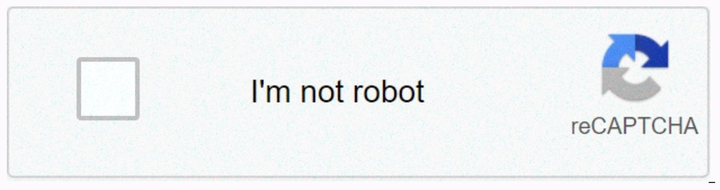

Continue

Transference and countertransference social work

This is an intermediate level course. After completing this course, you will be able to: Define and describe the transfer both as a therapeutic construction and as a therapeutic process. Define and describe countertransfer as both therapeutic construction and therapeutic process. Discuss archetypes most likely to trigger transfer and countertransference during non-analytical therapy. Identify how therapists are likely to contribute to the transfer and phenomena of countertransfer in their clinical activity. This course is based on the most accurate information available to the author at the time of writing. Cognitive psychology and the findings of neuroscience in terms of brain development, structures and activities continue to shed light on what was once considered only psychoanalytic concepts and processes. As a result, new information may emerge to replace some explanations in this course. This course may cause disturbing feelings in readers because of their own unresolved conflicts, but it also provides them with information about the processes by which they could resolve these conflicts. Introduction Sketch Contemporary Environments and Neuroscience Progress Language, Cultural Diversity, and context Phenomenon called Transference Transference: Classic Definition Transference: Totalistic Definition A description of transfer for non-analysts Phenomenon called Countertransference Countertransference: Classic Definition Countertransference: Totalistic Definition Descriptors of Countertransference A definition of Countertransference for Non-Psychanalysts Triggers Transfer and Archetypal Countertransference Material is embedded in the Culture Final Thoughts Footnotes References Introduction Transference and Countertransference are mental processes that allow us to move into the past from a setting to another. We do it unconsciously. Sometimes we benefit from this displacement, although usually only temporarily. But most of the time, sooner or later, we create problems in our lives and those with whom we interact because the past is not the present and one setting is not another, despite their similarities. We might think that these two unconscious processes won't interfere with our therapeutic efforts because we're not psychoanalysts. Transfer? Not. We focus on conscious processes. We help customers restructure the thoughts they articulate. We help them manage their feelings as they arise. We help them change their behavior. Countertransfer? Not. Before, during and after sessions, we deal with personal issues that become obvious, if not for us, then for others. Unfortunately, this presumption is incorrect, since transfer and counter-transfer take place outside the realm of consciousness. They take place in session after session, without us knowing whether we are trained to deal with them or not. In addition, they are powerful, ubiquitous, and ubiquitous. they have the potential to either do our work extremely or to diminish - even prevent - the good we hope to do. Hence the wisdom to become aware of the phenomena that are happening beneath the surface of our work, followed by their use in such a way as to become benevolent mediators and moderators of the positive therapeutic result. We can't stop them from being double-edged swords, but we can use respected psychoanalytic theory and noteworthy psychodynamic research to become competent in the fields of transfer and countertransfer. Now, for a theoretical, research-based presentation. Living deep in the unconscious mind where there is no time (Freud, 1917), transfer and countertransfer become activated when similarities arise between then and now, as well as here-and-there. Already encoded in subcortical neural pathways, the material in our unconscious mind is propelled into our conscious mind as we try to deal with the psychological phenomena - usually painful - that we face. With the help of brain activity, I unconsciously re-surfaced and re-enact conflict-ridden experiences as if the past were present and one setting were another. We transfer thoughts, feelings and attitudes, especially about people who look like others. We assign them roles once played by others. We assume old roles ourselves. All unconscious. Why are we doing this? For at least two reasons. One of them is that we have had conflicts in the past and/or within a certain framework. They were intrapersonal, interpersonal, or both. The ones we could fix, we did. The ones I couldn't, they stay. All conflicts are painful. Unsolved conflicts are twice painful. Because we have to get rid of the pain, our brain has been evolutionaryly programmed to try to resolve the conflict by repeating or reconstituting it. She unconsciously concluded that these methods would work sooner or later. In other words, we will be better off once a new experience replaces the memories of a past or other event. Thus, if our relationship with our mother was conflicted because, although she should have loved, she was abusive; we assign a maternal role to our spouse and a role as a child ourselves. We hope, indeed, unconsciously I believe, that in this reenactment our husband will treat us better than our mother did in childhood. Our conflict will be resolved and our pain will be replaced by a sense of well-being. A second reason is that we live in fear - indeed terror - of some things that happened at the beginning of our lives, starting with our birth

and shortly afterwards a death that we witnessed. Our little goldfish or our loving grandparents have died. They shouldn't have, but they did. Thus, we are left with a painful conflict: What we don't want to happen, happens. We don't have the power to stop him. We should have the power, but we don't. however, we find that we can escape our emotional pain by projecting it: by transferring it from within us to ourselves. We give our parents power over death, for example, by listening carefully when I tell them to pay attention to traffic before crossing the street lest we get killed. Then we prove it by obeying them. Crossing the street so they say we should, we enjoy the illusion that death has no power over us. We need help. That's the good news. The bad news is that we are not solving our conflict because of the desire to prevent death and the lack of power over it. So we try again and again to get that power through the transfer process. In other words, the initial transfer solves our problem. It's a creative projection (Becker, 1973, 158) of something inside us for someone outside of us. It serves an adaptive response to our need to enhance - indeed, to expand - ourselves. It allows us to survive with the help of others. We can transfer our terror to the inevitability of death - over which we are powerless - to others. According to Becker (1973), transfer is an illusion, but an illusion that improves our lives (158) that brings us comfort. Indeed, transfer is actually necessary for our psychological well-being when we use it. It's the benevolent edge of a double-edged sword. The malevolent edge? Our relief is only temporary. Others will inevitably fail to live up to our expectations that they can prevent death from happening. That's what's going to happen, and then our emotional pain will come back to life. Our sense of well-being will give way to the pain inherent in our original conflict: the desire to prevent death – indeed, to be responsible for life – but not to be able to do so. At the same time, because we benefit from the transfer, we continue to use it. Our relief, however temporarily, serves as a positive consolidation. We were programmed by operational conditioning to repeat the process. Again and again and again. It will be a compulsion, according to Freud (1912) more than a century ago. In conclusion, although the transfer does not effectively resolve the intrapersonal conflict, we continue unconsciously to use it. What we really need to do is learn to resolve our conflict, confronting it fairly, experiencing the pain of our powerlessness and processing that pain as best we can. We need to think about transfer on a conscious level. We must undermine its influence on our unconscious mind. Indeed, we must turn it against it and thus benefit from it. We have to fool the double-edged sword that we call transfer and its counterpart: the countertransfer. Therefore, this course: A course for non-analytical professionals whose activity is significantly influenced by transfer and countertransfer, despite the fact that they have specialized in dealing with conscious phenomena; A course that exposes the dangers of not undermining brain activity that imposes old schemes on new experiences simply because of similarities; A course that highlights stop displaced phenomena from running aggressively during therapy; and a course explaining how to benefit from conflict resolution, embracing the inherent pain inherent in it, mourning what ideally should not have happened, and to move on. This is the first course in a three-part series, based on the book Transference and Countertransference in Non-Analytical Therapy: Double-Edged Swords, by Judith A. Schaeffer, Ph.D. (Lanham, MD: University Press of America, 2007). (Note: To return to the course after you click a footnote, click the Back button in your browser.) Contemporary environments and neuroscience advances Three recent developments make this course particularly relevant to today's mental health professionals. First, 21st-century clinicians no longer have the option of indefinite treatment, even for the treatment of serious disorders, because of the concerns of managed care about profitability. They must identify and manage obstacles to progress as soon as they appear, so that clients complete their work in their assigned sessions. Thus, they must bring unconscious impediments to the light of consciousness. In addition, most managed care companies require clinicians to translate results into new observable behaviors and diminished symptoms. Clinicians need to define what they do through functions that measure change. They must be aware of all the variables that determine whether this change occurs. Thus, they must know the transfer and the counter-transfer affect the achievement of the objective. Second, customers and their families expect timely, ethical, and effective treatment. They belong to a contentious society eager to right the wrongs. While serious errors may be rare, unaddressed and counter-transferential transferred material can lead to mistakes that clients or their families may bring to the attention of complaints boards or lawyers. If clients commit complete suicide, for example, their survivors may consider the professionals who treated them responsible for not raising transferent signs of suicidal intent. Third, recent cognitive and neuroscientific discoveries have shown that transfer and countertransfer are actually instantaneous in the brain (Anderson and Przybylinski, 2012; Shore, 2003a; Pally, 2001; Gabbard, 2001). It is no longer scientific to deny their existence and activity in psychotherapy, regardless of the theoretical orientation of clinicians. In other words, transfer and countertransfer propel the unconscious conflicting material into the dynamics of analytical and non-analytical therapy. If non-analytically oriented therapists fail to observe these displaced phenomena during their sessions, they are limited in their ability to help their clients move beyond their one-sided accounts of problematic relationships and events outside therapy. In contrast, if therapists identify and decode the displaced material that manifests itself during Their perception of what happens in the relationship in therapy can complement and correct clients' accounts of what is happening outside of therapy. As a result, clients can realize that what happens in therapy is similar to unresolved conflicts in their presentation problems. This, in turn, can lead to conflict resolution. At the same time, therapists can also figure out, by countertransfer, old, conflicting interpersonal issues in their relationship with customers. Then they, too, can choose conflict resolution over mindless repetition. In conclusion, make good use if the transfer and countertransfer improves the work of otherwise effective non-analytical clinicians. It is even according to Marmor's (1989) prophetic words, the future of psychotherapy ... further development of short-term therapeutic techniques (259). Without them, regardless of orientation, therapists cannot resist the pressures of healthcare reform to reduce therapeutic time. Without them, therapists cannot deal economically and effectively with the flood of emotional and behavioural problems that our disrupted society has generated (259). Language, cultural diversity and context In this course, jargon is replaced by terms commonly used for the sake of readers who are not versed in psychoanalytic language. In addition, efforts are being made to identify common therapists and clients with cultural expectations that they bring to their interactions. Finally, certain aspects of analytical theories are placed in the context of non-analytical theories, so that readers can integrate new materials with what they already possess. The phenomenon called Transference We all engage in transfer. It is a ubiquitous and ubiquitous phenomenon that occurs in many life situations (Brenner, 1982). It appears in almost all close relationships (Gelso & Bhatia, 2012, 384). We relive the past in a way that is inappropriate for the present (Greenson & Wexler, 1969). I misinterpreted or misinterpreted this in terms of the past. We unconsciously send the message to select people in our present lives that have replaced significant ones in our past. We impose what has taken place in one framework on what is currently happening, usually because in the previous framework we have not been able to resolve a conflict. We're replacing what's still worth our attention because it's making us nervous. In this course we focus on establishing psychotherapy, because research shows that positive therapeutic results depend on the proper management of transfer in non-psychoanalytic therapy, not less psychoanalytic (Gelso & Bhatoia, 2012). Moreover, in the whole psychotherapy, transfer becomes concentrated, pronounced and intense (Wilson & Weinstein, 1996). Note that in this course, in accordance with psychoanalytic tradition, the transfer is attributed to clients and countertransfer to therapists. In fact, however, both customers and therapists engage in transfer and countertransfer. We'll start with the transfer. It is a challenge to define the transfer, the term has been used inconsistently and ambiguously since Freud's use in the early 20th century. Its precise was never agreed upon. Thus, we will simply explore how the transfer was described and defined in the select, representative literature. Then we will create a theoretical definition that distills the essence of the transfer from its complexity. Finally, we will formulate an operational definition usable in clinical practice. Transference: Freud's classical definition (1917) description of the transfer serves as a classical prototyping definition of both a construction and a process. As a construction, the transfer is displaced clients, the beginning of life, unresolved conflict feelings and the attitudes that surface in response to facing their therapist. Transfer is a matter of memories displaced by affective and somatic states related to the beginning of significant other life. It is a matter of memories remembered by clients when engaging in therapy in such a way that they are indistinguishable from events that have occurred in the past outside therapy. The transfer is ... unconscious manifestation ... memory as it penetrates into the greater consciousness of the self, breaking it, causing it to stop and even sometimes taking over it entirely (Meares et al, 2005, 290). As a process, transfer is the unconscious shift of clients of feelings, attitudes, sensations and thoughts about or toward people in their early lives to their therapist. Almost always, customers do this because they could not resolve conflicts with those early people. Instead, they repressed them, burying them deep in the unconscious mind. Thus, Freud (1917) believes that the transfer serves the purpose of offering customers new editions of old conflicts (454) so that they can solve them. In other words, the transfer is that customers make an early life event reappear in their unconscious minds, an event from which they had to quickly dissociate due to overwhelming emotional impact (Schore, 2003a). Leave (1993) calls the transfer an unconscious movement of conflicting desire and/or belief in space and time from one person from the past to the present. It provides another chance for customers to deal with mental pain long enough and well enough to resolve the conflict that caused the pain in the first place (Freud, 1917). Interestingly, the unconscious mind prefers to avoid direct conflict resolution. He wants the conflict to be resolved indirectly. Thus, a problem: Avoidance is strengthening because it provides temporary help from mental pain. Over time, the pain recurs, and the transfer must be rehired. Thus, conflicts never get the direct attention they need to be resolved. Another problem: Sooner or later, this takes a significant tax on the psyche. Research of Pierro and Colleagues (2008) reveals new, useful data. Unconscious mind wants closure after gathering information But especially if there's a strong J on the Myers-Briggs scale, he wants to close it as soon as possible. Thus, people with a preference J (Jury) to P (Perception) are vulnerable to the use of transfer as a means of avoiding conflict resolution. A reasonable inference is that this also applies to people with P and because of the growing suffering when the conflict remains unresolved (Ecker & Hulley, 1996). At the same time, the transfer should be appreciated for what it does. The relief it offers when it is done is desirable, even necessary, for operation, explains Becker (1973). It is an adaptive response to our awareness that we need a connection with others to cope with what life brings us. It is not possible to do so individually. In particular, we cannot stop death from happening, but we can cope with its inevitability by transferring our mortal terror and our need to have power over it to another person. In other words, the transfer solves a problem. It's a creative projection (Becker, 1973, 158). It is an illusion, but an illusion that improves life (158). Transference as the involvement of projection and introjection In the therapeutic framework, transference is the projection of aspects of a figure in the client's past on the therapist. For example, as clients move their fear of their critical mother to their therapist, they attribute their mother's habit to their mother's habit of criticizing them. You're like my mother, she feels the client, and like my mother, you're going to criticize what I'm doing, and I'm no stronger to stop you than I could stop her. But I can at least reassure you by doing the homework you assign. Another example would be Caucasian clients who unconsciously project their own unwanted and unacceptable qualities onto a racial minority therapist and would make Whiteness a standard against which it is assessed (Tummala-Narra, 2019). As customers engage in projection, therapists engage in introjection. I'm unconsciously getting what clients send. You perceive me as your critical mother and you think I'm going to criticize you, the therapist feels. Then she says to her: There's nothing I can do to stop you from fearing my criticism, but I can come to your aid by overlooking the fact that you haven't done your homework. Or the racial minority therapist whose countertransfertransfer transfer of his client unconsciously, I have to be extremely careful to come across as having the manners of white people. Ironically, observing this subtle effort, clients then tend to confirm their belief that their therapist is not really white. They might even unconsciously conclude that his inferior work, like a non-white, is the reason he is not making progress. It is extremely important to note that therapists who engage in introjection receive projections without identifying with them or who hold them and their feelings about them (Stamm, 1995). They accept the projections without necessarily confirming the perceptions inherent in them (Schafer, 1968). Rather, the confirmation of the therapists of a projection depends in the first by their own countertransfer: countertransfer: unresolved conflicts (Westen & Gabbard, 2002). It depends on the extent to which the [client] projection meshes with aspects of unresolved therapists ... Conflicts.... (Meissner, 1996, 43). Some therapists, for example, have not resolved their own conflict because mothers criticize their children, despite having to accept them unconditionally. Their mothers are likely to have been typically critical and, as a result, they hold mother templates as critical. Thus, they unintentionally confirm their customers' projection of them as critical. They are therefore engaged in a form of error-finding. They usually bring their customers' attention to being slightly late, for example. On the other hand, therapists who have resolved their own conflict over critical mothers are not likely to confirm a projection of them as critical. They don't find fault with the client who sends them their projection being critical. Usually, I don't draw the customer's attention to be a little late. Or they ask to explore with the client why he or she didn't do his homework. They come across to their client as respectful and/or curious rather than critical. 1 It's also important to remember that design customers don't recognize what they design as their own. He feels alien to them. Something they dislike seems to come to them, but it's not theirs. They can sit back and criticize their therapist for what appears to be his or her negative trait or habit, blind to the fact that they are finding fault with themselves and thus designing that unwanted trait. Therefore, although the authors of DSM-5 do not address direct transfer, they rate projection as a defence mechanism that is almost invariably unadaptative (Kupfer et al, 2013, 819; American Psychiatric Association, 2013). Transfer that unconscious? Freud (1912) insisted that the transfer be considered fundamentally unconscious. Although customers may become aware of something calling for their further transfer, they are not aware of the relationship between this present stimulus and a past phenomenon. Their feelings about their therapist, for example, seem reality-based in here and now. Theorists see transfer as an unconscious meta-language that makes sense from clients to therapists. According to neurologist Schore (2003a), the right hemisphere of clients communicates emotional states in nonverbal ways in the right hemisphere of therapists. 2 Therapists receive the message at a certain instinctual, subliminal level, that they have become the figure of the mother of their clients, for example, and that their clients feel the same way towards their real mother. Therapists might later recall a gesture or posture of clients that probably served as a stimulus to their awareness, but at the time they were not aware of this stimulus. Their customers simply and mysteriously sent a message that simple and mysterious received. As an unconscious process, transfer is no more accessible to the conscious mind of customers than other unconscious processes. While they may become distressed by bodily sensations, fantasies, dreams and other manifestations of transfer, they do not connect their suffering with the transferred material. As a result, they either move on to a problem they are aware of or attribute their suffering to an unmuted phenomenon, purely here and now. Customers who transfer their fear of a critical mother to therapists, for example, may experience cold, metallic sensations. They could unwittingly assume posts indicating avoiding them project a negative maternal role on their therapist. But if they try to find an explanation for what they feel or do, they simply attribute what happens to their negative therapist methods. Without learning new skills, they cannot access the material they have displaced. However, with these abilities, they can process misplaced materials and thus prevent an inappropriate behavioral response to a transferent experience. The transfer itself, together with an unconscious reaction to it, cannot be prevented, according to Anderson and Przybylinski (2012). But after picking up clues or transfer manifestations, customers can choose adaptive behavioral responses to the transferred material. To use Anderson and Przybylinski's (2012) excellent recommendation, therapists can help customers design and install an If-Then scheme that they can then hire quickly. If this happens, then I will say/do this, can guide their behavior, whether it is verbal or non-verbal. Thus, over time, they will form the habit of responding differently after their initial reaction. Transference as Fantasizing Without such intervention, most clients rarely object to transferential material when testing reality. They don't use their conscious minds to distinguish facts from fantasy. If their conscious mind does something, it does not take into account the misplaced material as an illusion unworthy of additional attention. Thus, transfer is a form of unconscious fantasies that require the left hemisphere to test reality, or the left brain, to be held in the state of abbey (Herron & Rouslin, 1982). Transfer occurs naturally because communicating right-to-right-brain in the center of sea transfer does not prevent the left brain from acting. Consequently, the transfer process involves a misperception and extremely simplified knowledge, working together to distort reality. In addition, this activity of the right brain occurs immediately and effortlessly after similarity cues have been detected (Anderson & Przybylinski, 2012). One or two similarities are recognized, while many dissimilarities are rejected. Clients simply fantasize, for example, that their therapist another critical person with whom they had a conflicted relationship. They don't take the time to assess whether this fantasy fits the reality it's a figment of their imagination.3 Indeed, it doesn't even occur to them to do so for up to two weeks (Glassman & Anderson, 1999). In conclusion, according to its classical definition, the transfer is only a repetition of the desires, feelings, fantasies, attitudes and bodily sensations initially experienced in relation to the figures of early childhood and now improperly and unconsciously misplaced to the therapeutic framework. The client's transferent experience is something like: I want a mother who accepts, non-critical, and doesn't perceive you as one, a therapist. I perceive you as no different from my real mother. As a consequence, I feel the same negative feelings towards you that I felt towards her. According to the classical definition of transfer, the fantasy that begins and supports the transfer can be represented by the similarities between the therapist and another significant element of early life. The experience here and now of the therapist and the experience of the client there and then of another become temporarily identical (Nunberg, 1951). The past is reconstructed in the present, because the client regresses at an early stage, observes similarities between the therapist and the beginning figure of life and allows these similarities to guide perception. The therapist is perceived as being so similar to a person in the past that he or she is the same person. Thus, the therapist becomes a person with whom the client is still in conflict (Freud, 1940). In other words, the past predetermines the present in the fact that customers cannot fail to perceive their revived ideas, feelings and sensations as simply present realities (Chodorow, 1996). Transference just happens when something in the clients experience their therapist, usually of a visual and/or auditory nature, serves as a reminder of a similar past experience recorded in the clients' memory. Even the slight similarities, such as the nuances and facial features, gestures, tone of voice or the similarity of the names become cores of truth (DeLaCour, 1985) that allow customers to re-experiment the entire model of their relationship with another person who is still unconsciously significant. They even feel the setting and atmosphere in which a meeting with the original person took place (Rioch, 1943). For example, my critical mother had piercing eye piercing, the client remembers on an unconscious level, and so does my therapist. My therapist seems to be my critical mother. That's her. The scene was set (Anderson and Przybylinski, 2012). The piece can - and does not - move on. Thus, the transfer is his own motivation; [is] an embedded model that pushes [customers] to engage in a certain type of pattern of file-by-file, memory-priming behavior (Levin, 1997, 1141). It is driven by a compulsion that Freud (1912) called a compulsion of repetition. Transference as positive and/or negative Initially, Freud (1912) considered the transfer to be positive Negative. Either its inherent conflict is overshadowed pleasant or pleasant feelings, or is flooded with disturbing or painful feelings. In the case of positive transfer, Freud (1912) believed that clients transferred needs that a previous figure had not met to their therapist, hoping that the therapist would meet them. A healthy part of the customer hopes to create a different outcome from the previous experience. This part wants the present to be better than the past. In the case of negative transfer, in designing their negative feelings towards a figure passed on to their therapist, clients support their fear that their therapist will behave like the past figure. An unhealthy part of the client has a desire to repeat what is known, even if it is harmful, because it is familiar and safe (Stark, 1994). The client is invested in keeping things that way they were. Indeed, clinical evidence supports the conclusion that when negative transfer prevails, the therapeutic relationship and its effectiveness will be diminished if the therapist does not help [the client] to obtain an understanding of sources of negative experience and perceptions. In the absence of understanding, [clients] will simply accept the accuracy and credibility of their negative projections on the therapist.... [They] ... I simply believe that the therapist thinks or feels negative towards [them] or that [their] negative reactions to [their therapist is] justified (Gelso & Bhatoia, 2012, 388). Freud (1912) advised therapists to simply ignore positive transfer. Or they might consider it an advantage because it had the potential to help form the therapeutic alliance. Instead, therapists had to interpret negative transfer because it was a duty that, left alone, would weaken or destroy the therapeutic alliance. Over time, however, clinicians discovered that the positive transfer was very strong. It has proven even stronger and more durable than negative transfer (Berk & Anderson, 2000). It has also proved to be more subtle and therefore difficult to detect (Anderson & Przybylinski, 2012) and therefore harmful. For example, it could encourage a culturally re-implementing agreement (Wolstein, 1996, 507) to maintain the non-conflicttherapeutic therapeutic relationship and thus avoid difficult conflict resolution work. Therefore, even some early Freudian theorists advocated for the interpretation of positive transfer if it seemed to interfere with therapeutic work. Just as importantly, they began to notice that negative transfer could become a positive experience if therapists were able to make their clients aware of their transfer and engage in hard conflict resolution work. 4 Transference as Conflictual Although a paradigm shift in psychoanalysis has de-stressed conflict in the transferred material (Anderson & Przybylinski, 2012; Olds, 1994), the concept of conflict remains central the original classical definition of the transfer. Transferential conflict is an incompatibility of conflicting desires so that satisfaction reason has a negative influence on another (Westen, 1988, 172). Satisfying a sexual desire, for example, can conflict with one's moral values. Transferential conflict can also arise from a significant difference between what it needs or wants and what it becomes. A child who needs protection from a parent, for example, and is instead neglected, will experience conflict. The child will find it difficult to reconcile his need to be protected with the neglect he is experiencing, thinking: Shouldn't I need protection? Or shouldn't I get the protection I need? Conflict is expected even from a neuroscientific perspective, because desires, beliefs, values and goals are likely to be processed by relatively independent neural circuits. In addition, each hemisphere of the brain forms two independent self-representations or self-images, one stored on the left and one on the right, which are used again and again in new situations. Customers may want something that their right brain even likes as their left brain tells them it's illogical to have that desire. Similarly, customers can choose to endure what they experience as harmful, even if it is painful. For example, to maintain a kind of relationship with a parent that would be in line with the right brain image of being in a family, clients can allow them to continue to endure neglect in the hands of that parent, which would be a violation of their brain image left by themselves as rational and therefore unwilling to endure painful neglect. Customers who are involved in the transfer try to dissipate its inherent conflict by suppressing their memory of it or blocking it from consciousness. They hope they don't realize that they wanted a relationship with a careless parent, for example, or were neglected for maintaining a relationship with the parent. This, of course, lays the foundations for the phenomenon of transfer to occur when new, similar circumstances remind customers of their old desires or experiences of not having their needs met. When their therapist has to cancel their appointment because of an avoidable emergency, for example, clients will remember or have been neglected, and thus will feel overwhelmingly neglected by their therapist at present. Transfer: The totemist definition of the totemist definition of transfer, which is broader than its classical counterpart, was actually formulated early on, because Freud's contemporaries disagreed as to whether or not the transfer should be limited to the displacement of phenomena from the early past. Could it also be based on later customer experiences or those currently occurring outside the therapeutic framework? Couldn't it be interpersonal, in addition to the intrapsychic in which the therapist participated in, contributed to, or even instigated his training? if the transfer were a really useful construction during actual therapy, it should not include these experiences and Moreover, as early Freudians focused on parental figure links to models revealed in the transfer, they found it even more important to focus on customers' reactions to their therapists - as representing others in their current lives - than to help clients discover the origins of the beginning of their lives. Early Freudians also noted that highlighting the early sources of life of transferent models could remove the defense clients they still needed to operate (Bauer & Mills, 1989). You may not be able to face the fact that the parent who was more protective of them than the other parent actually failed to do so on a very significant occasion. They may need to defend themselves against this painful achievement by engaging in reaction training, a defense that allowed them to preserve, even beautify, positive aspects of their parents' image. However, as adults, they had the resources to cope with how someone currently, their therapist, was disappointing to them. Early Freudians also observed that the conflicting material was at least involved in the problems that brought clients into therapy. Moreover, the tensions and conflicts that occurred during therapy were strikingly similar to those that occur outside it, making therapy a virtual slice of life. It was a slice of the life of a particular client encouraged by a certain therapist. Therefore, by the mid-1920s, Rank and Ferenczi (1925) theorized that focusing on displaced materials that had an impact on the therapist-client relationship – a phenomenon here and now – would eventually expose previous conflicts that still needed to be resolved. They seriously wondered whether positive therapeutic outcomes depended exclusively or even primarily on resolving the conflicts of early childhood revealed in the transfer. 5 Thus, for most theorists and therapists, including Freud, the concept of transfer eventually acquired a more inclusive meaning, which is now its totalist definition. Transfer is the unconscious shift of the client's attitudes, feelings, sensations and thoughts from another person in the client's life – past or present, within or outside the therapist – to the therapist in an attempt to reconstruct and resolve the conflict. The totemist definition of transfer becomes clearer when it contrasts with the classical definition, point by point. Note that the items they share are not reviewed. Transfer: A reconstitution In the totemist tradition, the transfer is a re-enactment rather than a repetition. Motivated by a strong desire for a positive result, clients unconsciously assign roles and functions previously taken by others to their therapist, in the hope that their needs will eventually be met. unconsciously wanting role-relationship with another role-responsiveness application of the therapist (Sandler, 1976, 44). They insist that their therapist be an active participant. They prod, provoke, and coerce. As a result of this manipulation, their unconscious unconscious therapist Thus, the client updates an internal scenario within the therapeutic relationship that results in the fact that [the therapist] was drawn into a role written by the internal world of [clients] (Westen & Gabbard, 2002, 101) in their unconscious effort to resolve the conflict. Especially the story of this interpersonal dynamic are powerful emotional reactions to therapists that make them break out of their usual roles and their customers become self-destructive, visibly stupid or acting in wild, exaggerated ways (Weiss, 1993). Customers also set up reconstructions in an unconscious effort to disprove long-term pathological beliefs, in particular those related to their self-identity and self-esteem (Gazzillo et al, 2019). Customers are highly motivated, both consciously and unconsciously, to deconfirm [their pathogenic beliefs] and get better (174). And they have a more or less articulated plan, though unconscious, to do so (Gazzillo et al, 2019; Weiss, 1998). For example, they want their therapist to respond to them so that they can think they are valuable and competent. Thus, they use the transfer to test reality, telling themselves if I am helpless, then my therapist will take over and solve my problems. If not, she will return them to me so that I take responsibility for doing so. According to Cooper (1987, 518) so well, the transfer is an adventure from which [customers hope to] come out changed and renewed. 6 Totalist transfer emphasizes the unconscious participation of the therapist through a phenomenon called countertransfer. It is an integral part of a transfer phenomenon. The transfer causes countertransference (Racker, 1968). Similarly, the countertransfer causes the transfer. Thus, transferential-countertransferential adoption emphasizes an early observation of Freud himself: It is a fundamental request of all transfers, which underlie all special requests, that [the therapist] ... should participate in a world endowed with special significance (Freud, 1900, 747). While the client unconsciously tries to reanimate problematic interpersonal relationships, the therapist cooperates unconsciously. The client and the therapist become entangled in a complex interaction, a kind of psychic force field composed of mixed transfer and countertransfer processes (Meissner, 1996, 42). Transference: A dynamic phenomenon According to its toalist definition, transfer is dynamic rather than static. It evolves as customers derive positive or negative meaning from their seemingly benevolent or malevolent therapeutic words and actions. Noting such attitude indicators, would be the quality of the voice, the degree of energy, the level of professionalism, and from person to person heat, clients quickly project their feelings and attitudes towards pre- or non-therapeutic people on their therapist. Moreover, they ensure that their projections become strong and intense when they meet a special therapist, who has associated with their relational conflicts. Seen in a slightly different light, totalist transfer is dynamic in that it is an organizing activity in which clients engage unconsciously in response to a number of variables: memories of early life and subsequent life of others, current experiences with others and the real attitudes, words and behaviors of therapists today (Stolorow, 1993). Clients require the organization of prior perception of the present. They actively, though unconsciously, form here-and-now psychic reality. 6 They structure and organize the present experience in such a way that the past comes to life and is reconstituted (Bachant & Adler, 1997). They want the mental pain they still have to go away. In other words, totalist transfer is not just a matter of customers who unconsciously revive old images, thoughts, emotions and sensations and perceive them as present reality. It's not just, you seem to be my parent. Rather, it's you're my parent. I know that. That's what I say. What's more, you'll love me as a parent and take away my pain. Put simply, in the totalist tradition, transfer is an unconscious insistence that memories of the negative behaviors of others past are replaced by positive experiences with others nowadays. 7 Indeed, the totalist transfer is dynamic in that it is a double process in which therapists unwittingly engage. First, they act in such a way as to give clients the opportunity to reconstruct previous or non-therapeutic relationships. Their characteristics, interpersonal behavioural patterns and traits make it possible to play transferential role. They actually inspire the roles their clients design. They collaborate with clients in writing scripts for the roles they will be asked to play. Second, as their own transfer - referred to as countertransfer - is triggered, therapists with an appropriate unresolved conflict unconsciously transform the roles their clients attribute them in subtle, idiosyncratic ways. They shape a law-making by subjectively responding to the projections they receive. They give their customers additional materials with which they can continue to adopt the transfer. Therapists who indicate that they disagree at all with something that their customers say, for example, allow their clients to embellish their critical mother's projection. 8 I recall that the classical definition already implies that therapists provide the core of truth (DeLaCour, 1985) to customers. While consciously fulfilling their roles, therapists also unconsciously contribute other variables, fragmentary, disguised, that serve as reminders of people from customers' conflict past. 9 Therapists currently use a harsh voice, for example, and thus give customers cue sin to notice similarities between therapists and outsiders who have verbally abused them. However, the newer totemist definition adds that customers unconsciously send a therapists that they have already activated the potential to assume the role that is now assigned to them. Those who might be critical, for example, are already perceived as critics. Therapists then unconsciously introjecture the message and, if their countertransfer allows it, adopt the role of a critical person. They could use a slightly denigrating voice tone, for example, or use it to a greater extent than usual. 11 Thus, the totemist definition of transfer underlines the strong influence that the characteristics and personal behaviour, based on the countertransfer of therapists, have on the content and form of the transfer of customers (Cooper, 1987). Transfer: A shift of the totalist transfer interpersonal experience is the shift of any interpersonal experience in life, not just an early experience. It adds the recent past to the early past, as well as the present to the past as sources of customer conflict (Strachey, 1934, 1969). The totemist definition of transfer adds what happens interpersonally outside of sessions to what happens in sessions and also adds what happens intrapsychicly in the client since childhood. An example would be the increasingly frequent negative perception of us immigrants. After the points tummala-Narra (2019), Perceptions [immigrants]... based on projections of unwanted parts of the self ... justifying the demonisation of racial minorities. (4) 12 With Jungian theorists, the totemist definition of transfer has become so broad that it includes archetypal phenomena: universal and transpersonal materials common to humanity throughout the ages and therefore capable of serving as prototyping interpersonal templates. Universal archetypes trigger transfer, and archetypal transpersonal themes form its content. The old, worldly, collective and transcultural material appears as being of the client (Jung, 1966). Archetypes reveal their strong relevance in generation by generation, culture by culture, and individual by individual (Dieckmann, 1976). Thus, according to the Jungians, the transfer is both a new experience and a transposition of an old one, whether unique to the individual or inherited. It is a personal phenomenon based on a universal memory from then and there. I am an older brother in competition with my therapist, my younger brother, a client fantasies, for example, in response to a trigger related to the deficit and universalized in Brother Rivalry Archetype. A description of the transfer for non-analysts The next description of the transfer will serve as a definition in the rest of this course. It is an operationalized definition that provides a concrete template by which non-analysts can verify a suspected occurrence of transfer phenomena. Transfer is a matter of the following: Unconscious and compulsive clients trying to re-enact in unresolved interpersonal conflict therapy past or outside therapy, together with the conflicts they have as a result of archetypal phenomena. Clients unconsciously participate in similarities between their therapists and others with whom they have unresolved conflicts during their therapy sessions. Then they let these similarities motivate them to move past phenomena into the current therapeutic framework. They project other people's qualities onto their therapists. Clients unconsciously organize their relationship with the therapist during sessions so that, without consciously addressing past or present conflicts, they can reduce or eliminate their emotional pain. Customers assign therapists roles originally played by other significant people with whom customers are still in conflict. They try to reconstruct conflicting experiences and have them turn well. At the same time, introject or unconscious therapists take into their clients' projections: messages that they are like others and behave as they have done. At the same time, clients unconsciously allow their therapist to design pre- and extra-therapeutic materials that they can develop in transfer phenomena. Both clients and therapists unconsciously allow themselves to be influenced by universal archetypes that suggest they play certain roles and assign their corresponding roles to each other. The phenomenon called Countertransference Countertransference: Classical Definition Classic Countertransference is a mirror of the classic transfer. It is the therapists' own transfer being determined by the transfer of clients (Freud, 1910). It is the feelings of therapists and attitudes towards a significant early figure of life being displaced to the client (Freud, 1912). When defined as a construction, countertransference refers to the reactions of unconscious therapists to customer feelings and attitudes towards a past significant figure being displaced to therapists. It's an automatic reaction quickly triggered by unresolved therapist conflicts. In other words, counter-transfer is a matter of repression of unresolved conflict inghes, feelings and attitudes that emerge as they experience customer displaced conflicts. Countertransfer is a fusion between past and present. When the old material is transferred within the therapeutic framework, the past becomes present. When defined as a process, classical countertransfer refers to the transferent communication of clients calling from the feelings and attitudes of unconscious minds of their therapists related to their own early conflict ingelike experiences of life. Although there may be some exceptions, this calling forth usually depends on two dynamics. One is that clients unconsciously send memories of conflicting early life experiences to the mind of their unconscious therapist, and the unconscious therapist receives them. Neurologist Olnick (1969) explains that communication of the right brain of therapists are connected to communication with the right brain of their clients Using visual, auditory and subliminal signals, clients project on their receptive therapists the traits or habits of people who have led to customers' early life conflicts. The second dynamic on which the call depends is that therapists already have unconscious memories of their own early conflict ingegotexperiences that can be called upon by customer transfer. They have conflict-based templates that allow them to transfer assumptions or assumptions within the therapeutic framework (Herron & Rouslin, 1982). You're a brother who bullied me and I'm about to do this now, an unconscious therapist is thinking of a client who projected on him the traits of a brother who once victimized him. Thus, the countertransfer is determined by the match between what [the client] projects on the therapist and what pre-existing structures are present in the intrapsychic world of the therapist (Gabbard, 2001, 9). In classical tradition, counter-transfer refers only to those reactions that are caused by displaced mental conflicts that clients have transferred from an early relationship to the therapeutic relationship and that therapists still have with people in their early years. These conflicts are triggered by the correct hemispheric, non-verbal communication of clients and therapists, but they are not based primarily on what happened during therapy sessions. Consequently, they are not justified in terms of objective data. They're inappropriate or irrational. Therapists may be disturbed by customers who come late for a session, for example; but if the countertransfer is not at work, therapists are not indignant. On the other hand, if therapists were often expected because of a parent's insensitivity and transfer this attribute to their clients, they become outraged. 13 Counter-transfer, like transfer, is subject to a habit of the unconscious mind called a repetition constraint. Due to repeated projection and introjection, the feelings and attitudes in the unconscious mind of the therapist are easily and quickly reactivated. They are not subject to reality testing, but simply make unconscious therapists re-use old perceptions and re-make old judgments. They've established the scene on which therapy is taking place. It is generally assumed that therapists introject or unwittingly take in customer projections before customers introject therapists projections. However, it is more likely that introjection, would be projection, is a simultaneous activity of therapists and customers. Or, customers can first introject as therapists offer kernels of truth, on which customers can base their transfer. These kernels can be not only the therapist's piercing eyes - which are like the eyes of the client's mother - but also the subtle therapist's habit of criticizing others, which corresponds to her client's scheme of mothers as people who invariably find something wrong with their child. Indeed, in the definition of it is a matter of transferring customers activating unconscious therapists templates of what life and people are like because of unmet needs of early life and unfulfilled desires. The countertransfer takes place automatically. Then, as soon as it is suspected of the conscious mind, it is itself repressed or rejected. Signs of its presence, called derivatives or manifestations, can be observed by the conscious mind - the therapist may become aware of trembling in disgust, for example - but countertransference as such occurs in the inaccessible field of the unconscious mind. That part of the psyche, which is simply called unconscious, is a receptive organ (Freud, 1912, 115) or delicate receiving apparatus (Money-Kryle, 1956, 341) that has no choice but to introjecte other projects. He is incapable of using the function of testing the reality of the conscious mind to distinguish between the fantasies of his own reality and objective reality. Merge from the past with the present. Includes one person in another. Distorts perception, affects intuition and darkens judgment. Therefore, a therapy scenario, would be this: I am not the younger brother of this client, the conscious mind even knows that the more influential unconscious mind concludes, I feel like the younger brother of my client. I'm him. In conclusion, the classic countertransfer takes place because of the conflicting wishes and needs of therapists. Therapists who have not resolved their conflict between their desire for their mother's unconditional love and her real-life restraint of love, for example, tend to experience older maternal clients, equally limited in their ability to value others, including their therapist. This, in turn, informs the attitude of the therapists and the behaviour towards

these customers. They feel spaced away from their customers. They're pulling out of them. Minimizes their verbal interactions with them. Thus, unless the countertransfer is detected and processed by the conscious mind of the therapist, it is very likely to undermine the positive therapeutic result. If detected and worked with, however, countertransference can all but ensure positive therapeutic result. Like the transfer, it's a double-edged sword. Countertransference: Totalistic Definition Countertransference becomes even more complex in its toalist definition. Because of the wide disagreement over how totalist countertransfer is defined, we will explore only two representative definitions. At first, it is important to note that the two definitions envisaged, like most totalist definitions, imply the following three elements of the classical definition. First, the counter-transfer of therapists takes the form of emotions, sensations and cognitions related to their clients. Secondly, the counter-transfer involves an unresolved conflict that has been repressed in the therapists. Thirdly, in addition to the fact that it depends on projection and introjection, countertransfer also depends on identification, a phenomenon clients and the therapist actually see parts or aspects of the other person as belonging to themselves. They identify it as theirs. The broadest definition According to Heimann (1950), totalist countertransfer refers to all the attitudes and feelings therapists experience towards clients, both unconscious and conscious. It is the total reaction of therapists to their clients within the therapeutic framework. It consists of the unconscious, unresolved conflicts of therapists, which are generated by the transfer of clients, as well as the conscious and justifiable reactions of therapists to the real experiences during therapy. This includes reactions to what clients say and do in therapy and what they report going through outside therapy (Kernberg, 1987). Thus, the broadest definition does not limit countertransfer to unconscious, starting material, past, subjective, or fantasy. Rather, it is the therapists' response to both the real attributes of customers and the attributes that therapists only dream of. A client might indeed be boirish, but a therapist could label him as boirish simply because he resembles a boorish person in the therapist's past. Also, countertransfer is a reaction to the present and recent material no less than the starting material. For example, if therapists are glorified by trainees they supervise, they could unconsciously assign adulatory roles similar to their clients. Then, when customers don't admire them, therapists are disappointed. In other words, the totalist countertransfer, which is subjective in that it appears in the therapist's mind, may also have an objective component insofar as it is a reaction to the actual behavior of clients in sessions. It is a product of the present therapeutic relationship, as well as of the past and present non-therapeutic relationships that both clients and therapists transfer to their therapeutic meeting. Interesting new research supports the theory that totalist countertransference is neither rare nor rare. Gazzillo and colleagues (2015), for example, found that the emotional reaction of all 144 clinicians studied in clients with personality disorders was powerless, the degree of helplessness dependent on the level of the client's general pathology. Moreover, the reaction of clinicians to clients with a histrionic personality disorder was a feeling of being overwhelmed and sexualized. Their reaction to clients with narcissistic personality disorderwas their desire to be parents, even if they felt humiliated. Their reaction to clients with phobic personality disorders was simply a desire to be parenting. In its broadest sense, totalist countertransference consists of affecting, cognition, and bodily sensations arising from the unmet needs of therapists and customers. It is occasioned by what I do therapists both knowingly and unknowingly. It's triggered so what therapists bring to sessions independently - what's set to go - - previously fashion therapists consciously and unconsciously schemes about people and the professional roles that therapists think they need to play. They can transfer a maternal role to the therapeutic session, for example, when working with a disoriented client who hits them as a child-like. Totalistic countertransfer is a matter of therapists confronting clients with the feelings and attitudes that therapists initially associated with other people with whom they still have problematic interactions (Racker, 1968). It is also a matter of unconscious therapists attributing to clients roles specific to their own interpersonal experiences and how they are currently defined. Therapists send messages asking their clients to take out certain roles that will meet their still unmet needs and fulfill their still unfulfilled wishes. For example, therapists who have suffered from dominated fathers tend to assign a dominant role to their clients, usually older men, in the hope that their clients will choose not to dominate. Thus, they will satisfy the long-term need of therapists for self-determination. Similarly, therapists who see their role as quasi-medical tend to assign patient roles to their clients. They give them a chance to be healed and thus fulfill their desire to heal others. Of course, the counter-transfer of therapists also creates opportunities for customer transfer. In behavior in certain ways on their own, therapists create opportunities for customers to relate to them in ways reminiscent of customer relationships: early, later and even contemporary. As beneficiaries of therapists' behavioural tactics, clients experience their own unresolved conflicts and discover more and more aspects of their conflicts. Therapists who are somewhat authoritarian, for example, allow clients to return to a student role if this role has remained confrontational for them. In countertransfer, customers find themselves, says Sandler succinctly (1976). In addition, in its broadest sense, the totalist countertransfer includes transpersonal and transcultural archetypes that appear as material specific to therapists and are transferred within the therapeutic framework. In fact, according to Jung (1966), archetypes are the main triggers of transfer and countertransfer. Therapists might consider themselves superior to their clients, for example, because of God and the Archetype Goddess. They could classify clients as inferior to them, even as therapy begins or does so when clients transfer their tendency to become a victim from a life-early situation to the therapeutic setting. Racker (1968) believed that totalist countertransfer depends not only on projection and introspection, but also on identification: a phenomenon by which customers and therapists actually see parts or aspects of the other person as themselves. Identification includes (1) projective identification, a mental activity employed by a single person; and (2) (2) identification, an appropriate mental activity engaged by another person. In analytical tradition, projective identification is attributed to the client and the introjective identification, to the therapist. Klein (1946) defined for the first time projective identification as children's fantasies of getting rid of unwanted feelings by attributing them to someone else. Today, however, most theorists define projective identification as omnipotent fantasy that we can divide from an unwanted part of our personality, put it and the emotions it incites in another person, and then recover a modified version of what was put in another person (Grinberg, 1962; Ogden, 1982). Due to the fact that we unconsciously pressure others to identify with or own what they receive, and that they routinely succumb to this pressure, we experience a sense of unity with these people (Schafer, 1977). Schore (2003a) adds that those who engage in projective identification become dependent on the people in whom they project the unwanted part. They need people to learn to handle the side. They may even need to work with recipients to manage it. For example, clients who have anger management issues first unconsciously put their anger into their therapist. They then unconsciously observe what their therapist does with anger. They notice the therapist no longer speaks, for example, so that she is calm when she says something. Interestingly, clients will speak unconsciously in a very calm way in order to help their therapist regain calm. In the course of projective identification, clients unconsciously place in their therapist a part of their identity that they are not able or unwilling to hold as their own. At the same time, the therapist participates by unconsciously internalizing that part in a process called introjective identification. Clients use projective identification to put in their therapist a distressed part of themselves for two reasons (Hinshelwood, 1999). The first is that the part is related to memories of an experience in which others treated them badly, which suggested that they were bad people. The second is that the part is the cause of the client treating someone else stupidly, which also implies that they are bad people and makes them not want to own what they do and the fault they bear. It's either, you abuse me and therefore painful me. I must be a bad person; or I'm treating you badly and I can't stand that in me. I can't stand being a bad person. When they become beneficiaries of their clients' project, therapists identify with their clients and/or those who have been affected by them. Grayer and Sax (1986) observe that in any given session, therapists usually move back and forth; identifying first with the customer, then with a person affected by the customer, then with the customer, and so on. Projective identification a three-step process that takes place First, clients unconsciously put an unwanted part of themselves in their therapist to defend themselves against mental pain (Ogden, 1982). They unconsciously scapegoat: place in their therapist something in them, which feels so unbearable that it must be expelled (Heath, 1991). Indeed, they do so so completely and so involuntarily that they attribute what they expel not more to themselves, but to their therapist. Abusive clients who are not able to tolerate this trait themselves, for example, engage in projective identification by perceiving their therapist as abusive. In this way, they experience their therapist, not themselves, as abusive. Secondly, clients put pressure on their therapists to experiment and behave in a manner consistent with the projective fantasy they received (Ogden, 1994). Customers stimulate intense, unexplained and ego-distonic emotions in their therapists (Maroda, 1995), which causes them to go through an affective experience according to what they receive. They feel abusive, for example, and detest it (Kernberg, 1987). Moreover, as therapists resonate with what they have received, they internally amplify the emotions related to it (Schore, 2003a). They get very troubled without understanding why. They find it hard to put what's going on in words. Projective identification is thus considered a form of non-verbal communication. By placing the pain of being abused in their therapist, for example, clients allow their therapist to know through experience how painful it was for them to be abused. This is especially important for customers when they cannot describe an experience. Consider the following vignette: In the therapy session, the client denied sexual abuse. In fact, he laughed when he heard the suggestion that others with his symptoms were usually sexualized at an inappropriate age. However, her therapist experienced a vague, partly comfortable, partially uncomfortable sexual attraction for her client. It was not like she perceived the client as physically attractive; it was simply an attraction there by itself. Over time, when the therapist revealed her countertransferential reaction, the client revealed that she had engaged in sexual relations at the age of five with a nanny. He liked it, he said, even though he didn't have any other fond memories of the person. As the therapist and her client talked about what happened as a child, it became clear to her that what happened to her in therapy was a law-making. She realized that although her client told her she liked it, she actually got into conflict over it. He liked what he found out later that he shouldn't have done. When he put in his therapist his projective fantasy of having a sexual relationship with her, however, he could enjoy the memory of the original experience without having to own it. In the third clients who are involved in the projective identification unconsciously attempt to recover the part they have expelled. They want want get the feel of what their therapist has gone through. They want to know it's the expelled part, now that the therapist's had something to do with it. They feel that their therapist actually felt what they themselves could not tolerate and not only tolerated it, but also treated effectively with it. Consequently, the part is less terrifying and their negative feelings are either gone or at least more manageable (Ogden, 1994). In the vignette above, for example, the client would have felt that his therapist had managed the sexual fantasy he had designed. Thus, by using projective identification, customers are able to dream that they can safely take over or re-enter their original experience. They will be able to benefit from shaping their therapist. They will be able to manage controlled feeling, for example, by rebelling against her, just like their therapist. Although it was adversely affected by a client's projection, the therapist was able to contain it (Pick, 1985). 14 Now, in a safe interpersonal environment, the client can metabolize a negative emotion into something positive (Schore, 2003b). However, it is not always the case that therapists manage adaptively the feelings they have introduced. If they cannot tolerate them, confirm customers' belief that their feelings are indeed unbearable and unmanageable. Then they feel worse. They experience despair and despair (Bion, 1967). According to Grinberg (1962), who was among the first to link the projective identification of countertransfer, the projective identification represents the adoption of the transfer-countertransfer and the responsiveness of the roles. Projective identification is a form of customer pressure to help their therapist process affective experiences they have failed to deal with (Schore, 2003a). In which the therapist becomes as much an active participant as the client (Plakun, 1998), projective identification is visibly interpersonal, rather than simply being intrapsychic, as Melanie Klein (1946) conceived it. A close look at introjectic identification, an unconscious process by which therapists experience a state of feeling that customers have put into them in an attempt to disown, reveals significant challenges for therapists. It takes one of two forms as therapists identify with what they have received and own as their own. In the first, called concordant identification, therapists feel like their client. They feel abused, for example, and I feel sorry for the client who was abused by her mother. The subjective reality of the client seems to test to be based in their own current reality. Thus, consistent introiective identification enhances the empathy of therapists for their clients. Second, called complementary identification, however, therapists feel the impact of what the client has done to another person. They experience what has been beneficiary of the client's shares. Consequently, they not with her client, but with the person with whom the client interacted. To use the last example, the therapist experiences the frustration of the mother resorting to the abuse of a stubborn child. With this, there is good news and bad news. The good news is that the experience provides valuable information about what customers have contributed to their problems. The bad news is that therapists must now struggle with mysterious, inexplicable negative feelings towards their client. Unless they quickly process these feelings, they will adopt them, adding a new pain to their client's psyche. Even if concordant identification is the reaction of therapists, they cannot do psychological work for their clients. Being empathized with can media healing, but that healing will only be temporary unless clients learn to heal, they can only do it if they face their pain, process it, and in most cases change what they do to prevent its recurrence. This could be the refusal to accept victimization as a fundamental label of self-identification, for example, where they were actually victimized and to be victimized at present. In other words, only when clients become aware of the conflict inherent in the transfer and engage in the hard work of resolving the conflict can they free themselves from the pain of abuse.15 This pain remains because the past becomes present through a constraint of repetition at the heart of the transfer (Freud, 1912). A narrower definition Some theorists, such as Blum (1986a), find the totalist definition of countertransference so comprehensive that it is difficult to use in clinical settings. Therefore, they offer a less comprehensive one: countertransfer is just those feelings and attitudes that are unconscious, irrational and inappropriate because they are displaced; and it is only those that are conflicting or problematic. If customers really act badly in the session and the therapists get angry, that reaction is called counter-reaction, not countertransfer. If, on the other hand, clients project on therapists an early life picture of themselves as acting badly, but not actually acting badly in the session, and therapists introject that old image, their angry reaction is called countertransference. Thus, the countertransfer is labelled irrational and inadequate; defies logic, strictly speaking. The present is not past.16 One person is not another, no matter how much it resembles. In other words, countertransfer is composed only of unconscious reactions. Countertransfer is a matter of imagined perceptions or fantasies that therapists are unaware of. In addition, countertransfer involves only conflict-based reactions of therapists. If a therapist has resolved her conflict over waiting for her mother to meet her needs and finding her mother instead carelessly, projection - but not - will take place. The client who resembles a mother could design his own neglect, but the therapist will not feel neglected, at least not appreciably. Countertransfer Descriptors Regardless of whether they are defined as classic or totalist, countertransfer can be described in the following ways. Countertransfer is subtle Although the signs or manifestations of countertransfer are sometimes easily detectable, they are almost always very subtle. They tend to be disguised or feelings, desires, images, gestures, fantasies, associations, bodily sensations, and urge to respond differently from the way they usually do. They could take the form of silence, boredom, fatigue, fragmentary thoughts and various combinations of these phenomena (Grayer & Sax, 1986). In response to a client who does not like women, for example, a female therapist might feel chest pain or have speech difficulties. Or he can see a picture of a person he doesn't like. You might feel humiliated. They might want to end the session. Even therapists who make every effort to be beautiful can give subtle clues about their negative co-aparising feelings. As customers pick them up, even strong positive transfer can become negative (Anderson & Przybylinski, 2012). Countertransfer is unique and varied As the transfer, the countertransfer takes many unique forms in each client-therapist relationship. It would be more accurate to say that there are countertransfers rather than countertransference. Special clients remind therapists of other people, and therapists unconsciously impose idiosyncratic templates on the therapeutic relationship and assign specific roles to their clients. In addition, when clients and therapists represent different ages, ethnic groups, genders, religions, political affiliations and socio-economic layers, their effect on each other is very distinctive. Even with the same therapist-client dyad, in no two sessions no phenomena of countertransfer tend to be identical. This is especially true for customers with personality disorders (Hennissen, 2019). Countertransference: Both simple and complex Countertransference, would be the transfer, involving simplified perceptual and cognitive processes. In order to associate a client with a person that a therapist does not like, for example, the therapist must reject all aspects of both people, except the common trait or behavior the therapist dislikes. Even before that, the therapist must accept the client's transferent message that the therapist reminds him of a person he doesn't like with whom the therapist has relatively little in common. Maybe it's his age. Maybe it's his age and slightly authoritative tone of voice. Maybe it's his age, the authoritative tone of his voice, and the similarity in his clothes. But it's not the hundreds of similarities that justify identifying one person as another. At the same time, countertransfer involves complex fantasies. After focusing on certain data, therapists further to embellish their fantasies. To use the previous example, add to their emotion of dislike such evidence, would be physical sensations of being hit in the chest or an urge to get rid of the customer dislike them. Gazzillo and colleagues' research (2019) shows that destresscans can cause people to lose their clear thinking and become pseudo-logical or illogical. Of course, therapists more recognize and deal with conflicting materials in their unconscious, the less they will fantasize about it. However, it is extremely difficult to complete this work. Thus, new customers can call without money the deeply repressed material of therapists, only partially examined. In fact, although therapists vary in their sensitivity to countertransferal fantasies, none manage to avoid it completely (Herron & Rouslin, 1982). Countertransfer is complex in another way. It is a complicated process that not only begins with anxiety-riddled, repressed material, but is itself repressed because of the extra anxiety it incites. Then it re-appears when similar conditions occur, only to be pushed unconscious once again. Repeating compulsion at work? The countertransfer is both positive and negative Freud (1910a) initially considered countertransference as negative. It was the unwanted reaction of therapists to the transfer of their clients. Because it interfered with the therapeutic work, it was to be rejected. Over time, however, theorists observed that the countertransfer was either positive, in which it was essentially conflict-free or negative as it is was conflict-based. However, in the course of the development of their totalist definition, theorists realized that counter-transfer has both negative and positive aspects. On the one hand, usually in difficulty therapists. They have to use energy to repress. This, in turn, limits introspection, clouds of thought, interferes with communication, and leads to misunderstandings that mar treatment. On the other hand, if detected and coded, the countertransfer alerts therapists to what happens in their relationship with customers (Racker, 1968). This increases therapists' knowledge of their clients' personal traits and interpersonal patterns. In fact, some of these traits and patterns are accessible only through the countertransfer reactions of therapists (McDougall, 1978; Cohen, 1952). In conclusion, the countertransfer is a double-edged sword. Countertransfer is governed by the Laws of the Unconscious Mind The countertransfer is governed by an unconscious law of the human psyche to repress what is anxious and thus painful. It is also governed by what is called Talion's law: React to positive transfer by positive countertransfer and negative transfer by negative countertransfer (Racker, 1972). This happens quickly and automatically, i.e. in milliseconds and at under-aware levels (Sternberg et al, 1998). It is not a conscious intent. Consider, for example, falling asleep in a session, which usually makes therapists feel At least initially, however, they will assid their sleepy off to customers being boring; bringing non-essential material or repeating ad nuseam. Because they are not aware of the transfer of the material themselves, they do not realize that they are retaliating in returning negative countertransference for negative transfer. But this is very likely what happens in addition to the customer actually being boring. When accurately decoded, the countertransfer often produces the taliconic motivation. Another law of the unconscious mind to which countertransfer is subject is the law of elaboration: Build, remove and give details of your fantasies. Therefore, just as dreams are usually elaborate, confusing, and bewildering, countertransfer requires therapists to feel and behave according to the identifications they make. In subtle and varied ways, they play elaborate roles and perform detailed functions characteristic of figures from the past (Bion, 1961). Unconsciously they take their roles to the heart and play them to the end. That's the bad news. Countertransfer can be revealing The good news is that once the countertransfer is accurately detected and decoded, it reveals to therapists how it influences the therapeutic process, for better or worse. If they like old people because of their sweet grandparents, for example, and they send this message to older clients, the latter feel appreciated and accepted. The therapeutic alliance is launched smoothly and solidly. If, on the other hand, therapists do not like old people because of disgruntled grandparents, they tend to perceive their clients in a negative light. Consequently, the latter feel devalued and rejected, and the therapeutic alliance is fragile at best. Similarly, if therapists continue to associate their elderly clients with their sweet grandparents, but no, they tend to infantilize them. If it is accurately detected and decoded, however, the countertransfer provides therapists with data about what is happening between themselves and their clients, as well as how they and/or their clients influence the therapeutic process. Countertransfer opens the door to life slices: the client's life, the therapist's life and the life that the client and the therapist share within the therapeutic framework. It gives therapists a first-hand experience of what their customers communicate, despite their efforts not to. Indeed, the true message of the customers is understood primarily in what their communication does to therapists. Much more important than what clients consciously say in therapy are the attitude and affects with which they unwittingly say, because in these elements lies both the fullness of meaning and the impact of customer communication on others. How the therapist feels and behaves because of the client's transfer can be as important as what the client says, and perhaps more (Pally, 2001, 91). A customer What should I do? for can inspire a therapist to give advice, help the client to think through alternatives, or turn the question back to the client, all depending on whether the countertransferential reaction of the therapist is one of pity for the inexperienced one being forced to act immediately, trusting in one who wants to become more analytical, or impatience with one who wants to remain addicted. In conclusion, therapists stand to get their most meaningful perspective in how they need to plan their work with clients by decoding their own countertransference. For this reason, counter-transfer, even more than transfer, was called the central instrument of therapeutic work (Brodbeck, 1995). Countertransfer is the map that guides the clinician through the hidden jokes of the transfer (Davies & Frawley, 1994, 152). Countertransfer is the most valuable research tool in the client's subconscious that the therapist has (Heimann, 1950). A definition of countertransfer for non-psychoanalysts The following description of the countertransfer will serve as a definition in the rest of this course. It is an operationalized definition that provides a concrete template by which non-analysts can check the countertransfer phenomena they suspect. Countertransfer is a matter of the following: Countertransfer is an unconscious process by which therapists allow clients to transfer nonverbal communications to obtain their own transfer: their unresolved conflicts. Therapists respond to customer transferent communications based on significant, conflicting relationships, therapists, have previousor or currently face, or experience as a result of archetypal phenomena. Countertransfer is an unconscious process by which therapists participate in similarities between their clients and others with whom they have unresolved conflicts. This allows them to replace previous or extra-therapeutic conflicting experiences. Countertransfer occurs when therapists unconsciously take customer projections and identify with customers or those affected by customers' verbal and non-verbal behaviors. They experience affects once felt by their customers or recipients of customer behaviors. In the first case, therapists tend to empathize with clients during the experimentation of their subjective world. In the second case, therapists tend to empathize with those customers relate to during the course of experiencing what customers are doing for them. Thus, the countertransfer shed light on how therapists can plan to help customers. Countertransfer is an unconscious process by which therapists assimilate clients into the thematic structures of their own subjective, conflicting world. Therapists come to their workplace with unconscious scheme, templates or independent images of customers. They unconsciously impose them on customers. sheds light on what therapists need to do to meet their own needs and meet their own desires outside of therapy and are therefore released for concentration on clients during treatment. If they fail to do so, therapists will unconsciously assign to clients roles initially played by significant others with whom therapists are still in conflict, in an unconscious effort to meet their own needs and fulfill their own desires. Their work will not be successful. They can even behave unethically. Triggers transference and countertransfer Countless and varied stimuli trigger transfer and countertransference in everyday life. The realms of the unconscious mind in which transfer and countertransfer live are multi-structured, multi-layered and multi-faceted. Unconscious psychological life is no less complex than biological life. During psychotherapy, however, transfer and countertransfer seem to be triggered primarily by what are called archetypes. One explanation is that therapy is an extremely interpersonal process, which derives from its primary participants, patterns of cross-cultural interaction, would be taking care of infants and children or appealing to powerful others when in danger. Specific cultures have developed somewhat unique forms of maternal care and turning to those in authority, but all cultures have learned to survive by adoption, such as archetypes Mother and God and Goddess Archetypes. A second explanation for trigger transfer archetypes and countertransferism is that therapists and clients hold archetypal beliefs about situations that tend to occur in therapy. Those who are in danger of decompensation, for example, must depend on those who know how to protect and defend them, believe customers and therapists unconsciously. Hence the triggering power of the Father's Archetype. We will focus on five of the archetypes that evoke three major dynamics that directly affect the treatment relationship: attachment and intimacy, authority and sexuality (Westen & Gabbard, 2002). Because they appear and reappear in different forms and intensities influenced by culture during therapy (Dieckman, 1976; Kernberg, 1975), they can cause significant problems or disturbances in social, professional, or other important areas of operation (Kupfer et al 2013, 21), including clients and therapists operating within the therapeutic framework. Archetypal Material is embedded in Jung Culture (1966) argued that universal themes, collective beliefs, transcultural images, and primitive interpersonal scripts known as archetypes persistently attract the attention of the unconscious mind in which they inhabit. Thus, they can become structural elements of the human psyche. They may ask to be used as models for interpersonal interactions. They may require therapists and clients to resonate with them, even adopt them, in the therapeutic framework. Indeed, Schafer stresses, therapists [and clients] become in some respects the mother, father, brother, child and lover [to others] (354). However, the exact nature of the transfer activity depends on the cultures of the client and therapist, the culture being broadly defined to include ethnicity, age, socio-economic class, political affiliation, gender, sexual identity, religion and other demographic characteristics. For example, sibling rivalry in a Korean culture defined by a hierarchy of gender and age, as well as the influence of in-laws, is different from its expression in a single-parent, Anglo-American family culture that emphasizes individual responsibility. Thus, therapists must observe the archetypal transfer through the lenses of interwoven and ever-evolving cultures with which a particular client and themselves identify. Put succinctly, ethno-cultural transference is a basic variable in therapeutic work. The sociocultural histories of the client and the therapist influence the therapeutic dynamics (Comas-Diaz and Jacobsen, 1991). Individual narratives and interpersonal therapeutic dynamics are undoubtedly shaped by culture. Therefore, therapists need to understand customer narratives in terms of what is under [their] meanings, and in what context they were formed... and anxiety [that it creates in] client and therapist (Tummula-Narra, 2015, 283). In addition, therapists should notice long-standing similarities between cultural identifications. You also need to be careful to manipulate the culture of which customers as a defense mechanism. All Latinos are late, said by a client who arrives late, for example, may not be a valid excuse as much as an attempt to limit interaction with the therapist, because God and Goddess Archetypes have incited fear in the late-trade. In addition, therapists must be wary of their unconscious bias against cultures other than their own. If they see them as inferior, for example, they may not hold high expectations from clients. They may be physiologising them or deeming them too rooted in their ways of changing. Several other culture-specific issues can be found in the footnotes that follow this text. The Mother's Archetype Mother's Archetype is the most powerful trigger of transfer and countertransfer in therapy, as it equates to our need for secure attachment and simple intimacy. It is a matter of our desire to be unconditionally loved. This corresponds to our need to be truly evaluated, if only by one person. It allows us to discover our ability to illuminate the mother's face, an experience that becomes the fundamental basis of self-image and self-esteem (Casement, 1991, 93). Indeed, the human face is... a wonderful primary miracle; it naturally paralyzes [one] by its splendor, if you give in to it as the fantastic thing is (Becker, 1973, p. 147). At the same time, Mother Archetype promotes maternal complementary, which give attitudes and On the positive side, these variables are essential for establishing the interdependent cultivation environment, necessary for the formation of Thus, as therapy begins, it is not uncommon for clients to regress, becoming psychological children, even infants. They unwittingly give clues that hold non-verbal expectations of symbolic bodily contact, to be held, fed, and kept warm and dry. On an even deeper unconscious level, clients, like infants, fantasize about returning to the mother-child symbiotic state in which there are no more separate individuals (Benedek, 1953). They dream of a psychological, pseudo-biological fusion, in which they enjoy undivided attention and unconditional positive attention. Thus, the initial transfer triggered by the Mother's Archetype is usually positive. This is true, perhaps especially true, even for customers who had an abusive mother (Anderson & Przybylinski, 2012). 17 For, contrary to all evidence, they still hope to be loved. They automatically re-experience a positive assessment when they first interact with their therapist (p. 375). Interestingly, this is the case, despite clients picking up the equal number of negative and positive characteristics of their therapist as soon as they come into contact. It's just that positive transfer proves stronger than negative (Berk & Anderson, 2000). Then, as therapist and client are alone in numerous therapy sessions, they can not help but focus on each other's feelings and attitudes (Greenacre, 1954). Therapists take care of their clients closely, as do the figures of the client's mother. Clients experience understanding, non-judgmental professionals (Macalpine, 1959) who do not make emotional counter-demands (Greenacre, 1954) and thus seem to love them unconditionally. On a deep lye level, the setting of therapy serves as the second uterus. For most clients, regardless of gender, most therapists come across as having a maternal-breastfeeding attitude towards a suffering patient-child (Greenacre, 1954). Even when they don't satisfy their customers, they replicate the early experience of their mother's clients, which is a combination of satisfaction and deprivation (Greenson & Wexler, 1969), with satisfaction having a greater and more durable effect. Thus, therapy gives clients a perfect chance to recreate their child life in transfer (Bollas, 1983). By experimenting with their therapist as a mother, clients can unconsciously move their experiences with their original caregiver (Tower, 1956). They can expect that their therapist will meet all their needs and repair all their injuries (Horowitz et al, 1984). If only they are made to seem needy and please their therapist in a certain way, they can induce the care of their therapist (Goldin, 1985). Therefore, at first the functioning of the Mother's Archetype tends to be overwhelmingly positive. However, it may soon become negative. It can even become dangerous for customers with pronounced depression, anxiety, addiction problems and phobias et al, 2015), as they and their therapist resist the mother-child relationship by evolving an adult-adult relationship. In short, clients' journey to independence may rightly include an experience of dependence on their therapist, but this addiction must ultimately yield to healthy independence. It must be transient and temporary, not too long-lasting or permanent. Unfortunately, therapists with unresolved maternal-child problems are vulnerable to forgetting this. They are prone to infantilization of their clients and the addiction of habituating on them. They make customers who are dependent and want to be cared for in terms of their therapists as the main agents of change (Chused & Raphling, 1992). In subtle and diverse ways, they make the mistake of assuring customers that not only are they deeply interested in them, but also in their intention to meet their needs, rather than helping them to assume this responsibility (Plakun, 1998). Another inherent danger in the Mother's Archetype is that customers' expectations of being maternal are often higher than the actual performance of therapists. Inevitably imperfect mother therapists; they do not indeed fully compensate for the early experiences of customers in what deprives them. Thus, therapy can become an occasion of strong transferential conflicts within a client and between the client and the therapist, as the maternal functions promoted by the Mother Archetype replace the key atitudinal and behavioral variables necessary to achieve and maintain therapeutic objectives. Gabbard (1996) still puts a danger. Clients with pronounced must be maternal may have a strong impulse to defend against the very therapist-client fusion they craved. Because they are also afraid of being swallowed or immersed in the fusion process, they withdraw and become resistive. They even try to seduce their therapist, because they prefer a sexualized relationship than the threat of getting lost. Therefore, even if they are spared customers attempts to seduce, therapists should not forget that the positive result depends on how much balanced customers need to be held close with their need to be held separately. They must provide customers with space in which to become their own source of food and care. They must promote the self-sufficiency and autonomy of customers. They must even allow clients to pursue a narcissistic desire to have omnipotent control over them in the course of becoming their own source of unconditional acceptance and in terms of positive. Therapists who unconsciously hold the belief that they must be benevolent and self-give to the point of getting customers from them whatever they want whenever they want are particularly vulnerable to acting in the Mother Archetype. At first, this regulation seems benign, even beneficial. Customers benefit from therapists who are unconditionally empathetic and constantly available. Over time, however, this proves malevolent. Therapists eventually get fed up. In light of their self-care needs, they cannot sustain the posture of being available at any time. In addition, like all therapists have an instinctual sadistic trait against which they cannot defend themselves endlessly (Pick, 1997). It is only a matter of time before they rebel against a system whereby customers can make endless use of them, forgetting that they themselves have set it up. Thus, they become emotionally abusive to their clients, albeit in very subtle ways. Besides, it's only a matter of time before the seemingly positive intimacy generated by the Mother's Archetype becomes negative tangle. Therapists eager to help customers make progress, for example, could start by using educational intervention. Its initial use is effective. But by excessively using this intervention so easily, therapists unwittingly send customers a message three times greater: They know much more than their customers, they can make changes, their customers can't. Over time, some therapists actually start to do the work that customers should do. Thus, they allow clients to remain passive, dependent beneficiaries of care. This is especially true for customers whose interpersonal style is anclitic. For this addiction triggers over-involvement and over-protection in their therapist (Hennisson, 2019). For example, clients stimulate positive counter-transfer as they assume the role of a needy child and their therapists project their need to be a benevolent carer. Then, if their countertransfer remains positive, therapists who have introjected and embellished the role of unconscious caregiver turn this role into primary doer or the only source of care. Finally, as clients become profient in non-participation – fail to do homework they agreed to, for example, or make a habit of asking for advice rather than thinking things by themselves – experience worrying countertransferential anxiety, which in turn gives rise to negative transfer. Then it becomes very difficult for them to establish and maintain a functional alliance working with the client. Thus, because of the deep influence of the Mother's Archetype on the unconscious mind, therapists must maintain a delicate balance. They should allow customers control over what they do in sessions and between sessions, along with how and when they do it. But they must also require that clients take primary responsibility for their own growth and development through age-appropriate, ego-syntonic self-care. Equally important, therapists should not be insistent on keeping close to customers, nor determined to maintain separation. Despite the negative countertransfer, they must not become silently detached or intrusive. They will do so if they remember that the need for their clients to feel safe in therapy because they are owned by their therapist is figurative. Her may experiment as children, but should not be infantilized (Anderson & Przybylinski, 2012). They are, in fact, adults (Casement, 1991), or have the potential to be. At the same time, however, therapists must in mind that carefully selected interventions, would be reflective listening, can give customers a sense of being physically owned, which is more real than if a real holding... occurred (Winnicott, 1988, 61). Understanding the transmission of their therapist through language will seem to them that the therapist would keep them in the past, that is, when [they] had to take place, the moment when love meant physical care and adaptation (Winnicott, 1988, 62). To sum up, the Mother's Archetype is generally the most relevant archetype in therapy, because, like the prototyping mother-child relationship, therapy involves repeated, intimate contact between two people through conscious and unconscious channels of communication (Tower, 1956). Remembering the uterus, therapy is a golden opportunity for clients to find, once again, the missing mother figure (Ferenczi, 1909). It is a chance to enjoy again the quasi-union mother-child of the first months of life (Greenacre, 1954). Similarly, therapy becomes an opportunity for therapists to play maternal roles to create and nourishing new forms of psychic life. In the hands of therapists who provide security through holding their clients, even so allow them to move freely, the Mother Archetype facilitates therapeutic progress. At the same time, the Mother's Archetype can prove dangerous. In the hands of therapists who do not detect or deal with the negative transfer of their clients and the problematic aspects of their positive transfer, along with their own problematic countertransference, the Mother Archetype can moderate therapeutic progress and media treatment failure. The Father's Archetype The Father's Archetype embodies another essential aspect of human development: morality and its foundation in authority. 18 Mother may be the main moral socialiser (Badcock, 2009), but the father represents consciousness, that psychological phenomenon that facilitates doing what is right and good for others, even if it is personally difficult (Nunberg, 1951), to preserve and protect life. Thus, the Parent Archetype highlights the human instinct to sacrifice itself for the good of the species. It encourages her to protect and defend life even at the cost of her own life. Therefore, the Father's Archetype is a major trigger for transfer and countertransfer to therapy. Freud once said that the death of a man's father is the most important event of his life (Reik, 1937). It could hardly be any different for both men and women, when that protector and defender of life leaves, never to return. Clients easily move conflicting material from their biological father to their therapist, regardless of gender, because one way or another they want to use therapy to protect or restore their intrapersonal and interpersonal life. It is not uncommon for their problem to be a violation of conscience, although they rarely describe it in terms of morality. Therapists paternal roles, because they see preserve or renew psychological life. That life, they come to realize, is often a matter of resolving an extremely damaging conflict between behavior and moral values. This is especially true of clients with significant depression and/or anxiety. This is especially true for people whose suicidal ideation correlates with PTSD (Colson et al, 1986) and those whose interpersonal style is highly dependent (Hennisson, 2019). Indeed, the preservation and protection of life is a matter of members of society living under a moral code. Everyone must develop their consciousness and respect the distinction between right and wrong. For most, it's a matter of resolving conflicts of conscience: self-change when one's behavior harms others. Unfortunately, however, the human condition often reveals the opposite: it does not act morally, but expects others to do so. Thus, customers present with goals to get others to change. They also unconsciously want their therapist, not them, to take responsibility for achieving their goal. Efficient therapists, however, help customers realize that they are the ones who

need to change, even to the point of sacrificing what is dear to them. Therefore, the conflicts inherent in the Father's Archetype develop within customers, as well as between clients and therapists. It has long been noted that most therapists choose their profession because of a deeply-sitting savior complex (Little, 1951; Cohen, 1952). Thus, Father Archetype appeals to them. They believe they are meant to save both themselves and others. In fact, by introsing their clients the archetypal Father transfer, they can save themselves by saving their clients. Consequently, they are appealing to establish a paternal relationship with their clients (Westen & Gabbard, 1998). They establish a treatment framework, suggest a treatment plan, and impose certain expectations on their clients. Therapists who unconsciously believe they are innate and omnipotent are particularly vulnerable to the adoption of the Father's Archetype. They think they have the right to dictate morality. If something is wrong with them, it is wrong for their customers; if it is suitable for them, suitable for their customers. And they easily adopt a corollary faith: They are absolutely necessary for the progress of customers. Customers must be saved, healed and protected, and they are saviors, healers and protectors by excellence. Ironically, therapists who fail to recognize their savior complex may even wear unconscious bans against their customers getting well. The disease, after all, makes the presence of the therapist a necessity. The danger then arises for at least two reasons. Firstly, although most customers want to get well at a conscious level, at a many want to remain ill. Their symptoms allow them to feel connected with an early, omnipotent father figure. They want to keep [a] perfectly imagined, or at least strong, powerful, from their past. [They want] to see the therapist as omnipotent rather than experiencing the disappointment of seeing the actual therapist (Alpert, 1992, 147). Secondly, therapists are particularly vulnerable to remedial functions, and customers become people to whom therapists want to make up for them (Little, 1951; Pick, 1997). Indeed, repressed desires to save and perform restorative functions are the very basis of the countertransfer within the therapeutic framework (Volkan, 1995). When therapists hear about – indeed share – the pain of their clients, they want to bring them back to an emotional life without pain. If customers are allowed to be restored, everything is fine. If not, therapists become more and more anxious, which in turn increases their desire to heal. And the vicious circle starts again. Particularly vulnerable to the negative side of the Father's Archetype are therapists who had a depressed mother. Unless they have done considerable personal work, their depressed mother, whether alive or deceased, continues to induce rescue and repair fantasies (Racker, 1972). While on the surface this need would seem to be positive or at least harmless, it inevitably becomes harmful for several reasons. First, repair needs easily become restorative impulses, which in turn easily become constraints (Little, 1951). Therapists unconsciously hold customers with disabilities because they want to do them good again and again. Secondly, the needs of the therapists cause them to identify unconsciously with the unconscious prohibitions of customers to get better, which come from their primitive aggressive instincts. Thus, as customers express their early aggressive tendencies by countering the efforts of therapists, therapists unwittingly exploit customers' disease for what they do for them (Little, 1951). Third, the repair needs of therapists prevent the movement of customers from being a victim to whom repair is due to the fact that it is a person who does what it takes to survive. This includes strong strengthening rejection from self-pity and special attention from others. All of this is not to deny the beneficial potential of the Father's Archetype. In the hands of therapists who promote the development of consciousness, personal responsibility and self-protection against avoidable or abandonable emotional pain, Father Archetype mediates and/or moderates positive therapeutic results. Rivalry brother archetype jung's (1966) Brother Rivalry Archetype triggers transfer and countertransfer in therapy, as it promotes expectations of getting a road, winning over competitors, and relieving others if victory is not at hand. Although clients may see therapists as parents when starting therapy, as therapists reveal their shortcomings, clients consider them as simple brothers competing for some obscure prize or favorite place in the family. This can also happen when clients with histrionic or psychopathic traits learn that therapists have other clients (Ferenczi, 1909; Gazzillo et al, 2015; 2015; 2019). The archetype of sibling rivalry evokes the need for clients for psychological space that allows them to become different from their siblings themselves, while still belonging to a family. This extends to becoming different from their therapist, who is another brother. The Sibling Rivalry Archetype also evokes the need for customers to make therapeutic progress as soon as possible for the sake of becoming a formidable competitor. However, clients tend to define progress in terms of relief from the pain it has brought into therapy, rather than dealing with their contribution to that pain. Schafer (1997) explains that customers usually want to address relatively superficial materials. They want others to change. And they want their therapist to solve their problems and do it quickly. Thus, they will not have to hold themselves responsible for making difficult changes in the way they think and behave. Therapists with unresolved conflicts in terms of being liked by their clients because they take responsibility for fixing their problems and not be liked because they assign their clients primary responsibility for change are particularly vulnerable to Brother Rivalry Archetype. They tend to compete with customers; work more than customers to achieve treatment goals. They give in to be not only resourceful people, but also older brothers, who can be used to the point of being abused. They leave what is practically appropriate in therapy, namely facilitating the problem solution, to become taking primary responsibility for it. Therapeutic progress depends much more on them than on their clients. On an unconscious level, these therapists also make the constellation of therapy a virtual family in which they compete with those who are out of therapy to be of the greatest help to clients. They want their customers to make them the main objective of their domestic world. Customers should follow the example of their therapists. Family members don't have to interfere. Thus, in the course of therapeutic work, clients must go from responding positively to the help they get to being indebted to their therapist for all that is done for them; indebted and grateful. Then, in so far as their customers express their gratitude, these therapists may fall into the insidious trap of meeting their affiliated needs, first or foremost, through their work. They can go so far as to unconsciously encourage erotic feelings in clients. For example, they may ask for unnecessary details of clients' sexual fantasies (Gabbard, 1996) for their own satisfaction. Similarly, these therapists can unconsciously encourage customers' erotic fantasies about them, only to become cold and distant in response to customers' longings. They can give clients the message that sexual feelings unacceptable, even disgusting. Unfortunately, given the transfer, this can confirm the beliefs of its own customers. Trapped in the combustivity characteristic of the transfer, customers can then re-enact prior victimization (Schafer, 1997). 1997). if therapists do not engage in limit violations, if Brother Rivalry Archetype is not approached properly, competition between client and therapist can occur in key areas would be achieving the goal. Therapists can ask customers to change, and then customers rebel against the work they involve. Or they finish therapy (Ogden, 1994) and thus gain the competition of just who is responsible for their lives. Alternatively, they comply with the requirements of their therapist on the outside and for the moment, enjoying all the while that they are the winners of the contest. Put succinctly, Brother Rivalry Archetype challenges therapists to deal with their clients and their inclination to compete, rather than collaborate, to fight for resources rather than share them, to get their way rather than compromise, and win over others rather than with them. The archetypes of God and goddess Archetypes God and Goddess trigger transfer and countertransfer to therapy due to the need for the development of autonomy (Jung, 1966). They promote twin fantasies of omnipotent and self-sufficiency (Klein, 1957). They feed the authority-based illusions to be smart enough to fool the gods and strong enough to rectify mistakes by punishing and rewarding others. Gabbard (1996) believes that God and Goddess Archetypes are particularly influential in therapy because of clients' feelings of inferiority and their belief in the superiority of their therapist. Especially for clients with depressed/exhausted narcissistic disorders and paranoia (Gazzillo et al, 2015), therapists' ability to use therapeutic interventions can serve as a painful reminder of the superior creative powers of others and their own inferiority (Epstein, 1977). In fact, envy is aroused in some clients mainly by the interpretive ability of their therapist (Klein. 1957). Ironically, while therapists just want to facilitate introspection by interpreting, in fact, this can be a therapeutic mistake. 20 He was an attractive but needy customer who had just been in love. However, he was also sedusing a vulnerable married woman. When the woman finally decided to end their emotional affair, the man was so angry that he vowed to reveal her husband's affair. He wouldn't have heard anything else. His therapist wondered whether she should simply reflect her client's feelings or share her countertransferanger triggered by his total disregard for the harm he was doing to a third party. She chose the latter, just for her client to stop therapy. He couldn't - he wouldn't - entertain thoughts of personal responsibility for what he did and planned to do. He perceived himself as a god above all reproach. He believed he had the right to punish others. He wanted to mitigate his loss by experiencing omnipotence. In retrospect, the therapist realized that it would have been better for her to continue to make the use of intrapersonal diagnosis of her client's transfer rather than share her She needed to find out experientially why the client was resentful of suggestions that he focus on his personal responsibility, why he found it so painful to do so, and why he just couldn't do it at the time. Once these reasons were addressed, he might have been able to reduce his defenses and explore the fear of taking responsibility for his actions. He may never have assumed this responsibility, but premature termination has eliminated even that possibility. Instead, God and Goddess Archetypes set the stage for an unsuccessful outcome, despite a well-intentioned therapist and a usually effective intervention. She needed to address her goddess's problems: her assuming that she had power over her client and the right to highjack the therapeutic process. 21 It would have been wiser for her to focus on the struggle for power in which they were because of the functioning of the archetypes of God and the goddess. Both wanted to get rid of their emotional pain by controlling the therapeutic process (Schafer, 1997). She unconsciously wanted to get rid of her feelings of helplessness by asserting her godly authority over a vulnerable client. Her client unconsciously wanted to transfer his anger towards the woman who rejected him to his therapist. He would thus enjoy the illusion of tricking and punishing his therapist. He would receive help from being under her godly control by assuming his own godly authority. It would be an amazingly powerful, though illusory (Grinberg, 1997) experience of healing its affiliated pain. Clients and therapists who face the failure of the parental holding environment are particularly inclined to embrace God and the Goddess of Archetypes. Because they had to support and feed, they instinctively adopt the scheme of being omnipotent self-sufficient (Modell, 1980). They really think they have to mother their therapist or client as much as they once did their parents. In doing so, they will gain power over those they parents. Paradoxically, the fear of being personally omnipotent is also embedded in God and Goddess Archetypes. Thus, customers and therapists fear the endless power and authority that this state transmits, and even more so, they cannot find well-modulated support: an equal or at least strong partner (Stein, 1993). At the same time, they fear absolute domination and control by that companion, as they associate constant power with eventual covert enslavement. They fear they have put themselves at risk to be exploited (Modell, 1980). Therapists who hold the unconscious belief that they are superior to others because of their education, experience, and professional success are particularly vulnerable to adopting the archetypes of God and the goddess. They assume they're extraordinarily talented. That they are skillful in their perception, analytical and synthesis skills, instinct, and ability to deal effectively with affects. Some people even think they're magical. Because they're have a certain amount of knowledge a priori due to their experience and education, they succumb to fantasies of having innate power and authority (Bion, 1967) in the therapeutic framework. When, moreover, clients transfer their reverence and awe culturally encouraged to the professionals called the doctor, they are tempted to believe that they are in fact superior to their clients, even superior to the people in general (Cohen, 1952). Unsuspected and unrecognized in the unconscious, this countertransferent force becomes a recipe for ultimate therapeutic failure. God and Goddess Archetypes also inspire the fantasies of an ideal world with which unconscious therapists identify (Racker, 1972). Their deductions are the truth. They are offended and ashamed when customers challenge them and most likely project their own shame. Thus, they become depressed 22 and to other things, would be poor assessments, increase their fear of their incompetence being revealed. Instead, they attribute the failure of treatment entirely to customers. They also believe that therapeutic failures cannot and will not be tolerated. Although they do not consciously deny that mistakes are part of being human, they unconsciously view possible failure as a reason to defend themselves against what would otherwise be healthy feedback. Thus, they fail to learn the lessons that therapeutic mistakes learn and ultimately increase the likelihood of future failures. Unfortunately, in response to the therapists' fear of professional failure, customers tend to develop an even stronger resistance to working with them. They are even beginning to hate their therapists (Blum, 1997), which in turn makes self-belief therapists dislike, even hate, both themselves and their customers. 23 They may even wish to attack or annihilate the customers they hate and, finding this unacceptable, project it onto their customers. When customers, especially teenagers, receive this projection identification, the worst proves true. They engage in self-destructive behaviours24 or activities dangerous to others (Ogden, 1994). The therapist thought he liked his teenage client, despite the therapeutic challenges he offered. Apart from not going to school, he ran away from home and got high. He often thought about how he thought he was really listening to her; in fact, he listened and listened and listened, then responded empathetically. Rarely provoked her, and when she did, she was respectful and gentle. However, his client continued his self-destructive behaviour. Can I continue to like this client? The therapist started to wonder. I want so badly that maybe I'm fooling myself. Maybe that's why my client regularly refers to parents who can barely stand it. Finally, the therapist had to admit that the time and energy he was spending to help someone change that apparently didn't change could be leading to more negative countertransference than he wanted to admit. Recognize. decided to share this thought in the hope of helping his client. I find your behavior so frustrating, he said. No matter what we plan and what you say you're going to do, you'll almost never do it. Maybe my negativity is something you feel. Maybe you won't change because you feel like I don't like what you're doing and therefore I don't like you. The client listened carefully, but said nothing. At the end of the session, however, she referred to no one really want her, not even her parents. Listening carefully, the therapist kept his client's pain. And he kept her in the next sessions until, when he finally lost his grip on her, he didn't have to act. After revealing this vignette, denying therapists unpleasant truths about themselves during the adoption of Archetypes God and the Goddess can weaken, if not destroy, therapeutic and working alliances. In contrast, by recognizing their negative countertransference, therapists can empower customers to recognize their own deep pain. Another way in which therapists adopt the Archetypes of God and Goddess is by engaging in manic interpretive activity as a way to control depressive anxiety related to feelings of clinical impotence (Epstein, 1977). This tends to be the case when clients belong to medical, legal, and other highly respected professions. But manic activity only makes things worse. It is a thing for therapists to periodically direct the therapeutic process. It's another for them to maintain control over it. One reason is that clients tend to be ambivalent both about the therapeutic link (Fox, 1998) and about the power and authority that they assume their therapists have. They both love and hate their therapists. They both idealize and depreciate them (Olinick, 1996). They want to get their attention, but deny their authority (Freud, 1915). Paradoxically, they want to surrender to their therapist's authority - even turn over self-responsibility - but stay in control. If clients surrender, sooner or later they rebel and demand that their almighty therapist return their power. However, we must not return their responsibility. Because they want to do what they want without facing consequences. Indeed, writes Schafer (1997), the refusal of customers to take responsibility for their lives is even more pervasive than their constant desire to do so. 25 A second reason why therapists maintain control over therapeutic activity is that it leads to their negative response when therapeutic success is minimal or apparently non-existent. It allows them to express their anger in ways that feel good at the time: to covertly punish their clients, to get subtle revenge, to engage imperceptible revenge. It even allows them to justify their customers' hatred. Of course, therapists consciously try to keep these feelings from clients. Unconsciously, however, they act out. Thus, customers experience countertransferential countertransferential resulting in therapeutic impasses and failures (Blum, 1997). 26 Finally, some therapists adopt the Archetypes of God and goddesses unconsciously believing that they can use any available therapeutic measure, even sexual involvement with clients, to ensure therapeutic success (Searles, 1975). In conclusion, undetected and unaddressed God and Goddess archetypal phenomena are extremely dangerous. The fantasies of therapists and omnipotence clients are major obstacles to effective therapy (Bion, 1967). We need to infify the other, the constant placement of select individuals on pedestals, the reading in them of the additional powers [for] the more they have, the more they rub us, becker writes (1973, 148). And thanks to God and the Archetype Goddess, often the other is actually our ideal self. Thus, the responsibility of therapists to rely with Archetypes God and Goddess. They and their clients could, for example, translate God and goddess into a heroism and a heroism whose integrity and courage can be imitated (Becker, 1973). Finally, both individuals and society could benefit from what cannot be eradicated: the influence of the Archetypes of God and the Goddess. Animus and Anima Archetypes Jung's Animus and Anima Archetypes trigger transference and countertransference in therapy, because both therapists and clients hold deep, unconscious expectations of completion. They want to be whole people. They want to add another person's strengths to their own. They always try to bring themselves into the power of a partner who seems to be composed of all the qualities that [they] have failed to achieve in [themselves] (Jung, 1969, 156). Strictly speaking, the archetypes of Animus and Anima refer to the strengths of the male and female sex. In contemporary use, however, they relate to the sex or perception of one having a male or female orientation. Animus, an archetype in the female psyche, is the repository... the ancestral experiences of all female men (Jung, 1966, 209). Anima, a comparable archetype in the male psyche, is a detailed sketch of the ancestral experiences of men. Men are compensated by a female element, because women are of a masculine element, because both sexes seek fulness, completeness and unity. Both men and women gain strength and power by attachment to what they are not (Jung, 1966). The animus brings with it logic and cognitive, especially the ability to discriminate (Jung, 1966). If the transfer and counter-transfer become fully operational, the animus, partly so argued, can be seen in the workplace in women, in disputes in which they have an unshakeable sense of justice and righteousness. Of course, men can argue in a very feminine way, too, when they are anima-possessed and have thus been transformed into anima animus (Jung, 1966, 153). With women, the argument soon becomes a matter of personal vanity and touchiness rather Content. With people, the argument soon becomes a matter of power, whether it be truth or justice or another ism. Their dialogue becomes marked by truisms, clichés, platitudes, opinionated opinions, insomitions, misconstructions and misinterpretations. 27 Nothing is important but to prove its point of view, so that the therapeutic alliance can be seriously weakened, even destroyed. Granted that most therapists manage animus well enough to resist falling into an obvious argument, they can be straight and judge in their interpretations. They can be laid on having the last word. They may be too sensitive to customers rejecting their ideas. Their clients, in turn, will tend to reject any their therapist says for the sake of being right. In turn, anima brings with it relational and emotional, especially the much needed connection in interpersonal relationships (Jung, 1966). Thus, it can become a life-giving energy source. It can help both men and women learn to accept a partially positive, partly negative self-image in themselves and each other. Thus, they can enjoy elementary, feminine dynamism (Ulanov, 1984). On the other hand, animation can make both men and women extremely alert to each other's shortcomings and reluctant to explore their own contribution to problematic relationships. Wanting to maintain an overly positive self-image, clients and therapists can consciously but unconsciously collaborate with the honest, honest interpersonal evaluation. They may become offended by the involvement of personal weakness. They can abandon the fruitful assessment by retaliation in passive-aggressive ways. In conclusion, the archetypes of Animus and Anima can mediate significant fulness and completeness in individuals. They can mediate openness to the contributions that each gender has to the truth that needs to be discovered and the wisdom that must be acquired in order for family systems and society to be unified in good health. At the same time, Animus and Anima Archetypes can ruin therapy by bringing the worst into clients and therapists, regardless of gender. They can mediate the despicable behavior, both verbally and non-verbally, which leads therapy to a disastrous end. Final Thoughts First, it is more than clear that all archetypes are double-edged swords: benevolent or malevolent. It all depends on what therapists do with the transferent and countertransferent material they trigger. Second, given the potential for archetypes to wreak havoc in interpersonal relationships, it is crucial for therapists from cultures that differ from those of their clients to discover ways in which specific archetypes might be the impact of their interactions. They must detect transfer and counter-transfer phenomena as soon as possible (Mishne, 2003). They can then help their customers become aware, review amend the outdated conclusions that determine their contemporary approaches in their lives (Renik, 1990, 199). These also be able to work with clients to resolve personal, interpersonal and cultural conflicts that are under different human needs and otherwise lead to endless aggression. Neither therapists nor clients can deny these needs, because they are universal and are an integral part of psychological functioning. But they can learn appropriate ways to meet them. Footnotes (Note: To return to the course after clicking a footnote, click the Back button in the browser.) Note 1. Some theorists, would be Meissner (1966), hold that projection... creates pressure in interpersonal interaction to attract the other member of that interaction to meet the inherent expectations and requirements of the projection. I prefer to distinguish between projection and projection identification, in which the latter – but not the former – creates pressure. See the next section for a more detailed explanation. (Go back) Note 2. See my book Transference and Countertransference in Non-Analytics Therapy: Double-Edged Swords. (Lanham, MD: University Press of America, 2007) for a more in-depth explanation derived from recent neuroscience and cognitive research. Note 3. Thus, therapists must learn to identify conflicting desires, urges, and fears that come in a very early time, which energize customers to perceive something in the present. They can then help clients subject these phenomena to reality testing (Freud, 1912). Note 4. In addition, clinical experience has led Freudian theorists to regard the transfer as a mixture of positive and negative elements. Sooner or later, the transfer that seemed positive revealed the conflicting basis. Clients might perceive their therapist as a protective father, for example, but eventually notice that he does not or cannot protect them from any pain. Instead, the transfer that appears to be negative has finally shown its positive aspects. In particular, if clients could be helped to express their negative transferential emotions and experience their therapist as non-retaliation as he or she drew attention to the transfer, they could discover the positive effect within the negative transfer. The hatred of the therapist who fell briefly in providing protection, for example, usually camouflaged longing and love of parenthood, which was projected on the therapist. Note 5. Influenced by this thinking, many theorists of the late 20th century place a major emphasis on transfer transfers during therapy (Kernberg, 1987; Binder, 1996). They advise therapists to interpret what is happening in the handy session (Danvanloo, 1978; Malan, 1976b; Sifneos, 1979; Luborsky, 1984; Strupp & Binder, 1984). They argue that while therapists can obtain information about customers' interpersonal history, they should not include this data in their interpretations 1976a). Their first priority is to help customers understand that although their problems probably began in early, early child-parent experiences, its situation rather than its previous origins. Indeed, many contemporary clinicians who think about transfer in a totalist sense prefer not to distinguish between past and present conflict material. They see it as virtually impossible to tease apart from the past. Are customers angry just because their therapist criticizes them? Or are they more angry than usual because they get this criticism as similar to that of their teachers, adding injury to injury, so to speak? Asking customers can be helpful, for those who are particularly insightful may have vague suspicions, but strong customer emotions are likely to obstruct clear associations. Note 6. Searles (1975) provided another explanation for the transferent reconstitution of customers: customers unconsciously try to contribute to the emotional growth, integration and maturation of their therapists. Customers offer their therapists an opportunity to resolve their own conflicts. Instinctively realizing that their own growth and integration depends very much on that of significant ones, clients assume that if their therapists become mature, their maturity will be weakened. At the same time, customers unconsciously want significant others to change, so that they don't have to make fearsome personal changes themselves. They have identified with their long-lasting immature emotional states and dysfunctional relational patterns to the extent that the change themselves feels like losing themselves. In addition, customers want to be mature without suffering the pain of personal change. Solution? Becoming mature by being involved with a therapist who has matured during the resolution of conflicts that they, as clients, have introduced into the therapeutic framework. Of course, this will only work if the transfer and countertransfer are treated at a conscious level. Note 7. Attempts to heal simply by adopting miscarry transference eventually, because they do not involve any real integrative processing (Ferenczi, 1909). Instead of requiring customers to distort rational control and, consequently, to change the nature of similar present relationships, the transfer – in itself – allows them to adopt past relationships with all their distorted attributions and illusions (Freud, 1940). For example, clients can adopt a parent-child relationship with their therapist, assigning themselves the needy inability to take care of themselves and their therapist's inventiveness and desire to meet their needs. They do not subject these illusions to reality testing. They fail to take into account their own potential for self-nurturance or their therapeutic perceptions of them not as dependent children, but as resource adults. Consequently, these customers cannot integrate a capacity for self-nurturance into their psyche. They keep a need others and remain in conflict with the refusal of others to perform this leaving their current relationships no healthier than their past. Thus, therapists must help customers determine if ... self-images and [interpersonal] patterns came from, how they could have been adaptive at the time they were initiated, and whether they are still adaptive or self-defeated and unadaptive and therefore need to be changed (Bollas, 1987, 3). Through effective transfer-focused therapy, clients will see what they are doing to avoid pain - indeed, they will run smack in pain - and eventually, by dealing with it, will discover from experience that they can cope, even embrace it, and survive. Thus, the identification and treatment of the transfer becomes the main means by which customers reduce, if not completely eliminated, their unique, historical and potential mental pain (Leave, 1993). Note 8. Cognitively, the transfer can be revealed anywhere along a continuum from simple or fragmentary thoughts to elaborate schemas or scripts that organize and give meaning to repressed experience. This particular therapist resembles another person with whom I should have felt good, clients might unconsciously think. Alternatively, customers could use Buxom, smiling women are the parent figures that will make for cultivation we did not receive as a scheme whereby they classify each individual with these characteristics as maternal. Note 9. Transfer and counter-transfer sometimes occur without a transfer-countertransfer interaction (Meissner, 1996, 307). However, the view of countertransfer as inherently interactive has become increasingly operative (Gabbard, 1994). Note 10. Therapists unconsciously introject what they are given: messages about roles, functions, self-definitions, and traits. Because these messages are repeatedly given, therapists hear them, read them, and take them to heart on an emotional, non-cognitive level, without being aware of what they are doing. In other words, introjection is always present as a companion for projection. Note 11. There is an element of reality in which those who are given a projection have some of the unacceptable attribute or at least the potential to act unacceptably (Searles, 1975). Note 12. We continue to believe that the leaders who warn us that migrants in our country are terrorists. We must be on guard lest they enter our country. We perpetuate fear, even terror, of our own death. We do not resolve the conflict out of a desire to deny our immortality and realize that we cannot defeat death (Becker, 1973). Note 13. For example, therapists might experience frustration as a result of their good customer template when customers say little or nothing, even if they come on time. However, therapists are also influenced by the unconscious need of their clients to punish them for the promptness demanded from them, as are their parents, of the cost to them. Current customer behaviour is a manifestation of customer transfer as well as communication they received from their therapists. Note 14. Thus, the traits are not the same as they were originally, because the recipients contained them and managed them in their own unique ways, without even being aware of them. In most circumstances, recipients lived with unwanted traits without allowing them to damage other aspects of the self, (Little, 1957) or self as a whole. Ironically, if the traits were not totally ego-distonic to the recipients, somehow the recipients may even have enjoyed them. Controlling people who need control, for example, can feel pleasant for those who control. When recipients are criticized for traits, however, they consider what happened problematic. To the extent that there is a kernel of truth in the recipients having at least some aspects of unwanted traits, they become defensive. They are caught between becoming aware of painful feelings related to unwanted traits and denying them. Note 15. Therapists should remember that it is not only customers who engage in projective identification. They do this themselves, unconsciously, of course. For example, they project their fantasy of omnipotence, which is easily transferred from a previous narcissistic period of development; assigns their clients the role of cured patients in the hands of their therapists; and then the pressure of their clients to be cured. Thus, therapists must own and process their projective identifications no less to help their customers do so. Note 16. Winnicott (1965) considers that the fact that therapists bring their own unresolved conflicts to support the therapeutic situation as unrealistic, even abnormal. It is both abnormal and unrealistic, for example, to desire to be demanding with an older female client, simply because she is like teachers of women who have been demanding with the therapist in the past. What would be normal and realistic, by contrast, would be the need for the same therapist to hold the older female client strictly responsible for being prompt for her sessions, as the therapist not all clients. The client's promptitude provides income each week, additional income from the next client, and the therapist's sense of achievement, all of which reflect the therapist's work ethic and personality. Note 17. The real abuse that some clients have suffered presents special difficulties, because in the mental structure of many victims there is a figure who is, paradoxically, both a protective image and a persecuting image (Kalsched, 1996). Note 18. Would an Islamic or Christian fundamentalist culture have a special impact in the case of Father Archetype? Note 19. These therapists consciously conclude that failure with a client is much more than a personal matter (Sharpe, 1930). This means that customers do not will do better, and therapists will be failures. Note 20. It is not unusual for customers to have a deep, passive desire to defeat the therapists they love when they realize that therapists are much more and insightful than they are. You are so great, my fate lies in your hands; do everything you can and I will still defeat you (Stein, 1981), customers unwittingly warn that envy will settle down. Like the envious people in everyday life, customers try to defeat others rather than acquire the skills they possess. Note 21. What could be the impact of therapists belonging to a majority culture and their clients belonging to a minority culture? White privilege in the case of an African-American client? Gender in a patriarchal institution? Note 22. What could be the impact of Asian cultures that consider shame to be totally unacceptable to themselves? Note 23. Blum (1997) believes that transfer hatred can become an even bigger problem than the love of transfer, as it gets deeper into the psyche of customers and therapists than their love: It threatens their fundamental self-esteem. However, the hatred of transfer and the hatred of countertransfer are easily repressed or denied, as they seem contrary to the therapeutic alliance. Customers should not hate their attentive and inventive therapists, and therapists should not hate their needy and vulnerable clients, they support cultural and psychotherapeutic traditions. If hatred is present, it must be denied, according to conventional wisdom. Then, like other denied and repressed emotions, hatred intensifies at an unconscious level, even so it is minimized or rationalized on a conscious level. As a result, hatred can be adopted unwittingly by customers, and even therapists. In turn, acts of hatred, would be the preservation of a grudge, are strongly reinforced by the resulting experiences of self-strengthening power and pleasant justification. Hate tends to be strong when fears of intimacy come to the surface. However, desperately customers want to be in a close, loving relationship, few have learned to tolerate the stress of this intimacy. When surfaces and therapists do not draw attention to it - let alone help clients to deal fully with it - clients often resort to such hate-based maneuvers as significantly reducing the effectiveness of their therapist. They induce guilt in their therapists, especially those who must be necessary, thus acting and destroying any concrete plan for improvement (Herron & Rouslin, 1982). Note 24. Perhaps nothing causes a conflict greater than the suicidal wishes of customers and the anti-suicide position of therapists, for the possibility that clients commit suicide often reminds therapists of the losses they had to accept in their families of origin. Therefore, therapists face conflicts related to the possession and limitation of their clients' suicidal wishes and who wish to eliminate them at any cost and as soon as possible. In turn, the inability of therapists to resolve these conflicts can easily lead to significant loss of the ratio or even loss of therapeutic alliance. Note 25. Conflicts occur in therapy as therapists try to determine and interpret clients' refusal to take for their lives and their therapy. The most obvious thing, within God and Goddess Archetype, therapists must balance their need to finally be responsible for the therapeutic process with their clients the need to decide whether or not they will take responsibility for their lives, including their therapeutic life. Note 26. Therapists must resolve the thorny conflict of accepting their clients because they are while challenging them to grow into maturity and responsibility. Therapists must strike a satisfactory balance between respecting customers' perspectives and questioning the inevitable distortions they harbour, in particular in the field of immature interpersonal relations (Handley, 1995). Note 27. What could be the impact of American political affiliations, especially in an election year? He's referring to the American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders, (5th edition). Washington, DC: Author. Alpert, M.C. (1992). Accelerated empathic therapy: A new dynamic short-term psychotherapy. International Journal of Short-Term Psychotherapy, 7, 133-156. Andersen, S., & Przybylinski, E. (2012). Experiments on transfer in interpersonal relationships: Implications for treatment. Psychotherapy, 49, 370-383. Bach, S. (2019). The inner world, the instinct and the sense of reality. Psychoanalytic psychology. Online publication in advance. ,doi.org/10.1037/pap0000256. Bachant, J., & Adler, D. (1997). Transfer: Co-built or brought to interaction? Journal of the American Psychoanalysis Association, 45, 1097-1120. Badcock, C. (2009). Printed brain: Genes establish the balance of the mind between autism and psychosis. Philadelphia, PA: Jessica Kinsley Publishers. Becker, E. (1973). Denial of death. NY: Free Press. Benedek, T. (1953). The dynamics of the countertransfer. Menninger Clinic Bulletin, 17, 201-208. Berk, M., & Anderson, S. (2000). Impact of previous relationships on interpersonal behavior: Behavioural confirmation in the social-cognitive process of transfer. Journal of Personality and Social Psychology, 79, 546-562. Bion, W. R. (1967). Notes about memory and desires. Psychoanalytic Forum, 2, 272-273 and 279-280. Blum, H. P. (1986a). Countertransference and technique theory: Discussion. Journal of the American Psychoanalysis Association, 34, 309-328. Blum, H. P. (1997). Clinical and development dimensions of the urine. Journal of the American Psychoanalysis Association, 45(2), 359-375. Bollas, C. (1983). Expressive use of countertransfer. Contemporary psychoanalysis, 19, 1-34. Bollas, C. (19887). Shadow of the object: Psychoanalysis of the known unknown. London: Free Association Books. Brenner, C. (1976). Psychoanalytic technique and psychic conflict. NY: International Universities Press. Brodbeck, H. (1995). Psychoanalyst as participant and observer in the psychoanalytic process: Some thoughts on countertransference from a perspective and contemporary thinking, 18, 531-558. Carsky, M., & Chardavoyne, J. (2017). Transference focused psychotherapy and language of action. Psychoanalytic Psychology, 34, 397-403. Casement, P. (1991). Learn from the patient. New York: The Guilford Press. Chodorow, N. (1978). Reproduction of motherhood: Psychoanalysis and gender sociology. Berkeley: University of California Press. Chodorow, N. (1996). Reflections on the authority of the past in psychoanalytic thinking. Quarterly psychoanalytic, 65, 32-51. Chused J., & Raphling, C. (1992). Analyst's mistakes. Journal of the American Psychoanalysis Association, 40, 137-149. Cohen, M.B. (1952). Countertransfer and anxiety. Psychiatry, 15, 231-243. Colli, A., Gaiardini, G., Degl'Innocenti, B., Monti, M., & Foresti, G. (2019). What psychoanalysts do in their daily clinical practice: empirically derived prototypes of the psychoanalytic process. Psychoanalytic psychology. Colli, A., Tanzilli, Al, Dimaggio, G., & Lingiardi, V. (2012). Patient personality and therapist's response: An empirical investigation. American Journal of Psychiatry, 171, 102-108. Colson, C., Allen, J., Coyne, L., Dexter, N., Jehl, N., Mayer, C., & Spohn, H. (1986). Anatomy of countertransfer: Staff reactions to difficult patients of the psychiatric hospital. Hospital and Community Psychiatry, 37, 923-928. Comas-Diaz, L., & Jacobsen, F.M. (1991). Ethnocultural transfer and countertransfer to therapeutic diade. American Journal of Orthopaedics, 61, 392-402. Cooper, A.M. (1987). Changes in psychoanalytic ideas: Interpretation of transfer. Journal of the American Psychoanalysis Association, 35, 77-98. Davies, J.M., & Frawley, M. G. (1994). Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective. New York: Basicbooks. DeLacour, E. P. (1985). Aspects of the interpretation of the transfer. Smith College Social Work Studies, 56, 1-14. Deutsch, H. (1926). Occult processes during psychoanalysis. In G. Devereux (Ed.), Psychoanalysis and Occultism (pp.133-146). New York: International Universities Press. Dewald, P.A. (1994). Supportive and active psychotherapy. Northvale, NJ: Jason Aronson, Inc. Ecker, B., & Hulley, L. (1996). Deep therapy focused briefly. San Francisco, CA: Jossey-Bass. Epstein, L. (1977). Therapeutic function of uri in countertransfer. Contemporary psychoanalysis, 13, 442-461. Ferenczi, S. (1909). Sex in psychoanalysis. New York: Basicbooks. Fox, R. (1998). Undisputed positive countertransfer. Journal of the American Psychoanalysis Association, 46, 1067-1087. Franch, N. (1996). Transfer and countertransfer in the analysis of a child with autistic nuclei. International Journal of Psycho-Analysis, 77, 773-786. Freud, S. (1900). Interpretation of dreams. Standard edition, 5. London: Hogarth Press. Freud, S. (1910). Future perspectives of psychoanalytic therapy. Standard 11: 141-151. London: Hogarth Press. Freud, S. (1912). Transfer dynamics. Standard edition, 12: 99-108. London: Hogarth Press. Freud, S. (1915). Comments on transfer-love. Standard edition, 12: 157-171. London: Hogarth Press. Freud, S. (1917). Introductory lectures on psychoanalysis. Standard edition, 16: 317-326. Freud, S. (1940). A sketch of psychoanalysis. Standard edition, 23: 139-207. London: Hogarth Press. Gabbard, G.O. (1994). Sexual excitement and love countertransfer in the analyst. Journal of the American Psychoanalysis Association, 42, 1083-1106. Gabbard, G.O. (1996). Therapeutic approaches to erotic transfer. In F. Flack (Ed.), Hatherleigh's Guide to Psychotherapy (pp. 231-247). New York: Hatherleigh Press. Gabbard, G.O. (2001). What can neuroscience teach us about transfer? Canadian Journal of Psychoanalysis, 9 (1), 1-18. Gazzillo F., Curtis, J., Bush, M., & Dazzi, N. (2019) Unconscious patient testing activity in psychotherapy: A theoretical and empirical overview. Psychoanalytic psychology, 36, 173-183. Gelso, J., & Bhatia, A. (2012). Passage of theoretical lines: The role and effect of transfer in nonanalytical psychotherapies. Psychotherapy, 49, 384-390. Gelso, C. J., & Hayes, J. A. (1998). The psychotherapy relationship. New York: John Wiley & Sons, Inc. Gelso, C., & Hayes, J. (2007). Countertransfer and inner experience of the therapist. Dangers and possibilities. Mahwah, NJ: Erlbaum. Glassman, N., & Anderson, S. (1999). Activation of consciousnessless transfer: Using significant-other representations to go beyond the given subliminal information. Journal of Personality and Social Psychology, 77, 1146-1162. Grayer, E. D., & Sax, P. R. (1986). A model for the diagnostic and therapeutic use of countertransfer. Clinical Social Work Journal, 14, 295-309. Greenacre, P. (1954). The role of transfer: Practical considerations in relation to psychoanalytic therapy. Journal of the American Psychoanalysis Association, 2, 671-684. Greenson, R. R., & Wexler, M. (1969). Non-transfer relationship in the psychoanalytic situation. International Journal of Psycho-Analysis, 50, 27-38. Grindberg, L. (1962). On a specific aspect of the countertransfer due to the projective identification of patients. International Journal of Psycho-Analysis, 43, 436-440. Grinberg, L. 1997. Is the fear of the psychoanalyst transferring? International Journal Psycho-Analysis, 78, 1-14. Handley, N. (1995). Transfer concept: A criticism. British Journal of Psychotherapy, 12(1), 49-59. Heath, S. (1991). We're dealing with the therapist's vulnerability to depression. Northvale, NJ: Jason Aronson. Heimann, P. (1950). Countertransfer. International Journal of Psycho-Analysis, 31, 81-84. Heimann, P. (1960). Countertransfer. British Journal of Medical Psychology, 33, 9-15. Hennissen, V.; Meganck, R.; Van Nieuwenhove, K.;

Norman, J.; Loeys, T., & Desmet, M. (2019). Therapists' responses to addicts and self-critical (introjective) depressed external patients: A multi-level approach. Psychotherapy, 1-12. Herron, W. G., & Rouslin, S. (1982). Problems in psychotherapy. Washington, DC: Orgin. Hinshelwood, R. (1999). Countertransfer. International Journal of Psycho-Analysis, 80, 797-818. Hoglend, P. (1993). Interpretations of transfer and long-term change after dynamic psychotherapy of short to moderate length. American Journal of Psychotherapy, 47, 494-507. Hoglend, P. (1996). Analysis of transfer in patients with personality disorders. Journal of Personality Disorders, 10(2), 122-131. Jung, C. G. (1921). Psychological types. Collected work (Vol. 20). Princeton, N.J.: Bollingen. Jung, C. G. (1946). The psychology of transfer. Collected work (Vol. 16). Princeton, Bollingen. Jung, C. G. (1966). Archetypes and the collective subconscious. Collected works (Vol. 9, Pt. 1). Princeton, N.J.: Bollingen. Jung, C. G. (1969). The psychology of transfer. Princeton, N.J.: Bolingen. Kalsched, D. (1996). The inner world of trauma: the archetypal defense of the personal spirit. New York: Routledge. Kernberg, O. F. (1987). An approach to the theory of ego-object relationships versus transfer. Quarterly psychoanalytic, 56, 97-221. Kernberg, O. F. (1994). Love within the analytical framework. Journal of the American Analytical Association, 42, 1137-57. Kernberg, O. W. (1975). Limit conditions and pathological narcissism. New York: Jason Aronson. Kiesler, D. J. (1982b). Confronting the client-therapist relationship in psychotherapy. In J.C. Anchin & D. J. Kiesler (Eds.), Manual of Interpersonal Psychotherapy (pp. 280-295). New York: Pergamon Press. Klein, M. (1946). Notes on some schizoid mechanisms. International Journal of Psycho-Analysis, 27, 99-110. Klein, M. (1952). The origins of the transfer. International Journal of Psycho-Analysis, 33, 433-438. Klein, M. (1957). Envy and gratitude. London: Tavistock. Kupfer, D. J. et al. (2013). Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition. Washington, D.C.: American Psychiatry Publishing House. Bear, J. (1993). An interpretation of the transfer. International Journal of Psycho-Analysis, 74, 739-755. Ledoux, J. (1995). Emotion: clues in the brain. Annual review of psychoanalysis, 46, 209-235. Ledoux, J. (1998). Emotional brain: the mysterious foundations of emotions. New York: Simon & Schuster. Ledoux, J. (2002). Synaptic self: Our brain becomes who we are. New York: Viking. Levin, F. (1997). Integrating some views of the mind and brain on the transfer: phenomena. Journal of the American Psychoanalysis Association, 45, 1121-1151. Levy, K., & Scala, J. (2012). Transfer-focused psychotherapy. Psychotherapy, 45, 391-403. Little, M. (1951). Countertransfer and patient response to it. International Journal of Psycho-Analysis, 32, 32-40. Luborsky, L. (1984). Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment. New York: Basicbooks. I. (1959). Development of transfer. Quarterly psychoanalytic, 19, 501-539. MacLean, P.D. (1990). Brain trion in evolution: Role in paleocerebral functions. New York: Plenum Press. Malan, D. H. (1976a). The frontier of short psychotherapy. New York: Plenum Press. Malan, D. H. (1976b). To validate dynamic psychodynamic psychotherapy. New York: Plenum Press. Mandal, M. K., & Ambady, N. (2004). The laterality and universality of facial expressions of emotions: Interface. Behavioral Neurology, 15, 23-34. Mann, D. (1973). Time-limited psychotherapy. Cambridge, MA: Harvard University Press. Mann, D. (1999). Clinical practice in psychotherapy. In D. Mann (Ed.), Erotic Transfer and Countertransfer (pp. 1-25). New York: Routledge. Marmar, C. R., Gaston, L., & Thompson, L. W. (1989). Alliance and outcome in depression end of life. Journal of Mental Nervous Diseases, 177, 464-472. Marmor, J. (1989). The future of dynamic psychotherapy. International Journal of Short-Term Psychotherapy, 4(4), 259-284. Maroda, K. (1995). Projective identification and countertransfer interventions: Because feeling is first. Psychoanalytic Magazine, 82(2), 229-247. McDougall, J. (1978). Primitive communication and use of countertransfer. Contemporary psychoanalysis, 14, 173-209. Meares, R., Stevenson, J., & Comerford, A. (2005). Distinct model of P3a event and related in borderline personality disorders. NeuroReport, 16, 289-293. Meissner, W. (1996). Therapeutic alliance. New Haven, CN: Yale University Press. Modell, A. H. (1980). It also affects their non-communication. International Journal of Psycho-Analysis, 61, 259-267. Money-Kyrle, R. (1956). Normal countertransfer and some of its deviations. In D. Meltzer & E. O'Shaughnessey (Eds.), Works collected by Roger Money-Kyrle (pp. 330-342). Strathtay, Perthshire: Clunie Press. Nunberg, H. (1951). Transfer and reality. International Journal of Psycho-Analysis, 32, 1-9. O'Crowley, A.M. (1999). Transfer analysis: Interpretation and changes in psychotherapy. Dissertation Abstracts International: Section B: Science & Engineering, 60(4-B), 1866. Ogden, T. H. (1982). Projective and psychotherapeutic identification. New York: Jason Aronson. Ogden, T. H. (1994). The concept of interpretive action. Quarterly psychoanalytic, 63 (2), 219-245. Ogle, C., Rubin, D., & Siegler, I. (2012). Impact of the time of development of trauma exposure on PTSD symptoms and psychosocial functioning among older adults. Developmental Psychology, 49, 2191-2200. Olnick, S. (1969). About empathy and regression in each other's service. British Journal of Medical Psychology, 42, 41-49. Pally, R. (2001). A leading role for nonverbal communication in psychoanalysis. Psychoanalytic investigation, 21, 71-94. Pillow, P.A. (1997). Reflections on the therapeutic system, as seen from the science of chaos and complexity: Implications for research and treatment. In F. Masterpasqua & A. Pillow (Eds.), Psychological Sense of Chaos: Translating Theory into Practice (pp. 253-272). Washington, DC: American Psychological Association. Pick, I.B. (1997). I'm working on the countertransfer. In R. Schafer (Ed.), contemporary Kleinians of London (pp. 348-367). Madison, CN: International University Press. Pierro, A., & Kruglanski, A. (2001). Sequestration and freezing on a scheme of significant persons: The need for closure and the effect of transfer to social judgment. Bulletin of Personality and Social Psychology, 34, 1492-1503. Plakun, E.M. (1998). Regulatory acts and treatment of survivors of abuse. Harvard Review of Psychiatry, 5, 318-325. Racker, H. (1968). Transfer and countertransfer. New York: International Universities Press. Racker, H. (1972). Meanings and uses of countertransfer. Quarterly psychoanalytic, 41, 487-506. Rank, O., & Ferenczi, S. (1925). Development of psychoanalysis (C. Newton, Trans.). New York: Nervous and Mental Illness Publishing Company. Reik, T. (1937). Surprise and psychoanalyst. New York: E.P. Dutton. Renik, O. 1990. The concept of transfer neurosis and psychoanalytic methodology. International Journal of Psycho-Analysis, 71, 197-204. Rioch, J.M. (1943). The phenomenon of transfer in psychoanalytic therapy. Psychiatry, 6, 147-156. Sandler, J. (1976). Countertransference and role response capability. International Journal of Psychoanalysis, 3, 43-47. Schafer, R. (1959). Generative empathy in the treatment situation. Quarterly psychoanalytic, 28, 342-373. Schafer, R. (1968). Aspects of internalization. New York: International Universities Press. Schafer, R. (1977). Interpretation of the transfer and conditions for love. Journal of the American Psychoanalysis Association, 25, 335-362. Schafer, R. (1997). Vicissitudes to remember in countertransference: fervent failure, colonization and remembering otherwise. International Journal of Psycho-Analysis, 78, 1151-1163. Schore, A. N. (2003a). Affects disorder and self disorders. New York: W.W. Norton & Company. Schore, A. N. (2003b). It affects self regulation and repair. New York: W.W. Norton & Company. Schore, A. N. (2011). The self-default brain is at the heart of psychoanalysis. Psychoanalytic Dialogues, 21, 75-100. Searles, H. (1975). Patient as therapist to analyst's/Nontransference. In P. Giovacchini (Ed.), Tactics and Techniques in Psychoanalytic Therapy: Countertransfer (Vol. II, pp. 95-151). New York: Jason Aronson. Sharpe, E. (1930). The technique of psychoanalysis. International Journal of Psycho-Analysis, 2, 361-386. Sifneos, P. E. (1979). Short-term dynamic psychotherapy: Evaluation and technique (second ed.). New York: Plenum Press. Smith, H. (1990). Clues: Perceptual edge of transfer. International Journal of Psycho-Analysis, 71, 219-228. Stamm, B. (1995). Secondary traumatic stress: Self-care problems for clinicians. In Researchers and Educators. Lutherville, Sidran press. Stark, M. (1994). Primer on working with resistance. New York: Jason Aronson. Stein, M. (1981). The undisputed part of the transfer. Journal of the American Psychoanalysis Association, 29, 869-891. Stein, G. S. (1993). A transfer psychosis. Journal of Clinical Psychoanalysis, 2, 345-262. Sternberg, W. F., Bailin, D., Grant, M., & Gracely, R.H. (1998). Competition changes the perception of harmful stimuli in male and female athletes. Pain, 76, 231-238. Stolorow, R.D. (1993). An intersubjective view of the therapeutic process. Menninger Clinic Bulletin, 57, 450-457. Strachey, J. (1934, 1969). Nature of the therapeutic action of psychoanalysis. International Journal of Psycho-Analysis, 50, 275-291. Tower, L. E. (1956). Countertransference Journal of the American Psychoanalytic Association, 4, 224-255 Tummala-Narra, P. (2019). Fear of immigrants. Psychoanalytic psychology. . Ulanov, A. (1984). Transfer/countertransfer: A Jungian perspective. In M. Stein (Ed.), Jungian analysis (pp. 68-86). Evanston, IL: Northwestern University Press. Vanaerschot, G. (1997). Empathic resonance as a source of experience improvement interventions. In A.C. Bohart & L. Greenberg (Eds.), Empathy reconsidered: New Directions in Psychotherapy (pp. 141-165). Washington, DC: American Psychological Association. Volkan, V. (1995) Six steps in the treatment of the organization of personality at the limit. Northvale, NJ: Jason Aronson, Inc Weiss, J. (1993). psychotherapy works. New York, NY: Guilford Press. Weiss. J. (1993). Unconscious plans of patients to solve their problems. Psychoanalytic Dialogues, 8, 411-428. Wells, J., & Wrye, H. (1991). Maternal erotic countertransfer. International Journal of Psycho-Analysis, 72, 93-106. Westen, D. (1988). Transfer and processing of information. Clinical Psychology Review, 8, 161-179. Westen, D. (1998). The scientific legacy of Sigmund Freud: Towards a psychodynamic psychological science. Psychological Bulletin, 124, 333-371. Wilson, A., & Weinstein, L. (1996). Transfer and proximal development area. Journal of the American Psychoanalysis Association, 44, 167-200. Winnicott, D. W. (1949). Hatred in counter-transfer. In the collected documents. London: Tavistock. Winnicott, D. W. (1965). Maternal primary concern. In J. D. Sutherland (Ed.), By Pediatrics in Psychoanalysis (pp. 300-305). London: Hogarth [International Psycho-Analytical Library]. Winnicott, D. W. (1988). Human nature. London: Free Association Press. Wolstein, B. (1996). Transfer analysis as an interpersonal process. American Journal of Psychotherapy, 50, 499-509. Take the test