

THE BEHAVIOUR INSTITUTE
Diploma in Trauma-Informed Psychotherapy

UNIT 5 • CORE READING 1 OF 6

01

What Transference and Countertransference Actually Are

Two old ideas, still doing genuine clinical work

What This Document Covers

This document establishes the basic definitions of transference and countertransference before this unit moves into how they specifically show up in trauma work. Understanding the foundational concept properly makes everything that follows considerably easier to apply.

Where These Ideas Come From

Transference and countertransference originate in psychoanalytic theory, developed originally by Freud and considerably expanded by subsequent generations of clinicians. Despite their age, and despite modern psychotherapy having moved in many directions since their original formulation, both concepts remain genuinely useful, practical clinical tools, recognised well beyond psychoanalytic practice specifically.

Transference: Bringing the Past Into the Room

Transference refers to the process by which a client unconsciously redirects feelings, expectations, and relational patterns originally connected to significant figures from their past — most often caregivers — onto the therapist. This happens outside conscious awareness. A client is not deliberately deciding to treat their therapist like an important figure from their history; the redirection happens automatically, often without the client recognising it is happening at all.

Transference is not inherently negative, and it is not a sign of a client being unusually difficult or disturbed. It is, in a genuine sense, a normal feature of any relationship carrying emotional significance, and it becomes clinically visible in therapy partly because therapy is specifically structured to create the kind of emotionally significant, somewhat asymmetric relationship in which transference reliably surfaces.

Countertransference: The Therapist's Own Response

Countertransference refers to the therapist's own emotional reactions to a client, which can be shaped both by the client's transference and by the therapist's own history and unresolved material. Countertransference was originally viewed primarily as an obstacle — something to be minimised or eliminated through the therapist's own analysis. Modern clinical understanding takes a different view: countertransference, properly recognised and reflected on, is a genuinely valuable source of clinical information, not simply an interference to be managed away.

Pause and Consider

Think of a relationship in your own life — not necessarily therapeutic — where you noticed yourself reacting to someone in a way that seemed to belong more to an earlier relationship than to the person actually in front of you. What did that experience feel like from the inside, before you recognised what was happening?

Why These Concepts Are Not Just Historical Curiosities

It would be easy to treat transference and countertransference as artefacts of an older therapeutic tradition, superseded by more modern, evidence-based approaches like those covered in Unit 4. This would be a genuine mistake. Even within thoroughly modern, structured approaches like TF-CBT or EMDR, transference and countertransference dynamics continue to operate — they are not specific to psychoanalytic technique, but appear to be a feature of therapeutic relationships generally, regardless of the specific treatment framework being used on top of that relationship.

A practitioner unfamiliar with these concepts does not thereby avoid transference and countertransference occurring. They simply lose the ability to recognise and work with dynamics that are happening regardless, often to the detriment of both the client's progress and the practitioner's own wellbeing, covered further in Document 3.

A Basic Illustration

Consider a straightforward, everyday example. A client consistently arrives a few minutes early to every session, and becomes visibly anxious on the rare occasion the practitioner is running a few minutes behind schedule. Explored gently, this pattern connects to a childhood in which the client's caregiver was frequently, unpredictably late, leaving the client with genuine uncertainty about whether they would be collected at all. The practitioner, in this ordinary, unremarkable scenario, has become a stand-in figure onto whom an old, anxious expectation about unreliable caregiving has been transferred — despite having done nothing in the current relationship to suggest unreliability.

On the countertransference side, a practitioner might notice their own reaction to this pattern — perhaps a pull toward over-reassurance, or conversely, irritation at what could be misread as excessive anxiety over a minor scheduling matter. Neither reaction is inherently wrong, but both are worth the practitioner's own reflection, since either could shape how the situation gets handled if left unexamined.

What's Next

The next document goes further into transference specifically, addressing how it tends to show up with particular intensity and specific, recognisable patterns in trauma work — not simply as a general therapeutic phenomenon, but shaped directly by the relational trauma covered earlier in this course.

A Few Things to Take With You

- Transference is the unconscious redirection of feelings and expectations from significant past relationships onto the therapist
- Countertransference is the therapist's own emotional response, shaped by both the client's transference and the therapist's own history
- Neither concept is exclusive to psychoanalytic technique — both appear to operate within any therapeutic relationship, regardless of treatment framework

- Modern clinical understanding treats countertransference as genuinely valuable clinical information, not simply an obstacle to be eliminated

Before You Move On

- Thinking about the reflection prompt earlier in this document, what did recognising the pattern change about how you responded to that relationship, if anything?
- Why do you think countertransference was originally viewed primarily as an obstacle, and what shifted in clinical thinking to change that view?
- How might a practitioner unfamiliar with these concepts unknowingly be shaped by them anyway?