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# TRANSFERENCE AND ITS USEFULNESS IN PSYCHOTHERAPY IN THE LIGHT OF EMPIRICAL EVIDENCE

The paper is aimed at finding answers to the following questions: (1) Is there empirical evidence for the psychoanalytic concept of transference? (2) Is there empirical evidence for the usefulness of working with transference in psychotherapy? Objections concerning the reality and practical value of transference have been summarized. A review of research dedicated to transference has been conducted, covering fundamental research in the psychology of social cognition as well as research on psychotherapy using both psychodynamic and nonpsychodynamic approaches. Studies from the first group confirm the existence of transference. Studies from the second group indicate conditions in which working with transference in psychotherapy seems to be efficient. Implications for psychotherapy practice have been formulated.

**Keywords:** transference, transference interpretation, psychoanalysis, psychotherapy, social cognition.

Transference is a concept derived from psychoanalysis. It refers to the phenomenon that was first observed and described towards the end of the 19th century by Sigmund Freud (Breuer & Freud, 1895), who later elaborated his understanding of this concept in his subsequent publications (1905, 1915, 1917, 1937). He initially considered this phenomenon to be a hindrance to treatment, but his ideas evolved and he eventually came to recognize transference to be “an inher-

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ent necessity," elevating its status to that of one of the central processes taking place during psychoanalytic treatment.

Transference is understood in psychoanalysis as the transfer of feelings, attitudes, thoughts, desires, fantasies, or behaviors originally experienced in the past with significant others (e.g., parents, siblings, grandparents, or teachers) to a different person that the individual is currently in an interpersonal relationship with (Laplanche & Pontalis, 1973; Moore & Fine, 1990). This phenomenon has several characteristics. First, it is largely unconscious: the person does not realize the source of his or her transference. Second, transference appears spontaneously. Third, it can concern feelings of different valence. Fourth, transfrence is sometimes dynamic – it may change in time, and a particular person may resemble more than one significant figure from the past.

The phenomenon of transference is used for therapeutic purposes in classical psychoanalysis, in its subsequent schools, and in psychodynamic psychotherapy (cf. Etchegoyen, 2005). As the therapy progresses, more and more of the patient's emotions focus on the analyst, giving rise to so-called transference neurosis. Freud wrote that in such a case the original symptoms become detached from their source and the patient's conflicts are enacted in his or her relationship with the analyst (cf. Strachey, 1934). The technique of work consists in tolerating the patient's transference with regard to the therapist, analyzing and interpreting its meaning and source, as well as demonstrating its connection with symptoms and personality. Interpretations of transference consist in showing to the patient the connection (usually similarity) between how he/she experiences or experienced relationships with people in his or her life in the past and how he or she is experiencing the relationship with the therapist. As a result of this process, transference can be undergo modifications, which will effect a change in the patient's patterns of entering into relationships.

Even though transference interpretation is one of the main and standard techniques in the psychodynamic approach, it has been the subject of much controversy among researchers and practitioners. The controversy concerns transference itself as a phenomenon and transference as a technique of work in psychotherapy (Hoffman, 1983; Handley, 1995; White, 2014). The legitimacy of using transference as a therapeutic technique is called into question, and one of the reasons is inconsistent research results (Frances & Perry, 1983; Gabbard, 2006). The controversy also concerns more specific problems – such as whether to interpret transference in the early phase of therapy or later, whether to interpret negative or positive transference, whether to interpret transference only in relatively healthy people or in those with personality disorders (Andersen & Przyby-

linski, 2012; Gelso & Bhatia, 2012; Levy & Scala, 2012; Marmarosh, 2012). It is worth adding that even psychoanalysts differ in their conviction regarding the degree to which transference should be used in therapeutic work (Cooper, 1987; Grinberg, 1997).

The aim of the present article is to look for answers to the following questions: (1) Is the phenomenon of transference confirmed by research? (2) What is the usefulness of work with transference in the light of research? The first question is about whether transference is a real, objective phenomenon. The second question is about whether it is worth using and how it can be used in therapeutic work, in the psychodynamic approach as well as in nonpsychodynamic approaches.

## DOUBTS SURROUNDING THE PHENOMENON OF TRANSFERENCE AND THE LEGITIMACY OF ITS USE IN THERAPEUTIC WORK

Some authors, such as Szasz (Szasz, 1963; Langs 1982; Schlein 1984; Smith, 1991), claim that transference is a fiction, created and maintained by psychoanalysts for defensive purposes – it allows them to make it through the strong emotions that appear in such an intensive relationship (for both parties) and to avoid responsibility for their own influence on the patient. Szasz even believes that transference constitutes a kind of patient abuse, since it sets the patient against reality testing.

Shlien (1984) believes transference to be merely a professional tradition, a convention, or a mental habit based on the illogical assumption that a given experience resembling a past experience must be a repetition. To support this, he refers to an analogy: *"When one tastes a lemon at age 30, does it taste sour because it tasted that way at age three? It always tastes sour."*

Smith (1991) claims that using transference is a case of an explanatory vicious circle. The psychoanalyst assumes the existence of unconscious experiences that he or she then verifies by means of transference interpretation. Moreover, it is not clear what mechanisms enable the psychoanalyst to recognize what is transference and what is not.

Similar charges against transference are also formulated by existential psychotherapists (May, 1967; Boss, 1963; Binswanger, 1962; Judd, 2001). They claim that the idea of transference negates the "real," genuine relationship between the patient and the therapist. It does not encourage the patient to take responsibility for his or her behavior, either.

A critical perspective on transference in the classical sense can also be found in some psychoanalysts. According to Macalpine (1950), the patient's reactions considered to represent transference are not spontaneous repetitions of past experiences but a real response to the conditions in which psychoanalysis takes place. These conditions are described as rigid and infantile – the patient is maintained in the position of a child and continually frustrated. It is these conditions that actively evoke strong feelings towards the psychoanalyst. In addition, having some knowledge about psychoanalysis, many patients actually expect the experience of transference.

A less radical criticism was formulated by later psychoanalysts. For example, Gill (1982) opposed Freud's original conception describing the psychoanalyst as a blank screen and the treatment of transference merely as a form of reality distortion. In his opinion, some of the patient's reactions to the psychoanalyst are a response to the psychoanalyst's actual behavior. Still, it is worth noting that the evolution of psychoanalytic views on transference led to a great change in its use. In accordance with the intersubjective approach in contemporary psychoanalysis, the analyst is not a passive recipient of transference, performing the function of a blank screen or mirror, but participates in creating it in the course of a reciprocated encounter of two minds (Bollas, 1983; Storolow & Antwood, 1997). The analyst experiences the patient as a living person and, using his or her subjective experience, may try to communicate to the patient the subjective states that appear in him/her in response to transference dynamics (Bollas, 1983). A thorough discussion of changes in modern psychoanalytic thought is beyond the scope of the present paper (cf. Hoffman, 1983; Cooper, 1987).

Although most theorists of nopsychodynamic schools have not rejected the phenomenon of transference as something that happens in therapy, it is evident that these schools no longer see transference as meaningful and sometimes they have given up exploring this phenomenon during therapy altogether. For example, Rogers (1951) acknowledged the existence of transference in therapy but did not study it directly, and Perls (1969) confronted his patients with the fact that he was not their parent. In the publications of cognitive-behavioral therapists there are few mentions of transference and few guidelines for working with it (cf. Cartwright, 2011). It was not until the so-called third wave of cognitive-behavioral therapy in recent years that functional analysis psychotherapy (FAP; Tsai et al., 2009) developed a number of techniques for assessment and work with transference.

## INDIRECT EVIDENCE FOR THE EXISTENCE OF THE TRANSFERENCE PHENOMENON FROM BASIC RESEARCH

Direct and indirect evidence for the existence of the transference phenomenon can be found mainly in the psychology of social cognition – the currently dominant approach in social psychology.

What may be regarded as indirect evidence is the well-confirmed and well-documented fact of our knowledge about the world being organized in the form of schemas, which are activated and actively influence information processing, including the processing of information about social life. In the case of transference, we may be dealing with the activation of social schemas – concerning the types of people, containing prototypical characteristics (cf. Cantor & Mischel, 1979), schemas concerning stereotypical relations (Baldwin, 1992), schemas concerning situations (Cantor, Mischel, & Schwartz, 1982), or scripts concerning the course of events (Abelson, 1981). Together with a schema or a script, the related affect, expectations, or desires are also activated (Carlson & Carlson, 1984). The therapist may simply resemble a specimen from a given category that is activated or, simply, the therapy situation reminds the patient of a similar life situation.

The schemas listed above develop as a result of past experiences and as a result of contact with people that one used to be close to in the past, and what plays an important role in their emergence is the tendency of human memory to generalize individual events into broader entities (Singer & Moffitt, 1991-1992).

People are more inclined to assimilate new information in such a way that it fits into the activated schema rather than to accommodate or modify the schema. Persistent adherence to schemas has been confirmed many times (Greenwald, 1980), which manifests itself in the stability of the transference phenomenon observed during therapy and sometimes in difficulties with changing it.

The activation of schemas and scripts is usually automatic and unconscious (Bargh, 1997). For this reason, the patient may not realize the activation of a schema but only feel the affect associated with a person. For the same reason, the analysis of transference may sometims be the only way to access the unconscious material.

## DIRECT EVIDENCE FOR THE EXISTENCE OF THE TRANSFERENCE PHENOMENON FROM BASIC RESEARCH

Direct evidence not only of the fact that the transference phenomenon is real is the research conducted by Susan Andersen and collaborators since the 1980s. Andersen has proposed a model according to which the self-concept and personality are constituted by a repertoire of relational selves (Andersen & Chen, 2002). Every relational self has developed in a relationship with a significant other and, as a schema, it contains idiosyncratic knowledge about the relationship with that person as well as socially shared knowledge independent of the relationship – for example, concerning the social role. A relational self-schema combines knowledge about a significant other with knowledge about oneself and knowledge about the relationship with that person. When an individual meets someone who, in a certain respect – even subtly or unconsciously – resembles their significant other (e.g., in appearance, personality, or nonverbal behavior), the relational self associated with that significant other is likely to be activated. The relational self is used in the relationship with the new person – in the interpretation of and behavior towards the new person. Just like other types of schemas, relational selves become chronically available when they are frequently used. This process often takes place unconsciously and automatically. This is how the phenomenon of transference can be understood in the sociocognitive approach. Transference does not have to concern only significant others from a person's childhood and does not have to perform a defensive function. It is a cognitive phenomenon that happens in everyday life, and its consequences may be positive as well as negative.

Andersen and colleagues carried out a number of experiments confirming the reality of the transference phenomenon (Andersen & Przybylinski, 2012). These experiments consisted of two parts divided by a two-week interval. The participants were informed that they would take part in two unrelated studies. In the first part, the participants described two significant others (e.g., a person they liked and a person they disliked) using a specified number of statements. They also selected those statements from the list that were irrelevant to the description of that particular person. In the second part, the participants were informed that they would take part in a study concerning social skills and that their task would be to get to know a person during a conversation. Before the conversation, they received the characteristics of their potential interlocutor, allegedly established on the basis of an earlier interview. In experimental conditions, these characteris-

tics coincided with those of the particpant's significant others to a certain extent (minimum or large, depending on the condition). In control conditions, they were characteristics of another participant's significant other. The description contained irrelevant statements as well. In the next step, the participants met or imagined meeting that person, unknown to them, and went on to rate them (or the relationship with them) on various dimensions.

Studies in which the above methodology was applied showed that the particpants in direct or indirect contact with individuals who reminded them of significant others were more confident in their rating of the new people's traits (Andersen & Baum, 1994; Andersen & Cole, 1990), reacted faster in the lexical decision test to words previously used for decribing their significant others (Miranda & Andersen, 2007), verbally or nonverbally transferred positive or negative affect (Andersen, Reznik, & Manzella, 1996) and ambivalent feelings to the new people (Berk & Andersen, 2008), expected acceptance or rejection from the new people to a greater degree (Berk & Andersen, 2000, Miranda, Andersen, & Edwards, 2011), showed stronger motivation to get closer to the new person (Berk & Andersen, 2000), transferred the same attachment style (Mikulincer, Gillath, & Shaver, 2002), reproduced the self-regulatory mechanisms known from the relationship with their significant other (Berenson & Andersen, 2006), and even triggered behaviors in their interlocutors that followed the pattern of transference (Berk & Andersen, 2000).

Other studies showed that evoking the image of significant others activated in the participants – in their relationship with the newly met people – a self-concept corresponding in terms of content and valence (Hinkley & Andersen, 1996), corresponding feared and hoped-for selves (Miranda & Andersen, 2007), and a similar inconsistency within the self-concept (Reznik & Andersen, 2007).

## EVIDENCE FOR THE EXISTENCE OF THE TRANSFERENCE PHENOMENON FROM RESEARCH ON PROCESS IN PSYCHOTHERAPY

What can be regarded as confirmation of the reality of transference in a situation of psychodynamic psychotherapy is the results of studies using the method developed by Luborsky and Crits-Christoph (1990), allowing to recognize the *Core Conflictual Relationship Theme* (CCRT) in the patients' words. In this method, it was assumed that the narrative threads concerning contacts with other people, frequently found in psychotherapeutic patients, attest to stable patterns of

entering into relationships, characteristic for particular patients. A relationship theme consists of the following three consecutive components: (1) desire with regard to someone (a request, a need, an intention), (2) the response of others (experienced, anticipated, fantasized), and (3) the response of the self, anticipated or obtained (in the form of a thought, a feeling, a behavior, or a symptom). A majority of patients exhibit several themes, one of which is usually dominant. In studies using this method, independent judges analyze patients' utterances written down.

In the first study, covering patients with different diagnoses, a high similarity was found between each patient's interpersonal theme and the way that patient experienced his or her relationship with the therapist (Fried, Crits-Christoph, & Luborsky, 1992). Not in every patient was there such a similarity at the very beginning of therapy, which the authors interpret as attesting that transfrence had not occurred in them by that time. Similar results were obtained in two replications of that study, with a somewhat modified procedure (Connolly et al., 1996; Connolly, Crits-Christoph, Barber, & Luborsky, 2000).

Evidence for the existence of the transference phenomenon has also been provided by studies on psychotherapy conducted using nonpsychodynamic approaches. In a few of such studies it was demonstrated that both patients and therapists noticed transference contents (Ryan & Gizinski, 1971; Beach & Power, 1996; Gelso et al., 2005; Connolly et al., 1996). Still other studies showed that in those therapies variables such as mother's cold attitude in childhood, the style of relating, personality disorders, and ego strength determined the type of transference to the therapist (Woodhouse et al., 2003; Bradley et al., 2005; Arachtingi & Lichtenberg, 1998).

## CORRELATIONAL RESEARCH ON THE EFFECTIVENESS OF TRANSFERENCE INTERPRETATION

Some of the studies showed that the use of transference interpretations was a predictor of symptomatic improvement (Malan, 1976a; 1976b; Marziali & Sullivan, 1980; Marziali, 1984), while other studies demonstrated that the use of transference interpretations was not significant (Piper, Debbane, Bienvenu, de Carufel, & GaRant, 1986), lowered the degree of improvement (Høglend, 1993; Piper, Azim, Joyce, & McMallum, 1991), or contributed to the patients' interruption of therapy (Piper et al., 1999).

This inconsistent picture can be clarified by studies exploring the variables moderating the investigated relationship. Those studies showed that transference interpretations had a negative impact on patients when they were inaccurate (Crits-Christoph, Cooper, & Luborsky, 1988; Piper, Joyce, McCallum, & Azim, 1993), when they were perceived by patients as blaming and hostile (Henry & Strupp, 1994), when they were presented too early to individuals with interpersonal difficulties (Connolly, Crits-Cristoph, Shelton et al., 1999), and when they were presented to patients with avoidant personality disorder (Schut et al., 2005) or with Cluster C personality disorders (Svartberg, Stiles, & Seltzer, 2004).

The inconsistency of the findings presented earlier concerning transference interpretations can be understood better in the light of research on the dynamics of transference. Those studies show that what promotes symptomatic improvement is not the emergence of a negative picture of the therapist (Marmarosha et al., 2009) but the situation in which this negative picture emerges and, still during therapy, changes into positive (Blatt, Stayner, Auerbach, & Behrends, 1996) and in which this negative picture is associated with a strong insight (Gelso, Kivlighan, Wine, Jones, & Friedman, 1997).

## EXPERIMENTAL RESEARCH ON THE EFFECTIVENESS OF TRANSFERENCE INTERPRETATION

An important element of the debate on the benefits of using transference interpretations is research concerning transference-focused psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 2006), based on Kernberg's model and developed especially for patients with personality disorders.

Several studies have demonstrated the effectiveness of this approach in the treatment of patients with borderline personality disorder (Clarkin, Yeomans, & Kernberg, 2006; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Levy et al., 2006; Doering et al., 2010). One of them was a randomized controlled study comparing TFP, supportive psychodynamic therapy (without transference interpretation), and dialectic-behavioral therapy. No differences were observed between these approaches regarding effectiveness in the reduction of symptoms. However, TFP was found to be more effective in reducing the tendency to attack and get irritated; it was also found to cause an increase in metacognitive and sociocognitive skills. Another randomized controlled study showed that TFP was more effective compared to psychotherapy of other orientations in reducing the number of suicide attempts, borderline personality disorder symptoms, the gen-

eral level of psychopathology, the frequency of hospitalization, therapy interruption rate, global functioning, and personality organization (Doering et al., 2010).

Høglend et al. (2006) conducted the first and so far the only randomized controlled study concerning the effectiveness of transference interpretation in a psychodynamic therapy consisting of 40 sessions, in which the compared conditions differed only in the presence and degree of transference interpretation (low, medium, or high as well as absence in the control group). The remaining interventions were identical in both groups and the therapy was conducted by the same therapists with similar competence levels. An improvement was observed in the patients in all the groups, but no differences were found between the groups before the beginning, in the middle, and after the completion of therapy on any of several measures of improvement. What was observed was significantly greater symptomatic improvement in patients with a low quality of object relations in the group in which transference interpretations were used than in the group where such interpretations were not used. This result was found to persist a year and three years after the end of therapy (Høglend et al., 2008). It was also found that patients with a low quality of object relations, being in a weak therapeutic alliance, benefited from transference interpretations more than patients with a high quality of object relations and a strong therapeutic alliance (Høglend et al., 2011). Other analyses of data from that study (Johansson et al., 2010) showed that the mediator of the effectiveness of transference interpretations in patients with a low quality of object relations was an increase in insight.

## DISCUSSION

The research findings cited above make it possible to answer the first of the questions posed positively, confirming the observation made by the originator of psychoanalysis. Numerous studies, mostly experimental ones, show that transference as a phenomenon really does exist in relationships between people. Firstly, those studies prove that newly met people considerably resembling significant others from the past are perceived the way those significant others used to be perceived, and that in relationships with them it is possible to feel much as one felt with the significant others. This process takes place even when the newly met person resembles a significant other only minimally. Secondly, studies support the observation that transference proceeds automatically and unconsciously. Thirdly, they show that transference is a common phenomenon, taking place in everyday situations in healthy people. Studies also support the psychoanalytic

idea that people are motivated to repeat their past relationship experiences (Fairbairn, 1952).

Studies on the transference phenomenon concerning process in psychodynamic psychotherapy confirm the reality of the transference phenomenon during psychotherapy. These are correlational studies, however. The methodology applied in them has its shortcomings – it cannot be excluded that transference is only an artefact of psychodynamic therapy, generated by the belief of therapists, who, by interpreting patients' behavior in terms of the patient–therapist relationship, suggested such a link to patients too. What argues against this interpretation is the already presented findings of research on nonpsychodynamic psychotherapy. They show that transference really does take place also in nonpsychodynamic therapies and has a similar intensity there.

While the answer to the first question is unambiguous, the answer to the second one is more complex. The presented results of correlational studies on the effectiveness of transference interpretations are not consistent. Some of them show that transference is worth interpreting while others show this to be disadvantageous. Studies that take moderating variables into account show that the effectiveness of transference interpretations depends on various factors. It turns out that when negative transference dominates, the therapeutic relationship and its effectiveness weakens if the therapist does not try to establish the sources of negative transference. In the case of no insight, the patient simply accepts the reality of his or her perception and sees the therapist as the source of difficulties. Thus, transference – particularly negative – may have both advantages and disadvantages. When the patient experiences an insight, such transference helps in the treatment. In the case of no insight, work with it may carry a risk of deterioration. Studies taking into account the dynamic aspect of transference show that negative transference may lead to improvement provided that it is either overcome or understood in the course of therapy. Otherwise, its effects may limit symptomatic improvement.

Experimental studies on the effectiveness of transference interpretation suggest that using transference interpretations is not necessary to achieve improvement, but at the same time transference-based therapy has an advantage in the form of greater change in personality and metacognitive skills. The results of the first of the presented studies show that transference interpretations are recommended in the case of patients with a low quality of object relations. The last study has a considerable advantage over those reported earlier. Its experimental character in the form of randomization and the control of the intensity of trans-

ference interpretation makes the differences obtained difficult to attribute to factors other than transference interpretation.

## Recommendations for practice

The common occurrence of transference in life as well as in psychotherapy of various orientations makes it inadvisable for therapists to ignore it. Transference is a vehicle of valuable information about the patient's functioning in relationships. This knowledge would very often be impossible to obtain from the patient in a different way because it is usually unconscious. Transference is also connected with therapeutic alliance, which in turn is one of the main determinants of therapy effectiveness (Martin, Garske, & Davis, 2000). Especially ignoring negative transference may disturb therapeutic alliance. For instance, a patient convinced that the therapist rejects or does not accept him or her will limit self-revelation.

As research shows, interpreting transference can be beneficial in the case of patients with more serious disorders – those who exhibit a low quality of self–object relations and who need to work on their personality and metacognitive skills. It is those patients who exhibit the greatest difficulty in distinguishing reality from the imagined aspects of another person, and it is in those patients that insight is the mechanism which influences improvement the most.

Some of the correlational studies demonstrating the negative relationship between transference interpretation and improvement show that such interventions are risky. This conclusion was reached by Gabbard and colleagues (1994), who wrote of transference interpretation as very risky and at the same time very fruitful. There is agreement that such interpretations require the therapist to show care and tact. As Geller (2005) observed, these consist in "the capacity to tell patients something they do not want to hear in a manner in which they can hear it." The studies cited here show that transference interpretations should be accurate, adjusted to the process, as well as communicated to the patient in an accepting manner and without hostility. Due to the risk involved in transference interpretation, this technique should not be overused (e.g., by constantly relating the entire material to transference) but should be applied very carefully.

The benefits that – despite the already cited criticism of the phenomenon – the awareness of transference may bring to therapists of nonpsychodynamic orientations must not be forgotten, either. The knowledge that the patient's emotional reactions to the therapist may be partly the emotions that he or she used to

feel for other people can help the therapist to take a distance and feel relief, especially when these emotions are very strong.

Research results do not suggest, however, that transference interpretations are the only technique enabling therapists to make use of transference. It is conceivable that, knowing the history of a patient's relationships, it is possible to help the patient to realize the transference pattern and teach him or her to recognize the factors activating that pattern. This would enable the patient to gain greater control over the process of transference before it manifests itself in the relationship with the therapist. On the other hand, given the automatic character of the process and its tendency to recur, it may be difficult to recognize and control transference before it manifests itself in the relationship. Ways of using transference in therapy other than its interpretation require further study.

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