

TRANSFERENCE AND COUNTERTRANSFERENCE



Arno Remmers

M.D., psychotherapist, International Trainer of PPT private lecturer and supervisor at the Wiesbaden Academy for Psychotherapy (WIAP) (Wiesbaden, Germany)

Email: arno@arem.de

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Abstract

Psychodynamic therapists use the interpersonal experience in therapeutic relations to understand the subconscious background of a client's disorder, use it for diagnosis, treatment plans, interventions and supervision. Transference and countertransference were defined and described in the article. In the presented article the five skills of the therapist were distinguished in the five stages of therapy, beginning with the perception of one's own feelings in the transference.

Keywords: transference, countertransference, positive psychotherapy, five stages of therapy

Introduction

*"Every person transmits experiences unconsciously to new situations and people and each patient transfers to their therapist".
(Gerd Rudolf 2004 p. 142)*

Conflict is defined as a difficulty of one individual or Psychodynamic therapists use the interpersonal experience in therapeutic relations to understand the subconscious background of a client's disorder, use it for diagnosis, treatment plans, interventions and supervision. The feelings, body sensations, impulses to act or memories of former relations and persons coming up in the therapist, as well as intuitive imaginations and fantasies in the therapist are subjects of the interactive transference and countertransference process. The mainly subconscious or preconscious sensations in the therapist are described as countertransference. They represent a mixture of the therapist's own ideas and experiences in life, and of the ones that are specific for the encounter

with this unique client. The contents of countertransference can represent a specific subject, a conflict content, a relationship pattern or specific characteristics of the client's and the therapist's personalities.

Transference is defined as the way a client unconsciously perceives the therapist as a feeling, acting, interacting and reacting person, comparable to a situation or person in the client's earlier life.

Verbalization of the contents of transference and countertransference helps to understand and work with conflict contents and personality structure, resistance and defense mechanisms, specific relationship patterns and phases of development that are subconsciously reflected and restaged in the therapeutic interaction.

Methodology

Transference reflects experiences of earlier interactions that are unconsciously projected onto the therapist. Transference includes, above all, **repressed expectations, fears, longings, desires,**

experiences, drive impulses, relationship needs, relationship patterns and interaction stereotypes.

The following **questions to yourself** are suitable for recognising typical transference patterns:

- **Whom** does my counterpart see in me, how/who will I be for my counterpart in therapy? (Role, family constellation, reference person)
- **What** does my counterpart see in me, as often in certain others? (Content, conflict issues, relationship patterns)
- What does my counterpart **expect from** me, as often from others? (Wishes, needs, fears)
- Which of my patient's **reactions** seem inappropriate, distorted or incomprehensible to me in relation to the therapeutic situation?
- Does my patient talk about feelings, wishes or views of third parties that could also apply to our therapeutic situation or to me as therapist?

The challenge to the other person to recognise the transference is the subject of therapy:

- Which feeling, which person, which episodes, which wishes and fears does my person and our encounter remind the patient of? (Affects, recognition of situations and persons).

The analysis of transference and interaction makes the patient and therapist aware of the significance of current relationship patterns that used to be helpful, protective, functional for certain situations, but which today can become dysfunctional relationship patterns. The expectations, experiences, conflict contents contained in them can also be seen as abilities in therapy and thus become new resources. The corresponding question is, for example, "When in your life has this experience helped you, been useful, protected you from something? In this way, patterns of interaction can also be recognised together in the encounter with each other and finally modified in the therapeutic relationship.

Transference is linked to "models" (Freud 1912), to "imagines" such as father, mother, brother or sister imago... Freud emphasises that the patient "inserts the doctor into one of the psychic series which the sufferer has hitherto formed" (Laplanche and Pontalis 1972). - Arlow (1979): Transference phenomena are characterised by a considerable rigidity with which patients distort the inherently ambiguous reality of the therapeutic relationship from the point of view of feature similarity with early attachment figures. - transference is "a specific illusion that occurs in relation to another person and that, without the subject's knowledge, represents in some of its features a repetition of the relationship to a significant figure of one's own past" (Sandler et al. 1996, cited in Wöller, Kruse 2001). The emphasis on transference in the "here and now" of the therapeutic situation has been in the foreground since Gill et al. (1982). - Kohut (1971): Mirroring self-object transferences arise from the need for a self-object through whose feedback to the patient the self can continue to grow. This can result in a self-object countertransference in which the therapist feels the patient as a part of him/herself. Fosshage (1994): "In treatment, too, the patient comes with self-object needs,...and sooner or later directs them towards the therapist in the expectation that the therapist will deal with them in a way that promotes development." "At the same time, the patient also harbours fears that his negative experiences could be repeated again in the relationship with the analyst, some patients virtually expect this" (after Hartmann H. P., W. Milch 2000)

"Positive transference phenomena: Positive characteristics are attributed to the therapist without knowing him/her any better....

Negative transference phenomena: patient expects that therapist will condemn, despise or not take him seriously for what he says....

Erotised transference phenomena: conviction of the patient to be desired by the therapist or to present him/herself as an attractive sexual partner" (according to Wöller W, J. Kruse 2001).

Countertransference includes all the sensations, actions, communication patterns and associations that arise in the therapist on the occasion of a therapeutic encounter and are typical for this encounter.

The perception of a countertransference can be dressed up in questions like:

- What does this patient trigger in me?
- What am I thinking while I am with this person, what am I doing differently than usual?
- What do I experience differently in the interaction with this person than usual?

- What do I wish for this patient and myself, what fantasies do I have?
- What do I fear for the patient and myself?

Forms of perception of countertransference:

1. Physical perception of feelings, posture, vegetative reactions
2. Perceiving one's own patterns of action, therapeutic considerations as specific to this encounter.
3. Communication patterns and body language encounter
4. Fantasies, images, desires, digressions, fears, memories of previous encounters or episodes of one's life.

Countertransference includes concordant and complementary emotions and fantasies. Concordant countertransference triggers co-occurring emotions and fantasies with the counterpart. Complementary countertransference phenomena show opposing feelings and thoughts that are warded off in the counterpart (in the case of conflict and defence) or cannot be expressed by the counterpart at all (in the case of structural restriction).

Unconsciously defended, tabooed, internally sanctioned strivings can evoke in the therapist, in the countertransference, precisely what the patient has defended as content and fantasies. In conflict-related therapy, these can be made available to the other person as a theme. More important, however, is the reflection of the meaning of the countertransference, the becoming aware of these phenomena, for the therapist him/herself, so that experience shows that the interaction changes in the following sessions, even if the countertransference contents are not verbalised with the patient. In this way, it is possible for the patient to overcome the defence, to become aware of the actual desires, fears, feelings, memories that have so far prevented an appropriate perception and dealing with situations and strivings.

Laplanche and Pontalis (1972):

Countertransference is the "totality of the analyst's unconscious reactions to the analysand's person and especially to the analysand's transference". British School (Melanie Klein, Paula Heinemann, Betty Joseph, Pearl King): Countertransference is no longer seen as an obstacle but as an important indication of the patient's denied or repressed affects (after Hartmann H. P., W. Milch 2000).

Rudolf (2004)

"...what emerges with a regularity in the countertransference to neurotic patients: The idea of taking on a certain role towards the patient, which in connection with the patient's own role shapes a relational figure: affirming each other, rivaling each other, courting and eroticising each other, punishing or rewarding each other, caring for each other."

In the structure-related therapy of so-called "personality disorders", the usually very intensive countertransferences are to be kept in containment and are important information about the structural needs of the patient. They refer, for example, to what was not possible for the parents, such as positive feelings that trigger concern, patience, protection, love, closeness, attachment in the countertransference, or to negative feelings that also existed in the parents that trigger, for example, rejection, distance or anger in the countertransference. Here the importance of the primary actual abilities as an existential need of a child to its parents becomes clear - the intensity of the countertransference is carried by an unconscious appeal and the existential fear and aggression behind it, which are transferred to the therapeutic situation.

Rudolf (2004):

"The countertransference sensations in structurally vulnerable patients refer to the otherness, often strangeness of the patient: This patient is so very different, difficult to comprehend, in places uncanny, threatening and menacing."

Countertransference analysis supports the effective "corrective emotional experience" (Alexander 1937) of the therapeutic relationship by making the patient and therapist aware of the transferred and repressed elements of interaction.

The **perception of a countertransference** can be grasped in terms of **affect, emotion, ability, aspiration, desire, apprehension, draft action, defence, relational pattern, conflict content, related to** the psychodynamics and sociodynamics of the patient and related to the patient's transference patterns.

Countertransference dimensionally differentiated, according to H. Faller 2000:

1. Factor **"sympathy"**: fascination, erotic attraction, admiration, sympathy, interest.
2. Factor **"helpfulness"**: compassion, concern, willingness to help, need to become active, grief.
3. Factor **"anger"**: need for demarcation, feelings of annoyance, anger, tension.
4. **Hopelessness** factor, feelings of guilt, feelings of powerlessness.
 - Positive countertransference: Higher sympathy scores and helpfulness than in many other patients, medium anger scores.
 - Weak countertransference: Few countertransference feelings (common in first examinations).
 - Ambivalent countertransference: Simultaneous helpfulness, anger and little sympathy (rarer)
 - Negative countertransference: Little sympathy or helpfulness, on the other hand anger (rare).

Discussion

Through the patient's transference, the therapist gets into a certain **role** which is occasionally perceived differently before, during the therapy session and in retrospect of the encounter with the patient. The unconscious role assumption often only becomes conscious after the session or in supervision and can be a reenactment of earlier scenes of the patient. The role can be described by its function and the contents that emerge in it.

In which role do I experience myself when I start the therapy session?

What role do I experience in the session?

Looking back, what role did I get in the therapy session?

If at first I always feel "motherly caring" or "fatherly trusting" towards the patient, in a "sibling competition" or in the "older sibling role", I can differentiate this more closely: What kind of care is meant? What kind of trust or confidence is at stake? Is my patience required, my time, is my

action or my sense of justice called for? Am I seen as a role model? The actual skills are suitable to describe what is specific to the role.

Five skills of the therapist are to be distinguished in the five stages of therapy, beginning with the perception of one's own feelings in the transference .

1. Observation and distancing:

The ability to listen patiently and empathetically to the patient in an atmosphere of acceptance, to understand the patient and the function of the symptom and to add other points of view: This is about empathy and the ability to distance oneself, the ability to perceive the feelings that arise and to name them. In therapy, this corresponds to the phase of connectedness, incipient trust, hope and change of location.

2. Differentiation and inventory:

The ability to ask precise questions, define content, describe antecedents, psychodynamics, diagnoses, interactions and possibilities. What is required here are the critical and analytical skills and the ability to translate the feelings arising in the transference into concepts of ability, conflict content and relational patterns, and to relate them to the patient's history. This phase of differentiating conflict and self-help potential through content description prepares the further therapeutic phases.

3. Resource activation and encouragement in the patient's situation and environment:

The ability to accompany the patient, to use methods to strengthen him and to mobilise his self-help: Knowledge and use of physical, medicinal, behavioural, psychological, family and group-oriented as well as meditative possibilities as temporary help for the patient to activate his self-help potentials. The ability to develop the feelings that the patient lacks himself and to place them alongside one-sided feelings is particularly necessary in structure-oriented treatment. In conflict-oriented treatment, the defended feelings will emerge in the complementary countertransference, which the patient can confront. This step is about mobilising the resources for self-help - the patient and his/her family become active participants in the healing process.

4. Conflict resolution strategies:

The ability to deal with conflicts in a targeted way through a structured approach and to work out the patient's responsibility for changed actions and their effects Methodology and counselling; be able to openly train affective-emotional change

possibilities with the patient and enable him/her to deal responsibly with unchangeable feelings and affective ways of acting; recognise the connection to countertransference and bring it into supervision (Setting, coping, verbal and active content-based conflict management, family therapy).

5. Target expansion:

Being able to focus on the future after conflict management therapy: Effectively teach self-help and achieve patient independence.

To enable the patient to consciously experience sensations and differentiate their content in relationships (Phase of detachment, seeing problems and therapy as a chance for a new beginning, self-help alone).

Conclusions

Transference is defined as the way a client unconsciously perceives the therapist as a feeling, acting, interacting and reacting person comparable to a situation or person in the earlier life.

Verbalization of transference and countertransference contents helps to understand and work with conflict contents and personality structure, resistance and defense mechanisms, specific relation patterns and development phases that are subconsciously reflected and restaged in the therapeutic interaction.

Five skills of the therapist were distinguished in the five stages of therapy, beginning with the

perception of one's own feelings in the transference.

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