Transference & Countertransference

"… There is neither such a thing as reality nor a real relationship without transference. Any 'real relationship' involves transfer of unconscious images to present day objects. In fact, present day objects are objects, and thus real, in the full sense of the word only to the extent to which this transference … is realized." Hans Loewald (1960)

Transference most often refers to the displacement of feelings towards parents or siblings or other significant people on to the therapist. Transference can be either positive or negative. A key feature of these transferences is that they are largely unconscious. When transference occurs the client brings the whole history of an old relationship into the new relationship, rather than seeing the other person for who they really are.

Countertransference is used to refer to transference that happens in the opposite direction: the therapist's unconscious reactions to the client.

Although transference has traditionally been explored in relation to psychopathology, it is not inherently pathological, rather it is part of the human process of making meaning that helps humans to predict, understand and make sense of interpersonal events (Andersen and Bert 1998).

Transference does not just occur in the therapy relationship. Transference is ubiquitous - it occurs in relationships, with friends, lovers, bosses, doctors, teachers and others. We expect others to respond to us as we have been treated before, by our mother, father, siblings and other significant people. Consequently we behave according to those expectations (Grant 2000).

Although transference is ubiquitous it has a special meaning in the context of the therapeutic relationship. Gelso and Hayes (1998:11) define transference as 'the client's experience of the therapist that is shaped by [their] own psychological structures and past, and involves displacement onto the therapist of feelings, attitudes and behaviours belonging rightfully in earlier significant relationships'. Transference includes the feelings towards the therapist as well as how the client expects to behave and feel and what the clients expects from the therapist. Clients may distort the therapist's behaviour to conform to these expectations. Alternatively clients may behave towards the therapist in ways that actually produce such reactions.

Freud, who initially identified transference in his early work as a doctor and then clarified it in his work with 'Dora', grew to think of it as a 'template'. He saw the transference template as a core relationship pattern that provided a prototype or

schema for interactions in subsequent relationships (Luborsky and Crits-Christoph 1998). Andersen and Berk argue that such patterns learned early in life influence current behaviour because they are stored in memory and are then activated and applied to other relationships.

Transference is a largely unconscious process. Part of the process of psychodynamic psychotherapy is helping the client become aware of the transferential material thereby making the unconscious conscious. Transference is one of the cornerstones of psychodynamically oriented therapies.

Transference is important whatever the form of therapy, even if the construct is not part of the therapeutic model. Transference-like phenomena can create misunderstandings and impasses in therapy. Transference can disrupt the therapeutic alliance, which as we know is imperative to the process of any therapeutic endeavour.

Rowan (19830 argues that one of the central differences between humanistic and psychoanalytic psychotherapies is the way transference is regarded and explored. Whereas psychoanalytic therapy fosters and works with transference as a way of getting the neurotic issue alive in the therapy room, humanistic therapies have a variety of other ways of working with transference in the here-and-now.

Rogerians do this by being constantly attuned to the feelings of the client, whether overt or covert and focusing on the immediacy of the experience in the therapy room.

Existentialists focus on the task by paying close attention to their own internal responses and working with those responses in relation to the client.

Gestaltists get the client to talk directly to the person rater than about them (Rowan 1983).

In many ways the humanistic therapies were a reaction to the determinism of the psychoanalytic approaches and the somewhat technical and mechanistic quality of the behavioural approaches. This meant that in the early phases of development humanistic therapies eschewed concepts such as transference and projection. Within the last decade however there has been a move to integrate these concepts into humanistic models. Thus, although the focus is primarily on authenticity and the ‘real’ relationship between client and therapist, there is now acknowledgement that transferential phenomena occur and must be understood and explored.

Person-Centred Humanistic Approaches

Person-centred therapy is essentially interested in the therapeutic conditions needed to create a real, authentic relationship between therapist and client. In this sense Person-centred therapists are not so interested in transference however the crucial importance of empathic understanding promotes the reprocessing of experiences in a way that soothe and calms:

> I believe that empathic understanding plays a particularly crucial role in therapy with clients who have suffered empathic failure in childhood… The ongoing presence of a soothing empathic person is often essential to the [client's] ability to stay connected without feeling overwhelmed. (Warner 1996: 140)

Person-centred psychotherapists do not deny that transference exists but rather they do not privilege working with the transference over other processes in therapy and do not see resolution of transference as central to facilitating change. (Rowan 1983, 1992). On the other hand they do focus on internal responses of the therapist towards the client as a source of understanding the client. They are more likely to disclose these counter-transferential responses in an attempt to maintain authenticity in the therapeutic relationship. Although it is accepted that the client will replay their past in the present relationship with the therapist, there is no agreement among such therapists whether this should be given priority.

Certainly the interpersonal approach within the person-centred model does accept the notion of transference but suggests working with the transference is only really necessary when interpersonal difficulties become chronic; they then need to be addressed to create a stronger alliance between therapist and client (Watson *et al*. 1998). For example:

Catriona has been coming to therapy for six months and has been making progress in addressing the concerns that initially brought her to therapy. For the last four sessions Catriona has been withdrawn and irritable in sessions and has talked about quitting therapy because 'It's not doing any good'

Therapist: I have a sense that something changed about five sessions ago between us. Are you angry with me about something?

Client: No. I'm not angry, it's just that this isn't working.

Therapist: You know we've been exploring how you retreat in your relationship with your partner when you feel hurt or can't get what you want. I wonder if in exploring

your relationship you've felt hurt by me? Like I'm saying that the relationship difficulties are all your fault.

Client: Well, yes, when you put it like that, I have been feeling that you don't really understand what I have to put up with and somehow you think it's my fault.

Therapist: That must be painful for you Catriona. And thinking about what you've told me about your mother always seeing you as the one who was responsible when you and your sister fought, I can see how that would make it difficult to feel comfortable being open here, with me. Do you think that might be affecting your feeling that what we are doing here isn't working?

Client: Mmm… yes, I think so.

Therapist: Do you know what I did or said that left you feeling that I thought the arguments with your partner were your fault?

Existential and Experiential Approaches

The central tenets of the existential-experiential approaches include and focus on the person as an experiencing process that is constantly changing, an assumption that the individual can be understood phenomenologically through the meanings they use to make sense of the world, an assumption that inevitable pain and death are primary to being human and create existential anxiety and an emphasis on taking responsibility for how we live our lives (Yalom 1980, van Deurzen-Smith 1988 Potash 1994). Key figures in the development of existential therapy include Frankl (1969), Yalom (1980), May (1990), and Maslow (1968).

Existentialists typically emphasise the development of a real as opposed to a transferential relationship to the therapist. Rollo May (1990) has critiqued analytic theory for lacking the concept of the encounter so central to the real or I-Thou relationship. For him transference 'is to be understood as the distortion of the encounter' (May 1990: 55). He feels that psychoanalysis lacks a norm of human encounter and has oversimplified the love relationship.

Yalom (1980) argues that a singular focus on transference impedes therapy because it prevents the development of an authentic therapist-client relationship. He also feels that it encourages the therapist to conceal their own self, which interferes with the ability to relate authentically to clients. The capacity to relate deeply to a therapist as a

real person is what produces change as the client experiences feelings that have been dissociated for years and moves to an awareness of the love within.

> On the other hand writers like Brugental and McBeath (1995) speak directly about the importance of transference in existential therapy, arguing that the client's 'self-and-world construct system' represents patterns that are inevitably played out with the therapist. This enactment is essential to the therapeutic process because the patterns are manifested in the here and now:
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> Some of the most penetrating and powerful therapeutic work takes place when the client's projections (transference) intersect with the therapist's own projections (countertransference) in what may initially be an unconscious collision. When this hidden conjunction is recognised, brought into the open and worked though in the immediate situation, the results can be truly life-changing.
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> (Brugental and McBeath 1995: 117)

Although there is not a focus on interpretation as a process in working through the transference, there is an emphasis on tracing the patterns through as many of the client's life venues as possible. It is assumed that the patterns will spontaneously repeat themselves and can be explored for what is valued and what needs to be relinquished.

For existential-experiential therapists working with transference is not necessarily the major process, nor is transference deliberately elicited as it might be in psychodynamic psychotherapy. There is an assumption that some transference reactions will disappear without working through them if the relationship between therapist and client is strong.

In working with transference, instead of using interpretations, experiential therapists are likely to do something active such as inviting the client to imagine the significant other in the chair and having a dialogue or going inside oneself to identify and symbolise thoughts and feelings to be worked through (Greenberg *et al* 1998).

Gestalt Therapy

The three main cornerstones of gestalt therapy are field theory, phenomenology and dialogue.

Field theory provides a way of thinking about the whole gestalt of the person; phenomenology provides a process of defining, working with and increasing the client's awareness and dialogue provides the focus on the relationship between the therapist

and client, with a concentration on the contact and withdrawal process (Yontef 1998; Clarkson 1999). There is a focus on responsibility for self, the here-and-now, authenticity in the I-Thou relationship and on 'experiments' that lead to awareness and wholenesses (Herman 1996; Clarkson 1999). The emphasis in the therapy is on directing awareness to sensations, feelings and thoughts so that awareness is developed about how the client organises their experience.

Although originally gestalt therapy was far more interested in the real encounter between therapist and client rather than the transferential relationship, it has moved in the last decade to a far greater focus on the interpersonal world and its distortions. The emphasis in practice has moved from confrontation and cathartic interventions to one of stressing relationship between therapist and client (Yontef 1997). However even the originators of gestalt therapy saw the importance if somewhat differently understood place of transference in therapy.

> The importance of new conditions in the present was perfectly understood by Freud when he spoke of the inevitable transference of the childhood fixation to the person of the analyst ; but the therapeutic meaning of it is not that it is the same old story but precisely that it is now differently worked though as a present adventure: the analyst is not the same kind of parent. And nothing is more clear, unfortunately, than that certain tensions and blocks cannot be freed unless there is real environmental change offering new possibilities.
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> (Perls *et al.* 1969: 234)

Gestalt therapists' emphasis on 'unfinished business' provides a handy container for dealing with transference. They stress how the urgency of unfinished business from the past can be re-enacted in the current client-therapist relationship. The projection of the original 'fixed gestalt' onto the therapist is considered by many gestalt therapists as an important step in understanding the archaic blocks to a full therapeutic relationship based on mutuality. Although transference has a place the goal of gestalt therapy is a full and complete authentic meeting between two people (Heard 1995).

The here-and-now can be understood as a bridge between the past and the present that allows understanding and change (Herman 1996). The focus on the here-and-now allows the past to live in the present so that completions and change are possible in the transferential relationship.

Adapted extracts from Core Concepts in Psychotherapy - Transference and Projection by Jan Grant and Jim Crawley

Food for thought...

1. How would you describe transference and countertransference in a few words?
2. Are you aware of any transference, positive or negative, with your therapist and if so what have you learned about it?
3. What are your immediate thoughts or feelings about working with transference and countertransference as a therapist?
4. How do you think you could work with transference in the therapy room?