Transference countertransference therapeutic relationship

Describe the transference-countertransference element of the therapeutic relationship

An examination of the development of transference and counter-transference as a therapeutic tool with an exploration of the ways in which it can be defined and used in a therapeutic setting, with an overview and brief discussion of the way the concept of transference/counter-transference has been received by different schools of therapy.

Introduction

This essay explores the development of transference and countertransference from their origins in Freud's work to their current uses in different psychotherapeutic schools. The Kleinian contribution is identified as a major catalyst to re-thinking countertransference as a resource rather than simply an obstacle to treatment.

An unseemly event and a fortuitous discovery

In 1881, the physician Dr Josef Breuer began treating a severely disturbed young woman who became famous in the history of psychoanalysis as " Anna O". She had developed a set of distressing symptoms, including severe visual disturbances, paralysing muscular spasms, paralyses of her left forearm and hand and of her legs, as well as paralysis of her neck muscles (Breuer, 1895, in Freud and Breuer 1985/2004, p. 26). Medical science could not explain these phenomena organically, save to designate them as symptoms of what was then known as " hysteria", so Breuer took the radical step of visiting his young patient twice a day and listening carefully to her as she spoke about her troubles. He was to make a powerful discovery which deeply influenced his young assistant, Dr Sigmund Freud: whenever Anna

found herself spontaneously recounting memories of traumatic events from her early history, memories she had hitherto had no simple access to through conscious introspection, her symptoms began to disappear one by one. But for the purposes of this essay, one event was to be of pivotal importance: just as Breuer was about to conclude his treatment of the young woman as a success, she declared to him that she was in love with him and was pregnant with his child.

Perhaps unsurprisingly, Breuer was traumatised and withdrew from this intimate method of treatment promptly. Freud's original biographer, Ernest Jones, reports that Breuer and Freud originally described the incident as an " untoward" event (Jones, 1953, p. 250); but where Breuer admonished himself for experimenting with an unethically intimate method which may have made him seem indiscreet to the young woman, Freud studied the phenomenon with scrupulous scientific neutrality. He, too, had experienced spontaneous outbursts of apparent love from his psychotherapeutic patients, but as Jones (1953, p. 250) observes, he was certain that such declarations had little or nothing to do with any magnetic attraction on his part. The concept of transference was born: patients, Freud argued, find themselves re-experiencing intense reactions in the psychotherapeutic relationship which were in origin connected with influential others in their childhoods (such as parents or siblings). Without being aware of doing so, patients tended to *transfer* their earlier relationship issues onto the person of the therapist.

As Spillius, Milton, Couve and Steiner (2011) argue, at the time of the *Studies in Hysteria* , Freud tended to regard manifestations of transference

as a predominantly positive force: the patient's mistaken affections could be harnessed in the service of a productive alliance between therapist and client to explore and analyse symptoms. But by 1905, his thinking about transference began to undergo a profound change. Already aware that patients could direct unjustifiably hostile feelings toward the analyst as well as affectionate ones, his work with the adolescent " Dora" shook him deeply when she abruptly terminated her analysis in a surprisingly unkind and perfunctory manner (Freud, 1905/2006). He had already worked out that both the positive and negative manifestations of transference functioned as forms of resistance to the often unpleasant business of understanding one's own part in the events of the past (it is, for example, a good deal easier to lay the blame for one's present-day failings on " bad" or unsupportive figures from the past or on their selected stand-ins in the present than it is to acknowledge that one rejected or failed to make full use of one's opportunities). But he began to realise that Dora had actively *repeated* a pattern of relationship-behaviour with him that had actually arisen from her unacknowledged hostility toward her father, as well as to a young man she had felt attracted to, because both had failed to show her the affection and consideration she believed herself entitled to.

She took her revenge out on Freud – and she was not alone in actively re-enacting critical relationship scenarios inside the therapeutic relationship; other patients, he began to see, also frequently actively relived relational patterns in this way while totally unaware that they were repeating such established patterns. By 1915, transference was no longer a *resistance* to recovering hazy and unpleasant memories for Freud; instead, it was an

active, lived *repetition* of earlier relationships based on mistakenly perceived similarities between here-and-now characteristics of the analyst and there-and-then characteristics of previously loved or hated figures (Freud, 1915/2002)

The interplay between psychical reality and social reality

Melanie Klein, a pioneer of child psychoanalysis, accepted Freud's view of transference as a form of re-enactment, but using her meticulous observations of the free play of very young (and very disturbed) child patients, she began to develop the view that it was not the dim-and-distant past that was re-enacted but, on the contrary, the present. Psychical reality and social reality were not coterminous or even continuous; they were involved instead in a ceaseless dialectical interplay (Likierman, 2001, esp. pp. 136 – 144). Real people may constitute the child's external world, but for Klein, the only way to make sense of the often violent and disturbing content of the children's play she observed was to posit the existence of a psychical reality dominated by powerful unconscious phantasies involving frighteningly destructive and magically benevolent inner figures or " objects" (Klein, 1952/1985). Children didn't simply re-enact actual, interpersonal relationships, they re-enacted relationships between themselves and their unique unconscious phantasy objects. In spontaneous play, children were dramatising and seeking to master or domesticate their own worst fears and anxieties, she believed.

Klein's thought has changed the way transference is viewed in adult psychotherapy, too. If transference involves not simply the temporal transfer of unremembered historical beliefs into the present but the immediate

transfer of phantasies, in the here-and-now, which are active in the patient's mind, handling transference becomes a matter of immediate therapeutic concern: one does not have to wait until a contingency in the present evokes an event from the past, nor for the patient to make direct references to the therapist in her associations, because a dynamic and constantly shifting past is part of the present from the first moments of therapy in Kleinian thought. For example, Segal (1986, pp. 8 – 10) describes a patient opening her first therapy session by talking about the weather – it's cold and raining outside. Of all the issues a patient could choose to open a session – the latest political headlines, a currently active family drama, a dream, a quarrel with a work colleague, and so on – it is always significant when a patient " happens" to select a particular theme; for Segal, following Klein, this selection indicates the activity of unconscious phantasy objects. Transference is immediate: Segal asks whether the patient is actually exploring, via displacement onto the weather, her transferential fear that the analyst may be an unfriendly, cold, and joy-dampening figure.

Countertransference, its development and its use by different schools of therapy

The foregoing has focussed on transference but implicit throughout has been the complementary phenomenon of countertransference, from Breuer's shocked withdrawal from Dora's transferential love to Freud's distress at being abruptly abandoned by Dora who, he later realised, was re-enacting a revenge scenario. Intensely aware that emotions could be roused all too easily in the analyst during a psychoanalytic treatment, Freud was exceptionally circumspect about any form of expression of these feelings to the patient. In his advice to practitioners, he suggested that the optimal

emotional stance for the therapist was one of “ impartially suspended attention” (Freud, 1912b/2002, p. 33). He did not, however, intend this to be a stable, unfluctuating position of constantly benevolent interest; he urged therapists to be as free of presuppositions and as open-minded as possible to their patients’ spoken material, to be willing to be surprised at any moment, and to allow themselves the freedom to shift from one frame of mind to another. But he was unambiguous in his advice about how the therapist should comport him- or herself during analysis:

“ For the patient, the doctor should remain opaque, and, like a mirror surface, should show nothing but what is shown to him.” (Freud, 1912b, p. 29)

As his paper on technique makes clear, Freud considered the stirring up of intense emotions on the part of the therapist as inevitable during analytic work; but he also considered these responses to the patient an obstacle to analytic work, the stirring up of the therapist’s own psychopathology which required analysis rather than in-session expression. The analyst had an obligation to remove his own blind-spots so as to attend to the patient’s associations as fully and prejudicially as possible.

By the 1950s, psychoanalysts were beginning to explore countertransference as a potential source of insight into the patient’s mind. As Ogden (1992) draws out in his exploration of the development of Melanie Klein’s notion of projective identification, Kleinian analysts such as Wilfred Bion, Roger Money-Kyrle, Paula Heimann and Heinrich Racker began arguing that it was an interpersonal mechanism rather than an intrapsychic one (as Klein had

intended). Patients, they believed, could evoke aspects of their own psychic reality, especially those aspects they that they found difficult to bear, inside the mind of the analyst by exerting subtle verbal and behavioural pressures on the therapist. Therapists should not, therefore, dismiss such evoked emotions as purely arising from their own psychopathology, but as a form of primitive, para- or pre-verbal communication from the patient. As Ogden (a non-Kleinian) puts it:

“ Projective identification is that aspect of transference that involves the therapist being enlisted in an interpersonal actualization of (an actual enactment between patient and therapist) of a segment of the patient’s internal object world.”
(Ogden, 1992, p. 69)

Countertransference, in other words, when handled carefully and truthfully by the therapist, can be a resource rather than an obstacle, and as such it has spread well beyond the Kleinian School. For example, while advocating caution in verbalising countertransference effects in therapy, the Independent psychoanalyst Christopher Bollas (1987) suggests that the analyst’s mind can be used by patients as a potential space, a concept originally developed by Winnicott (1974) to designate a safe, delimited zone free of judgement, advice and emotional interference from others, within which people can creatively express hitherto unexplored aspects of infantile experience. Bollas cites the example of a patient who recurrently broke off in mid-sentence just as she was starting to follow a line of associations, remaining silent for extended periods. Initially baffled and then slightly irritated, Bollas worked on exploring his countertransference response

carefully over several months of analytic work. He eventually shared a provisional understanding with her that came from his own experience of feeling, paradoxically, in the company of someone who was absent, who was physically present but not emotionally attentive or available. He told her that he had noticed that her prolonged silences left him in a curious state, which he wondered was her attempt to create a kind of absence he was meant to experience. The intervention immediately brought visible relief to the patient, who was eventually able to connect with previously repressed experiences of living her childhood with an emotionally absent mother (Bollas, 1987, pp. 211 – 214).

Other schools of psychoanalytic therapy such as the Lacanians remain much more aligned with Freud's original caution, believing that useful though countertransference may be, it should never be articulated in therapy but taken to supervision or analysis for deeper understanding (Fink, 2007).

References

- Bollas, C. (1987). Expressive uses of the countertransfeence: notes to the patient from oneself. In C. Bollas, *The Shadow of the Object: Psychoanlsyis of the Unthought Known* (pp. 200 – 235). London: Free Associations Books.
- Breuer, J. (1883-5/2004). Fraulein Anna O. In S. Freud, & J. Breuer, *Studies in Hysteria* (pp. 25 – 50). London and New York: Penguin (Modern Classics Series).
- Fink, B. (2007). Handling Transference and Countertransference. In B. Fink, *Fundamentals of Psychoanalytic Technique: A Lacanian Approach*

for Practitioners (pp. 126 – 188). New York and London: W. W. Norton & Company.

- Freud, S. (1905/2006). Fragment of an Analysis of Hysteria (Dora). In S. Freud, *The Psychology of Love* (pp. 3 – 109). London and New York: Penguin (Modern Classics Series).
- Freud, S. (1912/2002). Advice to Doctors on Psychoanaytic Treatment. In S. Freud, *Wild Analysis* (pp. 33 – 41). London and New York : Penguin (Modern Classics Series).
- Freud, S. (1912/2002). On The Dymanics of Transference. In S. Freud, *Wild Analysis* (pp. 19 – 30). Londona nd New York: Penguin (Modern Classics Series).

  Freud, S. (1915/2003). Remenbering, Repeating and Working Through. In S. Freud, *Beyond the Pleasure Priciple and Other Writings* (pp. 31 – 42). London and New York: Penguin (Modern Classics Series).
- Jones, E. (1953). *The Life and Work of Sigmund Freud: The Formative Years and the Great Discoveries, 1856-1900 – Vol. 1.* New York: Basic Books.

  Klein, M. (1952/1985). The Origins of Transference. In M. Klein, *Envy and Gratitude and Other Works* (pp. 48 – 60). London: The Hogarth Press & The Institute of Psycho-Analysis.
- Likierman, M. (2001). *Melanie Klein: Her Work in Context.* London and New York: Continuum.
- Ogden, T. (1992). *Projective Identification and Psychotherapeutic Technique.* London: Maresfield Library.

- Segal, H. (1986). Melanie Klein’s Technique. In H. Segal, *The Work of Hanna Segal: Delusion and Artistic Creativity & Other Psycho-analytic Essays* (pp. 3 – 34). London: Free Associations Books/Maresfield Library.
- Spillius, E., Milton, J., P., G., Couve, C., & Steiner, D. (2011). *The New Dictionary of Kleinian Thought.* East Sussex and New York: Routledge.

Winnicott, D. W. (1974). *Playing and Reality.* London: Pelican.