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Countertransference and the Process of Cure

Curative Factors in Dynamic Psychotherapy

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Countertransference and the Process of Cure

Robert J. Langs

It is now rather well known that countertransference (narrowly defined to mean those primarily inappropriate and pathological responses of a psychotherapist or psychoanalyst that are based on pathogenic unconscious fantasies, memories, and introjects, and related inner disturbances; see Langs, 1976c) was first viewed entirely as an obstacle to the cure of the patient in psychotherapy or psychoanalysis (see Freud, 1910, 1937). Largely as a result of Heimann's (1950) landmark paper, it subsequently was recognized that countertransference reactions, even when restricted to the narrow definition proposed here, could prove useful in understanding the patient, and could therefore contribute positively to the curative process. Eventually, writers on this subject attempted to develop a balanced view of the potentially constructive and damaging effects of countertransference.

In this presentation, I undertake a rather careful study of both the detrimental and the helpful consequences of countertransference. I will concentrate on relatively new perspectives, beginning with a broad conceptualization. I will then offer specific comments on the influence of countertransference on the therapist's selection and use of a given treatment modality, demonstrating its effects in the choice of one of three basic

therapeutic procedures. I will also focus on how countertransference influences the conceptualization of, and therapeutic techniques with, resistances and will briefly indicate how countertransferences shared among therapists and analysts have interfered with the development of a valid conceptualization of the process of cure.

The Process of Cure

Before I take up our main themes, a brief definition of psychoanalysis and psychoanalytic psychotherapy is in order. (Hereafter I will refer to the two interchangeably.) Together, they may be viewed as treatment modalities that take place in a specified setting and under a particular set of conditions. They are geared toward alleviation of symptoms through cognitive-affective insight into unconscious processes and contents, and by means of inevitable positive introjective identifications with a therapist capable of sound management of the framework and valid interpretations. According to this definition, there are two major avenues of cure: one that is object-relational and interactional, involving unconscious identificatory processes; and the other involving the achievement of affectively meaningful, valid cognitive insights. In general, the former tends to be broadly ego-enhancing, whereas the latter entails specific forms of nonsymptomatic adaptive resolutions of specific unconscious fantasy-memory constellations (Langs, 1976a, 1976c).

In the interest of focusing solely on countertransference issues, we must bypass many other issues pertinent to the process of cure, including those contributions that stem from the analyst's essentially sound and valid functioning (his noncountertransference-based endeavors; see Langs, 1976c). It should be recognized, however, that the analyst's contributions always fall somewhere on a continuum; that is, no intervention, attitude, or response of the analyst is ever either entirely pathological or entirely free from a modicum of disturbance. Further, the therapist's inner state and the emergence of countertransferences are consistently under the influence of the patient's communications, and are always but one element of the conscious and—especially—unconscious interaction between patient and therapist: (in that sense, they are products of the bipersonal field; Langs, 1976a, 1978).

Countertransference as an Impediment to Cure

The difficulties that analysts through the years have had in understanding and mastering countertransference are foreshadowed in Freud's (1910, 1937) few terse comments on this critical topic. Freud restricted himself entirely to the detrimental and limiting aspects of countertransference, stating that no analyst could carry an analysis further than his own countertransferences would permit (1910). Much later, he wrote (1937) that analysis was an impossible profession, and briefly

described some of the special stresses of analytic work and the need for occasional periods of reanalysis. Freud noted that countertransferences could interfere with the analyst's function as a model for the patient (a precursor of the writings of those who followed Freud on the influence of countertransferences on the identificatory processes in analysis) and, in addition, commented on the readiness with which some analysts become inappropriately defensive and divert the implications of the patient's material away from themselves.

These few remarks on countertransference stand in contrast to Freud's (1912a, 1912b, 1913, 1914, 1915) more extensive writings on transference. A review of Freud's case histories (1905, 1909, 1918) reveals that countertransference is almost entirely neglected (e.g., in the Dora case, where it is obviously implicit and yet not discussed; see Freud, 1905; Langs, 1976b).

With this background, let us now consider the detrimental consequences of countertransference. Much has been written about the limitations and wide range of negative therapeutic effects that can derive from the therapist's own psychopathology. Virtually any unusual subjective experience of the therapist, or any unsatisfactory or idiosyncratic intervention or behavior, signals the presence of countertransference (Cohen, 1952; Langs, 1974). Far more difficult to recognize are the countertransferences reflected in the therapist's accepted, long-standing,

basic attitudes toward the patient, and in interventions that seem natural and appropriate at first glance. There is therefore a need to review and monitor every therapeutic intervention—and period of silence—for possible countertransference-based influence, and to pay special attention to the patient's responsive material as a *commentary* on each intervention (Langs, 1978). In this approach the therapist examines the indirect, derivative material from the patient for valid unconscious (nontransference) perceptions and responses to countertransference-based communications before addressing distorted, transference-based reactions. Nonvalidation of an intervention is also taken as a sign of countertransference, it being proposed that sound interventions receive Type Two derivative confirmation —i.e., indirect, disguised extensions of the analyst's interpretations in which truly unique and unanticipated realizations appear so that previously disparate material finds new unification and integration (in essence, the intervention generates the emergence of a *selected fact*—a realization that unites previously disparate observations; Bion, 1977; Langs, 1978).

A reevaluation of the clinical psychoanalytic literature reveals that therapists have several major blind spots regarding the detrimental influence of countertransferences. First, therapists fail to recognize the evident pervasiveness of countertransference expressions. Second, they fail to appreciate that countertransference expressions may significantly traumatize patients and result in treatment stalemates and distinctly poor therapeutic

outcomes. Further, countertransferences may serve to "fix" the patient's psychopathology to a degree that virtually precludes insightful cure. At some point, pervasive unresolved countertransferences call for the termination of the therapy. In such cases, termination must be undertaken tactfully and entirely at the behest of the patient's derivative communications, which will consistently include the patient's unconscious realization that therapy is not feasible because of the therapist's disturbances.

Many analysts view countertransference as an essentially intrapsychic process that is sometimes evoked by the patient; in this view, countertransference is generally well-mastered by the analyst and is relatively peripheral to the therapeutic work with the patient except for occasional major interferences or blocks (Reich, 1951, 1960; see Langs, 1976c). Many believe that countertransferences (somewhat less than transferences) belong to the realm of fantasy and are an inner problem of the therapist with only secondary consequences for the patient.

A distinctly different perspective arises when countertransference is viewed as an inevitable, continuous, and essential component of the communicative interaction between patient and therapist (Langs, 1979a). In this view, the therapist's interventions are appreciated not only for their manifest contents and functions but for their full latent implications as well. Thus the pervasiveness of the unconscious component of the analyst's work

comes to the fore, as does the realization of the inevitability of a modicum of disturbance—*inevitable countertransferences* (Langs, 1979a)—in every silence and intervention of the therapist, even when these are essentially sound and valid. Beyond this expected minimum arc more pervasive expressions of the analyst's pathology: *preponderant countertransferences*.

In this characterization, countertransference is part of the actualities of the here and now in psychotherapy: those immediate realities filled with unconscious implications that reverberate with dynamic and genetic aspects for both participants (see Chediak, 1979). Countertransference-based expressions are therefore conveyed through the therapist's conscious and unconscious communications to the patient; the latter are actualities containing both surface and deeper meanings and functions, and their unconscious influence will override any other conscious intention or meaning of the therapist's interventions.

Thus, the detrimental aspects of countertransference are best conceived as critical conscious and—especially—unconscious disruptive communications from the therapist to the patient. These communications are unconsciously perceived and introjected by the patient, generating valid perceptions and introjects which are distinctly destructive and negative. On rare occasions, these processes take place consciously, but the analyst cannot depend on such direct identification by the patient. The psychoanalytic

literature indicates that countertransference is characteristically acknowledged by the analyst only in the presence of a manifest error, or on direct confrontation from the patient. The far more subtle (though sometimes gross) continuous expressions of countertransference, as well as the patient's continuous unconscious introjective and cognitive responses, have been very much neglected.

The analyst's countertransference-based expressions have a multitude of negative effects. On some level, such attitudes and behaviors repeat earlier childhood traumas that contributed to the patient's neurosis and therefore justify and reinforce it. In Racker's (1957) terms, the analyst's actual behavior corresponds to a current pathological introject in the patient, itself derived from intrapsychic factors and earlier traumatic experiences.

Other effects of countertransference include the patient's valid unconscious belief that he and the analyst are alike in some important way (Little, 1951)—another way the patient justifies his neurotic adjustment. This belief also reflects a loss of the essential differentiating gradient that renders the therapist a more mature and integrated object than the patient (Loewald, 1960), thereby interfering with the therapist's serving inevitably as a growth-promoting introject. In addition, in the presence of significant countertransferences, the unconscious and functional therapeutic work will be directed more toward the therapist than toward the patient (Searles, 1975;

Langs, 1976a). At such times, the *designated therapist* becomes the *functional patient*, and both participants in the treatment situation unconsciously engage in curative efforts directed toward the therapist's "neurotic" manifestations. And while some benefit may accrue to the patient when this type of unconscious curative endeavor proves beneficial to the therapist, he nonetheless suffers an interlude during which his own neurosis is largely set to the side. Despite such neglect of the patient's psychopathology, he may experience some degree of symptom alleviation, leading to the false conclusion that an insightful process is occurring.

The problem of establishing criteria, however broad, of junctures at which the therapist's countertransferences have so traumatized the patient and so interfered with the usual process of cure that termination—and possibly referral—is necessitated has seldom been addressed (see, however, Greenson, 1967; Langs, 1976c). The first step in dealing with therapeutic stalemate or regressive reactions in patients who are not responding to therapeutic work is to obtain supervisory consultation. The therapist should simultaneously make extended efforts at self-analysis and, if the problem is of large and fixed proportions, return to personal analysis or therapy. These endeavors are far less destructive to patients than sending them directly for consultation—a measure that modifies the confidentiality of the treatment situation and disrupts the essential one-to-one therapeutic relatedness. As I have shown elsewhere (Langs, 1975b, 1979c), on an unconscious level such

disruptions exert uniformly detrimental effects on the patient and tend to reflect significant countertransference difficulties in the analyst—however shared and common they may be.

It should be recognized, however, that a critical factor in resolving countertransference-based treatment stalemates (and clinical experience indicates that many treatment stalemates *are* countertransference-based) is the therapist's effort at self-analysis as a means of gaining access to the underlying unconscious fantasies on which the countertransference-based reactions are based. At such times, unconsciously and through derivative communications, patients will usually engage in strong therapeutic efforts on the therapist's behalf. By carefully monitoring the patient's material for such efforts, the therapist can rectify countertransference influences while simultaneously analyzing the patient's responsive material.

It is essential, too, that as quickly as possible the main therapeutic thrust be centered again on the patient's illness. All too often, the primary unconscious therapeutic work deals with the analyst's rather than the patient's pathology; this is a serious and detrimental distortion of the therapeutic process. It is well to realize, however, that there are therapeutic interactions which ultimately succumb to the analyst's countertransferences. These can be recognized by persistent evidence of the presence of pathological input from the therapist and from a sensitive monitoring of the

patient's material in that light. Embedded in such material are, as a rule, unconscious directives that would lead the therapist toward an appropriate and necessary termination under these conditions.

With the recent emphasis on the positive potential of countertransference, one must not forget its consistently destructive consequences. There can be no doubt that unrecognized and unresolved unconscious countertransference fantasies exert a continuing detrimental influence on the therapeutic interaction and that they have a wide range of negative consequences for the patient—e.g., pathological acting out, symptomatic crises, and untoward regressive episodes. Unrecognized countertransference is the single most frequent basis for therapeutic failure. It is countertransference, rather than transference (as stated by Freud, 1905; and Bird, 1972), that is by far the hardest part of analysis—and therapy.

The Effects of the Resolution of Countertransference

Having specified the ever-present negative consequences of countertransference, we can now consider the ways in which countertransferences may ultimately contribute to the cure of the patient. As a bridge to that topic, we may briefly reflect on those therapeutic interludes of major countertransference-based expressions, after which the therapist recognizes his or her error (via self-analysis and by monitoring the patient's

derivative material), rectifies it in the therapeutic bipersonal field, and analyzes and works through the patient's reactions to the disturbance so generated. In such work, the therapist gives full credence to the patient's nontransference functioning—his valid unconscious perceptions and introjects of the therapist's psychopathology—by implicitly accepting the validity of such communications and in no way treating them as essentially distorted or inappropriate. Later, the therapist moves on from this valid core to work with the patient's subsequent distortions and the extensions of his reactions from the nontransference to the transference sphere. The latter responses constitute expressions of psychopathology evoked largely by the therapist's countertransferences; when these are both rectified and the patient's responses successfully analyzed, we have one type of therapeutic interlude in which disturbances in the therapist have indeed contributed to the process of cure.

To summarize, the type of therapeutic interlude described above has the following central characteristics:

(1) Countertransference expressed as a technical error—the analyst repeats on some level an earlier pathogenic interaction

(2) Unconscious perception and introjection by the patient (reinforcement of pathological introjects and neurotic maladaptations)

(3) Unconscious communications from the patient reflecting his or her detection of the countertransference problem and, as a rule, unconscious efforts to cure both the pathological introject and the analyst (unconscious reparation by the patient)

(4) Detection and resolution of the countertransference difficulty by the therapist (implicit benefit from the patient's therapeutic endeavors and a shift to constructive interventions that, as a rule, now serve to distinguish the therapist from the past pathogenic figure)

(5) Rectification of the countertransference influence in the therapeutic interaction with the patient

(6) Interpretation and working through of the patient's responses to the total sequence

The most critical factor in this sequence is the analyst's capacity to recover and to rectify the therapeutic situation. Failing that, destructive countertransference influences will continue to prevail. The main curative possibility in this situation lies in the patient's unconscious appreciation of the therapist's difficulties and subsequent mobilization of his or her own therapeutic resources.

In contrast, when the analyst is capable of restoring noncountertransference-based functioning to the point where it overridingly characterizes the therapeutic work, the patient has the opportunity for an

experience—however painful initially—with considerable curative potential. It is this capacity of the analyst to recover and resume valid interpretive work that generates a series of new, constructive introjects in the patient and that provides much-needed cognitive insight.

I must stress, however, that such a sequence includes an interlude during which the analyst's behavior is pathological and destructive (or seductive). And while much is gained by affording the patient an inadvertent opportunity actively to reexperience his or her pathogenic past in the present (Winnicott, 1956), there is nonetheless a significant difference between this type of sequence and one in which the therapist has not behaved pathologically and has maintained both a relatively countertransference-free therapeutic stance and the capacity to manage the therapeutic environment.

While countertransference-based errors are inevitable and reflect the analyst's humanness and limitations, they leave a destructive imprint despite the possibility of considerable ultimate therapeutic gain. This point deserves emphasis since there has been an all-too-ready tendency among analytic writers to accept the type of sequence outlined above as if it were the optimal form—or sometimes, the only possible form—of therapeutic work. There is no sound basis for such a generalization, and a therapist must continue to strive to minimize countertransference expressions and their effects. Therapeutic work that is not unduly traumatic is certainly preferable to

treatment situations in which interludes of major pathological expression and recovery are recurrent.

In perspective, then, the type of sequence described here makes the best of a disturbing interlude during which the most significant therapeutic gain takes place when the analyst has regained optimum functioning. Thus, in such situations it is not the countertransference per se that contributes to the curative process, but rather the therapist's recovery from the countertransference disturbance. Let us now turn to situations in which countertransference more directly contributes to curative effects.

Countertransference and Cure

There are several ways in which countertransference can contribute to alleviating the patient's symptoms. As we shall see, some of these effects entail neither positive introjective identifications with the therapist nor sound cognitive insights. They are based instead on an uninsightful curative process that I will discuss below.

First, as already noted, an appreciation of the unconscious communicative interaction leads directly to the recognition of a modicum of *inevitable countertransference* every time the therapist is silent or actively intervenes (Langs, 1979a). Of importance to the present discussion is the realization that the continuous existence of inevitable countertransference

implies that patients in therapy always—to a greater or lesser degree—feel the pressure of their own pathological introjects and pathogenic past. Therefore, on one important level, their associations and behavior constitute responses to the therapist's unconscious countertransference fantasies; the latter are communicated in derivative form via the therapist's attitudes, interventions, and silences. As a result, every analytic interaction—including valid interpretations—is influenced by countertransference.

It appears, then, that countertransferences are ever-present in psychotherapy and psychoanalysis. They stand high among the inevitable stimuli for the patient's reactions, and are therefore an integral part of the curative process. We can no longer think of psychotherapy as simply based on efforts to interpret the patient's fantasies and communications. These expressions are stimulated by adaptive contexts—precipitants—within the therapeutic interaction—essentially, the therapist's interventions and failures to intervene—to which countertransference consistently contributes. Countertransference is therefore an essential aspect of the curative process, though it must be recognized that a positive outcome of such effects requires their consistent recognition, rectification, and the analysis of the patient's direct and derivative reactions.

Several curative mechanisms are involved in a patient's responses to the therapist's countertransferences. I have already alluded to unconscious

curative efforts directed toward the therapist, which, if successful, lead to ego strengthening in the patient and ultimately to a positive introjective identification with the therapist. When such unconscious curative efforts are thwarted or when the therapist fails to respond to them with a resolution of the prevailing countertransference constellation, however, as a rule there will be an interlude that is quite detrimental to the process of cure. As Searles (1975) noted, the inevitability of offering patients opportunities unconsciously (and quite rarely consciously) to cure the therapist fosters the actualization and reliving of the patient's early childhood efforts to "cure" pathogenic primary objects. Often, such reliving provides an opportunity for a successful resolution of previously pathogenic responses; and thus helps to modify the influence of earlier failures in this regard. It must be stressed again, however, that this type of therapeutic experience must find appropriate limits, so that the treatment does not become the therapy of the therapist, with the negative consequences far outweighing the positive ones. In addition, the therapist must implicitly reveal his or her ongoing struggle against countertransference expressions in order to provide the patient with a critical positive introject; the absence of signs of such a struggle is highly destructive to the therapeutic interaction.

So far, I have discussed the curative potential of countertransference in terms of its ultimately insightful and constructive possibilities. I have stressed the positive potential in the patient's unconscious reactions to

countertransference and have detailed how the cycle of expression, recognition, rectification, and interpretation is actually one dimension of every cure. There are, however, several additional ways that countertransference can lead to symptom alleviation—by contributing to uninsightful symptom relief. Let us now consider these possibilities.

Unresolved Countertransferences and Symptom Alleviation

It is well known that symptoms may be alleviated without insight and adaptive structural change. I propose that all such "cures" are countertransference-based.

In 1958, Barchilon specifically described countertransference cures founded on transference-based patient reactions to the therapist's pathological unconscious need for uninsightful symptom resolution. Such "cures" are based on a wish to please the therapist; to get well because of love or dependency on the therapist to maintain his or her omnipotence, and to acquire—through identification—the therapist's modes of conflict resolution. Some time later, to stress the significant role played by the psychopathology of both patient and therapist in such an outcome, I coined the term *misalliance cures* for this type of uninsightful symptom relief (Langs, 1975a, 1976a, 1976c). More recently (Langs, 1980), I attempted to define some of the specific ways in which countertransferences provide the patient with both

defenses and defensive barriers, as well as with pathological gratifications and superego sanctions, all as a way of providing symptom relief that involves neither insight nor the development of new adaptive resources.

To clarify, countertransference expressions invite both projection and projective identifications of the patient's psychopathology onto and into the therapist. More broadly, this loading of the unconscious communicative interaction with the therapist's psychopathology gives patients an opportunity to place their own, similar disturbances into the therapist, and thereby cover over their own illness with that of the therapist (Langs, 1976a). These projective mechanisms may temporarily relieve patients' symptoms. Quite often in such clinical situations, therapists or their supervisors will find that patients' communications reveal little of their own psychopathology but much of their unconscious adaptive functioning; the therapists' interventions, on the other hand, show evident disturbance.

Finally, countertransference-based interventions tried to stir up aspects of the patient's psychopathology—in addition to the already noted recollections of his pathogenic past and his adaptive resources. On this basis they may provide the patient with an opportunity to work over actively mobilized conflicts, fantasies, and memories—conscious and unconscious—which might not otherwise have been activated. Clearly, such interludes will have little positive effect unless the countertransference is rectified and the

proper analytic work carried out with the patient. It is, however, especially valuable for a patient to experience with the therapist an initial replay of a past pathogenic interaction, his responsive conscious and unconscious fantasies, memories, and introjects, and then to discover the analyst's capacity to recover and be different, while simultaneously analytically resolving the unconscious pathological constellation so mobilized.

Another type of symptom relief occurs when patients react to the therapist's preponderant countertransferences by firming up their own defenses as a protection against the seductive, provocative aspects of the therapist's expressed pathology. As Searles (1959) has so clearly shown, the analyst's expressions of countertransference not only involve pathological sexual and aggressive needs but also constitute unconscious attempts to drive the patient crazy. Such attempts imply an unconscious wish in the therapist for the patient to be the container of the therapist's psychopathology. Thus, patients may mobilize their defenses in order to justify a termination dreaded on any other basis (the therapist is seen as a terrifying object and introject), as a means of taking protective flight from the overwhelming threat contained in the therapist's pathological behaviors and interventions. Such interludes need not be characterized by gross disturbances in the therapist; repeated communication of more subtle countertransference-based expressions may well have the same devastating effects.

Communicative Style and Countertransference

In a recent study (Langs, 1978, 1978-1979), I attempted to demonstrate clinically three types of communicative interactions between patients and therapists. I defined a Type A communicative mode in which illusions and symbolic expression predominate. The patient expresses himself by representing the significant adaptive contexts in the therapeutic interaction, and by conveying meaningful clusters of associations which serve on an indirect or derivative level as a means of expressing pertinent and coalescible responsive unconscious perceptions and fantasies, and their genetic echoes. The therapist in this type of communicative field proves capable of securing and maintaining the ground rules of therapy and the therapeutic environment, and of responding in an essentially interpretive way to the patient's material.

The Type B communicative style is characterized by the use of projective identification and action discharge, and may exist in the patient or the therapist or both. Finally, the Type C communicative mode is identified by the development of impenetrable barriers, lies, and falsifications, and by efforts to destroy meaningful interpersonal links—efforts that may characterize the communications of the patient or the therapist.

A Type A communicative field implies a relative absence of countertransference, restriction to occasional expressions of preponderant

countertransference and the minimum of inevitable countertransference. It also implies the therapist's capacity to recognize, rectify, and interpret the relevant countertransference difficulty and the patient's responsive material.

Therapists who are inclined to the Type B mode of communication, however, usually have extensive countertransference difficulties and consistently tend to projectively identify aspects of their psychopathology into the patient. Often, insight fails to develop. Under these conditions, the patient may experience periods of symptom relief by functioning as a container of the therapist's pathology, by metabolizing or detoxifying the disturbances involved, and by returning these projective identifications to the therapist in some less disruptive, more benign form. In this way, countertransference may foster the development of a capacity for what Bion (1962) has termed *reverie*, an ability to receive pathological projective identifications and properly to manage and reproject the disturbance involved. Again, however, the risk is considerable that the disturbing elements will dominate and that the patient's resources—even on an unconscious level—will fail to meet the challenge, leading to significant regression. Nonetheless, despite the dangers involved, some degree of symptom relief can occur on this basis.

The Type C therapist is also functioning under the influence of significant—and usually preponderant—countertransferences. To the

unsuspecting observer, the pathology often goes unrecognized. Recently (Langs, 1979d, 1980) I proposed that most therapists and analysts present their patients with falsifications of, and barriers to, the disturbing underlying truths within both participants in the therapeutic dyad. I have suggested the term *lie therapist* to describe such therapists in order to emphasize nonmorally the extent to which such therapy is designed to falsify or create barriers against the chaotic truths pertinent to the neurosis of the patient (and secondarily to that of the therapist).

Technically, the countertransference-based interventions of such therapists can be identified through several characteristics: the use of unneeded deviations in the therapeutic ground rules and framework; the use of noninterpretive interventions; and the failure consistently to interpret within an adaptive context that uses the therapeutic interaction as the fulcrum. These deviant responses, many of which are still generally accepted as standard practice, express countertransferences and offer the patient lies and barriers to the truth rather than insight. They may lead to periods of symptom relief by helping patients to seal off their inner disturbance and their threatening unconscious perceptions and introjects of the therapist.

Since the truths of the therapeutic dyad are ultimately terrifying, such barriers provide interludes of welcome relief. But they offer no sense of understanding, they preclude growth and the development of new and

constructive adaptations, and they require consistent pathological reinforcement. The expressed psychoanalytic cliché—the use of psychoanalytic concepts and terms clinically as jargon and as formulations devoid of dynamic interactional meaning—is among the most significant means through which these barriers are erected. In addition, alterations in the basic framework, ranging from unnecessary changes in hours to deviations from neutrality, confidentiality, and the like, serve similarly to seal off chaotic truths and to projectively identify into the patient aspects of the therapist's pathology (as a rule, such interventions function primarily as both barriers and projective identifications). Elsewhere (Langs, 1979c) I have used the term *framework deviation cures* for such uninsightful symptom relief based on alterations in the framework.

Thus, countertransference can mobilize or reinforce the patient's defenses or alleviate the patient's symptoms through the development of shared fictions created to avoid pathogenic truths. Many of these falsifications cover over truths related to the immediate therapeutic interaction, and especially to the therapist's countertransference-based communications. As such, they involve a pervasive denial of the countertransference; often, they prompt expressions of negation and denial in the patient's material.

It should be noted, too, that in these conditions we are usually not dealing with Type A communicative defenses, which ultimately reveal their

own derivative meanings and functions, as well as the material defended against. In a Type C situation, there are relatively refractory and impenetrable nonderivative lies and barriers through which a view of the truth is impossible. These fictions can proliferate for long periods of time, generating an extended situation of lie therapy and, at times, symptom relief based on lie-barrier systems. The detection of these situations requires a careful evaluation of the unconscious implications of the therapist's interventions and a search of the patient's derivative communications for indications of misalliance, falsifications, nonmeaning, and essential nonrelatedness.

In all, then, there are several avenues through which uninsightful symptom relief may develop in response to persistent, inevitable, and noticeably preponderant countertransferences. These formulations help to account for symptom alleviation in nonanalytic psychotherapies and in psychotherapy that focuses on manifest content (a remarkably common occurrence; see Langs, 1979d) or on what I have termed Type One derivatives (attempts to interpret the patient's material through isolated readings of inferences and symbolic implications divorced from the ongoing adaptive therapeutic interaction; see Langs, 1978).

Of necessity, therapists and analysts must work with what I have termed Type Two derivatives (material organized around significant, ongoing adaptive contexts within the therapeutic interaction; see Langs, 1978) for

there to be true, largely countertransference-free, insightful, and positively introjective modes of cure. Even interpretations cast in this mold, however, may be under the influence of significant countertransferences, since the form of an intervention does not guarantee its validity. This leads us to the ultimate criterion of sound, insightful psychotherapy: distinctive, Type Two derivative validation of specific interventions (see Langs, 1978).

Clinical Material

The following clinical vignettes will illustrate and clarify some of the ideas presented in this paper.

Case 1

Mr. A was a young man in psychotherapy once a week with Dr. Z because of periods of depression and difficulties in holding a job. After three months of therapy, in the last session before the therapist was to take an extended winter vacation, the patient began by asking if this was their last meeting before the interruption. He was unsure whether he would continue therapy both because he feared that he was boring the therapist and because he felt somewhat better than he had before beginning therapy. He expressed his need for a woman but felt confused—something in him was trying to come out.

Dr. Z pointed out that this was the last session before his vacation and that Mr. A was talking about quitting, needing a woman, and having difficulty in getting things out—all against the backdrop of his vacation. Mr. A responded that the threat is the vacation and then suddenly mused that his father is the one who is paying for therapy. He guessed that he didn't want the therapist to leave and that he wanted their relationship to be more reciprocal. The patient described his problems with closeness, and then looked at a throw rug on the floor of the therapist's office, stating that it somehow looked like a face. Dr. Z pointed out that the patient had been talking about Dr. Z's vacation and that Mr. A would himself like to leave in response. He added that Mr. A was putting aside his thoughts of closeness by talking about images in the rug.

The patient fell silent for a while and then arose from his chair, walked over to Dr. Z, and shook his hand. Dr. Z suggested that there was something from within Mr. A that was pressing for expression and that by shaking his hand, Mr. A. had changed the way in which they worked verbally. Mr. A stated that he wanted to touch someone and noted that he had never touched the therapist before. He gave the therapist a check and left, describing himself as feeling very confused.

In discussing this session, we might best view the therapist's first intervention as premature and ill-defined. Dr. Z himself felt that he had

identified the most critical adaptive context of the patient's material as his own vacation; he stated that he had been attempting to play back some pertinent related derivatives (see Langs, 1978), especially since the patient showed a major resistance in his thoughts of quitting. In retrospect, however, Dr. Z found the intervention wishy-washy and too general, and felt that he should have waited for the patient to offer more specific derivatives. He also felt that perhaps some overlooked and disruptive interventions on his part in the preceding session or two had contributed to the patient's thoughts of termination.

Despite these subjective and objective qualifications, this particular intervention does not appear to be basically erroneous, since it is a valid effort to play back some important themes related to the known adaptive context of the therapist's vacation, in the therapeutic context of thoughts of prematurely terminating the therapy. Since the intervention is indeed quite vague and indefinite, we might best place it somewhere in the middle of the continuum along which interventions are assessed for countertransference and noncountertransference-based input: it has a distinct mixture of validity and error.

The patient's response appears to be in keeping with this evaluation. His conscious comment that the threat is indeed the therapist's vacation is what I have elsewhere termed a *primary confirmation* (Langs, 1979b) and is of little

value in assessing the psychoanalytic validity of an intervention. The latter must rely on indirect communications from the patient in the form of Type Two derivatives that coalesce to produce a selected fact (Bion, 1962) that lends new and unanticipated meaning to the material at hand.

In some ways, the reference to the father's payment for treatment meets these last criteria for psychoanalytic validity, since it alludes to a number of modifications in the framework of therapy that were never rectified or explored with the patient. These included a major reduction in the therapist's fee at the initiation of treatment and several self-revelations by the therapist which modified both his anonymity and his neutrality. It may well be that these alterations in the framework—along with the rupture in the therapeutic hold created by the therapist's vacation—created doubts about treatment in the patient's mind, evoked his unconscious need to disturb the therapist, and interfered with the patient's own hold on Dr. Z (see Langs, 1979c).

Without allowing the further development of indirect, derivative communication, the therapist intervened a second time after the patient saw the image of a face in the rug. Here, the qualities of prematurity, generality, and accusation are striking, despite the therapist's conscious wish to confront the patient with what he thought was an important resistance. This confrontation disregards the critical role of indirect communication from the patient and may well constitute a pathological projective identification from

the therapist into the patient, based on the former's guilt and sense of disturbance about his vacation.

There is also evidence that among the patient's unconscious fantasies and responses to the therapist's vacation were intensified unconscious homosexual fantasies and needs (cf. his need for a woman), responses that were rendered especially dangerous in the face of the unanalyzed reduction in the therapist's fee. This modification in the framework had made the boundaries of the therapeutic relationship uncertain and had raised questions, expressed indirectly by the patient, about the therapist's management of his own unconscious homosexual fantasies and countertransferences. Thus, there is some suggestion that this second premature intervention—and to some degree, the first comment as well—was designed to create barriers to the emergence of the patient's unconscious homosexual fantasies and perceptions. In all, there is considerable evidence that this second intervention reflects preponderant countertransference, as well as serving as a disruptive projective identification and lie barrier.

It is striking, then, that the patient's handshake some minutes before the end of this session appears to validate the two formulations made here of the therapist's interventions. (In supervision, both assessments were made immediately after each intervention had been described.) The handshake reveals the extent to which the communicative bipersonal field had been

disrupted, the boundaries between the patient and therapist rendered unclear, and action discharge and projective identification fostered in lieu of symbolic communication. It also confirms the evaluation that the therapist's disruption of the patient's communication of his image of the face served as an unconscious directive to reject symbolic Type A communication in favor of either Type B action discharge or Type C barriers.

Once symbolic communication failed, the patient turned to the Type B mode of communication. The result is not only direct physical contact, and gratification for both patient and therapist of the underlying, unresolved, pathological homosexual fantasies, but also a disturbing projective identification of this disruptive homosexual constellation. The physical contact probably served magically to undo the pending separation and to convey the patient's unconscious perception and introjection of the therapist's difficulties in managing both that vacation and the underlying homosexual stirrings in himself and in Mr. A. The avowed confusion with which the patient ended the hour is an interactional product with contributions from both participants.

The patient's reference to his father's paying for therapy is filled with unconscious implications, only one of which I wish to stress: the father is the key genetic figure in this therapeutic interaction. Material from earlier sessions suggested strong latent homosexual conflicts in Mr. A's father and a

powerful latent homosexual overcast to the father-son relationship. Mr. A's father had also shown a relative intolerance for his son's efforts at play and self-expression, and it seems clear that the therapist's preponderant countertransferences unconsciously replayed the patient's pathogenic experiences with his father.

On one level, the patient's sudden handshake may be viewed as an unconscious effort to stress the unrecognized and uninterpreted homosexual fantasies and perceptions. It may also contain a curative wish directed toward the therapist. For the moment, however, the therapist had failed to recognize, understand, and resolve within himself this area of countertransference. In addition, he did not rectify such countertransference expressions in the therapeutic interaction; nor did he accept the patient's unconscious curative endeavor or interpret his other unconscious responses. The handshake therefore constituted a significant repetition of the patient's—and therapist's—pathogenic past, a neurotic vicious circle (Strachey, 1934; Racker, 1957) that would serve only to reinforce the patient's neurosis and his pathological unconscious fantasies, memories, and introjects. The therapist lacked the insight and inner management to turn the situation into a curative experience—as the premature handshake clearly bore witness.

Despite this failing, the handshake may also reflect a mobilization of adaptive resources in the patient in response to the therapist's unresolved

countertransference. This view is supported by material in the hour after the therapist's vacation, in which the patient spoke in some detail of his sexual encounters with women during the previous weeks. The woman with whom he was most involved, however, was too seductive, and he was impotent. Mr. A also spoke of his extensive fears that he would become a homosexual. He had made plans to cancel the next session to be with some friends who were visiting him. He also mentioned that he had begun to paint.

This material, which is of course highly condensed here, reflects the patient's wish for a symbolic communicative space in which he could express and analyze the unconscious aspects of his psychopathology, and his continued concern about the homosexual contaminants that are disturbing the therapeutic relationship. The material does show the mobilization of some adaptive resources but they are ineffectual in the face of the therapist's and patient's unresolved homosexual conflicts.

In summary, then, the therapist's countertransference at this juncture was based primarily on unconscious homosexual fantasies. Their presence afforded the patient an opportunity to experience in the immediate therapeutic interaction aspects of an earlier pathogenic interaction with his father. However, the therapist's failure to identify, resolve, and interpret his countertransference expressions and their repercussions for the patient ultimately led to an interlude of therapeutic failure which culminated in a

form of "acting in" by the patient. Still, on an unconscious level, the handshake can be viewed as an effort to make the therapist aware of his unresolved homosexual countertransference and of the need to resolve and rectify it.

For Dr. Z, the handshake had just that effect: he felt seduced by the patient and wondered if he had contributed, and he felt disturbed because the act had taken place before the actual end of the session. In some way, the handshake may represent a compromised metabolism of the homosexual projective identifications of the therapist, including appropriate and nonpathological aspects as well as inappropriate and unresolved ones. The latter aspects deserve emphasis since the patient was unable to deal with his introjective identification with the therapist through a verbal response; his behavioral reaction indicates a significant failure in containing and metabolizing.

There was some indication in the hour after the vacation that the patient had experienced temporary symptom relief through unconsciously perceiving the therapist as having more significant homosexual pathology than himself. This perception had led to his involvement with several women, though ultimately he became impotent and fearful of both his own homosexuality and that introjected from the therapist.

Case 2

Miss B had been in therapy for several years, because of periods of confusion, depression, and instability in her social life. She had spent most of one session discussing whether she should go out on her birthday with a former boyfriend, T, who had disappointed her of late. She decided to ask him to take her out and to tell him where to take her. A girlfriend of the patient wanted to arrange a blind date, but Miss B felt frightened, wondering if it would be sexual and yet feeling it was crazy to back away, so she would try. She talked too about her need for treatment and her feeling that recently she had been getting something from her sessions; she no longer felt disorganized and crazy and was working on her problems with men.

In the next hour, she spoke of her birthday and ruminated about how she should not feel upset because her boss forgot about it. She had been at a bar, but refused to become involved with a queer-looking man who tried to engage her attention. At another bar, she spoke to a man who turned out to be a marriage counselor, but she thought he was crazy and felt that he was pestering her. She had seen T, who slept with her but berated her for being involved with other men. He accused her of being a tramp, and the patient regretted having told him about her other relationships; she felt he had torn her apart. She then ruminated about refusing to feel guilty and being entitled to have relationships. She wished she could analyze things better.

The therapist intervened and suggested that the patient had analysis on

her mind and seemed to feel that analyzing things was disruptive. He noted that Miss B had alluded to a crazy therapist and to how T had betrayed her confidence. He suggested that she was struggling with her involvement in treatment and with just how intense she wished that involvement to be. The patient said that this wasn't so, adding that the therapist analyzed everything but never explained why she does what she does; instead, he picks things apart. In the past (referring to an earlier phase of therapy, during which the patient paid a low fee and the therapist offered many noninterpretive interventions), she had felt that the therapist was much more involved in her life. Sometimes she would like more of that, but now she feels that she really doesn't need it and that she's doing better. She feels that the therapist is helpful, though at times she is annoyed with him and thinks about how she could hurt him. Still, she doesn't feel depressed at this time and is glad that she has spoken up.

The therapist suggested that the patient had perceived his comment as confusing, adding that this perception was reflected in her reference to an earlier, perplexing period of treatment. Miss B agreed and said that she wanted to stay in therapy but had mixed feelings that were like those she had had at the bars—as if she were both there and not there. When she first came to treatment she felt crazy, but when she stops she won't feel crazy.

In brief, the therapist's first intervention is an attempt to identify

certain ill-defined anxieties and fantasies about therapy and the therapist—an attempt to analyze an unconscious resistance. The comment lacks a specific adaptive context, however, and thus fails to allude to the essential Type Two derivatives—unconscious fantasies and perceptions—necessary for a valid intervention. The intervention is therefore limited to Type One derivatives that lack specificity vis-à-vis the immediate adaptive context, and it does not touch on the convoluted expressions that are the hallmark of neurotic communication.

In addition, the therapist has set aside sexual derivatives in favor of a more deinstinctualized, ill-defined description of the patient's anxieties and conflicts. Such an approach fosters a countertransference-based Type C barrier designed to cover up more specific unconscious sexual fantasies and perceptions related to the therapeutic interaction. Along the me-not-me interface (Langs, 1978)—taking all associations to refer to both the patient ("me") and the therapist ("not me")—this material alludes not only to the patient's sexual conflicts but also to those of the therapist. Similarly, either or both members of this therapeutic dyad may feel threatened and attacked.

In all, then, the first intervention could be placed in the middle of the countertransference-noncountertransference continuum. The therapist makes a valid attempt to identify a resistance and its unconscious basis, but he does not specify its adaptive context and fails to include his own

contribution to the resistance (which is actually an *interactional resistance*; see Langs, 1976a). The central unconscious countertransference fantasies, memories, and introjects appear to revolve around sexual matters and to extend considerably beyond inevitable countertransference.

The patient's responses support these formulations in that they emphasize that the intervention is insufficient. The allusions to the therapist's previous involvement in the patient's life suggest possible current infringements on the boundaries and framework of the therapeutic relationship. The patient even seems to feel hurt rather than helped by the intervention.

The therapist's second intervention introduces the idea that the patient is feeling confused, without such a communication in the patient's material. This intervention falls toward the countertransference-dominated end of the continuum: it has definitive qualities of a preponderant countertransference-based expression. Subjectively, the therapist immediately sensed that he was attributing to the patient his own sense of confusion; in retrospect, he was also able to see that he was diverting the patient from the sexual material. This intervention constitutes a projection (the therapist attributes his experience to the patient) and a projective identification (through this erroneous intervention, the therapist actually confuses the patient, and interactionally places his own confusion—and his use of confusion and

intellectualization to defend against sexual conflicts and fantasies—into the patient). The intervention may also be viewed as the therapist's attempt to create a falsification that will serve as an impenetrable barrier to the underlying sexual material (especially his own) and the apparent chaos attached to it (Bion, 1977; Langs, 1978, 1980).

The patient responds by experiencing this confusion in her own terms; she communicates her introjection of the therapist's physical presence but emotional absence (lack of understanding) in the session. Her closing comments about leaving therapy in order to avoid feeling crazy in all likelihood reflect her struggle against the therapist's efforts to drive her crazy by confusing her. As a *commentary* on the therapist's interventions, then, her response strongly supports the thesis of the presence of significant preponderant countertransferences. The patient's response also reveals her curative efforts directed toward the therapist. In regard to Miss B's neurosis, the therapist's countertransference-based interventions appear to have provided the patient with defenses and barriers, reinforcing her own tendencies along these lines. Such an interlude could be followed by some degree of momentary uninsightful symptom relief.

The patient began the next hour by describing how she felt depressed and burdened. She planned to go to night school and talked of how hard she was working. She described an incident in which she had planned to sell her

present car, which was in need of extensive repairs, and to buy a new one; she had been unable to do so because T had not shown up as promised to take her to the car dealer. Her brother would have taken her. T is uncaring and Miss B should have known. She talked of feeling lonely and let down by her girlfriends, and of lacking goals. T is passive, but she herself lets people take advantage of her; he doesn't know where he's heading, nor does she.

The therapist said that the patient seemed very upset and in a lot of pain. She is talking about people who offer her aid but in the end disappoint her, and of feeling alone and forced to do things for herself—without goals, not knowing where she is going. He added that something more must be stirring up these feelings. After a long silence, Miss B said that the therapist must be talking of therapy. She feels paralyzed and blocked, as if there were a fog in the room between them. She feels that anything she said would be criticized by the therapist, even though she knows this isn't so. Somehow, in the past, when the therapist gave her guidance and talked to her, it was better; now she doesn't know where she's headed and feels no sense of security. Sometimes she feels she doesn't need treatment, but is afraid of leaving—it's like a security blanket. The therapist then said that Miss B was indicating that something in therapy was not satisfying and was evoking feelings of disappointment. The patient responded that it was what she felt in the last session: they hadn't connected and she felt misunderstood.

In this session, the therapist's first intervention took the form of playing back derivatives of the patient's unconscious perceptions and fantasies in an effort to generate surface links and bridges to the therapeutic relationship and to the therapist's specific interpretive failures in the previous hour (Langs, 1978). He had been aware of some of his insensitivities and failings in the previous session—expressions of his countertransference—although he had not defined their relationship to his own sexual conflicts and anxieties. He had struggled to organize the material in this particular session around the adaptive context of his interventions in the preceding hour, and was able to recognize the implications of the relatively valid images of the uncaring insensitivity of the patient's boyfriend, T. He was also aware that the patient's view of T and herself as being alike in their goallessness was a sound and telling commentary on his failure to intervene correctly, and that the patient's depression derived in large measure from her disappointment in him as a therapist. Through his own subjective reappraisal of the unconscious implications of his interventions and a monitoring of the patient's material for valid commentaries on his work, he was able to identify several expressions of countertransference in the preceding hour.

During this earlier session, the therapist had struggled with the decision about whether to remain silent and await clearer, coalescing derivatives, or to play back the derivatives that he had identified. After the hour, he realized that he had again omitted all sexual referents, and that, once he intervened,

he should have mentioned the fact that the patient utilized her boyfriend as a means of conveying her unconscious perceptions and fantasies about himself. He also recognized that the patient was feeling burdened with his problems and that this feeling too might have been pointed out in terms of her experience of the situation. In all, then, Dr. Y felt that he might have suggested that Miss B referred to her boyfriend as a means of describing her feelings toward Dr. Y, and added that this undoubtedly had further implications, as did her sense of being burdened by T's problems. Further self-analysis enabled Dr. Y to identify the general nature of his unconscious countertransference-related conflicts and fantasies. Though the working through had not reached the point of full rectification, progress had been made.

Despite these limitations, the therapist felt that his first intervention in the second hour was essentially sound and valid. I agree and would therefore place this intervention toward the noncountertransference end of the continuum, largely in the sphere of inevitable countertransference, though I would note the fragments of continued preponderant countertransference related to sexual matters. Nevertheless, on the basis of the derivatives in the particular hour (and every session should be its own creation; see Langs, 1976a, 1978), the failure to allude to the boyfriend had less countertransference significance in the second hour than the comparable omission in the preceding hour.

There are clear indications here of the therapist's ability to benefit from the patient's unconscious curative (largely derivative) attempts to alert the therapist to the effects of his craziness, his unconscious seductiveness, and his many unsuccessful interventions. Miss B also directed the therapist to some of the hostile and attacking qualities of his earlier interventions, and through a derivative representing a response to an introjective identification, she clearly expressed the wish for a more effective therapist. Benefiting from his monitoring of these derivative communications and from a period of self-analysis, the therapist was in some measure able to resolve his countertransference; to intervene in a more effective, valid manner; and implicitly to accept and benefit from the patient's unconscious curative efforts. Nonetheless, there is evidence of a residual countertransference—an air of unresolved and inappropriate seductiveness—to which the patient will continue to respond.

The above evaluation finds validation in the patient's immediate reference to the treatment situation after the therapist's first intervention. It is also supported by her many comments about her own sense of paralysis and fog, which convey her unconscious appreciation of the recent interactional resistances generated by her and by the therapist. Her comments about the therapist's failure to provide her with enough guidance may, in this context, be taken to allude to those aspects of his intervention that were unsound, while her reference to using treatment as a security

blanket conveys an effort to desexualize the unconscious therapeutic interaction—a defensive need expressed by both patient and therapist.

The second intervention, however, addresses the manifest content of the patient's material without an adaptive context, and is essentially countertransference-based. The therapist felt the need to respond to the patient's depression, and proved intolerant both of this depression and of the possible appearance of other derivatives. This intervention reflects the return of preponderant countertransference, and the offer of a seemingly reparative comment that will serve to deaden the communicative field and create a Type C barrier.

This relatively rapid reemergence of countertransference-based expressions reflects the therapist's relative failure to master his own psychopathology. In a sequence of this kind, in which there is an expression of countertransference, a period of resolution, and then an upsurge of new expressions of the therapist's pathology, patients are quite likely to suffer and regress, to become depressed, and to experience a sense of failure.

The patient responded to the second intervention by referring again to her sense of dissatisfaction and of being misunderstood in the preceding hour. In the immediate adaptive context of this intervention, her commentary reveals her introjective identification of the therapist's inability to understand

the implications of her present associations. The patient's comment that she felt distant from the therapist is an incorporative introjection of the therapist's use of this last intervention as a means of creating distance between himself and the patient. Thus, his wish to be supportive, however sincere, actually led to an intervention that was experienced either as seductive—thereby requiring a distancing response—or as lacking in empathy and understanding—thereby creating distance rather than implicit support.

While the material in these two sessions is lacking in genetic derivatives, those available from other sessions indicate that the patient had repeatedly experienced failures in empathy in her relationship with her mother, who also was quite intolerant of her sexual needs. It seems likely, then, that the therapist's interventions repeated this earlier pathogenic interaction, which was significant to the patient's borderline pathology and fear of being driven crazy, her depressive propensities, and her difficulties in relating to men. It seems self-evident that as long as the therapist unconsciously behaved in this pathogenic way—as long as he was incapable of any enduring rectification and self-analytic modification of his countertransferences and was unable to interpret them to the patient—the therapeutic interaction would not lead to insightful, introjective identificatory, adaptive inner change.

A more positive, if brief, sequence may be seen in the patient's responses to the therapist's first intervention in this second hour. First, there is the validation of the therapist's silent hypothesis (Langs, 1978) that the patient was unconsciously alluding to her relationship with the therapist. In addition, in the adaptive context of this particular intervention, the reference to things being better in the past can be seen as an affirmation of the therapist's comment. In this context, the allusion to the security blanket has positive connotations (in addition to other meanings discussed above). While the patient's response is certainly a mixed symbolic communication—a *transversal* communication (Langs, 1978)—that embodies both positive and negative elements, it has a distinctly constructive aspect that is lacking in her responses to other interventions.

Unfortunately, the therapist intervened a second time before the patient could continue her associations. We therefore do not know whether the patient would have provided additional communications that would have permitted further interpretation of this unconscious communicative interaction and its genetic components—the essential work that leads to the curative effects of the therapist's inevitable and preponderant countertransferences.

Concluding Comments

This presentation has been an elaboration and clarification of the generally accepted, though often misused, thesis that countertransference in the narrow sense, while detrimental to the process of cure, is nonetheless essential to that very process; that once expressed, it can be significantly modified and ultimately contribute to a positive and insightful therapeutic resolution of the patient's neurosis. It has been necessary to specify, however, that unresolved and repetitive countertransference expressions can destroy insightful therapeutic interactions and generate a stalemated or detrimental therapeutic outcome, significantly fixating the patient's neurotic adaptation so that it becomes virtually unmodifiable. Preliminary clinical indications suggest that these detrimental effects carry over to any new attempt at therapy. Once patients' defenses, barriers, and pathological gratifications have been satisfied by a therapist, they are loath to seek other solutions to their neurosis. Instead, such patients characteristically tend, consciously or unconsciously, to defend their previous destructive therapists and to prefer their own neurotic adjustment to an anxiety-provoking but truthful and sound therapeutic exploration.

The positive effects of analytic work based on the sequence described earlier—that is, a notable countertransference is expressed; then the analyst recognizes it, rectifies its influence, and fully interprets the patient's responses—are now rather well known. Less clearly understood are the important differences between this type of therapeutic experience and those

in which the therapist has not expressed himself through repetitive or preponderant countertransferences. While we can make only a rough estimate, a broad review of the clinical psychoanalytic literature suggests that the sequence in which significant countertransferences play a role is far more common than is usually recognized. In terms of present therapeutic techniques, most ultimately valid therapeutic work appears to take place on such a basis (Langs, 1980), though all too often the countertransference elements are not recognized, rectified, or interpreted.

Countertransference expressions do indeed actively mobilize the residuals of the patient's pathological past and his present psychopathology; they afford an opportunity for living analysis and working through in the here and now. Nonetheless, therapeutic efforts in which countertransferences play a lesser role offer a steady, reliable image of the therapist as a sound container with secure holding capacities—a person capable of genuine, extensive, persistently constructive therapeutic efforts in the face of threat and danger. Such an approach implicitly offers a far more therapeutic image of the therapist and clearer, more viable interpretations accurately developed around the main truths of the therapeutic dyad than does therapy in which countertransferences generate repeated disturbances in both the identificatory and cognitive spheres.

There are, of course, many inevitably traumatic aspects to a sound

therapeutic experience, and to the inevitable expressions of countertransference that arise in the course of the most effective therapeutic work. In the long run, while both courses—those with and without significant expressions of preponderant countertransference—can lead to constructive inner change in the patient, the latter is less risky and less likely to conclude with negative residuals.

Little attention has been paid to the role of countertransferences in noninsightful symptom alleviation. Many therapists accept the criterion of symptom relief as validation of their interventions and as a sign that countertransferences are in abeyance, failing to recognize the pathological means through which such effects may be realized. The present study of countertransferences has been designed to formulate several such avenues of "cure" as a means of promoting their identification in clinical practice.

We may conclude that countertransference is the single greatest hazard to cure, and yet one of the several essential components to insightful adaptive change. Since countertransference is based on unconscious fantasies, memories, perceptions, and introjects, the possibility that the therapist will fail to recognize countertransference expressions is considerable. For this very reason, the monitoring of the therapist's subjective state and the patient's material for countertransference expressions—for their contributions to cure as well as for their interfering aspects—becomes a first-

order requisite for all therapists.

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