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Transference and Countertransference¹

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This scope of this paper is limited to [TAP 21-A]² Performance Domain 1 and the clinical supervisor's role in providing support and training for Alcohol and other Drugs (AOD) counselors in regard to transference and countertransference. The focus of this article will be a review of effectively identifying issues that arise from transference and countertransference, the warning signs that transference is negatively impacting the counselor patient dyad, and strategies for making adjustments to correct negative transference. Countertransference and transference issues that emerge during the interaction between the counselor and client can become pathological and personally or socially harmful or these positive aspects of transference may be capitalized on to support rapport and the therapeutic alliance.

Transference is a term denoting attribution to the counselor via projection of subjective unconscious emotions, ideas, and motivations; sometimes it connotes the total analytic relationship" (Transference, Jung, 1946, p.135). In essence when something about someone reminds the client of someone or something in the clients past the client transfers emotional and psychological needs from the past into the present.

There can be both positive and negative transference between the client and the counselor. In positive transference the client likes the counselor based on feelings, or past memories, and negative transference occurs when the opposite is true. Wachtel (1993) describes a much more context driven transference and countertransference relationship. Wachtel asserts that it is one thing to know that seeing others as hostile may come from past experience. It is another thing if the client "also understands *when* such a tendency is most likely to be evoked, what behaviors or characteristics of others tend to elicit this particular proclivity, his understanding is much more precise and differentiated" Another aspect of this more context driven way to look at the

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transference relationship on the part of the client is that it allows “a greater sense of authenticity and spontaneity because his strengths are pointed out along with his weaknesses” (Wachtel, 1993, pp. 59-60).

There are many reasons that the concept of transference and countertransference are important to addiction counselors. Primarily most addiction counselors are or have struggled with similar issues as those the client brings to the counselor client dyad. This is important because when the counselor identifies with someone based on the fact that they remind the counselor of someone from the past the counselor's experience is described as “Countertransference.” Countertransference arises from the counselor's subjective experiences as a response to engagement in the counseling process. The countertransference is what the counselor projects onto the client and includes certain emotions and attitudes. A consensus has developed that countertransference experiences are best understood as compromise formations between forces that impinge on the mind of the counselor. These include the counselor's “perceptions and understanding of the client, the projections and covert messages contained in the client's communications, and the memories, phantasies and conflicts aroused in the counselor by these communications” (Heninmann, 1950, p. 82).

It is a reasonable assumption that both “transference and countertransference issues lie in the dialectic process between two persons in which each is equally involved” (Jung, 1946, p. 136). Jung's theory is very different from Freud's original formation of these concepts. Freud's theory of transference was that it arose most easily when the therapist was the “tabula rosa” or blank slate of doing very little interaction (Wachtel, 1993, p. 54). Therefore transference and countertransference are two aspects of the same process: the dialectic relationship. Treatment is nothing but the mutual influence in which the whole being of the counselor as well as that of the client plays its part. Wherein lies the primary difficulty experienced by counselors working with dependent clients.

Restoring the client to a condition of wholeness involves restoring the ego to aspects of the client's mind content which is capable and should normally be a component of the conscious mind (Jung, 1946, p.13).

Arguably transference and countertransference issues with the alcohol or other drug dependent client are different than those in non-dependent clients. Analytically speaking the term dependence is not simply referring to a drug, but to dependence on any person, drug, or activity which provides the client with pleasure and relief from psychic pain (Arroyave, 1986, p.202). This also brings to mind the ideas of internal versus external locus of control to which we will return later. The client's boundaries, developmental tasks, emotional maturity, dependent or addictive behaviors, and coping strategies all play important roles in the success or failure of the dialectic relationship. One of the key processes in the formation and therapeutic values of the dialectic relationship is switching the external tension reduction or alcohol to the therapist (Krueger, 1982, p. 601)

This process may be difficult when the counselor shares an identity relationship with the client. Identity relationships are conscious or unconscious perceptions of self. Krueger (1982, p. 599)

states: “The countertransference reactions may stem from reactions to:

1. the drinking behavior;
2. the alienating, provoking, characterological features of the patient; and
3. the countertransference to the client's character pathology” (p.599).

These beliefs, attitudes, and perceptions of self are those events, relationships, and experiences the counselor brings to the counselor client relationship. As such these perceptions are the basis for empathetic response or reaction formation to the client and the client's perceptions of self. Empathetic response is an integral piece of the person-to-person relationship and allows the counselor to get into the closest possible relationship with the client and address the client's psychological development. Jung explains:

One could say that in the same measure as the doctor assimilates the intimate psychic contents of the client into himself; he is in turn assimilated as a figure into the client's psyche. I say ‘as a figure’ because I mean that the client sees him not as he really is, but as one of those persons who figured so significantly in his previous history. He becomes associated with those images in the client's psyche because, like them, he makes the client divulge all his intimate secrets... the transference therefore consists of a number of projections which act as a substitute for a real psychological relationship, and this is very important, since it comes at a time when the client's habitual failure to adapt has been artificially intensified... (Jung 1946, p. 136).

Accordingly the client relates to the counselor in order to adequately meet the psychological needs in response to recovery. One could say that the client uses the counselor as an external locus of control. This relationship is one that requires trust and nurturing. This may be difficult due to the incidents which have placed the client in recovery. If the client was coerced into recovery via legal, or familial concerns the transference from the client to the counselor involves the unconscious redirection of feelings based on past relationships that initiated the coercion into treatment. This experience can become a positive phenomenon. Jung suggests that this is:

A bond established by the transference- however hard to bear and however incomprehensible it may seem – is vitally important not only for the individual but also for society, and indeed for the moral and spiritual progress of mankind. So when the counselor has to struggle with difficult transference problems, he can at least take comfort in these reflections. He is not just working for this particular client, who may be quite insignificant, but for himself as well (Jung, 1946, p. 234-5).

The client turns to the counselor as the human relationship that guarantees some successful alleviation of the psychic pain and turmoil that was experienced during the addictive state. In many instances the counselor is viewed as the person that has successfully completed the transition from addiction to a normal lifestyle. The client's transference of unconscious expectations about recovery becomes the focal point of the recovery process. This is considered pertinent to the client and the counselor and can be true even if the client is coerced into treatment. This appears to indicate countertransference and transference compliment each

other to provide a common ground upon which the client and counselor can build a therapeutic alliance. Stated another way the client and counselor use the dialectic relationship to work towards mutual understanding based on what may be unfounded transference or countertransference beliefs.

Conditions for change in the counselor patient dyad are impeded when the counselor restricts the patient's options out of fear that the patient will choose poorly and the counselor will lose control. Roger's theory on conditions for *therapeutic change states*:

For constructive personality change to occur, it is necessary that these conditions exist and continue over a period of time:

- Two persons are in psychological contact
- The first, who we shall term the client, is in a state of incongruence, being vulnerable and anxious
- The second person, who we shall term the therapist, is congruent and integrated in the relationship
- The therapist experiences unconditional positive regard for the client
- The therapist experiences an empathetic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client
- The communication to the client of the therapist's empathetic understanding and unconditional positive regard is to a minimal degree achieved

No other conditions are necessary. If these six conditions exist, and continue over a period of time, this is sufficient. The process of constructive personality change will follow (Rogers, 1957, p. 96).

In reading the above list the question arises: "What is psychological contact?" This question may relate to the earlier quote from Jung (1946, p. 136) which speaks of transference "as a substitute for a real psychological relationship". If transference is "projections" - presumably from past relationships, or situations, - then how does the alcohol and drug counselor have a relationship which is not based on projections? One projection of the counselor to the client could be the expectation that what worked for the counselor should also work for the client. Another projection could be one based on a co-occurring disorder diagnosis. Because one client from the past with Anti-social personality disorder had a particular outcome does not mean that the one in the present will have the same outcome. Even if multiple cases' from the past turned out the same does not mean that a similar case in the present will turn out that same way. The counselor should be paying ongoing attention to the ways in which the interventions affect not only the therapeutic relationship but also the clients' motivation. The job of the supervisor is to help the beginning counselor establish a framework in which to get better at the counseling work. Gone are the days when programs could claim treatment success because the client left after 30 or 90 days of inpatient client sobriety. Client treatment success is measured now by what has happened 90 days after treatment if not six months or one year later.

In Rogers (1951) landmark work: *Client-Centered Therapy* he explains why transference is not a problem in his system (p.197-218). In the course of a discussion on the counselor-client

relationship Rogers makes the statement; “The whole relationship is composed of the self of the client, the counselor being depersonalized for purposes of therapy into being “the client’s other self.” (p. 208). An implication of this statement is that the counselors’ value system is as much as possible put aside so that the client’s value system can become much clearer to the client.

A good supervisor provides the counselor with oversight that will help develop three personal characteristics, or attitudes, from the therapeutic relationship: congruence, unconditional positive regard, and accurate empathetic understanding. Using these characteristics and the client-centered reflective technique the counselor helps the client gain clarity about tasks and goals.

Congruence is the most important of the three personal characteristics and exists in a continuum where inner experience matches the outer expression of that experience. It is the ability to openly express negative and positive attitudes about self. This may include expression of anger, frustration, liking, concern, boredom, annoyance, etc. In this aspect of the dyad self-disclosure between the counselor and patient must be appropriate.

Unconditional Positive Regard of the client by the counselor is the deep and genuine unconditional caring and acceptance of the client as they are. It should be understood that it is not possible to genuinely feel acceptance and unconditional caring at all times. The client is not evaluated on good or bad, rather judgment is based on the patient’s feelings, thoughts or behaviors.

Accurate, Empathetic Understanding is when the counselor understands the client’s experience and feelings as if they were his/her own, without becoming lost in those feelings. This allows the counselor to see the world through the client’s eyes and facilitates a deep subjective understanding of the client in the here and now.

Transference issues become especially difficult if the inappropriately expressed actions, thoughts, and emotions of the client cause the counselor to address the client’s issues as if they were the unattended issues of the counselor. Commonly this is referred to as living vicariously through the client.

For example: A client recently released from prison presents for treatment at the request of the parole officer. After completion of the appropriate paperwork the client is placed in the care of a counselor with a history that includes recidivism and recovery. The client seeks information from the counselor that validates that the counselor understands the client’s adversity. The conversation explores the counselor’s past experiences and via countertransference the counselor’s inappropriate thoughts and emotions from the past are drawn into the present. This draws the conversation away from the client and towards the counselor. The counselor becomes the client and the client becomes the counselor. This role reversal and is one of the warning signs of negative transference. Below are several other red flags a supervisor should be aware of when supervising counselors.

- The counselor appears to be preoccupied with one client’s success more than other clients on the counselor’s caseload

- The counselor shows affection for or speaks of the client in endearing terms
- The counselor makes exceptions for the client beyond those considered for other clients
- Counselor is unusually demanding of the client and expects a greater degree of compliance to program rules
- The counselor is argumentative or defensive when questioned about the client.

Transference and countertransference are integral parts of the therapeutic process. They commonly occur and are not pathological unless they are personally or socially harmful. When a person transfers feeling from the past that they experienced with parents or others to the counselor this typically creates tension between the dyad because they are opposites. It is from the tensions created between the counselor and the client that allows the client to grow and transform.

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