

What passes between client and therapist?

Stephanie M. Cobb imagines three perspectives on transference and countertransference

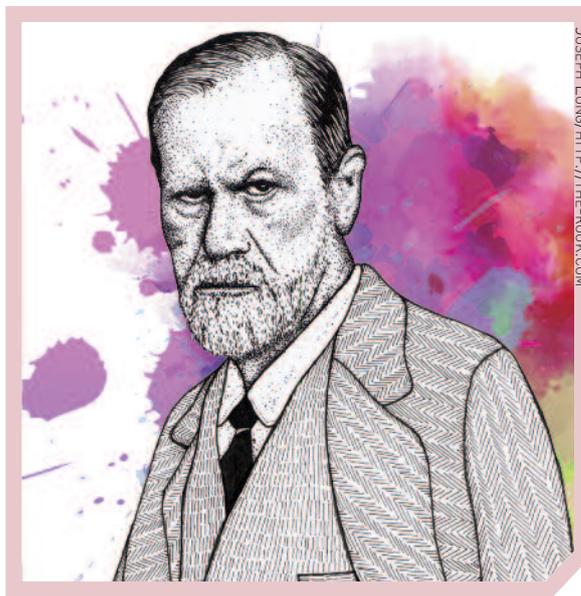
Transference has been defined as 'the client's experience of the therapist that is shaped by his or her own psychological structures and past', often involving 'displacement onto the therapist, of feelings, attitudes and behaviours belonging rightfully to earlier significant relationships' (Gelso & Hayes, 1998, p.11). Countertransference describes the therapist's reaction to the client in terms of both feelings and behaviour. Originating in the psychoanalytic tradition, transference and countertransference were once seen as fundamental to successful outcomes in psychotherapeutic treatment. However, over time, the emphasis has gradually shifted toward the 'real' relationship between client and therapist and some psychologists have even questioned whether the concept of transference exists at all.

Nevertheless, during the first year of clinical training, my cohort were invited to consider how the transference phenomenon has developed and changed over time. I began to think about how important historical figures in psychology might have talked about these ideas,

had they ever met. I therefore invite you to suspend academic expectations for just enough time to enjoy the imagined presentation that follows.

Sigmund Freud

Sigmund Freud was born in 1854 in what is now the Czech Republic. Educated in Vienna, he practised medicine until the late 1880s, before turning his attention to studying the psychological origins of nervous disorders. 'As an explorer, he was first in his field' (Lomas, 1973, p.37).



Dr Freud, I'd like to give the reader some idea of how we have come to know about the concepts of transference and countertransference. Can you talk us through their discovery?

Freud: *Well, it was actually my colleague, Joseph Breuer, who first documented the transference phenomenon, although he did not name it, in his work with Anna O. She developed intense erotic feelings for him in the later stages of her analysis, and I believe he was rather troubled by them. We were working together on trying to uncover unconscious material from the patient's past through hypnosis, but we often encountered resistance from those who were fearful of revealing shameful memories. We discovered that such patients were inclined to subconsciously transfer their shameful phantasies onto the analyst. I first used the term transference in my Studies on Hysteria from 1895.*

Did you realise the significance of your discovery immediately?

Freud: *Actually, at first we all found it rather a nuisance! Having the client's past relationships transferred onto oneself was a serious obstacle to effective psychoanalysis, and we tried our hardest to avoid it. But as time went on, I found that helping patients relive past conflicts in the present could become vital to the effectiveness of the treatment (Malan, 2004).*

Can you explain a little more about how transference works?

Freud: *In my view, it is unsatisfied or repressed wishes and experiences from the patient's past, usually from childhood, that become transferred onto the person of the therapist, revealing the source of their neurosis. For example, they may at times see the analyst as a punitive father and at other times as a seductive lover. If handled correctly, the transference allows patients to re-experience childhood conflicts in the safety of the consulting room. With the help of the analyst's interpretations, these past conflicts can be worked through to a satisfactory conclusion. Countertransference arises from*

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unresolved conflicts in the analyst's past and must be guarded against at all costs. Responding emotionally to patients is highly detrimental to the analytical process. In order to give rational interpretations whilst being confronted with such strong emotions as love and hate, one must maintain a professional distance at all times (Nye, 2000).

Some of my colleagues in the psychoanalytic school have subsequently challenged my view of the therapeutic relationship. Carl Jung, for example, sees the countertransference as quite natural and believes that the analyst should be at liberty to share his thoughts and feelings with the patient. For Jung, the transference should be lived through without the need for interpretation and the countertransference is simply an inevitable interaction with it. He published numerous papers in the decades following my death suggesting countertransference can be a useful device in uncovering unconscious dynamics within the patient (Jacoby, 1984).

Melanie Klein

Melanie Klein's work, in the field of object relations, represents a unique departure from the ideas of Freud. She made a major contribution to our understanding of the internal worlds of both children and adults. A controversial figure, who analysed her own children, she had a profound influence on psychodynamic theory and practice.

Mrs Klein, your ideas in particular have been seen as a direct challenge to those of Dr Freud. How would you respond to that?

Klein: *I really never saw myself as opposing Dr Freud's work, simply developing and*

extending it to increase our understanding of the workings of the human psyche. However, I did conflict with his daughter, Anna, in the 1940s on the thorny issue of transference.



Can you tell us about your view?

Klein: *I believe that infants are capable of forming basic object relations from the moment they are born. Experiences of social interaction from earliest infancy form the basis of the internal world of object relations. This in turn shapes the person's interaction with the outside world throughout their life. Object relations theorists, such as Winnicott, Fairburn and I, prioritise relationships as the fundamental tenets of psychological functioning rather than the instinctual drives that Dr Freud identified. The transference relationship with the analyst therefore, provides an indispensable insight into the internal world of the patient and brings past relationships to life in the consulting room, even when the analysand is still a child.*

Do you agree with Dr Freud that countertransference should be avoided?

Klein: *On the contrary. The emotional reactions experienced by the analyst are absolutely crucial to understanding how the patient relates to others. Countertransference allows the analyst to enter the patient's world and bring the transference into consciousness through interpretation (Grant & Cawley, 2002). Paula Heimann was the first to explicitly state the value of countertransference and did much to alter the general view of it. She asserts that 'the analyst's unconscious understands that of the patient. This rapport on a deep level comes to the surface in the form of feelings which the analyst notices in response to the patient'*

(Heimann, 1950, as cited in Sandler, 1976).

In the classical Freudian view, psychosexual conflicts experienced in the formative years are re-experienced as a result of an unconscious wish to gratify childhood desires. In the Kleinian tradition of object relations, early significant relationships are repeated in therapy, and feelings, emotions and behaviours associated with those relationships are re-experienced in relation to the therapist.

Carl Rogers

From the existential, phenomenological approach, Carl Rogers drew his person-centred, non-directive approach. The founder of humanistic psychology gives us another lens through which we can view these concepts.

Mr Rogers, would you share with us a little about your style of working?

Rogers: *Certainly. In person-centred work, we try to understand the client's problems just as he sees them himself. We don't formulate clients into diagnostic categories. The client is encouraged to believe in his ability to solve his own problems by providing an atmosphere of mutual respect. Gradually a situation develops in which the client can risk revealing more and more about himself, knowing that the therapist will respond calmly and continue to respect him at all times (Lomas, 1973).*

Can you tell us your view of transference Dr Rogers?

Rogers: *Of course, clients will always experience some positive and negative feelings during therapy sessions. Certainly a proportion of these emotional reactions will be based on past experiences but I don't believe it is necessary to pay those feelings any special attention (Nye, 2000).*

'Transference phenomena occur in every human relationship' (Jacobs, 2010). In fact they are so much a part of everyday life that we no longer need elaborate manipulations to bring them out (Lomas, 1973). There is no need for the therapist to make interpretations because if he is genuine, accepting and empathic, the meanings of these feelings will nonetheless become clear to the client. What is more, to describe the therapist's reaction to the patient as countertransference is 'unsatisfactory' to say the least (Malan, 2004, p.131). These reactions may be entirely natural and not transferred from anyone else.

Contemporary forms of psychotherapy

There are several contemporary forms of

perspective. *Journal of Cognitive Psychotherapy: An International Quarterly*, 11, 231–250.

Sandler, J.J. (1976).

Countertransference and role-responsiveness. *International Review of Psychoanalysis*, 3, 43–47

looking back

psychotherapy, which are supported by a substantial evidence base, where concepts comparable to transference have recently been identified. Cognitive behavioural therapy (CBT), for example, has become a powerful player since its emergence in the 1970s. Originally aimed at alleviating anxiety and depression, CBT centres on how thoughts influence feelings and behaviours and how modifying core beliefs can lead to behavioural change (Beck, 1991). CBT has been criticised for its 'mechanistic' and 'technical' view and for not making use of the therapeutic relationships (Jacobson, 1989). However, very recently transference-like phenomena have been identified in CBT work with clients with complex problems, such as personality disorder, where the therapeutic relationship takes a much more central role (Grant & Crawley, 2002).

Freud: *Ah yes, I have heard about these developments. CBT and psychodynamic therapies have arisen from opposing philosophies, but in the 1990s the two traditions came much closer together when cognitive therapists began to accept the existence of unconscious cognitive processes. Schemas, for example, are unconscious 'cognitive representations of one's past experiences with situations or people' which help us understand future events (Goldfried, 1995, p.55). The client may form a 'person schema' of the therapist which is influenced by schemas from previous situations. For example, if the client perceives the relationship as one of authority and dominance, then a schema of the parent or teacher may be evoked. These schemas are connected to another concept known as a script. Scripts are schemas that affect habitual behavioural sequences. These can be activated in therapy when the client's behaviour elicits similar responses from the therapist as he would experience in other relationships in his life. Working with the transference can help uncover dysfunctional schemas and scripts (Grant & Crawley, 2002).*

Rogers: *To me, introducing the notions of transference and countertransference in cognitive therapies serves only to re-mystify the therapeutic process (Rudd & Joiner, 1997). I would always concentrate on the 'real' relationship between client and therapist.*

Freud: *Even though CBT concentrates mainly on the client's relationships outside the therapeutic situation, the therapist can still use the transference to observe how the client relates in the microcosm of the consulting room. He can then make inferences about the client's problems out*



in the world. This is particularly helpful when working with patients living with personality disorder, who are acutely sensitive to the therapist response (Grant & Crawley, 2002). I hope that future cognitive therapies will develop these ideas to make even more use of the multitude of resources available through the therapeutic relationship.

“enhanced mentalising increases capacity to deal with adversity”

Mentalisation based therapy (MBT) is just such a cognitive therapy, in which the therapeutic relationship assumes paramount importance and transference work is central to affecting change (Allen, et al., 2008).

Klein: *As I understand it, mentalising represents an awareness of the mental states of oneself and others and having the ability to interpret these mental states. For most people this is very much a part of everyday life, but for some, especially those who have suffered early trauma, it is extremely difficult and confusing. While impaired mentalising impacts negatively on clients' daily lives, enhanced mentalising increases capacity to deal with adversity, such as psychiatric problems. A secure attachment relationship provides an optimal environment in which mentalising ability can develop, and in MBT it is the therapist's job to provide a secure*

base from which the client can safely explore painful aspects of their past and present (Allen et al., 2008).

When transference occurs in MBT, the interpretation takes the form of active mentalising of the relationship between client and therapist, carefully linking behaviour to a hypothetical model of the patient's mind. With clients having limited mentalisation capacities, transference work concentrates on the here-and-now relationship of the consulting room. However, as this capacity increases, interpretation of the current relationship moves into the context of understanding past relationships. Mentalising the transference in this way shows the client how the same behaviour can be interpreted in different ways by different minds (Allen et al., 2008).

Freud: *It seems to me that the MBT approach has further developed psychoanalytic ideas about understanding the past through the therapeutic relationship.*

Klein: *Gestalt therapy and psychoanalysis also agree on several fundamental issues. Both place emphasis on conscious and unconscious conflict and past traumatic experience, they share the concept of internalised objects and identify defensive processes that distort reality (Nielsen, 1980).*

Rogers: *But gestalt therapy concentrates on the here and now and de-emphasises the transference. When transference does arise, Gestalt therapists use what they call 'empty chair' dialogues to avoid transferring past relationships onto the therapist. The client enacts both roles so that unresolved feelings from the past are transferred onto an internal object rather than onto the therapist (Nielsen, 1980).*

The terms *transference* and *countertransference* are constructs employed by the psychodynamic tradition of psychology to describe a particular aspect of the therapeutic relationship. Even though some other schools, such as CBT, may not employ these particular terms, it has been suggested that analogous concepts do exist. As William Shakespeare famously wrote, 'That which we call a rose, by any other name would smell as sweet'.

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