References
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Transference, Countertransference and interpretation: the current debate

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Introduction
Issues on Interpretation of Transference and Countertransference have been important for psychotherapists practising with a wide variety of therapeutic modalities.
In fact, Interpretation of Transference and the use of Countertransference can be powerful therapeutic tools for the therapist and allow the therapist and the client to shed light on the client’s relationship pattern and problems.
For the past ninety years or so, the words Transference and Countertransference have had different meanings for different modalities of therapy and school orientations and they have been the object of controversies and heated debates.
In the current debate a summary and critical discussion of the more prominent psychoanalytic schools will be given.

Keywords
Transference, Countertransference, Psychotherapy, Psychoanalysis
The later psychoanalytic period: transference and countertransference interpretation

It was not until 1905 that Freud started to talk about Transference as he came across it in clinical practice.

In particular, in his Dora’s case, Freud discussed the reasons why his patient dropped out from treatment. He started to hypothesise that interpretation of dreams’ symbols was not the only important component of therapy, and came to realise that he overlooked another important and new phenomenon in therapy that he named as “transference”.

Freud learnt that such transference, that he conceived as the patient’s repetition or recreation in the relationship with the therapist of actual past events or fantasies, was another important way in which the individual can express unconscious material. As Freud (1905, p.116) defined transferences:

“What are transferences? They are new editions of facsimiles of the impulses and fantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment.”

Freud (1912) had spoken of “positive” transference as opposed to “negative” ones; he further divided positive transferences into which helped the therapeutic work and those that hindered it.

The repetition of the past in the form of transference in the therapeutic relationship was seen by Freud as a consequence of the so-called “repetition compulsion” (Freud, 1914).

Freud himself became well aware of the evolution and different stages his techniques went through, over different periods in his professional career.

As he summarised (Freud, 1914, p.147):

“It seems to me not unnecessary to keep on reminding students of the far-reaching changes which psycho-analytic techniques have undergone since its first beginnings. In its first phase – that of Breuer’s catharsis – ...next, when hypnosis had been given up, the task became one of discovering from the patient’s free associations what he failed to remember…; finally there was evolved the consistent technique used today, in which the analyst gives up the attempt to bring a particular moment or problem into focus. He contents himself with studying whatever is present for the time being on the surface of the patient’s mind, and employs the art of interpretation mainly for the purpose of recognising the resistances which appear there, and making them conscious to the patient.”

On “countertransference”

The term “countertransference” has also undergone a number of radical changes in meaning since it was introduced by Freud in 1910.

Initially, like transference, it was regarded as a hindrance to analysis (Freud 1912), representing the need for further analysis on the part of the analyst.

As Sandler pointed out (1992, p.82):

“Just as transference was, early on, seen by Freud as an obstruction to the patient’s flow of free associations, so countertransference was consistently regarded as an obstruction to the freedom of the analyst’s understanding of the patient. Freud (1913) regarded the analyst’s mind as an “instrument”, its effective functioning in the analytic situation being impeded by countertransference”.

Freud repeatedly stressed the limitations imposed on the analytic work by the analyst’s psychological blind spots (analyst-based countertransference).

Since Freud’s first conceptualisation of the term countertransference, there have been a number of different lines of development.

In particular, the rise of the object-relations school in Britain and the interpersonal school in U.S began to push for a wider definition. Of particular importance, in this respect, has been the work of Winnicott (1949), Heimann (1950), and Little (1951).

Klein perspective on transference

The analytic technique introduced by Melanie Klein has emphasised the centrality of transference interpretation.

As Segal (1986, p.70) reported in her paper “The Curative Factors in Psychoanalysis”:

“Melanie Klein has enriched and expanded our concept of transference. By paying minute attention to processes of projection and introjection, she showed how, in the transference relationship, internal object relations are mobilised by projection onto the analyst and modified through interpretation and experience as they are reintrojected. Similarly, parts of the ego projected onto the analyst undergo modification in this new relationship ... the role of the analyst is to understand this process and to interpret it to the patient”.

As Sandler (1992, p.49) pointed out, initial techniques was focused on the patient’s destructiveness, and patient’s fantasies were interpreted to the patient immediately and very directly in part-object language (breast, nipples, penis, etc.). In later stages less emphasis has been put on the destructive and part-object issues in therapy.

A major extension of the Kleinian theory of transference has been developed by Joseph (1985) who broadened the concept of transference to the point that he argued that whatever occurs in the analysis can be considered as transference.

The aim of the therapy is to make emotional contact with the patient in the “here and now” of the analysis.

On countertransference

With the introduction of the concept of “projective identification” (Klein, 1946), Klein explained how object relationship is acted out in the transference and how externalisation of internal object relationships is played from the patient onto the therapist. Projective identification has been equated with the notion of countertransference.

As Bateman and Holmes put it (1995, p. 111):

“In projective identification, the patient projects disavowed aspects of himself onto the analyst, who becomes unconsciously identified with those parts and may begin to feel or behave in accordance with them. The first aspect of this process is clearly allied to transference while the second can be correlated with countertransference in view of its obvious interactional aspects.”

The Kleinian perspective on Transference

Rosenfeld (1952) disputed Freud’s original contention about transference in psychotic patients, and concluded that transference does occur in psychotics.

Such transference is a peculiar one, and it is different in its quality from the so called “neurotic transference”.

In this respect, it seems that the psychotic individual has lost the capability to understand the “as if” metaphor in the transference relationship with his analyst.

As Sandler commented (1992, p. 71):

“What seems to be the distinguishing feature in the transference of psychotic patients is the form that it takes – a form that is closely related to the psychotic mental state of the patient. A transference wish which might be resisted in the neurotic, or (being subject to reality testing) produced in a disguised form, might find expression as a delusional conviction in the psychotic.”
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Freud repeatedly stressed the limitations imposed on the analytic work by the analyst’s psychological blind spots (analyst-based countertransference).

Since Freud’s first conceptualisation of the term countertransference, there have been a number of different lines of development. In particular, the rise of the object-relations school in Britain and the interpersonal school in U.S began to push for a wider definition. Of particular importance, in this respect, has been the work of Winnicott (1949), Heimann (1950), and Little (1951).

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A major contribution to the notion of countertransference was given by Heimann (1950, 1960); she moved away from the classical Freudian idea that countertransference is a hindrance in therapy, and she did not link countertransference with Klein’s concept of projective identification. In fact Heimann proposed that countertransference has to be seen as an asset to therapy, in fact it allows an additional avenue of insight into the patients’ unconscious mental processes. Heimann, regarded countertransference as all the feelings the analyst experiences towards his patient, and she suggested that it is not just part of the transference-countertransference dynamic within the relationship.

Further advances in the understanding of the countertransference was put forward by Bion. In particular, Bion’s (1962) formulation of the container and the contained linked projective identification with developmental processes and related to the idea of normal countertransference in which the transference-countertransference dynamic moves along constructively in the therapist-patient relationship.

Segal (1977) agreed also with the Bion’s concept of “container”; she further pointed out that the analyst’s function of containing the patient’s projections can be disrupted by the patient’s seductive or aggressive way of relating with the therapist, in a way that he will create anxiety, confusion and attack of the link in the therapist’s mind.

Object Relations perspective
Balint (1949, 1968) and Winnicott (1958) emphasised the importance of the patient’s regression as a means of having access to important past material and having an understanding of previous significant relationships of the patient.

In the analytic relationship, the analyst will have a “holding function” (Winnicott, 1951) and will guide the patient in a safe and contained environment to explore the past in a regressed state.

Kernberg (1987) would suggest that analysis of the transference is in effect the analysis in the here-and-now of past internalised object relations as well as the analysis of conflictual element between different aspects of the psychic structure. He sees also the internalised object relationship as being formed from fantasy as well as reality. Also Sandler (1967) would tend to see transference as “an emotional experience of the past as it is now remembered” and not as it actually happened.

The link in the therapist’s mind.

Ego-psychology perspective on transference and its interpretation
As Sandler (1992, p. 151) pointed out, from 1897 to 1923, the problem of interpretation was seen as predominantly one of bringing unconscious material to consciousness. After 1923, the structural viewpoint emphasised the role of interpretation as being addressed to the ego of the patient, and the ego’s strengths and weaknesses had to be taken into account.

Anna Freud (1936) became more and more focused on the above issue and finally she proposed a differentiation of transference phenomena in relation to the ego, according to their degree of complexity. She emphasised the importance of the interpretation of ego-defences (ego-mechanisms) over the symbolic interpretation (id content).

There has been a tendency to widen the concept of transference over the decades. In particular, the so called “English school” of psychoanalysis found expression in thoughts of James Strachey (1934) according to whom the only effective interventions in psychoanalytic treatment were transference interpretations. It was thought that these needed to be related to processes of projection onto the analyst of the “primitive introjected imago” which were regarded as forming a significant part of the patient’s superego.

As Sandler reported on this subject (1992, p. 158):

“Strachey (1934) suggested that the crucial changes in the patient brought about by interpretation are those that affect his super-ego. Interpretations that have this effect are considered “mutative”, and in order to be effective they must be concerned with processes occurring in the immediate “here and now” of the analytic situation.”

Strachey himself, in his paper on “The Nature of the Therapeutic Action of Psycho-Analytic”, summarised the aim of therapy as follows (1934, p.159):

“1. The final result of psycho-analytic therapy is to enable the neurotic patient’s whole mental organisation, which is held in check at an infantile stage of development, to continue its progress towards a normal adult state.

2. The principal effective alteration consists in a profound qualitative modification of the patient’s super-ego, from which the other alterations follow in the main automatically.

3. This modification of the patient’s super-ego is brought about in a series of innumerable small steps by the agency of mutative interpretations, which are effected by the analyst in virtue of his position as object of the patient’s id-impulses and as auxiliary super-ego.

4. The fact that the mutative interpretation is the ultimate operative factor in the analytic action of psycho-analysis does not imply the exclusion of many other procedures (such as suggestion, reassurance, abreaction, etc.) as elements in the treatment of any particular patient.”

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Rappaport (1956) was one of the first theorists who correlated the intensity of the sexual demanding reactions (as seen in erotic transference) in analysis with the severity of the patient’s pathology. He noticed in particular that, in the analytic situation, borderline and psychotic individuals equate the analyst with the parent; in essence psychotic patients have lost the “as if” quality in the relationship (that is present in the neurotics).

On countertransference
Kernberg (1965) also developed in a deep way the concept about countertransference. He pointed out, in accord with views expressed by others (e.g. Winnicott, 1949) that the full use of the countertransference can be considered of particular diagnostic importance in the assessment of the suitability for treatment of personality disordered patients and psychotic patients.

Interpersonal perspective
Searles and Fromm-Reichmann (1950) seek to show that, by their detailed presentations, patients’ thought processes represent repetitions of earlier interpersonal relationships.

Interpersonal theorists emphasised the interpersonal perspective of the transference-countertransference interactions. As Loewald (1986) emphasised, transference and...
And again (p.78): “In those varieties of transference described in this chapter (psychotic transferences), the patient may not possess or use these self-critical and self-scouring elements, and it is that writers on these forms of transference refer to the disappearance of the “as if” quality of the transference”.

**On countertransference**

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Interpersonal theorists emphasised the interpersonal perspective of the transference-countertransference interactions. As Loewald (1986) emphasised, transference and
Countertransference are not separate issues, actually they are two faces of the same dynamic interpersonal process.

Langs (1978) also emphasised the concept of “bipersonal field” where he located countertransference as an interactional phenomenon in the therapist-patient relationship. It is the analyst’s emotional task to distinguish between his own unconscious fantasies from those of his patients (Money-Kyrle, 1956).

Searles (1963) in particular identified four types of transference psychosis, and he related each of the types of transference psychosis to damaging family patterns.

Searles also emphasised the importance of the countertransference perceptions by which the therapist can assess the type of psychotic disturbance.

Discussion on recent developments and controversies on psychoanalytic techniques

Problems on transference
- There are, first of all, some difficulties to give a unitary definition of transference.
- The concept of transference differs according to different schools.
- In particular, the term “psychotic transference” has been used in a variety of ways, “ranging from situations where the analyst feels out of touch with the patient, to attempts by the patient to force the analyst to think for him” (Searles, 1963) Bateman & Holmes, 1995. Another use of the term “transference psychosis” has been to describe transient psychotic symptoms occurring in the analytic session in patients who face intolerable and painful situation (Wallerstein, 1967).
- There is still a dilemma about considering transference as a distortion of reality (classical view) or as a valid representation of a present unconscious situation, coloured by experience from the past (contemporary view).
- There is also a dilemma about transference as a general phenomenon (as held by contemporary psychoanalysis) occurring in every setting versus transference as a specifically analytic phenomenon (as held by Freudian and classical analysis).

In this respect, it sounds as if there is now general agreement that transference is found within all relationship, (nevertheless, the analytic situation clearly enhances and promotes the development, observation and reflection on transference phenomena).

In recent years there has been a revival of interest in extratransference interpretations. As Halpert (1984) defined them, they are interventions of transference that may spontaneously occur in the patient’s immediate life without evident processing through the analytic situation.

In this respect, Blum (1983) emphasised that analytic understanding of the patient should encompass the overlapping of transference and extratransference spheres, fantasy and reality, past and present.
- Another dilemma is either considering transference as the whole or only part of the analytic situation. This aspect might have important implications in therapeutic techniques.

As Bateman & Holmes emphasised (1995, p. 104):
“There are important implications for technique in these differences, as the analysts taking a partial view may endeavour to develop an area of their relationship with the patient that is free from transference distortions, while those taking a total view will not. Interventions by analysts taking a partial view may then include confirming or reality-orientated statements as well as interpretations to correct the distortions of reality by transference.”

According to Bateman & Holmes (1995, p.105), many analysts believe that validation or invalidation of patient transference should depend on the developmental level at which the patient is operating. Psychotic people, for example, often have a defective grasp on reality and therefore they need to rely on the analyst’s “ego function”; with such patients (differently from the neurotics), direct confrontation with their inner world is therefore discouraged.

Problems on countertransference
The term “Countertransference” has also undergone a number of radical changes in meaning since it was introduced by Freud in 1910.

Initially, like transference, it was regarded as a hindrance to analysis (Freud 1912), representing the need for further analysis on the part of the analyst.

Nowadays, countertransference has acquired a wider meaning.
As Bateman and Holmes (1995, p. 109) defined it:
“Broadly speaking, the term “Countertransference” now applies to those thoughts and feelings experienced by the analyst which are relevant to the patient’s internal world and which may be used by the analyst to understand the meaning of his patient’s communication to help rather than hinder the treatment, i.e. “patient-derived Countertransference”, in contrast to the earlier notion of “analyst-derived countertransference” (Langs, 1976).

Problems on interpretation
It sounds as if, in the context of the analytic techniques, there are different varieties of interpretations and it is difficult to define what interpretation is.
In fact, we can have the following varieties: content interpretation (that is aimed to bring unconscious meaning to consciousness), symbolic interpretation (that is the translation of symbolic meanings as they appear in dreams, slip of tongue etc), defences interpretation (that is aimed at showing to the patient the mechanism he uses to deal with painful feelings involved in a particular conflict) (Sandler, 1992, p.157).

“According to Loewenstein (1951), interpretation can be defined as verbal interventions that produce dynamic changes which we call insight. As Sandler pointed out (1992, p.153):
“we can readily conceive of interpretations that are correct but not effective, and conversely of interpretations that are incorrect but effective (Glover, 1931).

Defining an interpretation by its aim rather than by its effect could produce greater conceptual clarity.”

In any way, as Spence (1982) pointed out, the truth of an interpretation or reconstruction can never really be known. What the therapist does when he delivers an interpretation is to tell the patient, in a coherent, persuasive and consistent way, the patient’s narrative truth (that not necessarily coincides with the historical truth).
- Another important dilemma is about considering “interpretation” as a unitary process vs. interpretation as made of sequential steps.

Nowadays, it sounds as if most of the theorists tend to agree with Greenson’s view (1967) on interpretation, according to whom interpretation is made of numerous steps such as: confrontation, clarification, preparation for interpretation, interpretation and reconstruction of the material brought or enacted by the patient in therapy.

Conclusion
This essay highlighted the fact that there is a huge body of research around psychoanalytic techniques.

Different schools will define interpretation of transference and Countertransference differently in accordance to their theoretical framework.
Countertransference are not separate issues, actually they are two faces of the same dynamic interpersonal process.

Langs (1978) also emphasised the concept of “bipersonal field” where he located countertransference as an interactional phenomenon in the therapist-patient relationship. It is the analyst’s emotional task to distinguish between his own unconscious fantasies from those of his patients (Money-Kyrle, 1956). Searles (1963) in particular identified four types of transference psychosis, and he related each of the types of transference psychosis to damaging family patterns. Searles also emphasised the importance of the countertransference perceptions by which the therapist can assess the type of psychotic disturbance.

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As Bateman & Holmes emphasised (1995, p. 104):
“...There are important implications for technique in these differences, as the analysts taking a partial view may endeavour to develop an area of their relationship with the patient that is free from transference distortions, while those taking a total view will not. Interventions by analysts taking a partial view may then include confirming or reality-oriented statements as well as interpretations to correct the distortions of reality by transference.”

According to Bateman & Holmes (1995, p.105), many analysts believe that validation or invalidation of patient transference should depend on the developmental level at which the patient is operating. Psychotic people, for example, often have a defective grasp on reality and therefore they need to rely on the analyst’s “ego function”; with such patients (differently from the neurotics), direct confrontation with their inner world is therefore discouraged.

Problems on countertransference
The term “Countertransference” has also undergone a number of radical changes in meaning since it was introduced by Freud in 1910.

Initially, like transference, it was regarded as a hindrance to analysis (Freud 1912), representing the need for further analysis on the part of the analyst.

Nowadays, countertransference has acquired a wider meaning.
As Bateman and Holmes (1995, p. 109) defined it:
“...Broadly speaking, the term “Counter-transference” now applies to those thoughts and feelings experienced by the analyst which are relevant to the patient’s internal world and which may be used by the analyst to help rather than hinder the treatment, i.e. “patient-derived Counter-transference”, in contrast to the earlier notion of “analyst-derived counter-transference” (Langs, 1976).”

Problems on interpretation
It sounds as if, in the context of the analytic techniques, there are different varieties of interpretations and it is difficult to define what interpretation is.
In fact, we can have the following varieties: content interpretation (that is aimed to bring unconscious meaning to consciousness), symbolic interpretation (that is the translation of symbolic meanings as they appear in dreams, slip of tongue etc), defences interpretation (that is aimed at showing to the patient the mechanism he uses to deal with painful feelings involved in a particular conflict) (Sandler, 1992, p.157).

“According to Loewenstein (1951), interpretation can be defined as verbal interventions that produce dynamic changes which we call insight. As Sandler pointed out (1992, p.153):
“...we can readily conceive of interpretations that are correct but not effective, and conversely of interpretations that are incorrect but effective (Glover, 1931). Defining an interpretation by its aim rather than by its effect could produce greater conceptual clarity”.

In any way, as Spence (1982) pointed out, the truth of an interpretation or reconstruction can never really be known. What the therapist does when he delivers an interpretation is to tell the patient, in a coherent, persuasive and consistent way, the patient’s narrative truth (that not necessarily coincides with the historical truth).

- Another important dilemma is about considering “interpretation” as a unitary process vs. interpretation as made of sequential steps.

Nowadays, it sounds as if most of the theorists tend to agree with Greenon’s view (1967) on interpretation, according to whom interpretation is made of numerous steps such as: confrontation, clarification, preparation for interpretation, interpretation and reconstruction of the material brought or enacted by the patient in therapy.

Conclusion
This essay highlighted the fact that there is a huge body of research around psychoanalytic techniques.
Different schools will define interpretation of transference and Countertransference differently in accordance to their theoretical framework.
It is important for the psychotherapist to have an awareness that the above concepts are not unitary and they can have more than one meaning according to the context where they are used.

In the future it will be important to find a common language across different psychoanalytic schools. In psychotherapy practice in general, definitions of important concepts such as transference, countertransference and interpretation should improve client’s understanding and also improve communications amongst different professionals

References

16. Freud, S. 1914 Remembering, repeating and working-through (further recommendations on the technique of psychoanalysis), SE 12.
17. Freud, S. 1916 Observations on transference love (further recommendations on the technique of psychoanalysis), SE 12.

Key Words:
Psoriasis, Hypnotherapy, Demonstration therapy, Regression, Catharsis, Integrative hypnotherapy, Bodywork

One-Session Demonstration Treatment of Psoriasis

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Abstract

A brief survey of contemporary research in the field of hypnosis and psoriasis is made emphasising the need for further qualitative and quantitative studies. A rationale for one-session demonstration treatments utilising hypnosis is outlined before discussing a treatment session with a psoriasis ‘patient’. The approach utilised was essentially an example of integrative hypnotherapy incorporating both direct and indirect approaches as well as hypnaanalysis. Gestalt work and bodywork conducted within an overall humanistic-phenomenological context. Recognition of the importance of common curative factors such as ego strengthening and goal setting is also discussed. Follow-up reports at six, 12 and 30 months showed that the patient continued to show improvements in her skin condition with few remissions, as well as increases in confidence and self-esteem.

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