
This paper will advance three hypotheses which, as will be shown, are interrelated: (a) in the course of a successful psycho-analysis, the analyst goes through a phase of reacting to, and eventually relinquishing, the patient as being his oedipal love-object; (b) in normal personality-development, the parent reciprocates the child's oedipal love with greater intensity than we have recognized heretofore; and (c) in such normal development, the passing of the Oedipus complex is at least as important a phase in ego-development as in superego-development.

Since I began doing psycho-analysis and intensive psychotherapy nine years ago, I have found, time after time, that in the course of the work with every one of my patients who has progressed to, or very far toward, a thoroughgoing analytic cure, I have experienced romantic and erotic desires to marry, and fantasies of being married to, the patient. Such fantasies and emotions have appeared in me usually relatively late in the course of treatment, have been present not briefly but usually for a number of months, and have subsided only after my having experienced a variety of feelings—frustration, separation-anxiety, grief, and so forth—entirely akin to those which attended what I experienced as the resolution of my Oedipus complex late in my personal analysis—specifically, about five years ago.

As I shall detail later on, with the first few patients toward whom I found myself having such feelings, I reacted with much anxiety, embarrassment, and guilt. My training had been predominantly such as to make me hold rather suspect any strong feelings on the part of the analyst toward his patient, and these particular emotions seemed to be of an especially illegitimate nature. My observations of colleagues' work with their patients, observations made in the course of listening to case-presentations or during informal chats with colleagues about our work or, in the past five years, while doing supervision, strongly suggested to me that these colleagues were not insusceptible to experiencing such feelings themselves. But it was only a rare one who openly acknowledged the presence of them in himself; so I remained, until very recently, largely convinced that I have an unusual propensity for exploiting analytic patients for the purpose of grappling with my own unresolved Oedipus conflicts.

And psycho-analytic literature is, in the main, such as to make one feel more, rather than less, troubled at finding in oneself such feelings toward one's patient. As Lucia E. Tower (12) has recently noted, ... Virtually every writer on the subject of countertransference ... states unequivocally that no form of erotic reaction to a patient is to be tolerated... But in relatively recent years, an increasing number of writers, such as P. Heimann (6), M. B. Cohen (2), and E. Weigert (13), (14), have emphasized how much the analyst can learn about the patient from noticing his own feelings, of whatever sort, in the analytic relationship. Weigert (13), defining counter-transference as empathic identification with the analysand, has stated that
... In terminal phases of analyses the resolution of counter-transference goes hand in hand with the resolution of transference...

In some respects the present paper may be regarded as complementing that by Weigert from which I

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2 Throughout this paper I shall use, oftentimes, the terms 'analyst' and 'analysis' in reference both to psycho-analysis of neurotic patients, and psycho-therapy of psychotic patients. I do this for two reasons: first, I wish to avoid awkwardly repetitious qualifications, and second, I have found that in the relatively late stages of treatment with which I am concerned here, psychotherapy with a psychotic patient gradually takes on the characteristics of psycho-analysis, as the various special conditions which obtained in earlier phases (i.e., non-utilization of the couch; severe limitations to the use of free association and analysis of the transference, and dream-analysis; etc.) diminish and typically psycho-analytic interaction emerges.

have just quoted. These additional passages from her article show her view of countertransference, in the special sense in which she defines it, as being an innate, inevitable ingredient in the psychoanalytic relationship, and they show, in particular, the feelings of loss which the analyst experiences with the termination of the analysis. But I wish to point out that the particular variety of countertransference with which she is concerned here, is evidently that of the analyst's reacting as a loving and protective parent to the analysand, reacted to as being an infant:

There are plausible reasons why in the last phase it is especially difficult to achieve and maintain analytic frankness. The termination of analysis is an experience of loss which mobilizes all the resistances in the transference (and in the countertransference too), for a final struggle. ... 'Recently Adelaide Johnson [(8)] described the terminal conflict of analysis as fully reliving the Oedipus conflict in which the quest for the genitally gratifying parent is poignantly expressed and the intense grief, anxiety, and wrath of its definitive loss are fully reactivated.3 . . . Unless the patient dares to be exposed to such an ultimate frustration he may cling to the tacit permission that his relation to the analyst will remain his refuge from the hardships of a reality that is too competitive or too frustrating for him. By attuning his libidinal cravings to an aiminhibited, tender attachment to the analyst as an idealized parent, he can circumvent the conflicts of genital temptation and frustration.

... the resolution of the countertransference permits the analyst to be emotionally freer and spontaneous with the patient, and this is an additional indication of the approaching end of an analysis.
... When the analyst observes that he can be unrestrained with the patient, when he no longer weighs his words to maintain a cautious objectivity, this empathic countertransference as well as the transference of the patient is in a process of resolution. The analyst is able to treat the analysand on terms of equality; he is no longer needed as an auxiliary superego, an unrealistic deity in the clouds of detached neutrality. These are signs that the patient's labor of mourning for infantile attachments nears completion. ...

In my paper I am stressing the point that before an analysis can properly terminate, the analyst must have experienced a resolution of his countertransference to the patient as being a deeply beloved, and desired, figure not only on this infantile level which Weigert has emphasized valuably, but also on an oedipal-genital level. Weigert's paper, which helped me to formulate the views which I am setting down here, might be put with mine, that is, as expressing the total point that a successful psychoanalysis involves the analyst's deeply-felt relinquishment of the patient both as being a cherished infant, and as being a fellow adult who is responded to at the level of genital love.

The paper by L. E. Tower (12) comes similarly close to the views which I advance here. Unlike Weigert, she limits the term countertransference to those phenomena which are transferences of the analyst to his patient. It is all the more striking, therefore, that she finds even this classically-defined countertransference to be innate to the analytic process:

... It is my belief that there are inevitably, naturally, and often desirably, many counter-transference developments in every analysis (some evanescent—some sustained), which are a counterpart of the transference phenomena. Interactions (or transactions) between the transferences of the patient and the countertransferences of the analyst, going on at unconscious levels, may be—or perhaps always are—of vital significance for the outcome of the treatment. ...

... Virtually every writer on the subject of countertransference ... states unequivocally that no form of erotic reaction to a patient is to be tolerated. This would indicate that temptations in this area are great, and perhaps ubiquitous. This is the one subject about which almost every author is very certain to state his position. Other 'countertransference' manifestations are not routinely condemned. Therefore, I assume that erotic responses to some extent trouble nearly every analyst. This is an interesting phenomenon and one that calls for investigation. In my experience, virtually all physicians, when they gain enough confidence in their analysts, report erotic feelings and impulses toward their patients, but usually do so with a good deal of fear and conflict. ...

In our selection of candidates for training, we are disposed to pay close attention to the libidinal

I was interested to read a second reference, this time by L. E. Tower (12), to this same paper by Johnson. Tower notes that

'... A paper presented to the Chicago Psycho-analytic Society four years ago [namely, in 1951] by Adelaide Johnson touched tangentially on this problem [of countertransference affect] and evoked the most massive anxiety and
countercathexis in the audience I have observed in many years of psycho-analytic meetings. This reaction seemed all out of proportion to the valid objections which could be raised against the argument of the paper.

Johnson's paper, entitled 'Some Heterosexual Transference and Countertransference Phenomena in Late Analysis of the Oedipus', has not been published, and I was unable to obtain a copy of it. But Johnson informs me that some of her more recent concepts about this subject are contained in the paper entitled 'The Incest Barrier', by M. J. Barry, Jr. and herself (1), which I shall discuss shortly.

resources of the applicant, on the theory that large amounts of available libido are necessary to tolerate the heavy task of a number of intensive analyses. At the same time, we deride almost every detectable libidinal investment made by an analyst in a patient. ... various forms of erotic fantasy and erotic countertransference phenomena of a fantasy and of an affective character are in my experience ubiquitous and presumably normal. ...

I have for a very long time speculated that in many—perhaps every—intensive analytic treatment there develops something in the nature of countertransference structures (perhaps even a 'neurosis') which are essential and inevitable counterparts of the transference neurosis. These countertransference structures may be large or small in their quantitative aspects, but in the total picture they may be of considerable significance for the outcome of the treatment. I believe they function somewhat in the manner of a catalytic agent in the treatment process. Their understanding by the analyst may be as important to the final working through of the transference neurosis as is the analyst's intellectual understanding of the transference neurosis itself, perhaps because they are, so to speak, the vehicle for the analyst's emotional understanding of the transference neurosis. Both transference neurosis and countertransference structure seem intimately bound together in a living process and both must be taken continually into account in the work which is psychoanalysis. ...

... I doubt that there is any thorough working through of a deep transference neurosis, in the strictest sense, which does not involve some form of emotional upheaval in which both patient and analyst are involved. In other words, there is both a transference neurosis and a corresponding countertransference 'neurosis' (no matter how small and temporary) which are both analysed in the treatment situation, with eventual feelings of a substantially new orientation on the part of both persons toward each other.

While I was engaged in writing a preliminary draft of this paper, there was presented at the May 1957 meeting of the American Psychoanalytic Association, in Chicago, a paper which is highly relevant to this one. That paper, entitled 'The Incest Barrier', was written by M. J. Barry, Jr. and A. M. Johnson (1). The authors kindly provided me with a copy of it, for my purposes here. In their paper, they set out to elucidate the nature of the incest barrier, both as it exists in the family and as it exists in the analytic relationship. They present evidence that the barrier against mother-son incest is universally and rigorously present, by contrast to a barrier against father-daughter incest which is not universally present in all cultures, and of
which the authors were able to find many cases in our own culture, whereas in their own material they encountered no instance of mother-son incest. In directing especially detailed scrutiny, then, to this especially rigorous incest barrier—that having to do with mother-son incest—the authors present a detailed examination of the terminal phase of the analysis of a male patient by a woman, a situation which they regard as being suited to show us the nature of the mother-son incest barrier. It is in their study of this analytic situation that Barry and Johnson make observations which are of closest relevance to the present paper. Although they do not link the analyst’s feeling-responses, as I do, to her own Oedipus complex, they describe these responses with a candour which I consider courageous and badly-needed; they leave the clear impression that the patient’s experiencing of, and eventual relinquishment of, his oedipal strivings are met, in the analyst, by deeply felt reciprocal responses. The spirit of the paper, as well as its conclusions, are adequately conveyed by the authors’ final paragraph:

A study of the terminal phase of analysis of a patient by an analyst of the opposite sex provides some insight into the nature of the [mother-son incest] barrier. Even after analysis of castration anxiety in the classic sense is meticulously pursued, there still is a deterrent to incestuous genital fulfillment. Sensitive, subtle, and frank examination of this last barrier indicates that it is mutually set up by both participants. It arises from the recognition that there is no compelling desire to bind the participants together in any relationship historically rooted in infantile dependency. There always persists the unconscious memory of the transference dependency. Real maturation and necessary growth derive from renunciation of incestuous goals by both protagonists. Renunciation comes about by recognition of the separate individualities of the protagonists and the deeply felt acknowledgment of mutual love and respect for the individualities concerned. From this separation comes realization of the capacity for feeling loved but unbound. The recognition of one’s capability for being loved when one is not helpless and dependent forecasts the seeking of a new adult love object outside of the analysis.

In presenting now, from my own work, clinical examples of the concepts which I am putting forward here, I shall be brief, and not only because discretion makes it difficult to go into great detail; I think a few brief examples will be quite sufficient for my purpose.

One of my earlier experiences with what I think of as oedipal love in the countertransference occurred in the course of the analysis, several years ago, of a woman in her middle twenties. Initially, she had manifested a poorly-established sexual identity; her femininity was considerably repressed, with an overlay of much penis-envy. But over the course of four years of an unusually successful analysis, she developed

into a woman whom I found very likable, warm, and sexually attractive. I found myself having, particularly during about the last year of our work, abundant desires to be married to her, and fantasies of being her husband. As in each of these clinical instances which I shall recount, there was an abundance of 'carry over' of such responses on my part, into both waking life after the analytic sessions, and into
dreams as well. I reacted to such feelings with considerable anxiety, guilt, and embarrassment; and when the end of the analysis drew near, there occurred an incident, somewhat amusing to me in retrospect, which highlighted how guarded I felt about such responses in my overt behaviour in the sessions. At the end of one of the sessions near the close of our work, she made some statement which feelingly expressed her sense of sadness and loss at the prospect of our approaching separation. I replied with a comment which felt to me, in the making of it, inappropriate; which she reacted to as being inappropriate; and which in retrospect I well know to have been inappropriate: I laughed rather anxiously and indicated to her that I felt, about this coming separation, much as did the Mrs. Gilbreth, of Cheaper by the Dozen fame, whom I had recently seen quoted as having said to her husband, when the youngest of their twelve children was now passing out of the phase of early infancy, 'It surely will be strange not to be waking up, for the first time in sixteen years, for the two-o’clock feeding!' Although I believe my tone conveyed the sense of genuine loss which had been conveyed in Mrs. Gilbreth's own statement to her husband, I noticed that the patient looked uncomfortably startled, and murmured something about thinking she had become older than that. This incident helped me to realize to what an extent I had been continuing, over-long, to highlight her infantile needs and desires—which had been, indeed, legitimately a prominent part of her analysis earlier—in order to avoid frankly seeing how desirable an adult woman she had become, an adult woman who could never be mine.

With her I never became, at this relatively early stage of my analytic career, as free to experience, and openly to allow the patient to see, such feelings, as I have become in more recent years. But she was well enough aware that I had such responses to her, as she let me know before the close of her analysis, when she brought me a magazine cartoon which nicely served to spoof me about having such feelings while acting as though I were interested only in intellectual matters. Repeatedly, since then, I have had comparable experiences in the analysis of neurotic patients, whether women or men, and I have grown successively less troubled at finding such responses in myself, less constrained to conceal these from the patient, and increasingly convinced that they augur well rather than ill for the outcome of our relationship, and that the patient’s self-esteem benefits greatly from his sensing that he (or she) is capable of arousing such responses in his analyst. I have come to believe that there is a direct correlation between, on the one hand, the affective intensity with which the analyst experiences an awareness of such feelings—and of the unrealizability of such feelings—in himself toward the patient, and, on the other hand, the depth of maturation which the patient achieves in the analysis.

As usual, it seems that the analyst’s own inner awareness is the main thing here; when one recommends his doing much along the line of overtly expressing such feelings to the patient, one is on dubious and shaky ground. An analyst who is relatively undisturbed at experiencing such feelings will not make any particular point of expressing them to the patient; and the patient, when he or she has achieved sufficient ability to recognize and accept the analyst as a real person, will sense that the analyst has such feelings and that he is able to cope safely with them.
The schizophrenic patient, with his relatively poor contact with reality, needs oftentimes for the therapist to be more open in frankly expressing his feelings, including those which arise from the particular area which I am describing here, than the analyst who is working with a neurotic patient need ever become. I shall make a few more observations, now, about the work with schizophrenic patients in this regard.

For the past eight years I have devoted the greater portion of my time to intensive psychotherapy with patients suffering from chronic schizophrenia, and I have found that in this kind of work it is more difficult, but even more important, to be able to allow into one’s awareness such responses to the patient as I have been describing, than is the case in the analysis of neurotic patients. That is, it is at least somewhat less disconcerting to find oneself feeling romantically and erotically responsive to a neurotic patient who, late in analysis now, is realistically a desirable marital partner, than it is to find oneself feeling thus toward a schizophrenic patient whom one’s fellows might perceive as being more than anything else, grossly ill and anything but attractive. But, for at least three reasons, I have found it essential to the patient’s recovery that his (or her) therapist be ‘susceptible’ to experiencing such responses to him, and preferably with as little as possible of accompanying anxiety, guilt, and embarrassment.

The first reason is that when the schizophrenic moves, in the course of his therapy, into the phase of the Oedipus conflict, he makes erotic and romantic demands upon the therapist with a tenacity, and an often truly astonishing obliviousness of incest-taboos (and of the realities of his own and his therapist’s life-situations), which require, for their resolution, something different from the therapist than a repression of responsive romantic and erotic feelings and fantasies which the analyst, in working with the neurotic patient who has a relatively strong ego, may be able to get by with. I do not knowingly practise, and am distinctly opposed to, a therapist’s entering into any form of erotic behaviour with any patient, schizophrenic or otherwise, or departing from his basic analytic role by expressing romantic love to a patient. But I have repeatedly found it beneficial, rather than harmful, in the therapy with my schizophrenic patients candidly to allow them to see that they do move me deeply in this respect, when such feelings are genuinely present in me—acknowledging this at times which are appropriate to the interaction of the moment, and acknowledging it in a fashion which leaves me clear in my own mind, even if it is perhaps not yet clear in the mind of the patient, that I remain the therapist rather than becoming the patient’s lover or would-be wife or husband. The beneficial effect of such acknowledgements resides in the investigative freeing-up which they foster—the resolution of what had become a stereotyped situation of the patient’s being absorbed in making incestuous appeals to, or demands upon, the therapist, in a fashion which had been throttling the mutual investigation of the patient’s difficulties. Some acknowledgements do not magically work this result, but they constitute one of the therapeutic measures which are valuable here. When, on the other hand, a therapist dare not even
recognize such responses in himself—let alone expressing them to the patient—the situation tends all the more to remain stalemated at this level.

The second reason why the therapist needs to have much inner freedom in this regard, a reason integrally related with the first one, is that the schizophrenic patient’s abysmally low self-esteem is nourished by whatever emotional responses, whether romantic or erotic or angry or whatever, the patient is able to arouse in his therapist; his self-esteem is too low to tolerate the degree of unconscious denial or repression of feeling which the neurotic patient can tolerate on the part of an analyst. And a third reason is that the intensive psychotherapy of schizophrenia tends so greatly to drive a therapist away in discouragement that any basis for his feeling drawn to his work with the patient, whether an erotic basis or whatever, is precious and to be welcomed as providing a foundation-stone for the further elaboration of a constructive therapeutic relationship.

One of my first experiences, of the sort under discussion here, with a schizophrenic patient, occurred about the end of the second year of my work with a hebephrenic woman in her middle thirties. In the course of one of the therapeutic sessions with this woman, who was mute and dishevelled and whose behaviour was conspicuously bizarre, I was extremely startled to find myself having fantasies of being married to her, fantasies which were accompanied by powerful affects of romantic love. For many months thereafter, on innumerable occasions both during and between the sessions, I found myself feeling similarly about her, oftentimes with strong erotic impulses; and during this period I had at least a dozen romantic-and-erotic dreams about her. I let her know, on a number of appropriate occasions, in response to various communications from her in our hours, that I had such feelings toward her; and on at least two occasions I frankly admitted that I felt jealous in response to her very conspicuously showing a romantic preference for another male therapist on our staff. The subsequent course of her therapy firmly convinced me that my freedom to experience, and even to express to her, such feelings was one essential factor in the relatively successful outcome of my work with this woman who had been, at the beginning of our work, unusually deeply ill.

Another early experience of this sort with a schizophrenic patient occurred in approximately the twelfth month of my work with a 50-year-old, single woman who was suffering from schizophrenia with marked depressive features. Thus far I had seen her to be a drab, colourless, wraithlike individual devoid of any capacity to arouse romantic or erotic feelings in anyone. I was therefore astonished upon awakening, one morning, to remember that I had had a sexual dream about her. From now on I began seeing her with new interest, and it was not long before I began to discern previously-unnoticed little evidences of seductiveness on her part. In the ensuing several months, she progressed to the point where she was so attractively feminine a person that it would not be difficult for any man to think of her in sexual terms, and sexual conflicts which had played an integral rôle in her schizophrenic breakdown came now into the therapeutic investigation. I found every evidence, subsequently, that my sexual dream...
about her had constituted a most valuable landmark in a deepening, and eventually successful, therapeutic relationship.

When experienced toward a patient of one's own sex, such feelings as these are likely to be particularly anxiety-provoking. During my first two years of work at Chestnut Lodge, I was seeing a paranoid schizophrenic man in his middle thirties, a sensitive, highly intelligent, physically handsome man who manifested a gratifying improvement over the course of our work. But after about eighteen months, I began growing uneasy at the intensity of the fond and romantic feelings which I had come to experience toward him, and particularly alarmed during one of our sessions, while we were sitting in silence and a radio not far away was playing a tenderly romantic song, when I suddenly felt that this man was dearer to me than any one else in the world, including my wife. Within a few months I succeeded in finding 'reality' reasons why I would not be able to continue indefinitely with his therapy, and he moved to a distant part of the country. To be sure, he had been voicing a persistent desire to make this move, all through our work together; but I am certain that it was my anxiety about these recently-recognized responses in myself that caused me to find, now, that it somehow made excellent sense for him to leave here.

Subsequently, upon carefully examining the detailed notes I had kept concerning his case, I saw many indications that I had fled from going further, with him, into the exploration of the intense fondness which had prevailed, behind a screen of mutual rejection, between himself and his mother. For many months I had endured from him such sarcasm, scorn, and rejection as he and his mother had characteristically directed at one another; but I was unable to brave the fondness which now came up in the transference.

At that time I had not yet worked through such feelings in my own analysis. Four years later, after the completion of my personal analysis in which I had become relatively at ease about such feelings, in the course of my work with a paranoid schizophrenic man in his early forties I was gratified to find myself able to go ahead constructively in a situation which was much more challenging in this regard than that with the former man had been. This second patient was much more deeply ill than the first, and by ordinary standards so unattractive in his physical person and his mode of dress that it would seem incredibly embarrassing, and even frightening, to find oneself feeling any significant degree of personal attraction toward such an individual. Whereas the first man had been predominantly heterosexually oriented in his sexual history, this man had been exclusively, and very conspicuously, homosexually oriented. My work with him came to involve my exposure to a remarkably intense combination of both poetically tender feelings and sexual feelings (as well as, of course, comparably intense murderousness). After an initial two-year period in which negative feelings seemed clearly to predominate in the transference and the countertransference, I began finding myself feeling surprisingly fond of him, and to be having not infrequent dreams of a fond and sexual nature about him. One morning, as I was putting on a carefully-selected necktie, I realized that I was putting it on for him, more than for any of the several other patients I was to see that day.

He referred to us, now in the third and fourth years of our work, as being married, and at other times expressed deeply affective fantasies of our becoming married.
When I took him out for a ride in my car for one of the sessions, I was amazed at the wholly delightful fantasy and feeling I had, namely that we were lovers on the threshold of marriage, with a whole world of wonders opening up before us; I had visions of going upon innumerable rides with him, going to look at furniture together, and so on. When I drove home from work at the end of the day I was filled with a poignant realization of how utterly and tragically unrealizable were the desires of this man who had been hospitalized continually, now, for fourteen years. But I felt that, despite the tragic aspect of this, what we were going through was an essential, constructive part of what his recovery required; these needs of his would have to be experienced, I felt, in however unrealizable a form at first, so that they could become reformulated, in the course of our work, into channels which would lead to greater possibilities for gratification. And I felt a solid sense of personal satisfaction that I was able, now, to go through feeling-experiences with a male patient which years before, even in much lesser degree than this, would have scared me away.

Not only my work with patients but also my experiences as a husband and parent have convinced me of the validity of the concepts which I am offering here. Toward my daughter, now eight years of age, I have experienced innumerable fantasies and feelings of a romantic-love sort, thoroughly complementary to the romantically adoring, seductive behaviour which she has shown toward her father oftentimes ever since she was about two or perhaps three years of age. I used at times to feel somewhat worried when she would be playing the supremely confident coquette with me and I would be feeling enthralled by her charms; but then I came to the conviction, some time ago, that such moments of relatedness could only be nourishing for her developing personality as well as delightful to me. If a little girl cannot feel herself able to win the heart of her father, her own father who has known her so well and for so long, and who is tied to her by mutual bloodties, I reasoned, then how can the young woman who comes later have any deep confidence in the power of her womanliness?

And I have had every impression, similarly, that the oedipal desires of my son, now eleven years of age, have found a similarly lively and wholehearted feeling-response in my wife; and I am equally convinced that their deeply fond, openly-evidenced mutual attraction is good for my son as well as enriching to my wife. To me it makes sense that the more a woman loves her husband, the more she will love, similarly, the lad who is, to at least a considerable degree, the younger edition of the man she loved enough to marry.

Freud, in his descriptions of the Oedipus complex (3)(4)(5), tended largely to give us a picture of the child as having an innate, self-determined tendency to experience, under the conditions of a normal home, feelings of passionate love toward the parent of the opposite sex4; we get little hint, from his writings, that in this regard the child actually enters into a mutual relatedness of passionate love with that parent, a relatedness in which the parent’s feelings may be of much the same quality and intensity as those in the child (although this relatedness must indeed be of considerably more importance in the life of the developing child than it is in the life
of the mature adult, with his much stronger, more highly-differentiated ego and with his having behind him the experience of a successfully-resolved oedipal experience during his own maturation).

But in the very earliest of his publications concerning the Oedipus complex, namely his volume, The Interpretation of Dreams(3), the first (German) edition of which appeared in 1900, Freud makes a fuller acknowledgement of the parent’s participation in the oedipal phase of the child’s life than he does in any of his later writings on the subject:

'… a child’s sexual wishes—if in their embryonic stage they deserve to be so described—awaken very early, and ... a girl’s first affection is for her father and a boy’s first childish desires are for his mother. Accordingly, the father becomes a disturbing rival to the boy and the mother to the girl ... The parents too give evidence as a rule of sexual partiality: a natural predilection usually sees to it that a man tends to spoil his little daughters, while his wife takes her sons’ part; though both of them, where their judgement is not disturbed by the magic of sex, keep a strict eye upon their children’s education. The child is very well aware of this partiality and turns against that one of his parents who is opposed to showing it. Being loved by an adult does not merely bring a child the satisfaction of a special need; it also means that he will get what he wants in every other respect as well. Thus he will be following his own sexual instinct and at the same time giving fresh strength to the inclination shown by his parents if his choice between them falls in with theirs.' (3pp. 257–8).

Theodor Reik, in his accounts of his coming to sense something of the depths of possessiveness, jealousy, fury at rivals, and anxiety in the face of impending loss, in himself with regard to his two daughters, conveys a much more adequate picture of the emotions which genuinely grip the parent in the oedipal relationship than is conveyed by Freud’s sketchy account, given above. Reik’s deeply moving descriptions occupy a chapter in his Listening with the Third Ear(10). Written at a time when his daughters were twelve and six years of age; and a chapter in his The Secret Self(11), when the older daughter was now seventeen.

Returning to a further consideration of the therapist’s oedipal-love responses to the patient, it seems to me that these responses flow from four different sources. In actual practice the responses from these four tributaries are probably so commingled in the therapist that it is difficult or impossible fully to distinguish one kind from another; the important thing is that the therapist be maximally open to the recognition of these feelings in himself, no matter what their origin, for he will then be in the best position to discern, insofar as is possible, whence they flow and what they signify, therefore, concerning the course of the patient’s analysis.

First among these four sources may be

4 My whole paper is written, purely for the sake of simplicity of presentation, on the assumption that the child’s Oedipus complex is normally a ‘simple’ one, whereas actually we know that it is really a ‘complete’ one, as Freud pointed out in 1923 in the first German edition of his volume, The Ego and the Id(5). He mentioned here that
'... one gets the impression that the simple Oedipus complex is by no means its commonest form, but rather represents a simplification or schematization which, to be sure, is often enough adequate for practical purposes. Closer study usually discloses the more complete Oedipus complex, which is twofold, positive and negative, and is due to the bisexuality originally present in children: that is to say, a boy has not merely an ambivalent attitude towards his father and an affectionate object-relation towards his mother, but at the same time he also behaves like a girl and displays an affectionate feminine attitude to his father and a corresponding hostility and jealousy towards his mother. ... (5pp. 42–43).

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mentioned the analyst's feeling-responses to the patient's transference. That is, when, as the analysis progresses and the patient enters into an experiencing of oedipal love, longing, jealousy, frustration, and loss with regard to the analyst as a parent in the transference, the analyst will experience, to at least some degree, responses reciprocal to those of the patient—responses, that is, such as were present within the parent in question, during the patient's childhood and adolescence, but which the parent presumably was not able to recognize relatively freely and accept within himself. Some writers apply the term 'countertransference' to such analyst-responses to the patient's transference; but I prefer not to do so. The second source consists in the counter-transference in the classical sense in which this term is most often used: the analyst's responding to the patient in terms of transference-feelings carried over from a figure out of the analyst's own earlier years, without awareness that his response springs predominantly from this early-life source, rather than being based mainly upon the reality of the present analyst-patient relationship. It is this source, of course, which we wish to reduce to a minimum, by means of thoroughgoing personal analysis and ever-continuing subsequent alertness for indications that our work with a patient has come up against, in us, unanalysed emotional residues from our own past. This source is so very important, in fact, as to make the writing of such a paper as this a somewhat precarious venture; the author of such a paper must expect that some readers will charge him with trying to portray, as natural and necessary to the analytic process generally, certain analyst-responses which in actuality are purely the result of an unworked-through Oedipus complex in the author himself, which are dangerously out of place in his own work with patients, and which have no place in the well-analysed analyst's experience with his patients.

I surmise that although this source may play a relatively insignificant rôle in the responses of a well-analysed analyst who has conducted a number of analyses through to completion—to a completion deep enough to include a thoroughgoing resolution of the patient's Oedipus complex—it is probably to be found, in some measure, in every analyst. That is, it seems to me that the nature of analytic work presents to the analyst such a peculiarly powerful and conflictual feeling-experience in this regard—a fostering of his deepest love towards the fellow human being with whom he participates in such prolonged and deeply personal work, and a simultaneous, unceasing, and rigorous taboo against his behavioural expression of any of the romantic or erotic components of this love—as to necessitate almost any
analyst’s tending to relegate the deepest intensities of these conflictual feelings to his own unconscious, much as were the deepest intensities of his oedipal strivings toward a similarly beloved, and similarly unobtainable and rigorously tabooed, parent. I believe that our time-honoured horror of such classical countertransference feelings has only served to increase the likelihood of their remaining in the analyst’s unconscious, and I hope that this paper will help analysts—in particular, the less experienced analysts—to a readier awareness, and thereby diminution, of these countertransference feelings, just as I have been helped, in dealing with other kinds of countertransference feelings, by such papers as those written by P. Heimann (6), M. B. Cohen (2), and E. Weigert (13).

A third source is to be found in the appeal which the gratifyingly-improving patient makes to the narcissistic residue in the analyst’s personality, the Pygmalion in him. He tends to fall in love with this beautifully-developing patient, regarded at this narcissistic level as his own creation, just as Pygmalion fell in love with the beautiful statue of Galatea which he had sculptured. This source, like the second one which I have just mentioned, can be expected to hold relatively little sway in the well-analysed practitioner of long experience; but it, too, is probably never absent, and I think it is much more powerfully present, even in analysts of great experience and professional standing, than one may like to think. Particularly in articles and books which describe the author’s new technique or theoretical concept as an outgrowth of the work with one particular patient, or a very few patients, do we see this source very prominently present, in many instances.

The fourth source, based on the genuine reality of the analyst-patient situation, consists in the circumstance that the nearer a patient comes to the termination of his analysis, the more he becomes, per se, a likeable, admirable, and basically speaking lovable, human being from whom we shall soon become separated. If he is not himself a psychiatrist, we may very likely never see him again; and even if he is a professional colleague, our relationship with him will become in many respects far more superficial, far less intimate, than it has been. This real and unavoidable circumstance of the closing analytic work tends powerfully to arouse within the analyst feelings of painfully frustrated love which deserve to be compared with the feelings of ungratifiable love which both child and parent experience in the oedipal phase of the child’s development. Feelings from this source cannot properly be called countertransference, for they flow from the reality of the present circumstances; but they may be difficult or impossible to distinguish fully from countertransference.

There are, then, four more or less powerful sources tending to promote feelings of deep love with romantic and erotic overtones, and with accompanying feelings of jealousy, anxiety, frustration-rage, separation-anxiety, and grief, in the analyst with regard to the patient. These feelings come to him, like all feelings, without tags showing whence they have come, and only if he is relatively open and accepting of their emergence into his awareness does he then have a chance to set about finding out their origin and thus their significance in his work with the patient.
Finally, in line with the considerations which I have presented so far, I shall make a few remarks concerning the passing of the Oedipus complex in normal development and in successful psycho-analysis.

In The Ego and the Id, the first German edition of which appeared in 1923, we find italicized a passage in which Freud stresses that the oedipal phase results in the formation of the superego; we find that he stresses the parents’ opposition to the child’s oedipal wishes; and, lastly, we see this resultant superego to be predominantly a severe and forbidding one:

The broad general outcome of the sexual phase governed by the Oedipus complex may, therefore, be taken to be the forming of a precipitate in the ego ... This modification of the ego ... stands in contrast to the other constituents of the ego in the form of an ego-ideal or super-ego.

... The parents, and especially the father, were perceived as the obstacle to realization of the Oedipus wishes; so the child’s ego brought in a reinforcement to help in carrying out the repression by erecting this same obstacle within itself. The strength to do this was, so to speak, borrowed from the father, and this loan was an extraordinarily momentous act. The superego retains the character of the father, while the more intense the Oedipus complex was and the more rapidly it succumbed to repression (under the influence of discipline, religious teaching, schooling and reading), the more exacting later on is the domination of the superego over the ego—in the form of conscience or perhaps of an unconscious sense of guilt. ... (5pp. 44–5).

I shall not enter into the subject of pre-oedipal origins of the superego, a subject which has been dealt with by M. Klein (9), E. Jacobson (7), and others. My point here is that, aside from that subject, I regard Freud's above-quoted description as applicable more to the child who later becomes neurotic or psychotic, than to the 'normal' child. Since we assume that there is no adult who is wholly free from at least some neurotic difficulties, I assume that Freud's formulation holds true to some degree in every instance. But I believe that to the extent that a child’s relationships with his parents are healthy, he acquires the strength to accept the unrealizability of his oedipal strivings, not mainly through the identification with the forbidding rival-parent, but mainly, rather, through the ego-strengthening experience of finding that the beloved parent reciprocates his love—responds to him, that is, as being a worthwhile and lovable, individual, as being, indeed, a conceivably desirable love-partner—and renounces him only with an accompanying sense of loss on the parent’s own part. The renunciation is, I think, again something which is a mutual experience for child and parent, and is made in deference to a recognizedly greater limiting reality, a reality which includes not only the taboo maintained by the rival-parent, but also the love of the oedipally-desired parent towards his or her spouse—a love which antedated the child’s birth and a love to which, in a sense, he owes his very existence.

Out of such an oedipal situation the child emerges, with no matter how deep and painful a sense of loss at the recognition that he can never displace the rival parent and possess the beloved one in a romantic-and-erotic relationship, in a state different from the relatively ego-dimensional, superego-dominated state which Freud described. This child emerges, rather, with his ego strengthened out of the
knowledge that his love, however unrealizable, is reciprocated; and strengthened, too, out of the realization, which his relationship with the beloved parent has helped him to achieve, that he lives in a world in which any individual’s strivings are encompassed by a reality much larger than himself. My views here represent, I feel, not an attempted contradiction of, but rather a shift of emphasis from, those of Freud; where he stressed that the oedipal phase normally results mainly in the formation of a forbidding superego, I think of it as resulting mainly in enhancement of the ego’s ability to test both inner and outer reality.

All my experience with both neurotic and psychotic patients has indicated to me that, in every individual instance, insofar as the oedipal phase was entered into in the course of their past development, it led to ego-impairment rather than ego-growth primarily because the beloved parent had to repress his or her reciprocal desire for the child, chiefly through the mechanism of unconscious denial of the child’s importance to the parent. More often than not, in these instances, I find indications that the parent would unwittingly act out his (or her) repressed desires in the form of unduly seductive behaviour towards the child; but then, whenever the parent came close to the recognition of such desires within himself, he would unpredictably start reacting to the child as being unlovable, undesirable.

In the cases of many of these parents, it appears that primarily because of the parent’s own unresolved Oedipus complex, his marriage proved too unsatisfying, and his emotional relationship to his own culture too tenuous, for him to dare to recognize the strength of his reciprocal feelings towards his child during the latter’s oedipal phase of development. The child is reacted to as a little mother or father transference-figure to the parent, a transference-figure towards whom the parent’s repressed oedipal-love feelings are directed. If the parent had achieved the inner reassurance of a deep and enduring love towards his wife, and a deeply-felt relatedness with his culture including the incest-taboos to which his culture adheres, he would have been able to participate in a deeply-felt, but minimally-acted-out, relationship with the child in such a way as to foster the healthy resolution of the child’s Oedipus complex. Instead, what usually happens in such instances, I think, is that the child’s Oedipus complex remains unresolved because the child stubbornly—and not unnaturally—refuses to accept defeat within these particular family circumstances, where the acceptance of oedipal defeat is tantamount to the acceptance of irrevocable personal worthlessness and unlovability.

And it seems to me clear enough, then, what this former child, now a neurotic or psychotic adult, requires from us for the successful resolution of his unresolved Oedipus complex: not such a repression of desire, acted-out seductiveness, and denial of his own worth as he met in the relationship with his parent, but rather a maximal awareness on our part of the reciprocal feelings which we develop in response to his oedipal strivings. Our main job remains always, of course, to further the analysis of his transference; but what I have just described seems to me to be the optimal feeling-background in the analyst for such analytic work.
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