapists of all levels of experience may live through phases of almost masochistic submission to some of the patient's aggression, disproportionate doubts in their own capacity, and exaggerated fears of criticisms by third parties. During these phases, the analyst comes to identify himself

with the patient's aggression, paranoid projection, and guilt. Secondary defenses against this emotional position of the analyst, especially his characterological defenses, may obscure this basic situation.

The reappearance of the old neurotic character structure of the analyst in a peculiar complementary integration with the patient's characterological pathology is one form this chronic countertransference bind may take. One other frequent secondary defense is a narcissistic withdrawal or detachment of the therapist from the patient, so that empathy is also lost and the possibility of continuing an analytic approach with that patient is threatened. There are cases which are discontinued, emotionally speaking, quite some time before an unsuccessful termination actually occurs. One other defensive solution, perhaps more pathological than the one mentioned, is the narcissistic withdrawal of the analyst from reality, with the appearance of unrealistic certainty of being able to help this patient (one might say, the reappearance of archaic omnipotence). The therapist now tends to establish himself in a kind of island with such a particular patient, helps the patient to deflect his aggression from the analyst to external objects, and absorbs some of this aggression in masochistic submission to the patient, rationalized as "total dedication," which also provides some narcissistic gratification. After a period of time this latter defensive operation tends to break down, frequently in a rather abrupt way, after which the symptomatology of the patient reappears and simultaneously treatment often comes to an end. Such a "Messianic spirit" is quite different from authentic concern for the patient, because mature concern has to include reality.

Narcissistic withdrawal from the patient in the form of passive indifference or inner abandonment by the therapist, and narcissistic withdrawal from external reality in a complementary relationship with that patient, are potential dangers particularly in analysts whose narcissism has not been sufficiently worked through in their own analysis. Such analysts fall back more easily on their narcissistic character defenses; this happens not only because of the defensive return to old character patterns, but also because these character

defenses themselves are so often directed against pregenital conflicts involving early aggression. Countertransference regression is especially threatening in these cases.

THE IMPORTANCE OF CONCERN AS A GENERAL TRAIT OF THE ANALYST

One important force active in neutralizing and overcoming the effect of aggression and self-aggression in the countertransference is the capacity of the analyst to experience concern. Concern in this context involves awareness of the serious nature of destructive and self-destructive impulses in the patient, the potential development of such impulses in the analyst, and the awareness by the analyst of the limitation necessarily inherent in his therapeutic efforts with his patient. Concern also involves the authentic wish and a need to help the patient in spite of his transitory "badness." On a more abstract level, one might say that concern involves the recognition of the seriousness of destructiveness and self-destructiveness of human beings in general and the hope, but not the certainty, that the fight against these tendencies may be successful in individual cases. In an analysis of the importance of hope as a basic human tendency, Menninger (27) describes hope as the manifestation of the life instinct against the forces of destructiveness and self-destructiveness. Money-Kyrle (28) says that concern for the patient's welfare stems from the combination of reparative drives in the analyst counteracting his early destructive tendencies, and from his parental identifications. Frank (7), in a different context, stresses the importance of the therapist's faith in himself and his technique as a prerequisite for therapeutic success. One might, in addition, describe concern also negatively, saying that it does not mean an abandonment of the analytic position, of the analyst's neutrality; concern for the patient cannot mean abandonment of reality either.

Psychoanalysts of different orientations would describe different genetic and dynamic conditions underlying the capacity for concern. Winnicott (47) suggests that concern stems from modulated and restricted guilt feelings. He suggests

that the child's successful working through of repeated cycles of aggression, guilt, and reparation makes this development possible. Whatever its origin, the manifestations of the analyst's capacity for concern may be described in connection with the immediate reality of the treatment situation of any particular patient. In concrete terms, concern implies ongoing self-criticism by the analyst, unwillingness to accept impossible situations in a passive way, and a continuous search for new ways of handling a prolonged crisis. It implies active involvement of the therapist as opposed to narcissistic withdrawal, and realization of the ongoing need of consultation with and help from one's colleagues. The last point is important: willingness to review a certain case with a consultant or colleague, as contrasted with secrecy about one's work, is a good indication of concern.

There are professional pressures on the analyst tending to restrict his capacity to accept his limitations and his efforts to overcome them. During his analytic training, the candidate has to struggle with the temptation to use his patients narcissistically because their treatment may be a requisite for his graduation: the wish to keep a "good" patient and to get rid of a "bad" patient may represent a countertransference reaction strongly influenced by the candidate's wishes or fear in connection with the fulfillment of his requirements. Benedek (1) further describes some of the countertransference complications arising in the analyst within the setting of a psychoanalytic society. Pressures which act on the analyst when he is part of a complex treatment setting also influence his countertransference and may limit, realistically or in his fantasy, his inner freedom to deal with difficult treatment situations. Savage (37) mentions this point in connection with psychoanalytically oriented therapy of schizophrenic patients in a hospital setting. Main (25) conducted an illustrative research involving the study of countertransference reactions occurring in a hospital setting.

Not all difficulties or crises in treatment, however, involve countertransference binds. The therapist's lack of experience or of technical or theoretical knowledge has to be differentiated from his countertransference reaction. This is not easy because these two factors influence each other.

The analyst's insight into the meaning of his countertransference reaction does not itself help the patient. What helps the patient is the analyst's using this information in his transference interpretations; the analyst's taking the necessary steps to protect himself and his patient from treatment situations which might realistically be impossible to handle; and the analyst's providing the patient, through their relationship, evidence of the analyst's willingness and capability to accompany the patient into his past without losing the sight of the present.

SUMMARY

Contrasting views of countertransference and its clinical use are outlined. It is suggested that countertransference may be helpful in evaluating the degree of regression in the patient and in clarifying the transference paradigms in borderline personality organization..

Patients with the potential for severe regression in analysis or expressive psychotherapy tend to foster serious countertransference complications, especially "counteridentification."

It is suggested that countertransference complications in the form of "counteridentification" are related to the partial reactivation of early ego identifications and early defensive mechanisms in the analyst. While these counteridentifications may be the source of important information about the analytic situation, they are also a serious threat to the analysis, and predispose the analyst to the development of "chronic countertransference fixation."

The following signs of chronic countertransference fixation are described: reappearance of abandoned neurotic character traits of the analyst in his interactions with a particular patient; "emotional discontinuation" of the analysis; unrealistic "total dedication"; "micro-paranoid" attitudes toward the patient. These countertransference complications present themselves especially in the treatment of patients with a potential for severe regression, particularly in borderline personality organization.

The importance of "concern" as a general trait of the

analyst, helpful in protecting him from the countertransference complications mentioned, is described. Some of the characteristics, preconditions, and realistic limitations of the development of concern are mentioned.

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