Transference and the Therapeutic Relationship – Working For or Against It?

Abstract
In this article I start by contextualizing transference and its origins which will then lead me to a discussion on the history of the concept and the changes it has suffered through time. I will argue around its usefulness for the therapeutic endeavour and its place within other modalities, with a particular emphasis on a relational-integrative stance.
I end the article with clinical examples of my own practice.

Key – Words: ; Contextualization; Integrative; Intra-personal; Inter-subjective; Relational; Transference.

Author:
João G. Pereira
Criminal Psychologist, Full Member of the Portuguese Order of Psychologists. Integrative Psychotherapist and Counselling Psychologist in Doctoral Training, Metanoia Institute and Middlesex University, London. Member of the British Psychological Society. Associate Member of the European Association of Counselling Psychology. Psychotherapist at the drug and alcohol service and psychotherapy department, South Essex Partnership University NHS Foundation Trust, United Kingdom
Email: joao_pgpereira@hotmail.co.uk
Origins

The term *transference* was first used by Freud in *Studies of Hysteria* following his joint work with Breur and the treatment of cases such as Bertha Pappenheim (famously known as Anna O.) or Emma Eckstein (Breur & Freud, 1885).

Through his early investigations Freud became aware of deep and intense feelings emerging in the therapeutic relationship, most of them operating at an unconscious level. He realized that these unconscious forces would, at times, distort the way the patient sees their therapist and the relationship (he later became interested in similar forces operating in the therapist, but not for now). Freud divided these unconscious forces into two different mechanisms: the *template* and the *repetition compulsion* (Kahn, 2002). The first means that our earliest relationships form in our minds templates into which we attempt to fit all subsequent relationships. The second is a strange, very common need to replay old traumatic situations possibly as an attempt to understand and, perhaps re-construct, the original situation.

These perceptions and emotions were, therefore, based on past experiences but *transferred* to the therapist on the here and now, thus the use of the term *transference*, term that in Greek and Latin means *to carry across* as Clarkson (1995) reminds.

From the 1890’s Freud realized that the patient’s free association typically turned away from the difficulties that brought him to therapy, to feelings about the analyst. The analyst became the focus of hopes, fears, desires and anger. These strong feelings could generate dependency, sexual obsession, terror or hatred (Gomez, 1997). Although these are normal between human beings, what seemed peculiar, according to the classical definition of transference, was that the feelings were inappropriate to the situation; they were a repetition of the past. Seen historically as a structural entity *the* transference was idiosyncratic, arising from the patient’s unique individual history (Allen & Allen, 1991). Freud believed that most transference productions contained repressed material, coming primarily from unresolved
oedipal wishes (Freud, 1920). At this early stage transference was seen as a setback, hindering the process of analysis and impeding the discovery of hidden memories.

**Definitions, re-definitions and contextualization**

Contextualized within the beginnings of psychoanalysis, where the analyst role was to promote a neutral and *blank screen* environment, the concept of transference was seen as an intrapersonal phenomenon arising merely from the patient. It was also perceived, initially, as an impediment to the analytical work of making the unconscious conscious: “what id was now ego shall be” (Freud, 1933, p80). According to the goal of uncovering hidden fantasies and wishes Freud divided transference into three different categories: positive transference, negative transference and un-neutralized erotic transference (Freud, 1912). Positive transference consisted on the patient’s feelings of affect and trust for the analyst; Freud warned that nothing should be done to this kind of transference as it provided a very useful ally to the analytic endeavour. Negative transference consisted primarily in hostility and suspicion; these transferences should be interpreted to the patient or they would make the work impossible. Erotic transference occurred when the patient showed erotic feelings for the analyst; this type of transference was seen as a form of positive transference that should be interpreted to the patient as representing feelings about parental figures and not really about the analyst; if these feelings persisted, however, they would pose a serious threat to the work and the patient should be immediately referred.

Transference was thus imbedded in a psychotherapeutic context where the analyst had a position of power, a *scientist* emotionally distant from the patient, assigned with the intellectual ability to bring insight to the patient’s internal conflicts.

Even if Freud changed his mind a number of times, either redefining the concept of transference or adding new facts or discoveries, a kind of an orthodox definition of the concept emerged; the following quote from
Greenson (1965, p156) is paramount: “The experience of feelings, attitudes, fantasies, and defences towards a person in the present which are inappropriate to the person and are a repetition, a displacement of reactions originating in regard to significant persons in early childhood”.

One can easily find elements of the classical conceptualization of transference in the above definition (e.g. feelings inappropriate to the situation; repetition of the past); however, Greenson’s further explanations, which discriminate other relationship components such as the working alliance and the real relationship, create a major problem for the classical view: the idea of the analytical situation as interpersonal rather than one where the patient merely projects onto the analyst as on to a blank screen (Allen & Allen, 1991). This view of the analytic situation, and consequently of transference, as interpersonal had already been introduced by authors such as Heimann (1950) or even earlier by Ferenzi or Jung who, by distancing themselves from Freud, evidenced the importance of the intersubjective relationship in their psychoanalytical experiments (cited in Mueller, 1976, p.41). These ideas paved the way to major conceptualization changes and are on the basis of the contemporary view of transference and psychoanalysis.

With the suggestion of intersubjectivity in the field, the person of the therapist, with his unique personality and emotional reactions, has gradually taken a position of relevance in the analytical endeavour. Consequently, another concept has grown in importance: the idea of countertransference. With its meaning shifting throughout times, from undesirable to inevitable and useful, is now seen as indispensable (Kahn, 2002). According to Rycroft (1972) countertransference can be divided in two categories: 1. the analyst transference onto the patient or 2. the analyst responses to the patient’s transference.

The first type of transference has been regarded by many as an undesirable interference on the analytical process. Winnicott (1975), for example, regarded as abnormal countertransference “those ideas that arise from the analyst’s past unresolved conflicts that intrude on the present patient” (p.175). The second kind of countertransference, on the contrary, has
been seen by many as facilitative and a useful instrument of research into the patient’s inner world (Clarkson, 1993). Heimann (1950) described it has one of the most important tools of the analyst work.

This second line of thought, with the analyst playing an equal important role in the therapy room and the idea of transference and countertransference as an intersubjective phenomenon, has led to a certain number of debates that are currently on the core-front of the psychotherapeutic world. A good example is the article from Bachant and Adler (1997) where they ask: is transference co-constructed or brought to the interaction by each participant? It is worth reading for a detailed view of this discussion.

So far I have been looking into different definitions of what is transference and countertransference and the role that each participant takes within it, whether it is intrapsychic or intersubjectively constructed. One other topic that has led to several debates and redefinitions regards what gets transferred and from when (developmentally)? Freud thought of transference productions as primarily embedded in oedipal wishes and conflicts, always having as their subject some portion of infantile sexual life (Freud, 1920). This idea has been disregarded by many, with Melanie Klein being instrumental in bringing transference beyond oedipal issues. Rather then seeing the human being as a system of biological drives, Klein locates herself on an object relations way of thinking where the need for relationship is primary; the self is made up of internal relationships at both conscious and unconscious levels (Gomez, 1997). Parts of the self (e.g. good-self, bad-self) can, therefore, be transferred, as well as parts of others (Allen & Allen, 1991). This is most characteristic of a pre-oedipal phase of development which is regarded as symbiotic, where the dual relationship and the attachment with the mother (or mother figure) is paramount as well as the predominance of the opposition activity-passivity (Doron and Parot, 2001). Although regressions to pre-oedipal issues occur in many clients they are more frequent in borderline and psychotic patients (Allen & Allen, 1991; Kerberg, 1976). Maroda (1991) mentions that there is no way of escaping them when treating these severely disturbed clients.
Otto Kernberg, who has published extensively on psychoanalytical treatment of borderline patients, has integrated the original instinctual drive’s theory by Freud (who neglected the object) with the object relations theories (who neglected the drive) (Klein and Tribich, 1981). He advocates that treatment of borderline patients activates primitive object relations (pre-dating the consolidation of id, ego, and superego), resulting often in chaotic transference states (cited in Allison, 1994, p409). Kernberg (1988) illustrates how interpretation of these chaotic transferences and the prevalent primitive defence of splitting, leads to the transformation of part-object relations into whole-object relations. From being considered non-analysable, these patients, who were now capable of oedipal phase transferences, could benefit from psychoanalytical work (Allison, 1994).

As observed above transference and regression is seen, by most psychoanalytical authors, as essential to treatment. The work undertaken with transference, meaning, overall, interpretation and working through, would thus allow for significant change to occur, particularly if the development of the transferential relationship led to what is known as transference neurosis. Maroda (1991), when speaking about transference neurosis, mentions: “the objective of an analytic treatment is to go beyond the establishment of a good working alliance or positive transference to a stage of dynamic conflict” (p. 67). The development of a transference neurosis in treatment would, therefore, offer the possibility for resolution and integration. Psychoanalysis, in this way, allows for a different and more productive final scene for the re-enacted drama (Maroda, 1991).

Does transference hinder or enrich the therapeutic endeavour? How can it bring change? Is transference neurosis necessary?

What strikes me in the conceptualization of transference neurosis is whether the concept would apply in brief and medium term psychotherapy,
either of psychodynamic or other orientation. My experience of brief therapeutic work at the National Health Service (NHS) and other mental health and substance misuse organizations tells me that this kind of regression may be dangerous, as it opens a wound that time may not allow to repair. According to Burton and Davey (2003) there is a consensual opinion within object relations theorists that transference interpretations are not useful in short term work and that it is preferable to stay with the present behaviour and avoid regression invitations. There is inclusively a critical tone, particularly within phenomenologico-existential and humanistic approaches, regarding the concept of transference, which is seen as a therapist defence against the direct experience of themselves, the client and themselves-in-relation-to-the-client (Spinelli, 2003). Therapy is seen as a real relationship between two people who are each reacting to the other in the here-and-now; concurrently, feelings are not seen as a reproduction of past relationships.

Another concern, brought to my mind largely through supervision, is the lack of mentalization capacity (Fonagy, Gergely, Jurist and Target, 2002) who characterises some clients, particularly the most severely disturbed. With a fragile sense of self, interpretations can be felt as direct attacks as clients cannot clearly distinguish the therapist comments as part of a subjective analytical exercise. Therefore, instead of classical interpretations, authors like Fonagy and Bateman (2007) suggest careful attempts of increasing their reflective capacity by asking and wondering in a spirit of inquisitive curiosity.

The classical idea of neutrality also changes in brief work, being replaced by focus, which, in psychoanalytic terms, means that transference is manipulated to some extent (Grand, Rechetnick, Podrug and Schwager, 1985). In this sense, transference neurosis, as it is traditionally defined, may not occur as conflict does not arise naturally.

Furthermore, the discussion around the usefulness of transference for the therapeutic endeavour would not make sense if it was not possible to distinguish it from reality. I believe some authors have gone too far (e.g. Kahn, 2002) in affirming that transference represents all reactions. Surely every human reaction is embedded in a frame of reference that was built overtime, with special emphasis on the infancy. However, as Sandler (1992) suggests,
not all reactions contain colourings from the past or represent a *re-enactment* of the past, with the quality of *as if* it was the past or, in more disturbed patients, lived as the past with no distinction from reality whatsoever. I acknowledge the difficulty to distinguish between what is *real* and what is *transference* but that is why psychotherapy should be, in my opinion, a collaborative endeavour and a journey of discovery. The paramount method may not be *interpretation* which, by entailing a power position on the analyst will end disempowering the patient. Patients severely disturbed, who may lack mentalization capacities (Fonagy et al., 2002), may also take interpretation as intrusive or a direct attack to their *self*. Therefore, the method may have to be less *cold* and *more* human, entailing a genuine curiosity and a wondering collaborative tone as well as paying attention to the other types of relationship taking place (Clarkson, 1995), for example, the *adult-to-adult here-and-now existential encounter* between two people.

The place of transference within an integrative framework and in time-limited (evidence based) practice. Relationship with other modalities.

Despite some critiques from practitioners with a *purist* stance (e.g. humanistic or phenomenologico-existential) the concepts of transference and countertransference have crossed borders outside the psychoanalytical and psychodynamic approaches. It is a well known concept for practitioners of every modality and has a particular important place within a relational-integrative framework (e.g. Clarkson, 1995).

It is perhaps pertinent to note that, within many contemporary psychotherapeutic approaches, including integrative, transference is not seen as a pathologic manifestation. As Pam James (2003) noted, taking a developmental stance, “distress is seen as a part of human experience as apposed to pathology”. Transference/countertransference interplays may give us an indication of the nature of distress, which may allow both therapist and
client to work collaboratively towards *expanding* the client’s repertoire of choices and ways-of-being in the world. In this way, transference will not be treated as *pathological material* that needs to be made conscious in order to achieve a *cure* (as in classical psychoanalysis). Within a relational (intersubjective) perspective the question is not “what’s wrong with the client” but rather “what’s wrong for the client” (DeYoung, 2003) which emphasizes the developmental-relational history of the client as a *good* reason to justify the present way-of-relating.

I believe transference and countertransference phenomena is acknowledged by most psychotherapy modalities but treated and named differently: script based *racket-systems* and *games* in transactional analysis; schema based *negative-automatic-thoughts* and *interpersonal strategies* in the cognitive-behavioural approach; *conditioned* maladaptive responses or *stimulus generalization* in behaviourism; *rigidity of constructs* in personal constructs psychology; and *narrative prototypes* in narrative psychotherapy to name just a few.

As DeYoung (2003) puts it, transference phenomena are also treated in an individualistic way in many modalities rather then relationally. Terms like for example “your stuff”, “my stuff” in gestalt therapy or the “roles you’re caught in” in transactional analysis, do not seem to acknowledge the embeddedness and interdependency of any self with many other selves.

Like the *common factors* research points out, independently of the model or technique used, what seems to be important is the quality of the client-therapist relationship. I agree with Maroda (1998, p.47) when she says that “intrapsychic change occurs primarily through interpersonal means, and that the vehicle for change is the emotional engagement that occurs between analyst and patient”. In this way, it is not only the transference but the *transference/countertransference dance* that occurs in therapy that is important, as it is also the therapist engagement in this process and his/her emotional transparency/congruence (as far as possible and useful); this may include, at times, self-disclosure from the therapist. Maroda (1998) discusses the controversial issue of self-disclosure in more detail.
Clinical examples

Below are some examples of my current practice in the NHS. Again, if everything was transference, the following examples would lose their meaning:

Mary came to therapy often with a cheerful (I’m OK) attitude. Although she went through difficult stories about loss, death and betrayal during many of the sessions she did not let herself experience her corresponding emotions. I understood later the nature of my countertransference, which was usually to be left with the weight of the unexpressed feeling at the end of each session. Clarkson (1993) defined this type of countertransference as “concordant reactive countertransference”.

Teresa had been a difficult to engage client, taking a good couple of months before she started to attend sessions regularly. When she finally started to engage I made a double booking, forgetting about her appointment. This seemed meaningless at the time.

Teresa has had a neglectful mother; did she transfer (through projective identification) this experience to me, provoking my unconscious response of double booking (thus acting neglectfully, as her mother did)? Clarkson (1993) referred to this as “destructive countertransference”, thus hindering the relationship.

I did not like my client Paul. He was 20 years older than me. I felt he rejected me for being inadequate or incompetent, which resembles the way I felt, at times, with my own father. This countertransference, named “destructive proactive” by Clarkson (1993), led, I believe, to the unsuccessful and premature ending of therapy after 3 sessions.
As it is often difficult with subjective experiences not all these examples were worked through with the clients, due to difficulties grasping it within appropriate time. However, its therapeutic potential is evident.

Conclusion

Transference has a history almost as long as psychoanalysis. First described by Freud in the 1890’s was initially seen as a regrettable phenomenon which interfered with the analytical work of uncovering hidden memories and wishes. However, it quickly became one of the cornerstones of psychoanalysis and an influence for most forms of psychotherapy. Freud has come to realize that transference provided him with the most powerful tool to the effect of bringing insight and facilitating the working through (Freud, 1914). Of particular importance was the phenomenon he described as transference neurosis which meant that at some point in therapy, the transference became so strong that the most significant problems of the client would manifest themselves in the relationship with the therapist (Freud, 1914).

Later contributions, from Ferenzi to Jung or Melanie Klein and, more recently, authors like Kohut or Storolow, made readjustments and redefinitions to the concept introducing important ideas like the ones of intersubjectivity and self-psychology.

Transference is not seen as an intra-psychic isolated phenomenon anymore; most contemporary theorists see it as a relational occurrence, speaking instead of transference/countertransference interplays. This change of mentality can be well summarized in the statement of a very goofy psychotherapist, whom I had the privilege to meet personally for a consultation:

“(…) instead of the pre-Freudian conception of I will try to help your problem or Freud’s early formulation in the form of I have a technique for understanding your mind, we have something like, Let us understand what is going on between us. This is how you seem to feel towards me; this is how I feel towards you. What can we make of it? What does it tell us about your characteristic attitude to people?” (Lomas, 1987, p51).
I wonder how much of these changes have been *knowledge* driven or socio-politically and culturally driven? For example, what influence does the phenomenon of democratization of societies have on the *collaborative* tone seen in most contemporary psychotherapies? Does the end of authoritarian regimes shape psychotherapy, which has nowadays *less powerful* therapists, in an *equal position* with the client? How much of that power and political authority is returning with the threat of terrorism and global warming, and to what extent does it direct the new wave of CBT and other manual driven therapies?

References


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