Transference and Countertransference

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TOPIC. *The utility of transference and countertransference in professional nursing relationships.*

PURPOSE. *To provide an introductory text for nurses new to these concepts.*

SOURCES. *Literature specific to transference and countertransference illustrated by examples related to professional practice.*

CONCLUSIONS. *Transference and countertransference influence relationships in ways that under certain conditions may be unhelpful to all concerned. Understanding how transference and countertransference manifest themselves has implications for the safe structuring of professional relationships.*

Search terms: *Countertransference, nursing relationships, transference*

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Transference and countertransference manifest themselves in all relationships—therapeutic, personal, and professional. Do the ideas of transference and countertransference have utility for health professionals and their work? Transference and countertransference are evidently complex events and are not easily verifiable. Given the relative dearth of empirical validation for these occurrences, the ideas may seem to have little relevance outside psychoanalytically informed therapies. Nonetheless, the concepts seemingly remain potent.

In addition to a rich psychoanalytic literature (e.g., Banon, Evan-Grenier, & Bond, 2001; Gibault, 2002), references to transference and countertransference are found in current nursing literature (O'Brian, 2001; Winship & Hardy, 1999). Some knowledge of the ideas seems important, given the closeness of many nursing relationships. Understanding the concepts may help in making sense of complex events, even if we never fully understand their meanings.

Before entering into a detailed discussion and review of related literature, it is important to define briefly the terms that form the organizing framework for this discussion.

The unconscious is an area of the mind outside of perception that contains aspects of personalities that are inaccessible to conscious awareness. This expression of our personality, therefore, is beyond conscious control. Unconscious conflicts cannot be studied directly and perhaps are never fully understood. Aspects of unconscious struggles, nevertheless, can be inferred from behaviors. According to Freud's theory, the unconscious is the *id:* the home of our instincts and impulses and repressed material.

Transference is the technical term used to describe an unconscious transferring of experiences from one interpersonal situation to another. It is concerned with revisiting

past relations in existing circumstances. Thoughts and feelings about significant others from one's past are projected onto a therapist (or others) and influence the therapeutic relationship. Transference informs the therapist about unresolved issues and is used to further the development of the relationship and the therapeutic process.

Countertransference refers to a consequence of transference and is complex in that it has different meanings. For example, the term is used to describe not only a direct personal reaction to transference but also the entirety of experiences in response to another person. The term is used when therapists respond to the patient's transference issues with transference issues of their own. One purpose of psychotherapy supervision is for the therapists to receive feedback and guidance to make them aware of unconscious projections and responses to the patient and the patient's transference.

Throughout psychoanalytic literature, transference is viewed as a source of conflict *and* creativity and can influence life choices, including occupations. A person might repeatedly be drawn to settings, relationships, and people, for better or worse, because of links with previous life events. Consequently, the past and present are indiscriminate. Understanding the concepts of transference and countertransference, therefore, might help nurses understand more clearly the possible genesis of some human behavior and direct the nurse to implement the most effective interventions.

According to Sigmund Freud (1923/1953), a person's early formative experiences *are* critical, and relationships experienced in childhood are mirrored with significant others throughout life. Earlier events manifest themselves in repeated difficulties in relationships, dreams, ambivalence, and errors of speech. Expressions of the unconscious are also thought apparent in art, poetry, and literature (Mcardle & Byrt, 2001). The ideas of transference and countertransference offer a means to unravel the complexities of human life. Unhappiness and conflict can be addressed through understanding unconscious human motivation.

Transference

Transference is a psychoanalytic term referring to undifferentiated associations, in which past issues are reflected into current relationships. Freud (1927/1972) suggested that the transferring of both feelings and thoughts could occur between people and settings and occur unconsciously. An important feature of transference is that it is considered to be many layered, so feelings, thoughts, and attitudes linked to more than one person and to people of different genders can show themselves in current relationships. Transference is considered a form of resistance and a mental defense, called on to protect oneself from unresolved childhood memories. Yet it is also thought to be invoked to bring about positive changes. Freud described transference as "new editions and facsimiles of impulses and phantasies" (1923/1953, p. 82) originating in the past. Instead of remembering, the person transfer attitudes and conflicts are enacted in current relationships, sometimes with unfortunate results. Manifestations are likely to occur in all human encounters; feelings toward the significant other often begin to emerge early on in relationships.

Transference can positively or negatively distort communications and color situations. Strong feelings of attraction, love, anger, rage, or revulsion can be directed to another (or others) because of repressed derivatives of earlier life conflicts (Gabbard, 1995; Plakun, 2001). Fenichel (1960), in an attempt to define transference, noted: "Derivatives can appear as concrete emotional needs, which are directed towards a person [people, situation or setting] who just happens to be present. Resistance distorts the true connections. The person misunderstands the present in the form of the past and then instead of remembering the past he strives without recognizing the nature of his action, he relives the past and to live it more satisfactorily than he did in childhood. He transfers past attitudes to the present" (p. 29).

Reassigning feelings, thoughts, and attitudes from original situations to the present could consequently be considered a fundamental aspect of building our relationships with others and our representations of the

world. Ideas concerning the nature of transference, however, are equivocal. According to Coren (2001), there are fundamentally two viewpoints regarding this complex concept:

1. Transference is comprehensive; everything occurring clinically, between a patient and therapist (or between a person and a significant other) is transferred from other significant relationships. Yet, as Mann (1997) suggested, this view negates the possibility of reality-based behaviors originating in the present moment. All interactions may not necessarily develop from transference or countertransference.
2. "Transference neurosis," also called "classical transference," relates to a person's early experiences with significant others and shows in related behaviors. Positive manifestations of transference can show as attitudes toward another and be seen in the giving of gifts in frank and subtle forms, feelings, and actions of altruism, admiration, and love or erotic feelings for another. Conversely, negative transference can lead to feelings of mistrust, hostility, and in stronger configurations feelings of hatred. (Winnicott, 1949)

Typically, transference is invoked by a specific characteristic of another such as facial features, speech, or perceived yet subtle similarities to the original relationship. This could conceivably include moods, atmospheres, or the poignancy of a situation. For example, a person might view another as he or she believed his or her parent (or other) to have been. Alternatively, he or she might behave toward another as though that person was a desired parent. It is also possible to relate to others, as a parent or in similar ways to which an individual experienced his or her own parent(s) (Suler, 2002).

Countertransference

Countertransference is a response to transference that can complicate or impair communications in various situations. Countertransference is invoked by aspects of transference and is again typified by feelings, thoughts, or attitudes unfitting to aspects of the contemporary relationship. Countertransference can also manifest in positive or negative ways. The main features of both transference and countertransference are the intensity of feelings experienced by a person toward a notable other, feelings that are unfitting to the current relationship (Koo, 2001). Nonetheless, Rolf (2001) recommended that a practitioner should identify repeated and diverging personal feelings in order to discern effectively countertransference issues.

Malan (1979) described countertransference as transference from therapist to patient or a corresponding response to transference. This was a term used to make a distinction between the therapist's and the client's feelings. Manifestations of transference invoke counterfeelings in another related to life experiences with his or her notable others. Affiliations, therefore, might relate to strong links with the past rather than to current reality-based relationships. According to Malan, the term countertransference is neither "elegant" nor an "accurate" term to describe what he considered complex phenomena, subscribing to what might be viewed as an all-inclusive view of transference and countertransference. Malan believed all feelings, attitudes, and thoughts occurring in formal relationships, and between or among two or more people, should be considered (potentially) as derived from transference and countertransference. He also cautioned that vigilance is needed when undertaking psychoanalytic work in order to recognize each as they occur.

Ens (1999) similarly advised that to view countertransference purely in terms of derivations of past relationships would be wrong. She suggests that a definition could more properly include "natural and expected emotional responses elicited in the therapist in the context of his or her relationship with the patient" (p. 322). Because of this all-inclusive view, child analyst Fordham (1996) proposed that expanded views might no longer be helpful.

Expressions of Transference and Countertransference

Other manifestations of transference and countertransference, both positive and negative, may include

perceiving another as an ideal. Under certain circumstances, personal behaviors could be modeled on that person. Persistently arguing and disagreeing or, alternatively, seeking affection from and confiding in another, might occur because of transference and countertransference. A person could have trouble maintaining concentration and lose the ability to articulate thoughts and feelings with a significant other, or else dream about a person and/or become preoccupied with fantasizing. Becoming overinvolved with another is also possible, as is losing objectivity.

Transference serves as a means of alleviating anxiety by preserving the past, so opportunities for self-development are at the same time possible and restricted.

In the workplace, individuals might fail to keep appointments and experience recurrent difficulties with time and a personal or professional boundary, or dread engagements with a key person and feel discomfort throughout meetings. A person might, in some instances, behave toward another as though he or she were unimportant. Repeated misunderstanding of exchanges with significant others and/or persistent preoccupations with issues of confidentiality are possible. Strong feelings of affection or dislike for a person can transpire or, conversely, another is idealized and treated as a rescuer (Koo, 2001; Raphael-Leff, 1993).

While extensive, the examples illustrated are not exhaustive and merely show the complexity of feelings and attitudes that lend structure to human relationships. Coren (2001) viewed transference as a psychological defensive operation or "idiom," much like the vernacular of language through which attempts are made to construct present experience in familiar ways. Somewhat differently, Kennedy (1998) has described transference events as binaries, in which a person is simultaneously in reality and phantasm.

Transference serves as a means of alleviating anxiety by preserving the past, so opportunities for self-development are at the same time possible and restricted. Unlike its close but primitive counterpart, projection (a psychological mechanism through which elements of a person's feelings are repudiated and attributed to others), transference offers a way of restoring the psyche to a situation of equanimity. Transference and countertransference allow opportunities to try out different ways of relating. Nonetheless, a person who is attuned to subtle meanings and nuances of behavior in selective people or settings will have little or no relevance to others. Consequently, events occurring because of transference and countertransference can be perplexing to observers.

Transference and corresponding countertransference are thought not to be limited to therapeutic relationships. With varied intensity, they are, according to psychoanalytical discourse, a part of the whole of human experience, so they form a natural part of the way people establish relationships with each other. Problematic manifestations of transference and countertransference are possible and can go unrecognized, as illustrated in the following example.

Example 1

A competent and articulate nurse is in polite disagreement with her new manager, who is a man. The disagreement concerns a routine work issue that the nurse normally takes in stride. Although the nurse feels sure she has a strong case, she inexplicably cannot express her views clearly to the manager. Frustrated, he criticizes the nurse for not putting forward a clear argument in her defense. The nurse becomes anxiously tearful, incoherent, and childlike; although she tries to relieve the situation, she feels incapacitated by strong negative feelings. Members of the ward staff are puzzled by the unusual behavior shown by the nurse to the

manager. The incident has prompted in the nurse unresolved issues concerning her excessively critical and overbearing father.

This situation shows a conspicuous example of transference with countertransference. In most instances, however, responses to transference and countertransference will likely be experienced in more understated ways. Moreover, as Freud (1923/1953) seemed to suggest, transference may be more often concerned with personal characteristics arrived at throughout maturation, rather than obvious instances of childhood difficulty. Examples from North American literature also illustrate how transference and countertransference are thought to influence relationships outside of therapeutic domains. By way of illustration, Malmquist and Notman (2001) write:

> Courts and regulatory bodies have tended to use the psychoanalytic concept of transference to decide issues in which there has been a complaint of impropriety—be it romantic, financial, or social in nature—arising after termination of treatment. However, multitudes of treatment approaches are currently employed in psychiatry, and often their practitioners either do not use the concept of transference or deny its validity. If the concept is used, it is often present in many settings outside therapy. (p. 1010)

Working relationships have strong potential to invoke the transferring of feelings, thoughts, and attitudes from significant-other relationships to the work setting. Typically, archaic images are imposed on others, sometimes with alarming consequences. Sometimes this occurs independently of the other person; at other times feelings are complimentary or reciprocal and encompass countertransference.

Transference, either positively or negatively, can influence professional rapport:

> A nurse discusses aspects of assessment with a patient, and together they negotiate the boundaries of their professional relationship and possible goals. The nurse noted the patient's initial overcompliance, but took this to be a positive sign that the relationship was progressing satisfactorily. However, as their relationship developed, the nurse began to feel a little uncomfortable because the patient constantly sought her approval and often wondered aloud if he had upset her. It became clear as time passed that the patient viewed the nurse as other than a helping professional and more of a confiding friend, sometimes inquiring about her personal life and asking to arrange meetings outside working hours. The nurse began to worry and dread meetings with the patient. She subsequently began to distance herself from the patient and became overly busy with other activities. She spoke of feeling trapped and stuck in a situation where working together seemed impossible because of the patient's clinginess.

In some instances, occupational transference might be discerned as a texture—that is to say, the difference between feelings of comfort with one person, work group, or setting and discomfort with another. Transference also might influence significant exchanges, again influencing the nature of communications in the workplace.

Characteristically, work environments are relatively consistent. For this reason the likelihood of transference and countertransference occurring between workers is perhaps heightened. Consequently, atmospheres in the workplace, the content and emotional tone of an individual's dreams about work, slips of the tongue and compulsive ways of behaving, and egocentric working alliances assume significance. Each extends rich sources of discerning clues to invocations of transference and countertransference in occupational settings. Dominance, submission, self-abasement, and aggression in the workplace, in some instances, also might be derived from transference and countertransference relationships.

Examples Related to Professional Practice

Kelly (1998) applied the concepts to nursing relationships and discussed ways in which issues of transference and countertransference can lead to strong feelings among

patients, nurses, and other professionals. Sometimes, manifestations are negative and conflict-ridden, and rejections can occur between nurses and patients. Nurses may struggle with feelings of inadequacy. Strong countertransference responses can be invoked by working closely with clients who are resistant to change. To manage uncomfortable feelings, a nurse or other professional may regard a patient as noncompliant (and vice versa), so treatment and care regimens designed to be helpful can be confounded with subsequent personal, professional, and economic penalties.

Strong countertransference responses can be invoked by working closely with clients who are resistant to change.

Robbins (2000) similarly discussed ways in which transference and countertransference can bring about disruptions in relationships. Situations can occur, Robbins suggested, through which a person can be forced to experience the aggression of another because of transference and countertransference enactments. Sadomasochistic relationships are examples that can be acted out between people (or groups of people). In addition, detracting from another's personal qualities can cause profound difficulties in relationships in that for some grandiose self-images are maintained by devaluing others who appear as rivals. Robbins offered a helpful means of differentiating devaluing from other more everyday types of valuation and suggested that, whereas *criticism* can be constructive and include appraisals of qualities, strengths as well as weaknesses, *devaluation* is typically a defensive and hostile gesture, intended to exert control and weaken another.

Other applications of these two psychoanalytic concepts include the assessment of individuals who deliberately self-harm (Jones, 1996), psychotherapy with cancer patients (Straker, 1999), domestic violence (Wexler, 1999), and consultation-liaison. There is, nonetheless, a relative dearth of literature concerning transference in text-based relationships developed online. This new and rapidly developing aspect of communication might offer a useful area for research.

Discussion

Recognizing feelings that may influence the course of relationships in both positive and negative ways seems an important nursing task. Understanding something of how attachments can occur outside of awareness could prove helpful to nursing relationships. A better grasp of what helps individuals develop constructive human relationships along with complexities will likely enhance professional practice, although, as Menzies-Lyth (1988), in her study of hospital social systems, suggested, it is doubtful that "blueprints" will succeed in bringing about helpful changes in the workplace. Subsequently, supervision and sensitivity groups, which accommodate thinking carefully about psychodynamic work and nursing relationships, could have something to contribute, in that they can offer a space away from the work setting to think about the complexities of professional relationships (Winship & Hardy, 1999).

Conclusion

Some understanding of psychoanalytic ideas could prove helpful to understanding difficulties that may occur in professional relationships, whatever the circumstances. For example, when relational difficulties are evident in professional relationships. Addressing all issues in a therapeutic way would be inappropriate. Nevertheless, flexible strategies to deal with problems could be used successfully, including considering whether it is likely to be helpful for some individuals to continue to work together closely.

Acknowledgments. The author thanks Mary Paquette, *PPC* Editor, and the three anonymous reviewers for

helpful guidance. Thank you also to Kevin Mullarky, lecturer in Mental Health Nursing, University of Manchester, and David Menkes, Professor in Psychological Medicine, North Wales Section of Psychological Medicine, Wrecsam, for many valuable comments about this work.

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