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THE ORIGINS OF THE NOTION OF COUNTERTRANSFERENCE

The notion of countertransference (*Gegenübertragung*) was introduced by Sigmund Freud, and yet we rarely encounter it in his writings. It was used the first time in a letter dated June 7, 1909, in which Freud answered a letter sent to him three days earlier by Carl G. Jung, who informed him about the difficulties he encountered in the treatment of a twenty-year-old Russian patient (Sabina Spielrein).[1] Freud wrote:

> Such experiences, though painful, are necessary and hard to avoid. Without them we cannot really know life and what we are dealing with. I myself have never been taken in quite so badly, but I have come very close to it a number of times and had *a narrow escape* [emphasis added for phrase appearing in English in original]. . . . But no lasting harm is done. They help us to develop the thick skin we need and to dominate 'countertransference', which is after all a permanent problem for us; they teach us to displace our own affects to best advantage. They are a '*blessing in disguise*' [quoted phrase is in English in original].
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> *(Freud and Jung, 1906–13, pp. 230–231)*

Consequently, for Freud, the feelings and the countertransference temptations experienced by the analyst in his or her work with patients must not be denied; rather, the analyst should try to reach a position of uninterest towards them in this regard.

As regards Spielrein's treatment, Freud did not know the whole story; Jung had not been clear about his own degree of involvement in the erotic transference-countertransference dynamics that had been established with Spielrein. Freud got the complete picture only after receiving two letters, one from Spielrein and the other from Jung. In the first letter, dated June 11, 1909, we read: "Four and half years ago Dr. Jung was my doctor, then he became my friend and finally my 'poet'

i.e. my beloved. Eventually he came to me and things went as they usually go with 'poetry'. He preached polygamy; his wife was supposed to have no objection, etc., etc." (Carotenuto, 1982, p. 93). In the second letter, written on June 21, we read: "Although not succumbing to helpless remorse, I nevertheless deplore the sins I have committed, for I am largely to blame for the high-flying hopes of my former patient . . . imagining that I was talking theoretically, but naturally Eros was lurking in the background. Thus I imputed all the other wishes and hopes entirely to my patient without seeing the same thing in myself" (Freud and Jung, 1906–13, p. 236). Learning about these facts, Freud wrote to Spielrein to apologise for having damaged her with his untrue allegations, acknowledging that it had been Jung's fault, not hers (cf. Carotenuto, 1982).

It is however necessary now to mention the influence that Otto Gross had on Jung during the (almost mutual) analysis of the former on the latter; they were the only psychoanalysts that, in Freud's opinion, were really original thinkers (Jones, 1953). Gross's name appeared in Jung's correspondence with Freud on June 28, 1907, in a letter in which the Swiss analyst described Gross as psychopathic, despite being gifted with a very brilliant mind.[2] Regarding the psychoanalytic thinking of Gross, who had been a pupil of Emil Kraepelin in Munich, it is important to remember that he saw Freudian psychoanalysis as a helpful tool both for the therapy of a suffering individual and for the establishment of a sexual revolution – *pour épater la bourgeoisie* – on a collective level, but attributed little value to sexuality as an aetiopathogenetic element in mental illnesses, envisaging psychoanalysis as closely linked to the quality of the social context and to the frustration of the 'relational will' of each individual (Heuer, 2001).

However, as mentioned earlier, Gross suffered from psychic disorders and had been addicted to cocaine and opiates for a long time; for this reason, in the early months of 1908, his father Hans Gross (a famous Austrian jurist and magistrate, professor of criminology in Prague and Graz, the father of modern criminal psychology) got in touch with Freud, asking for help. In turn, Freud contacted Jung (letter of April 19, 1908), asking him to start an analytic treatment with Gross. In the end, Jung took on the referral, with the promise on the part of Freud (letter of May 6, 1908) that it would be a short-term referral (a few months), to give Freud enough time to take on the patient himself in analysis. The promise to see the patient starting in autumn, however, was retracted only a few days later (letter of May 18, 1908). The resulting treatment, in the end, became one of the elements that damaged the relationship between Freud, Jung, and Gross (Vitolo, 1987). The deeper Jung delved into the analysis of Gross, the more he became aware of the enriching element of that experience, an analytic journey in which "whenever I got stuck, he analyzed me. In this way my own psychic health has benefited" (Freud and Jung, 1906–13, p. 153). As we know, the end of this psychoanalytic treatment was unfortunate, even if it cannot be said that it came out of the blue. It is enough to remember the distress of Jones, who knew both of them, when he learned about this analysis, at the beginning of May: "I hear that Jung is going to treat him psychically, and naturally feel a little uneasy about that for Jung does not find it easy to conceal his feelings and he

has a pretty strong dislike to Gross; in addition there are some fundamental differences of opinion between them on moral questions" (Freud and Jones, 1908–39, p. 1). An example of these differences regarding moral issues is given by Jung himself in a letter written to Freud on September 25, 1907:

> Dr. Gross tells me that he puts a quick stop to the transference by turning people into sexual immoralists. He says the transference to the analyst and its persistent fixation are mere monogamy symbols and as such symptomatic of repression. The truly healthy state for the neurotic is sexual immorality. Hence he associates you with Nietzsche. It seems to me, however, that sexual repression is a very important and indispensable civilizing factor, even if pathogenic for many inferior people. Still, there must always be a few flies in the world's ointment. What else is civilization but the fruit of adversity? I feel Gross is going along too far with the vogue for the sexual short-circuit, which is neither intelligent, nor in good taste, but merely convenient, and therefore anything but a civilizing factor.
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> *(Freud and Jung, 1906–13, p. 90)*

It is well known that Jung was never convinced of the sexual origin of neuroses, and he deeply criticised the Freudian theory of sexuality (see 'Transformations and Symbols of the Libido', written in 1911). Indeed, it seems that the incapability to acknowledge the role played by sexuality within human relationships and neuroses was already present in Jung from the very beginning of his relationship with the father of psychoanalysis; this issue eventually led to his breakup with Freud when what had initially been a personal need to deny the importance of sexuality later became a technical problem (Bettelheim, 1983). However, in the years 1907–1908 Jung was a fervent sexualist (Appignanesi and Forrester, 1992). His relationship with Spielrein was at the same time the cause and the effect of this new temporary attitude towards sexuality, a turning-point in which the almost mutual analysis with Gross was a crucial element. This can be clearly inferred from Spielrein's words, when she told Freud that Jung "arrives, beaming with pleasure, and tells me with strong emotion about Gross, about the great insight he has just received (i.e., about polygamy); he no longer wants to suppress his feeling for me, he admitted that I was his first dearest, woman friend, etc., etc. (his wife of course excepted), and that he wanted to tell me everything about himself" (Carotenuto, 1982, p. 107).

Going back to the topic of Gross's treatment: On June 19, 1908, Jung gives up; in his letter to Freud, after explaining his reasons and affirming the impossibility of a positive and stable outcome of Gross's psychic conditions, the Swiss psychiatrist confesses that "For me this experience is one of the harshest in my life, for in Gross I discovered many aspects of my own nature, so that he often seemed like my twin brother – but for the Dementia praecox. This is tragic. You can guess what powers I have summoned up in myself in order to cure him" (Freud and Jung, 1906–13, p. 156). Finally, it is interesting to point out that Jung himself compared the treatment of Gross to that of Spielrein: "Like Gross, she is a case of fight-the-father,

which in the name of all that's wonderful I was trying to cure gratissime (!). . . . During the whole business Gross's notions flitted about a bit too much in my head. . . . Gross and Spielrein are bitter experiences. To none of my patients have I extended so much friendship and from none have I reaped so much sorrow" (Freud and Jung, 1906–13, p. 229).

The privileged position as an 'external observer' in which Freud found himself, not only in the Jung-Spielrein affaire but also before, first with Josef Breuer and Bertha Pappenheim (Anna O.) and then with Sándor Ferenczi and Elma Pàlos, allowed him to reflect with greater objectivity and to reach some conclusions on a phenomenon from which he was not himself immune. According to Johannes Cremerius (1986), if one follows the various stages of the 'Spielrein tragedy', one can notice certain correspondences between the dates in which he learned more about her and those in which new aspects of the transference-countertransference dynamics emerged from his thoughts.

Before moving on, it would be interesting to take a step back, to the pre-analytical origins of the so-called talking cure, that is, Breuer's treatment with Pappenheim, which took place between November 1880 and June 1882. Freud was informed about it by Breuer himself in November 1882, and he came to know all its details in the summer of the following year. What captured Freud's attention and made him think about this clinical history in depth was not its theoretical explanation as formulated by Breuer, which included hypnoid states and catharsis, but rather the sexual significance present in the clinical material and, even more so, the revelation of the transference-countertransference dynamics established between the doctor and the patient. One should remember that it is precisely in *Studies on Hysteria* (1892–95) that Freud introduced the notion of transference (*Übertragung*), that is, a phenomenon that was so frequent as to be an established fact in certain analyses, according to which "the patient is frightened at finding that she is transferring on to the figure of the physician the distressing ideas which arise from the content of the analysis" (p. 302). In this early formulation the transference was simply seen as one of many forms of resistance, an obstacle against the establishment of a necessary trusting relationship between doctor and patient, whose unconscious motives had to be discovered and interpreted.

It might be helpful to remember that the choice of the name Anna, in order to conceal that of Bertha Pappenheim, had been neither casual nor exempt from transference-countertransference connotations. One should consider, first of all, that in the same year, 1895, Freud gave the name Anna to his younger daughter. Anna was also the name of one of Freud's favourite patients, Anna Lichtheim, a young widow, the daughter of Freud's teacher of religion, a relative of Sophie's godmother, and a friend of Mathilde Breuer's (the godmother of Mathilde Freud, whom Freud had wished Ferenczi to marry). Moreover, it seems that the name of Irma, mentioned in the famous dream about the injection (Freud, 1900), concealed a combination of two patients: Anna Lichtheim and Emma Eckstein (who would later become the first woman psychoanalyst). We have already mentioned the former; the latter was the patient that Freud, preoccupied with neglecting organic causes in favour of

psychogenic ones, asked Wilhelm Fliess to see. He operated on her, leaving in her nasal cavity almost half a metre of gauze. In the light of these data, it is possible to assume that the presence of Irma in Freud's dream represented at the same time an erotic countertransference, medical malpractice, disappointment in idealised colleagues, and his wife's pregnancy – all elements that were also present in the Breuer-Pappenheim treatment (Britton, 2003). In his letter dated January 9, 1908, Freud later shared with Karl Abraham his own free associations about that dream as well as his interpretation of it: "Sexual megalomania is hidden behind it, the three women, Mathilde, Sophie and Anna, are the three godmothers of my daughters, and I have them all!" (Freud and Abraham, 1907–25, p. 21). Having said this, it should be acknowledged that Freud did not allow such deep and secret awareness to become an inhibiting source of shame, which was what had happened to Breuer; instead, it became the source of his brilliant intuition and the driving force for the constant evolution of his ideas about the transference and the countertransference (Britton, 2003).

Let us now consider the notion of transference for a moment. It made its appearance on the psychoanalytic scene in *Studies on Hysteria* (Breuer and Freud, 1892–95), but it is in *Fragment of an Analysis of a Case of Hysteria* (1905) that Freud reached a veritable formulation of a theory about the transference. One should consider that such revision/elaboration of the theory of transference, which was later the object of constant development for many decades, was not an element separated from the rest; indeed, it was part of the context of the new understanding of the genesis of neurosis that Freud had reached after abandoning his theory of seduction (cf. Makari, 1997).

'Dora's Case' is the clinical history of Ida Bauer, an eighteen-year-old girl who came to Freud's study in October 1900; she was taken there by her father because of her neurotic disorders and depression. Let us briefly see what Freud tells us about the history of this young patient. Ida was holidaying in Merano with her parents, Philip and Katherina Bauer, and a couple of friends, Hans and Peppina Zellenka (Mr. and Mrs. K.). During this holiday, Hans Zellenka discovered that his wife was betraying him with Philip Bauer, a fact which led him to court his rival's daughter. One day Ida, who was secretly in love with Mr. Zellenka (who reminded her of her father), was approached by him; he suddenly embraced her and kissed her on her mouth. Upset by this, she slapped him and ran away. During her psychoanalytic treatment, Ida confessed that in that situation she had felt a certain sexual excitement, aroused by the pressure of his erect member against her body: "She declared that she could still feel upon the upper part of her body the pressure of Herr K.'s embrace" (Freud, 1905, p. 29). Such a feeling upset her and made her feel deeply ashamed. According to Freud, this was a real and present event which had brought her back to past childhood phantasies of being seduced by her father. From that moment on, the first signs of hysteria began to appear: feeling nauseated and horrified by men.

When Ida informed her father about the event a few days later, he (and Mr. Zellenka) called her a liar and accused her of having made everything up.

At that point she left the holiday resort ahead of time. Ida's psychoanalytic treatment, which was interrupted by the patient only eleven weeks after it had started, seemed to fully confirm Freud's hypotheses on the sexual origin of hysteric symptomatology and on dreams as revelations of unconscious conflicts. Preoccupied as he was about retrieving his patient's memories and reconstructing her past history, Freud did not notice in time the resistances that his explanations caused in the patient, and he was not aware of the transference which, otherwise, he might have interpreted to the patient. (Freud himself, in his afterword, suggested other interpretations that he could have made.) This, however, was not the only reason for Freud's difficulties in handling this case; there was another, less clearly visible reason, albeit cumbersome and compelling: his own countertransference.

'Dora's Case' was drafted by Freud immediately after the premature end of the treatment, within a few weeks, but it was only in 1905, when he wrote his afterword and then decided to publish his work (without his patient's authorisation, which fuelled a great argument), that the father of psychoanalysis fully realised that Ida had interrupted the treatment because of the transference of loving and erotic feelings towards him.[3] Apparently he did not realise, or at least he did not declare publicly, that his difficulties in the treatment of Ida also derived from his own countertransference. At this point we might ask ourselves, together with Freud (1905): "What are transferences?"

> They are new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment. Some of these transferences have a content which differs from that of their model in no respect whatever except for the substitution. These then – to keep to the same metaphor – are merely new impressions or reprints. Others are more ingeniously constructed; their content has been subjected to a moderating influence – to sublimation, as I call it – and they may even become conscious, by cleverly taking advantage of some real peculiarity in the physician's person or circumstances and attaching themselves to that. These, then, will no longer be new impressions, but revised editions.
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> . . . [T]ransference is an inevitable necessity . . . there is no means of avoiding it . . . [it] has to be detected almost without assistance and with only the slightest clues.
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> *(Freud, 1905, p. 116)*

Even if this definition is the most complete that Freud ever gave of the concept of transference, it is evident that it was still not considered as the real driving force of the analytic process. However, it should be noted that for Freud the transference, or rather the transference interpretation, never became the only therapeutic

instrument; in his clinical practice with patients he also established a personal, non-technical relationship (cf. Freud, 1937a; Lipton, 1977).

Another fundamental contribution on the transference is 'The Dynamics of Transference' (Freud, 1912a), the first work that the Viennese Master devoted entirely to this topic. In this essay, Freud used the term *imago* (introduced in psychoanalysis by Jung in 1911) to indicate the internal figures (mother, father, siblings, etc.) that belong to the subject's past; such figures constitute the object of transference shift on the person of the analyst. More precisely, what is transferred are some elements of the unconscious parts of infantile conflicts. Moreover, in the wake of the contribution of Ferenczi (1909), who had shown the patient's tendency to try to get the analyst to play the role of a parental figure, loved and feared at the same time, Freud examined the role of the transference affects of love and hate within the analytic process, ultimately believing that it was necessary for the analyst to take into consideration the affective qualities of the patient's transference.

Freud suggested the distinction between a 'positive' transference (friendly, affectionate feelings that can reach consciousness; it is an instrument of cooperation), originating from the loving relationship with a preoedipal mother (the tender feelings that are typical of this kind of transference are seen as originating from erotic sources; the earliest relationships are always established with sexual objects) and a 'negative' transference (hostile, erotic-aggressive, unconscious feelings; it expresses itself as a resistance against treatment), which derives from oedipal desires and conflicts. These two components of the transference, the positive and the negative, are often both present in the transference that the (psychoneurotic) patient develops towards the analyst; they must be acknowledged and treated separately. Therefore, a certain ambivalence (a term introduced by Bleuler in 1909 and again in 1911) is normal; however, it becomes a problem when it is excessive, as in the case of neurotic individuals, because the transference may become essentially negative, thus hindering the positive outcome of the therapeutic work: "Transference to the doctor is suitable for resistance to the treatment only in so far as it is a negative transference or a positive transference of repressed erotic impulses" (Freud, 1912a, p. 105). To conclude this brief discussion of the concept of transference, we can say that Freud envisaged it as a resistance, or an obstacle, letting other people investigate the notion of irreprehensible positive transference (in more recent terms, secure attachment); this legacy was particularly evident for Ferenczi, whose works were all approved by Freud, except 'Confusion of the Tongues Between the Adults and the Child' (Ferenczi, 1932), which he criticised for political, not scientific reasons.

Going back more specifically to the countertransference, we could say that Freud linked the transference-countertransference dynamics of the 'analytic' couple Breuer-Pappenheim to that of the Jung-Spielrein affaire; two stories distant in terms of time, which share surprising similarities, with the difference that the erotic involvement of the first couple took a symbolic, symptomatic form and remained at an unconscious level in both members, whereas in the second couple it reached a conscious level and was enacted with great awareness.

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It is clear that the countertransference was initially noticed as an erotic countertransference of male analysts towards young women patients, and that "Dominating the countertransference means . . . that the (male) analyst will not succumb to the (female) patient's seduction" (De Urtubey, 1995, p. 684). This fact, however, should not be seen with contempt or as the source of facile accusations, at least not before considering it within the historical-sociological context of that time. First of all, it should be remembered that most of the patients who went to the studies of psychoanalysts were women (until 1905 all clinical cases were women patients) who suffered from hysteria, that is, a disorder that belongs to the oedipal stage, which, by means of an amorous transference, reproduces and tries to fulfil instinctual (tender and sensual) desires within the analytic situation. Freud's idea of the analyst's rule of abstinence derives from the problems related to the oedipal, amorous desires of his women patients, and not from drives of any other type; this rule was based on the following principle of the psychoanalytic method, according to Freud:

> I shall state it as a fundamental principle that the patient's need and longing should be allowed to persist in her, in order that they may serve as forces impelling her to do work and to make changes, and that we must beware of appeasing those forces by means of surrogates. And what we could offer would never be anything else than a surrogate, for the patient's condition is such that, until her repressions are removed, she is incapable of getting real satisfaction.
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> *(Freud, 1912a, p. 165)*

In addition, substitutive satisfactions, external to the analysis (e.g., repetitive or perverse sexual practices; Freud, 1918) as well as those concealed within it (e.g., unconscious masturbatory behaviour; Ferenczi, 1919) were abolished; the only possible discharge was verbalisation, since it allowed interpretative work to take place.

Going back to the link between the concept of abstinence and the instinctual needs of hysteria, one should remember that it was Freud's lifelong concern, and that it was inappropriately extended also to the treatment of other forms of psychopathology (Cremerius, 1984). But the ethical-professional preoccupation about abstinence which Freud had to deal with was also mixed with feelings of pride: "To be slandered and scorched by the love with which we operate – such are the perils of our trade, which we are certainly not going to abandon on their account" (Freud and Jung, 1906–13, p. 210). One should also keep in mind that the pioneers of psychoanalysis saw themselves, each one from his own perspective, as a new kind

of scientist. Ultimately, scientists are not like philosophers who leaf through pages of books to inquire about knowledge and construct their thoughts and new structures of knowledge; rather, they are empirical explorers who find their way through human territories and unexplored materials, possibly jeopardising their objects of study and also, in some way, at their own risk (Meneguz, 2011).

The public debut of the concept of countertransference took place in the course of the Second International Conference of Psychoanalysis, which occurred in Nuremberg on March 30–31, 1910; Freud had already talked about it in the course of a meeting of the Psychoanalytic Society of Vienna on the ninth of the same month. On that occasion, it seems that Freud had decided to discuss the fundamental and delicate issue of the analyst's psychic state, following the suggestion of Ferenczi (Jones, 1953), who had published one of his works on technique the previous year. Talking about innovations in the technique, Freud said:

> We have become aware of the 'countertransference', which arises in him as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this countertransference in himself and overcome it. . . . We have noticed that no psycho-analyst goes further than his own complexes and internal resistances permit; and we consequently require that he shall begin his activity with a self-analysis[4] and continually carry it deeper while he is making his observations on his patients. 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.
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> *(Freud, 1910a, pp. 144–145)*

Countertransference, therefore, was seen as "the whole of the analyst's unconscious reactions to the individual analysand – especially to the analysand's own transference" (Laplanche and Pontalis, 1967, p. 92), as an endopsychic response of the clinician due to a personal, unresolved resistance (that is, an unconscious which is still too extended; 'blind spots' in his or her analytic perception, according to Wilhelm Stekel's 1911 metaphor), which made working on the patient's unconscious difficult.

The fact that Freud (1910a) introduced the concept of countertransference when talking about 'The Future Prospects of Psychoanalytic Therapy', however, suggests that he did not just see the countertransference as an obstacle to get rid of (such a position is a given fact), but he also perceived, as in the case of the transference, that a better understanding of it might lead to new, important contributions to the psychoanalytic technique. A confirmation of this hypothesis can be read in the letter that Freud wrote to Ferenczi on January 4, 1928:

> For my recommendations on technique which I gave back then were essentially negative. I considered the most important thing to emphasize what one should not do, to demonstrate the temptations that work against analysis. Almost everything that is positive that one should do I left to 'tact', which has been introduced by you. But what I achieved in so doing was that the

> obedient ones didn't take notice of the elasticity of these dissuasions and subjected themselves to them as if they were taboos. That had to be revised at some time, without, of course, revoking the obligations.
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> . . . What we undertake in reality is a weighing out, which remains mostly preconscious, of the various reactions that we expect from our interventions, in the process of which it is first and foremost a matter of the quantitative assessment of the dynamic factors in the situation. Rules for these measurements can naturally not be made; the analyst's experience and normality will have to be the decisive factors. But one should thus divest 'tact' of its mystical character for beginners.
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> *(Freud and Ferenczi, 1920–33, p. 332)*

It is, however, necessary to contextualise Freud's intervention in what can be defined as the third level of the development of the technique: to identify and overcome resistances. The first two levels had been (a) to interpret symptoms and (b) to discover complexes.

Freud's comment on the countertransference at the Nuremberg Conference deeply affected Ferenczi, who felt he was not receiving from the Master all the affection he would have needed. The Hungarian analyst agreed with what Freud expressed, but in a letter dated April 5, 1910, it is possible to read how he found the constant repression of the countertransference extremely exhausting. At the beginning of that letter Ferenczi quotes a sentence that Freud said to him: "Man *must* love something", referring to manual work or science; however, he adds that this is not enough, because "one must also love people if one wants to be happy" (Freud and Ferenczi, 1908–14, p. 158, emphasis in original). A few lines later, the Hungarian analyst writes that

> continuing analytic practice brings with it an increase in this need for support. Already, before the establishment of your requirement of 'suppression of countertransference', we all did this instinctively, and this continual suppression has to add up to something disturbing when one such as I, after ten to twelve hours of work, is so completely isolated and does without every love object.
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> *(Freud and Ferenczi, 1908–14, p. 159)*

Ferenczi seems to complain to Freud, stating that such repression is even more difficult for someone who, just like him, is not (or does not feel) loved enough (*in primis* by the very father of psychoanalysis).

Still in 1910, in response to a 'self-analytic' letter in which Ferenczi apologised for having 'drowned' him with excessive questions, requests, and demands during a holiday they had spent together in Syracuse, Italy, regretting that he had not been reprimanded enough so that a good relationship might be reestablished, Freud wrote: "Quite right, it was a weakness on my part; I am also not that ψα superman whom we have constructed, and I also haven't overcome the countertransference. I couldn't do it, just as I can't do it with my three sons, because I like them and I feel

sorry for them in the process" (Freud and Ferenczi, 1908–14, p. 221). It is clear that such paternal and positive countertransference had prevented Freud from acting and behaving in a certain manner, the way he saw as 'correct', towards his favorite pupil, the only one with whom he entertained a true extraprofessional relationship.[5]

Four years later Freud wrote 'Observations on Transference Love' (1914a) which, quite probably, is the result of his reflections on the Jung-Spielrein affaire and on the relational dynamics between the Swiss doctor and the Russian patient. In this essay Freud follows the same line he traced in 1910, but this time he invites his colleagues to pay more attention to the transference situations in which they become the objects of erotic attraction on the part of their own patients:

> For the doctor the phenomenon signifies a valuable piece of enlightenment and a useful warning against any tendency to a counter-transference which may be present in his own mind. He must recognize that the patient's falling in love is induced by the analytic situation and is not to be attributed to the charms of his own person; so that he has no grounds whatever for being proud of such a 'conquest', as it would be called outside analysis.
>
> *(Freud, 1914a, pp. 160–161)*

> Our control over ourselves is not so complete that we may not suddenly one day go further than we had intended. In my opinion, therefore, we ought not to give up the neutrality towards the patient, which we have acquired through keeping the counter-transference in check.
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> *(ivi, p. 164)*

The notion of countertransference remained essentially the same for the rest of Freud's life, who from the year 1915 stopped making reference to it. It is, however, possible to perceive a different view of such phenomenon when, in 1912, suggesting the use of free-floating attention, Freud described an emotional-receptive unconscious, never fully theorised, as the basis of analytic listening:

> [The analyst] must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone. Just as the receiver converts back into sound waves the electric oscillations in the telephone line which were set up by sound waves, so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free associations.
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> *(Freud, 1912b, pp. 115–116)*

The doubt remains whether with the choice of the telephone metaphor Freud wanted to implicitly convey that unconscious transmission in analysis is a two-way road, or if he remained faithful to the view of an objective analyst-observer. In

Freud we find two notions of countertransference. In one, the countertransference is linked to the concept of transference (endopsychic, nonhistorical, impersonal, automatic), in which the role of the analyst in the transference of the patient is not considered active.[6] In the other, the countertransference is seen as a tool for analysis: 'the unconscious as a receiving organ', 'using one's unconscious as a tool for analysis', and so forth (on the importance of the analyst's personality, cf. Freud and Pfister, 1909–39; Freud, 1913a). These two notions show two opposite conceptions of countertransference. The first refers to a monopersonal view of the analytic relationship: That is, the unconscious is a tool for analysis, but the analyst must limit himself or herself to performing a receiving function, like a telephone, because if the analyst enters into a relationship of affectionate confidence with the patient, he or she loses the possibility of analysing resistances (Freud, 1912a). The second refers to an interactive view of the analyst-patient relationship based on the premise that "the Ucs. is alive and capable of development . . . subjected to influences from the Pcs" (Freud, 1912a, p. 74), and that "the Ucs. of one human being can react upon that of another, without passing through the Cs" (p. 194). Also remarkable is the comparison of the analyst-patient interaction with the game of chess (Freud, 1913b). Freud was not able to conceptualise this interactive dimension because he was surrounded by a context of irregular conduct on the part of some colleagues, and he had to 'rule over' the phenomenon. Moreover, he was not fully aware of the role of women in society and of the shadows of men in relation to women as dangerous, instinctual creatures who threatened the spiritual, orderly world of men (something which had already been well described by Henrik Ibsen, Guy de Maupassant, Arthur Schnitzler, August Strindberg, Frank Wedekind, and others).

In a letter on December 31, 1911, Freud wrote to Jung that "an article on 'counter-transference' is sorely needed" (Freud and Jung, 1906–13, p. 476). Unfortunately, it was never written. One of the possible reasons for this may be that, as Freud wrote in a letter sent to Ludwig Binswanger, dated February 20, 1913, "The problem of counter-transference . . . is – technically – among the most intricate in psychoanalysis" (Freud, 1908–38, p. 112). In the same letter, it is also possible to discover that Freud was worried about what the analyst might need to do if the obstacle of the countertransference was encountered:

> What we give to the patient should, however, be a spontaneous affect, but measured out consciously at all times, to a greater or lesser extent according to need. In certain circumstances a great deal, but never from one's own unconscious. I would look upon that as the formula. One must, therefore, always recognize one's counter-transference and overcome it, for not till then is one free oneself.
>
> *(Freud, 1908–38, p. 112)*

Freud (1914b) also suggested being wary of the countertransference that might be developing in the analyst, and not abandoning the impassibility that has been reached by restraining it.

Let us now pause to reflect some more about the reasons that may have ultimately convinced Freud of the need for an article on the countertransference. To do this, it is necessary to step back and see what recent events (obviously, in addition to past events) might be the basis of the firm stance of the father of psychoanalysis.

The previous statement taken from the letter of December 31, 1911, to Jung was linked to the story of Mrs. C, a patient who was in treatment with Freud beginning in October 1908, whom he, at a certain point, had tried to refer to Oskar Pfister. Mrs. C, taking advantage of a break in her treatment with Freud, had gone to Zurich to talk to Jung about the condition of her sister. On this occasion she also had the opportunity to complain to him about the reserve and the scarce affective participation of Freud. According to what Freud wrote, Jung's reply to Mrs. C on that occasion was that "I myself was unable, often very much *malgré moi*, to keep my distance, because sometimes I couldn't withhold my sympathy" (Freud and Jung, 1906–13, p. 447). But let us see now what Freud thought about it:

> Frau C – has told me all sorts of things about you and Pfister, if you can call the hints she drops 'telling'; I gather that neither of you has yet acquired the necessary objectivity in your practice, that you still get involved, giving a good deal of yourselves and expecting the patient to give something in return. Permit me, speaking as the venerable old master, to say that this technique is invariably ill-advised and that it is best to remain reserved and purely receptive. We must never let our poor neurotics drive us crazy.
>
> *(Freud and Jung, 1906–13, pp. 475–476)*

Moreover, in the same period Freud was unwillingly about to begin a psychoanalytic treatment of Elma Pàlos. Elma was the daughter of Gizella Altschul-Pàlos, the woman with whom Ferenczi had had an affair since 1904. In July 1911, Ferenczi had decided to take Elma in therapy, even if she was the daughter of his own partner, because of the deep depression in which the young woman had fallen after the death of a friend who had killed himself because of her. From the very beginning (see the letter of July 14), Freud had expressed to his pupil and colleague his own doubts about the possibility that the treatment of a person belonging to one's own personal milieu might take place in a positive way (this might make us smile if we think that in the years 1919–1921 Freud himself would analyse none less than his own daughter Anna). Quite soon, the relationship between Ferenczi and Elma took a nonanalytic direction: In November, the Hungarian analyst confessed to Freud his phantasy of marrying Elma and by December he first admitted that he had not been able to maintain the "cool superiority of the analyst" (letter of December 3) and then that he wanted to marry Elma (letter of December 30). It must be said that, during the whole period in which these events took place, Ferenczi continued his relationship with Gizella; she was aware of what was happening between her lover and her daughter and she had also contacted Freud for advice.

The constant warnings and invitations to caution that Freud gave to Ferenczi, who in the meantime had become engaged to Elma, in the end gave some results:

On January 1, 1912, Ferenczi wrote that "the scales fell from my eyes, and . . . I had to recognize that the issue here should be one not of marriage but of the treatment of an illness" (Freud and Ferenczi, 1908–14, p. 324); he asked Freud to treat Elma, who had accepted this possibility. Considering the situation, Freud felt obliged to accept the referral, hoping that the analysis of the erotic transference and the oedipal complex would prevent the marriage. In the same month, Freud started the psychoanalytic treatment of Pàlos, a tranche of analysis that lasted from New Year's Day until Easter 1912. Even if at that point Ferenczi claimed that Elma's love for him was mostly a transference towards the father, after all, he thought that the analysis with Freud would allow him to marry Elma 'free from transference' because if it is true that the erotic transference was very visible to him by now, the same thing cannot be said about his erotic countertransference. Moreover, it is possible that such referral to Freud concealed Ferenczi's own unexpressed desire to be analysed by Freud. Elma remained in analysis with Freud until April, and in the same month she restarted her treatment with Ferenczi, but this time only to finish the analysis. In the end, Ferenczi married Gizella in March 1919, while Elma married another man.

It should be remembered that erotic relationships between analysts and patients were a very common thing in those years. A direct and raw account of this was given by Wilhelm Reich, a psychoanalyst (who became a member of the psychoanalytic society of Vienna in 1920) who was often accused by many of improper sexual behaviour with his patients. In the course of an interview, Reich (1967) said that during the first years that followed the birth of psychoanalysis there were cases in which psychoanalysts, with the pretext of a medical examination, inserted their fingers in their patients' vaginas. This was a rather frequent occurrence. Some psychoanalysts were hypocritical about such things; they wanted their women patients to believe that nothing was the matter and masturbated them during the sessions. Reich's denunciation is confirmed in the minutes of the psychoanalytic society of Vienna. For example, in the one dated November 3, 1909, Eduard Hitschmann saw as a prejudice (*Befangenheif*) the refusal of Isidor Sadger to perform the 'absolutely necessary' examination of the sexual organs of the women patients who requested psychoanalysis (Falzeder, 1994). In the light of what has been said, one can quite understand Freud's concerns about the public view of psychoanalysis, his passionate defence of it, and his incessant activity in order to prevent his 'creature' from going astray or from running into any judiciary problems.

As Antonio Imbasciati (2007) suggests, it seems that Freud's deontological preoccupation prevailed over the scientific question: what is the meaning of this phenomenon in terms of the analyst's unconscious? This question was dismissed by considering the countertransference (or rather, countertransference enactments) as the analyst's own responsibility, as the consequence of a limited, incomplete analysis. This gave the phenomenon an embarrassing, damaging reputation, thus making a dialogue and exchange with colleagues difficult. As we have seen, however, Freud encouraged his followers to examine the issue in depth, probably seeing it as closely linked to the future of psychoanalysis, recommending that future works related to that issue should be circulated only among experienced colleagues, and

not published: "I believe an article on 'countertransference' sorely needed; of course we could not publish it, we should have to circulate copies among ourselves" (Freud and Jung, 1906–13, p. 476). One should note, however, that some authors (Strachey, 1958; Blanton, 1971) believe that the limited amount of information divulged by Freud showed not just fear of the threat that psychoanalysis might have had to face if the phenomenon of countertransference (here meant as the analyst's falling in love with a patient) had become public, but also, and mainly, reluctance to make the psychoanalytic technique known to patients in specific detail.

Freud already shows his knowledge that the analyst constantly influences the progression of the treatment in his reflections on the case of Dora (Freud, 1905), but it is in *Analysis Terminable and Interminable* (Freud, 1937a) that he not only confirms Ferenczi's (1927b) position in 'The Problem of the Termination of the Analysis', but also goes beyond it and transforms it, acknowledging that the treatment is affected not only by the weaknesses of the analyst, but also by his or her whole personality, by what makes the analyst what he or she is, for better or worse. More precisely, Ferenczi (1927b) expresses his conviction that "analysis is not an endless process, but one which can be brought to a natural end with sufficient skill and patience on the analyst's part" (p. 86), and reaches the conclusion that "when we have gradually learned to take into account the weak points in our own personality, the number of fully analyzed cases will increase" (p. 86). From this, Freud reaches the conclusion that during the analytic process it is indispensable to consider not only the ego of the patient but also the personal characteristics of the analyst as factors that influence the psychoanalytic treatment, facilitating it or making it more difficult.

Notes

1 Sabina Spielrein was admitted to the Burghölzli neurological clinic of Zurich on August 17, 1904, and the doctor who took her on and filled in her file was Carl Jung. Her discharge from the clinic took place in June 1905, but the therapeutic treatment (in which Jung used the psychoanalytic method for the first time) went on for several years, and their extra-analytical relationship lasted until 1910. The Burghölzli was the most important psychiatric clinic in Europe. Jung had been working there since December 1900 as an assistant of Professor Eugen Bleuler, who was famous for having introduced the new term 'schizophrenia', whose underlying concept rejected the merely organismic view of mental illness and distanced itself from Kraepelin's nosographic configuration, embracing the psychogenetic hypotheses of mental illness introduced by Pierre Janet and Freud. Bleuler had been interested in the work of the father of psychoanalysis since he had reviewed his book *Studies on Hysteria* (Breuer and Freud, 1892–95; cf. Bleuler, 1896).

2 Ferenczi was of the same opinion; in a letter sent to Freud on March 22, 1910, he claimed: "There is no doubt that, among those who have followed you up to now, he is the most significant. Too bad he [Gross] had to go to pot" (Freud and Ferenczi, 1908–14, p. 154).

3 In 1905, when he wrote his afterword and published his work, Freud had in mind only the heterosexual dimension of the transference developed by Ida, in which he could only play the part of Philip Bauer or Hans Zellenka; as a matter of fact, he wrote that "at the beginning it was clear that I was replacing her father in her imagination" (p. 118). Freud acknowledged Ida's homosexual link to Peppina Zellenka only many years later, in a note added in 1923: "The longer the interval of time that separates me from the end of this analysis, the more probable it seems to me that the fault in my technique lay in this omission:

I failed to discover in time and to inform the patient that her homosexual (gynaecophilic) love for Frau K. was the strongest unconscious current in her mental life. . . . Before I had learnt the importance of the homosexual current of feeling in psychoneurotics, I was often brought to a standstill in the treatment of my cases or found myself in complete perplexity" (p. 119, n.1). One should note, however, that Freud did not seem to become involved as a 'female' object of his patient's transference; apparently, he had not yet grasped the fact that an analyst, regardless of his or her actual gender, may represent both male and female figures in the transference.

4 Subsequently, under the influence of Jung and the Zurich group, Freud will ask for a personal analysis (Freud, 1912b), and he will suggest different ones for them every five years (Freud, 1937a), keeping the self-analysis (knowing that it alone would be incomplete). It is interesting to know that by 1920 that which had been known as 'didactic analysis' was called 'control analysis' (cf. Eitingon, 1923); basically it was about the discussions and the difficulties that the candidate found on the supervised cases that he or she followed on his or her training (Hinshelwood, 1999).

5 According to Judith Dupont (1989), nephew of Alice Balint (first wife of Michael Balint, a pupil and friend of Ferenczi), this holiday period spent together was disappointing for both of them. Each one wanted to make the other 'fit the mold' of their desires: Ferenczi wanted an exclusive, almost fusional relationship with a friend; Freud was looking for an efficient companion, devoted, attentive, independent, and respectful of his reserve. On the issue of the analyst's reserve, Freud (1912b) claimed that it was necessary not to reveal to one's patient any information about oneself, such as one's private life, vices, or virtues: "The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him" (p. 118).

6 One should remember, however, that in 'Remembering, Repeating, and Working-Through', Freud (1914b) wrote that transference proper, that is, "transference neurosis", is caused by the psychoanalytic treatment (hence transference as an "artificial illness" that appears in the analytic situation, p. 154). It is in this work, probably, that Freud began to give shape to the idea of "the transference as the only working tool", which later became "the transference as a necessary working tool". Also, in 'Observations on Transference Love', Freud (1914a) wrote that the love of the patient for her analyst "is provoked by the analytic situation" (p. 168). Therefore, the transference became the lynchpin for the theoretical modifications that followed. This is not surprising, especially if one considers that in Freud, more than in other analysts, theory is rooted in clinical experience, and the best innovations originate from clinical failures. This process of revision also had an impact (though not explicitly) on the concept of transference itself (cf. Freud, 1937a, 1937b, 1938).

counter-resistance, similar (in type and intensity) to the patient's resistance in the situation. What actually happens to the analyst is the acquisition of a systematic awareness, reached through a continuous self-investigation of the various types of counter-resistance, and the ability to immediately grasp the specific form afflicting him/her in any given moment.

Now we come to the person who probably preceded everyone on the issue of countertransference: Carl Gustav Jung. His clinical experience, accumulated, alongside Bleuler, in his work with psychotic patients at the Burghölzli Clinic, soon gave rise within him to the conviction that the clinician's personality is the basic element of the therapeutic process. The reflections this belief triggered brought him to propose the necessity of training analysis for every psychoanalyst and, above all, influenced his conception of the analytical situation: a bi-personal situation, in which the clinician him/herself is influenced by the patient in front of him/her, and in which the here and now assumes great importance. Thus, this Swiss psychiatrist placed less emphasis on clinical work, with respect, for example, to Freud, on the reconstruction of the patient's past and on the recuperation of representations repressed in the unconscious, in favour of a greater concentration on the treatment of the 'current conflict'. It should also be remembered that Jung modified the psychotherapeutic setting, reducing the sessions to one or two per week, and abandoning the couch in favour of the face-to-face.

It is evident that for Jung the analytic relationship is above all a relationship, in which the patient "will turn to the doctor . . . as an object of purely human relationship" (Jung, 1921–28, par. 286), a partner who exercises an absolutely indispensable influence on the patient, an influence that he "would rather call . . . human interest and personal devotion" (ivi, par. 271). From this, Jung is led to the conclusion that what counts for him in the treatment (whose aim is to enable the process of 'individuation' in the patient) is the flowing together of the personalities of the analyst and the patient, between whom there exists a subtle unconscious relationship. The use of countertransference is crucial, enhanced as it is by the self-awareness reached through the experience of a training analysis and a continuous self-analysis. It is a countertransference that is received and controlled, in that it is a foundation for the transformative reciprocity that characterises analysis. Jung maintained that:

> It is futile for the doctor to shield himself from the influence of the patient and to surround himself with a smoke-screen of fatherly and professional authority. The patient influences him unconsciously none the less, and brings about changes in the doctor's unconscious which are well-known to many psychotherapists: psychic disturbances or even injuries peculiar to the profession, a striking illustration of the patient's almost 'chemical' action. One of the best known symptoms of this kind is the countertransference evoked by the transference. But the effects are often much more subtle, and their nature can best be conveyed by the old idea of the demon of sickness. According to this, a sufferer can transmit his disease to a healthy person whose powers then subdue the demon – but not without impairing the well-being of the subduer.

> Between doctor and patient,[3] therefore, there are imponderable factors which bring about a mutual transformation. In the process, the stronger and more stable personality will decide the final issue. I have seen many cases where the patient assimilated the doctor in defiance of all theory and of the latter's professional intentions – generally, though not always, to the disadvantage of the doctor.
>
> *(Jung, 1929, par. 163–164)*

By means of the acceptance of the doctor's vulnerability – a kind of mediator in the therapeutic process – Jung took a step forward in the development of the concept of countertransference as a fundamental tool towards awareness and participation in the analytic treatment (according to David Sedgwick, 1994, it was precisely Jung who used countertransference for the first time as a therapeutic technique). It is obvious that from this point of view, training analysis becomes necessary for acquiring a knowledge of one's own limits, in order to treat one's own infantile aspects that would risk colluding with some of the patient's necessary work if one considers that: "every treatment that probes at all deeply consists in the doctor's examining himself, for only what he can put right in himself can he hope to put right in the patient. It is no loss, either, if he feels that the patient is hitting him, or even scoring off him: it is his own hurt that gives the measure of his power to heal. This, and nothing else, is the meaning of the Greek myth of the wounded physician" (Jung, 1951, par. 239).

Previously I hinted at the fact that, according to Jung, it is the clinician's personality that represents the necessary therapeutic factor (cf. Stefana, 2016). At this point, it would be interesting to hear what Jung himself had to say. In 1929, he wrote:

> Hence the personalities of doctor and patient are often infinitely more important for the outcome of the treatment than what the doctor says and thinks (although what he says and thinks may be a disturbing or a healing factor not to be underestimated). For two personalities to meet is like mixing two different chemical substances: if there is any combination at all, both are transformed.
>
> *(Jung, 1929, par. 163)*

> [Thus we can say that:] the doctor is as much 'in the analysis' as the patient. He is equally a part of the psychic process of treatment and therefore equally exposed to the transforming influences.
>
> *(ivi, par. 166)*

> [Or again, in 1957:] Fairly narrow limits, however, are set to the psychotherapy of severe cases. . . . The thing that really matters is the personal commitment, the serious purpose, the devotion, indeed the self-sacrifice, of those who give the treatment. I have seen results that were truly miraculous, as when sympathetic nurses and laymen were able, by their courage and steady

> devotion, to re-establish psychic rapport with their patients and so achieve quite astounding cures. . . . But even so one can bring about noticeable improvements in severe schizophrenics, and even cure them, by psychological treatment, provided that 'one's own constitution holds out'.
>
> *(Jung, 1957, par. 573)*

It is to be added that: "The consensus is that Jung was an unusually skilled psychotherapist who took a different approach with each one of his patients according to their personality and needs" (Ellenberger, 1970, p. 681).

Allow me to digress here, in order to point out how close Jungian thought is to that of Ferenczi, who, a few years before, had written: "How many famous doctors owe their successes to the dependable, calm, gentle or even energetic behaviour that they knew how to adopt with their patients? All of us have been able to ascertain how much a similar psychological help, delivered by friendly, stimulating, and benevolent words, or even simply from the doctor's appearance, might have a greater effect on the patient than drugs themselves, even in the case of organic illnesses" (Ferenczi, 1923, p. 187; my translation from Italian version). This shows how much in agreement Jung and Ferenczi were in their endorsement of the vital importance that the analyst, and his way of working, has in the interpersonal relationship with the patient, in terms of the therapy's results.

Purely as a matter of information, I would like to point out that in 1930, William Healy, Augusta Bronner, and Anna Bowers also dealt with the concept of countertransference, even if in a rather cautious manner. According to these authors:

> What is spoken of as 'countertransference' must also be reckoned with in connection with the analytic situation. By this is meant impulses on the part of the analyst to respond to the patient's affective trends. Schilder thinks that there is operative here an important psychological law regulating human relations and that the patient's feelings will of necessity call for complementary ones on the part of the analyst.
>
> *(Healy, Bronner, and Bowers, 1930, p. 444)*

In these same years, Theodor Reik (1932, 1935), having been analysed by Abraham in 1913 (an analysis paid for by Freud, with whom he underwent analysis in 1935), was hard at work on developing the theory of the analyst's 'insight', based on the idea that the clinician must be able to allow him/herself to be surprised by his/her own unconscious. He theorised, in agreement with Freud (1915a), that the unconscious of each member of the dyad was in communication with the other, and therefore that the clinician could gather in this way the unconscious material of the patient. For Reik, the analyst must maintain a receptive attitude towards the material the patient brings, as well as towards his/her own internal voices, and must also pay attention to the correspondences between the two. This provides greater space to intuition than to logical-rational thought, which means being able to trust in the unconscious and allowing oneself to be surprised, convinced that this may lead to an