Section: Theoretical reviews and research in PPT

PSYCHODYNAMICS OF TRANSFERENCE AND COUNTERTRANSFERENCE IN THE PSYCHOTHERAPY WITH SEXUAL TRAUMA

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Abstract

In this article, we emphasize the nature of transference and countertransference while working with sexual trauma. Such kind of trauma can evoke intense emotional, cognitive, and somatic reactions. In order to avoid projective distortions and maintain the therapeutic stance, therapists need to develop an awareness of their reactions and use this dynamic as a pathway to a deeper understanding of the client's or patient's trauma. This article reviews theoretical perspectives from classical psychoanalysis to positive psychotherapy, illustrating methods for identifying and using transference and countertransference as therapeutic tools. In addition, the article discusses the prevalence and impact of sexual abuse on mental health. It describes how these psychodynamic processes work within an evidence-based framework to support emotional recovery.

This article emphasizes the need for ongoing self-reflection and supervision for therapists to prevent professional burnout and increase their therapeutic effectiveness while working with patients and clients with sexual trauma.

Keywords: transference, countertransference, sexual trauma, Positive Psychotherapy

Introduction

Transference and countertransference are key phenomena in the psychotherapeutic relationship, which psychotherapists of various psychodynamic schools study. These processes are especially important while working with cases of sexual violence, as traumatic experience is also transferred to the therapeutic space.

Transference can manifest as a way of recreating past experiences to interpret and integrate them, becoming a kind of 'clue' on the way to healing. Countertransference, in turn, emphasizes the therapist's reactions to the client/patient arising in response to the transference. This phenomenon involves not only conscious but also unconscious reactions of the therapist, which can be related to many factors.

When working with clients/patients who have experienced sexual violence, transference is often accompanied by intense reactions that have occurred in their experience. Such reactions as feelings, sensations, thoughts, fantasies, fears, and actions can cause complex countertransference reactions that must be carefully addressed. It is important for the therapist to be able to recognize these processes and use them as a tool to gain a deeper understanding of the client's traumatic experience.

The article explores the phenomena of transference and countertransference and the

peculiarities of their processing in the therapy of sexual violence. We also emphasize the practical aspects of therapeutic work and the avoidance of typical difficulties.

Methodology

2.1. Definitions of transference and countertransference: from classical psychoanalysis to positive psychotherapy.

Transference and countertransference are key concepts in psychodynamic psychotherapy. The concept of transference was first introduced by Freud S. & Breuer J. (1956), who described how patients reproduce their past emotional experiences in their relationship with the analyst. Later, Freud S. (1912) emphasized that transference is an integral part of therapy that helps to identify and integrate unconscious conflicts. Other researchers have significantly expanded and deepened the understanding of transference: Jung C. (1954) believed that transference has an archetypal dimension associated with the collective unconscious and can express universal symbols and themes; Klein M. (1932) emphasised that transference reflects the patient's internal objects, creating an opportunity for rethinking traumatic experiences; Kernberg O. (1965) considered transference as the main tool in working with patients from the boundary level of personality organisation, emphasising the need for conscious analysis by the therapist; Winnicott D. (1971) noted that transference allows the patient to re-experience and integrate early emotional experiences in a safe therapeutic space; Bion W. (1961) considered transference as a form of unconscious communication and emphasised the importance of the therapist's "container function" for processing strong emotions of the patient; Yalom I. (2001) emphasised the importance of transference in existential and group therapy, noting that it can be both a resource and a challenge in therapeutic work.

Countertransference is the therapist's emotional and psychological reaction to the client/patient, which can be both conscious and unconscious. It was introduced by Freud S. (1910) in the context of psychoanalysis while analyzing psychoanalytic emotional reactions to a patient. After Freud S., the concept of countertransference has been developed by other psychotherapists: Klein M. (1932) developed the idea that countertransference is a tool for understanding the patient's inner world and emphasised that through countertransference the therapist gains access to the patient's unconscious projections; Kernberg O. (1965) went deeper to investigate countertransference in cases with patients of borderline functioning, noting that the therapist must be actively aware of their emotional reactions in order to avoid their influence on the therapeutic process; Winnicott D. (1971) emphasised the importance of creating a therapeutic space where transference and countertransference become tools for restoring the patient's emotional balance, helping him to recreate early experiences in a safe environment; Bion, W. (1961) stressed that the therapist can use his emotions as a key to understanding the patient's unconscious communications and proposed the concept of "container function", according to which the therapist accepts and processes intense emotional experiences of the patient, facilitating their integration into his experience. Countertransference is a valuable tool for understanding the patient's inner world. However, Caligor, E., Kernberg, O.F., Clarkin, J.F. and Yeomans, F.E. (2019) identify four levels of countertransference, among which the key is the unconscious response to the patient, which manifests itself when other factors (therapist's personal conflicts, universal reactions to human relationships or external circumstances) are excluded, and reflects the therapist's deep processes that remain beyond his or her awareness. In this type of countertransference, if a patient makes the therapist feel ashamed, it may indicate that the patient is also experiencing similar feelings. Understanding and working with these reactions helps to deepen the therapeutic process and to better understand how the patient's past experiences influence their current relationships and behavior. In positive psychotherapy, transference and countertransference are the focus of research by Peseschkian N. (1987), Goncharov M. (2013), Kirillov I. (2019), Peseschkian H. and Remmers A. (2020), Dobiała E. (2020) Remmers A. (2021; 2023), Henrichs C. and Hum G. (2021), who emphasize the importance of interpersonal dialogue for the patient's healing and development.

Kirillov I. (2019) defines these concepts in the method of positive psychotherapy:

1. Transference is the ability of a person to spontaneously reproduce in the here and now, in an actual situation (including therapy), the significant emotional experience of the underlying conflict "there and then." Transference gives the therapist direct access to the patient's inner world.

2. Countertransference is the ability of a therapist to respond spontaneously to circumstances and behavior based on their own emotional experience. Exploring one's emotional experience allows the therapist to use conscious countertransference as a powerful tool for diagnosis and therapy.

2.1. Sexual violence: prevalence, forms, and impact on mental health

It was mentioned by Borumandnia N. and Khadembashi N. (2020) that about 35.6% of women in the world were subjected to sexual violence. Thus, it is hard to provide such statistics regarding men as it can be difficult to assess the scale of the problem. Shevchuk T. (2018) specifies that according to the United Nations Children's Fund (UNICEF), approximately 150 million girls and 73 million boys under the age of 18 experience sexual violence and exploitation every year.

Memories of traumatic events can often be repressed, and transference and countertransference are important tools for accessing the trauma hidden in the underlying conflict. A study by Williams (1995) found that only 16% of women who recalled experiencing sexual violence had initially repressed these memories. Complete amnesia is particularly common in cases of childhood sexual abuse: between 19% and 38% of survivors could completely forget the events.

This phenomenon raises several complex questions: Are such memories merely the product of morbid fantasies? Are people capable of creating physical sensations that they have never experienced? Where is the line between morbid imagination and rich fantasy? Is it possible that I am between memories and fantasies? These questions remain actual for many survivors of sexual violence and those who support them. Traumatic reactions are often irrational, uncontrollable, and strong. It can be difficult to control impulses and emotions, leading to feelings of "madness" and thoughts that one no longer belongs in this world. An important first step in recovery is learning to feel, name, and understand your internal world (feelings, thoughts, emotions, fears).

Van der Kolk B. (2014) specifies that between 36% and 51% of patients in psychiatric wards have experienced sexual abuse in childhood or adolescence, which indicates a close connection between trauma and the development of mental disorders. It is worth noting that people who have experienced trauma often doubt their memories, while psychotic hallucinations usually do not. Van der Kolk B. (2014) emphasizes that a characteristic feature of traumatic memory is a tendency to internalize doubt, even when these memories seem to be similar to hallucinations or delusions. This feature reflects the difficulty of integrating traumatic experiences into a person's personal history, which leads to the fragmentation of memories and partial dissociation.

Thus, therapists often work with repressed memories, even if patients unconsciously repress these experiences. Countertransference and transference help therapists recognize and process these traumatic experiences, creating space for emotional recovery.

In order to understand the patient's displaced experiences, it is advisable to consider the types of sexual violence, in particular, taking into account social and cultural factors. Brown J. and Walklate S. (2011) identify the main forms of sexual violence: sexual harassment, rape, domestic violence, and the impact of war and conflict on the spread of sexual violence. These categories align with international standards set out in reports by the World Health Organization (WHO) and the United Nations (UN) and with materials from psychological and human rights organizations. According to the WHO, sexual violence encompasses any forced sexual act or act directed against a person without their consent, including physical, emotional, and psychological violence (WHO, 2021). The UN Declaration on the Elimination of Violence against Women (1993) expands this concept to include sexual violence, trafficking, and violence in intimate relationships, which underscores the importance of addressing these forms of violence at the international level. In the national context, the Law of Ukraine "On Preventing and Combating Domestic Violence" (2019) defines sexual violence as a form of domestic violence that includes any act of a sexual nature committed without the consent of an adult or regardless of consent against a child. This

category also includes acts of a sexual nature committed in the presence of a child, coercion to have sexual intercourse with a third party, and other offenses against sexual freedom or inviolability of the person (Law of Ukraine, 2019). It is worth noting that sexual violence does not always involve physical touch; it can also occur in the absence of bodily contact when a person either witnesses or is a victim of sexual violence without physical interaction.

Discussion

Understanding the types of sexual violence in international and national contexts is an important element for effective psychotherapy, including in the context of working with transference and countertransference. Psychotherapists often face transference and countertransference when working with patients who have experienced sexual violence. According to Herman J. (2015), patients may unconsciously project their emotions onto the therapist, seeing him or her as both a saviour and an abuser, which makes it difficult to build trust, reflected in traumatic transference and countertransference as a response to the patient's unconscious.

Kernberg O. (1984) specifies that the therapist's countertransference reflect the patient's internal processes, helping to identify their unconscious roles formed through traumatic relationships (he calls this process - dyads). Ruppert F. (2008) explains that trauma provokes a split of the personality into three parts: surviving, traumatized, and healthy self. All these parts are functioning through dissociation to maintain psychological balance.

Van der Kolk B. (2014) specifies that survivors of childhood sexual abuse may repress their sexuality and experience shame in response to feelings or images that remind them of the trauma experience. Natural bodily pleasures can cause discomfort and guilt due to the activation of traumatic memories. In the process of verbalising the trauma (voicing, working through transference and countertransference), these patients may experience various physiological reactions, such as increased blood pressure, migraine attacks, or emotional withdrawal without visible physical changes. This reaction is evidence of dissociation as a defence mechanism to avoid emotional overload.

3.1. The Model Dimensions concept while exploring transference and countertransference

In this context, understanding the origin and specifics of role model sexual abuse becomes an important tool for the therapist. This approach allows for a deeper exploration into the patient's unconscious processes, using the mechanisms of transference and countertransference. Thus, in specific situations, the therapist may unconsciously identify either with the patient's experiences of violence or with his/her perpetrator, which can be difficult to maintain neutrality and can trigger hidden emotional reactions. Below, we will consider the role model's experience of sexual violence and the typical feelings that a therapist may experience in countertransference.

1. **"I" sphere.** *Sexual abuse of a child by those who care about him/her (parents, siblings, relatives)*. E Studies show that 80 per cent of cases of sexual abuse of children are committed by relatives or persons close to the family, which significantly increases the traumatic effect, as these people enjoy the child's trust. Violation of physical and psychological boundaries leads to the loss of the ability to distinguish between care and violence, distorting basic ideas about the world and self-worth. Touching that causes pain, or the absence of it, can create a distorted perception of bodily contact, creating a dichotomy: "a fervent desire for human touch with a simultaneous fear of physical contact." In countertransference, unconscious identification with the victim can cause the therapist to feel powerless or alienated or identification with the perpetrator can evoke complex, uncontrollable emotions, ranging from guilt and shame to unexpected arousal or pleasure, depending on the patient's unconscious processes.

2. **"You" sphere.** *A child as a witness of sexual violence between significant adults.* A child as a witness of sexual violence between significant adults. This experience reinforces violent models as an acceptable form of interaction in the child's mind. This creates a risk that the child may repeat these behaviours or avoid intimacy in future relationships. Fear of intimacy and emotional isolation often accompany such experiences, creating a distrust of relationships and a desire to avoid close contact. The therapist, unconsciously stepping

into the patient's shoes, may experience a fear of intimacy or, conversely, unconsciously distance themselves, experiencing anxiety in the context of close relationships.

3. **"We" sphere.** *The child is a witness of violence by significant adults against other people.* Observing violent acts, even without physical contact, can create the perception that any relationship contains elements of dominance and submission. This may lead to the development of aggressive or passive behavioral strategies in adulthood, where the individual identifies with the aggressor or victim, repeating these roles in the relationship. The therapist under countertransference may feel powerless in the face of authority or an increased desire to control, which can affect his neutrality.

4. **"Primer - We" sphere.** *Impact on generation from significant adults how they attitude to the of sexual violence.* Transmission of transgenerational trauma. Once sexual violence becomes part of the family narrative heritage, it can be transmitted through generations using behavior. These patterns form attitudes towards sexuality, intimacy, and violence in the family. Cultural taboos on discussing sexual violence contribute to further trauma and make it difficult to deal with. It was also proven by the research of Lytvynenko and Tereshchenko (2024), who mentioned that unresolved traumatic experiences affect the behavior and worldview of subsequent generations. It can be manifested as distrust, overprotection, or control, which become part of family history and determine the nature of future relationships of descendants. In this context, the therapist may unconsciously identify himself as a defender or observer of trauma. It can activate the need to intervene or feel uncomfortable when traumatic topics touch on their boundaries.

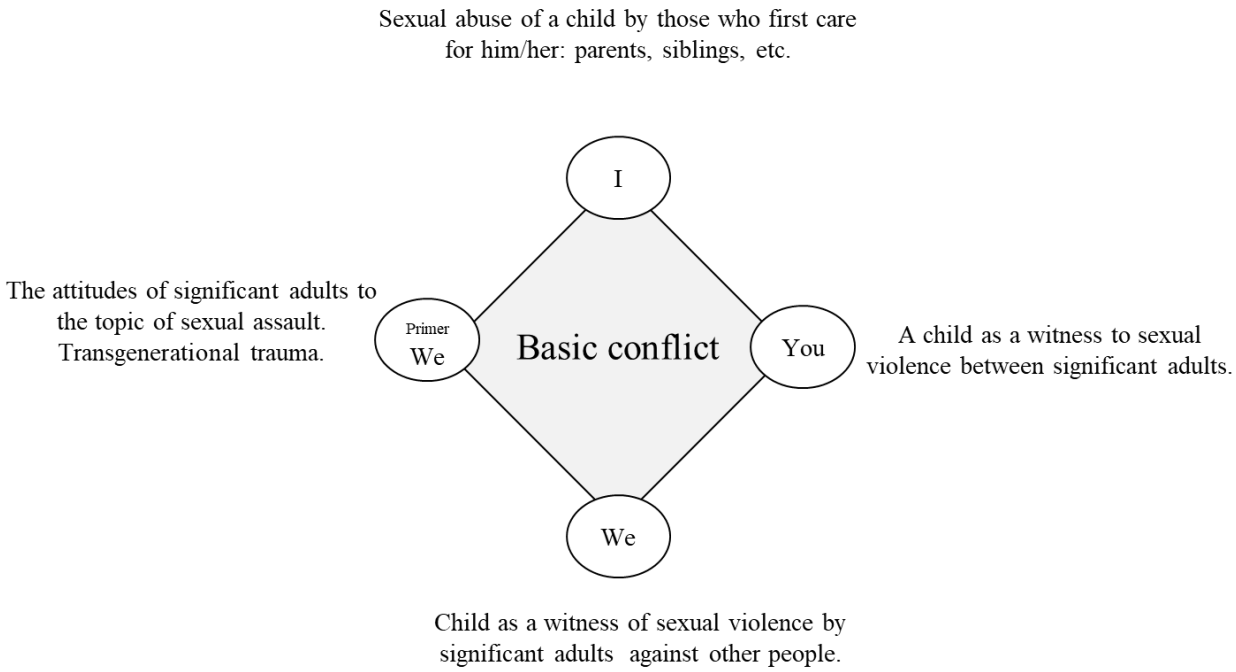

Figure 1. A model of sexual trauma formation

3.2. The Balance model concept while exploring transference and countertransference

The process of providing therapeutic support to a survivor of sexual violence poses profound emotional, physical, mental, and meaningful challenges to the therapist. Peseschkian H. and Remmers A. (2020) note that the Balance model helps to analyze not only the patient's transference but also the therapist's countertransference, which allows the therapist to interpret their reactions more deeply and increases the effectiveness of therapy. Understanding these channels helps the therapist be aware of their reactions and regulate them effectively, thus ensuring empathy and professional effectiveness in working with trauma. Thus, in the process of

psychotherapy, transference and countertransference can become effective tools for contacting the patient's repressed and painful experiences, which can manifest through the four channels of cognition of the world. According to Goncharov M. (2013), these channels cover all temporal dimensions: feelings and thoughts related to the present, experience of the past, and fantasies and expectations of the future.

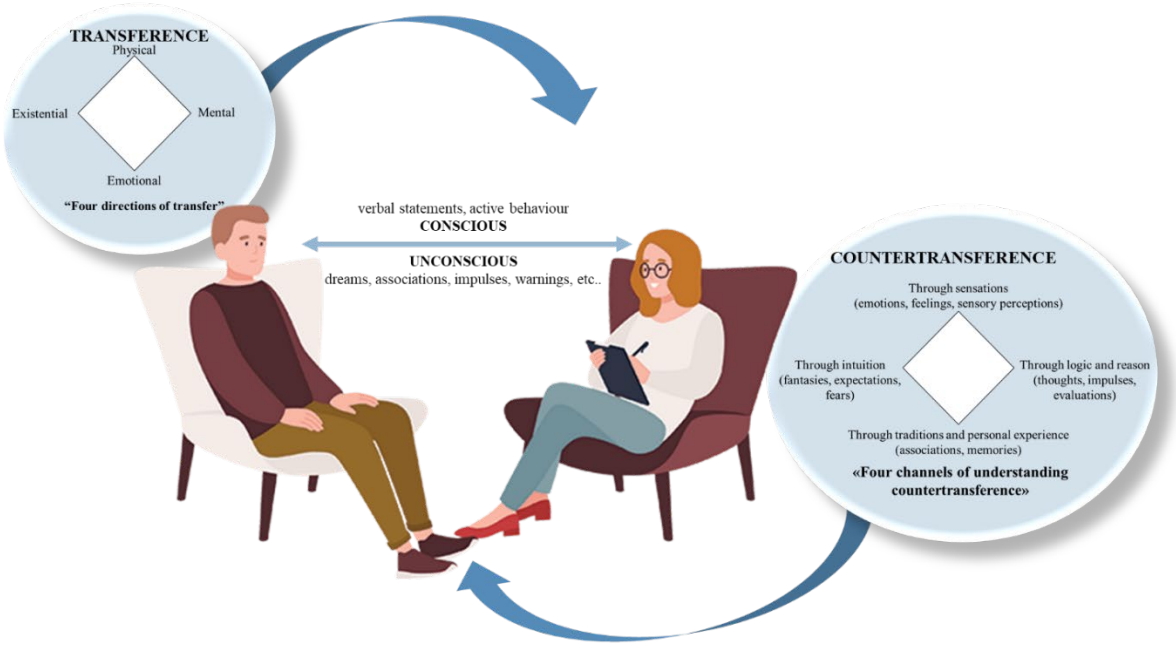

Figure 2. Transference vs. Countertransference in Therapy

Through sensations (emotions, feelings, sensory perceptions). The therapist may experience intense emotions during sessions, such as anger, powerlessness, or pain, in response to stories of violence. Such feelings may reflect not only compassion for the patient but also their own unresolved experiences. Countertransference can include sensory reactions, such as physical discomfort or fatigue, which indicate the deep emotional impact of the patient's stories.

Through logic and reason (thoughts, impulses, evaluations), the psychotherapist may encounter the desire to intellectualize the patient's experience to create distance from their own emotions. It is important to resist the temptation to rationalize the patient's experience to protect oneself from emotional overload. Evaluations or impulses that arise during therapy, such as judgment of the aggressor or guilt over not being able to help, can also be manifestations of countertransference.

Through traditions and personal experience (associations, memories), therapists may unconsciously activate their own memories or associations that reflect their past experiences. The patient's story can resonate with the therapist's own experience of trauma or loss. In this case, it is important to be aware of these reactions and use them to understand the psychodynamics of the interaction.

Through intuition (fantasies, expectations, fears). Intuitive reactions, such as feeling threatened or fearing failure, may reflect the therapist's fears about personal limitations or professional competence. Sometimes, the therapist fantasizes about saving the patient or expects rapid progress. Such processes can create a risk of going beyond the limits of their role.

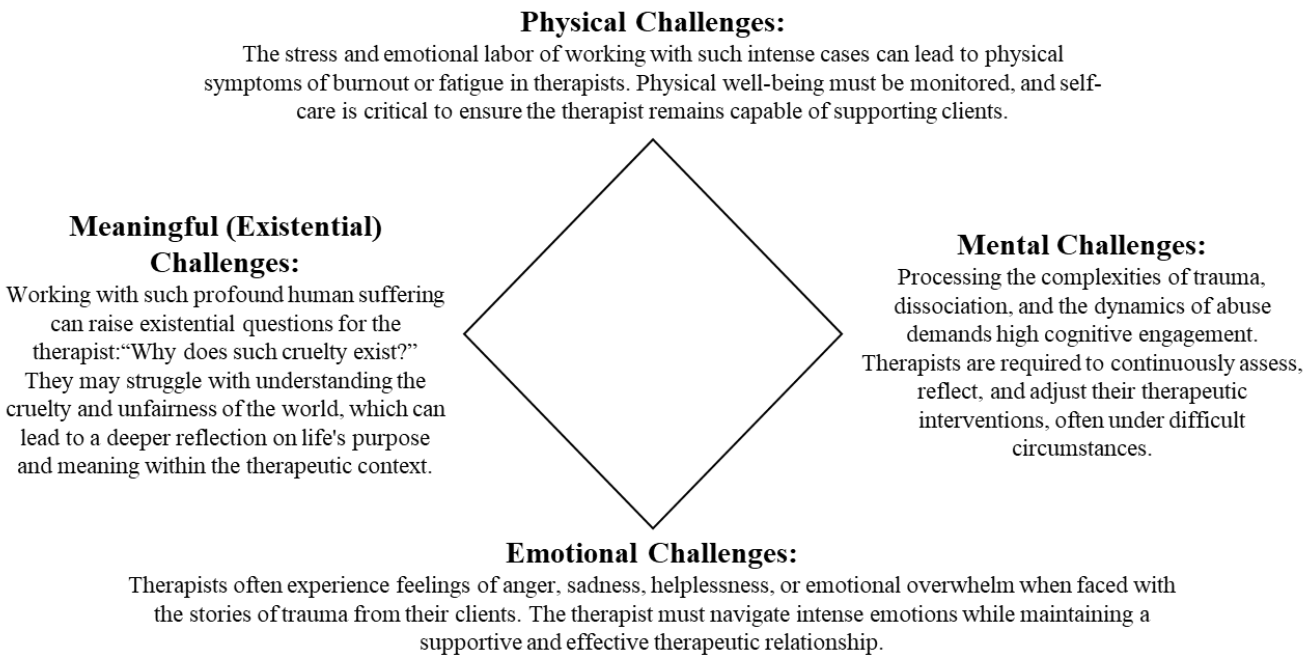

Figure 3. Challenges in working with sexual violence trauma

3.3. 3 stages of psychodynamics while exploring transference and countertransference

Dobiała E. (2020) emphasizes the changing role of the therapist, who initially helps the patient to set boundaries and later becomes a container for emotional processes of transference and countertransference, which contributes to a deeper processing of the patient's emotions at the individual and group levels. Henrichs C. and Hum G. (2021) also explore the role of transference and countertransference through the method of positive psychotherapy, emphasizing the importance of these processes through the lens of the three stages of psychodynamics: attachment, differentiation, and detachment for structured communication between therapist and patient. The authors note that these processes help to uncover unconscious conflicts and improve the therapeutic interaction.

In this context, we propose to consider the dynamics of transference and countertransference (attachment, differentiation, detachment) in cases of trauma caused by sexual violence.

- **Attachment:** The patient and therapist can become trapped in unconscious reactions related to the patient's traumatic experience, which manifests itself through transference and countertransference. The therapist's awareness of his/her countertransference (reflection on the Balance model) and its verbalization facilitate the transition to the verbalization stage. After analyzing their reactions, the therapist can reflect on their feelings, thoughts, and sensations by asking the patient: "Is it possible that you are feeling something like this right now?" For example, if during therapy, the therapist suddenly feels fearful or disgusted with the patient and perceives them as a seducer, he or she might say, "Could it be that you feel fearful or disgusted with me because you perceive me as someone who is seducing you?" Further, the therapist can elaborate in the next intervention: 'How often do you experience something like this in our relationship or other situations? Who else have you experienced something like this with?'
- **Differentiation:** The therapist must notice and verbalize transference and countertransference dynamics. This can help the patient to gradually realize the nature of their reactions (according to the Balance model) in the therapeutic process. At first, the therapist actively monitors the moments when the patient "transfers" past emotions or behavioral patterns to the situation in therapy, helping to make them aware of this through clear verbalization, for example: "Maybe now you feel afraid or irritated in my presence, as you have in the past with other people." This verbalization, which

emphasizes the roots of these reactions in past experiences, allows the patient to look at the situation objectively. Over time, the patient begins to notice when a certain emotional pattern is triggered in the relationship with the therapist. He or she realizes that these reactions may only reflect his or her inner experience and not a real threat to the relationship. Over time, this helps the patient to distance himself from such reactions, realizing that they are only an echo of past experiences that do not always correspond to the current circumstances.

- **Detachment:** At this stage, transference and countertransference lose their intensity because, by this time, the patient has learned to recognize and control their reactions. At this stage, the patient is no longer trapped in a vicious circle of 'inner conflict' or, if such dynamics arise, can recognize them in time and react accordingly. The patient begins to react differently, developing new behavior patterns based not on old traumatic experiences but on new experiences. For example, if previously the patient perceived authority figures as a threat or felt fearful in their interactions, which could cause associations with the traumatic experience of sexual abuse, now they can react more calmly to such situations. The patient no longer needs the active intervention of the therapist, as he or she has learned to monitor his or her reactions. Being at this stage indicates greater emotional maturity and the completion of an important phase of the therapeutic process when the patient can choose their reactions and manage their behavior both in the therapeutic relationship and real life.

Working with cases of child sexual abuse is often accompanied by complex emotions - a sense of numbness, powerlessness, and a strong desire to protect the child and bring justice to the perpetrators. This emotional burden raises existential questions: "How can the world be so cruel? Why did this happen to them?" Avoiding or distancing oneself from such cases is not an acceptable solution because children and adults who have experienced such traumas need attentive and empathetic support, even if the interaction with them causes the therapist to experience strong emotional feelings.

When working with survivors of sexual violence, there is often a tendency for them to unconsciously reproduce the dynamics of relationships with their perpetrators in other life situations. This poses an important therapeutic challenge: How to help the patient make sense of these behavior patterns without reinforcing harmful patterns? Such patterns often manifest themselves in the therapeutic process through transference, which requires the therapist to be aware of and able to keep the focus on their emotional reactions. In such cases, countertransference can manifest as feelings of regret, defensiveness, or even alienation, which requires increased attention in the work of the therapist.

Similar challenges arise when working with perpetrators of sexual violence. Communication with such patients often evokes intense anger and internal dialogues such as: "Who raised you like this? How could you do this? How can such people exist in the world?" Although such patients make up about one in ten, the therapist must work on their emotional reactions to provide space for effective therapy, controlling possible countertransference, such as rejection or excessive anger.

There are also cases when survivors of sexual violence bring to therapy stories of themselves committing or almost committing similar acts but were able to stop themselves. Sometimes, such patients re-enact this scenario in their minds, and they can act as both the victim and the perpetrator. This creates a particularly challenging situation for the therapist, as it is necessary to help the patient understand and accept this part of themselves without re-traumatizing them and avoiding judgment. Transference and countertransference in such cases take on a multifaceted meaning: the therapist may experience feelings of guilt or identification with both sides of the conflict.

Such situations require a significant level of self-reflection and supervisory support from the therapist to maintain professional balance and avoid falling into the trap of the transferred scenarios. Neutrality in this context is not an emotional detachment but rather a deep regulation of one's own emotions, which allows one to remain effective in the therapeutic interaction. Each meeting with such patients requires ongoing supervisory discussion and personal therapy to maintain the ability to reflect and effectively process professional challenges.

Finally, while emotional neutrality remains the goal, it does not mean indifference. Emotional sensitivity and authentic presence are essential components of the therapeutic

process. Maintaining this balance requires ongoing development and personal and professional support, including supervision and self-help. Working with such patients is possible, but the therapist's effectiveness depends largely on the availability of support systems that help them cope with countertransference and maintain regulation of their emotional reactions.

Conclusions

The psychodynamic process of transference and countertransference play a key role in therapeutic work with patients who have experienced or become perpetrators of sexual violence. These phenomena not only reveal deep unconscious conflicts but also become a powerful tool for understanding and integrating the patient's traumatic experience. In working with cases of sexual violence, trauma is often accompanied by intense emotional reactions, which poses difficult challenges for the therapist and increases the importance of constant self-reflection and supervision.

The therapy process requires the therapist to be not only aware of their own reactions but also to regulate them effectively while maintaining neutrality and empathy. Maintaining professional neutrality, however, is not indifference; it requires deep emotional sensitivity and authentic presence to provide a safe environment for the patient. The use of transference and countertransference as tools for recognizing trauma patterns helps the therapist gain a deeper understanding of the patient's inner world dynamics and facilitates emotional recovery.

Thus, working with transference and countertransference in the context of sexual violence trauma requires the therapist to be supported by supervision, personal therapy, and the professional assistance system. Only under these conditions can the therapist ensure the effectiveness of the therapeutic interaction and support the patient in the process of healing and integration of painful experiences.

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