Countertransference – A phenomenon that enriches the therapeutic process

A literature review with clinical illustrations by

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any degree or diploma of a university or other institution of higher learning, except where due acknowledgment is made in the acknowledgments.

Signature

Rachel Cox
Date: 28/01/05

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I acknowledge AUT Ethics Committee for granting approval and providing ethical guidelines for the purpose of this dissertation. Approval was granted under number 02/33 on the 27 April 2004. I would also like to thank the clients who granted the use of clinical material from our therapy sessions to be used to enrich this dissertation.

ABSTRACT

The objective of this literature review was to understand and describe the complex theoretical concept of countertransference and to identify how countertransference helped the therapist to understand the client's psychological processes. Literature on countertransference from the past century has been examined using a modified systematic literature review, and psychodynamic concepts that underpin countertransference have been identified and investigated. These included identification, projective identification, introjective identification and empathy. The identification process detailed ways a client communicates with the therapist through conscious and unconscious means. The therapist also receives information about the client via her own thoughts and emotional responses - classified as countertransference. Countertransferential responses via the introjective identification process, gives the therapist access to experiences that the client is, as yet, unable to put into words. The therapist then makes sense of her responses within the therapeutic relationship with the client. This dissertation also explores the benefits and cautions of the therapist utilising countertransferential responses.

CHAPTER ONE
INTRODUCTION

Does countertransference[1] help the therapist to understand the client's process? This was my question of interest as I began to experience countertransference in the clinical setting. Countertransference was a concept taught within the psychotherapy training curriculum, yet when experienced first hand I began to question how such emotions could be used therapeutically. Feeling empathy, compassion and sadness for my client initially felt part of what it was to be a therapist. Yet when I felt angry, critical, inadequate, hopeless, numb or sleepy I questioned whether these feelings could be used therapeutically, as they often opposed the client's feelings and at times felt un-empathic. I was also sometimes left feeling confused with experiencing a clearly different emotional state to my client, and sometimes I questioned the validity of my emotional responses. I wondered, was I to explore these feelings further, or ignore them?

Motivated by my questions, and alongside the countertransference concept learned in my training, I set out within this dissertation to understand the theoretical and clinical aspects of countertransference by exploring the question, **'how does countertransference help the therapist to understand the client's process?** This question will be discussed and developed throughout chapters three, four and five of this dissertation.

The methods used to source literature on countertransference are outlined in chapter two. Also described in this chapter is the modified literature review used in this dissertation, the inclusion and exclusion criteria and the synthesis of material.

The focus of chapter three is to explore the theoretical concept of countertransference. This chapter begins by looking at the origin of countertransference, and then reviews

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[1]The definition of countertransference I align myself with is the broad definition given by Tansey and Burke (1989):

> The therapist's total response to the patient, both conscious and unconscious. This total response includes all the thoughts and feelings that the therapist experiences in reaction to the therapeutic interaction whether they are considered to be 'real' or neurotically distorted (p. 41).

Given the centrality of countertransference to this dissertation, a considerably fuller definition of countertransference will follow in Chapters Three and Four.

countertransference literature from the past century. A historical timeline of theoretical perspectives is given and contributions to the concept of countertransference are discussed. In defining the countertransference phenomenon a section on current perspectives includes benefits and cautions, and identifies common themes. These include the mutually created and intersubjective nature of the therapeutic relationship, identification processes and empathy.

Chapter four begins with a brief exploration of views on the therapeutic relationship, to give context to countertransference which occurs in this clinical setting. As identified in chapter three, the common themes that underlie countertransference - projective and introjective identification, are thoroughly explored, and their relevance to the therapeutic relationship discussed. The concept of empathy is discussed and draws together the previous discussions on the therapeutic relationship, projective identification, and introjective identification. Clinical examples and vignettes are used throughout this chapter to illustrate the theoretical concepts described in the literature.

Chapter five summarises past and present views on countertransference, its effect on the therapeutic relationship and the relevance it has to understanding the client's process. It concludes with implications and limitations of this literature review and highlights further research potential.

Appendix A contains a copy of AUT Ethics Committee approval for this dissertation, the consent form used for gaining permission from clients, and the information sheet the clients received.

CHAPTER TWO
METHODS

This chapter describes the modified systematic literature review used in this dissertation. The sourcing and synthesis of literature is described, inclusion and exclusion criteria identified, and the use of clinical illustrations are discussed.

A Modified Systematic Literature Review

A systematic literature review is a critical summary of literature on a topic of interest. In this dissertation the research topic of interest is the therapist's countertransference. The technique used in a systematic literature review aims to generate empirical objective answers to specific research questions by means of collecting, evaluating, and synthesising information from relevant scientific studies. This approach is used to minimise bias by viewing the evidence in its objective reality, and is considered easily reproducible. Systematic literature reviews use explicit methods of quantitative deductive reasoning and objectivity, and are primarily grounded within a traditional positivist paradigm (Crotty, 1998; Davidson & Tolich, 2001; Greenhalgh, 1997; Polit & Hungler, 1997).

However, this review is systematic in the method of sourcing literature – yet differs in that it uses a qualitative subjective approach - a naturalistic paradigm, not an empirical positivist one (Polit & Hungler, 1997). Due to the scarcity of research on countertransference, the literature in this dissertation largely cannot be considered to be empirically based. The literature included in this dissertation is derived from author's anecdotal descriptions and observations of others and their own clinical experiences, and from conceptual and theoretical discussion and development.

To determine how countertransference helps the therapist to understand the client process, the aim is not to obtain one precise answer to this specific research question – more about exploring ideas and theories. Such ideas and theories will then be synthesised and critiqued. Clinical vignettes and examples will be used to illustrate the researcher's interpretation using the theoretical concepts identified in the literature review. Consequently this literature review can be described as a modified systematic literature review.

Sourcing of Material

The literature search began by searching psychoanalytic and psychological databases as the concept of countertransference has its origins in psychoanalysis. Other key databases were searched (refer to Table 1.0 below) to investigate what literature was available, then kept mainly to PEP and PsychInfo databases to keep literature at a manageable level within the limitations of this dissertation.

Table 1.0: Databases Used

Psychoanalytic and Psychology databases	Health, Education, and other databases
PEP	ERIC
PsychINFO	EBSCO Host: Health Source and Medline
PsychARTICLES	
Wiley Interscience: Journals under psychology	Wiley Interscience: Journals under Life and Medical Sciences.
Psychematters	Proquest 5000 International

In this literature review I searched databases and read books under the title or subject matter pertaining to the therapist's feelings and thoughts. My initial question was "are the therapist's feelings valid to the therapeutic relationship?" On searching databases I realised the question I was asking was "How does the therapist's countertransference help to understand the client process?" As my question became more defined so did my search criteria. I used the following search words (Table 2.0) to source information in books, journals and the above mentioned databases.

Table 2.0: Search words used

Unconscious communication	Therapist's emotions
Psychic knowing	Psychotherapy and countertransference
Feeling responses of the therapist	Countertransference
Intersubjective communication	Countertransference and the therapeutic relationship
Psychotherapy and the therapists feelings	Countertransference and empathy

Searching the above databases using the search word countertransference at times resulted in the same articles being found. Consequently I mainly used PEP and PsychINFO databases as these databases gave a wealth of literature on countertransference and covered a cross section of literature discovered on other databases. From my literature search I obtained articles that were cited in the material sourced in the databases. I also utilised reading recommendations from experienced therapists and lecturers on the subject of countertransference and the therapeutic relationship.

Inclusion and Exclusion of Material

Greenhalgh (1997) describes that "when undertaking a systematic review, not only must the search for relevant articles be thorough and objective, but the criteria used to reject articles as flawed must be explicit and independent of the results of those trials" (p. 114).

When using the key word countertransference for example, to search for relevant literature on the databases I was inundated with an abundance of literature. Within the limitations of this dissertation I had to limit the articles to those that were deemed relevant to the research question. I mainly chose articles that were specifically relating to countertransference. To ascertain, at first glance whether they were applicable to this dissertation, I read the abstracts, titles and at times skim read the articles. I also only included articles that were written in English as this is the only language I understand.

Literature that was excluded was material that discussed for example, how to use countertransference such as Strean (1999) or Goodman (1995) which discussed when to contain or disclose countertransference, or articles that referred to the therapist's countertransference directly relating to a specific clinical disorder. Although these articles pertain to the therapist's countertransference it did not assist in answering my question as it referred more to the management of countertransference. Also excluded were articles written in other languages which may have been useful in helping answer my research question.

I narrowed the search down using the key search word 'countertransference'. This related directly to my research question in that I was discovering how the therapist's countertransference helps to understand the client process.

Clinical Illustrations

AUT Ethics Committee granted ethics approval (Appendix A) that enabled clinical examples and vignettes from my clinical practice to be used within this dissertation. These examples and vignettes were used to illustrate themes identified in the synthesis of the literature, and do not serve as evidence. Permission was also sought and granted by the client to use their clinical material from our therapy sessions for the purposes of this dissertation (Appendix A). All client names and identifying features have been changed in an endeavour to keep the clients' identity anonymous.

Synthesis and Discussion of Literature

In answering the question "how does countertransference help the therapist to understand the client's process" a systematic approach was employed in the exploration, compilation, and examination of literature. After reading the relevant literature and taking notes, synthesis came about by organising the material into relevant areas of historical and current perspectives on countertransference. The literature was compared, contrasted and discussed and apparent themes emerged. In accordance with the aim of this paper, the literature was reviewed with the aim of exploring differing ideas on this subject. This approach does not comply with the traditional positivist definition of a systematic literature review where one definitive answer is sought, and therefore is classified as a modified systematic literature review.

Chapter three begins the identification, exploration and discussion of countertransference based on reviewed literature.

CHAPTER THREE
DEFINING COUNTERTRANSFERENCE

The term 'countertransference' encompasses theoretical concepts regarding the ways in which the therapist experiences their client. In this chapter some of the plethora of literature over the past century on countertransference is reviewed. It incorporates two sections – 1) a historical perspective, and 2) a current perspective. A timeline approach is used in this chapter to provide a context for the theory of countertransference, and to track the evolution of the understanding of how countertransference helps the therapist to understand the client. I have chosen prominent authors who have contributed significantly to the theoretical development of psychoanalytical concepts. This focus on psychoanalytical concepts has been chosen as it is an area that interests me and is the main modality of my training. The review of literature in this chapter is focused toward clarifying how countertransference helps the therapist understand the client's process.

A Historical Perspective

In the late nineteenth century Freud was the founder of numerous psychoanalytic concepts relative to the development of personality. Many authors refer to Freud as the 'Father of Psychoanalysis' and this striking congruence among these authors, such as Bernstein (1999), Blum (1979), Hardin (1988), Loewald (1977), Mahony (1979) and Wolf (1991), to name a few, can be seen as a testament to his contributions to psychoanalysis.

There are theorists who have introduced major psychoanalytic concepts divergent from Freud yet have used his theories as the foundation on which to expand and build their own (Fairburn, 1952; Kohut, 1959, 1971; Kernberg, 1976; Loewald 1977; Winnicott, 1949). While such theorists have revised and transformed aspects of Freud's theories, there are the more strict followers who have extended his basic premise (Arlow, 1985; Brenner, 1976; Grossman, 1992). Thus it is apparent the impact Freud has made on the psychoanalytic world.

The concept of counter-transference[2] was first mentioned by Freud in 1910 in his essays on psychoanalysis. He wrote very little on countertransference after this. Freud stated:

> We have become aware of the counter-transference which arises in the physician as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognise his counter-transference in himself and overcome it (p. 144).

Countertransference as referred to above was viewed by Freud (1910) as a hindrance and an obstacle that could interfere with treatment. He believed it related to the personal history of the therapist where unresolved conscious and unconscious conflicts were activated by the client's transference reactions and felt such countertransference was to be recognised and overcome with the help of self-analysis or analysis (Freud, 1910; Gabbard, 2001; Mitchell & Black, 1995). Therapists should have evenly suspended attention, be neutral observers and not be distracted by countertransference. If the therapist felt strong emotions toward the client something was wrong (Freud, 1910). These feelings were considered merely a displacement of feelings from the therapist's past difficulties onto the therapeutic relationship[3] which were considered an irrelevant intrusion and interference into the therapy (Abend, 1989; Bateman, Brown & Pedder, 2000; Gabbard, 2001; Mitchell & Black, 1995).

In the 1920's, Melanie Klein, a devoted follower of Freud was considered a pioneer of child psychoanalysis. She retained many of Freud's concepts which gave context to her clinical findings (St Clair, 2000; Rycroft, 1995). She too followed his classical perspective and thought negatively of countertransference believing it was the therapist's way of shifting responsibility onto the client for their own feelings and self-deficiencies (Spillius, 1988). As it stood in the 1920's countertransference was thought to be therapeutically counterproductive.

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[2] Counter-transference as first mentioned by Freud is now more commonly written as countertransference and will be written this way throughout this document.

[3] It is necessary to note at this point that much of the literature refers to the 'analytic process', or 'psychoanalytic/therapeutic relationship' or similar (yet rarely specifically mentions the client process). According to the following definition, for example of a psychotherapeutic relationship, I believe the terms used incorporates the client process and will assume this throughout the dissertation. I feel Sutherland (1968) best describes this as 'a personal relationship with a professional person in whom those in distress can share and explore the underlying nature of their troubles…' (p. 509).

However, by the 1940's this negative view of countertransference began to shift more into the positive realm through the writing of Winnicott (1949) and Heimann (1950). Winnicott was among the first theorists to consider that countertransference was a phenomenon that was beneficial in understanding the client's process. Winnicott regarded countertransference as a way of the therapist understanding repetitive self-object configurations of the client's internal world, and thus vital and valuable (Bateman, Brown & Pedder, 2000; St Clair, 2000; Rycroft, 1995; Teyber, 2000; Winnicott, 1949).

In contrast to literature of previous years that promoted the detrimental aspects of countertransference as previously mentioned, Winnicott (1949) wrote about the positive aspects of it in a paper, 'Hate in the Countertransference.' Winnicott discussed the usefulness of countertransference, suggesting that perhaps more of the abnormalities in countertransferential feelings stemmed from repressed feelings in the therapist which needed further analysis. He believed countertransference to be unique to each therapist in that their identification with the client comes from that therapist's personal experiences and development and viewed this as a "positive setting for analytic work" (p. 69). The therapist needed to have great tolerance, patience and objectivity when sitting with hate in the countertransference to avoid tailoring therapy to the needs of the therapist, rather than the needs of the client. Winnicott illuminated the dangers of inappropriate timing of interpreting hate to the client, yet felt analysis was incomplete if hate was not commented on.

Winnicott (1949) viewed psychoanalysis as an interactive process that made countertransference inevitable and made the distinction between objective and subjective countertransference. Objective countertransference is the therapist's reaction to the client's personality and observed behaviour, in the same manner that others exposed to such behaviour are likely to act. Thus giving the therapist valuable insight into possible relationship dynamics between the client and others. The subjective aspects of countertransference are more related to affective reactions of the therapist relative to transference that relate to the therapist's past unresolved conflicts and idiosyncrasies (Wilson & Lindy, 1994; Winnicott 1949).

Heimann (1950) paralleled Winnicott (1949) in the beginning as she too viewed countertransference as something other than the therapist's own unresolved conflicts transferred on to the client. Her belief was similar to Ferenczi's (Mitchell & Black,1995) in that she believed the psychoanalytic approach as being a "relationship between two persons" (p. 81) where the degree of feelings experienced by the therapist were to be consulted and made use of. That is, countertransference consisted of more than just the therapist's own transference onto the client ('counter' referring to additional factors). This is similar to Winnicott's (1949) subjective and objective concepts of countertransference. For example, countertransference cannot be precisely divided into just the therapist transferring feelings from a past relationship on to the present relationship with the client, or simply to feelings the therapist has toward that client in their own right. Some of the countertransference is also created by the client (Heimann, 1950).

Both Heimann (1950) and Little (1951) felt the therapist's emotional response when in relationship with the client provided valuable information about the client's unconscious process and guides him toward a fuller understanding of the client. Heimann said that "if an analyst tries to work without consulting his feelings his interpretations are poor" (p. 82). If he did consult his feelings he was more able to make interpretations that enabled him to check that he had heard the client correctly. She stated "…not only is it part and parcel of the analytic relationship, but it is the patient's creation, it is a part of the patient's personality" (p. 83). She felt countertransference was the creation of both the therapist and the client, yet focused on the causes in the client.

By contrast, Little (1951) focused more on the effects of countertransference on the therapist and stated:

> both [transference and countertransference] are essential to psycho-analysis, and counter-transference is no more to be feared or avoided than is transference; in fact it cannot be avoided, it can only be looked out for, controlled to some extent and perhaps used (p. 7).

Heimann (1950) agreed with Freud's view that the therapist's own analysis is necessary, yet not with the aim of recognising and overcoming countertransferential feelings, more with the aim of "enabling him [the analyst] to sustain his feelings as opposed to discharging them like the patient" (p. 9-10). She believed if the therapist was able to have free floating

attention to his own spontaneous feelings and emotions and the client process, the more his unconscious would tune in with that of the client to provide a fuller understanding of the client's process.

Heimann (1950) believed that the therapist's immediate emotional response to his client was an important indicator of the client's unconscious processes, impulses and defences. Such strong emotional responses serve as a beacon for the therapist to focus their interpretations on, as they are relevant to the client's associations. Heimann believed that fierce (intense) emotions (for example love, hate, anger and helplessness) can force a person into action. Hence if the therapist's emotional response was intense it could propel them into action, which may not be therapeutic and could defeat the client. The aim would be to hold on to such strong emotions to contemplate their meaning. However, what was not discussed by Heimann was the aspect of mild or subtle emotions and the effect these may have on the therapist. It seems plausible that less intense emotions are also relevant to the client, and that there could be even more potential to act these out due to their mild or subtle nature.

During 1947-1975 there was a great increase in literature produced where concepts of countertransference were expounded upon. The shift from countertransference being a hindrance came about along side the change in classical (Freudian) psychoanalytic concepts of one-person framework to a more contemporary two-person approach (Heimann, 1950; Mitchell and Black, 1995; Racker, 1968; Weigert, 1954; Winnicott, 1949). It was Freud's (1910) belief that the therapist should remain somewhat detached from their client, a blank screen, that anything more than a mild benevolence toward the client is considered a disturbance that needs to be managed. Where as Ferenczi (Mitchell & Black, 1995), a disciple of Freud for example, embraced the feelings of the therapist and suggested that at times these feelings should be expressed. Ferenczi believed it was the therapist's responsibility to provide "measured love and affection, rather than abstinent non-gratification of the patient's needs and wishes" as Freud's writing suggested (cited in Mitchell & Black, 1995, p. 135).

Opposition to the growing trend of the usefulness of countertransference was found in writing by Fliess (1942, 1953) and Reich (1951, 1960). Fliess (1953) viewed the client's

transference to be “an occurrence desirable and prerequisite to the treatment” (p. 268). The client’s striving in his transference conflict is delineated by Fliess (1942) into four phases:

> (1) The analyst is the object of the striving; (2) he identifies with its subject, the patient; (3) he becomes this subject himself; (4) he projects the striving, after he has 'tasted' it, back onto the patient and so finds himself in the possession of the inside knowledge of its nature, having thereby acquired the emotional basis for his interpretation (p. 215).

However, Fliess (1953) viewed countertransference as the therapist transferring onto the client. He stated “when the analyst (counter) transfers upon the patient he revives his own conflicts, which are neither the object of the analysis, nor can they be resolved” (p. 268). Fliess found the term countertransference confusing, the concepts difficult to define and created “interferences with analytic procedure” (p. 284).

Although, not categorised as countertransference by Fliess (1953), similarities can be drawn between his concepts of ‘transient trial identification’ and Heimann’s (1950) concepts of countertransference. These similarities included the concept that the therapist’s unconscious was open to the client’s unconscious communication, and emotional responses and experiences of the therapist gave insight into the client. He considered transient trial identification to be an important factor in psychoanalysis. This meant for example, the ego boundary of the therapist needed to be expanded in order to include another person and their pathology within themselves. This enabled the therapist to take in conscious and unconscious information of the client’s personality. Through this trial transient identification the therapist was able to be empathic, to read between the lines, take in other information at a preconscious level. Here the therapist experienced emotional responses that, once scrutinized, give valuable information about the client.

Reich (1951) and Weigert (1954) saw obstacles in the countertransferential process as stemming mainly from the therapist. For example under-identifying could have resulted in the therapist’s inability to identify[4] with the client which may result in the therapist behaving in a sort of removed preoccupied manner. Whereas, over-identification could have led to the therapist’s inability to put himself outside the client, to listen, to understand

[4] In this context identification is where the therapist temporarily takes on and identifies with aspects of the client’s identity (McWilliams, 1994).

and to respond freely to the client, having an inability to ascertain where the client ends and the therapist begins (Reich, 1951, Weigert, 1954).

Weigert (1954) noted that identification with a psychotic client was difficult as it was harder to follow the client on their regressive path. The danger was that the therapist may lose faith and perspective and join in with the client's despair. The therapist's prejudice was also cited by Weigert as impeding identification. If your prejudice prevents you from identifying with a client you cannot be empathic as "prejudice and empathy are absolutely incompatible" (Weigert, 1954, p. 244). Weigert highlighted here the impossibility of the therapist being a blank screen and illustrates how the therapist's personality and experiences influences the therapeutic environment.

If the therapist used the therapeutic interaction as a means for narcissistic gratification and self assurances, his ability, according to Reich (1951), to free associate, to observe solemnly, and to evaluate realistically was greatly distorted. The result saw the therapist placing high demands on the client to behave in such a way as to provide such gratification, which is not therapeutic.

It has become quite apparent that the 1950's saw prominent authors viewing countertransference as an important aspect of psychoanalysis and an important tool for understanding the unconscious of the client, although not without its obstacles. Money-Kyrle (1956) described countertransference as a psychoanalytic concept from the past that had been enhanced, and believed it to be a useful indication of something occurring in the client that was to be analysed.

Money-Kyrle (1956) described some aspects of countertransference as useful or "normal counter-transference" (p. 360), and other aspects were considered disturbed. For example: the therapy situation is seen as a rapid oscillation between projective[5] and introjective[6] identifications, where the therapist introjectively identifies with the client's projective

[5] "Projective identification represents an interactional phenomenon in which the projector, by actual influence, unconsciously elicits thoughts, feelings, and experiences within another individual which in some way resemble his own (Tansey & Burke, 1989, p. 45).

[6] Introjective identification is the therapist's temporary identification with aspects of the client's projective identification (McWilliams, 1994).

identification and then through some understanding re-projects[7] the client by making an interpretation based on empathic insight. Re-projection parallels Fliess's (1953) view described on page 12, in the four phases of the client's transference conflict. That is, the therapist is transferred onto by the client, he identifies with the transferences, experiences it giving further emotional understanding of the client, then projects this, via interpretation, back to the client. The therapist is able to partially identify with his client as the client can represent previous immature or ill parts of the therapist that have since been analysed. Normal countertransference refers to the therapist internally understanding and re-projecting the client (Money-Kyrle, 1956). However, Money-Kyrle (1956) referred to disturbed countertransference as periods of non-understanding of what is being projectively identified. The therapist may be introjectively identifying with an aspect of the client that he has not yet understood about himself hence his slowness to re-project the client as he can not distinguish what belongs to him and what belongs to the client. In reality, however, it is the disturbed countertransference that consumes more analytic time and "yet it is precisely in them, that the analyst by silently analysing his own reactions, can increase his insight, decrease his difficulties, and learn more about his patient" (p. 365).

As the psychoanalytic field has evolved over the past century so too has the theoretical complexity of countertransference. Racker (1968) and Sandler's (1976) literature attempted to specifically define various aspects of countertransference in an attempt to deepen understanding of the concept.

The 1960's saw Racker's (1968) clinically invaluable contribution to countertransference. A South American therapist known for his many papers on psychoanalytic process, Racker expanded on Klein's (Spillius, 1988) ideas in his study of transference and countertransference highlighting the importance of the dyadic relationship. His concept of complementary and concordant countertransference arose from his understanding that within this relationship is the necessity of the therapist to identify with the client's projection. Projection, first coined by Freud as the expulsion of unwanted impulses, is

[7] Re-project relates to the therapist introjectively identifying with the client's projective identification. The therapist understands the client through his introjective identification which he then uses to inform his empathic response or interpretation. The therapist then responds (re-projects) to the client in a manner that is more palatable to the client, based on his understanding of his introjective identification (Money-Kyrle, 1956).

where the client perceives specific aspects of themselves to be located in another. Such as, a client might deny her own feelings of anger yet is very aware and preoccupied with feelings of anger she sees as being located in the therapist (McWilliams, 1994; Mitchell & Black, 1995; Racker, 1968).

Racker's (1968) contribution has added another dimension to countertransference. It specifically linked aspects of complementary and concordant identification as being part of countertransference. Concordant identification can be broadly described as the therapist having an experience similar to that of the client. For example, as a therapist I may get to feel small and helpless and powerless when in the room with a client, thus getting a (empathically) felt experience of what it may have been like for the client in the past. This felt experience gives me an insight into the client's process. Whereas, complementary identification is the therapist feeling an opposite or another emotion to the client. The client will often experience the therapist in this scenario as un-empathic. Such as, the client experiencing themselves as helpless (the victim) and the therapist as powerful (the persecutor), and the therapist actually feels drawn to act like the persecutor which reconfirms and complements early parent-child roles of the client's past that were problematic (Racker, 1957, 1968).

Similar to Racker's (1968) complementary countertransference is Sandler's (1976) term 'Role Responsiveness' which refers to the subtle unconscious communication and conduct by the client that elicits the therapist to feel, behave or react as others have acted in the client's past. This communication includes projective and introjective identification by the client and therapist respectively.

An example of projective identification is the client seeing the therapist as weak and oversensitive so that this aspect of the client is denied and externalised, as if it is occurring in the other. Whereas, introjective identification is where the therapist internalises such a projective identification and in fact may start to feel weak and oversensitive. Sandler acknowledges the tendency to act in accordance with the role the client demands of the therapist and states, "he may only become aware of it through observing his own behaviour, responses and attitudes, after these have been carried over into action" (p. 47). This is not to say that the therapist does not, at times, catch the countertransference response in himself

without acting it out. Sandler's theory is similar to Racker (1968) in that identification with the client's projection enables further understanding of the client's process.

Sandler's (1976) term 'compromise' acknowledges the effect a client has on the therapist. It takes into account the admixture of the therapist's own personality and the client's influence within the therapeutic interaction to satisfy certain needs or wishes. It can be seen as a compromise between the client eliciting the therapist to become an actor in the client's role play, and the therapist's tendency to act or feel that way anyway. However, the degree of pressure exerted by the client highlights important information or wonderings about being in interaction with that client, as the more intense the pressure the more likely it relates to the client's projective identification then to the therapists own behavioural tendencies. Sandler believes it is through this dynamic interaction that countertransference emerges. It is the awareness of such countertransference responses in relationship with the client that can be used to gain a deeper understanding of the client. Information that may be gathered from the therapist's countertransference may be along the lines of: 'is this feeling or behaviour familiar to the client?', 'if so, how is it familiar, with whom or when' and, 'who, in the transference, does the client see the therapist as behaving like?' for example.

In a 1965 review of empirical countertransference literature, Kernberg collates ideas from the previous 50 years of theoretical writing on countertransference. He categorised authors into classical or totalistic schools of thought, thoroughly and thoughtfully comparing and contrasting their views. I found this article to be a successful attempt to bring together many (potentially) complex concepts; his prose was lucid and refreshing which made it easy to become fully immersed. Two schools of thought were emerging under the distinction of classical or totalistic perception of countertransference. Classical viewed countertransference as the therapist's reaction due to their own unresolved conflicts to the client's transference (Fliess, 1953; Kernberg, 1965; Reich, 1960). By contrast, the totalistic perspective related to "the total emotional reactions of the psychoanalyst to the patient in the treatment setting" (p. 38). Kernberg in his totalistic perspective implies that countertransference only relates to 'emotional reactions' occurring in the therapy room. Missing from his discussion is the place of the therapist's thoughts or bodily responses in

the therapy room, and thoughts, emotions and dreams relating to the client outside the treatment setting.

Kernberg (1965) concluded that "countertransference may be helpful in evaluating the degree of regression in the patient and in clarifying the transference paradigms during severe regression" (p. 53). However, countertransference complications stemmed from patients with the potential to regress excessively as this fosters counter-identification in the therapist which can threaten analysis and lead to "chronic countertransference fixation" (p. 53). Antithetically, counter-identification can highlight important information about the therapeutic relationship between therapist and client (Kernberg, 1965).

Kohut, the originator of self-psychology, discussed in his 1971 article that the therapist's awareness of reactions and feelings he has in relation to his client are important tools that can be used to understand the client's inner experience (Kohut, 1971). Despite the significance of Kohut's contribution to psychotherapy literature, sourcing literature specifically on countertransference by Kohut was difficult.

Summary – A historical perspective

Major contributions to the concepts of countertransference by Freud, (1910), Winnicott (1949), Heimann, (1950), Money-Kyrle, (1956), Racker (1968), and Sandler (1976) were evident. Initially viewed as an obstacle to therapy by Freud (1910) and Klein (Spillius, 1988), the beneficial stance came about through viewing therapy as a more dynamic interaction between client and therapist as highlighted by Winnicott (1949) and Heimann (1950). The earlier emphasis on the therapist being a neutral observer and a blank screen for the client to transfer onto became less important. It became more evident that the therapist's affective, physical and cognitive experience was to be acknowledged and utilised to help form the basis for empathic responses, interpretations and treatment plans. The unconscious of the therapist was said to be open to the client's unconscious, and the therapist's ego boundary was seen as needing to expand to accommodate the unconscious communication from the client (Fliess, 1953; Heimann, 1950; Money-Kyrle, 1956). Winnicott (1949) classified the therapist affective response in relationship to the client into subjective or objective categories, while Money-Kyrle (1956) made a distinction between normal or disturbed countertransference.

Winnicott (1949), Fliess (1953), Racker (1968) and Sandler (1976) noted identification as an important factor in understanding the client's unconscious and conscious world. Racker (1968) found that concordant identification resulted in having an empathic understanding of the client, and complementary identification could be felt by the client as un-empathic. Both positions, however, provide valuable insight into the client's way of relating. The view of countertransference was broadened to encompass the rapid oscillation in interaction with the client, between projective and introjective identification and re-projection (Money-Kyrle, 1956). The client's relational dynamics can also be observed and analysed through what Sandler (1976) termed as role responsiveness. This too gives deeper insight into the client as it demonstrates how it is to be in relationship with the client and reflects past relationship dynamics.

The therapist's self analysis and self awareness was considered vital (Fliess, 1953; Freud, 1910; Heimann, 1950; Winnicott, 1949). It was the therapist's scrutiny of his feelings and identificatory experience that gave credibility to the degree in which this experience related to the client's process or the therapist's process and prevented counter therapeutic responses. Countertransference cautions were based on the therapist reacting to strong emotions, which could see them acting out, or discharging overwhelming emotions into the therapeutic relationship, which were seen as counterproductive. It was also considered inappropriate for the therapist to transfer on to the client as his own conflicts are then revived and the therapist's issues are not the object of analysis (Fliess, 1953; Heimann, 1950). Counter identification saw the therapist becoming fixated on countertransference issues which was seen as counter-therapeutic (Kernberg, 1965).

By the 1970's countertransference was increasingly considered an important phenomenon in the therapeutic relationship that could help the therapist to further understand the client. Countertransference is the creation of both the therapist and client, and is inevitable within the interactive process of therapy (Heimann, 1950; Little, 1951; Winnicott, 1949). The therapist analyses and utilises his emotional responses to the client to inform his interpretations, to check whether he has heard and understood the client correctly, and to understand the client's unconscious processes, impulses and defenses. The therapist's experiences when consulted foster attunement to the client, and can be used as a tool in the therapeutic work (for example via interpretations). Countertransference is a way of

understanding the client's internal world, via the therapist understanding repetitive relational patterns, through his own identificatory experiences and emotional responses to the client (Heimann, 1950; Little, 1951). The client communicates to the therapist through projective identification. It is by the therapist's introjective identification with the client's projective identification, and the therapist analysing his own emotional response, that enables further insight into the client's process.

The 1970's positive regard for countertransference and the insights it brings to the client's process is apparent. The next section investigates more current concepts and perspectives on countertransference from the 1970's to early 2000.

Current Perspective

This next section will look at the progression of countertransference from 1970 to 2000 and concludes with a chapter summary.

By the 1980's and according to Abend (1989) and Silverman (1985) the Freudian perspective was that countertransference could both help and hinder treatment. That even though countertransference was important in increasing the therapist's understanding of the client, it could also lead to distortions, blind spots and enactments and could be seen as the therapist's excuse for being so focused on their own emotional responses. Kleinian followers had a more favourable view about countertransference. This shift in view was relative to the concept Klein developed late in her life of projective identification. The therapist's experience, which incorporates projective and introjective identification, is vital in discovering the clients' dynamics (Mitchell & Black, 1995; St Clair, 2000)

Second generation self-psychologists, such as Stolorow, Brandchaft and Attwood (1987) regard countertransference as giving them valuable information about the client through repetitive transferences That is, current relationships are constructed on experiences of important past relationships and therefore the countertransferential information received by being part of this relationship gives valuable insight into the client's unconscious processes (Stolorow, Brandchaft, & Attwood, 1987). Increasingly, in contrast to the pre 1980's dominant view that countertransference was the client's creation, many authors of the

1980's-1990's believe that the therapeutic relationship is a more 'mutually' created intersubjective one. Yet, note the importance of the therapist's ability to step out of the intersubjective milieu to get a perspective of their own experience as well as that of their client (Attwood & Stolorow, 1984, Dunn, 1995; Jones 1997; Ogden, 1994).

A recent significant contributor to the conceptual development of countertransference and its relationship to the intersubjective relationship is Ogden, an American psychoanalyst. Ogden (1994) expanded on Sandler's (1976) concept on the interactional dynamic that occurs between therapist and client. Ogden refers to this as "the analytic third", which he clearly describes as "the interplay of the analyst's subjective experience, the subjective experience of the analysand and the intersubjectively-generated experience of the analytic pair" (p. 3). His article is well illustrated with clinical material to enhance the reader's understanding on how the relationship between subjectivity and intersubjectivity influences psychoanalysis and in turn, the generation of clinical theory. According to Ogden (1982, 1992, 1994) countertransference is more than just the therapist feelings, thoughts and bodily sensations, and cannot be considered merely as unresolved emotional conflicts of the therapist that should be overcome. Rather the individual subjective experiences of the therapist created within the intersubjective interaction of the therapy room represent symbolic psychological activity of the client. Ogden, through his clinical examples, demonstrates this perspective and believes the therapist's self-experience does indeed provide a vehicle for understanding the client's internal process (Ogden, 1994).

Ogden (1982) has incorporated concepts similar to Sandler's (1976) role responsiveness and compromise. He illustrates how the client projects aspects of the self on to the therapist so that the client can then treat the therapist in a manner matching such a fantasy. It is within this interaction that the therapist receives strong messages of ways the client wants him to behave that offers countertransferential clues to the clients unconscious fantasies (Mitchell & Black, 1995; Ogden, 1982).

Of interest was how certain aspects of countertransference can negatively affect the therapeutic relationship as briefly discussed next. Ogden (1992) believes it is impossible to work with every client interested in analysis and feels a disservice is done to that client if we, the therapist, work with them knowing we do not like them (or in fact have very strong

countertransferential feelings such as hate or erotic feelings). These feelings can be considered as negative countertransference. Theoretically, such negative countertransference is thought to be able to be analysed away, by the therapist, enabling him to work with such a client (Ogden, 1999). However, he found when powerful negative countertransference was consciously present (in the initial meeting) it was very difficult to build a strong therapeutic relationship on such negative foundations.

Clinical examples were used by Ogden (1999) to explore countertransference resistance, countertransference enactment, and countertransference acting in. For example, in rich clinical detail Ogden (1999) illustrated a situation where a therapist unconsciously resisted analysing her countertransference anxiety in the initial session with a client. In hindsight, with the help of clinical analysis the therapist recognised her unconscious fear of the client, and that the anxiety this induced was counterproductive to therapy. This highlights the need to acknowledge countertransference via self-analysis, reflection or through clinical supervision, in order to understand the complex dynamics occurring in therapy.

Ogden (1999) continued to discuss countertransference acting in, which is considered behaving in a manner that is counterproductive. For example, when the therapist demonstrates a way of behaving that relieves anxiety, consequently reducing psychological strain. This prevents further analysis of that particular anxiety provoking situation. Not to say that the therapist should never relieve anxiety, more that through feeling the anxiety and wondering about it together, deeper insight into the client's emotional dynamics is gained. Whereas, countertransference enactment is behaving as important people in the client's past have. I found Ogden's (1982, 1994, 1992, 1999) writing to be thought provoking and insightful. His clinical examples greatly enhanced my understanding – this was especially helpful as his writing proved to be theoretically dense at times.

In undertaking a literature review based on countertransference research findings Gelso and Hayes (2001) amalgamated key concepts that mainly focused on impediments created by the therapist's countertransference and its management. They do, however, acknowledge the deficit in published research articles on positive aspects of countertransference and highlight the need for further research into the precise mechanisms showing how the therapist's countertransference assists analysis of a client. I too, found it difficult to source

research based literature on countertransference. They found countertransference to be more than just the "therapists' reactions to clients that are based on therapists' unresolved conflicts" (p. 1042). They believe that countertransference may originate from transference or other occurrences and be consciously or unconsciously generated.

Gelso and Hayes (2001) believe countertransference to be triggered by three main aspects: 1) client attributes; 2) therapy content; and 3) therapy process. For example, 1) when the client (or aspects of the client), remind the therapist of a significant person in the therapist's life; 2) when the material the client brings is similar to therapist's unresolved issues; or 3) the therapy process which refers not to the words spoken but what happens around these words, unspoken cues. They believe that countertransference needs to be divided into what is the therapist's unresolved conflict as opposed to reactions of the therapist in relation to the client. This is in direct contrast to Ogden's (1994) view which opposes solely attributing qualities to the therapist or client. The task of therapy is more about attempting to "describe as fully as possible the specific nature of the experience of the interplay of individual subjectivity and intersubjectivity" (Odgen, 1994, p. 4).

Countertransference can have a damaging effect on therapy, according to Gelso and Hayes (2001), if it is not acknowledged or managed effectively. Whereas countertransference managed well, acknowledged or reflected upon, can be advantageous to the therapy, deepen the working alliance, allow deeper insight into the client and can bring balance in power between client and therapist (Gelso & Hayes, 2001). They state "the therapist will occasionally experience reactions to the clients that are triggered by their own personal conflicts" (p. 1050). Yet if attended to, the therapist can prevent responding counter therapeutically to the client.

Tansey and Burke's (1989) definition of countertransference is a totalistic view which incorporates perspectives from some of the main contributors to countertransference theory. Their broad definition is:

> The therapist's total response to the patient, both conscious and unconscious. This total response includes all the thoughts and feelings that the therapist experiences in reaction to the therapeutic interaction whether they are considered to be 'real' or neurotically distorted (p. 41).

This definition includes what Winnicott (1949) termed subjective and objective countertransference. The first is where the therapists idiosyncratic reactions arising from the therapists own personal conflicts, and the latter includes reactions to the client as other therapists would react in a similar situation.

Tansey and Burke (1989) apply Freud's caution regarding transference to countertransference. That is, transference is "the greatest danger and the best tool for analytic work" (Freud cited in Racker, 1957, p. 303). Their belief is consistent with Freud's (1910) view that the therapist should direct his evenly suspended attention to his own thoughts and feelings as well as to the client. Tansey and Burke state "the therapist is encouraged to treat all thoughts and feelings as potentially important sources of information about the interaction with the patient" (p. 41). It is not for the therapist to become resistant to the client's influence yet more about the therapist appreciating how the client is acting upon them. This is a perspective Sandler (1976) referred to as 'compromise' and 'role responsiveness' (p. 47).

Tansey and Burke (1989) found that identification underlies the countertransference phenomenon and their comprehensive account of countertransference is divided into three sub phases of projective identification, introjective identification, and empathy. They demonstrate that not all the therapist's countertransferential responses to the client can be considered as a result of projective identification and at times may not be considered empathic. However, these authors have given clarification via their convincing account of the inter-relationship between projective identification, empathy and countertransference.

Broadly, projective identification is the influence a client has to evoke in the therapist a similar feeling to his own, or to relate to his experiences of being in relationship with another (Tansey & Burke, 1989). These feeling may match or be complementary to the client's relational experiences. It is through the interactional pressure from the client that the therapist experiences a heightened or intensified affective response in interaction with the client. Tansey and Burke classify this as an introjective identificatory response to the client projective identification. The more neutral experiences of self in interaction with the client are less likely to be considered as a result of projective identification.

Tansey and Burke (1989) believe introjective identification only occurs in interaction with another and is as a result of successful projective identification. This interactional communication is conveyed unconsciously by both the client and the therapist.

The therapist over time creates an 'enduring representation of self' in interaction with the client which is referred to as their 'work ego' (Tansey and Burke, 1989 p. 52). The work ego is created through interactional introject of client-therapist relating. There are two components to this internal model, the first being a self-representation of the entire therapist experiences when interacting with the client. The second is the object-representation which refers to the therapist's impression of the client's experience of self/object/therapist relating (Tansey & Burke, 1989).

Tansey and Burke (1989) describe empathy, in part, to come from the therapist's ability to free associate and to critically scrutinise client reactions, within this work ego. They describe this as a move from thinking and feeling with the client, to thinking about the client more objectively. This concept comes from Schafer (1959) and relates to oscillating between the experiencing ego and the observing ego. Tansey and Burke further discuss how empathy comes about through identification, and state that the empathic process can lead to true emotional knowledge of the client.

Although, Tansey and Burke discuss the therapist's countertransference as "experiences in reaction to the therapeutic interaction" (p. 41), they omit to make clear how they consider countertransference occurring outside of the projective identification process. Similarly, because they identify projective identification as dependent on two people being in the presence of each other, they also omit to make clear how they consider countertransference occurring outside the therapy room away from the presence of the client (in contrast to Ogden's (1994) discussion of the 'analytic third').

Apart from the above omissions, I find Tansey and Burke's (1989) definition to be very comprehensive, thoroughly comparing and contrasting other authors on the issue of countertransference and concluding with their own stance giving full explanation of terms and meanings. Their comprehensive and descriptive writing pulls together many concepts that I had found in other literature on countertransference. Their theoretical and conceptual

discussions were based on their participation in study groups where clinical work was discussed, hypotheses generated and then tested through later interventions posed to their clients. Their writing also incorporated knowledge gained by researching literature on projective identification, empathy and countertransference, and from experience gained through clinical supervision and clinical experience. Their work can be viewed as an example of being soundly based in both existing theory and informed and carefully considered clinical practice. Consequently, Tansey & Burke's writing informs my own clinical practice.

The current perspective on countertransference is that it is a phenomenon to be acknowledged, analysed and used to inform the therapeutic process if managed appropriately. To encapsulate countertransference's theoretical journey over the past 100 years the literature referenced is summarised below. In doing so further consideration will be given to the research question 'how does countertransference help the therapist to understand the client's process?'

Summary – From past to present

The plethora of literature on countertransference was overwhelming. Therefore the authors I have chosen to use in the historical and current perspective of countertransference are well known and respected writers on psychoanalytic concepts as reflected by the regularity with which their names appear in psychoanalytic literature and professional discussion. In addition, they have added the most to my understanding of countertransference. Countertransference over the past 100 years has been well documented. Freud (1910) considered it an obstacle to therapy, and it was not until the 1950's that it was regarded as a therapeutic tool and an instrument for understanding the client (Heimann, 1950; Little, 1951; Winnicott, 1949).

More recently, the concepts of countertransference are seen as similar to the early 1950's belief in that the psychoanalytic process is about a dyadic relationship, where the therapist understands the client through the identification process. These concepts have been further expanded on with attention drawn to the processes of projective and introjective identification and empathy.

The modern view of countertransference incorporates concepts from Winnicott (1949), Heimann (1950), Racker (1968), Sandler (1976), Tansey & Burke (1989) and Ogden (1994) to name a few authors. The therapeutic relationship became more commonly viewed as a mutually created one where the client re-enacts past relational dynamics with the therapist. The intersubjective and interactional nature of the therapy relationship was emphasised, and attention was focused on the subjective experience of the therapist and the client, and the intersubjective environment created between them (Ogden, 1994). Within this relational approach countertransference occurs. It was identified that the interplay between projective and introjective identification is crucial to the therapeutic relationship and underlies the countertransference phenomenon. This has particular significance for understanding the client's process: it means that the therapist's subjective experiences, and his experience of the intersubjective relationship, once acknowledged and analysed, can represent symbolic psychological information about the client. In addition, empathy comes about via the identificatory experiences of countertransference; it is through the process of empathising and clarifying perceptions that true emotional understanding of the client occurs. However, not all the therapist's countertransferential responses to the client can be considered as a result of projective identification (Tansey & Burke, 1989).

Cautions regarding countertransference relate to strong emotions that pull the therapist to react, and if possible, should be contained by the therapist and wondered about. Negative countertransference was viewed as potentially disrupting the ability of forming a working alliance. Ignoring countertransferential feelings can also have a damaging effect on therapy. The therapist is advised to have personal psychoanalysis and clinical supervision. Through the use of self analysis and clinical supervision the therapist aims to further understand her countertransference responses to the client. She can identify the relation her countertransference has to her own idiosyncrasies and internal conflicts, and also analyse how this relates to the client's world. Clinical supervision is also a way in which countertransference and blind spots can be illuminated.

Therefore, the contemporary view of countertransference is that it is created by the subjective and intersubjective experiences of both therapist and client. It is not without its cautions and clearly leads to further understanding of the client's process.

Wilson & Lindy (1994) best sum this up in their comment:

> Countertransference may provide more than clues to disavowed traumas that are being re-enacted in the treatment: it may provide the only vehicle by which the patient can translate a horrendous story from action to narrated form (p. 69).

As I found Tansey and Burke's (1989) material so comprehensive and credible, Chapter Four goes on to further examine the key concepts identified by them, of identification – projective and introjective, and empathy. This examination of psychoanalytic concepts will be in conjunction with other literature, grounded in the therapeutic relationship, and illustrated with clinical examples.

CHAPTER FOUR
COUNTERTRANSFERENCE

In this chapter context is given to countertransference by defining the concept of a therapeutic relationship. In conjunction with other literature, Tansey and Burke's (1989) definition of countertransference is then explored more comprehensively: the processes they identify that underlie countertransference - projective identification, introjective identification and empathy, will be further examined to ascertain how countertransference helps the therapist to understand the client's process. Throughout this chapter clinical examples and vignettes are used to illustrate theoretical concepts gleaned from the literature. A brief summary will conclude this chapter.

The Therapeutic Relationship

According to Mitchell and Black (1995) "What appears disorganised and meaningless is organised and made meaningful, at first in the analyst's experience and, through interpretation over time in the patient's" (p. 108). This quote illustrates an occurrence between therapist and client within the therapeutic relationship.

A therapeutic relationship can be viewed as a relationship between two people (therapist and client) who are working toward an agreed goal usually relating to positive character change and symptom relief. It is the readiness of both parties to work together, and the client's willingness to engage in the psychotherapeutic relationship, that allows change to occur (Christensen, 1998; Clarkson, 1995; Ogden, 1994). Yet at times, it may be difficult to maintain the therapeutic relationship in the face of, and resisting change (Bateman, Brown & Pedder, 2000; Casement, 1999; Christensen, 1998; Clarkson, 1995; Fortinash, Holoday-Worret, 1996; McWilliams, 1994; Rawlins, Williams & Beck, 1993).

A therapeutic relationship is essential to gain the best possible outcome for the client (Fortinash & Holoday-Worret, 1996). The ability of the therapist to empathise, contain and clarify perceptions and feelings of the client allows trust to be established, which may, in turn, allow the client to confide more in the therapist, creating positive alliances (Kohut,

1959; Tansey & Burke, 1989). The role of the therapist in the therapeutic relationship is important. Burke (1992) states:

> No longer is the therapist portrayed as the expert who reads with certainty the hidden meanings of the patient's unconscious, but rather as a person trained to conduct an analytic inquiry by providing a valuable perspective from within the familiar and entangled relational patterns the patient finds repeated in the consulting room (p. 242).

Within this repeated relationship countertransference is acknowledged and made use of by the therapist. It is used as a means to explore and understand the client's conscious and unconscious process. This is achieved by either exploring the repeated relationships via interpretations, or by the therapist being aware of his affective reactions and thoughts in relationship to the client and holding on to those difficult feelings (Burke, 1992; Casement, 1999; Ogden, 1994). In turn, the therapist gets an affective experience of what it might be like for the client, and the client in turn feels empathically understood by the therapist (Casement, 1999; Goodman, 1995; Racker, 1957; Stern, 1994; Winnicott, 1949). Winnicott (1949) refers to this as creating a holding environment within the therapeutic relationship where difficult emotions of the client are contained by the therapist.

However, as discussed in chapter three, countertransference is not always easily used. For example, Heimann (1950) believed when intense violent emotions were felt in relation to the client, it often resulted in the therapist 'doing' instead of 'being' and could prevent the therapist from taking a step back to ponder and observe the situation. When the therapist was unable to hold such intense emotions and acted it out, their intense emotional response often defeated the client, which Heimann described as counter-therapeutic (Casement, 1999; Heimann, 1950). Therapists try not to make such mistakes yet it is inevitable, according to Casement (1999). He believes not all is lost when mistakes are made and states:

> Patients make unconscious use of these mistakes in ways that throw new light on the therapeutic process. The ensuing work with a patient is often enriched by the experience of the therapist being able to learn from the patient. In this way the therapy is restored from what might have become seriously disruptive (p. 3).

Over time, the therapeutic relationship has increasingly been considered as an interactional relationship 'between' client and therapist, where both participants affect the other consciously and unconsciously as they get to know each other and themselves in relation to the other (Casement, 1999; Sandler, 1976; Tansey & Burke, 1989; Winnicott, 1949).

Ogden (1994) found that the client and the therapist exist in relationship to each other, each having their own thoughts and feelings (individual subjectivity) yet together creating a dynamic intersubjective tension. It is in acknowledging the therapist's subjective and intersubjective experience that an insight is gained into what may be happening for the client.

In summary, a therapeutic relationship is mutually created relationship between therapist and client where both effect each other. It is through the therapist's perspective on the client's relational patterns that the client gains understanding, in turn engendering psychological growth and wellbeing. The therapist perspective is based on his countertransference created through his subjective and intersubjective experiences, and by utilising his theoretical knowledge and clinical skills.

A common theme within the different views of countertransference is that identification plays a substantial role (Armony, 1975; Casement, 1999; Fliess, 1953; McWilliams, 1994; Money-Kyrle, 1956; Racker, 1968; Sandler, 1976, 1987; Tansey & Burke, 1989; Weigert, 1954). In the following sections identification will be defined, with particular focus given to projective identification, introjective identification and the connection with empathy to the therapeutic relationship. Clinical examples and vignettes have been incorporated to illustrate theoretical perspectives. Countertransference within these examples will be examined to address the research question.

Identification

Identification is a process which begins in infancy whereby: 1) a child takes on an aspect of another (like a parent) and makes this part of himself, or 2) another is seen as like oneself (extend aspects of one self into another), 3) one's identity is fused with another and it is difficult to distinguish which aspect belongs to which individual (McWilliams, 1994; Rycroft, 1995). Identification can be considered a normal part of psychological development: for example, a child wishes to have attributes like her mother, that is: 'Mummy's really kind and I want to be just like her.' This is suggesting some form of choice to be like her mother. This can be a deliberate and selective, yet partly unconscious process. However, it can become problematic, especially when used as a defense against

emotional stress. That is, when a person takes on aspects of another in an automatic unconscious manner without having any subjective option. For example, as a way of coping with fear of abuse, a person may identify with the aggressor's behaviour as a way of managing their own fear and take on aspects of the aggressive other. Therefore, identification can have both positive and negative effects (McWilliams, 1994; Rycroft, 1995; Schafer, 1968; St Clair, 2000). St Clair (2000) describes identification as "a process by which an individual becomes like or gets an identity from another" (p. 196).

The two types of identification that are universal amongst many of the complex definitions of countertransference are projective and introjective identification (Money-Kyrle, 1956; Racker, 1968; Tansey & Burke, 1989). In the next section projective identification will be examined, referring briefly to views of other authors who have contributed significantly to the concepts, and then an in-depth discussion of Tansey and Burke's (1989) definition.

Projective Identification

This section begins with an overview of projective identification as conceptualised by other authors. Particular attention is focused on Tansey & Burke's (1989) comprehensive perspective and then is followed by Vignette 1 – Priscilla, used to illustrate the themes identified so far.

Klein (1946) introduced the term projective identification referring to an infant's psychological mechanism employed as a means to defend herself against intense feelings of anxiety. The infant attempts to manage her anxiety by attributing an aspect of her inner anxiety on to an external object – often a mother. It is through her unconscious connection or identification with this aspect of anxiety that the infant can observe, modify and control it in the outer external world, and eventually create an adaptive response to it for re-internalisation (Klein, 1946; Mitchell & Black, 1995; St Clair, 2000; Tansey & Burke, 1989).

Racker (1957, 1968) made major contributions to the concept of projective identification. He breaks it down into two categories; complementary and concordant identification as

discussed in chapter three. In both instances it gives the therapist information about the client's relational patterns and self experiences.

For example, when in a therapy session with Beatrice I felt pressure to behave in a manner that kept the peace, 'not to rock the boat', so to speak. I found myself treading gently and tentatively making interpretations to her. The client was unconsciously communicating her desire to avoid turmoil, which she projected on to me. In this instance, her projection allowed her to take on the corresponding feelings of anxiety and overwhelm, a role I later learned was indicative of her mother's behaviour. The client unconsciously projected her self-experience of peacekeeper on to me – an illustration of Racker's (1968) complementary identification. In this instance, I not only had an experience of what I imagined it to be like for my client, I also got a sense of how unsafe it must have felt for her around a mother whose breakdown felt imminent. I also learned of the dynamic role my client played in her family drama.

Langs (1976) believes projective identification to be the main unconscious interactional communicating factor between therapist and client. Langs emphasis is on the "interactional efforts" of not only the client but also of the therapist as a means to transmit inner aspects of self into the other with the aim of externally managing such aspects and to "evoke adaptive responses for reintrojection" (p. 277).

Ogden (1982) describes projective identification as a client's desire to get rid of unwanted parts (unconscious, endangered, or internal objects) and deposit them in another in a powerfully controlling manner. This part is felt to inhabit the other person and is partially lost to the projector. The interpersonal interaction sees the recipient pursued to think, feel and act in a manner congruent with the projected feelings.

Trixie provides an example of the projective identificatory process. Trixie held down two jobs working frantically to help others with mental health issues to survive in society without suffering. Trixie did not register this suffering as being a projected part of her, but was highly attuned to it in others. Her frantic efforts were an unconscious attempt to control and modify this terrifying projected part of herself, by not wanting others to suffer as she had suffered, and by avoiding her own pain. This disavowed part of her relates to the

unexpressed trauma she suffered when both her parents died unexpectedly. Two years after their death Trixie had a psychotic breakdown – an experience that emphasised her feelings of loss and abandonment, where she felt unsupported and unloved.

In forming their definition on projective identification, Tansey and Burke (1989) refer to prominent authors on the subject such as Klein (1946), Racker (1957), Kernberg (1975), Langs (1976), and Ogden (1982). Tansey and Burke's writing is not merely theoretical conceptualisation; it is also rooted in clinical experience. Their detailed illustration of the application of concepts within clinical examples gives their writing credibility.

Projective identification incorporates an interactional process of projective identification and introjective identification. Within the therapeutic relationship this process can result in the therapist being aware of playing a role (or the pressure to play this role) in the client's drama, and highlights how the client induces feelings in the therapist in an unconscious manner (Casement, 1999; & Tansey & Burke, 1989).

Tansey and Burke (1989) highlight the complexity in theoretical concepts around projective identification by giving an overview of other authors' view. However, the extensiveness of Tansey & Burke's (1989) and Ogden's (1994) definitions can be confusing. Tansey and Burke break down projective identification into two stages to broadly 1) "the projector's experience of inducing a feeling state within an object" (p. 44); and 2) Introjective identification which includes the "reactions of the object to this induced state" (1989, p. 44). This differs greatly from Ogden's (1994) complex three-stage, definition of projective identification. Tansey and Burke's aim here is to give clarity and precision to each process by separating them out into projective identification and introjective identification, which I feel they achieve.

Tansey and Burke (1989) and Ogden (1994) agree that projective identification has adaptive, defensive and communicative means. It begins in infancy and is employed throughout development in an effort to promote ego integration, and the degree of primitivity or pathology relates to the personality structure of the individual. Projective identification is used to avoid experiencing emotional pain. "…Projective identification represents an interactional phenomenon in which the projector, by actual influence,

unconsciously elicits thoughts, feelings, and experiences within another individual which in some way resemble his own" (Tansey & Burke, 1989, p. 45). Projective identification is a powerful way for the client to communicate to the therapist information about unwanted or unmanageable aspects of self.

Tansey and Burke (1989) incorporate Racker's (1957) view on complementary and concordant identification as part of their definition. For example, when projected upon the therapist can experience a feeling state similar or complementary to the client's own immediate experience. Therefore, the therapist temporarily experiences and identifies with an aspect of the client's internal world. It is within this feeling state that the therapist gets an understanding of the client's process, of what it may be like for the client.

Projective identification differs substantially from projection as it is an interaction between two or more individuals in an interpersonal relationship (where as projection can occur without the projected upon object being present). For projective identification to be successful there needs to be a corresponding introjective identification by the recipient of the projective identification (Tansey & Burke, 1989). Sandler (1976), who also felt projective identification was not "sufficient to explain and to understand the processes of dynamic interaction which occur in the transference and countertransference" (p. 46), describes this scenario as "second stage projective identification" (p. 17). That is that the projector has a real and actual influence over the countertransference of the therapist. Whereas, first stage projective identification, according to Sandler (1976), is when unwanted and overwhelming emotional aspects are projected into internalised objects. Henceforth the projector gains a feeling of control over what was felt as an external threat. In reality however, it is only the internalised objects that are affected.

Tansey and Burke (1989) further critique their definition on projective identification stating it is a 'broad view' and that not everything occurring in the therapist-client interaction is as a result of projective identification. For projective identification to occur there needs to be a heightened sense of self from the therapist (which is labelled 'identification') and a "degree of interactional pressure from the patient in order to label the therapist's introjective identification a direct response to the patient's projective identification" (p. 46). That is, the therapist processes many forms of communication that arise from the

interaction between therapist and client. Yet, not all reach the heightened intensity of self experience to be considered an introjective identification in relation to the client's projective identification. Projective identification is to be recognised in the therapist as "a temporary heightened experience of self that is qualitatively different from the usual more neutral experience of self in interaction with the patient" (Tansey & Burke, 1989, p. 46). It is necessary for the therapist to determine to what degree the client's interactional communication has influenced his identification experience – that is, how much has his experience been projectively determined and what aspect may belong to the therapist's own issues.

Below I include an example of this experience to illustrate how powerful this process can be. It is as if we take a walk in the client's psychological shoes for a moment.

Vignette 1 - Priscilla

Priscilla's reason for coming to therapy was to deal with her overwhelming emotions relative to her fear that her husband was having an affair. She presented to therapy very neatly dressed, meticulously made up, sitting with her knees together and her hands tightly clasped, sitting erect. She was very quietly spoken, almost child like.

In the first 10 sessions and intermittently since it was common for me to feel very unkempt in her presence, physically big compared to her, (in fact we are of similar build) clumsy and dishevelled, I had a sense of resentment before the sessions began. I noticed a sense of envy toward her with her slim figure, and toward what I imagined to be her perfect husband, marriage and affluent lifestyle. My countertransference feelings were in stark contrast to how Priscilla presented. I had an awareness of needing to tread carefully with this fragile little (baby) bird, like I might squash her. I noticed my growing feeling of frustration toward her.

The sense I make of my countertransference follows. The hypothesis generated is constructed from the help of supervision, knowledge gained in the subsequent sessions through acknowledging my countertransference, and from theoretical knowledge. I came to understand that Priscilla was projecting powerful aspects of herself into me to defend

against emotional pain. Emotional pain and hurt possibly about being unlovable triggered by her husband's actions and connecting to the past relationship with her mother. Priscilla spent the first sessions in tears unable to contain her grief in regard to her unfaithful husband. I could identify with what it might be like for her, could feel her grief and felt an empathic concordant identification with her.

In the ensuing weeks however, I began to become irritated with her. I had a strong urge to be dismissive of her tears and a desire to defend her husband. I contained my desire to act this out even though this was difficult. My thoughts were along the lines of 'for heaven's sake not this again, I don't have time for this, I have too much to do.' This coincided with my personal life where I was in the middle of exams and wanted to be home studying. I want to make two points here. Firstly, I feel Priscilla was unconsciously picking up on my unconscious communication – that is my frustration and dismissive desires as she began to stare at me with fixed wide eyed glares and I felt her slight anger. Secondly, I wondered what my personal life experience of not having time for her might tell me about her – to what degree was this feeling projectively determined?

I theorise that Priscilla through her projective identification was eliciting me to behave as her mother often did – cold, dismissive and uncaring. At this moment my countertransference was in the form of a complementary identification. I could have ignored my feelings of irritation and frustration and thoughts about not having time for her, and attribute them to my issues. After scrutinizing these feelings that lingered over a few weeks I believed they were also relating to the intersubjective experience created within our relationship. On making an interpretation relative to my feelings I learned that Priscilla's mother worked seven days a week, was often short tempered with Priscilla literally dismissing her saying "I don't have time for this." Priscilla believed her mother was too busy and pre-occupied to spend time with her.

I consider the relationship with her mother was repeated with her husband and re-created within the therapy sessions. This experience gave me insight into how Priscilla might have felt – angry, yet determined to be the perfect controlled child (and the perfect client) so as not to be further abandoned by her mother. First my complementary identification was to feel very imperfect, dishevelled and frustrated. Then I felt like the persecutory Mother –

irritated, dismissive and cold, which leaves Priscilla with her own enduring self-representation as the victim – unlovable and abandoned. In the situations mentioned above I get an experience of what it may feel like to be Priscilla and what it may be like to be in relationship with her. This experience has opened the door to many aspects of Priscilla's life and relational patterns and demonstrated to me that my countertransference as a therapist does indeed help illuminate the client's process. Although at this early stage in the therapeutic relationship the information my countertransference gave me I held and wondered about, and at times interpreted. However, in later session this information leads to interventions around separating out the client's transference behaviour of her relationship with her mother on to her husband.

This next section continues to define identification specifically focusing on introjective identification.

Introjective Identification

Tansey and Burke's (1989) definition of introjective identification is mainly referred to in this section. Their definition thoroughly compared and contrasted other authors' views with their own, which gave clarity to the concept.

Tansey and Burke (1989) state "introjective identification is an identificatory experience contingent on the interaction with the patient" (p. 49). More simply introjective identification is the therapist's temporary identification with aspects of the client's projective identification. Introjective identification cannot occur without the corresponding projective identification and vice versa. This experience has intrapsychic and interpersonal elements. That is, it relates to what is occurring within the mind of the therapist relative to the interaction between the client and the therapist.

I have used Tansey and Burke's example as I found the clarity it gave to the term 'introjective identification' extremely beneficial.

> The child who is dependent on the parents' presence for active guidance in this discrimination process can be said to engage in introjective identification (experience of following rules) in response to a clear projective identification (parents' exerting interactional pressure for rules to be followed) from the parents (p. 50).

This relates to therapy in that the therapist is dependent on input from the client. The client, through their interactional pressure – projective identification, tries to "unconsciously elicits thoughts, feelings, and experiences within another individual which in some way resemble his own" (Tansey & Burke, 1989, p. 45). It is through this interactional pressure that the therapist identifies with projected aspects of the client and in turn is in receipt of inside knowledge of the client.

Tansey and Burke (1989) differentiate between developmental and pathogenic projective and introjective identification - the latter more likely occurring in the therapy room. They also cleverly link the two, which is extremely useful as it clarifies how theory applies in the clinical setting using experiences of being a child that can easily be related to. For example: "The therapist's experience of projective identification is similar to that of the young child who is still actively forming the important introjects (representations of self in interaction with the parents) that will serve as a basis for self-guidance" (p. 51). In the therapy setting the therapist forms an introject, or internal model of the client-therapist relationship. This introject of the treatment process by the therapist is referred to as an 'interactional introject' which is made up of two parts: 1) Self-representation - which is the therapist's self-experiences of interactions with the client; and 2) Object-representations - which is the therapist's impression of the client's experience of their interaction; and the therapist's perception of the client's experience of relating to self and other (past and present).

The therapist's internal model begins building the moment the therapist comes in contact with the client and is continually modified over the ensuing sessions by the "taking-in" process (Tansey & Burke, 1989). This is classified as a 'transient identificatory experience' which becomes a more enduring identification overtime (Fliess, 1953; Tansey & Burke, 1989). As it does, it becomes part of the therapist's 'work ego' (named in chapter three), which refers to "an enduring representation of the self consolidated overtime from the images of self in interaction with patients" (Tansey & Burke, 1989, p. 52).

For example, I may feel sleepy when with Trixie and am able to identify this feeling as similar to an interactional introject of Beatrice. Having identified this, I need to check to see if any of my identification and consequent knowledge of Trixie relates to any aspect of

Beatrice. That is, when I feel sleepy with Trixie it usually means the client has emotionally disconnected – is this the case with Beatrice?

The 'Work Ego' therefore becomes a potential library filled with enduring representations of self and objects. As a beginning therapist, with limited experience constituting a small work ego, it may take longer to understand what is occurring in the interactional dynamic. Support and enlightenment offered by a clinical supervisor can be beneficial in gaining an objective perspective on what might have been missed in the previous session and foresight into what might yet be encountered. During the course of being supervised it is the aim of the therapist to internalise aspects of the supervisor. So that eventually the therapist has a capacity for their own spontaneous reflection when in relationship with a client as their own internal supervisor ego has been developed (Fliess, 1953; Casement, 1999).

Tansey and Burke (1989) stress that "the therapist awareness of self is vital" (p. 55). This is because a therapist also has other introjects derived from her own life experiences of relating to self and others. It is these introjects that the therapist may also identify with in relation to the client's projective identification. At times, the therapist may have temporarily reduced capacity to regulate intuitive response, to call on common sense or reason, or to stay related to the client, due to her identificatory experience with either the self or object representation of the interactional introject. Therefore, it is necessary for the therapist to 'scrutinize closely' their identificatory experience to recognise if her response is "solely as a result of the influence of the interactional introject" or if a parallel experience is occurring (p. 55). If the therapist continues to be aware of her self-experience and wonders about it and its relationship to the client she might discover "a similar but striking resemblance to a similar but unacknowledged experience suggested by the patient's material" (p. 56).

Therefore, introjective identification can only occur in response to the interactional pressure of projective identification. This identification can link to the therapist's own personal introjects, or through introjects created within the therapeutic relationship, yet both can provide information into the client's psychological world.

This next section draws together the previous discussions on the therapeutic relationship, projective identification, and introjective identification by exploring the role of empathy.

Empathy

So how does empathy relate to countertransference? First, let us explore definitions of empathy. Through the Winnicottian lens Symington (1996) sees the role of the psychotherapist is "to be in empathic understanding with his patient and to create thereby a new environment out of which a healthy ego can develop" (p. 5-6).

Greenson (1967) states, "the ability to empathize with the patient is an absolute prerequisite, it is our best method for comprehending the complex, subtle and hidden emotions in another human being" (p. 277). McWilliams (1994) specifically clarifies empathy as "the capacity to feel emotionally what the client is feeling" (p. 12), whether that be negative or positive affect. Empathy is often confused as the warm and sympathetic reactions to another regardless what the other is feeling emotionally. Rather, empathy is "feeling with" the client, not "feeling for" (McWilliams, 1994, p. 12).

Kohut (1959) refers to empathy as "vicarious introspection" (p. 459), which is a way of accessing another's psychological state by indirectly examining or experiencing the thoughts and feelings of the client by imagining what the client may be experiencing.

It is a consensus among some authors such as Racker (1948) and Rycroft (1995) that only concordant identifications have the foundation for empathy. In their view, it is through the therapist's identification with the client's self representation that results in the therapist feeling close and harmonious with the client. At this moment the experiential state of both therapist and client has a resemblance. Whereas, with complementary identification the therapist identifies with the client's object representation, hence the therapist's experiential state does not resemble the client's and is considered un-empathic.

By contrast, Tansey and Burke (1989) define empathy as more than:

> an intrapsychic event involving only concordant identifications taking place within the therapist – either with or without the patient's influence - to an

> interpersonal process in which a series of steps leads to an empathic outcome in the therapist's understanding of the patient (p. 58).

Their premise here is that both concordant and complementary identification can result in an empathic outcome eventually (Tansey & Burke, 1989). Tansey and Burke's argument is that complementary identification may not result initially in seeing the therapist experiencing similar emotions as the client. Yet, such identification "serves as a vehicle for an eventual concordant identification within the therapist" (p. 59), which allows for the empathic process to occur. Tansey and Burke do not view empathy as a static process but a series of steps that may begin with a complementary identification and work toward an empathic understanding via a concordant identification.

Fliess (1942) points out that the initial factor in empathy is making a trial identification, and states "a person who uses empathy on an object introjects this object transiently and projects the introject again onto the object" (p. 213). Therefore, the therapist gets an affective experience of what it might be like for the client, and the client in turn feels empathically understood by the therapist (Casement, 1999; Goodman, 1995; Racker, 1957; Stern, 1994; Winnicott, 1949).

According to McWilliams (1994) projection is the basis for empathy. She states, "since no one is ever able to get inside the mind of another person, we must use our capacity to project our own experience in order to understand someone else's subjective world" (p. 108). In this vein, one of the aims of therapy is for the therapist to become aware of her feelings in relation to her client. This intersubjective communication process acknowledges that therapy is not one-sided with only the client contributing to countertransference, but shows that the therapist also contributes. This intersubjective approach is advocated by other authors who believe that both the client and the therapist play an active role in projective identification (Grotstein, 1995; Natterson & Friedman, 1995; Ogden, 1994). It is apparent that within the therapeutic relationship there is an inter-connection between empathy, projective identification and countertransference, which is summarised below.

In summary, countertransference can occur at any stage in treatment - even before positive working alliances and trust have been established. It can occur as a result of projective

identification and through empathic responses to the client (McWilliams, 1994; Ogden, 1982). The therapeutic relationship can be viewed at times as a cyclical process whereby the therapist's countertransference informs her empathic response in relation to the client's process (Casement, 1999; Kohut, 1959; McWilliams, 1994; Tansey & Burke, 1989). Through her empathic response the client feels empathically understood, which engenders trust and confidence in the therapist. Consequently, the working alliance will strengthen, which promotes the client's ability to confide, transfer and project into the therapist, and in turn can create more countertransference within the therapist. It is important to note that the therapeutic role can be effected if there is a break in, or absence of empathy (Casement, 1999; McWilliams, 1994). However, empathy can be seen as an integral part of therapy. It not only allows us to comprehend the complex emotions of the client, it is the beginning of the client understanding themselves and thus engendering the opportunity for developing a healthy ego. Symington (1996) states "it is in the direct feelings between the psychotherapist and the patient, and their interpretation and enactment that emotional change is brought about" (p. 95). If the client only understands her problems from a cognitive perspective, it may be insightful but hard to utilise. It is in connecting with the feelings associated with the problem that emotional change can occur (Symington, 1996).

To follow is a vignette of my subjective clinical experience as a therapist. In examining my countertransference I will illustrate theoretical concepts and themes identified in this literature review.

Vignette 2 – Mavis

This vignette illustrates some of my countertransference experienced over a period of 10 months whilst in clinical relationship with Mavis. Three phases have been chosen to best group themes occurring over this time. Concepts identified within this literature review have been used to demonstrate how countertransference was used to understand the client process and inform interventions.

Mavis came to therapy as she was stressed, depressed and not coping with a work colleague. She was fearful of him and found him to be very aggressive. She was very forward in informing me of her high IQ and that she gets bored with dumb people, for whom she did not have time.

Phase 1: The beginning

I was aware of my countertransference before I had met her. The referral form informed me of her occupation – a professor and a scientist. I was worried that as a student psychotherapist I may not be erudite enough for her, that I may not be able to help her, and noticed my anxious feelings.

In the initial meeting she warned me of her aggressive streak, her bad offensive language and her intolerance for dumb people. I felt like she was attempting to scare me off. I was very nervous before each session. I felt anxious, inadequate and small during them. I felt like I was anticipating an attack, or about to be discovered as a fraud (not a good enough therapist). I felt dumb and I wondered how angry she may get with me for this. I wondered about my safety with her as I pictured her throwing furniture. She would often ask me questions, which I felt put me on the spot to prove to her my worthiness. At these times I felt overpowered by her. I felt I could never get it right with her as when ever I posed an interpretation to her she rejected it immediately.

Using the concepts identified in the literature reviewed in this dissertation, I hypothesise that Mavis, via projective identification, was projecting a part of herself that was fearful of how dumb she may be, whether she could do/understand/feel therapy, whether she would be good enough. Through her interactional pressure within this therapeutic relationship I introjectively identified with this aspect of dumbness and hopelessness. It was via my observing ego, I realised that my internal reactions to this client were from what Sandler (1987) refers to as a ‘compromise’ between my own tendency to feel dumb and not good enough, and the role the client was unconsciously projecting in to me.

My identification with her in this instance was a complementary one in that I was getting an experience of how impossible, hopeless and dumb she felt, while her conscious experience was to feel intelligent and capable. In using my countertransferential feelings as a guide I began to investigate with her what dumb meant to her. Over time I learnt that Mavis often felt like she was in an impossible position with her mother - no matter how hard she tried she could never get it right with her. Her attempts to say or do the right thing resulted in her mother berating her efforts, emotionally withdrawing, or smothering her. I wondered how envious the mother was of her daughter.

Phase 2: Enduring

When I made interpretations Mavis continued to 'bat away' any attempt to be curious or wonder what it might mean. I felt ignored, blocked out and invisible. I began to feel frustrated with her keeping me at bay and began to dread sessions. She increased her speed of talking and I felt like I had to endure her defensive barrage of words.

During the session I felt my thinking was destroyed and I had an overwhelming awareness of impotence. My complementary identification here was to get an experience of what I imagined to be Mavis's experience when in relationship with her mother. I felt shut down, ignored and useless. I became aware of my thoughts and wondered about envy. I was left wondering if the mother was envious of her brilliant daughter, and wondered if it was an envious projective identification I was feeling that was destroying my creativity, preventing me from thinking and feeling and making connections. I wondered if Mavis had experienced this, if this is part of what shut down her emotional ability to connect.

I made the following interpretation to her utilising my countertransference of hopelessness, like I was in an impossible position.

Therapist:	I can feel how hopeless and pointless it is for you to have what I say be so useless and of no help to you.
Mavis:	Its funny you should say that, my boss said to me today that there is NO therapist out there that could help me, and he's right.
Therapist:	So you feel totally helpless or powerless somehow, and I wonder if these feelings are familiar to you?

In using my countertransferential feelings as a guide I began to investigate with her what helpless and feeling shut down (impotent) meant to her. I began to be curious with her as to whether these feelings she experienced in the present may have been familiar and linked to her past.

My interpretations were based on my introjective identification and what Mavis said verbally. This enabled me to empathise with what I imagined to be a terrified little girl that could never get it right, and I wondered how vulnerable, powerless and scared she may have felt at home and consequently may feel in therapy. Through my subjective and intersubjective experience I was able to utilise my countertransference to understand more

about my client's past relationship with her mother. This was useful in understanding more about how Mavis may form relationships.

Gradually after many weeks I learnt that my client often felt inadequate when with her mother. Her attempts to please her mother were in vain, leaving my client feeling very nervous and hopeless. Her mother was often physically and verbally abusive, leaving her feeling unworthy, useless and powerless. As a way of coping with this overbearing, intrusive and abusive mother, this client would often alienate herself by studying. Her intellect was a defensive mechanism preventing her connecting with her own overwhelming emotions and an attempt to avoid the emotional explosions of her mother. I wondered how terrified my client was of connecting with her emotions and how much she needed to alienate me with her intelligence to avoid her feelings.

In relation to Mavis's reason for coming to therapy (her fear of an aggressive work colleague) this is the sense I make of it. Mavis informed me that her work colleague would often go through her desk and steal her stationery. Despite the appropriate anger this evoked, after finding out more about her relationship with her mother, I hypothesise that additionally Mavis may be projectively identifying her anger into her work colleague, unconsciously eliciting him to respond in an aggressive manner. I wonder if this was triggered by his invading her privacy, and whether it may relate to some historical unresolved anger with her intrusive mother.

In the above scenario between Mavis and myself, Mavis changes role and becomes momentarily the persecutor (powerful mother) leaving me feeling like the criticised victim (hopeless child). Therefore my immediate enduring self-representation here was as a victim which matches the clients enduring self-representation when in relationship with her mother. I had a very powerful feeling experience of the client's world. I am also curious and wonder if the client's choice of selecting a student therapist was in an unconscious attempt to re-create her family relational dynamics. That is, in this instance I get an experience of not being 'good enough' as she becomes powerful.

This example of complementary identification is complex in that it is not necessarily immediately apparent that the countertransferential response I had has anything to do with

the client's process. However, my experience here is that after sitting with these feelings for many weeks and bringing them into my conscious awareness (via clinical supervision) they told me a lot about my client and about my client's past relationships with her mother. This use of countertransference informed my next interpretation:

> Therapist: I am left feeling like some parents do; that they try to do their best and sometimes that feels like it's not enough. I was wondering if you might feel like I'm not enough, not strong enough for you.

It was in this interpretation that I felt something shifted for both myself and the client by acknowledging something that was previously unspoken. I felt Mavis stopped blocking me in that moment as I believe she felt empathically understood. I stopped feeling frustrated and noticed the pressure and defensiveness that I could feel previously had lessened.

Phase 3: Strength and Determination

Before the next session I realised I was looking forward to seeing Mavis. I noticed my feelings of warmth and compassion towards her. I became determined to engage her, to fight for her. I was not willing to be invisible or powerless any longer. I developed my work ego by trying a new stance of having a hard edge and a stronger voice. My past anxiousness was replaced somewhat with a willingness to stand up and be seen. It was as if in my determination to fight for her, that Mavis let go of her need to fight and to let something else occur.

This was the first session that Mavis had something urgent to discuss, and she initiated the discussion immediately. This was in stark contrast to previous sessions. Mavis talked of intellectual connections she had made to three very traumatic events. I was aware of feelings of absolute powerlessness and fear in the room and the tightness I had in my chest. I was also aware that she was holding her breath and pointed this out to her suggesting she take some time to take a few deep breaths. It was in this instance that I connected to a similar feeling I had in Phase one, a fear of being seen and exposed. I was readily available to her projective identification as it connected to my own past desires and fears about being seen and the corresponding vulnerability that came with this. I made an interpretation based on my countertransference wondering if by noticing her breathing somehow I had got too close, wondering how scared she was of getting close to anyone. At this point she was able to connect with grief. I too could identify with my own feelings of loss creating

empathic trial identification. In this instance I had a concordant identification with Mavis sharing an empathic understanding.

To follow is my brief synopsis of this vignette using the knowledge I have gained in writing this dissertation on countertransference.

I believe that Mavis unconsciously influenced me into a role corresponding to her parental introject. In introjectively identifying with aspects of her mother through the interactional pressure of projective identification, I acted out her mother. I interpreted too soon, as opposed to making only empathic responses with patience. Consequently, I became smothering and intrusive like her mother. This could be seen as counter-therapeutic and un-empathic. However, in my countertransference turmoil, upon scrutinizing my identificatory experience I realised my behaviour was uncharacteristic and was similar to her mother. This helped me to see relational patterns more clearly and informed my treatment plan. That is, do not make in-depth interpretations at this stage with Mavis, empathic responses are more therapeutic and less threatening and exposing.

The knowledge gained by utilising my countertransference highlighted Mavis's relational and internal conflicts. It helped to inform my treatment plan which prompted me to respond in a manner that was different to important past objects in Mavis's life which enabled something new to occur. To follow is a chapter summary.

Summary

Within chapter four the therapeutic relationship was defined with particular attention paid to the countertransference phenomenon. Specifically discussed in this chapter was identification, projective and introjective identification, with the link to empathy highlighted. Empathy was seen as an integral part in forming a working alliance within the therapeutic relationship and continued to be an important aspect in understanding the client through the empathic process, which included projective and introjective identification. Clinical vignettes were used to illustrate these processes.

Further insight has been gained in response to the question "how does countertransference help the therapist to understand the client process?" This chapter identified that within the

therapeutic relationship the interactional process of identification can be considered a vehicle that leads to empathic understanding with the client, of the client's process. Identification refers to the therapist temporarily taking on and identifying with aspects of the client's identity. This therapeutic environment of empathic understanding informs the therapist of appropriate treatment and promotes positive character change and symptom relief for the client. It is within the therapeutic relationship that trust is built and positive alliances created. In being contained by this safe holding environment, the therapist and client work together to bring clarity and understanding to the client's processes (Burke, 1992; Casement, 1999; Ogden, 1994; Winnicott, 1949)

When working together the client confides in the therapist - either consciously via verbal or physical communication, or unconsciously through projective identification (Racker, 1968). In response to the client's projective identification the therapist temporarily introjectively identifies with aspects of the client's experience. This identification links to the therapist's personal introjects and to introjects created within the therapeutic relationship relating to the client. Within this identification the therapist has inside knowledge of what it may be like in relationship with the client and how it feels from the client's perspective. The therapist at this moment has information about disowned, unwanted or unmanageable aspects of the client. The therapist's countertransference is informing her of previously unknown aspects of the client's world (Ogden, 1982; Tansey & Burke, 1989). At this point the therapist can feel, imagine and be curious about what the client may be experiencing and use this attunement with the client's process to inform the therapeutic work (inform interpretations and empathic responses, or merely to hold this information as a piece to the client's puzzle that may be connected and utilised later on).

In acknowledging her own thoughts and feelings, the therapist has the potential to empathically understand and feel with the client (McWilliams, 1994; Symington, 1996). As Greenson (1967) states "the ability to empathize with the patient is an absolute prerequisite, it is our best method for comprehending the complex, subtle and hidden emotions in another human being" (p. 277).

The next concluding chapter, chapter five, draws together the themes discovered in reviewing literature on countertransference in this dissertation. Limitations of this study,

recommendations for future research, and a personal note on how this dissertation has impacted on me as a new psychotherapist, are included.

CHAPTER FIVE
CONCLUSION

This dissertation began with the research question "how does countertransference help the therapist to understand the client's process?" This chapter encapsulates the development of countertransference concepts with a parallel focus given to discussing the research question. Recommendations for further research are highlighted, limitations and strengths of this study are identified, and I conclude by expressing the effect this dissertation has had on me.

Dissertation Summary

Through the modified systematic literature review process (chapter two) literature on countertransference and the therapeutic relationship was gathered and assessed. Most of the literature reviewed was conceptually, anecdotally and theoretically based and derived from clinical experiences and illustrations, theoretical discussions and case studies. There was limited research-based literature on countertransference. The main focus of these research articles was on the management of countertransference, or negative aspects of countertransference.

In this dissertation, the literature was then categorised into a historical context and a current view of countertransference (chapter three). This provided insight into the complex concept of countertransference and clarified common themes within the definition of countertransference. There was a progression from the negatively viewed controversial, yet simple concept of countertransference at inception, to an extremely complex theoretically dense and more positively viewed concept in modern times. This paralleled a progression from it initially being viewed as a hindrance to therapy - a phenomenon to be managed and overcome, but began to be recognised as an occurrence that could help the therapist to understand the client process when acknowledged and managed well.

Literature from the latter part of the century further explored the theoretical conceptualisation of countertransference and its increasing complexity was evident. The therapeutic relationship was seen as a dynamic interaction between the therapist and the client where the subjective and intersubjective experience of the therapist was to be

acknowledged and used to inform appropriate interventions and treatment relevant to the client. The more recent historical concept of countertransference was expanded upon in viewing contributions from authors in this era, and common themes of identification and empathy manifested. This information was collected by drawing on articles written by well known reputable authors that had contributed greatly to the development of psychoanalytic concepts and specifically to countertransference and the therapeutic relationship. These concepts were elaborated on in chapter four by gaining perspectives on the subject from other authors, then by using Tansey and Burke's (1989) writing more specifically.

Within chapter four the relevance of the therapeutic relationship was explored to understand the environment required for identification to occur. The establishment of a trusting relationship and the ability of the therapist to empathise and clarify perceptions and feelings of the client were considered essential to create a positive working alliance where change could occur. These conditions promoted a safe and contained environment where the client could confide in and communicate with the therapist. Both projective and introjective identification were considered important aspects of countertransference that led to the therapist understanding the unconscious and conscious world of the client. This understanding contributed to empathy, which can be seen as an integral part of therapy. Empathy not only allows us to comprehend the complex emotions of the client, it is the beginning of the client understanding themselves and thus engendering the opportunity for developing a healthy ego. Therefore, countertransference with its links to empathy and the identification processes clearly gives the therapist insight into the client's internal world.

How does countertransference help the therapist to understand the client's process?

Based on the literature reviewed in this dissertation, countertransference is a valid phenomenon that offers significant help to the therapist in understanding the client's process. The therapist's countertransference achieves this in the following ways. It is through the therapist's subjective and intersubjective experience of the therapeutic relationship and via the interactional pressure from the client that the therapist identifies with aspects of the client's projective identification. In acknowledging her identification by paying attention to associated countertransferential responses, the therapist has the potential to further understand and feel with the client. The therapist is then able to gain further insight into the client process by making empathic responses, interpretations, or by just

wondering what her countertransferential response could mean in relation to the client. The therapist also draws on her knowledge and skills as well as her countertransference to further understand the client's past problematic behaviour and emotional responses.

I discovered that within the therapist's capacity to empathise with the client, the therapist began to understand the client's subjective world - the client felt understood, which led to the potential for change to occur. However, identification is not always a direct link to an empathic understanding with the client. For example, complementary identification may mean the therapist experiences, or acts out the kinds of feelings I wondered about as I began this dissertation – feelings towards the client of anger, criticalness, inadequacy or hopelessness. Yet, these 'negative' experiences offer the therapist the opportunity to engage in an analytic process to gain clarity about the complex and hidden emotional world of the client.

Answering my research question was assisted by using my own clinical experience (Vignette 1 – Priscilla, and Vignette 2 - Mavis) to illustrate the theoretical concepts being described in the literature. Through the application of these concepts in my own work I learned that my countertransferential responses do impact on the therapeutic relationship, and when acknowledged do greatly help to inform my interventions. I discovered that understanding of the client's processes may not occur immediately, yet acknowledged the importance of always paying attention to such countertransference to prevent acting out the role the client has elicited me to play. Countertransference may also have links to my unresolved conflicts, and I may have parallel processes occurring simultaneously. Although, I think it is important to understand as much as possible the source of countertransference, specifically attributing the emotional affect to client or therapist is not so clear-cut.

This literature review focused on the countertransference of the therapist when in interaction with the client. It demonstrated many ways a client communicates with the therapist – consciously and unconsciously, verbally, physically and through the means of projective identification. The therapist receives communications via thoughts, feelings and bodily experiences. The acknowledgment of her countertransferential responses via the introjective identification process gives the therapist access to experiences that the client is,

as yet, unable to put into words. The therapist then makes sense of her emotional responses within the therapeutic relationship with the client.

This dissertation has clarified the benefits and cautions of the therapist utilising countertransferential responses. Countertransference is considered a valid source of information that helps the therapist understand the client, rather than a distraction, a hindrance to therapy and something to be overcome.

Recommendations for future research

This dissertation revealed potential areas for future research to provide a more balanced view on countertransference. More research is required with a particular focus on the usefulness of countertransference and how to use it to positively influence therapy. Further research is also needed regarding countertransference that does not occur out of projective identification. Countertransference literature frequently referred to strong emotional responses and the effect they have on therapy. I am left wondering about the more subtle or mild emotional responses. Are they more likely to go unnoticed, or perhaps be more readily acted out? This is subject matter for future research. Given the significance of countertransference as a tool within the therapeutic relationship, the implications of this literature review emphasise the need for continued exploration regarding how to use countertransference therapeutically.

Limitations and strengths of this study

The size and time constraints of this dissertation restricted the amount of literature that I could read and explore, it limited the depth I could go into, and confined the aspects that I could cover. For example some of the areas of interest that I would have liked to investigate further include literature that discusses countertransference that occurs outside the experience of projective identification, as I am left asking, does countertransference occur outside the projective identification phenomenon? I would also have liked to be able to include literature about how to use countertransference therapeutically to aid the client process.

One of the aspects I noticed in the literature was that there was a lot of repetition of concepts. I would have liked to have looked for additional concepts that may have come from further reading, and also from material that discusses the ways a therapist experiences their client, yet may not be classified as countertransference. However, this was not possible as I needed to remain focused to attend to the research question and to complete the dissertation within the allocated time frame.

Strengths of this study relate to the complexity of the subject matter. As a result of the dense theoretical conceptualisation in the literature about countertransference, my presentation of the material in this dissertation could be used as a learning tool for training psychotherapists, and as a reference point for a summary of the key theoretical concepts of countertransference.

On a Personal Note

I began this dissertation questioning whether the therapist's knowing, thoughts, feelings and intuition were valid to the therapeutic relationship. The concept of countertransference, referring to all the therapist's responses in relation to the client, related to my initial question. As I explored the historical context to countertransference I was able to precisely define my research question to, "how does countertransference help the therapist to understand the client process", within the context of a therapeutic relationship? Although through my training I learnt about the theoretical concept of countertransference, I did not know what this meant in practice. For me this highlighted a gap between my theoretical knowing and my clinical experience. This gap also accentuated and mirrored a personal struggle of my own - wondering if my feelings were valid. Ogden's (1992) quote below best encapsulates this for me relevant to my own personal development, and describes this as concepts and techniques that each therapist needs to discover for herself.

> Psychoanalytic concepts and techniques, in order to retain their vitality, must again be discovered by the analyst as if for the first time. The analyst must allow himself to be freshly surprised by the ideas and phenomenon that he takes most for granted (Ogden, 1992, p. 225).

As I have become grounded in countertransference knowledge through the process of this dissertation, I have similarly become grounded in the belief that my countertransference has a place in the therapy room. By linking theoretical concepts from this literature review to

my clinical experience I have significantly deepened my own grasp of the potential countertransference has for further understanding the internal processes of the client.

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APPENDIX A

Ethical Approval

Client Consent Form

Client Information Sheet