The Analytic Encounter

The practice of Jungian psychotherapy consists of two persons meeting in order to try to understand what is going on in the unconscious of one of them. The patient or analysand usually has symptoms, conflicts or other deep dissatisfaction with which he has been struggling by himself in vain, for they seem to be more powerful than any conscious will power at his disposal. He therefore needs help and comes to a psychotherapist. The source of his neurosis, narcissistic personality disorder, borderline state, etc., is hidden from both patient and analyst; together they explore unconscious causes, aims and meanings.

In this work the analyst tends to place much emphasis on dreams, trying to understand them and link them to the patient's life-history and especially to his conscious standpoint. But how does the patient experience this assistance? Who is the analyst for the patient?

If we want to explore the unconscious, it is not only of the utmost importance to investigate what is going on between the conscious situation of the patient and the unconscious responses or compensations depicted in dreams. Sooner or later it will also become important to consider what is going on between the two persons involved in this process. The so-called analytic relationship between the partners is absolutely necessary for a therapeutic process, but some aspects of it further this process and others tend to hinder it. The analytic encounter can become as complex as any intimate relationship. Unconscious fantasies stemming from vital needs tend to arise between the partners. Sometimes they are not intense but quite subtle, and thus escape being noticed at all by either analyst or patient. Yet they may influence the analysis by causing resistances, provoking strong illusions about the analyst or the patient, or tending to sexualize the relationship.

All this is well known by now, and the technical term for
these unconscious projections is transference or countertransference, depending on the direction of the projections.

The analytic relationship, however, is not identical with what we call transference and countertransference. Although there are those who would see all the interactions between analytic partners in such terms, as a matter of fact we also find real human relationship in the therapeutic situation. There are, as mentioned already, many places in the writings of Jung which show that he saw a difference between transference and human relationship in the analytic situation. I consider it of the greatest importance to increase our sensitivity to what is going on between the partners in analysis. Transference can hide itself behind apparently real human relationship; or sometimes what is interpreted as transference is really genuine human relationship. What is the difference between these two attitudes which are called transference and human relationship? What are the implications of these phenomena for the subtleties of the analytic situation?

The purpose of this book is to offer some answers to these questions, but first let us consider what the two pioneers in depth psychology understood by transference.

**Freud’s Views on Transference**

To Sigmund Freud must go the credit for first discovering the phenomenon of transference in psychoanalysis. Together with Josef Breuer, his first attempt to reach unconscious material was by means of hypnosis. In the state of hypnosis the patient could recall memories of early childhood he had forgotten or repressed.

Hypnosis seemed at first to be a perfect new method for getting at psychic trauma; recalling the traumatic event usually had a healing effect upon the hysterical patient. Freud never used hypnotic suggestion. He did not suggest to the patient in his hypnotic state a more positive attitude because he did not want the will of the doctor to influence the patient. Such influence he considered not genuine and of only temporary value, and therefore he used hypnosis purely to get at forgotten childhood memories.

Although it seemed at first to Freud and Breuer that this method was optimal, they found out fairly soon that many patients could not respond to it but resisted the attempts of the therapist to hypnotize them. Thus Freud was led to the discovery that resistance was part of the whole neurotic structure and was connected with the fear of recalling shameful and painful memories. From this insight he developed his theories of neurosis.

But Freud also discovered another cause of resistance to the therapist’s attempts to hypnotize—namely, any disturbance in the relationship between patient and doctor. In his “Studies on Hysteria” (1895), Freud mentions three possible reasons for the disturbance of this relationship. First, the patient may feel that the doctor does not take him seriously enough, or neglects him or ridicules his innermost secrets. It also may be that the patient has heard negative judgments about his doctor or his way of treatment. Second, the case may arise, especially with women, that a patient fears the loss of her independence through falling into a psychic and even sexual dependence on the therapist. As a third cause for a disturbed doctor-patient relationship, Freud mentions the fact that patients tend to get a shock when they discover the “transference” of shameful fantasies onto the person of the doctor.

Here the term transference appears for the first time, and Freud gives the following now-famous example to show what he means by it. After the termination of an analytic session a woman patient of his suddenly felt an intense wish that Freud would give her a kiss. Of course she did not mention it at the time; she was disgusted with herself for having such a thought, and spent a sleepless night. During the next session she was very disturbed and blocked in her associations until she had mentioned this fantasy. Freud tried to find out the cause of this wish-fantasy and came to the conclusion that the source for it was an experience which had happened to the patient many years ago. At that time she had had a talk with a man, during which she had noticed—and repressed—the sudden wish that this man might force a kiss upon her. Now this wish had come up again, “transferred” from its real object to the therapist. In this way Freud found out that unsatisfied or repressed wishes of the past tend to get transferred to a new object, namely the analyst.
At first this new discovery disturbed him, as he saw his method of psychoanalysis getting more and more complicated. But after a while he came to the conclusion that the occurrence of transference had many advantages for the healing process. It reactivated repressed childhood wishes and experiences and thus led to the core of the neurosis. This discovery of transference-love was a shock less to Freud than to his collaborator Breuer, who subsequently gave up psychoanalysis altogether, mainly because he took the love personally and could not bear it.18

Freud continued to study the phenomenon of transference, and more and more came to the opinion that it was in fact necessary for any successful psychoanalytic cure, as he called his therapy. Patients who were not able to fall into transference were not treatable by psychoanalysis. The forms of neurosis which tended to show transference-reactions when dealt with were conversion-hysteria, phobia and compulsion neurosis. These three forms were therefore treatable by classical psychoanalysis, and Freud called them transference neuroses.

Transference onto the therapist of infantile love-expectations, as well as repressed hatred and aggression, was for Freud the condition for successful treatment. On the other hand, it was exactly the transference which seemed, according to Freud, to sabotage quick healing; the original neurosis transformed itself during analysis to a new kind of neurosis, which he called again transference neurosis. In other words, the patient gets tied to the analyst and this dependence can remove him from all personal responsibility. He can feel himself to be the beloved infant of the analyst-father or mother and unconsciously does not want to give up this dependence. The healing of his neurosis would mean at the same time giving up his dependence on the analyst, and therefore he unconsciously refuses to get better. Thus transference can also cause a resistance against the healing process.

What advice does Freud give to the analyst for dealing with this state of affairs? How can the analyst help his patient to overcome this so-called transference-resistance? Here the famous “abstinence rule” comes in. This means that the analyst should not give any emotional response to the demands put upon him by the patient, except for the interpretation of motives. The analyst should remain as cool as a surgeon undertaking an operation.19

This keeping-out of emotional response is, in Freud’s view, for the benefit of the patient; at the same time he mentions that this attitude of objective, free-floating attention is also a protection for the emotional life of the analyst. Why is this cool, unresponsive attitude of the analyst to the benefit of the patient? Because transference is a form of neurosis, a wish to stay dependent on the doctor and not to become independent. Therefore any demand of the patient which is fulfilled by the analyst keeps the patient longer in dependence.

The job of the analyst, then, consists only and purely in interpreting the motives causing this dependence called transference. And the motives behind the transference seem clear to Freud. Demands and wishes whose gratification the patient seeks from the analyst are in reality repetitions of early childhood needs and conflicts. In his relationship to the analyst the patient repeats and relives the love, hatred, aggression and frustration he experienced as an infant in relation to his parents. The interpretation of transference behavior and fantasies consists therefore of showing the patient that his love or hate for the analyst is not something real and basic, that his feelings do not come out of the present situation but repeat former experiences, mostly of early infancy.

These interpretations aim at an important psychotherapeutic process, namely the transformation of repetitions into memories.20 Leading the patient to insight into his early fixations serves the healing aim of becoming conscious and dealing with those difficulties in an adult way. By this means the dependence called transference to the analyst can be overcome.

If we listen to Freud we get a clear-cut theory about the phenomenon of transference: early childhood experiences get transferred to the analyst, and the emotions and feelings involved are only repetitions of the original ones. We also get a technique for dealing with the transference: interpretation of motives with the aim of transforming the repetitions into memories. The abstinence rule forbidding any involvement on the part of the analyst makes sense in this context. The technique of treatment is a logical consequence of the whole
Freudian theory about the psyche and the occurrence of transference.

I think it is important to keep these first observations on transference phenomena in mind. They form a historical framework within which one may better understand Jung's starting-point. And after all there is much truth in them, and they give a valuable and most necessary point of view in any analysis.

The Contribution of C.G. Jung

Freud's straightforward, purely causalistic theory was for Jung too narrow and one-sided. Two main factors seemed to Jung to be neglected in the Freudian view.

First, Freud was concerned only with the cause of transference—he asked what caused this strange dependence, the transference neurosis. Jung thought that transference was an entirely natural occurrence in any relationship, and so it also happens often—though not always—during analysis. It must therefore have not only a cause but also a purpose. He became interested in the question of what meaning the transference might have.

Second, Freud believed that transference was a repetition of repressed childhood experiences. This would mean that only material from the personal life-history, the personal unconscious, would be involved in it. But in such a deep, frequently occurring and important phenomenon as transference, one would expect that archetypal contents from the collective unconscious would also come into play. In Two Essays on Analytical Psychology (1928), Jung describes a case where the dreams of a patient who had an intense transference to Jung showed clearly that unconsciously the analyst meant god, a spiritual, divine being, for her. Jung saw this as a projection of the Self—the archetype of wholeness and the regulating center of the psyche—onto the analyst. The patient was tied to and dependent on the analyst as long as she had not realized the projected content in herself, that is, her own center.41

I think also of a case of mine. The patient came to the analytic hour in an angry mood because the previous week things went wrong for him: a girl whom he seemed to love left him. He was angry with me, his analyst, because he felt that I denied him the pleasure of having and loving a girl, and that therefore fate was bad to him. On the other hand, of course, he knew that I had nothing to do directly with the breaking of his relationship with the girl. All the same, the irrational idea had taken hold of him that I should have intervened in the form of Venus—or at least her son Eros—and shot some love-arrows at the girl at the last moment. The patient did not let this fantasy come to consciousness at first because of its absurdity, but felt only intense anger. He knew that I had nothing to do with this break, that I was only trying, together with him, to find out why girls always left him after a certain time. Nevertheless, he got in a rage about his fate, and took it out on me; he quarreled with me as one quarrels with a god.

At this period the patient was so dependent on me that he always wanted advice for everything, or at least a later absolution once he had done something. There was more in this transference than just an ordinary father-projection, for unconsciously he bestowed superhuman power on me. He also thought that I knew the outcome of everything and was cruel because I did not tell him—for it was clear to him that if I was the master of his fate, I must already know everything in advance. This is only one example to show how archetypal contents may be activated in a transference situation.

Now if unconscious archetypal contents are involved in the transference, it follows that the motives behind the transference cannot be only a repetition of personal life-situations. In the unconscious we find also the seeds of further development, which may be brought to the attention of consciousness and gradually integrated with it. Transference is really a form of projection; in fact, the term transference is just the English translation of the Latin projectio, “projection.” We use the word transference as a technical term for the projections occurring in the patient-analyst relationship. According to Jung, we speak of projection when psychic contents belonging to subjective, intrapsychic experiences are experienced in the outer world in relation to other people or objects. This means we are not conscious that these contents are really part of our own psychic structure.

Some patients, for instance, will quite often say to me such
things as: "I know exactly what you think now, I can feel it—you think that my behavior is terribly immoral, you think that I am just no good," when I am really not conscious of any such thoughts. This kind of criticism is a basic problem for these patients. They are not aware that these judgments take place in themselves, that the negative self-criticism is projected onto the outer world and, of course, onto the analyst. They think that the analyst surely has negative thoughts about them although of course he cannot admit as much—the treatment needs a lot of psychological tricks, and so forth.

Of course, the observation of what contents get projected gives important clues to the analyst, showing in which areas growing consciousness is vitally needed for the patient. The projected contents are not only repetitions uncovering repressed material. New contents of the creative psyche may come up and are experienced first in projection. Thus the inner process of self-realization, the process Jung called individuation, is very often at work behind the specific coloring, contents and forms that a transference shows. This is one of Jung's most important insights into this strange phenomenon. And, of course, from this point of view, dealing with it becomes very complex. Rules and techniques for dealing with transference have thus lost their ground. The Jungian analyst is often faced with most delicate and difficult, yet sometimes rewarding, transference situations.

A Case Example

A twenty-three-year-old, extremely inhibited woman brought after the first analytical session the following initial dream:

I am in a house. There is an elderly man who wants to murder me and cuts open my arteries. I call for help and try to dress the wounds myself. Then I am able to escape and look for a doctor. The man follows me. In the end I am with the doctor, who binds up the wounds.

From her associations it was clear that this persecuting murderer represented an attitude she had experienced from her mother, and which became destructively effective and powerful inside herself. According to her description, her mother was a domineering, pious Catholic who tried from early on to convey to her children that a righteous life is saying prayers and fulfilling one's duties. She was suffering from a nervous heart condition and used this heart trouble for power purposes. If her children or husband resisted her, she fell ill and thus constellated guilt feelings in them.

My very sensitive patient was depressive and showed many of those symptoms which usually arise from a disturbed primal relationship and a lack of primary trust. Her behavior toward her mother had from early on been rebellious, essentially healthy. But her rebellion was invariably followed by guilt feelings and remorse. She then had to apologize to mother and mother forgave generously. Rebellion was a sin which had to be forgiven by mother and later by her father confessor in church. My patient could not of course see the utmost importance of her rebellious impulses and thus could not trust her own feelings. She became more and more cut off from her own nature and increasingly dependent on mother.

Jürg Willi, a Swiss psychoanalyst, says that the child of a mother suffering from a narcissistic disorder has to live from early on with the following paradox: I am only myself if I fulfill the expectations mother has of me. If, however, I am as I feel, then I am not myself. My analyands' unconscious feeling that she had no right to live her own life according to her own nature was expressed in the initial dream by her arteries being cut. In terms of the Jungian model the murderous old man would represent her mother's negative animus, now internalized.

With this problem she came to the doctor, presumably a healthy reaction to her inability to help herself. It seems that after the first hour she felt I had treated her "wound" adequately. Soon an intense and very complex transference developed, characterized by one particularly important incident: One day she brought a dream in which I had given her Jung's book on the divine child. After she had told me this dream, I went to my bookshelf and gave her the book to read. That was my spontaneous reaction, an impulse to which I gave in and which felt all right at the time. Of course, this reaction might be questioned. Some analysts might have preferred to get into her fantasies connected with the divine child and also with the fact that I, the analyst, gave her that book in the
dream. I spontaneously chose the concretization—the acting-out, so to speak—of the dream-fantasy. Naturally I wondered how she was going to react to it and thought there would be time to go into her fantasies in the next session.

The next time she came she apologized in distress that she was just not able to read the book because she hated it from the first line. She added that surely she was just too stupid to understand it, and again apologized. I sensed a mixed reaction within myself. I definitely could spot a feeling of disappointment that this book did not have a better effect on her and that she had to reject something which I thought valuable and therapeutically meaningful. I felt even an impulse of anger. Yet my inner reaction of disappointment and anger was mellowed by her excuses and her self-devaluation.

I thought again of her initial dream, in which the destructive man follows her to the doctor’s office. On the one hand, an important process had started in her unconscious, a process to which the meaningful symbolism of the divine child referred (as I saw also in later dreams). On the other hand, it was also evident that she had begun to repeat with me the pattern of rebellion and forgiveness she had experienced with her mother. It seemed that I, as her analyst, received not only the projection of the helping doctor but also of the murderous animus.

This complicated matters considerably. After all, she had dreamt I gave her that important book. This wish was surely directed at the doctor and had a deep meaning in relation to her inner development. But my giving her the book meant at the same time, to her, that I was saying: Look here, this is what you should read, this should be of concern to you and not something else, this is the way you ought to handle your inner child—all in the critical language that is typical of a negative animus. It was very important for her to revolt against that inner figure, which had become transferred onto me. But rebellion constellated intense guilt feelings and therefore she had to excuse herself again and again. Really allowing herself that rebellion was from one point of view more important than reading the book, therefore I did not go into her resistance to the dream, but interpreted her behavior as a repetition of her rebellion-and-repair pattern. I also remarked that her rebellion was healthy and represented her tendency toward independence. I could see that this interpretation was a great relief to her.

Yet after all, she really had dreamed that I was giving her the book, and I also wanted to talk with her about that. Seen in the context of her dream, everything looked different again. She admitted that at first she had felt more than pleased when I gave her the book. It meant that I was taking her dreams very seriously, as an important part of herself. She also experienced my belief that she would be capable of reading such a book as a great affirmation. Since early childhood, she had had fantasies about a knowing man with experience of life and complete understanding of all her inner turmoils. She said that when she came to the first analytical session, she knew that I was the man of her fantasies—and then immediately added, “But all this is just ridiculous and terribly exaggerated. And anyhow I am much too stupid to read such a book.”

Here you can see how the destructive animus got into action again as a resistance to the doctor and the healing tendencies in herself. In reality her mother had always reproached her with living in the clouds and exaggerating everything and told her that it was high time to become “reasonable.”

It seems to me that in this situation I represented on the one hand the knowing man of her fantasy who understood and supported her inner life—exactly in contrast to her mother. On the other hand, she was always afraid that I would criticize or ridicule her if she exposed herself and that I expected her to be reasonable—just like her mother. Now, if she experienced me as the knowing healer, not reading the book surely had to be seen as resistance to her own inner healing process. But if I represented the negative animus, not reading the book then had to do with healthy rebellion for the sake of her own growth. Her transference thus showed both the repetition of her interactions with the personal mother and the unconscious projection of what may be called the wise healer archetype.

Understanding the complexity of such a transference does not mean that it is necessarily easier to arrive at an adequate therapeutic response. As already mentioned, I interpreted the transference of her mother’s negative animus in a so-called
Transference and Countertransference

The Jungian Model

The following diagram shows the complexity of what is going on psychologically between two persons in the analytic relationship. It is a variation of Jung’s drawing in “The Psychology of the Transference,” inspired by what he calls the marriage quaternio, which he used to illustrate the various relationships between a man and a woman or patient and analyst. For my purposes I have slightly altered his drawing, so that it can serve as a model for all kinds of transference configurations between analysts and patients of the same sex or of opposite sex.

This model is useful in describing what typically happens in a deep analysis. The patient (P) comes for consultation to the analyst (A). P has certain difficulties or symptoms and wants to be free of them, wants to be cured. The analyst might tell him that psychotherapy depends mainly on mutual cooperation between P and A, in contrast to somatic medicine where chemotherapy works by itself or where one has to endure an operation passively. P has to pay a good deal of money for the analysis, and one would assume that he wants to do his best to
help the treatment. If both feel it would be worthwhile to give psychotherapy a try, P and A agree to cooperate and form a conscious relationship to discuss P's difficulties (line a).

This is all very well, but the situation often becomes more complex. The agreement to cooperate was made mainly by the ego of P and the ego of A, but both have their unconscious sides. Suppose the unconscious of P reacts to A (line e). He may look forward to the appointment with A, find that the discussions mean something to him, and feel relieved after the hour and safe in the relationship—or there may be anxieties: he does not like A, hates him for having to talk about disagreeable or painful things, or fears A might make fun of him or reject him if he gets to know shameful secrets. He feels confidence in A, or he mistrusts him. P may fear—especially, but not only, if A and P are of opposite sexes—that he or she might fall in love and become completely dependent on A. This prospect arouses anxiety and may be at the same time a wish. Very often P behaves and reacts to A as he does generally to all persons with whom he has a close relationship.

All this means that P expresses to A more or less intense emotions which belong in general not to A but to the experiences of P. A has therefore the possibility of entering to a certain extent into the unconscious of P by means of so-called active projection (empathy), feeling his way into the emotional and fantasy life of P. A wants, of course, to establish a relationship both to the ego and to the unconscious of P (lines a and e) and thus help P get in contact with his own soul (line d). A cannot in fact interpret a dream or any other aspect of P's life in an effective way without entering into P's whole situation—the conflicts, links and compensations between P's conscious ego and P's unconscious.

Now A too has some feelings as a result of the contact with P. He might find him a nice and valuable person and want to try and help him, or find him a bore, full of superficial nonsense, without the slightest bit of imagination or wit. P may seem to A to be agreeable and good-looking, or coarse, ugly and disagreeable. A gets ideas about the present state of P and about the way he ought to change. For instance, he would just like to shake him out of his passivity; or he thinks that P should finally just have the courage to sleep with a woman; or he thinks that P should dress more nicely and certainly go to a hairdresser. A must always be very careful when that little word "should" comes up. Maybe P "should" be different simply to fit the image that A unconsciously has of him. Or A gives a lot of special attention to P just because P loves and adores him; or P is hardly to be tolerated when he shows disagreeable resistance against A, indicating that A has the need to be loved and adored by his patient; or A is very disappointed when P does not show any improvement through treatment.

In fact the whole diagnosis as well as the interpretations and evaluations of P's material are based on the feelings and perceptions of A. And here we come to the tricky question: Does A really see P in an adequate light? Do A's evaluations, expectations and feelings correspond to the psychic reality of P, or does A project his own unconscious contents upon P (line f)? Who decides about this?

Jung's awareness of this problem was one of the main reasons why he demanded a thorough analysis of the analyst. In fact he was the first to do so, and it was on Jung's suggestion that Freud saw the importance of the so-called training analysis. Now it is compulsory in virtually every school of depth psychology. Theoretically the training analysis lessens the danger of wild projections from the side of the analyst because through it he becomes more conscious of what happens in himself. An increased awareness of his complexes, his weaknesses, his principles of evaluation and his personal standpoint or Weltanschauung is vitally important for his job, for there can be disastrous results if he projects those on P.

Of course, no training analysis, no matter how thorough, can prevent one completely from projecting. There are always blind spots and unconscious areas as long as we live, hence the countertransference, the inevitability that A will from time to time project unconscious contents onto P. Often P's remarks or behavior just hit a soft or weak spot in A; sometimes P has exactly the main complex that A suffers from. But with some effort and honesty they might still work very well together for the benefit of both.

Perhaps one of the most important qualities for A to have is his readiness to question his point of view, his reactions, feel-
lings, emotions and thoughts again and again in new situations, without losing his spontaneity. He must be aware of the constant possibility of projections from his side. For myself, I know that if problems of my patients bother me in an autonomous way, if "it thinks in me" about a certain patient, then I am caught in something I have to work out.

Of course, there is a considerable difference between a conscious concentration on the patient's situation and an uncalled-for preoccupation or fascination with him. The same holds true if A dreams about P. Something has to be worked on then in his own attitude. He may be unconscious about certain trends in P's psyche or in his own concerning the relationship. Also, if a patient dreams about the analyst one has to consider that the dream may reflect not only the projections of P toward A but also sometimes A's real attitude in the analytic situation. A dream criticizing the analyst must be taken seriously in the sense that A has to ask himself if this criticism tells him something about his own attitude and blind spots. For instance, there is the quite frequent dream that P wants to telephone A, but A is not there or the communication gets cut off. Now A has to ask himself if he is really open enough to P, or what attitude he could take for better communication, or at what point communication breaks off. That the lack of communication is very often the central problem of the patient is evident, and one tends to interpret such a dream mainly on the subjective level. But the consideration mentioned first is always very important—namely the question for A of where he stands in the present analytic situation.

All this means that the analytic process really does involve A as well as P. A must be aware of his own power drives, or of his needs to be father or mother, in order to have them under a certain control and to not seek the satisfaction of those needs unconsciously through the analytic relationship. We shall talk about all this (line c) in more detail later.

Now there is one other factor of relationship we have not mentioned so far: the relations between the unconscious of P and the unconscious of A (line b). These are the factors lying in the dark for A, as well as for P. This would be the state of participation mystique or identity which Jung has described. It is the area of common unconsciousness between the two partners. I think it is important for any analyst to know that such areas always exist and to watch out for any glimpses he might get into this matter. For instance, both can fall prey to an archetypal (that is, identify with it), which they then unconsciously act out together.

Take the archetype of the divine healer. In one form or another we always get infected by the plea of the patient for help, and already the healer archetype may be constellated. We want to give help. We may get overactive in suggesting things which should help the patient to feel better—he should paint, do active imagination, leave the job where he has difficulties, move away from his mother, etc. Things should move, our suggestions should initiate an improvement in the patient's condition—then we can feel ourselves being helpful in a therapeutic way. Sometimes this may even work; often it does not, and disappointment is the result. The analyst may blame the patient for not having the right attitude toward therapy, or he may despair about his own capacities as an analyst. The feeling is that he just does not know how to help this patient.

Now, any Jungian analyst knows that it is not his job to heal. Help can come only through a transformation of the patient's attitude, through his coming into a right relationship with his unconscious. But once the analyst is caught unconsciously by the healer archetype, this knowledge may be used overzealously and with premature timing. The emotional need to help wants an outlet.

In mythology the archetype of the healer is depicted in the image of Asclepius and often also of his father, Apollo. Now, Apollo is associated with the muses, with artistic and spiritual creativity, with the oracle; but he is also the shooter of arrows. His arrows can heal, but they can also wound and kill. The overactivity of an analyst when he is caught in the healer archetype reminds me sometimes of the arrows of Apollo. He has to shoot interpretations, suggestions and advice at the patient to fulfil his own need to help and heal. The result cannot be foreseen. For the patient, it may seem as if his plea for help is met by demands from the analyst—he should do this, and that, in order to feel better. These arrows into his wound may do the trick. The energy of the healer archetype can induce him to meet these demands; he may feel some
initial results, and a fruitful process may get started. But the demands may, for instance, also touch a difficult father complex which is unconscious. All the patient feels then is his inability to meet the demands and advice of the analyst. This can put him into despair about himself or cause great resistance to the analyst. And there is mutual despair—the patient feels he cannot get help, and the analyst feels he cannot help him. Sometimes there are helpful dreams in such situations, but by no means always, especially if the patient is resisting.

The problem may be that the analyst is unconscious of the impact his therapeutic enthusiasm has on the patient. That is why it is generally important to watch out for how the “demands” of classical Jungian analysis—writing down dreams, keeping a diary, painting, etc.—are experienced by the analysand. But if things get stuck this way, there is still the possibility of realizing their mutual participation in the healer archetype. Frustrations and bad experiences can lead the analyst to some insight as to why the patient seems unable to accept and make use of his help. Going into this question with the patient may also reveal his father complex, which was constellated and transferred to the analyst as a result of the analyst’s demands. The analysis of childhood material may then become of foremost importance: experiences which are related to the father have been transferred to the analyst and can therefore get analyzed to a certain degree.

All kinds of mutual influences and seductions can take place in an area of mutual unconsciousness. The “mother-child” or “father-child” relationship is very often acted out unconsciously. The analyst’s need to mother may induce a dependent childlike attitude in the patient, and vice versa. Often the patient seduces the analyst to be overprotective—to take special care, to worry about the patient’s exams, etc.—but it may also be the other way around. In this area there can be a kind of fusion between the unconscious needs and fantasies of analyst and analysand. The patient may have a dream showing the exact psychic situation of the analyst. Or the analyst may have a sudden, “irrational” anxiety attack concerning the patient and contact him by telephone, thereby preventing a suicide attempt. Telepathic and synchronistic events between the two are based also on this constellation.

Does Transference Influence Dreams?

It was Jung’s view that dreams are autonomous, spontaneous events which cannot be influenced directly. Freudians are generally of the opinion that transference influences dreams to a high degree—that the wish to please the analyst may produce dreams which the analyst likes or expects and which are in line with his or her views and concepts. In consequence, there would be “Freudian” or “Jungian” dreams, according to the standpoint of the analyst.

As far as I know there is no evidence that dreams are produced just because the analyst likes a special kind of dream. But it is true that through analysis dream contents and dream actions often change. As soon as we are in analysis, the contents of the analytical discussions are also conscious preoccupations to which the unconscious reacts accordingly. It is also a fact that we consciously know the dreams will be discussed with the analyst. We somehow do not dream only for ourselves anymore. This conscious knowledge has an impact on our dream life. Dreams are therefore very often messages to the analyst.

All this seems fairly obvious. Now the question is, whether the unconscious fusion between patient and analyst, referred to above, also influences the content of dreams. I think we cannot deny this possibility. And that would mean that dreams could unconsciously be induced by the analyst. I want to give you an example.

In a psychiatric hospital I treated a twenty-five-year-old woman who suffered from a serious condition due to an extremely negative influence from her mother. She showed all the symptoms which Erich Neumann describes in connection with a disturbed primary relationship between mother and child.29 Basically she felt that she had no right to live, she did not belong to the human race, everybody despised her, and God did not allow her a better fate than to be punished. Of course she transferred or projected all these contents also onto me, feeling that I despised her, made fun of her and rejected her. She could not bear it when I looked at her, as she felt herself to be terribly ugly, and often she would hardly talk because she felt that everything she said was stupid and that I
would reject her even more. To the tenth session she brought
the following dream:

I am in a large room. We are about ten girls waiting for
therapy. Dr. Jacoby enters and questions us all to find out who
knows anything of the meaning of the name J.S. Bach. A girl
says something about Isis and Osiris. Consequently Dr. Jacoby
chooses this girl and goes out with her.

Elsewhere I have examined this dream in detail, but in
connection with our question of whether the analyst can un-
consciously induce dreams of patients, there are some striking
facts. The patient had heard in the hospital that I was very
interested in music and that I had been a professional musi-
cian. She herself was musical to some degree and liked to play
the piano. Her whole striving at that time was to be loved and
accepted by me, but she had the constant fear of rejection and
the belief that God or fate would not allow her to be loved
and accepted. She was hardly aware of me as a human part-
ner but had already built me into her complex-world of want-
ing to be loved but being rejected. Now she dreams about J.S. Bach, about something which concerns me very deeply.

On her side, the dream might reflect an unconscious at-
ttempt to get really close to me. Bach is in reality my favourite
composer. His music is profoundly religious, and he expressly
wrote his works for the glory of God only. His fugues, works
of genius constructed in accordance with strict laws, can bring
about in a listener the experience of timeless bound to
time, in the same way that the mandala seeks to represent the
transcendent through geometric order. Psychologically speak-
ing, Bach's fugues may be seen as symbols of wholeness.
There is another most meaningful detail in this connection.
In the dream the analyst asks about the meaning of the name
of J.S. Bach. Now, Bach used the letters of his name, B A C H, as
a basic theme for one of his fugues. He died when he was
working on this very fugue, based on the theme made out of
the letters of his name. (In English: b-flat, a, c, b; in German:
B, identical with b-flat, H with b.) His lifework was com-
pleted. These are most impressive connections, none of them
known to the dreamer.

But further: a girl in the dream answers "something about
Isis and Osiris," and that does seem to be the right answer.
The patient's association to Isis and Osiris was Mozart's
"Magic Flute." It happens that Mozart, next to Bach, is my
favourite composer. His "Magic Flute" is mainly concerned
with the overcoming of the power of the dark goddess—the
central problem of this patient. Erich Neumann has published
an interesting psychological interpretation of the libretto of
Mozart's "Magic Flute." As mentioned before, I had viewed
this girl's symptomatology and life-history in light of Neu-
mann's work on disturbances of the primary relationship, so
Neumann was very much in my mind in connection to her. In
the "Magic Flute," the Queen of Night wants to use her
daughter Pamina to murder Sarastro, the priest of light,
in order to bring the solar circle under her whip. "The vengeance
of hell" is boiling in her heart, the subject of her famous aria.
But through her daughter Pamina's strong love for the prince
Tamino, which first has to hold true in the test of fire and
water, the girl is liberated from the power of her vengeful
mother and is initiated into the cult of Isis and Osiris.

All this was of course very far from the patient's conscious-
ness. For her, it was only important that in the dream I chose
not her, but the girl who knew about Isis and Osiris, the one
who knew the right answer; this was proof of how I rejected
her. But taking the dream on the subjective level, the girl who
knew about Isis and Osiris was a part of herself, which in
reality was projected onto her sister. Her sister was an artist,
and my patient felt that she herself had always been in the
shadow of her gifted and beautiful sister, toward whom she
had intense feelings of both admiration and envy. But accord-
ing to the dream, this "sister" was also in her: it was that
positive artistic and imaginative part of her which had found
contact with me and touched me.

I was truly moved by that dream—somehow it could also
have been a dream of my own in connection with that patient.
She had dreamed about something which really concerned
me, not only in relation to her but also in a general way. As a
matter of fact, the dream really belonged to us both, although
she was not yet in a position to understand its impact. And
how on earth did she come to have such a dream? I can only
speculate that it must have been born in our area of mutual
unconsciousness. I had not been quite conscious of the extent
to which the fate of this girl had already gotten under my skin. Whether it was her dream or mine, it contained a message of very deep meaning, which I could of course grasp better at that moment than she could, and which gave me an inner direction for the analysis.

It seems obvious that this dream would not have happened if this woman had not been in analysis with me. That she had a deep wish to please me and to be accepted is clear also. The astonishing fact is only the extent to which her unconscious grasped my own wavelength in dimensions which were far away from her consciousness. The dream had been **constellated**, as a Jungian would say, by the analytic encounter. And "constellation" means of course that she had this dream not only for the sake of pleasing me. To look at it that way would be a "nothing but" attitude. I had to consider it as referring to aspects of herself which began to be awakened through the relationship with me. As a matter of fact, this dream was an initial dream, and its contents were slowly realized in the course of the analysis.

### Transference, Identity and Projection

The preceding section illustrates quite well what can happen due to the unconscious connection between analyst and analysand (line b in the diagram on page 25). Unlike a conscious communication between one specific, personal ego and another distinctly separate one (line a), the unconscious connection indicates a state of identity or fusion, a oneness of the two.

In analysis this connection is called transference-countertransference, but any strong emotional tie involves this same state of what Jung calls **participation mystique**. The other person is a part of myself and the other way around. The sexual drive, wanting to unite with the other person (becoming "one flesh," as the Bible says), is the concrete physical side of this experience. It illustrates the basic human need to fuse with another person. The moment of orgasm, if fully experienced, brings a loss of ego-control and therefore a temporary loss of identity. Behind symptoms of impotence or frigidity, therefore, there is very often anxiety about giving up ego-control, of losing one's identity to one's partner and being at his or her mercy.

In any essentially healthy relationship, and often in analysis, the feeling-tones associated with this kind of identification are agreeable. But we can readily observe partners with strong emotional ties whose aim seems to be to destroy each other. This is popularly known as a "love-hate relationship." Edward Albee in his play "Who's Afraid of Virginia Woolf?" gives a startling portrayal of this kind of tie.

I know of one marriage, for instance, in which the destiny of each partner seems to be to inflict psychic torture on the other. Any objective outsider with sound reasoning would say that divorce would be the only way out. But if the husband leaves for a business trip of even two days—which happens not too often—he telephones his wife and complains of loneliness without her. He does not know how to spend an evening on his own. At one point the wife complained that she could not live with this man any more—if only she could have a few days' somewhere away from him! The opportunity for a vacation in the southern part of Switzerland came. She was with good friends—but the next morning she was lying in bed crying because her husband was not there and she missed him so much.

There also exist destructive friendships between persons of the same sex or business relationships of a competitive kind involving strong emotional ties between people who hate each other. The partners actually seem to need each other in order to act out their aggressive and destructive impulses.

It is because of all these complications that human relationships are so difficult. Working at a relationship problem consists of trying to become conscious of one's own part in the game. From the point of view of ego-consciousness, these complications are projections of what is going on down below. This means that as soon as the first glimpse of awareness, or a slight feeling of unreality, enters the mind of one of the partners, the state of complete identity begins to break down and it becomes possible to differentiate the projection of certain unconscious contents. This often first takes the form of disappointment in the behavior of the partner: he or she does not behave, act, or feel as we thought.
For instance, a young couple may be very much in love. They are one soul and one body and everything is just wonderful: for them it is an experience of heaven. Now if you come and say, "You feel that way only because you project an unconscious side of yourself," you psychologize the relationship in a destructive way. Why should these young people not have the important experience of paradise through fusion? The couple would either be angry at you or would laugh at your psychological explanations and decide that you don't have the slightest clue about what real love means—and rightly so.

Unfortunately, sooner or later the honeymoon comes to an end. One partner starts to suffer because the other does not fulfill certain expectations, and problems arise. Now it might be possible to talk about expectations and show which of these have to do with a projected animus or anima image—and only now can we properly talk of projection. The process of taking back the projections enlarges consciousness and results in a state of individual separateness. The two partners may then relate on a different level, recognizing and accepting the other's individual strengths and weaknesses.

The Therapeutic Value of Countertransference

Jung's view that analysis is a dialectical process in which doctor and patient are involved as whole persons, brings the so-called countertransference of the analyst into focus. Freud, already in 1910, first recognized some of the importance of the countertransference. He saw it mainly as a danger for the analyst to lose the neutrality which he considered essential to making correct interpretations of the patient's unconscious conflicts. Countertransference feelings were to be avoided as much as possible and eliminated by analysis or at least self-analysis. Jung was not of the same opinion. He felt that the analyst cannot help becoming at times even deeply affected by his patient, and that he had better accept this fact and be as conscious of it as possible.

It was not until 1950 that a number of papers appeared by Freudian psychoanalysts showing that countertransference is not only an obstacle in the analytic treatment but may also be used to uncover unconscious dynamics going on in the patient. For instance, Heinrich Racker's book *Transference and Countertransference* (1968), containing papers written by him mainly during the 1950s, gives detailed accounts of interactional dynamics between transference and countertransference. One is reminded of Jung's model of the dialectical interrelation between two partners when Racker emphasizes that in the analytic situation two persons are involved—each with a neurotic part and a healthy part, a past and a present, and a relation to fantasy and reality. Each is both an adult and a child, having feelings toward each other of a child to a parent and a parent to a child.

Thus the analysand can also be experienced unconsciously by the analyst as a parental figure. If the analyst is open enough to watch his feeling-reactions before the patient comes or in the course of the sessions, he may for instance find himself anxious not to disappoint the expectations of the patient. Or he may with a certain patient feel rather stupid and unable to come up with a meaningful insight at all. Another analysand may oscillate in him impulses to share some of his own problems because that analysand seems so warm, mature and understanding.

These are just examples of what may occur, feelings which if consciously reflected upon might be seen as signs of a somewhat unrealistic response from the analyst's side. Is that patient really so demanding and oversensitive that the fear of disappointing his expectations is realistic? Or is this reaction partly or entirely based on a counterprojection of a parental figure within the analyst, for instance a love-demanding mother who was narcissistically hurt by the slightest move of independent self-assertion? In this case the analyst unconsciously experiences his patient as if he had expectations like his mother's; he is afraid of loss of love if he disappoints his patient.

Or say he is unable to come up with a meaningful interpretation, and then begins to feel inadequate—could this mean that his patient is resisting, and identifying in a defensive way with his grandiosity, which has the effect of making the analyst feel stupid? Or does the analyst project onto the patient an overcritical parental figure for whom nothing was ever
good enough? Both interpretations can of course be true, and as mentioned before it is of tremendous importance to be open to the constant possibility of falling into what the Freudian psychoanalyst Racker calls neurotic countertransference—which the Jungian Michael Fordham calls illusory countertransference. If such projections are not recognized, they can be damaging to the analytic process and do harm to the patient.

Yet analysts now realize that countertransference can as well be used for the benefit of the analysis, since it is also an interaction with the transference of the patient. This is called syntonic countertransference by Fordham, in contrast to the illusory countertransference. Racker has proposed the term countertransference proper in distinction to neurotic countertransference. He differentiates countertransference proper (Fordham’s syntonic type) into two forms, namely the concordant countertransference and the complementary countertransference. I feel this is a useful distinction and want to give examples for each.

Recently a woman training to be an analyst came for supervision and brought with her for the first time a tape of an analytic session she had had with a woman patient of hers. To our amazement, in listening to this tape, we both had at certain times quite some difficulty in distinguishing her own voice from the voice of the patient. This happened mostly when the patient was talking very softly and obviously fighting to overcome feelings of shame. The candidate felt rather shocked at first and asked me whether she might be identified with the patient in an unhealthy way. I heard her interventions on the tape as being genuinely in tune to the atmosphere and situation of the patient at those moments, so I told her that to my mind she was responding in an empathic way to her patient. It was apparent that the patient needed this kind of response, for later on the tape one could hear that the patient became more confident in exploring her own feelings. I think that this candidate reacted to the needs of her patient with a concordant countertransference reaction.

I am probably experiencing concordant countertransference when I can allow myself to be spontaneously with the patient wherever he really needs me to be, and when I can be open and flexible enough to allow him to "use" me to a wide extent, according to his needs within the symbolic framework of the therapeutic situation. It is of course important for the analyst to be at the same time as aware as possible of where this is leading. But I have seen again and again that if I can let myself be "carried" to where the patient vitally seems to need me, I experience a deep sense of empathy which allows sensitive new insights to appear spontaneously.

Quite often feelings, emotions, thoughts or intuitions pop up in me which are in the patient’s mind and which he may express at that very moment. I am always amazed at these synchronistic or "quasi-telepathic" incidents. It is then a question of whether to mention this simultaneous experience or not. If I tell the patient that I was thinking just then exactly what he said, he may experience this as being too intrusive or may become afraid of not being able to keep secrets from me, since I am obviously able to "see through" him. Thus there may be a fear of his ego-boundaries being invaded. However, I have often found it to be valuable to share this common ground with the analysand. It may satisfy in a therapeutically important way his deep longing to be truly understood and empathized with. He may also begin to have more trust in the manifestations of the unconscious. Concordant countertransference therefore has a lot to do with the analyst getting in touch with the patient and with experiencing what Jung has called mystical participation.

Now let us consider a different incident. A young woman, an analysand of mine for over a year, came one day to the session and said, "I just don’t know whether I dreamt this or whether it really happened." She uttered this statement in a somewhat withdrawn, depressive and slightly childlike tone of voice. I heard myself reply rather quickly and with a slightly harsh and irritated tone: "Surely you must know whether something is a dream or reality." After this there was silence on both sides.

As we sat there, I realized that my quick reaction had come from a sudden shock-like fear that this patient might become psychotic, as she apparently no longer knew the boundaries between reality and dream; then I had felt an immediate reaction to deny this suspicion: It just cannot be true, I have
to tell her positively that she does know, she must know the boundaries.

We both continued sitting there in silence. I felt astonished at my reaction, which was quite foreign to my usual way of responding to patients in general and to this analysand in particular. "What strange and inadequate behavior," I heard a voice say in myself. And with this an idea popped up: that I had behaved like a parent who is worried when the child is not behaving reasonably and fears that something might be wrong with him. The parent's defense is immediate denial: It just cannot be true, I do not want it to be true. This idea seemed to be consistent with a growing insight into what was happening between us and thus gave me some relief.

I observed my analysand sitting there silently in a sulky mood. And just as I was wondering how I might bring up my understanding of what was happening between us, she said: "You know, I just felt very angry at you. You behaved exactly like my mother." So there it was. I told her that I had just come up with the same realization and that I had asked myself why I behaved in such a strange way. I added that I might have made a mistake by reacting in such a way but that at least I knew now very well how her mother must have behaved and what effect this behavior must have had on her, my analysand.

Now the ground was prepared to get into the question of what in my patient might have prompted my behavior, and whether and under what circumstances she provokes people in her surroundings to behave toward her as her mother did. In my patient's view her mother had been overanxious about the child's well-being, yet when the child had a real complaint she denied it, saying that it could not be so. These reactions had made my patient feel stupid, not taken seriously, even unreal. Mother always "knew" that the things the child experienced were not true experiences, thus my patient was still somewhat confused as to whether her own experiences could be felt as real and valuable or whether she should listen to her constant doubts about them. This confusion used to lead her into regressive attitudes where "mother knows best," and I think that it was such a regression that she unconsciously enacted with me.

With this woman I obviously acted out countertransference impulses of the kind Racker calls complementary. I virtually became the patient's mother, the most important figure of her past, an image or complex which was still operating within her at present. Strictly speaking, it was a mistake for me to incorporate and enact that figure so unconsciously—I had fallen into a trap laid unconsciously by my patient. Would it not have been better to simply dispassionately interpret what was going on between us? Yet the power of the complex thus became very vivid for both of us, and from a deeper viewpoint my mistake may even have been necessary. Anyway, it did no harm once it was recognized—on the contrary, for I had not previously been in empathy with the feelings of my patient; if I had, I might have commented on how her confusion must feel and what it might mean. Her regressive tone of voice had constellated in me a resistance against responding from a concordant point of view, which would have been more "correct"; instead, my response arose from a complementary countertransference.

Earlier I gave some brief examples of so-called neurotic or illusory countertransference, where the analyst feels rather stupid or blocked, and unable to arrive at any meaningful insight. In such a case, is he projecting onto the patient an overcritical parental figure for whom nothing was ever good enough? This really would be a sign of illusory countertransference. But I also mentioned the possibility that the patient is defensively identifying with his grandiosity (inflation) and in his "omniscience" knows everything better. Then the analyst's feeling might be a response to the inner state of the patient. In that case it would be a complementary countertransference response.

Naturally it can happen that the analyst has such an inflated, omniscient parental figure in himself, which at the slightest opportunity can make him feel stupid and inadequate, and which of course gets projected wherever there is a hook. And the hook is usually a patient with a similar problem. Thus it is often very difficult to make out whether the analyst is experiencing illusory or complementary countertransference. Is he projecting upon the patient or is he perceiving something in the patient via his countertransference feelings? Is it projection or perception?
In the example I gave of myself enacting my patient's mother, it was not too difficult to see the complementarity of the countertransference. I behaved in an unusual way. But often one's reactions do not feel so strange, but have only an increased emotional intensity. I think the reason why it is so important to be in touch with one's own wounds as much as possible is in order not to do harm to the patient by acting out neurotic transference-countertransference games. Very often countertransference feelings are in fact a mixture of illusory and syntonic, both unconscious projection and genuine perception. The analyst has to be constantly aware of both possibilities and needs to differentiate one from the other to the best of his ability. Thus, the analyst, simply by virtue of his or her daily occupation, is also constantly in analysis—as Jung so clearly points out:

The patient, by bringing an activated unconscious content to bear upon the doctor, constellates the corresponding unconscious material in him. . . . [Therefore] contents are often activated in the doctor which might normally remain latent. . . .

Even the most experienced psychotherapist will discover again and again that he is caught up in a bond, a combination resting on mutual unconsciousness. And though he may believe himself to be in possession of all the necessary knowledge concerning the constellated archetypes, he will in the end come to realize that there are very many things indeed of which his academic knowledge never dreamed.