

# *Transference and countertransference: Opportunities and risks as two technical constructs migrate beyond their psychoanalytic homeland*

ROBERT KING AND TOM O'BRIEN

The terms 'transference' and 'countertransference' have developed a wide use in psychotherapy and no longer hold an exclusive association with therapies based on psychoanalysis. These terms have become so commonplace there is a real risk that therapists will gloss over the complex, and even problematic, nature of the underlying constructs. Without an appreciation of this complexity, clinical use of the terms may result in more harm than good. ROBERT KING and TOM O'BRIEN return to the psychoanalytic meaning of the terms in order to minimise this danger. Regardless of the therapy framework, emotional responses of clients and therapists to each other can inform the work of therapy, and enhance the impact of therapeutic communication. However, transference and countertransference, when identified correctly, will only constitute a small part of the feelings that exist between therapist and client. Interpretation of transference and countertransference will be subject to errors and distortions, and these need to be identified and managed for effective use of these two technical constructs.

**T**he terms *transference* and *countertransference* have acquired a life of their own. Once neatly domesticated within psychoanalysis, they now roam through most forms of psychotherapy and beyond. My client seems to like me—is it just positive transference? I find my client 'creepy'—could it be negative countertransference?

Why do we dress up these simple feelings in psychoanalytic jargon? Probably in part because we want to reassure ourselves, and also let our colleagues know, that our work is not subject to the mindless passions of ordinary mortals. But, it is also likely that we want to harness these feelings and put them to work therapeutically. We want not just to gain some kind of intellectual control over them, but to

utilise them in the cause of therapeutic judgement and decision making.

This article is inspired by a concern that these terms have become so commonplace there is a real risk that therapists will gloss over the complex, and even problematic, nature of the underlying constructs. Without an appreciation of this complexity there is a risk that clinical use of the terms will result in more harm than good.

As a starting point, we must determine whether there is anything more to transference and countertransference than a positive or negative emotional experience of the other in the context of therapy? We think so. But, we also think that more turns out to be less than is often thought because transference and countertransference, when properly

identified, will only constitute a small part of the feelings that exist between therapist and client. Furthermore, there is sufficient difficulty in differentiating the transference (or countertransference) component in practice to demand a cautious approach to the use of these phenomena in the work of therapy.

Imagine my client does not like me, is always ready to find fault with what I do and is thinking of quitting therapy. Is it transference? The simple answer is...it might be. Perhaps he experiences me as the ineffectual mother who was unable or unwilling to protect him from the abuses of a tyrannical father. However, it might also be that I have done something to annoy him—said something he found demeaning, cancelled or changed an

appointment—and that he is a thin-skinned person who bears a grudge and does not forgive easily a minor transgression. It might be that he has prejudices or biases towards people like me in general—because of ethnicity, gender, age or whatever. It might be that the therapeutic alliance is weak—we could be at cross-purposes about the goals and tasks of therapy. Or, perhaps he does not want to be in therapy at all, but for some reason is unable to acknowledge this and finds it easier and more convenient to find fault with me. This all assumes I am not just a nasty sort of person who many people would have good cause to dislike.

In other words, the emotional response of the client to the therapist can have a variety of causes (see Table 1). Using the term ‘transference’ to refer to the negative emotional experience of the client in therapy is not only imprecise, but may also be dangerous if it absolves us from the responsibility of finding out what is actually going on. If we are to minimise this danger, it is necessary to return to the psychoanalytic meaning of the terms.

It is worth recalling that Freud’s first thoughts about transference were in relation to resistance to therapy. Freud thought that neurosis was largely a function of the repression of unacceptable ideas and impulses, and it would be natural for clients to resist the emergence of these ideas during the course of therapy. As repressed thoughts began to emerge, the client would seek any convenient distraction or diversion. Who better than the person of the therapist, who is both conveniently present in the immediate conscious experience of the client and is also the inquisitor responsible for activating these unwelcome thoughts. Furthermore, this resistance could be served almost equally well by hostility (negative transference) or love (positive transference). Intellectualisation with a little flattery (*“What a brilliant interpretation, Professor Freud... makes me think of a time when...”*) was probably more effective than abuse in diverting focus from uncomfortable thoughts. This explains why it was much easier for Freud to recognise transference in the Rat Man’s uncharacteristic abuse of him than in

the obsequiousness of the Wolf Man.

While it was useful to recognise that transference could be a form of resistance, it took an additional step to enable transference to take a central position in the work of therapy (Freud, 1905). This step, taken first by Freud, was both transformative and deeply problematic. Freud argued that transference takes the line of least resistance and seizes upon whatever

therapy were equally the royal road to this relational template. It was this development that brought transference into the centre of his work with his patients (Freud, 1915).

In other words, the emotional response to the therapist may have been activated and given its energy by resistance. However, the person created in the response was not the person of the therapist, but rather a

*...transference and countertransference, when properly identified, will only constitute a small part of the feelings that exist between therapist and client.*

is readily available to provide the ideational content as well as the emotional colouring of a positive or negative emotional response to the therapist. Given that the therapist assumes a benign, but neutral and professional, demeanor (more about this later), Freud concluded that any strong feelings—whether positive or negative—must be generated internally. Furthermore, Freud was of the view that a person’s internal representation of relationships was constructed using a template laid down in childhood. Therefore, just as dreams according to Freud were the ‘royal road to the unconscious’, the unprovoked emotional responses of the client in

foundational person in the emotional development of the client. At the core of the love or hostility expressed in the transference were feelings about a primary person in the life of the client, such as a mother, a father, a sibling or any other central person. Attentiveness to these feelings and the figure of their target enabled the therapist to access, in the immediacy of the consulting room, what the client could barely remember—the formative relationships that created the template upon which all subsequent important relationships were constructed.

The transformational element of viewing transference as a manifestation of core relationships, and not just

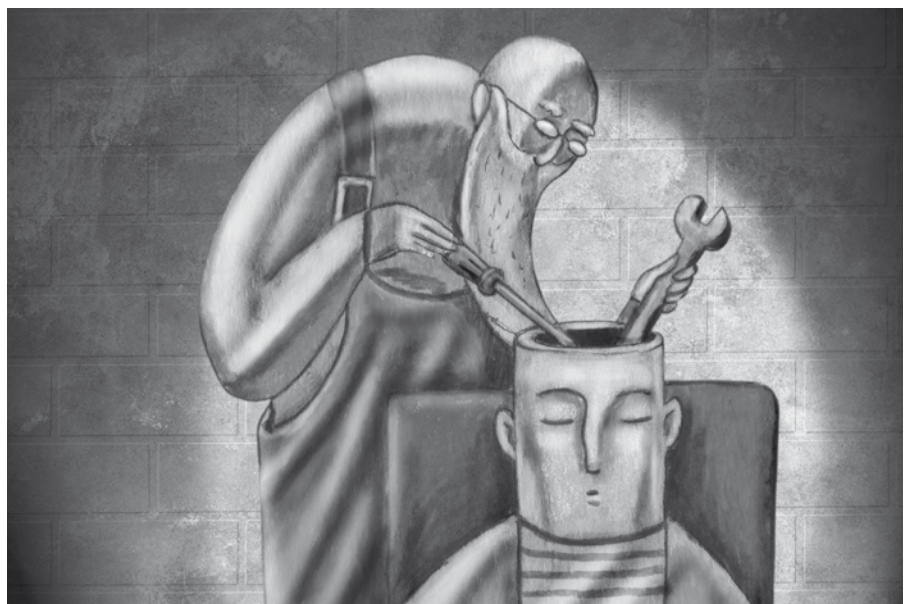


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	Positive	Negative
Stereotypical: emotional response to socially defined attributes.	The therapist is; <ul style="list-style-type: none"> <li>• well-dressed,</li> <li>• educated,</li> <li>• neat,</li> <li>• authoritative,</li> <li>• good-looking.</li> </ul>	The therapist is; <ul style="list-style-type: none"> <li>• sloppy,</li> <li>• foreign,</li> <li>• overweight,</li> <li>• young/old,</li> <li>• male.</li> </ul>
Situational: emotional response induced by therapist behaviour.	The Therapist is; <ul style="list-style-type: none"> <li>• attentive,</li> <li>• warm,</li> <li>• responsive.</li> </ul>	The therapist is; <ul style="list-style-type: none"> <li>• late,</li> <li>• yawning,</li> <li>• lacking eye contact.</li> </ul>
Alliance-based: emotional response based on state of therapeutic alliance.	<ul style="list-style-type: none"> <li>• I trust and feel safe with the therapist.</li> <li>• Therapist understands what I want to achieve in therapy.</li> <li>• Therapist clearly communicates how therapy works and what is expected of me.</li> </ul>	<ul style="list-style-type: none"> <li>• I don't know where I stand.</li> <li>• The therapist has his/her own agenda.</li> <li>• I don't know what I am doing here.</li> </ul>
Transference-based: response based on internal construction of the therapist rather than socially defined or actual qualities.	<ul style="list-style-type: none"> <li>• The therapist is very wise (just like my father).</li> <li>• The therapist will see me through thick and thin (just like my mother).</li> <li>• The therapist will never abandon me (just like the mother I wanted, but did not have).</li> </ul>	<ul style="list-style-type: none"> <li>• The therapist is taking pleasure in humiliating me (just like my father did).</li> <li>• The therapist is bored with me (and wishes I would go away just like my mother).</li> <li>• The therapist forgets who I am and mixes me up with other clients (I am the seventh of eight siblings).</li> </ul>

**Table 1. Classification of sources of positive and negative client responses towards therapists**

as resistance to therapy, was that it united the past and the present with an immediacy that could not be achieved through memory or accounts of relationships with third parties. The internal object world of the client was alive in the consulting room, open to examination by both therapist and client and, even more importantly, open to change. The transference both located the damage and made it available for repair, meaning that the therapy could truly become a 'corrective emotional experience'.

So, what makes this deeply problematic? There are two answers to this question. One pertains to the challenge of differentiating the transference component of client experience. The other pertains to the use of transference in a therapeutic intervention. We will consider them separately.

Freud's position was that therapeutic neutrality meant that emotional

responses to the therapist were likely to be transference. However, therapeutic neutrality is a myth. No matter how professional the demeanour of the therapist, nor how well-maintained the therapeutic frame, psychotherapy is an interpersonal process whereby the person of the therapist intrudes in more or less subtle ways. This may be through the décor of the consulting room, mode of dress, tone of voice or holiday arrangements. What this means is that when the patient responds to the therapist, the therapist is almost certainly implicated. Furthermore, the therapist may be blind to his or her own contribution.

Consider this example. The patient accuses the therapist of looking smug. The therapist does not think of himself as being smug and thinks his facial expression conveys neutrality—and an independent observer might agree that the therapist's face does in fact indicate neutrality. Does this mean

the therapist is justified in thinking that the accusation of smugness is best understood as internally generated, and probably evidence of transference? Context is important. Let us imagine that the client has just shared something with the therapist that is very painful. Instead of empathy and understanding, the client encountered a neutrality that was, perhaps not unreasonably, interpreted as indifference. In such circumstances smugness is not a big step, especially when we understand that the therapy is conducted in a room adorned with evidence of the therapist's success and good taste. In this context, it might be reasonable to conclude that the therapist has made a substantial contribution to the client's perception of smugness.

In reality, the emotional response of the client to the therapist is likely to be multifactorial or, as Freud put it, 'over-determined'. There may well be an element of transference in every emotional response. However, the size of that element is often difficult to determine. A therapist may be highly sensitised to the transference component and inflate it out of proportion, or may be completely insensitive and wonder why the client unexpectedly quit therapy. When a client responds negatively to the therapist, the therapist may be unconsciously motivated towards both kinds of error. A negative evaluation is unlikely to be welcome and, if the evidence is equivocal, the temptation is to ignore it and attend instead to evidence of a positive alliance. When it cannot be ignored, it is tempting to attribute it to the internal object world of the client rather than to failure on the part of the therapist. In other words, the psychical forces at work in the therapist do not necessarily favour accurate perception and attribution of negative affect from the client. Unfortunately, recognition of transference requires just these qualities.

The use of transference in therapeutic interventions may be even more problematic. To appreciate why, let us first assume that the therapist has identified correctly that a client response is primarily, or at least substantially, the result of

transference. What does the therapist then do with this knowledge? Sharing it with the client may simply generate resistance. Even if it does not generate resistance, it could easily be a therapist-induced diversion from what is most important to the client. In other words, interventions in response to

conducted almost entirely through exploration of transference. Anything the client says, however external or superficially unrelated to the person of the therapist, is interpreted through the lens of transference. Furthermore, interpretations are given with a confidence approaching certainty.

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transference may not be effective, even when accurate identification of the transference has occurred. Given the challenges to accurate identification discussed above, there is additional risk that 'transference' will be a function of the therapist's own intrapsychic processes and will simply confuse or alienate the client.

In the light of these difficulties, it is not surprising that therapists often simply ignore transference, as has been the approach of programmatic therapies such as cognitive behavioural therapy. However, transference does create opportunities for immediate and emotionally alive investigation of interpersonal experience. If, as is often the case, a client has entered into therapy mainly or partly to better understand relationships with others, it seems a waste to overlook the relationship that is most present and available. It follows that therapists may reasonably seek strategies and/or frameworks that best manage risks without discarding the opportunities.

We are aware of two broad strategies with dramatically different implications for technique. One might be termed 'transference focus' and the other 'cautious use of transference'.

#### *Transference focus*

Transference focus is most often associated with the Kleinian object relations tradition of psychoanalytic work. In essence, the therapist takes the position that the therapy is best

This is because they are largely based on countertransference (see below). The underlying principle is simple enough. Therapy is an interpersonal process. Whatever the client says is in part a function of the person to whom it is addressed or, more accurately, of the client's construction of that person. For a Kleinian, it is that part, however small, which is most salient. Transference interpretations begin early in therapy so that the client quickly learns that this is what therapy is about. In such a therapy, the client either appreciates the value of this kind of focus or quits. Arguments about the value, or even legitimacy, of transference interpretations are themselves viewed as a product of transference.

#### *Cautious use of transference*

'Cautious use of transference' takes the opposite approach. It acknowledges the pitfalls and uncertainties of transference and the real possibility that the therapist is wrong in forming their view that client response is due to transference. The cautious therapist looks for evidence in the form of repeated patterns of relationship, as described by the client. Transference is introduced only where it seems clear that the client's response to the therapist has similarities with other important relationships. Even then the approach to interpretation is careful and tentative.

#### **Countertransference**

Where the concept of transference was introduced by Freud, the concept of countertransference, especially the use of countertransference in therapy, was a later development associated with the British object relations traditions, in particular, the Independents and the Post-Kleinians (Spillius, 1988; Kohon, 1986).

Freud was not oblivious to feelings therapists have towards their clients. The central premise of his 1915 paper, '*Observations on Transference-Love*', was that therapists were vulnerable to reciprocate the affection expressed towards them by their clients—sometimes even falling in love with clients. His position was that therapists needed to understand that positive feelings communicated by clients were a function of transference rather than a response to the person of the therapist. He took the view that once the therapist understood the client was not in love with him or her as a person, but rather that the love was directed towards a more primary love object represented by the therapist, that the therapist could approach the work in a dispassionate and professional manner.

For Freud, intense feelings for or about the client were warning signs of the need for more personal analysis for the analyst. While Freud's advice was essentially that therapists should disregard or overcome any feelings they might develop towards clients, it is not surprising that others regarded these feelings as a valuable source of information. If, as Freud suggested, feelings towards a client were often a response to client transference, then it followed that careful attention to such feelings would inform the therapist about the nature of this transference. At the simplest level, positive feelings towards a client might imply that the client's transference was positive and negative feelings that the transference was negative.

Klein's theory of projective identification provided further impetus. Klein saw projection as a ubiquitous intrapsychic process. She thought that clients used projective mechanisms to expel unwanted thoughts and feelings, and that the nature of projection required a second person to whom the client could attribute these thoughts

and feelings. For Klein and her followers, projection was more than just attribution. It involved causing the other to actually experience the projected thoughts and feelings. The precise mechanism by which a person would come to experience, and even own, thoughts and feelings projected and disowned by another was not clearly articulated. However, it was presented as some variation on the identificatory processes associated with what we think of as empathy, hence the term 'projective-identification'.

If the therapist can, in effect, become custodian of thoughts and feelings expelled by a client, it follows that the therapist can develop a deep and intimate knowledge of these unacceptable thoughts and feelings by interrogating her or his internal state. This understanding can be made available to the client at a point in the therapy when the client is capable of thinking and not just expelling. At its extreme, this view of countertransference leads to the position that what the client says in therapy is of secondary importance compared with what the therapist is feeling and experiencing when interacting with the client.

However, the utility of countertransference depends on the ability of the therapist to discriminate accurately between feelings towards a client that are activated by client projections, and feelings better understood as having their origins elsewhere. Given the interpersonal quality of psychotherapy, feelings may not have a clear source in either party, but may arise in the course of interaction.

This is likely to be a more difficult task than interpretation of transference. Whereas the therapist may be dispassionate in the face of transference, by definition this is not the case with countertransference. Accurate interpretation of countertransference requires that the therapist must be able to make judgements that are cognisant of his or her emotional state and, at the same time, not influenced by this state. (Laine, 2007). Let us consider an example.

### Case example

*Therapist Angela has been working with client Ben for six months. Ben has a history of chronic dysphoria and interpersonal problems. Ben is rather passive in therapy. He does not have much*

*to say except to offer a narrative about what he has been doing during the week. From time to time he makes it clear that his dysphoric mood is not improving and he expresses some vague dissatisfaction with the therapy, which is not really helping and is expensive.*

*Angela does not look forward to seeing Ben. She notices having thoughts that it would be nice if Ben cancelled an appointment. She sometimes thinks she should introduce a discussion with Ben about the value of the therapy, but she is not sure how to begin such a discussion. During the sessions she often feels bored. A fifty minute session seems interminable.*

When she works with Ben, Angela feels demoralised and doubts her therapeutic skills. How does she know whether or not this is due to countertransference? It is possible that she feels inadequate simply because she lacks the capacity to help Ben and that another therapist would feel quite differently. It is also possible that she finds people like Ben irritating and that her feelings of boredom are a secondary effect of trying to control her irritation. In both instances, countertransference is a poor explanation. On the other hand it is possible that Ben is overwhelmed by feelings of inadequacy and despair and that he manages these feelings by projecting them and causing Angela to experience them. In such circumstances, Ben might actually feel better as Angela struggles. Equally, Ben might be subject to feelings of rage, which he finds unacceptable and transforms into a kind of deadness, which he conveys to Angela. In either of these cases, Angela's emotional state in response to Ben provides important information about Ben's internal state.

The critical question is how well

placed is Angela to determine which (or which combination) of these possibilities is most salient. If Angela is a rather self-assured person with some narcissistic traits she may be less likely to consider the first two possibilities

## *Privileging countertransference over more transparent client communications risks ruptures in the therapeutic relationship.*

and more likely to find the second pair attractive. On the other hand, if Angela is prone to self-doubt and somewhat depressive, she may well be drawn to one or both of the first pair of explanations. The central problem is that Angela is even less well placed to interpret her own emotional responses accurately than she is to interpret Ben's transference.

Traditionally, some combination of supervision and personal therapy are viewed as the mechanism by which objectivity about countertransference can be established. We agree that these are likely to be helpful, but they also rely on how Angela presents her emotional experience, which she has already processed and may well present selectively, either intentionally or unconsciously.

What this means is that, while countertransference may well provide valuable information about the internal world of the client, there is high risk of distortion. Privileging countertransference over more transparent client communications risks ruptures in the therapeutic relationship. However, it does not follow that countertransference should be disregarded. Noticing and thinking about emotional responses to the client is usually worthwhile. The issue is when the therapist should treat such responses as information central to an understanding and interpretation of the inner world of the client.

There are two circumstances when countertransference experiences may usefully inform therapeutic interventions. The first is when they align with other information communicated by the client. In such circumstances, countertransference

experience can form part of the evidentiary basis for a formulation. The second is when more transparent sources of information are yielding little that is new and/or the therapy is at an impasse. In such circumstances, reflection on countertransference may assist the therapist to access the source of the impasse, and interventions based on such reflection may assist the client to move forward.

### Conclusion

The terms transference and countertransference have developed a wide use in psychotherapy and are no longer associated exclusively with therapies based on psychoanalysis. We

think this is as it should be. Clients and therapists will have emotional responses to each other, regardless of the therapy framework. Furthermore, these responses have the potential to inform the work of the therapy with an immediacy that enhances the impact of therapeutic communication.

However, there are good reasons to expect that interpretation of transference and countertransference will be subject to error and distortion. Identification and management of these errors and distortions is critical for effective use of transference and countertransference.

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