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Transference and Countertransference in Group Psychotherapy*

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The physical symptoms and disturbed behavior of the emotionally ill are so easy to perceive that Freud pointed out their similarity to monuments erected to commemorate historic events. But the underlying psychic mechanisms and the germs of pathological dispositions are never visible to the naked eye. A more powerful lens than that provided by nature is required to see the mental anatomy. The investigation of inner realities with a view to helping people evolve into emotional maturity is the main occupation and preoccupation of the psychotherapist.

At this point in history we utilize two instruments—similar in some basic respects and different in others—to diagnose and investigate the functioning of the mind and to influence this functioning. One is psychoanalysis; the other is analytic group psychotherapy. Psychoanalysis as a research instrument has contributed as much to the science of human behavior as the microscope has contributed to the science of bacteriology. As a medical student in the thirties, I heard psychoanalysis referred to as the microscope of the mind. It seems appropriate to refer to the second instrument—analytic group psychotherapy—as the electron microscope of the mind.

One important difference between these instruments lies in their resolving power—that is, their ability to produce distinguishable images of internal realities. The older microscope has sufficient resolving power to magnify the psychodynamic events

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going on in the analytic twosome: the feelings and impulses of the patient impinging on the emotional perceptiveness of the analyst, and vice versa. The electron microscope is more powerful. With it we can perceive the impact of the feelings and impulses of six or eight group members on one another and on the group therapist.

Whereas the original microscope of the mind magnifies emotional patterns, the electron microscope giganticizes these patterns, and simultaneously intensifies them. They become more charged and produce more countercharge. Consequently, one may observe the reactivation in the group setting of pathological patterns that had apparently been fully resolved in the individual relationship.

For example, a patient, in analysis, worked through the emotional trauma of having failed her father, but the greater stimulus of the group situation revived the problem. Eventually she was able to stand up and recite a poem she had been unable to present in a school assembly in her childhood. This recitation lifted a massive burden from her mind—she had finally fulfilled her duty to her father. Another member of the group, who had mastered his overpowering hostility to objects and had eventually developed a positive relationship with me, resumed his original attacking attitude toward me when he entered the group—a startling transformation. And a woman who had developed the ability to handle personal criticism constructively in the course of individual psychoanalytic therapy, fell apart again when group members criticized her—a revival of her early experience as the inferior, humiliated sister in a strife-torn family.

The operational concepts of transference and countertransference facilitate the understanding and constructive use of the intense charge and countercharge that one is exposed to in conducting analytic group therapy. Before discussing the application of these concepts in the shared treatment experience, I shall briefly summarize the historic role they have played in psychoanalytic therapy since its inception.

Freud discovered the innate capacity of human beings to associate feelings developed for one person with another person, and he called this *transference*. In his first report on transference, in 1895, he also referred to it as the “false connection” of the patient's material with the person of the therapist and as *mésalliances*. These

were a source of great annoyance, he added, because their resolution entailed time and effort. But there is no hint of annoyance in his later formulations on transference. He described it in 1905 as

the revival of a "whole series of psychological experiences … not as belonging to the past, but as applying to the person of the physician at the present moment."

And in 1925 he pointed out that tendencies to transfer feelings are not the sole prerogative of the mentally ill: "Transference is merely uncovered and isolated by analysis. It is a universal phenomenon of the human mind, it decides the success of all medical influence, and in fact dominates the whole of each person's relation to his human environment."

Freud went on to explain that transference is used "… to induce the patient to perform a piece of psychical work—the overcoming of his transference resistances—which involve a permanent alteration of his psychic economy. The transference is made conscious to the patient by the analyst, and it is resolved by convincing him that in his transference attitude he is re-experiencing emotional relations which had their origin in his earliest object-attachments …"

The term *transference*, as Freud used it, implied the transfer of feelings that developed for persons perceived as separate from the self. Subsequent clinical experience with patients whose problems originated in the first two years of life, the so-called preoedipal or preverbal period, served to amplify the concept of transference. The preoedipal patient is unable to relate consistently to others as persons separate from himself because he has difficulty differentiating their feelings from his own. His attitudes when he is in a state of transference suggest the residue of undifferentiated feelings associated with primitive object relations. At times he appears to be wholly absorbed in himself, and tends to relate to others as part of himself or like himself. The concept of *narcissistic* transference facilitates the understanding of such phenomena, and it is helpful to distinguish them from the transference reactions described by Freud on the basis of his experience with patients with oedipal problems. The latter phenomena are more strictly identified today as *object* transference.

In fact, the original unitary concept of transference is being superseded by the notion of a continuum of transference states, ranging from psychotic transference or transference psychosis—the distorted transference manifestations observed in severely regressed inpatients—through narcissistic transference, to object transference. These distinctions are of more than academic importance. Persons with preoedipal problems are not responsive to the conventional approaches. The resolution of narcissistic transference

often entails the use of emotional communication and other noninterpretive procedures.

The counter-phenomenon was not systematically explored by Freud. In introducing the term *countertransference* in 1910, he briefly characterized it as a phenomenon arising in the practitioner "as a result of the patient's influence on his unconscious feelings." Regarding this influence as invariably disruptive to the analytic process, he warned against any tendency to countertransference. In the spirit of this warning, the first few generations of practitioners were trained to suppress their feelings for the patient. Adherence to the mildly benevolent attitude advocated by many training analysts encouraged the notion of the "mirror analyst." This ideal has been increasingly questioned since the early 1950s. It is now generally accepted that the analyst's participation is more than that of a neutral receiver of the patient's projections. The recognition that a two-way relationship is carried on in the analytic situation has given rise to a substantial body of literature on the potentially positive as well as the negative implications of the therapist's feelings for the patient.

Some implications of the therapist's narcissistic countertransference have also been recognized. We speak today of narcissistic countertransference when the therapist experiences the feelings he has in the session as having nothing to do with the patient but rather as feelings toward the self. As yet, little has been written about this problem because the understanding of narcissistic transference has just begun to develop. It is generally accepted, however, that in dealing with patients with preoedipal problems, such as defective ego boundaries and pathological defenses against aggressive behavior, it is important to distinguish between the therapeutic and anti-therapeutic use of emotional influence.

How does the group setting modify the transference-counter-transference situation? The most obvious change springs from the presence of multiple subjects and objects. In individual psychotherapy the patient transfers to the analyst and the analyst coun-tertransfers; in the group, patients transfer to one another as well

as to the therapist, and they may also develop transferences to the group as a unit; moreover, the transference emotions directed by one patient to another sway the latter to countertransfer. Thus we recognize the presence of countertransference as well as transference among the patient-members of the group.

Twenty years ago, when, after long service as a dimly seen presence behind the analytic couch, I assembled my first group, I

found that the greater abundance of sensory clues to my real identity, as well as the presence of many additional stimuli, had a profound effect on transference. The patients' more rounded and lifelike impressions of me encouraged speculation about my thoughts, feelings, and personal life much earlier than in the dyadic relationship. Their impressions and also their fantasies about me, however, were less sustained and less emotionally charged; the feelings the group members developed for each other mitigated the effects of their feelings for me.

The law of supply and demand appears to operate with respect to the patient's investment of mental energy in the treatment situation. In individual psychotherapy, the therapist is the only, transference object available, but the group setting shatters this monopoly and thrusts him into a highly competitive situation. In this buyer's market, the therapist enjoys a favored position; but as the group members shop around among the array of emotional bonds offered, they often engage in impulse buying. Even the inflection of a voice or an almost imperceptible mannerism may activate a transference relationship. One conscious involvement of this nature between a man and woman in the group produced so many verbal explosions that the others wondered repeatedly if they were observing a love duet or a war.

Two group members transferred to me their feelings for their own father, while I kindled memories of both parents in a third member. For another I represented at times the “ideal” father of his childhood fantasies, and still another related to me as the kind of person he had wanted his mother to be. The sixth member of the group reacted realistically to my presence at all times, but developed a mother transference to one co-member and became emotionally involved with another who kindled memories of childhood quarrels with his younger brother. His hostility toward his “brother” in the group stimulated a strong countertransference reaction in the recipient, and the two traded insults like angry siblings in the same household.

In the early stage of group treatment, the therapist is commonly related to as an all-powerful parent, but some members regard him as a prince of heaven or superhuman brain while others regard him as the devil's own helper. In the same session, a woman referred to me as a master of painless healing and a man furiously shouted that I should have worked for the Inquisition!

In addition to having such antithetical reactions, members of the group could also simultaneously express the same transference

attitudes. The tendency to develop group transferences mounted as they gradually became aware that they were expected to go on talking about themselves in the sessions but that the therapist did not join them in the process. This impersonal attitude tended to reawaken the feelings experienced when, early in life, they were frustrated by their original objects. When, on the other hand, the therapist gratified infantile cravings for words and understanding, the group tended to unite in a strong positive-transference attitude.

The transference phenomena described above, which were culled from the protocols of a group conducted in the early fifties, have been so widely reported that technical terms have been introduced for them in recent years. For example, references to multiple transference, lateral transference, and the dilution of transference are frequently encountered in the professional literature. As defined in *Comprehensive Group Psychotherapy* (Kaplan and Sadock, 1971), multiple transference denotes that the feelings and attitudes of a patient toward members of his own family become irrationally attached to the therapist and the group members simultaneously. The intensity of the transference to the group therapist is therefore reduced, which accounts for the reference to the dilution of transference. The term lateral transference is applied to those attitudes, values, and emotions that are attached to other patient-members rather than to the therapist. Various other terms have been coined to convey the multidimensional aspects of transference in the therapeutic group setting.

Before turning to the counter-phenomena, I want to remark briefly on the tendency of some group therapists to deprecate the significance of transference. This attitude is encountered among therapists who attempt to

provide patients with an immediately gratifying experience rather than helping them free themselves from their psychological straitjackets and working to catalyze emotional growth. Therapy that affords a high degree of gratification has an immediate appeal for the patient but later leaves him depressed, guilty, or no better than he was before.

Both unlearning and learning occur in group treatment addressed to more constructive goals; indeed, unlearning appears to be primary. And the process of unlearning patterns of maladapta-tion begins with the symbolic reactivation of these patterns in treatment. Maladaptive patterns have to be studied *in vivo* and liberated from their emotional charge. Transference is an essential instrument for reactivating maladaptive patterns with sufficient

intensity to resolve them in the group situation. After they are unlearned, the patient is capable of learning better ways to relate to others.

When a transference climate is created and maintained in the group, the individual obstacles to personality change manifest themselves sooner or later as resistances to cooperative functioning in the treatment sessions. These interfering forces are the resistances of each group member to verbalizing spontaneously his own immediate feelings and thoughts or to helping his co-members do the same. The primary task of the group therapist is to deal with these resistance patterns when they become strongly charged with transference.

What has just been stated is the well-known schema of analytic group therapy. What remains to be said is that countertransfer-ence, once regarded as an unwelcome if inevitable intruder, is now recognized as an important factor in the effective implementation of this treatment plan. Various recommendations for the use of countertransference feelings have appeared in the contemporary literature.

Even among therapists who are willing to utilize their feelings in the treatment process, however, a great deal of confusion exists both on the specific value of opening themselves up to a patient's feelings and on when the communication of their own feelings is desirable. Some of this confusion is dispelled when one recognizes that contact with the patient stimulates two different types of reactions. Before describing them, I want to make it clear that I am not referring to transference reactions of the therapist to the patient as a neutral figure, which occurs at the beginning of treatment before the patient has developed a transference. In principle, the communication of the therapist's transference feelings and attitudes through words or behavior is always out of order. What I am referring to is the therapist's reaction to the patient's transference feelings and behavior.

One type of reaction is based on the therapist's own adjustment patterns; in other words, feelings that the therapist developed for significant figures in his own life are often awakened by the patient's transference. Communication of these subjective, idiosyncratic reactions is never therapeutic. It is important to recognize these feelings and to counteract any tendency to use the patient as an outlet for the therapist's own emotional gratification.

The other type of reaction to the patient's transference is what Winnicott referred to as the objective countertransference—that

is, the emotions that are realistically induced in the therapist, the predictable feeling-response of the emotionally mature observer. The realistically induced feelings can be utilized in various ways and at times their communication to the patient is beneficial.

Probably the most widespread use of the induced emotions is made in diagnosis and the fact-finding process. They are a source of information that the patient may not be able to communicate verbally. The induced emotions often facilitate the understanding of specific problems that arise in treatment, or the reconstruction of significant preverbal experiences that the patient cannot remember. For example, a patient who is in a state of narcissistic transference often induces feelings of confusion in the therapist and the other group members. The patient may say the same thing over and over again; yet it is impossible to understand his communication. When he is questioned about it, he may indicate that he does not feel understood. Eventually, it may become clear that he had parents whom he could not understand or who did not understand him.

A growing number of practitioners also utilize the objective countertransference more actively—in other words, as a source of therapeutic leverage. In my own work with seriously disturbed patients, I make use of the objective countertransference in interventions that are formulated to make patients more aware of what they are

experiencing at the moment, and to help them verbalize these experiences in a progressive way. Highly narcissistic patients often get bogged down in repeating the same idea over and over again. An intervention infused with the feelings that the repetitive communication is inducing is often more effective in resolving such a resistance pattern than a purely intellectual explanation. Usually the use of the induced feelings in this way helps the patient get back on the track of progressive communication again, at least temporarily, and eventually to master the resistant behavior, that is, to work through the resistance pattern.

A patient with preoedipal problems induces emotions that can be utilized to immunize him against specific types of feelings that he is especially sensitive to in highly stressful situations, thereby reducing his disposition to future upheavals. Verbal injections of the feelings that he induces are fed back to him in graduated doses. I refer to these carefully timed verbal feedings as toxoid responses. The process of administering toxoid responses is analagous to immunizing the body against a particular antigen, such as that of diphtheria, by destroying its toxicity but rendering it capable of

inducing the formation of antibodies. After the therapist experiences the patient's feelings and understands how they originated, he returns them to the patient in a way that will help the patient discharge the toxic feelings in words. Identification with an emotionally responsive therapist helps the patient feel and verbalize destructive urges that have been warded off, and their toxic quality is thus gradually reduced.

In the individual relationship, the therapist has to give all of the toxoid responses, and he can do so with greater precision. He works on one germ at a time and provides a specific vaccine for one person. As an immunizing agent, the group therapeutic situation has a stronger impact. A general vaccine that will work for all group members requires more care and preparation, but one can work on several toxins simultaneously. The reactivation of intense multipersonal situations offers abundant clues to the various feelings that the group members need to experience, and abundant opportunities to inject these toxoids. A group requires a rather potent general vaccine, but fortunately the objective countertrans-ference endows the group therapist with a good deal of countercharge for this purpose.

The group experience is also a more natural immunizing process. The goal-oriented group therapist needs to carefully prepare his toxoid responses and adhere to the principle of injecting them only in terms of resolving transference resistance. However, it is amazing how frequently the members of a group inject toxoid emotions in one another. And the natural toxoids haphazardly produced through their interchanges may have a stronger impact. A woman whose feelings were substantially influenced by the objective countertransference reactions communicated by several other group members was reminded that that she had been confronted with similar reactions in our one-to-one relationship. “I know it,” she replied, “but these people don't swing the baloney for money.” Her group peers met her strong maturational need for admiration; they also catalyzed her first feelings of self-esteem as well as the heartening feeling that she was not as sick as she thought she was and that I knew that she was.

However, the feelings that group members pick up from one another are not invariably therapeutic. Given in too strong dosages or at times when they cannot be assimilated, these natural toxoids may produce unhealthy reactions. One therefore has to be alert to the danger that, instead of injecting multiple toxoids in each other, the group members will inject multiple toxins. For

instance, expressions of affectionate intimacy to a schizophrenic patient at a time when he is defending himself against the release of hostility have an antitherapeutic effect; that is, they serve to reinforce his infantile pattern of bottling up his aggressive impulses instead of verbalizing them.

The group therapist, whatever the goals of the treatment experience he is providing, has to assume responsibility for protecting the members of a group from feelings they are unable to cope with in the immediate situation. If the group is being conducted to facilitate the emotional maturation of the participants, the leader has to accept the responsibility of helping group members express their feelings in mutally beneficial ways. When tendencies to engage in destructive emotional interchanges in the sessions are observed, the therapist needs to intervene appropriately to head them off. The therapist who operates on the principle of *laissez-faire* is unlikely to secure significant results.

It is my impression that group treatment has to be structured to help patients experience specific feelings

that will meet their maturational needs. The more serious their problems, the greater their need for feelings that will facilitate appropriate behavior and thus ease their adjustment to reality. From this point of view, it is helpful to view the group therapeutic process as an instrument for producing constructive emotional interchange. The total constellation of feeling-states of the patient-members of the group and the therapist—in short, the emotional climate of the group—has to be understood, and controlled, at times, to minimize tendencies toward destructive interchanges and to maximize the potential for constructive emotional interchange. The discriminating use of the objective countertransference and its selective communication to resolve the obstacles to personality change facilitates the task of the therapist who commits himself to that always difficult undertaking.

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