Ferenczi's Contribution to the Concept of Countertransference

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Since the Nuremberg Congress in March, 1910, at which Freud employed the term “countertransference” (Gegenübertragung) for the first time in a scientific paper, up to around 1950, when it reappeared in the writings of Winnicott (1), Racker (2) and P. Heimann (3), the idea received scant attention from analysts. From that time on, however, the question of countertransference as an essential tool in the psychoanalytic technique became a fundamental part of psychoanalytic training and therapeutic work.

Sándor Ferenczi was one of the few analysts who, departing from the ideas postulated by Freud in 1910, endeavoured to elaborate and advance a theory of countertransference that could account for the difficulties that were gradually appearing in clinical psychoanalysis, and to put forward a metapsychology of the analyst’s psychic processes during the analysis. Moreover, he did so well ahead of countless other analysts who considered countertransference the key to understanding and unravelling the patient’s unconscious. Nevertheless, as a result of one of the most remarkable processes of censorship in the history of psychoanalysis, Ferenczi’s ideas were “forgotten” and condemned to silence. Even today, one still finds comprehensive papers on countertransference that fail to mention even the name of one of the most enthusiastic pioneers of psychoanalysis and the man who for twenty-five years was Freud’s privileged interlocutor.

I shall not attempt in this brief paper to elaborate on the scientific and political reasons for such a remarkable “silence”. I shall attempt instead to show how many of the ideas that emerged so suddenly in the 1950s, and which generated an endless stream of scientific studies on countertransference right up to the present, had already been intuited to a large extent by Ferenczi.

**Freud’s Point of Departure**

Freud knew that emotions arising in the patient during the analytic process could stir others in the analyst. In numerous letters, he wrote of the unease this caused him, not only with regard to his closest collaborators such as Jung, Jones, Oscar Pfister and even Ferenczi, but also himself. Thus, for example, Ernst Falzeder (4) in a paper from 1994 demonstrates the extent of Freud’s emotional and affective involvement in the treatment of his “great patient”, Elfriede Hirschfeld, over a period of eight years, which had undoubted repercussions on his theories on psychoanalytic technique. It is well known that the term “countertransference” appears for the first time in Freud’s letter to Jung of June 7, 1909 (5), in which he refers to Jung’s affair with Sabina Spielrein and the inherent dangers of an excessive emotional involvement which not even he himself had managed to avoid.

Nevertheless, the first time that Freud used the concept “countertransference” in a scientific text was in a paper he delivered to the Nuremberg Congress on March 30, 1910, entitled, “The Future Prospects of Psycho-Analytic Therapy” (6) (“Die
Zukünftigen Chancen der Psychoanalytischen Therapie’). A careful reading shows, as Etchegoyen (7) has pointed out, that Freud believed “that a knowledge of countertransference was closely related to the future of psychoanalysis and that an understanding of it would signify a huge advance for psychoanalytic technique”. Freud, however, also introduced theoretical and methodological changes that were totally revolutionary. As well as changing the field of observation of the analyst, who moves from being a simple observer to an active participant, psychoanalytic investigation stops being objective and what were formerly observations become experiences. For the first time, Freud signals the intrusive nature of certain psychic phenomena, which have the capacity to become “implanted” or “installed” in the analyst’s unconscious.

Freud adds, as a general rule, that the analyst must be aware of and control his countertransference, and “be able to cope with it” (“Bewältigung”) as an essential requirement of being an analyst. That is to say, Freud was pointing to the need to control the countertransference in the sense that it should be worked through and not merely “overcome”, as appears from Strachey’s translation. Were not these the theoretical hypotheses from which Ferenczi would develop his own theory of countertransference and some of his most brilliant intuitions?

It has always been argued that in later writings, especially in “Recommendations to Physicians” (8), Freud adopted a negative view of countertransference, referring to it as an “enveloping” obstacle that interferes with the analytic work and as a troublesome difficulty that needs to be controlled through self-analysis. I believe, however, that Freud was led to check and, in part, abandon his initial enthusiasm for the subject owing to his fear that such a complex issue, about which he lacked sufficient clinical data, would detract from and cast doubt on the therapeutic model he was postulating for psychoanalysis. Thus, for example, in a long letter to Jung of December 31, 1911, he reproaches, as he did with Pfister, Jung’s excessive emotional involvement with a patient, which he deems a grave mistake. Instead, his advice is to remain inaccessible to the demands of the patients and to maintain a strictly receptive attitude. At the time he believed that it would be better not to publish a paper on countertransference, but rather circulate copies of his ideas among the most experienced analysts.

In all likelihood, the outcome, both personal and analytical, of the “Elma affair”, in which Freud was involved as well as Ferenczi, motivated the writing of “Observations on transference-love” (9), in which countertransference is once again presented as a danger that must be avoided and controlled. Nevertheless, Freud’s awareness of the complexity of the subject is plainly seen in his letter to Binswanger of February 20, 1913:

The problem of the countertransference is one of the most difficult in psychoanalytic technique. What is offered to the patient must never be spontaneous affect, rather it must always be expressed consciously. In some circumstances, a lot should be offered, but never anything arising directly from the analyst’s unconscious. The analyst must always be aware of and overcome the countertransference to be free. However, at the same time, to give too little to a patient because the analyst loves him too much is to confuse him, and is a technical error. It is not easy and practice is required.

The “Control” of the Countertransference

Eight years after Freud’s text was published, Ferenczi took up the banner and reopened the debate. Perhaps he felt that circumstances had changed sufficiently to no longer justify Freud’s caution in requesting that the subject of countertransference be restricted to his small group of closest disciples. Also, it is likely that the celebration in Budapest of the 5th Psychoanalytic Congress marked a return to an interest in psychoanalytic technique. There, as in 1910, Freud delivered a paper, “Lines of advance in psychoanalytic therapy” (10), that encouraged the emergence of new ideas. In this paper, Freud outlined the theoretical formulation of the “active technique”, credit for which is often attributed erroneously to Ferenczi.

The first occasion on which Ferenczi, with Freud’s approval, addresses the issue of countertransference in some depth is in “On the technique of psychoanalysis” (11), which he delivered to the Hungarian Psychoanalytic Society three months after the aforementioned Congress.

One of the chapters in this text is devoted precisely to the “control of the countertransference” (“Die Bewältigung der Gegenübertragung”) and he employs the same word as Freud in his 1910 paper. From Ferenczi’s standpoint, psychoanalytic therapy demands a “twofold function” of the analyst: on the one hand, he must observe the patient, listen to his discourse and use his words to gain insight into
his unconscious, while on the other hand all the time, keeping his own attitude to the analysand under control and modifying it when necessary. For this reason, it was essential to control the countertransference. Nevertheless, whereas Freud proposed self-analysis to achieve this (6), Ferenczi considered that it was necessary for the analyst to have been previously analysed. His insistence on this point not only points to his unsatisfactory analysis with Freud but also introduces the idea that not even the most experienced of analysts can avoid committing serious mistakes unless he listens to and works through his own countertransferences.

The process of the ‘control of the countertransference’ is described by Ferenczi in the following phases. In the first:

one is miles from considering, let alone mastering, the countertransference. One yields to every affect that the doctor-patient relationship may evoke, is moved by the patient’s sad experiences, probably, too, by his fantasies, and is indignant with all those who wish him ill.

In these circumstances the possibility of performing a successful analysis is practically non-existent.

Ferenczi referred to his second phase as ‘resistance against the countertransference’, which is the opposite reaction to the previous one but equally likely to cause the analysis to fail:

If the psychoanalyst has learned painfully to appreciate the countertransference symptoms and achieved the control of everything in his actions and speech, and also in his feelings, that might give occasion for any complications, he is threatened with the danger of falling into the other extreme and of becoming too abrupt and repellent towards the patient; this would retard the appearance of the transference, the pre-condition of every successful psychoanalysis.

Some years later, Racker, too, would describe this idea in his paper ‘Transference and Countertransference’ (12). He spoke of the consequences of the analyst’s counterresistance and how, in his view, this aims at preventing the patient’s regression and converting the analysis into a monotonous process burdened by reiterative interpretations and incapable of producing the slightest transformation of the patient’s inner world. Moreover, in the same paper, Racker’s view of the analyst’s ‘objectivity’ is almost identical to that of Ferenczi. According to him, it swings between two poles, both of which are potentially neurotic, either to drown in the countertransference or to repress it in an obsessive attempt to attain the myth of the analyst as ‘free from anguish and anger’. In Racker’s view, the analyst can only be ‘objective’ with his patient when he himself has become an object of self-observation and analysis.

The third phase described by Ferenczi addresses the control of the countertransference in the strict sense of the term, which is only attainable after the successful completion of the first two phases. It is then that the analyst attains the mental state required to ‘be carried along’ during the treatment as the psychoanalytic cure demands. What is really innovative about this formulation is that for the first time countertransference is not viewed as a hindrance or a danger, but rather as an essential and efficient tool. In this sense, his ideas foreshadowed the intuitions of later analysts like Balint, Bion, de Forest, Racker, Winnicott, Little, etc., who also proposed the analyst’s countertransferential reaction as an indispensable technical tool in the analytic process. What is more, the analyst’s interpretation is the direct consequence of his working through of the countertransference.

In Ferenczi’s test, we also find many references to technical problems which as analysts we encounter on a daily basis — silences, resistances, drowsiness, acting out — not only in the patients, but in the analyst too. He also cautions against the tendency of some analysts to get involved in the patient’s real life through very direct advice or recommendations that fail to consider the transferential element accompanying the patient’s ‘real’ problems. He then goes on to suggest a beautiful metaphor in an unmistakably Ferenczian context: the situation of the analyst is similar in many respects to that of the midwife, who, as far as possible, attempts to remain a mere observer of a natural process, until required at critical moments to intervene with the forces to aid a birth that is not progressing spontaneously.

However, rather than controlling the countertransference, Ferenczi was, in fact, to discover it through the rigorous application of the active technique, the theoretical elaboration and clinical application of which revealed a series of problems that had hitherto been ignored. Starting from certain specific, repetitive actions of the patient — symptomatic actions that he called “formation of transitory symptoms” — Ferenczi attempted to infer with the patient’s unconscious space into which the libidinal investments withdrawn from the analytic work had been infiltrated. Once these were known, he encouraged the
patient to eliminate such behaviour, a masturbatory substitute, for example, and thus relinquish the consequent substitutive gratification. However, paradoxically enough, the more Ferenczi insisted on “activating” the patient, the more he activated, unbeknown to himself, his own countertransferring experiences.

The Countertransference-Transference Interaction

Following the formulation and the introduction of the concept of the “death drive”, Freud not only modified his conception of the psyche. New theories of narcissism, masochism and destructive drives, as well as the development of the ego through identification processes, shaped a much broader conception of the positive and negative transference. Without doubt, one of the factors that led Freud to develop a new metapsychology had to do with the difficulties he was encountering in his clinical work, especially in dealing with a negative therapeutic reaction.

Perhaps for this reason, at the Berlin Congress in 1922, Freud called on all analysts to reflect and write on the “relationship between psychoanalytic theory and technique and to gauge how much each had influenced theory and to what extent each nurtures or detracts from the other”, instituting a prize for the outstanding paper as he did so.

Ferenczi and Rank, who had been working along these lines for some time, immediately took up the gauntlet and jointly published one of their most brilliant and far-reaching works, which without doubt for many theorists still underpins great many contemporary conceptions in psychoanalysis. They entitled it, “The development of psychoanalysis” (13), with a subtitle fitting Freud’s call: “On the interdependence of theory and technique”.

In it, the authors elaborate on their scientific framework and present a technical and theoretical study of how to conduct the analytic process. Until then, the main objective of analysis had been “remembering”, to the extent that repetitions were regarded as obstacles arising from the patient’s resistances that needed to be “neutralised” by the analyst. In contrast, Ferenczi believed that the fundamental aim of analytic working through, and thus of the analyst’s interpretations, was the repetition compulsion and the multiple transference manifestations, which should be treated as “real unconscious material”. The key role that Ferenczi ascribed to transferential interpretation and the analytic process, to the detriment of the intellectualised identification of the unconscious content, fantasies and representations, implies not only a parallel modification of the countertransference but a fundamental shift in the very conception of analysis itself. Among other things, for example, Ferenczi notes that very often what is stirred is the analyst’s own narcissism (“narcissistic countertransference”), which may induce the analysand to limit his production to what he knows will be gratifying to the analyst. In this way, analysands attempt to avoid hostile material, thus reinforcing their unconscious guilt and hindering the analytic process. From this idea, Ferenczi elaborated a whole conception of countertransference-transference interaction not so much as a therapeutic tool, but rather as the fundamental core of analytic work.

A closer examination of this text, chapters II, IV and VI of which were generally disregarded as being Rank’s, enables us to grasp the full extent of Ferenczi’s intuitions and their striking contemporary relevance. In particular, in chapter IV, devoted to the interaction of theory and practice, Ferenczi highlights the need for the analyst to leave aside his theoretical constructs when approaching the analytic situation. Only by starting afresh in each case, or, in other words, by not retreating from new experiences, could original discoveries be unearthed. Bion (14) expressed Ferenczi’s intuition in clearer terms when he says that the analyst must come to the analytic situation “without memory and without desire”.

Ferenczi’s firm belief that what emerges in the “here and now” of the analytic process derives from the encounter between the analysand’s transference and the analyst’s countertransference enabled the deepest levels of the psyche to be fully explored. At the same time, it justified the need to allow the analysand to regress to whatever levels are necessary and confirmed the role of countertransference as an essential tool for recognising and detecting the most significant aspects of the patient’s transference as they unfold.

Ferenczi’s postulations were echoed in the psychoanalytic output of the time. One text that normally goes unnoticed is that by H. Deutsch entitled, “Occult process occurring during psychoanalysis” (15). The author shows how the analyst’s identification with the patient’s infantile drives and his self-analytic working through do not hinder the treatment but rather form the basis for a fruitful development.
of the analyst’s intuition and empathy. It is interesting to note that several of his ideas foreshadow the concepts of concordant and complementary countertransference as elaborated by Racker.

In early 1928, Ferenczi wrote “The elasticity of psychoanalytic technique” (16), confirming his almost complete departure from the active technique. It was a precursor to what two years later he would refer to as “neocatharsis”. In a few pages he describes a great many clinical observations and technical recommendations which may be summarised as the need for the analyst to acquire “Einfühlung” (empathy, capacity to “feel with” or be attuned to the patient). Once again, Ferenczi employs one of Freud’s terms, from a paper in 1910 (17). Nevertheless, whereas Freud’s “Einfühlung” appeared to be closer to the idea of an “indulgent sympathy” on the part of the analyst, Ferenczi extended it further. His conception of the term is almost synonymous with the notion of “empathy” in everyday use among contemporary analysts. Ferenczi not only stresses its importance, but locates it right at the core of the psychoanalytic technique.

It is not difficult to establish the similarity between the concept of “Einfühlung”, as postulated by Ferenczi, and Kohut’s description of “empathy” in “The Analysis of the Self” (18), Zetzel’s “therapeutic alliance” (19) and, in particular, the concept of “concordant countertransference” developed by Racker (2) twenty years later. P. Heimann herself, in one of her last works (1980) (20), points to the need for each analysand to feel that “the analyst is attuned to his emotions”.

Ferenczi thus attempts a thorough study of the significance of the analyst’s countertransference in the analytic process and, consequently, delves into the question of the analyst’s own analysis, the so-called second fundamental rule. In this area, his ideas are once again remarkably up-to-date, in that he defends the notion of the training analysis as a therapeutic analysis that should not be confused with a process of intellectual or theoretical study. According to Ferenczi, this analysis, more even than that of the analysand, should continue and penetrate far enough for the future analyst to enter in contact with the deepest, most recondite, aspects of his psychopathology. His firm conviction that the best analyst is a patient well analysed, gradually became an ideal, and began to be reflected in subsequent scientific writings.

From then on, Ferenczi gradually began to put forward certain technical modifications. First, as a therapeutic goal, he proposed the substitution of a rigid parental super-ego by a more flexible analytic one. Next, he suggested that an omniscient attitude should be given up in favour of a more friendly intuitive approach. In “The adaptation of the family to the child” (21), when discussing the adult’s inability to understand the child, he draws a parallel to the analytic situation. If the “first mistake of the parent is to forget his own childhood”, the first mistake of the analyst would be to attempt a cure without taking into account, and without sufficient analysis of, certain psychic conflicts, adopting instead an attitude of omniscient, hypocritical authority that precludes listening to the patient’s psychic pain. Particularly striking is his criticism in “The problem of the termination of the analysis” (22) of those analysts who bring about the termination of the analysis before the analysand feels that his life and conduct has undergone substantial psychic change. Analysis should adapt to the needs of the patient and should “die from exhaustion”.

A careful reading of Ferenczi’s writings from this time, without doubt his most fascinating and polemic from a psychoanalytic standpoint, reveals the desperate struggle of a clinician with psychoanalysis as his raison d’être to help his patients as efficiently as possible. His idealisation of and absolute belief in the therapeutic powers of psychoanalysis had brought about a sort of “furor sanandi” that led him, on occasions, to compare the analyst with a father, or rather an adoptive mother, whose task was to permit the patient to enjoy the benefits of a normal childhood. This seems to be Ferenczi’s objective in one of his most thought-provoking works, “The principle of relaxation and neocatharsis” (23), in which he combines Freud’s “classical technique” with a responsive therapeutic attitude facilitating the patient’s regression, provided that the analyst controls his “countertransference” and “counterresistance”.

In addition to his radical reversal of the surgeon metaphor, Ferenczi lays the groundwork for a theory of countertransference as a maternal formation. More than benefiting from the lifting of the repression, the patient may, in the course of analysis, accede to a reparatory experience of that which was denied to him during his childhood. Winnicott’s contribution, too, introduced a therapeutic technique in which the analytic process is likened to the mother-child relationship and the constant interactions therein. He
describes what he called “primary mother preoccupation”, which enables the mother to actively adapt to the child’s needs in a natural spontaneous manner. Like Ferenczi, Winnicott (24) held that the analyst and patient constitute an intersubjective relationship with similar characteristics, particularly the analyst’s capacity for empathy in relation to the analysand’s primary needs. Further derivations of this conception are Bion’s “reverie” (25), Paula Heimann’s “unconscious perceptions of the analyst” (20), or more recently, Leon Grinberg’s “projective counteridentification” (26, 27, 28). Bollas also offers an analogous theory of countertransference in his conception of the analyst as a “transforming object” (29).

**The Clinical Diary**

Ferenczi’s *Clinical Diary* (30), which can be considered a long letter to Freud between January 7 and October 2, 1932, contains a series of subtle intuitions and invaluable contributions to psychoanalytic technique. Some of the theorising contained therein, in particular with regard to countertransference, can still be considered valid today.

Right from the first page entitled “the insensitivity of the analyst”, he signals the main focus for his theorising: the analyst’s “real countertransference”. Countertransference, rather than being a hindrance, is, in fact, the analyst’s most valuable tool. As Ferenczi affirms:

one could almost say that the more weaknesses an analyst has, which lead to greater or lesser mistakes and errors but which are then uncovered and treated in the course of mutual analysis, the more likely the analysis is to rest on profound and realistic foundations.

Nevertheless, after demonstrating how analysis fosters a “refined sensitivity” in the patient that would enable him to grasp even the most obscure nuances of the analyst’s attitude were it not for the intensity of his own projections, Ferenczi endeavours to demonstrate that the transference is not a response to a spontaneous event, but rather is induced by the analyst himself and thus by the analytic technique. He goes on to add a criticism of a particular attitude to analytic work that could still be endorsed today:

the interpretation of every detail as expressing a personal affect toward the analyst…is likely to produce a kind of paranoid atmosphere, which an objective observer could describe as a narcissistic, specifically erotomaniacal delusion of the analyst. It is possible that one of all too inclined to assume too quickly that the patient either is in love with us or hates us.

Paul Heimann (3), in her renowned paper on countertransference, pointed out that analysts who pay little attention to their own psychic conflicts and the dynamics of their own inner world risk attributing to their parents what in fact belongs only to themselves. According to Heimann, this danger can be neutralised: “if the analyst has worked through his own infantile conflicts and persecutory and depressive anxieties in his personal analysis so that he can enter in contact with his own unconscious…”.

However, Ferenczi goes even further. To the extent that the countertransference constitutes the basis for his interpretations, he begins to consider the hypothesis that the analyst not only fails to become a good father or mother for the patient but, in fact, becomes an active participant repeating the traumatic situation that the analysand had suffered in childhood. In addition to fundamental thinking on psychoanalytic technique, it seems at this time that Ferenczi’s thoughts are those of a man who, close to death, confronts his own feelings of guilt, and who taking his capacity for empathy to its ultimate consequences identifies intensely with the patient’s suffering and pain. At such a level of penetration, “the tears of doctor and patient mingle in a sublimated communion, which perhaps finds its analogy only in the mother-child relationship”. This emerges the idea of “mutual analysis”, which Ferenczi attributes to his famous patient Elisabeth Severn, referred to in the “Diary” as R.N.

As he describes in his entry of May 5, Ferenczi’s first impression of her was one of dislike. Nevertheless, he was led by his tolerant, elastic technique and reactive formations to adopt an attitude of acceptance and responsiveness towards her. As a result, R.N. came to believe that the analyst had fallen in love with her. It was thus, at this stage, that Ferenczi became anxious and interpreted the negative transference. According to Ferenczi, the impact on the patient was indescribable and resulted in the reactivation of an infantile trauma. The patient affirmed that she could detect intense feelings of hate in the analyst, which he was attempting to repress and conceal by being hypocritically friendly. Ferenczi, knowing that the patient was right, admitted this and associated his countertransferential hate for his patient with the feelings of hate that his own mother had stirred in him as a
child. Ferenczi then agreed as an experiment to change places with the analysand. In all likelihood, Ferenczi was acting out his insufficient containing function, while unconsciously using the patient as a container for his feelings and emotions. Nevertheless, the idea of communicating the countertransferential feelings to the patient was followed up in the psychoanalytic literature.

In a celebrated, though controversial, paper, entitled “Hate in the countertransference” (1), Winnicott affirmed that the disclosure of countertransferential hate not only was not inadvisable but even beneficial to both the patient and the analytic process. Likewise, M. Little (31) defended the appropriateness of revealing the nature of the countertransferential feelings in order to encourage the patient to accept certain transferential feelings in order to encourage the patient to accept certain transferential experiences. As in later writings by Langs (32) and Searles (33), he postulated that, and one can almost hear the echo of Ferenczi’s mutual analysis, the patient could bring interpretations to the analyst that would greatly facilitate his gaining an insight into the countertransference. More recently, analysts like Epstein (34) and Gorkin (35) have put forward the need to include countertransferential confessions as an important part of the psychoanalytic technique.

The author who may well have taken furthest some of the intuitions contained in the Clinical Diary, though without mentioning Ferenczi, is Searles, an analyst who like Ferenczi has devoted a large part of his work to treating severely psychotic patients. In “The patient as therapist to his analyst” (33), he postulates the hypothesis that in the course of the analysis the psychotic patient needs to “create a made-to-measure analyst” in order to be able to introject and reconstruct in him a safer, less persecutory, inner world as an essential condition of overcoming the psychosis. Like Ferenczi, he departs from the hypothesis that every patient experiences the unconscious desire to become his analyst’s therapist and to “cure” him.

Besides the underlying criticism of Kleinian theory, which states that the fantasy of curing the analyst is nothing more than a reparatory act by the patient due to his own sadism, and Bion’s idea of a “parasitic relationship” in psychosis, Searles proposes an essentially symmetrical psychoanalytic relationship. Thus, the “therapeutic alliance” is equally applicable to each member of the analytic dyad, and the analyst’s acceptance of “the therapeutic impulses of the patient”, aimed at converting the analyst into a good-enough mother capable of containing or a sexually potent father, is of fundamental importance to the analytic process.

For my part, I do not subscribe to some of the theories I have just outlined, believing like M. Mancia (36) that to reveal countertransferential feelings to the analysand is, in fact, an admission of one’s own inability to work them through adequately enough, and a failure of the capacity to transform, upon which the creativity required in analysis is based. However, I believe that Ferenczi’s final clinical intuitions were the precursors of many contemporary theories which stress the usefulness of countertransference, projective identification and projective counteridentification as essential tools in the analytic process, the recognition of the emotional participation of the analyst and the possibility to penetrate the patient’s transference and to observe and interpret the countertransferential reactions.

At the end of his “Diary”, Ferenczi states that the therapeutic failure of many analyses is not due to inaccessible resistances, nor to the patient’s impenetrable narcissism, but rather to the analyst’s own difficulties, in particular, his insensitivity, lack of tact and empathy. By stressing the emotional participation of the analyst in the analytic process and the role of countertransference, Ferenczi also highlighted the importance of the persona of the analyst and, in particular, of his own analysis as a fundamental part of the work.

After Ferenczi’s death, some of his most brilliant clinical intuitions, especially those addressing the countertransference, were practically forgotten. Yet, for the sake of accuracy, it is worth pointing out that Melanie Klein, who had been in analysis with Ferenczi, was employing countertransference after 1919, or, in her words, “the communication from unconscious to unconscious”, from which she would later develop many of her well-known theories of the infantile mind and psychotic states. Fanny Hann-Kende (37), for her part, also emphasised the possible utility of countertransference in the psychoanalytic technique, taking into account Freud’s thoughts on telepathy, while Alice and Michael Balint (38) stressed “the inevitable intrusion of the analyst’s personality in the analytic relationship” and Izette de Forest (39, 40) highlighted the “interactive nature of transference and countertransference”.

However, it is only after the decade of the 1950s
that contributions on countertransference begin to appear more or less simultaneously, based on some of Ferenczi’s intuitions but modifying substantially their clinical and theoretical dimension.

Thus, at the 16th Congress in Zurich, Paula Heimann stressed that countertransference was the essential tool in order to gain an understanding of the patient’s unconscious material and for the formulation of adequate interpretations. Around this time, Racker postulated, although less radically than Paula Heimann, the hypothesis that the main source of the analyst’s feelings lies in the mind of the patient, and anticipated the idea of analysis as a bipolar space that years later would be taken up by the Barangers (41). M. Little (31), too, challenged the classical idea of the analyst-mirror and stressed the need to use countertransferential feelings when formulating interpretations. Sullivan (42), meanwhile, proposed the idea of the analyst as a “active observer”. From these theoretical advances, a long list of analysts of the stature of M. Khan, M. Mahler, Searles, Fromm-Reichmann, Rosen, Guntrip, Spitz, Nacht, Kohut, etc., continued to extend some of Ferenczi’s most inspired clinical intuitions, though almost always without mentioning his name.

**Conclusion**

In conclusion, I would like to mention that in his address in Madrid, in 1928, Ferenczi spoke of the debt of gratitude that Central Europeans owed to Spanish thinkers, art and literature. In return, in my own modest way, I would like to pay tribute to a man, who contributed decisively to the growth of psychoanalytic theory and practice. He analysed and extended some of Ferenczi’s most inspired clinical intuitions, though almost always without mentioning his name.

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