Episode 041: What is Transference and Countertransference?

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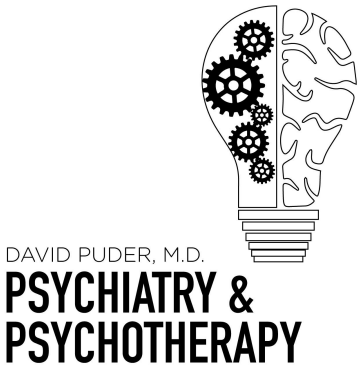

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There are no conflicts of interest for this episode.

On this week's episode of the podcast, I talk about transference and countertransference. It's the fourth episode in my four-part therapeutic alliance series where I discuss best practices on dealing with the doctor - patient relationship.

This series is dedicated to my mentor, Dr. John D Tarr.

Here are the three previous episodes:

Part 1 - Introduction

Part 2 - Logotherapy and Meaning

Part 3 - What is empathy and how to improve it

What is transference?

Historically the term "transference" refers to the feelings, fantasies, beliefs, assumptions and experiences unconsciously displaced on the therapist that originate in the patients' past relationships. More recently, transference is seen as the *here and now,* valid experience the patient has of the therapist.

It is "a mixture of real characteristics of the therapist and aspects of the patient's figures from the past—in effect, it's a combination of old and new relationships." (Gabbard)

How does transference work?

The patient's early experiences develop **organizing principles**, constructing a framework for future interpersonal interactions. (Maybe their dad was an abuser, so they project that you will abuse them.) Transference is the continuing influence of these ways

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of **organizing and giving meaning to experiences.** They crystallized in the past, but they continue in an ongoing way in the **here and now**. The therapist's actual behavior is always influencing the patient's experience of the therapist because of this.

When a patient visits a therapist, they seek a **new** developmentally needed experience, but they expect the **old,** repetitive experience.

There is often misattunement to painful circumstances that can't be integrated into a person's emotional world. For example—a child who can't demonstrate his emotion in a way that his parents can handle causes the parents to move away from the child, creating distance. The child then subdues the emotion and creates a new "ideal self" so they can interact with others and no be rejected. The child then doesn't know how to deal with strong emotion, even moving into adulthood.

Unintegrated affects become lifelong emotional conflicts and vulnerabilities to traumatic states. To handle the difficult situation, they develop defense mechanisms. Those defenses against affects become necessary to maintain psychological organization.

That "ideal self" will stay in place with others until you come along. If they see you as a safe person, they will express their emotions—anger and all—towards you.

This is where it's important to understand transference, and to be able to give your patient a safe place to express their emotions.

When we understand transference is happening, we can listen from the patient's world, acknowledge their subjective perspective, resonate with them, look for their meanings, and form and alliance with the patient's expressed experience.

Of course we must expect their hesitations to trust us, avoid us, have feelings of shame, guilt, and embarrassment...it is uncomfortable to share what one feels.

Positive Transference

Negative transference isn't the only type of transference—there is also positive transference, where you remind the patient of a positive relationship they had, so they

feel deeply connected to you. People with borderline personality disorder are very quick to attach, usually commenting that they have never felt so close to a therapist before. When someone does say very positive things to me, especially in the first few sessions, I let them know that it's also okay to express negative feelings towards me as well.

Transference-focused therapy

Kernberg wrote about transference focused psychotherapy. He hypothesized about the developmental birth of borderline personality disorder. By exploring and integrating these "split-off" cognitive-affective units of self and other representations, patients will be able to think more coherently and reflectively. They will be more realistic and accurate in their thoughts, feelings, intentions and desires about themselves and others. Integration will allow for increased modulation of affect, coherence of identity, increased capacity for intimacy, and improved functioning (Kernberg 2008).

Levy (2006) studied transference focused psychotherapy (TFP) vs dialectical behavior therapy (DBT) vs supportive psychodynamic psychotherapy for borderline personality disorder. He found that TFP had increased secure attachments (whereas the other 2 did not change it), with increased narrative coherence. It also improved reflective function—the ability to mentalize the thoughts, feelings, goals of another person.

What are some common transferences?

- Sibling rivalry
    - Competitiveness, comparing, jealousy.
- Maternal
    - Possibly see you as nurturing or abusive.
- Paternal
    - Possibly wants you to solve their problems, asks for direct advice.
- God
    - Where they want you to be all powerful or omnipotent.
- Erotic

    - One of their primary attachment figures might have sexualized them, so they might yearn for erotic attention and affection. Perhaps a patient falls in love with you, or someone similar physically to you.
- Idealizing or contemptuous
    - They could view you as a savior, or feel contemptuous to you.
- Passively hoping for a miracle
- A person prone not to trust will view the therapist with suspicion
- A person who struggles with anger will have anger towards the therapist
- Transferences are influenced by age, gender, clothing, bodily attributes, context, vocabulary & choice of words, personality characteristics
- Be a certain way to have you stay connected with them

How do deal with transference in therapy:

Here is the main, overarching principle when dealing with transference: have empathy. Be empathic. Be open to their feedback. Don't take things personally. Be connected with your patient. Developing a therapeutic alliance requires you being connected, and being connected requires you to allow your patient to explore their emotional world with you. That requires psychological safety.

When you are a safe place, they will hopefully be able to connect, and you can help them identify their transferences so they have a chance at developing healthy relationships in the future without bringing their past with them.

If my patient had a previous therapist, I always ask them, "What went well and what did not go well in your past therapy relationship?"

Other questions I ask are:

- "How would you like your past therapy to have been different?"
- "When you felt disappointed and misunderstood, were you able to share that feeling with your therapist?"
- "In what ways would you like your relationship with me to be like your experience with your last therapist?"

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- "What are some of your worries about what you might experience in your treatment with me?"

When I can tell they don't want to come to therapy. I normalize their feelings so they feel like they can share with me.

- "This is a laboratory where we look at what goes on between us, and when you tell me you are mad at me, I am going to be excited about your sharing your feelings, good or bad."
- "What are you feeling about leaving me for the day?"
- "What did you do when you were young and something bad happened to you?"
    - "Go to mom? Go to Dad? Go out alone?"
    - "When you looked for help how were you responded to?"
    - "Were you comforted? Did it help?"
    - "How did it make you feel when you wanted somebody to help your upsetness?"
    - "I want to be with you in this moment of sadness and loss."

When you sense an empathic strain, mending it is priority number 1. I might say, "Help me understand what I might not have understood here." Or, "If I said something that makes you feel worse about yourself then let's talk about it now." Try to prevent an empathic strain from progressing to an empathic rupture in your relationship by catching the strains early on.

Here are a few tips to handle when patients exhibit strong emotions towards you:

- Be enthusiastic and curious about patients' experiences when coping with intense feelings.
- Be particularly encouraging about them discussing their feelings, and **especially their feelings towards you**. Whereas in the past there might not have been a safe place to get angry, they are entitled to want to have a different experience with you.
- Say explicitly that they are allowed to have all of their feelings (including loving and hating) in the therapy relationship and that they will be dealt with in words and not in actions.
- Convey to them that they can feel secure and accepted and not reproached or rejected, even if they have negative feedback or feelings towards you.

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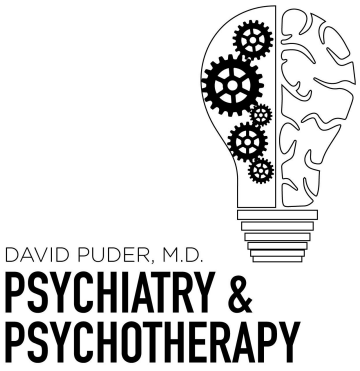

- You can work cooperatively to help them process and modulate their emotions.
- You can explore together what actions might be appropriate for them when the flooding feelings erupt and they are unsure about what might happen as consequences.
- Complicated emotions are inevitable: the opportunity we offer is to enhance ways of coping with desirable as well as disruptive emotions. Emotions may be congruent with experiences in the past, but not necessarily appropriate in the present context in which they recur.

When we are young, we are unable to metabolize emotions correctly, especially in the face of trauma or an unsafe caregiver. When we age, we transfer those patterns of belief onto every other relationship in our life, trying to recreate that. When you, as a therapist, offer a safe environment for a patient to experience those strong emotions, you are helping them rewire their belief system around those emotions. It allows them to interact with every other person in a new way.

Countertransference:

The original and narrower definition of countertransference centered around the therapist unconsciously experiencing the patient as someone from their past (similar to transference). Now, countertransference is seen as the therapists' total reaction to the patient.

First, it's important to note that therapists need to practice what they preach: do the work in your own therapy so you can identify your own transferences. The less clouded your vision is of what's happening in sessions, the better. For example, one therapist saw nearly every patient as a trauma victim, and occasionally led them to believe they'd been traumatized as well in the same way.

Countertransference is seen as a source of important information about the patient: it can be a major diagnostic and therapeutic tool. "Countertransference is an instrument of research into the patient's unconscious." (Paula Heimann)

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Now it is seen as a jointly created reaction in the clinician (some reactions from the therapist's past, some induced by the client's behavior).

There are **continuously fluctuating** levels of influencing the transference and countertransference by contributions from both patient and therapist during all their interactions. My mentor, Dr. Tarr, said, "To every relationship we bring learned expectations from past encounters."

One way to handle countertransference to make sure you are coming from a healthy place is to use your left brain to integrate with, and therefore dampen, the right brain. Learn from what you are feeling during the session, but observe yourself with curiosity.

Another form of possible transference is sexual attraction towards a patient. Studies show that 85% of male therapists at some point have erotic arousal towards a female patients. Obviously, it is important to not act on or tell your patient about those feelings.

You should also allow yourself to mirror the patient's emotions, as to follow the patient's emotional movements and unconscious content.

Before a patient enters the room, check in with yourself. How are you feeling? What are you feeling?

Here is a checklist I like to use before my sessions with patients. It is based on 7 basic emotions:

- Disgust
    - I dislike him/her.
    - I feel repulsed by him/her.
- Attraction
    - I have compassion for the patient.
    - If they were not my patient I would want to date him/her.
    - I feel sexually attracted to him/her.
    - If he/she were not my patient I would want to be their friend.
    - I look forward to sessions with him/her.
    - I wish I could give him/her what others never could, protect him/her like no one could...
    - I feel I understand him/her.
    - I have warm, almost parental feelings towards him/her.

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    - I self-disclose more about my personal life with him/her more than with other patients.
- Sadness
    - I wish I had never taken the patient on...
    - I feel sadness/depression in sessions with him/her.
    - I feel guilty about my feelings towards him/her.
    - I feel guilty when she/he is distressed or deteriorates, as if I must be somehow responsible.
- Angry
    - I feel dismissed or devalued.
    - I feel annoyed in sessions with him/her.
    - I feel criticized in sessions with him/her.
    - I feel angry with him/her.
    - I feel anger at people in his/her life.
    - I feel competitive with him/her.
    - I feel used or manipulated by him/her.
    - I have to stop myself from being aggressive or critical with him/her.
    - I feel pushed to set firm limits with him/her.
    - I feel resentful working with him/her.
- Dissociation/Shut Down
    - I feel confused in sessions.
    - I am overwhelmed by strong emotions with him/her.
    - I feel hopeless working with him/her.
    - I feel like my hands are being tied or that I have been put in an impossible bind.
- Sensorium issue
    - I feel bored in sessions with him/her.
    - My mind wanders to things other than what he/she is talking about.
    - I feel sleepy when talking with him/her.
- Fear/Anxiety
    - I feel anxious/frightened working with him/her.
    - I fear I am failing to help him/her.
    - His/her sexual feelings towards me make me anxious or uncomfortable.
    - I fear being incompetent or inadequate to help him/her
    - After treatment ends I worry about him/her more then most patients.

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It is completely normal to have feelings—both good and bad—towards patients. We are humans, not robots! Sometimes it might seem like you're supposed to be perfect or void of feelings towards your patient, but that doesn't allow a living, growing, healthy therapeutic alliance towards them. The important thing is to notice how you feel, without self judgement. Then, deal with those feelings in a healthy manner, like through seeking out your own therapy, getting a mentor, etc. However, sometimes merely allowing yourself to notice the feelings and owning up to the feeling of anger, attraction, boredom, or sadness, is enough to dissipate it.

It's easy to be busy after a session. It's better to practice noting your feelings. After all, how can we help our patients express and normalize their feelings if we cannot do it for ourselves?

Conclusion

If you are a mental health professional, I would love for this to be your community. We are in these trenches together, and it's pretty common for therapists to feel totally exhausted and burned out from all of the countertransference. I hope that through this community, we can develop better practices, help each other, and grow together.

If any of you have any questions or listen to the podcast, I'm active on social media. I'd welcome any feedback you have. My social handles are: Instagram **@Dr.DavidPuder**, Facebook: @DrDavidPuder, or Twitter @DavidPuder