TRANSFERENCE AND COUNTERTRANSFERENCE

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I first came to Australia as a migrant in 1973 and became an Australian citizen. I lived in Melbourne until 1978.

I returned to Argentina, where I graduated as a Psychologist and worked in a clinical setting for 11 years. I worked in mental health hospitals, welfare institutions and private consulting rooms, assisting individuals, couples, families, children and adolescents.

Over the period of my career as a Psychologist, I have completed a number of professional development courses, training and seminars. I returned to Perth in the year 2000 and I continued studying extensively.

I have been working at Asetts since May 2001. I began work as a volunteer assisting the Early Intervention Service. I then worked as an Early Intervention Caseworker until I was employed as a Counsellor/Advocate.

Through working at Asetts, my experience and interest in the field of trauma and torture has increased. I have learnt a lot about torture and trauma issues and I have become passionate about the subject. I am also committed to working cross-culturally, having myself a family history of migration.

Trauma and torture does not only affect clients, it also causes a secondary trauma in counsellors, consequently, it is very important for us to understand the impact of the trauma and the way it affects us, as well as to debrief and to have regular supervision sessions and other ways of detaching from the stories we hear. (e.g. to attend our own counselling sessions, to keep our mind and body healthy, to get enough sleep, time to relax and having social support).

In my professional capacity, one of the themes I am most interested in is that of transference and countertransference, and the important role they play in our profession. We, as counsellors, have to overcome many obstacles that we find in the treatment of Post Traumatic Stress Disorder (PTSD).

For a better understanding of the client's history, we do not only have to constantly work with boundaries and recognise ethical values, but we also have to take into account, transference and countertransference and how we should deal with these issues in everyday treatment.

Definition of Transference

When Sigmund Freud developed his theory the first thing he had to take into account was his own reactions whilst interacting with his clients. Once he overcame his reactions, (the emotions, as well as identification with some clients), he was ready to develop the concept of **transference.**

Transference means a movement from the client over to the therapist, of the client's former emotions, these could be friendly, hostile or ambivalent. These emotions originate in childhood. The client projects his irrational emotions and his memories of meaningful experiences, fantasies, and magical expectancies onto the therapist. The client then changes the reality of his objects, providing them with the qualities of the past, judging and treating them as he did in the past. In other words, the client projects unconsciously over to the therapist, his feelings, childhood emotions and experiences. This is to say that

a client would see in his/her analyst and will experience towards him/her the same desires and prejudices that he/she had towards his parents or carers.

Transference in its more specific form refers to the narrowing of this phenomenon into the area of greatest conflict and the expression of it within the psychotherapeutic situation or onto the person of the therapist.

Definition of Countertransference

The therapist is also a human being who has a history and unconscious desires. He/she then experiences the same process as the client and sometimes he/she re-enacts his/her traumatic experiences through the client history. This process is called **countertransference.**

Countertransference refers to psychodynamic phenomena in therapists rather than patients/clients. In its general sense, a countertransference is any emotional response on the part of the therapist consciously or unconsciously derived and arising from the dual unfolding aspects of treatment between client and therapist.

Trauma-Specific Transference

The terms transference and countertransference traditionally refer to the reciprocal impact that the patient and the therapist have on each other during the course of psychotherapy.

In the treatment of PTSD and comorbid states,(that is to say the trauma present prior to PTSD), transference processes may be trauma specific and/or generic in nature, originating from pretraumatic life course development as well as from traumatic events.

Trauma-specific transference reactions are those in which the patient/client unconsciously relates to the therapist in ways that concern unresolved, unassimilated, and unconscious aspects of the traumatic event.

These reactions include affective states (emotions, such as anger, anxiety, or happiness), behavioural tendencies, and symbolic role relationships. (By symbolic role we can understand the therapist taking the place of the mother or father's role). In the context of a safe-holding environment, the Trauma-specific transference (TST) reaction includes the tendency of the client to focus on the particular dynamics of the traumatic life event. The client casts the therapist into one or more trauma-specific roles through the transference process. (The therapist can take the place of the rescuer, perpetrator, or supporter).

The therapist, in a complementary manner, may feel as though he or she has entered one of these particular roles as part of the countertransference process. Countertransference positions (role enactments) range from positive (the therapist becomes a fellow survivor or a helpful supporter, rescuer, or comforter near the trauma) to negative (the therapist becomes a "turncoat" collaborator or hostile judge). In the worst case, the therapist may be seen as the perpetrator during a re-enactment in the therapy.

Now the role and dynamics of specific feelings evoked by the treatment situation, affective responses (therapist's emotional state) and the cognitive processes (both defensive and integrative) are significant in the advancement of assessments, diagnosis and treatment of (PTSD). Clinical work with survivors of PTSD commonly elicits strong affective reactions in the therapist, which may cause a rupture of empathy, a disruption in the treatment process, or treatment failure. For these reasons, it is especially important to understand affective responses.

The special nature of the interaction between a traumatised person and the therapist sets the stage for a broad range of empathic strain in the treatment situation. The empathic strains are forms of the therapist's response to the distress and pain manifested by the trauma survivor.

The empathic reactions, cognitive attributions, and defensive enactments only become countertransference when they cause the therapist or helper to leave the therapeutic role, leading to empathic strain or a rupture of empathy.

Countertransference responses during the course of treatment have a range of effects: they may delay or impede the telling of the trauma story: they may reproduce defences from the time of the trauma; they may reveal complementary components of the trauma story that are too painful to remember. Finally, in certain circumstances, countertransference processes may be the only available road to otherwise unacknowledgeable truths.

Summary

Countertransference reactions are unavoidable and integral to our work.

It is very important for the therapist and the client to work through these reactions to overcome difficulties in order to optimise the work of professionals, taking into account the self-care of the psychotherapist.

If we can integrate professional, ethical values and be able to listen, study, learn, explore, understand, train in order to assist survivors of torture and trauma and future generations, we will be able to offer the right kind of help for the recovery and the healing of our clients.

Edited and adapted from:

- Freud, Sigmund : Complete works. Second Volume. Translated from German to Spanish Language by Ballesteros. Edited by Bibiloteca Nueva. Madrid- Spain. 4th Edition: 1981.
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- Lindy, Jacob D. and Wilson, John P.: Countertransference in the Treatment of PTSD. - Empathic Strain and Countertransference. -1994 The Guilford Press, New York.

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