Use of Countertransference to Advance Therapeutic Efficacy

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Countertransference is a basic tenet of psychodynamic theory. Although it was initially considered an unwelcome phenomenon in psychiatry, attitudes have shifted, and many mental health professionals now consider it to be a useful therapeutic tool. In this article, the author discusses countertransference as defined by the International Psychoanalytical Association's Inter-Regional Encyclopedic Dictionary of Psychoanalysis (IRED) and examines its clinical impact by using constructed vignettes of psychodynamic psychotherapies to illustrate theoretical points. As IRED delineates, countertransferences may exist at the conscious or unconscious level. In addition, the author suggests that countertransference may also exist at the preconscious level. Clinicians' examination of all levels of countertransference has the potential to be revelatory and facilitate therapeutic action, whereas unexamined countertransference can interfere with effective treatment. For this reason, self-reflection on the part of psychiatrists is essential.

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Countertransference is a basic tenet of psychodynamic theory (1). Although it was initially considered an unwelcome phenomenon in psychiatry (2, 3), attitudes have shifted, and it is now widely considered to be an important therapeutic tool (1) that is relevant for many clinical situations. In this article, I examine countertransference and projective identification as defined by the International Psychoanalytical Association's Inter-Regional Encyclopedic Dictionary of Psychoanalysis (IRED), an online compendium of psychoanalytic concepts. This resource integrates contributions from North America, Europe, and Latin America, with entries of notable depth and breadth representing an international consensus on historical and current psychoanalytic thinking.

After defining countertransference and the related clinical phenomenon of projective identification, I present vignettes to elucidate theory. The cases presented in this article have been constructed to protect patient privacy.

COUNTERTRANSFERENCE DEFINED

IRED defines countertransference as the psychiatrist's "totality of feelings, attitudes, and thoughts" toward a patient (1). The concept may be further stratified into conscious, preconscious, and unconscious levels. On the conscious level, the psychiatrist is aware of their reactions to the patient and recognizes feelings or ideas that may immediately be translated into potentially therapeutic comments. In contrast, more deeply held countertransferences require self-reflection to be recognized and cannot be instantly applied. Of note, there is no time limit on the usefulness of information gained from the exploration of deeply held countertransferences; what is discovered through their examination is relevant throughout treatment, and the central organizing beliefs and relationship templates they elucidate tend to surface repeatedly over time.

More deeply held countertransferences may be characterized as either preconscious—that is, feelings or ideas that are not immediately obvious but quickly become apparent on self-reflection—or unconscious. Unconscious countertransference feelings and ideas become accessible only with sustained introspection, which may be accomplished through independent self-reflection, discussion with peers, supervision, or one's own treatment. Unexamined unconscious countertransference is often lived and acted on rather than thought or known (1). As a result, these countertransferences may contribute to the presence of blind spots and enactments that have the potential to hinder or disrupt treatment; commonly, they involve projective identification.

PROJECTIVE IDENTIFICATION DEFINED

Projective identification, whereby one's unacceptable feeling states are split off and projected into another person but remain recognizable as part of the self, is an unconscious defense mechanism (4) and an early form of unconscious communication. It is present from birth (5). Ridding oneself of intolerable states by expelling them serves as an unconscious defense, whereas causing the other to feel some version of one's experience is a form of unconscious communication.

The denial of intolerable states through projection reinforces rigid internal relationship templates whereby two absolute ways of being (roles) relate in fixed ways. Examples may include a powerful versus powerless role, an uninvolved versus a dependent role, and an oppressed versus oppressing role. These fixed relationship dualities shape both external and internal relationships. Externally, for instance, a person may use projective identification to manage unbearable feelings of helplessness by evoking feelings of helplessness in the other and, in so doing, feel powerful themselves. Internally, a valued logical part of the self may debase a disdained emotional part, deriding it for being weak. Addressing paradigms that shape external and internal relationships has a great therapeutic impact and is facilitated by countertransference, the psychiatrist's Richter scale for registering projection-related phenomena.

The psychiatrist must periodically examine their countertransference and tease out their experience from their patients' projections, which is a challenging task. After applying what they learn from that examination, the psychiatrist puts into words what they believe has unfolded, or is unfolding, in the treatment, usually over the course of many sessions. Through this process, the psychiatrist's understanding of and compassion for the patient are enhanced. They attempt to verbalize the patient's struggles as best they can, having experienced some version of those struggles via projective identification. Containing, processing, and, finally, articulating a modified form of what the patient originally "sent out" via projection make it possible for the patient to consider what previously had to be denied, expelled, or expressed unconsciously through action.

Receiving projections may induce the psychiatrist to behave as the patient's associated template commands. If, for example, the patient projects an aspect of themself that feels oppressed, the psychiatrist may find themself feeling trapped and without choices, saying little during a session. Alternatively, the psychiatrist may behave in an uncharacteristically authoritarian manner. Both of these reactions stem from the same relationship dyad that exists inside the patient. Here, the dyad consists of oppressed versus oppressing entities. As a result of projective identification, the psychiatrist is unconsciously drawn into relating in accordance with the reigning dyad and is pushed to adopt whichever role complements the patient's position. In this way, what is inside the patient is sent outside, into the psychiatrist, affecting the psychiatrist's feelings, thoughts, and behaviors—often without their awareness.

Consider the following example. A patient who has been in a string of abusive relationships talks about the despair she feels in response to her current boyfriend's relentless belittling, then abruptly changes the subject by criticizing the psychiatrist's office furniture. Caught off guard, and somewhat offended, the psychiatrist notices that memories surface of being taunted by classmates in school. This awareness helps in recognizing the patient's attack-or-be-attacked paradigm, a relationship template identified in earlier sessions that the psychiatrist had a chance to address in their own supervision and treatment.

As a result, rather than arguing or apologizing or avoiding the topic, the psychiatrist replies to the patient, "When you were telling me about your boyfriend's attacks, I wonder if you felt not good enough. Maybe it was a relief to focus on my office and have me be the one [who is] not good enough." In response, the patient quickly apologizes to the psychiatrist and says she didn't mean to be insulting. The psychiatrist recognizes this apology as the other side of the same attack-or-be-attacked dyad and floats an idea: "I wonder if what I just said might have felt humiliating, not unlike your boyfriend's criticism." The psychiatrist chooses the strong word "humiliating" because their personal memory suggests that it may resonate for the patient, having been evoked by projective identification. The patient becomes tearful in response to the comment, describes multiple humiliating incidents she has lived through, and then recognizes a pattern: to feel safe, she insults others. "The best defense is a good offense," she says quietly.

This previously unconscious relationship template, one that has trapped the patient in rigid roles and contributed to her involvement in serial abusive relationships, can now be slowly examined and modified. Next, I present other vignettes to more fully consider countertransference, starting with the levels that are most conscious.

VIGNETTES

Conscious Countertransference: Immediately Obvious

Case 1. An established patient enters my consulting room from the waiting room and stands, slowly removing their scarf and gloves and coat, then folding and setting each item down with care. I notice that I am feeling impatient, and I have the thought, "Why is this so involved today?" Aware of my countertransference, I reflect once the patient sits: "It seems like something is making it hard for you to get comfortable today." The patient sighs and shares that they don't want to say anything bad about their partner because it feels disloyal, but they just had a big fight. They reflect that their partner's idea of loyalty often leaves them feeling isolated. They then examine some of their wishes and fears surrounding commitment.

Case 2. A new patient repeatedly raises his voice and talks over me when I speak. I feel shut down and notice myself thinking, "He's not interested in anything I have to say." When an opportune time arises, I comment, "You seem to want me to be quiet and just listen." After a pause, the patient explains that to hear what I say means he has to leave his own thoughts. He shares that this reaction has been taking place for his whole life, with everyone, and is probably why he feels like he doesn't know what he thinks or wants, or sometimes even who he is.

In each of these cases, my articulating what I imagine is happening for the patient in response to immediately

available countertransference cues enables the patient to access internal experiences, feelings, and thoughts in a new way. This articulation facilitates further exploration and supports therapeutic efficacy.

Preconscious Countertransference: Quickly Accessible on Self-Reflection

During an initial evaluation, a young substitute teacher and amateur writer says little and keeps his face averted. When he stands at the end of the appointment, we make direct eye contact for the first time, and I observe epicanthal folds; a long, smooth philtrum; and a thin upper lip, features indicative of fetal alcohol syndrome.

On reflection, I realize I had associated this patient with many positive characteristics, which affected my clinical judgment. I had attributed his anxiety and depressive symptoms to an artist's struggle to support himself and had made favorable assumptions about the patient's intelligence, creativity, and perceptiveness. I had minimized the problem-solving difficulties he described having had since childhood and downplayed his reports of feeling jittery for as long as he could remember, traits that are also consistent with fetal alcohol syndrome.

Viewing the patient literally straight on revealed my preconscious countertransference. With this new information, I realized the high likelihood of this patient having real limitations. My romanticized notion of struggling writers had influenced what I had seen, heard, and focused on, as well as the conclusions I had reached. My awareness of my bias allowed me to create a more accurate formulation and provide more effective treatment.

Unconscious Countertransference: Accessible With Sustained Self-Reflection

Blind spots: warded-off countertransference. Countertransference thoughts and feelings that conflict with the psychiatrist's ideal version of themself may be repressed. Existing outside awareness, these repressed thoughts and feelings form blind spots that interfere with the psychiatrist's ability to observe and reflect during and after sessions (1).

A patient who has been coming twice a week for psychodynamic psychotherapy asks to decrease her meeting frequency for three months because she expects to be very busy. Because this patient had recently commented on the importance of our appointments, her request surprises me, but she is unwilling or unable to discuss matters further, simply repeating, "I'll be very busy" when the topic comes up over a number of weeks. Eventually, I agree to the temporary decrease. However, instead of being pleased, the patient expresses that she feels hurt and mistreated.

Given this reaction, it becomes clear that I had missed something, perhaps warded-off thoughts and feelings that were unacceptable to me. I decide to examine my countertransference more closely.

On initial self-reflection, I recognize having felt frustrated by the patient's insistence on altering the treatment frame, but nothing else surfaces—certainly no wish to hurt her—that would be inconsistent with my view of myself as helpful (i.e., that would contradict my self-ideal as a psychiatrist). Further introspection, however, uncovers more feelings, and I begin to see what I had been blind to: feeling thwarted, exasperated that my skills were being cast aside, and angry at the patient for creating this situation. This new awareness leads me to conclude that, although I consciously agreed to reduce the number of the patient's appointments in an effort to accommodate her and be flexible, my decision also provided a way out of a frustrating impasse for me and was a rejection of the patient. It communicated the message, "Fine—go."

Exploring all levels of countertransference earlier would have revealed what was brewing and perhaps prevented the enactment. However, I had closed down in order to ward off reactions (anger and impotence) that are inconsistent with my self-ideal (compassionate and effective). After some introspection, I might have suggested, "My not agreeing to decrease our meeting frequency and asking you to talk about it is frustrating; it makes you feel cornered, like you have to dig in." The patient's response, whatever it was, would have served as a springboard for further exploration.

Instead of trying to put the patient's states into words while tracking my thoughts, feelings, and impulses, I relinquished my therapeutic stance by agreeing to her request. In so doing, I participated in a countertransference enactment.

Enactments: unresolved unconscious countertransference discharged into action. Countertransference enactments can negatively affect treatment. It is easy to imagine the above example leading to a therapeutic rupture. However, addressing events in sessions that follow enactments can be opportunities for growth.

IRED suggests that enactments are shaped by the patient's unconscious fantasies, which are communicated to the psychiatrist unconsciously. Essential here is the notion that the psychiatrist is a cocreator of events (1). In the example presented, the patient and I had enacted a recurring interpersonal experience for her: abandonment. We had cocreated an "interactive, mutually constructed drama" (1) in line with her predominant unconscious fear. I had played my part in this drama, fueled by unexamined unconscious countertransference.

For days after the enactment, I review the treatment and search my deepest levels of countertransference (Box 1). I recall the patient describing feeling angry, trapped, devalued, and confused in relationships, and I recognize this state as remarkably similar to the one I had been struggling with. Was it communicated through projective identification? The patient had also routinely described feeling used by the people on whom she relies, in part because of betrayals she survived growing up. The corresponding internal

relationship template may be conceptualized as consisting of a needy self and a distracted, unreliably present other.

It follows, then, that the patient's growing awareness that she had begun to count on our meetings (as indicated by her recent expression of appreciation) made her feel vulnerable. It seems likely that she was unable to tolerate feeling dependent on me, and so she projected the needy aspects of herself. As a result, she did not need to meet; her request to decrease our meeting frequency proved that. I was the one who needed to maintain our schedule, and my insistence that we do so was unreasonable (i.e., I needed too much).

Projection of this needy part of herself allowed the patient to restore a safe equilibrium. However, I did not want these projections. They felt bad. As a result, I rejected my role as the one who needs and took on the role of one who is indifferent ("Fine, go; whatever"), and I agreed to decrease the frequency of her appointments. The patient, in turn, felt hurt and mistreated and saw me as an uncaring, self-absorbed other, which became evident in the material she shared in subsequent sessions. We had enacted her unconscious fear of being cast off in response to feeling dependent.

I explore my reaction to being seen as rigid and needy, the state that led to my saying "yes" to her request, and reconsider the patient. Through this lens, it seems likely that she had felt exposed and ashamed and disappointed in me for not understanding what she was going through, as well as desperately invested in not feeling any of those things.

In the next session, I offer the view of the patient's experience that I had gained from self-examination. I present it as one way of understanding recent events. Whether my hypothesis is correct is inconsequential. What is important is my construction of a thoughtful idea as a starting point for discussion. I say, "When I didn't agree to decrease our meetings, I think you felt like I didn't understand the pressure you're under, but when I did agree, I think you felt rejected. Both feelings are hard. Still, I think they may be easier than letting this treatment feel important to you."

The patient answers, "The feelings aren't hard." After a pause, she adds, "Well, maybe they are. But the hardest part is you not stepping up for me." She recalls her parents "letting" one sister overdose twice and another sister take "ridiculous risks" without intervening. Like them, I had left the patient in need, alone, overwhelmed, and in danger. She asks, "Isn't it your job to say no to things I want that aren't good for me? To make sure I'm safe?"

It is my job to a certain degree, but it is also my job to help the patient explore those expectations. Over the next several weeks, she expresses her disappointment in me and recognizes and articulates feeling angry with me and with her parents. She grieves aspects of her treatment and of her childhood. I accept my role without burdening the patient with self-disclosure and keep her dependent-uncaring relationship template in the back of my mind as I listen, addressing it with carefully timed comments as we proceed, while tracking my countertransference.

BOX 1. Recommendations for psychiatrists with regard to handling countertransference in practice

- Examine conscious, preconscious, and unconscious levels of countertransference to facilitate therapeutic action and avoid blind spots and disruptive enactments.
- Reflect on sessions after they have ended in order to elucidate countertransference material.
- Maintain an attitude of curious nonjudgment during introspection and self-reflection.
- Use countertransference to empathically understand and articulate the patient's experience.
- Describe what is happening in treatment (i.e., identify and address the internal relationship templates at play rather than behaving as they dictate).

CONCLUSIONS

In this article, I examined countertransference and projective identification. Using IRED, I defined the psychodynamic concepts of countertransference and projective identification and applied them to constructed case examples in order to demonstrate their potential impact on therapeutic effectiveness.

I advanced the theory that countertransferences may exist consciously, preconsciously, or unconsciously. Unconscious countertransference colored by projective identification often results in the psychiatrist's inadvertent adoption of specific roles in relation to the patient as determined by the patient's internal relationship templates. Living out these roles reinforces them. Exploring countertransference allows the psychiatrist to recognize the templates at play and address them during a session rather than to unconsciously behave in accordance with them (Box 1). This exploration makes modification of problematic patterns possible for the patient. Unexamined countertransference, on the other hand, can result in blind spots for the clinician and mutually created enactments. For these reasons, psychiatrist self-reflection is essential. Self-examination can be undertaken independently, in discussions with peers, during supervision, or in the psychiatrist's own personal treatment.

Tracking countertransference and articulating what the patient has previously only unconsciously felt or acted upon fosters patients' ability to tolerate difficult states and regulate their emotions. These processes lead to the internalization of a thinking, interested, and compassionate other (psychiatrist) who supports the patient's compassion and curiosity (toward the self and others) as well as their ability to reason, remember, and solve problems. In turn, the patient's reliance on projective identification as a defense mechanism is reduced and more adaptive defense mechanisms can emerge, along with a more integrated view of themself and others. As a result, disappointment becomes more tolerable, and patients become better able to forgive, grieve, and continue on with greater resilience.

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