

# TYPES OF COUNTERTRANSFERENCE

John Rowan (1983) "The Reality Game"

The following list of types of countertransference it was first published more than 30 years ago, by one of the elders of the humanistic tradition in the UK, John Rowan. He was then already modelling an interest and learning from the psychoanalytic tradition, trying to bring a more straightforward understanding to this convoluted aspect of theory.

As this handout has been used traditionally, it is interesting for us to still use it for study, but I'm trying to help you read it critically, and I have highlighted **questionable statements** and **significant assertions**.

**Ask yourself the following questions whilst you are reading it:**

- Taking into account that this was written several decades ago, how can you detect the underlying paradigm? How would you describe it? Do you stumble across any apparent shortcomings?
- What do you think about these distinctions and categorisations of types of countertransference?
- How clear and distinct are the various categories in your mind? Which ones seem to overlap, or be difficult to distinguish?
- How helpful do you find these distinctions in practice?
- What kind of notion of the 'unconscious' does John Rowan imply?
- What are the implications in terms of what is needed to make the unconscious conscious?
- When you think of your own experience, does this list/categorisation cover all transference/countertransference phenomena or are there major omissions that you can think of?
- Can you think of other principles at the root of transference/countertransference phenomena that would lend themselves to a more helpful categorisation?

1. **Defensive countertransference** is the most general type, and occurs when the client triggers off the therapist's unresolved struggles **with areas such as dependency, sexuality or aggression**. Flescher (1973) says: **"The therapist's unconscious readiness to accept or refuse specific material is an important suggestive factor in stimulating the patient to surrender or withhold such material."**
2. **Aim attachment countertransference** is about the therapist's motives. Unconscious need for success, power, omnipotence or money can distort the therapeutic relationship; so can desperate searches for love, recognition and admiration. Other things of this kind which can enter in are saviour and rescuer fantasies; voyeuristic impulses; the need to feel superior by working with sick or inadequate people; and attempts to alleviate guilt feelings by helping others. **[How do you see the difference between 1. Defensive countertransference and 2. Aim attachment countertransference ?]**
3. **Transferential countertransference** happens when the therapist responds as though the client is a parental figure or a sibling figure, etc. For example, if the client is silent and with-holding, the therapist may have feelings stirred up of parents and not being able to get through to them.
4. **Reactive countertransference** arises when the therapist responds to the client's transference distortions as if they were real. I had a client who used to accuse me from time to time of having lured him into therapy when he didn't know what he was doing. If I had replied to him by defending myself or explaining what had really happened, this could only have come from reactive countertransference. Instead, I invited him to work on his feelings about that, with good results. Similarly, a young therapist was very upset by being criticised for dressing in a sloppy way, and was even more hooked by criticisms of the room she was working in. She actually started to see the room in the same way as the client, instead of simply regarding it as a good opportunity to explore the client's feelings about sloppiness, untidiness and imperfection.
5. **Induced countertransference** is where the therapist takes up a role suggested by the client's transferential behaviour. For example, a dependent client may send out strong take-care-of-me

signals, which the therapist may respond to by giving advice, answering questions, giving reassurance and so forth – in other words, acting like a parent. **This is feeding the neurosis, not changing it.** There is an interesting misunderstanding which can arise here, about the meaning of the word ‘humanistic’. As used by analysts and many others, the word often just means ‘sloppy’. For example, if a client comes in with a huge bandage on, or tells us that a parent has just died, these people say that the ‘humanistic’ response is to express sympathy and to comfort the client, while the analytic’ response is to probe the client’s feeling about these matters. This is not my terminology in this book. Some humanistic therapists would act in the former way, and some including me – in the latter. I would agree totally with Brenner (1979) where he says: It is true enough that it often does no harm for an analyst to be thus conventionally ‘human’, in expressing sympathy to a patient whose father has just died, for example. **Still, there are times when his being ‘human’ under such conditions can be harmful, and one cannot always know in advance when those times will be.** As an example, for his analyst to express sympathy for a patient who has just lost a close relative may make it more difficult than it would otherwise be for the patient to express pleasure or spite or exhibitionistic satisfaction over the loss. This seems to me absolutely right. **A therapist is a therapist, playing a very strict role (this is one of the things which co-counselling has made crystal clear) and to step outside this role is to ask for trouble.**

6. **Identification countertransference** is where the therapist over-identifies with the client, entering into a covert alliance with the client’s neurotic aims. You can become aware of this whenever you find yourself blaming others for the client’s difficulties. Loeser and Bry (1953) say that this is the most common form of countertransference. It can also take a negative form, where the therapist avoids areas which are reminiscent of the therapist’s own problems. **[How do you see the difference between 1. Defensive countertransference and 5. Induced countertransference, 6. Identification countertransference and 7. Displaced countertransference ]**
7. **Displaced countertransference** occurs when the therapist displaces feelings from his or her own personal life on to a client, or when feelings towards one client are displaced and acted out on another. Also the therapist may displace feelings towards a client on to people in his or her personal life, such as family or friends. This is the source of that common experience of therapists that ‘all my clients seem to have the same problems at the moment.’ **[How do you see the difference between 1. Defensive countertransference and 2. Aim attachment countertransference and 7. Displaced countertransference ]**
8. Some writers on this subject (e.g. Freundlich 1974) say that there is such a thing as **conflict-free countertransference**, which is a mature relationship between therapist and client which is not driven by historical needs and fears: **‘It is characterised by autonomy, mutual respect, spontaneity, cooperation and an absence of exploitation and manipulation.’** I would just call this liking the client, or good therapist-client communication, rather than any kind of countertransference. **There would seem to be no need for any further therapy at this point.**