
Transference, Countertransference and Cognitive Behavioural Therapy

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In my training in the early 1980s, I was introduced (not in-depth) to CBT, behaviour therapy, family therapy and gestalt therapy. I was also introduced to the psychodynamic ideas around transference and countertransference. This paper briefly reflects on ideas that I have developed over a number of years about potential ways of bringing together psychodynamic and traditional cognitive-behavioural approaches when working with clients who do not appear to benefit from traditional CBT. It focuses on integrating ideas of transference and counter-transference into cognitive conceptualisations and uses hypothetical cases for illustration.

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Cognitive Behaviour Therapy 1 is the dominant therapy approach practised by Clinical Psychologists in New Zealand and taught in our Clinical Training programmes. CBT approaches continue to develop and treatment outcome research provides evidence that CBT approaches are effective with a wide range of presenting problems (Hollon & Beck, 2004). CBT provides accessible models for working therapeutically. These are often common sense and user-friendly for clinicians and for the many clients who respond well to them.

Whilst there is substantial empirical support for the effectiveness of CBT approaches (Hollon & Beck, 2004), Lambert and Ogles (2004) conclude in their decade review of research into treatment outcomes, that many

psychotherapies have beneficial effects on a range of client problems and that the difference in outcomes across a range of therapeutic approaches “are not as pronounced as might be expected” (p.180). This evidence of the effectiveness of a number of different therapy approaches has been consistent over the last three decades (Lambert & Ogles, 2004).

These reviewers (Lambert & Ogles, 2004) also confirm the previously established importance of the therapeutic relationship as a component of treatment effectiveness. As Lambert and Ogles (2004) state:

These relationship factors are probably crucial even in the more technical therapies that generally ignore relationship factors and emphasize the importance of technique in their theory of change. (p. 181).

Despite the ongoing evidence of the importance of the therapy relationship, and CBT’s emphasis on empirical investigation and validation, CBT theorists and therapists continue to pay less attention to the quality and the meaning of the client’s relationship with the therapist, relative to other approaches. As an example of this lack of attention, two key CBT texts commonly used and widely respected (Beck,1995; Padesky & Greenberger, 1995) make only brief mention of the importance of the therapeutic relationship. Beck, Freeman and associates (1990) provide more in-depth discussion of working within the therapy relationship with clients with personality disorders and use the terms transference and countertransference. The therapeutic relationship is also given a central position by Young, Klosko and Weishaar (2003) who combine cognitive, psychodynamic, attachment and Gestalt models in their schema-focused therapy. However, these

¹ The term CBT will be used throughout to refer to Cognitive and Cognitive Behavioural Therapies.

authors do not directly discuss the psychodynamic ideas of transference and countertransference.

In this paper, I talk about ways that the concepts of transference and countertransference can be applied by CBT therapists in their work with clients. Before doing so, however, it is important to briefly consider how these terms are used. Transference and countertransference can be regarded as cognitive-affective reactions or responses that occur within the therapeutic relationship. Transference refers to the process by which the client brings childhood patterns of relating into the therapeutic relationship. At any given moment, activation of a transference response manifests in how a client feels towards the therapist, thinks about the therapist and construes the therapists' attitude towards him or herself. Countertransference, on the other hand, refers to the therapist's cognitive-affective responses to the client. Sometimes the countertransference can be described as personal as the therapist's reaction to the client is based on his/her own personal dysfunctional beliefs, or unresolved issues. Objective countertransference refers to therapist's reactions to the client's transferences. One way of checking to see if the therapist's response constitutes an objective countertransference is to think about whether other therapists would be likely to have similar feelings in relationship to the client. Many clinicians, for example, would experience some negative feelings towards a client who is always late, cancels at the last minute or is irregular in payment. In the case of a negative personal countertransference (negative feelings towards the client), the therapist can use a CBT approach to work through her own automatic negative thoughts and personal beliefs that underlie the countertransference (Beck et al, 1990; Davis & Wright, 1994) in order to protect the client from any negative response.

In psychodynamic therapy, therapists observe and monitor clients' and their own responses within the therapeutic relationship. These processes can also be

examined from a CBT perspective. For example, a client's core beliefs may be: "I am unlovable" and "Others reject me". The client presents to the therapist seeking relief from the impact that these beliefs have on her life and relationships. However, beliefs that operate in daily life can also be triggered in therapy. The therapist may remind the client of some-one from the past, or the client may experience memories or emotions associated with past experiences. Having regular sessions with a therapist who is interested, concerned and accepting in itself can trigger transference responses. When a client experiences a transference reaction in a therapy session, the therapist may notice changes in the client. As examples, she may look away, seem to withdraw or appear to try harder to please the therapist. If the therapist notices a change in the client, s/he can then consider the possibility that the client is experiencing a transference reaction towards her. If this is so, it is possible that the client's core belief(s) have been activated. The client may be expecting criticism or rejection from the therapist, similar to what she has experienced in other earlier and sometimes current relationships.

Perhaps the most important contribution to understanding the complexities of the therapeutic relationship is the psychodynamic argument that objective countertransference can be a source of valuable information to the therapist who attends to his or her own reactions to clients (see Brown & Pedder, 1991; Jacobs, 1999). The notion of countertransference can also be integrated with CBT. If the therapist considers the possibility of a personal countertransference and put this aside, then the question arises: What is it about the client that is leading me to feel this way. As a therapist gains experience, it becomes easier to distinguish between personal and objective countertransference responses. If a therapist's reaction to a client is unexpected or out of keeping with how s/he normally responds or feels towards the client, s/he can alerted to another possibility: Is there something happening with this client that is not apparent to me? Has a transference reaction been triggered in

the client? If so, what might that be? How might this relate to the formulation?

To take an hypothetical example, imagine a client whom you have begun to see a few weeks before Christmas. She has a history of mild chronic depression but this has become worse in the last few months since her best friend went overseas. She cries a lot through sessions and although she appears to accept the CBT approach, she seems to prefer to talk to you about her worries and resists doing the agenda and working through it. She says she is getting a lot out of the sessions, it is just so good to have some-one to talk to, and she does not know how she would cope without seeing you. As a therapist you find yourself liking the client, appreciating her admiration and find yourself thinking that whilst you have planned to have a 4 week holiday over Christmas, you might make an exception for this client. In this instance, the countertransference can be described as positive. You like the client, you want to support her and if you examine your response, you might notice that you feel protective towards her.

The challenge for the therapist, especially recent graduates, is to know whether this urge to protect is based on sound professional sense (for example, the client is unable to cope with this length of break and may be at risk), or if this is a countertransference response. In this latter instance, the client believes herself to be incompetent, feels frightened of her emotional distress and is hopeful of engendering the therapist's support. The client is not so much motivated to challenge her own cognitions and dependent behaviour. Rather, at a level which is not fully conscious, she is more motivated towards engendering the therapist's support based on the belief that she cannot cope alone with the feelings of vulnerability triggered by her friend's departure.

Understanding the notions of transference and countertransference, the therapist can consciously consider that her urge towards protecting the client, and making the client a special case (by breaking into her holidays) is a reaction to the client's emotional and

cognitive responses related to her beliefs that she is incompetent and cannot cope alone. On the other hand, she might consider the above but decide to provide the client with the name of another therapist who is willing to see the client during this time, if the client feels unable to cope.

To further illustrate the use of countertransference reactions, we can consider a hypothetical male client who experienced damning criticism as a child, as well as public humiliations. This client is in a work situation that he dislikes intensely and has wanted to change his job for three years. However, he has not done so. He gets frustrated with himself and blames others whom he sees as stopping him from making changes. As therapist, you find yourself feeling moments of annoyance with him. These feelings come up suddenly and briefly during sessions. You attempt to not let them show as you realise this would be detrimental to him and your relationship. You wonder where the feelings come from. Between sessions you do not feel annoyed with him. You can see how "stuck" he feels. When you notice these feelings, you wonder if it could be a countertransference reaction. Are you are experiencing annoyance as a result of his transference reaction towards you? For example, he may be experiencing you as a "critical parent" or expecting (not necessarily consciously) that you will be critical of him and experience anger towards him as others do and have done. You have no way of knowing if he has begun to feel like this in the session but find yourself feeling some annoyance with him, a normal response to somebody who is "projecting" anger on to you or responding towards you as if you are likely to get angry with him. Once you have developed this as a potential hypothesis, you can then check it with the client. For example, you might say to him: I'm wondering how you are finding talking about this with me? If the client says something like: I imagine you are fed up with me; or, I feel really stupid talking about this, you must think I'm an idiot, then this partially confirms your hypothesis. It also allows you to work with the client and the thoughts and feelings he is having in regard to you.

Further, the hypothesis that: He may expect me to get angry with him , then allows you to consider other aspects of the therapy relationship and therapy progress. Could this, for example, account for why he is late or why he becomes uncommunicative at times, or why he complements you on your work with him? Are there similarities to how he responded within relationships in his childhood? Did he, for example, withdraw from situations; did he attempt to ingratiate himself; did he become a caretaker. Hence, the countertransference becomes a source of valuable and perhaps otherwise unattainable information, or at least, a source of potential hypotheses about the client. For a CBT therapist who is familiar with and works with the psychodynamic ideas of transference and countertransference, these hypotheses can be considered in the light of the cognitive formulation.

Becoming familiar with the notions of transference and countertransference therefore allows the clinician to move sideways, to take time to consider what is occurring out of conscious awareness for both client and therapist, and to consider how this relates to the cognitive formulation. It is an extra check also to ensure that we are making decisions that are professional and not based on urges that feel professional but are countertransference in origin. It provides us with a language to use when attempting to make sense of the sometimes complex relationship processes that occur in therapy. For relatively well-functioning clients, who are capable of building a therapeutic alliance and working in a collaborative relationship, these concepts may be less necessary. For therapists working with clients who have a history of disturbed relationship patterns, the ideas of transference and countertransference are likely to provide further understanding that can complement CBT formulations. This understanding, in turn, sometimes opens up new avenues for assisting the client.

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