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"*A Vital Christian Presence in Social Work*"

TRANSFERENCE AND COUNTERTRANSFERENCE FROM A MODERN PSYCHOANALYTIC PERSPECTIVE

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Abstract

This paper explores the following basic tenets of modern psychoanalysis: Mahler's paradigm of the first two psychological years of one's life; the conscious, subconscious and the unconscious; making the unconscious conscious; transference and countertransference, as well as narcissistic and objective transference. Author explains these terminologies from a modern psychoanalytic perspective and makes the concepts simple to the reader.

The concepts of transference and countertransference were identified at the early stages of psychoanalysis by Freud (1905, 1910, 1915). While various masters of modern psychoanalysis (Margolis, 1994a, 1994b, Spotnitz, 1989) have written excellent articles on these two concepts from the modern psychoanalytic perspective, first-time readers have consistently expressed difficulty in comprehending these key tenets of psychoanalysis. The goal of this paper is to explain these two psychodynamic ideas in simple terms as a prelude to reading from the masters' writings.

Before we can fully study these concepts, we need to examine the foundations of the psyche (emotions). To help us understand this, we first examine Mahler's paradigm of a person's first

two years of psychological growth. We find that our first two years play a major role in shaping our expectations toward life; this is registered in our unconscious. In order for us to understand what our unconscious is, we also consider the structure of the subconscious as well as the conscious. This article then addresses how the analyst fosters a “narcissistic transference” with her patient in order to help him to move on to “objective transference.” The ultimate goal in analysis is to help the patient to bring to the conscious what is in his unconscious, so he can choose to act constructively toward achieving goals in his life.

For simplicity’s sake, this article refers to the analyst as a “she” and the patient as a “he.”

Mahler’s First Two Years of Psychological Growth

Mahler’s (1968, 1975) schema of psychological growth has been widely accepted by the mental health profession. Basically, she writes that, from birth, every one of us goes through the autistic, symbiotic and separation-individual stages. Each stage has its own set of tasks that need to be “mastered” in order for us to grow healthily in the psychological realm. During the first ten months of life inside our mother’s womb, we had a carefree existence. We floated in our mother’s amniotic fluid, and all of our physical needs were met: ingestion of nutrients, excretion, and a warm environment. All we had to do while inside the womb was to *be*.

When birthed into this world, we do not quite grasp the fact that we are no longer alone (in the womb). Psychologically, we go through what is called “the autistic stage,” in which we psychologically feel/experience only ourselves. We are shut off to the world and are only aware of ourselves.

During the symbiotic stage, we experience our primary caretaker - for the sake of simplicity, we will refer to this person as our mother - as if she is one with us. We experience her emotions

and feelings as if they are our own. Similarly, we assume that however we feel is how she is feeling. At this stage, we are *one* with our mother. There are two sub-phases in this symbiotic stage. During the first sub-phase, we are one with our mother and she is one with us, *inside of us*. During the later sub-phase, we still feel that we are one with our mother, but she is now *outside of us*. She is a mirror image of us on the outside. We see and experience her as an exact reflection of ourselves.

The next stage, separation-individuation, also has two sub-phases: practicing and rapprochement. During the practicing phase, as toddlers, we discover that there is a world outside of us and our mother and we fall in love with this new world. This new world now captures our attention; we leave our mother's "emotional womb" and are fascinated by what's out there. However, we need assurance from our mother that she approves of us venturing out, leaving her behind. We then return to check in on our mother (rapprochement) to make sure that she still loves us. This sub-phase is exemplified by toddlers in the playground, where they play away from their mother, and after a while, run back to the waiting and watchful mother for a hug, for a sip of juice, to say, "Hi," and dash right back out again.

Once we have mastered these stages, we can then develop into secure and separate individuals. We become our own person, able to have healthy relationships with others and are set to tackle our life constructively.

Psychological Structure: The Triad

In order for us to better understand the topic of this paper, we have to first examine the basic components of our psychological structure: the conscious, the subconscious and the unconscious.

The conscious is where our cognition, thoughts and volition reside. When we interact with others and are aware of what we are communicating, it is the function of the conscious. When we make deliberate decisions about anything, it is an example of our conscious at work.

The transitional period between being awake and being asleep is an example of the subconscious: after awaking, we are not sure if the images, sensations, feelings and thoughts were “real” – did they really take place, or were they in our dreams? The subconscious gives us a glimpse of what might be residing in our unconscious. It is at the outer edges of our awareness, but we cannot quite grasp it. It is experienced as a vague sense of something, which we cannot quite pinpoint.

The unconscious is where most of our emotional memories reside. It is as if our unconscious has been making records of all that we have felt, sensed, touched and experienced, even from the womb – before we were able to think conscious thoughts. It “remembers” all our psychological/emotional experiences and, based on our life experiences, formulates its own judgments and assessments of how the world is. Our habits and reflective responses to stimuli reside here, as well as our coping/defense mechanisms. While our unconscious is busy taking notes of our emotional life experiences, our subconscious sometimes gets an inkling of them, and our conscious is largely unaware of what is going on.

Some of us reflexively lie to cover our tracks when confronted by others, even when there is nothing that needs covering up. When someone asks us a question, and we sense that the person might become upset with us or disapprove of us, our immediate response is to tell at least a white lie. After the incident, or even in the midst of the deception, we kick ourselves; we wonder why in the world did we lie, when there was no reason to do so? But what we fail to realize is that our coping mechanism was at work. Somehow, our unconscious has registered that if a person

approaches us with a suspicious or unhappy face, it means that we are in trouble; we had better cover our tracks and “get out of” the situation, by whatever means. This might have developed from frequent life experiences in which we got in trouble with others; having “earned” the reputation of being less than honest or perfect, we unconsciously see ourselves through that same lens. We know instinctively that we had better dig ourselves out of yet another hole, and we automatically deploy such tactics as blame shifting or disavowing of knowledge or responsibility.

Main Mechanisms of Psychoanalysis

The main mechanisms of psychoanalysis are designed to help the patient to “say everything.” In so doing, the patient is able to get in touch with his unconscious and, with the help of the trained analyst, to bring to the conscious what is in the unconscious. Once we become aware of our unconscious, we can then choose to view, think about, and better evaluate our feelings, values and life experiences. It is through the conscious that we make our decisions as healthy adults: we weigh our feelings, past experiences, expectations, desires and values; we examine alternatives and their possible consequences, and then we decide on the best course of action in resolving an issue or in accomplishing a goal.

Therefore, the goal of psychoanalysis is to help the patient to become aware of his unconscious so he can make conscious (and hopefully healthy) choices, in spite of past life experiences. The mechanism to get at this is the study of the patient’s transference and resistance, as well as the analyst’s countertransference in working with the patient.

Transference

The key concepts of psychoanalysis and psychodynamic psychotherapy are transference, countertransference and resistance. In order to work with the patient toward better mental health, the analyst studies the patient's transference by examining the feelings induced by the patient (countertransference), and also studies the patient's resistance toward "saying everything." Transference can be simply defined as the projection onto the analyst of one's unresolved feelings and issues connected with significant others from the past (usually one's parents). The patient experiences the analyst through the lens of his relationships and experiences with his parents and other significant people in his life; he experiences his analyst as though his analyst *is* a significant other from the past. So the patient does not really perceive the analyst as a separate and unique person from himself.

Since we were without words during the first two years of life, our unconscious remembers our feelings without words attached to them; it has wordlessly constructed a view of the world and core beliefs about who we are according to our experiences. (We see ourselves as lovable or detestable; having worth or worthless; having a voice or none; secure in our love and acceptance from our parents or rejected/abandoned/ neglected… etc.) This view of the world is locked in the recesses of our psyche and we perceive (and expect from the world), according to these early (pre-verbal) experiences. The analyst studies the patient's transference in order to understand what the patient's formative years were like, and moves deliberately with the patient through Mahler's four stages.

The transference itself involves four components: 1) how the patient feels toward himself; 2) how the patient's mother (primary care taker) felt toward him; 3) how he felt toward his mother; 4) how he wished his mother felt toward him.

The analyst studies these four aspects of the transference by experiencing the feelings induced in her. These induced feelings are called “objective countertransference.” We will go into more depth on countertransference later on in the article. For now, we can say that as the analyst feels/experiences these transference feelings from the patient, she begins to understand the psychic (emotional) core of the patient.

In order for the analyst to understand and use the feelings induced in her to help the patient, the analyst fosters a “narcissistic transference” through reliving, studying, and experiencing the first two years of the patient’s emotional life with the patient in analysis. During the first stage of Mahler’s psychological paradigm, the patient is in the autistic phase where he does not sense anyone outside of himself. In the context of treatment, an example of this is when the patient talks on and on without acknowledging the analyst’s existence in the room with him. One gets the sense that it doesn’t matter who is in the room listening to him; he is really unaware that someone other than himself is present. He would say exactly the same thing no matter who happened to be in the room. We refer to this as the patient “not making any contact.” This is a sign that the patient is in the autistic phase. The analyst asks two to three “object oriented questions” during these sessions to help the patient become aware that someone else is in the room.

By “object orientated questions,” I mean questions that have to do with the content of what is being said rather than feelings. These factual questions slow the patient down from going on and on, talking to himself. They interrupt his train of thought a bit to indicate to him that someone else is present. An example: James says, “What a hectic day I had today! I got up late because I didn’t hear the alarm. I must have just turned it off when it went off, but I really can’t afford to get to work late yet again. So I panicked when I got up and I just jumped out of the bed, put on

my clothes and ran out of the house…" The analyst interrupts and asks, "What time did you set the alarm for?" This is a factual question and it interrupts the patient's thoughts in the moment. The analyst is alerting the patient's unconscious that she, a separate being, is present in the room with him.

The second stage of Mahler's paradigm is the symbiotic stage. As mentioned earlier, there are two sub-phases in this stage. In the first sub-phase, the analyst is *one* with the patient, inside of him. It is as if the analyst were in the amniotic fluid with the patient, floating together as one inside the mother's womb. However the patient feels is how the analyst feels and however the analyst feels is how the patient feels. The patient is no longer alone and is totally accepted by the analyst. An example of fostering a narcissistic transference is the following: A schizophrenic patient of mine, Paul, tells me that his friend does not affirm his belief that an evil spirit was in the receptionist he spoke with on the phone when he called up his parole officer. In our session, Paul asks me, "What do you think? Do you believe me that the evil spirit was in the receptionist because she didn't transfer me to my parole officer?" I answer, "Paul, you and I know better. You and I know that the evil spirit prevented you from being able to get through on the phone. Your friend doesn't understand this, so don't share it with people who don't understand…but you and I know better." My joining Paul's reality helped him to feel that I understood him and that I accepted his reality and embraced his experience. This also enabled me to help socialize Paul to not talk about his brand of reality to others, and so alienate them.

This is the very reason why narcissistic transference works: it enables the patient to feel understood and accepted by the analyst. This builds trust. Once trust is established, the patient is then willing to take in what the analyst might have to say. Before trust is established, the patient is resistant and tends to fight against what the analyst or anyone else might have to say to him.

The analyst now moves on to the next sub-phase of symbiosis with the patient. She mirrors the patient so he can feel that she is still one with him, but now is outside of him. An example of this: The patient comes into the analyst's office and says, "Boy, am I a dedicated patient! It took me an extra 20 minutes to get here today because of all the traffic. I was persistent in getting here and nothing was going to stop me from coming to my session!" The analyst replies, "Boy, I am such a dedicated therapist. I knew the traffic was bad today and I made sure I left my house early so I could get here on time for our session. Nothing was going to keep me from coming to our session!" The patient feels at one with the analyst while seeing, outside of himself, a mirror reflection in the analyst.

Next is the practicing phase. This is when the patient starts to realize that he is a separate individual from the analyst. With children, this is the phase in which the toddler discovers that there is a world outside of his mother and him and falls in love with that world. He learns that he can actually walk away from his mother and go toward some object of interest that he can now explore on his own. We see this in treatment when the patient starts to talk about his own insights and his own discoveries about himself and his emotions. Things start to click for him and he is now "connecting the dots" for himself, realizing the basis of his own behavioral patterns with little prompting by the analyst. He is now stretching his insight muscles and his life outside of his sessions is getting better.

The patient might experience some set-backs during the next developmental phase: rapprochement. While he was doing well earlier in treatment, he might regress a bit; issues you and he thought he had resolved now come back for a short visit. Manifestation of dependence upon the analyst, as well as symbiotic or autistic traits, may now resurface in treatment. As long as the analyst continues to be consistent and gives the patient the right feelings (communicating

acceptance or encouragement, or eliciting frustration or anger – whatever is needed to help the patient grow) the patient is reassured. He sees that the analyst, just like his mother, approves of his growing away from her and becoming independent. He then becomes a separate individual emotionally.

The patient now enters the final phase–and ultimate therapeutic goal–of treatment: objective transference. By this stage, the patient has resolved his narcissistic transference of not being able to see the analyst as a separate and unique individual. He now sees that in addition to the analyst playing the role of helper and collaborator in his progress, she is actually a unique individual in her own right. The analyst is now seen as another human being with her own personality, quirks, idiosyncrasies, likes and dislikes, strengths and weaknesses. The analyst is (and was, all along) another person, who journeyed with him his path toward health; she is no longer merely someone (an object) upon whom he projects his own issues.

The patient now wants to hear the analyst's interpretations, insights, suggestions and ideas about his options in resolving his life issues. He now readily takes in her recommendations and weighs them on his own, and is then able to make his own decisions as to which path to take. What was in the unconscious during the narcissistic transference phase now comes to light in the conscious; now there are words with which to describe and think through, and to empower the patient to decipher his own psychological makeup.

This is a picture of the healthy adult: a person who is aware of his feelings, who accepts and embraces them, who understands where these feelings come from and who allows himself to fully feel them. He then looks at his life issues, considers options on how to resolve them and is able to see possible consequences of each option. With his rational mind intact and fully aware of his emotions, he chooses a solution that will integrate his beliefs, values and feelings. He

weighs each aspect carefully and takes the plunge and makes a constructive decision. He is ready to deal with the possible consequences of his decision, being willing to embrace the risks involved and the ambivalent feelings he will experience from saying “yes” to one option and thus saying “no” to another.

Countertransference

The terms “transference” and “countertransference” refer to feelings that get induced/evoked in the therapeutic relationship. Whether it is a transference or a countertransference has to do with the *direction* of the feelings. Those from the patient toward the analyst are transference; the analyst’s feelings toward the patient are countertransference.

There are two types of countertransference. Most mental health professionals have been taught to avoid all countertransference feelings; Freud was so afraid of the negative feelings induced by his patients that he would refer his patients out whenever these irritating feelings surfaced (Spotnitz, 1985). This is subjective countertransference: feelings the analyst feels, having do with her as a person. The analyst’s own unresolved issues are being awakened in her work with the patient. The analyst has a hard time staying objective in the treatment in order to fully “be there” for the patient, as she is bombarded with her personal feelings toward the patient and toward whomever the patient reminds her of in her own life.

The second type is objective countertransference. This involves the feelings the patient induces in the analyst that give precious information about the patient’s own feelings and transferences. It enables us to feel how the patient (as an infant) felt toward himself, how his mother felt toward him, how he felt toward his mother and how he wished his mother felt toward

him (the four components of transference). Objective countertransference is the key to our better understanding and eventually unlocking the emotional and psychological door to our patient.

During one's work with the patient, especially during the narcissistic transference stage, the analyst actually feels (objective countertransference) these four components of the patient's transference. The analyst's job during the narcissistic transference phase of treatment is *to feel how the patient feels*. The analyst then steps back a bit and asks herself, "Who is feeling these feelings? Am I feeling what the patient is feeling toward himself? Am I feeling what his mother felt toward him? Is this how the patient felt toward his mother? Is this how the patient wished his mother felt toward him? Or, are these my own feelings toward the patient?"

While the analyst may be quiet and appear passive, she is actively studying the feelings evoked inside of her during the session. When she is unsure how the patient might respond, she continues studying before giving an intervention.

Objective countertransferences come from the patient; the patient would induce these same feelings in most others. Marcia, for example, was abandoned by her father when she was two years old. Her mother, Enid, went on to have numerous relationships with men so she could have someone take care of her. Since Enid believed she would be more attractive to men if she did not have a daughter, she ordered Marcia to stay in her room and not appear during her boyfriends' visits. When Marcia turned 18, Enid pushed her out of the house and then moved without leaving forwarding address or phone number so Marcia could not follow her. From these rejections and repeated abandonment, Marcia grew up ingratiating herself to people around her. She would monopolize conversations and everyone's attention, often interrupting a conversation between two parties to tell how her life was going. She would focus on one sympathetic person and phone the person constantly, asking to be taken out, to be treated to meals and to sleep over at their

home. A pattern emerged: one by one, the people who came in contact with Marcia started to distance themselves; some had to repeatedly ask her to stop calling their homes everyday. What we have here is Marcia inducing in each person a desire to reject her. This same pattern would play out with the least compassionate to the most compassionate people. Sooner or later-but always-people would pull away from her. This is an example of objective countertransference. The key here is that everyone reacts to Marcia the same way; so it is not that others are uncaring, but rather that she induces others to reject her just as she was rejected by her parents.

As I conduct group supervision with my counseling students and mental health professionals, I often stop a case presentation to ask the group what feeling each member might have toward the patient being presented. If the majority of the group feels one particular way toward the patient, then it is most likely an objective countertransference (coming from the patient). When the majority of the group feels one way and the person presenting the case is feeling something very different from the rest of the group, then it might be an indication of subjective countertransference on the part of the presenter.

Many times how an analyst feels in the session is a combination of objective (coming from the patient) and subjective (coming from the analyst's own issues) countertransference. Another way to distinguish the type of countertransference is this: when the feeling felt during the session dissipates quickly after the session is over, then it is most likely an objective countertransference. When it is of a subjective origin, the analyst continues to feel the feelings induced by the patient, even two hours or more after the session. The analyst might even go on to dream about the patient. When these feelings linger and seem not to dissipate, it is a sign to the analyst that her own personal issues are most likely mixed in.

The Need for the Analyst to be in Analysis Herself

Talk therapy is not hard science; the analyst engages her *self* in this particular art. And since every analyst is a human being with her own issues, it is of vital importance that the analyst herself be in analysis. This is only ethical: to constantly scrutinize our own issues in order to grow as a person, and to separate our own issues from our patient's. We want to ensure that what we sense is going on with the patient in the therapy really belongs to the patient and is not a vestige of projection from our own unresolved issues.

As long as we have breath, we will have issues with which we need to grapple as a person, and especially as an analyst. It behooves us to continually work on ourselves, studying and separating our subjective countertransference from the precious objective countertransference our patients induce in us; only then can we be of some good in our work with our patients. Being in analysis ourselves also helps us to more fully experience what it is like to be a human being, each with her own life issues. Developing a keener sense of empathy with others and internalizing the voices of our own analyst, we become more emotionally attuned as analysts, ourselves.

Without the patient granting us the privilege of allowing us to join him in re-experiencing his early emotional journey, our work often times has little lasting effect; without such mutual re-experiencing, it would be hard for us to move on to the study and resolution of resistance that impedes our patient's quest for better mental health and achieving his life goals.

In summary, we have discussed the value of transference and countertransference in the therapeutic relationship. Narcissistic transference is established in order to help the patient move on to objective transference. This enables the patient to become aware of his unconscious. Once

that which was unconscious has come to the conscious, the patient is able to make constructive choices and live a healthier life.

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