

Specific Features of Transference Work in OLI Integrative Psychodynamic Psychotherapy: A Case Presentation

Nebojša Jovanović¹

OLI Center for Integrative Psychodynamic Psychotherapy, Belgrade · ORCID: 0009-0006-2142-9932
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Abstract

Transference represents a central construct in psychoanalytic and psychodynamic therapeutic processes, yet its understanding and the ways of working with it vary depending on the theoretical and methodological framework. This paper presents the specific features of working with transference within OLI Integrative Psychodynamic Psychotherapy (OLI IPP), a contemporary psychoanalytically grounded integrative modality with a pronounced developmental focus. Building on the classical psychoanalytic conception of transference as the repetition of earlier relationships and affective patterns within the therapeutic relationship, OLI IPP retains the analytic dimension of working with transference while expanding it through a developmental understanding of ego functions and basic developmental competencies of personality.

In this paper, transference is viewed not only as a regressive phenomenon, but also as an indicator of insufficient development of basic developmental competencies within emotionally significant relationships. Particular attention is devoted to distinguishing transference manifestations arising from the regression of previously developed capacities from those that indicate structural ego deficits. The theoretical presentation is complemented by an extensive clinical case presentation, which illustrates how transference processes, countertransference experiences, and the development of basic developmental competencies are intertwined in therapeutic work. The aim of the paper is to highlight the contribution of OLI IPP to understanding transference as a developmental context in which, alongside insight, learning, internalization, and the strengthening of ego functions necessary for lasting psychological change take place.

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¹ E-mail: jnebojsa1@gmail.com

Building on the psychoanalytic tradition, OLI Integrative Psychodynamic Psychotherapy (hereinafter OLI IPP) retains the central significance of transference as a context in which earlier relational patterns, affects, and conflicts are activated (Freud, 1923). However, within OLI IPP, transference is not understood exclusively as a phenomenon of repetition and projection, but also as a developmental space in which functions that could not be sufficiently formed or internalized in earlier development can be learned and rehearsed.

Accordingly, OLI IPP draws on core ego-psychological insights into the auxiliary ego and the transfer of ego functions, while further developing and systematizing them through the concept of basic developmental competencies of personality. These competencies are not derived from a single school; rather, they have been identified and described across major psychoanalytic traditions—classical psychoanalysis, ego psychology, object relations theory, and self psychology—under different names and in different conceptual vocabularies. Within OLI IPP, they are identified, integrated, clearly named, and situated within a coherent developmental model of the psychotherapeutic process.

In support of shifting the emphasis from interpretation alone toward affirmative and structure-building interventions, empirical findings are relevant: systematic reviews show that the relationship between transference interpretation and therapy outcome is not unequivocal (Yilmaz et al., 2024).

Conflict and Deficit: Two Sources of Psychopathology and Implications for Transference Work

Contemporary psychodynamic thought distinguishes two different sources of psychological difficulties — intrapsychic conflict and structural deficit — and this distinction has direct implications for technique. Killingmo (1989) showed that the pathology of conflict calls for interpretation, which uncovers repressed meaning, whereas the pathology of deficit calls for affirmative interventions that establish and build up missing psychic structures: in deficit there is no repressed meaning to be reconstructed, but an underdeveloped function that must be developed. Sugarman (1995) formulates the same problem as the question of whether psychoanalysis treats conflict or deficit, emphasizing that assessing the nature of the difficulty determines the choice of therapeutic approach.

Glita (2010) demonstrates the clinical usefulness of the concepts of deficit and defect in psychodynamic psychotherapy, drawing on Kohut, Balint, and other authors, and warns against the risk of a premature diagnosis of deficit as well as against the interpersonal nature of such an assessment, since deficit is also recognized through the countertransferential experience of the limits of therapeutic work. Druck (1998), in a paper titled precisely as an “attempt at integration” of conflict and deficit, defines deficit as compromised ego and superego capacities that go beyond the limited effects of neurotic symptoms, and argues for an integrative position according to which conflict and deficit are not mutually exclusive but coexist and intertwine in work with the same client.

That this distinction is not merely theoretical is confirmed by a recent metasynthesis of case studies: Krivzov and Meganck (2021) systematically analyzed published case reports in the treatment of medically unexplained symptoms and showed how the same clinical picture is conceptualized and treated differently depending on whether the therapist foregrounds conflict or deficit. In this way, the relevance of distinguishing

conflict and deficit is demonstrated at the level of case-study methodology as well, such as the one presented here.

In this light, transference cannot be reduced to a single phenomenon. In the classical tradition (Freud, 1912, 1914), transference is above all repetition and regression in the service of conflict, resolved through interpretation within the working alliance. Self psychology (Kohut, 1971), however, describes selfobject transferences — mirroring and idealizing — that are not primarily conflictual but express developmental needs and deficits in the regulation of the self. Racker (1968) emphasizes the inseparability of transference and countertransference, while Gill (1982) locates transference within the analysis of the “here-and-now” relationship. Together, these approaches show that a transference experience may simultaneously carry both a conflictual and a deficit-related component.

It is precisely OLI integrative psychodynamic psychotherapy that can be read as one response to the conflict/deficit dilemma. While retaining interpretive work on conflict, OLI IPP also understands transference as an indicator of the (under)development of basic developmental competencies and ego functions, and therefore extends work with transference from the interpretation of meaning to the development of missing functions — through the transfer of ego functions and the model of the “auxiliary ego.” In this way, conflict and deficit are integrated in OLI IPP into a unified framework of the theory of change, elaborated below through a specific approach to transference.

Transference in OLI IPP: Regression vs. Deficits in Basic Developmental Competencies of Personality

In OLI Integrative Psychodynamic Psychotherapy, transference is not understood as a process in which “something is transferred” from significant figures of the past onto the therapist, but rather as a situationally and developmentally conditioned change in the functioning of basic developmental competencies within the context of an emotionally significant relationship. It is like a fuse that trips under increased load because it is not rated to withstand it—one that functions adequately under lighter load. These “fuses” of our psyche are the basic developmental competencies discussed in OLI IPP.

When a relationship becomes sufficiently important, emotionally charged, or existentially relevant, the person’s emotional processing system can become overloaded. Under such conditions, the way a person perceives, experiences, and reacts can change significantly, creating the impression that patterns from earlier relationships are being activated. In OLI IPP, however, the key question is not what from the past is being repeated, but what is happening to emotional processing capacities within the present relationship.

Here, OLI IPP introduces an important distinction between the regression of developed competencies and the structural deficit of competencies.

In some clients, basic developmental competencies are fundamentally developed and available in most life situations. However, within emotionally significant relationships—such as the therapeutic relationship—they may become temporarily blocked or regress to a lower developmental level. In such cases, transference phenomena do not indicate a lack of functions, but rather their decompensation under emotional load. Treatment then focuses on restoring access to, re-establishing, and stabilizing existing competencies, so that they can once again be used at a more mature level.

For another group of clients, particularly those with pronounced ego deficits, the problem is not the regression of developed functions, but their insufficient or uneven development. In these cases, transference experiences are not the result of a decline in capacity, but indicate that certain basic developmental competencies were never sufficiently developed. The therapeutic relationship then serves not only as a context in which regression occurs, but as a developmental space in which these functions are formed for the first time.

This distinction has direct implications for understanding transference. In clients with developed but labile competencies, transference appears as a signal of overload and temporary regression, whereas in clients with ego deficits, transference emerges as a manifestation of a structural lack of functions. In both cases, the phenomenon may appear similar on the surface—idealization, devaluation, dependency, aggressive demands—but its developmental status and the appropriate therapeutic response differ substantially.

From this perspective, what is described in classical psychoanalysis as the “transfer” of relationships can be understood as a reactivation of a lower level of emotional processing, either due to the regression of existing capacities or due to their absence. It is not the object that is transferred; it is the level of functioning of competencies that changes.

Working with transference in OLI IPP therefore involves two distinct, yet interconnected developmental strategies. In cases of regression, the therapeutic focus is on restoring functions to their previously attained or a higher developmental level, whereas in cases of deficit, the focus is on the gradual development and learning of functions that were not sufficiently formed. In both cases, the aim is not permanent external support, but the internalization of capacities and their stable, autonomous functioning.

In this way, transference in OLI IPP acquires a clearly differentiated developmental meaning. It is no longer a single phenomenon with a single origin, but an indicator of the relationship between emotional load and the availability of competencies. Psychotherapeutic work is then not directed exclusively toward interpreting the past, but toward restoring or building the capacity to endure, understand, and live the present relationship at a more mature level. In this context, the therapist in OLI IPP assumes a more active and developmentally explicit role: not only as an analyst of transference meanings, but also as a teacher, guide, and trainer of basic developmental competencies, that is, ego functions.

This activity does not represent a departure from neutrality, but rather transparency in the transfer of functions that enables learning. The therapist does not remain hidden behind a “mirror,” but thinks aloud—demonstrating how they think, how they make connections, how they tolerate ambiguity, how they integrate contradictory information, and how they regulate their own emotional reactions. In this way, functions that the client has not sufficiently developed, or that have regressed under the pressure of transference, are demystified, and space is opened for their internalization.

One technique that has proven particularly useful in this process is the extraction of function from introjects (an introject is an internalized representation of another person and of the relationship with them, which takes on a particular function within the psyche). Instead of viewing the introject exclusively as pathological content to be interpreted or dismantled, it is mentalized: we explore which function a particular

parental behavior attempted to perform, what its intention was in meeting the child's developmental needs, and in what way this attempt was inadequate or harmful. By separating the function from the immature mode of its execution, what is referred to in OLI IPP as the maturation of introjects is made possible—a process in which raw, “swallowed” attitudes, demands, and prohibitions are transformed into more mature, flexible, and developmentally appropriate ego functions (Jovanović, S., 2025).

Such work simultaneously contributes to the mentalization of primary figures: parents are no longer experienced solely as “bad” or “good” objects, but as persons who often had developmentally meaningful intentions yet lacked adequate capacities to realize them. In this way, transference material is not exhausted in the repetition of the past, but becomes a field of learning in which earlier functions are recognized, separated from their immature forms, and developed into more mature basic developmental competencies that the client can use in present relationships.

In previous works on OLI IPP (N. Jovanović, 2013, 2025), the basic concepts of this psychotherapeutic modality have been presented in detail: basic developmental competencies (neutralization, mentalization, object wholeness and object constancy, tolerance of ambivalence and frustration), the concepts of secondary gain and counter-skills (rigid or maladaptive strategies developed around deficits in basic developmental competencies), and the two levels of therapeutic work (content and process levels). These concepts will now be connected with work on transference (which is also resistance).

Manifestations of Underdevelopment and Regression of Basic Developmental Competencies of Personality in Transference

In OLI Integrative Psychodynamic Psychotherapy, transference is understood as a relational context in which deficits, blockages, or regressions of basic developmental competencies become visible, as well as the specific counter-skills that organize around these deficits. It is important to emphasize that the underdevelopment of a given competency does not always manifest through its obvious “lack,” but often through excessive, rigid, or avoidant patterns that may initially appear adaptive or even mature.

Within the transference relationship with the therapist, these counter-skills become further crystallized, as the relationship is emotionally significant, asymmetrical, and developmentally challenging.

Neutralization: Impulsivity and Rigid Control

When neutralization is underdeveloped or has regressed, transference does not necessarily manifest exclusively through overt impulsivity and acting out. In some clients, affect is rapidly transformed into action: verbal outbursts, accusations directed at the therapist, abrupt termination of therapy, threats of leaving, or demonstrative withdrawal. The therapist is experienced as the immediate cause of the affect, and the relationship becomes a site of discharge. (Hartmann, 1955)

However, in other clients with the same deficit, an opposite counter-skill develops: the avoidance of all situations in which an impulse breakthrough might occur. In transference, this manifests as rigid control, emotional distance, “reasonableness,” intellectualization, or an excessive emphasis on calmness. The client may appear stable and self-controlled, but the therapeutic relationship remains emotionally “sterile,” without risk and without genuine contact. In both cases, the common denominator is the

inability to flexibly hold and process affect.

Mentalization: Concretization or Hypermentalization

In cases of deficits in mentalization, transference often manifests through the concretization of the relationship: the therapist is experienced in a personalized manner, as someone who “does something against me,” “does not understand me,” or “has hidden intentions.” Each intervention is experienced as a personal comment or attack, and the capacity for reflection on one’s own internal state is limited. (Fonagy et al., 2002)

At the same time, a maladaptive counter-skill of hypermentalization may develop. The client may then appear highly reflective, analytical, and psychologically sophisticated, but mentalization loses its connection to affect and reality. In transference, the therapist is experienced as a figure to be “read,” “uncovered,” or “exposed,” while the actual emotional experience remains unprocessed. Mentalization thus serves as a defense against emotional contact rather than as a means of understanding.

Whole-object integration: Idealization, Devaluation, and “Moral Pride”

Underdeveloped whole-object integration leads to transference marked by splitting: the therapist is experienced as either completely good or completely bad. Minor frustrations can result in sudden and intense shifts in the perception of the relationship. (Klein, 1946)

In addition to overt idealization and devaluation, counter-skills often develop that are masked as moral clarity, passion, or authenticity. The client may develop a neurotic pride in “pure emotions,” “uncompromising sincerity,” or a “clear distinction between good and evil.” In transference, the therapist may be experienced as someone who “relativizes,” “is not sufficiently clear,” or “does not take sides,” which is perceived as a threat to the client’s identity. The essence of the problem, however, lies in the inability to integrate opposing aspects of the relationship.

Object Constancy: Dependency and Emotional Withdrawal

In cases of insufficient object constancy, transference often manifests through fear of losing the relationship, hypersensitivity to interruptions, breaks, and changes in session schedules. The client continually checks the therapist’s availability and seeks confirmation of relational continuity. (Mahler, Pine, & Bergman, 1975)

At the same time, an opposite counter-skill may develop: emotional withdrawal and the minimization of the importance of the relationship, as an attempt to avoid the pain of separation. In transference, this may appear as distance, “self-sufficiency,” or insistence on independence, while underlying these manifestations is an inability to mentally maintain the relationship in the absence of the object.

Tolerance of Ambivalence: Polarization and Pressure on the Therapist

When tolerance of ambivalence is underdeveloped, transference becomes organized around the need to simplify relationships. The therapist is experienced as someone who must be either fully supportive or fully frustrating. Any attempt to simultaneously understand the client and set limits is experienced as a contradiction or a betrayal. (Klein, 1940)

In transference, a counter-skill of pressure often develops: the client implicitly or explicitly demands that the therapist take a clear side, make decisions on their behalf, or

confirm one position as “correct.” Ambivalence cannot be tolerated, but must be resolved externally.

Will: Passive Dependency and Oppositional Autonomy

Underdeveloped will in transference may manifest through passive dependency: the expectation that the therapist will lead the process, provide solutions, and assume responsibility for change. The client remains in a position of “I can’t,” “I don’t know,” “you are the expert.”

Conversely, an oppositional counter-skill may develop: a rigid rejection of any suggestion as an attempt at control. In both cases, the transference relationship becomes a site of struggle over responsibility, while the development of capacities for self-support and perseverance is avoided.

Initiative: Waiting and Sabotaging the Process

In cases of underdeveloped initiative, transference manifests through waiting for the therapist to “initiate the therapy.” The client may arrive without topics, repeat the same content, or remain in emptiness, with an implicit demand that the therapist assume the initiating role and “lead” the process.

At the same time, a counter-skill of passive sabotage may emerge: formal participation in therapy without genuine investment, which maintains the status quo and prevents change, while simultaneously allowing for secondary gain from “trying.”

In cases of underdeveloped or rigidly organized initiative, transference does not manifest only through passive waiting for the therapist to assume the initiating role, but also through an opposite maladaptive pattern of hyperactive initiative. In this latter case, the client assumes full control over the therapeutic process within the transference: selecting topics, defining goals, structuring each session, and leading the conversation—often with a pronounced need for the therapy to “make sense” and to move constantly toward solutions.

At first glance, such a client may appear motivated, responsible, and engaged. However, underlying this pattern is often an inability to surrender to the emotional process, a fear of losing control, and an avoidance of contact with the unpredictable or dependent aspects of the relationship. The transference relationship is then used as a space of organization and control, rather than as a space of experience and change. Initiative, instead of serving activation and development, becomes a counter-skill through which emotional vulnerability is avoided.

In both patterns—passive waiting and hyperactive control—the common denominator is a lack of flexible initiative that would allow both the initiation of the process and the capacity to surrender to its course. Therapeutic work in such cases is directed toward the development of initiative that does not serve control or avoidance, but authentic participation in an emotionally significant relationship.

In this way, through process analysis and the implicit “algorithms” or recurring patterns of forming relationships, transference in OLI IPP becomes a map of the functioning of basic developmental competencies, as well as a map of the counter-skills that have developed around their deficits. Transference patterns are neither random nor exclusively historically conditioned; they represent current survival strategies within an emotionally demanding relationship, which need to be understood, dismantled, and replaced by developmental capacities.

Of course, in work with transference it is always possible—and often very useful—to recognize the historical trace of a particular transference manifestation and to interpretatively link it to significant figures from the past. Such interpretations can deepen the understanding of the origins of certain emotional reactions and illuminate the developmental context in which relational patterns were formed.

However, the approach discussed here enables another important level of understanding. Through recognizing the process—that is, the pure pattern of relationship construction activated in transference—the client can gain insight not only into where something originates from, but also into how that pattern functions in present relationships. In this way, the focus shifts from the specific object onto which experience is “transferred” to the algorithm of establishing and maintaining emotionally significant relationships itself, which repeats independently of the particular person with whom the relationship is formed.

By analyzing this pattern—including the counter-skills activated within it and the secondary gains that sustain it—it becomes possible to clearly point to its consequences for relationships and to connect them with the difficulties that bring the client to psychotherapy. Thus, therapeutic work does not stop at insight into repetition, but opens space for learning and practicing alternative, more mature ways of processing emotions and building relationships, that is, for the development of basic developmental competencies capable of replacing maladaptive patterns.

In this sense, transference in OLI IPP remains a site of historical understanding, while at the same time becoming a laboratory for experimenting with new ways of relating, in which changes are not only understood but also concretely practiced and integrated into everyday life. Transference is viewed as the context in which the manner in which the client processes emotionally significant relationships is most clearly manifested. When basic developmental competencies are underdeveloped, partially developed, or prone to regression, their decline or absence becomes visible precisely within the transference relationship with the therapist. Transference then does not manifest primarily through the content of what is transferred, but through the specific way of experiencing, reacting, and organizing the relationship.

Case Study

(Jovanović, N., 1990)

The following case study illustrates how these theoretical principles are manifested and worked through in clinical practice. All clinical material is presented in anonymized and paraphrased form and serves exclusively for academic and educational purposes. Prior verbal consent was obtained from the client to present the therapeutic process.

Although it rests on a single case presentation, this format has a recognized value as a “bridge” between research and clinical practice (Binder, 2025).

In the following account, the reader will be able to follow two parallel dimensions: (1) the development of the transference relationship through its manifest content, and (2) changes in the manner of emotional processing, that is, in the development of basic developmental competencies.

I began working with M. when she first joined a group project, that is, a group activity within body-oriented psychotherapy. The group was not defined as therapeutic, but rather as recreational and educational. Its aim was to familiarize participants with the principles of body-oriented psychotherapy, help them become more aware of their own

bodies, recognize chronic muscular tensions, and—through group exercises—work on increasing bodily vitality and vibratory processes, releasing muscular tension, and expressing emotions.

As her motivation for joining the group, M. stated a need to get into better contact with her body. She complained that she had lost contact even with her basic physiological needs. She did not feel the need to go to the toilet until she began to experience abdominal pain caused by intense tension in the colon or bladder. She relied on the clock to determine when it was approximately time to attend to her physiological needs or to eat (she was markedly underweight). She described feeling as if her head and body were beginning to separate, and she was afraid that this meant she was “going crazy.”

These difficulties began to manifest following a summer vacation (five months earlier). During the vacation, she met a young man whom she experienced as overwhelmingly attractive. She described him as gentle and somewhat feminine, with full, sensual lips that reminded her of her younger brother. He was younger than she was, and she felt a strong urge to take the lead. When the relationship moved toward physical intimacy, she suddenly froze and developed acute choking sensations and panic while he was kissing her. She later described a moment of severely dysregulated sexual enactment that left her frightened and ashamed. After he left the country, she became preoccupied with the fear that she might have contracted HIV/AIDS.

In a panic-driven fear of AIDS and of going crazy, she sought psychiatric help and joined a psychotherapy group, which she soon left because she “got into a fight with the therapist, who was too harsh, yelled at her, and told her she was spoiled and rude.” As one of her motivations for joining the group I was leading, she also mentioned that at the first meeting she saw in my eyes that I was “something special, that I radiated an unusual warmth and that I could help her.” Her then-boyfriend also joined the group, as she put it, “more because of me than because of himself.”

During that period, they were unsuccessfully trying to end a one-year relationship (at her initiative), because M. felt that he was suffocating her, but she was unable to break up out of fear that this might trigger a dangerous escalation of violence—toward himself or toward her. In the following account, I will first present only the clinical material, leaving the theoretical connections for the end.

I felt ambivalent about M.’s participation in the group from the very beginning. On the one hand, I felt that she was highly motivated for therapeutic work and that she brought a certain dynamism into the group process through her readiness to present unpleasant material, thereby eliciting sympathy and compassion from some group members. On the other hand, over time it became increasingly evident that she needed me to focus on her more than on the group as a whole and that she needed to remain at the center of attention.

I felt that the group was not the most appropriate setting for working with her and began to consider proposing individual therapy. I was concerned that expressive body-oriented exercises might provoke more intense reactions in her, which would require a far greater investment of time focused on M. and could lead to dissatisfaction among group members, as well as anxiety due to the sudden breakthrough of contents and feelings for which they were not prepared. In addition, the group was not defined as a therapeutic one, and its size would have been inappropriate for working with this type of problem (15 members).

At that point, her problem with boundaries became clearer to me on an experiential level. I will describe several aspects through which this problem began to manifest more distinctly. One of the first group meetings began with a discussion about breathing. Group members shared their observations about limitations in their breathing, and some volunteered to lie down, try to relax, and breathe deeply. M. expressed a wish to try as well.

I felt a slight sense of discomfort, although at that moment I could not clearly define it. She began to breathe more deeply, and at first this was pleasant for her. She found my presence comforting and started to verbalize her experience of the situation. She had an image of something round above her head—something she wanted very much. It was enormous, and she felt that her desire was enormous, but that her mouth was small. She opened her mouth wide and began to choke, to call for help, panicked that her heart would stop, and asked me to reassure her that nothing would happen to her. I told her to stand up and that nothing would happen to her, after which she calmed down.

After the session, I felt uncomfortable and dissatisfied. I tried to understand and differentiate several mixed feelings. I felt concern for M. (even though she had my phone number in case of need), anger at myself for not having already suggested individual work, a sense of guilt, but also a certain anger toward her that I did not understand at the time. I also felt resistant to the idea of working with her individually, because I sensed that it would require a considerable investment of time and, above all, emotional engagement, for which, at that period, I was not fully prepared.

At that time, I experienced M. as a person who “grabs,” who shows little respect for the needs of others, and who, when her needs are not met, is ready to engage in destructive and self-destructive enactments. Her dramatic expressions of helplessness, panic, and similar behaviors—in the group, in her relationship with her boyfriend, and with her parents—were experienced as manipulative, aimed at forcing the other person (usually through guilt and fear for M.) to satisfy her needs.

I felt guilty for not following my initial impression and for including her in a group to which she had now become attached, as well as for the feeling that she had somehow intruded into my space more than I had wanted—that my boundaries were being violated. Alongside these negative feelings, she was unusually interesting to me; she often surprised me with the sharpness of her observations about herself and the group members, as well as with her sense of humor. I was moved by her tense yet powerful will to make something of her life.

The reactions of the group members were similar. M. evoked sympathy, compassion, and protective reactions in some group members, but also aggression because of her “lack of measure,” manipulation, and “hysterical behavior aimed at getting attention.” One group member described M. in the following way:

“She is capable of getting inside a person, of seeing them, of reading them better than many people, and of saying everything straight to their face, believing she is being honest. But she is not capable of feeling the other person or establishing contact. Maybe I am not ready for that, or maybe I don’t want to hear it. Maybe I don’t like someone crawling into my stomach. M. more openly says that she wants to touch someone in the group or hug them. It’s as if she has no moral limits, but she doesn’t really see the other person. It’s as if others are just objects for satisfying her needs. If someone is not ready for that, she will try to seduce them in various ways to get what she wants. When she takes up time, she thinks she has a full right to it because she needs it more. As if the

group exists for her. When she is in a crisis, she does not recognize the limits that are necessary for us to cooperate here as equals. She has a need to push through and break things..."

Her boyfriend offered similar observations. From the very beginning of their relationship, he played the role of her "manager." They met through music. He had many connections in the music scene and tried to support her career. Very quickly, their relationship turned into an "exclusive contract" of sorts. M. had a need to possess him completely and to be together all the time.

Before he met her, he had been constantly active, always on the move, and practical. He did not think much about himself or about psychology. She shook him up, "broke through his shell," and told him many things—that he was a latent homosexual, artificial and essentially feminine, and that he played the role of a macho man as a defense. She unsettled him deeply; he felt that the relationship was pulling him further and further in, yet he could not bring himself to end it.

These observations of M. by others represent only one side of the coin. On the other side is her fear for her own boundaries and the weakness of those boundaries in the opposite direction. I will mention several of her experiences that illustrate this.

At one of the early group meetings, a yoga instructor was present—someone with whom M. had previously attended a course. The instructor began to criticize some of the exercises from a yoga perspective, at which point M. interrupted her and said that she was advertising herself and that the group had come to listen to me and to learn about my approach to body work, not to hear a lecture on yoga. After the meeting, M. felt very disturbed, because she was afraid that this woman might harm her through mental or psychic influence. She knew this was unrealistic, but she felt that the instructor could enter her and harm her, as if she were a witch.

M. is often distressed when strong emotional expressions emerge in other group members. She describes her experience in the following way: "I feel as if the other person has entered me and that I am experiencing their feelings. When G. started sobbing, I felt as if something hit me in the stomach, like a knife. As if her sobbing and fear were taking over me and that I was going to lose control."

She reports several similar experiences: "I was standing in line at the grocery store and saw a woman who seemed interesting to me. At that moment, I felt as if I was leaving myself and entering her—or she was entering me—feeling and thinking as she did..."; "I feel that N. (my boyfriend) is suffocating me, that in the relationship with him I am losing myself. When I try to leave him, I panic that he will kill himself or do something terrible... or that he will kill me."

M. reported a dream that vividly reflects her lack of boundaries and problems with differentiation from the object: "I dreamed that N. and I were standing on some terrace. I felt that I should take care of him. As if N. was at the same time my mother. He falls from the terrace. In panic, I run downstairs and find a little girl who seems to be crazy. She has uncoordinated movements, like a broken robot doll. Each part moves separately, as if she is falling apart. That is me. When he falls—or when my mother falls—I fall apart too."

She further compares her feelings toward N. and toward her mother, describing her inability to say no to them or to separate herself. "My mother gets terribly inside me. She is strong, intrusive, always talking, snapping, killing me with words, with some masculine strength that hits me in the stomach. When I feel good, it's enough for her to

enter the room and start nagging or mocking me. I automatically begin to feel the same, as if cursed. I have no protective wall against her, as if I have no skin..." (She also physically appeared as "skin and bones.")

After several group meetings, I proposed individual work to M., explaining that there was not enough time in the group setting to work adequately on her problems. She accepted this gladly, pleased that I was "thinking about what was best for her." We began meeting twice a week. M. was "thrilled" with the therapy—"this is the real thing" for her. She compared me to people she had previously thought might become her teachers in life. I was the only one, she said, who did not impose himself or try to fit her into his own system of thinking.

She experienced me as a rescuer, "like some kind of sun from which she absorbs warmth and gets filled up... then she feels better, and she is better toward others." The sessions were filled with a wide range of material, often very painful, but chaotic.

For the most part, the content of the sessions was determined by everyday events—conflicts at home, conflicts with her boyfriend, and similar situations. I listened patiently, showing understanding and compassion, but I had the impression that much more important processes were being reflected—though unspoken—within the relational field between her and me, and that the concrete content was less important at that moment.

She had a habit of asking for another five minutes, asking to at least deepen the session a little because she had not yet told me everything, or calling me on the phone to "just tell me something briefly." At one session she described it like this:

"I want you to know every little detail about me, so that nothing important remains that you don't know—I'm afraid I might leave something out. Somehow, if you know everything about me, it's as if I am inside you, and then I feel safer. That's how it has been with my notebook-diary. I wrote everything in it; the notebook absorbs everything like some kind of whirlpool, but it pulls me away from reality. It's as if we are one, it and I... my best friend... no boundaries.

I had a dream. A very strange one, but I think very important. It left a strong impression on me. It starts with me looking at the night sky and seeing a dot far away in space. It comes closer to me out of the darkness and I begin to make out a shape. I see that it is a fetus approaching my face, but between me and it there is some invisible boundary. It looks at me in a pleading way. I want to reach for it because I know it is cold out there in space and that it is alone. I feel in this world like that fetus. I know that is me..."

After a few months of work, a noticeable tendency emerged regarding the scheduling of sessions. M. began to emphasize as a problem the fact that the most important things often happened when we did not have a scheduled session, and that she "barely survived" until the agreed appointment. Later, she would say that it felt "awkward" to tell me about it afterward, since she had not been able to do so at the moment when she needed me.

I sensed reproach in her voice, although she denied being angry with me because of this. Even increasing the frequency of sessions to three times a week did not help, because M. felt the need to call me precisely "when we had not agreed," to say that she was "in a crisis," and I would usually accept having an extra, unscheduled session. I felt that she did not want us to have fixed appointments, but rather to meet whenever she needed it, regardless of whether I was occupied or not.

I explained to her the advantages of having fixed session times—that knowing when she would see me could help her regulate herself between sessions. She replied that it was easy for me to tell her to postpone things, but that she was not capable of doing so; it was stronger than her. I decided to accept her idea of scheduling sessions according to her needs, but I warned her that it might happen that I would be unavailable at the time she called.

It soon became clear how much space this way of scheduling sessions opened for fantasies of rejection. There were times when, due to other obligations, I was not able to see her whenever she asked. Then questions would arise such as: “But weren’t you usually free at that time?” or “Don’t you work until five on Thursdays?” and similar remarks. She began to develop fantasies that I wanted to avoid her, that I was deliberately tormenting her “like a baby, by taking her off the breast.” On one occasion, this enactment became obvious even to her herself.

It was a holiday. One day before the holiday, M. had the opportunity to attend a session, but she did not call. She was aware that working hours were shortened on the eve of the holiday. On the holiday itself, she called around 10 a.m. and asked me to see her. I told her that I was sorry, but that I could not see her and suggested that we meet on Monday. In an angry voice, she told me that I was irresponsible and abruptly ended the call.

At our session on Monday, she described how overwhelmingly angry she had been with me. She said she had imagined coming to my office and destroying it, telling me that I was irresponsible and that I treated people like experimental subjects. She claimed that she could have lost control and caused serious harm, to herself or to others. She accused me of being responsible for the impulsive behaviors she had displayed during the weekend—shouting in the street, on the bus, and at home—insisting that none of this would have happened if I had been willing to see her. In her experience, I was a powerful figure holding her fate in my hands, able to handle her as I wished.

I reminded her that she could have contacted me the day before and that she might reasonably have expected that I would be unavailable on a holiday. She replied that this was precisely what she expected of me—that I should always be available. She described feeling intense rage when she heard sounds of celebration in the background during our phone call. She questioned how I could be enjoying something without her and how anything could be more important than her. She felt that she should be the most important person to me, and that since I had taken responsibility for working with her, I should always have time for her. I asked her whether this meant that I should always be at her disposal.

As the conversation continued, it became clear that she expected me to be constantly available and to anticipate when she would need me. This also revealed her need to control the relationship and to continually test whether I cared for her—something that the flexible scheduling arrangement readily facilitated. When she felt confident that she could almost always reach me when needed, she was sometimes able to postpone contact and even feel proud of herself for having managed something on her own.

A striking shift was evident in her experience of me depending on whether her needs were being met. When they were, I was perceived as a “special person,” the only one who truly understood her, almost a deity—an “embodiment of love.” When she experienced frustration or refusal, I became the “devil”: a powerful figure who tormented her, an irresponsible experimenter. In such moments, she described hating

me “from the depths of her soul” and feeling an urge to expose and destroy me.

In each of these affective states, there was only an intellectual awareness that the opposite experience existed, while the emotional reality of it felt completely inaccessible. “As if it were someone else who felt that, not me,” she said. One particular session illustrated this dynamic clearly.

The session began with intense anger toward her mother. She felt rejected and helpless, like an object that could be taken up when needed and discarded when no longer useful. This, she said, was how her mother treated her—as if she existed only in relation to her mother’s needs.

She then shifted to another topic which she described as even more important: her relationship with me. She spoke of persistent fantasies of physical closeness and felt that such contact would resolve all of her difficulties. She knew that I was her therapist and that such contact was not appropriate, yet she held onto hope. She said that this hope had drawn her to therapy from the very first moment she saw me, and that I should have understood this from the beginning.

Because I had listened to her and acknowledged her feelings without rejecting her, she felt she had allowed these feelings to grow. She experienced me as responsible for this and demanded a clear answer—yes or no—as to whether I would satisfy her expectations. I responded that I would not.

She stood up, said that everything disgusted her, that she hated me, that her own needs disgusted her, and that she hated herself for having needs. She declared that she never wanted to see me again and left the room.

After several minutes, however, she returned, explaining that she had been unable to leave the building due to an intense fear that she might die if she moved away. She felt compelled to resolve the situation with me and urgently wanted to know what I now thought of her and whether I would still be willing to see her.

I told her that she had enacted precisely what she had described earlier in relation to her mother: I had been idealized as long as there was hope that I would satisfy her needs, and when that hope was denied, I became unbearable and she felt driven to reject and discard me as an object. She began to cry and said that she recognized how she repeated with others what she experienced her mother as doing to her. She felt as if her mother lived inside her and described a recurring pattern of seeking closeness through seduction, control, and urgent demands rather than through genuine contact.

With sadness, she recognized that the specific person involved was often interchangeable—someone onto whom she could attach an intense fantasy and then attempt to secure through manipulation. She acknowledged that she had related to me in the same way and expressed relief that I had not allowed this dynamic to be acted out, and that I had neither merged with her nor rejected her as an object.

Throughout the therapeutic process, M. did not show a lack of associations or affect. On the contrary, she was often flooded by internal material or external events. The central difficulty lay in integrating contradictory contents and opposing emotions. I experienced her as a person “without flesh,” lacking sufficiently strong psychological defenses, as if whatever occurred was immediately expressed. She described herself as a “whirlwind,” moving in a disorganized way and pulling in whatever came along.

She felt a strong need to write down everything that emerged during sessions in order to organize it, to prevent disintegration, and to create structure. She described this as something she was learning for the first time—that her thinking was becoming more

directed and organized. Initially, she relied on me for this function, but gradually she began to do it herself, and she felt proud of this new capacity.

One of her dreams expressed this experience vividly. She dreamed that a dome fell from a tower and water poured out. She felt that the tower represented her body and the dome her head, while the water symbolized her emotions overwhelming her. For the first time, she did not panic. A flood occurred, and she found herself in a small boat with three other people. Two behind her were the parents of a close friend—kind people who accepted her. At the stern stood a young man who resembled me. In the dream, she knew that the boat and all its occupants represented herself.

She saw a small child in a state of panic. She took the child into her arms, and although the child was initially inconsolable, she felt capable of calming it. She sensed that her own body could contain the child's panic and maintain balance. She felt proud as the child settled. This reminded her of the ego states—Parent, Adult, and Child—from Transactional Analysis.

M. often described herself as someone who lived “on the border.” Although her parents were divorced, they lived in the same apartment: her mother with her brother in one room, her father in another, and M. in between. She felt she belonged nowhere. As a child, she frequently served as an intermediary between her parents, both of whom confided in her and sought her allegiance. She experienced them as entering her and struggling within her.

She described a recurring dream in which she was a specially chosen border guard defending a vital central station, which she knew represented her mind. Countless paired figures approached—representations of her parents—while she attempted to protect the center from disintegration. She interpreted this as an expression of her lifelong position between opposing forces.

Her accounts of family dynamics further illustrated diffuse boundaries and pervasive intrusion. Her father was emotionally distant and withdrawn into intellectual pursuits, while her mother was experienced as intrusive, dramatic, and controlling. M. described feeling repeatedly invaded, emotionally overwhelmed, and unable to protect her inner space.

To conclude this case presentation, I will briefly describe a session that took place after one year and nine months of work. The session began with intense guilt toward her father following a hospital visit after his surgery. She oscillated between anger toward him and fear of losing him. She recognized how aggression had served as a way to secure attention and contact, while simultaneously evoking catastrophic fantasies of harm.

We spoke about the difficulty she had in allowing love and hatred toward the same object to coexist. When these feelings came close together, intense guilt and fear of disintegration emerged. She described the experience as “a short circuit.”

She then connected this pattern to her relationship with me, noticing that whenever she sensed reduced availability, she felt compelled to test or control the relationship. She recognized her difficulty tolerating separation, waiting, and emotional emptiness without resorting to old defensive strategies.

Toward the end of the session, she expressed discomfort with positive feelings such as gratitude, which she associated with vulnerability and dependence. With visible embarrassment, she said she felt grateful for having met me and noted with surprise that she could express this feeling and survive it.

I did not interpret this moment but focused on maintaining contact with the emerging affect and allowing it to be endured without action. In subsequent sessions, demands and testing behaviors diminished, while her capacity to articulate insecurity increased. Although old patterns reappeared at times, they were recognized earlier and with less intensity.

This shift did not eliminate conflict, nor did it resolve her relationships with significant figures. However, the way M. processed emotionally meaningful relationships changed. The transference relationship ceased to be primarily a site of repetition and became a space in which new forms of emotional regulation and relatedness could be experienced.

This case illustrates that therapeutic change occurs not only through insight into past experiences, but also through transformation in the processing of emotions within the present relationship. When a client can tolerate ambivalence, recognize impulses without acting on them, and remain in contact despite shame and insecurity, the development of previously unavailable basic developmental competencies becomes possible. In this sense, the transference relationship functioned not only as a means of understanding, but also as a space for learning and maturation.

Interpretation of Content and Integration with Theoretical Concepts

In the “clinical picture,” that is, in the characteristic way M. functions in relationships with others and in relation to herself, one can observe those features that Kernberg (1975) identifies as characteristic of borderline personality organization: (a) low tolerance for anxiety, (b) limited impulse control, and (c) insufficiently developed channels of sublimation. The primary defense mechanism in M. is splitting. The ego protects itself from excessive anxiety through dissociation and the active maintenance of distance between positive and negative introjects.

In M., it is striking that these opposing ego states are alternately activated as if governed by a rigid on-off switch, with the initial stimulus for the shift being frustration, non-gratification of her needs, abandonment, or rejection (that is, what she experiences as abandonment or rejection). As long as these states remain separated from one another, M. does not experience intense anxiety. When they come closer together—as occurred in the later work in her feelings toward her father—a tearing sense of guilt develops, along with fear of destroying the object through her own aggression and fear of ego disintegration (as reflected in the dream of falling from the terrace). This points to difficulties in achieving a stable transition from the paranoid-schizoid position described by M. Klein (1940) toward the depressive position and its characteristic defensive capacities. Due to the intensity of aggression, the ego fails to achieve a fusion of positive and negative identifications and to neutralize aggression, which in turn reinforces splitting.

Splitting also helps explain the perception of others that M. is unable to respect other people’s boundaries, as well as her own sense of being justified in her expectations of others. On the one hand, a tendency toward primitive idealization leads to unrealistic expectations of the object, which in such moments is experienced as omnipotent, entirely good, and without limitations. In these states, M. loses contact both with the realistic capacities of the other person and with her own boundaries, resulting in demands that inevitably remain unmet. When frustration occurs, idealization abruptly reverses into devaluation, and the object is experienced as malevolent, cold, or rejecting.

This sudden shift in states further intensifies internal instability and contributes to the reactivation of splitting as the primary defense mechanism. In the transference relationship with the therapist, the same pattern is clearly repeated: in certain phases, the therapist is experienced as the only person who can understand, help, and protect, while in other phases the therapist is experienced as emotionally unavailable, frustrating, or rejecting. These shifts are not proportionate to actual events in the therapeutic relationship, but are instead determined by internal movements within the ego structure, which fails to integrate opposing feelings toward the same object.

When positive and negative experiences move closer to one another, there is a sudden increase in anxiety, an intense sense of guilt, and fantasies about the destructive potential of one's own aggression. In such moments, the limited capacity to neutralize aggressive impulses and to sublimate them becomes evident, further destabilizing ego functioning. The dream of falling from the terrace can be understood as a symbolic expression of fear of losing control and of the disintegration of the ego structure at moments when defensive separation ceases to function.

The analysis of this case indicates that, in M., the central therapeutic task was oriented toward strengthening ego functions that enable the tolerance of ambivalence, the integration of opposing affects, and the gradual abandonment of primitive defense mechanisms. To the extent that the ego gradually becomes able to endure the simultaneous presence of love and aggression toward the same object, it becomes possible to reduce the need for splitting and to establish a more stable relationship to oneself and others. From this perspective, the therapeutic process with M. cannot be viewed exclusively as the resolution of individual conflicts, but rather primarily as long-term work on transforming structural modes of functioning that underlie her interpersonal difficulties and inner instability.

Process Analysis: Transference, Resistance, and the Development of Basic Developmental Competencies of Personality from the OLI IPP Perspective

In the preceding case presentation, the clinical material was analyzed at the level of content. From the perspective of OLI IPP, however, the key locus of change lies in the way the therapist intervenes in real time within the transference relationship, with the aim of developing basic developmental competencies that allow for a different mode of processing experience.

Neutralization

In M., intense affects rapidly shifted either into action or into rigid control. Therapeutic interventions were not directed toward suppressing aggression or toward its direct discharge, but rather toward modeling neutralization. The therapist remained emotionally present and calm in moments of her anger, pressure, and demands, thereby demonstrating that intense affect can be endured without acting upon it. Through thinking aloud and naming what was occurring within the relationship, the therapist slowed down the process. Affect was gradually translated into mental content rather than impulse.

At the same time, the therapist also neutralized his own potential reactive anger, neither entering into a power struggle nor withdrawing, thereby implicitly demonstrating a more mature mode of processing aggression.

Mentalization

When M. lost the capacity for reflection and experienced the therapist concretely (as a partial object) as depriving or malevolent, the therapist did not attempt to convince her otherwise, but instead redirected attention to process: how her experience of the relationship was changing in that moment and how that experience influenced her reactions. Through questioning, joint reflection, and shifting the focus from “what you are doing to me” to “what is happening within you,” the therapist supported the restoration of mentalization within the transference relationship itself. Thus, mentalization was not treated as an abstract capacity, but as a functional process embedded in affect regulation.

Whole-object integration (Object Wholeness)

The abrupt alternation between idealization and devaluation of the therapist was not directly interpreted as a defense mechanism, but was lived through within the relationship. The therapist remained the same—consistent, emotionally available, and with clear boundaries—both during phases of idealization and during phases of attack. This made it possible for the client gradually to experience that the object could remain the same despite changes in her internal states, which constituted a foundation for the development of object wholeness.

In addition, the therapist drew the client’s attention to the pattern of splitting as it emerged within the relationship—how it appeared, when it occurred, what function it served, which needs it satisfied, what it protected her from, and what its negative consequences were—thereby enabling a gradual preparation for the depressive position and for the tolerance of ambivalence.

Object Constancy

In working with separations, pauses, and fluctuations in availability, the therapist used a realistic yet predictable structure. In certain situations, he responded to her initiatives for additional sessions that were not prearranged but arose in response to her needs, when it was assessed that this had developmental value; at the same time, he clearly pointed out the reality that this would not always be possible. Of particular importance was the fact that he anticipated and explicitly named the possibility of her anger and dissatisfaction in such situations, thereby helping frustration to be experienced rather than avoided or discharged explosively.

Tolerance of Ambivalence

The therapist did not attempt to “resolve” ambivalence, nor to persuade the client either to love or not to hate. On the contrary, he remained in contact with both affects, without reacting intensely either to expressions of love or to attacks. This made it possible for positive and negative affects to appear simultaneously within the relationship, without a breakdown of the relationship itself. This “survival of ambivalence” had a strong developmental effect: the client learned to tolerate opposing emotions without resorting to splitting.

Tolerance of Frustration

M.'s non-developmental needs were not gratified—the therapist did not remove frustration, did not “rescue” her from discomfort, nor did he guarantee constant availability. At the same time, frustration was neither cold nor punitive. The therapist helped the client recognize how frustration activated her relational pattern, how it led to pressure, dramatization, and secondary gain, as well as the long-term damage this pattern produced in her relationships outside therapy. This corresponds to the principle of optimal frustration, in which frustration is neither avoided nor imposed, but used developmentally.

Will

M.'s will was strong, but it had become instrumentalized toward the coercive gratification of needs. The therapist gradually redirected her will away from controlling the relationship and toward enduring the process: remaining in therapy even when dissatisfied, tolerating waiting, and accepting that change does not occur immediately. In this way, will ceased to serve pressure and began to serve development.

Initiative

When M. assumed complete control over the therapeutic process or, conversely, passively expected the therapist to lead, interventions were directed toward the development of flexible initiative. The therapist accepted her proposals while simultaneously using them as material for process analysis—how difficult it was for her to surrender, how control functioned to avoid emotional uncertainty, and what a different form of initiative might look like.

Process of Change

In this case, the transference relationship was not merely a site of repetition, but a site of learning. Through his own manner of responding, the therapist separated functions from introjects. He demonstrated that the functions the client had “swallowed” from her parents were not pathological per se, but that the way in which they had been used was immature and destructive. Through the relationship, new ways of processing emotions were gradually introduced, which could then be generalized to relationships outside therapy.

From the OLI IPP perspective, this case demonstrates that work with transference is not limited to interpretation, but involves the therapist's active participation in the development of ego functions through consistency, survival, thinking aloud, optimal frustration, and the modeling of more mature basic developmental competencies. Within this framework, transference in OLI IPP is not merely a place where the past is uncovered, but a space in which one learns how relationships are built, endured, and transformed.

Conclusion

Work with transference in OLI Integrative Psychodynamic Psychotherapy is grounded in the classical psychoanalytic understanding of transference as a central space of the therapeutic process, while simultaneously expanding it through a developmental and functional framework. In this approach, transference is not viewed exclusively as the repetition of earlier relationships and conflicts, but also as a context in which deficits, blockages, or regressions of basic developmental competencies—that is, ego functions enabling mature processing of emotional experience—become visible.

The presented theoretical framework and clinical material point to the importance of distinguishing between transference phenomena that arise from a temporary regression of previously developed capacities and those that reflect structural ego deficits. This distinction has direct implications for therapeutic technique, as it requires different types of intervention: the deblocking and stabilization of existing functions in the former case, and their gradual development, learning, and internalization in the latter. In this way, work with transference shifts from an exclusively interpretative level toward the integration of interpretation, corrective emotional experience, and procedural learning.

Within OLI IPP, the transference relationship becomes a developmental space in which, in addition to insight into repetition, the transfer of functions, strengthening of basic developmental competencies, and the construction of secondary ego autonomy take place. In this process, the therapist does not remain merely an analyst of transference meanings, but also becomes an active bearer of functions that the client is not yet able to perform independently, with a clear temporal limitation and the aim of their internalization. Thus, change is not exhausted in understanding the past, but is confirmed in the client's increased capacity to regulate affects, tolerate ambivalence and frustration, maintain relational continuity, and assume responsibility for her own functioning in present relationships.

Conceived in this way, transference enables a connection between the classical psychoanalytic tradition and contemporary developmental and integrative approaches to psychotherapy. OLI Integrative Psychodynamic Psychotherapy thus offers a model of work with transference that preserves the depth of analytic understanding while simultaneously providing clear, clinically applicable guidelines for developmental intervention and enduring psychological change.

References

- Binder, P.-E. (2025). The Single Case Study is a Crucial Bridge between Research and Practice. *Journal of Contemporary Psychotherapy*, 55(2), 119–126.
- Druck, A. B. (1998). Deficit and conflict: An attempt at integration. In C. S. Ellman, S. Grand, M. Silvan, & S. J. Ellman (Eds.), *The Modern Freudians: Contemporary psychoanalytic technique* (pp. 205–229). Northvale, NJ: Jason Aronson.
- Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York: Other Press.
- Freud, S. (1912). The dynamics of transference. *Standard Edition*, 12, 97–108.
- Freud, S. (1914). Remembering, repeating and working-through. *Standard Edition*, 12, 145–156.
- Freud, S. (1923). The ego and the id. *Standard Edition*, 19, 3–66.
- Gill, M. M. (1982). *Analysis of transference. Vol. I: Theory and technique*. New York: International Universities Press.

- Glita, P. (2010). Usefulness of the concepts of deficit and defect in the psychotherapeutic process. *Archives of Psychiatry and Psychotherapy*, 2, 51–59.
- Hartmann, H. (1955). Notes on the theory of sublimation. *The Psychoanalytic Study of the Child*, 10, 9–29.
- Jovanović, N. (1990, November). Some open questions in working with borderline personality organization: The problem of defective ego boundaries—A two-year therapy case presentation [Case presentation]. Eastern European Psychoanalytic Seminar (in cooperation with the International Psychoanalytical Association), Belgrade, Serbia.
- Jovanović, N. (2013). *Sposobnost za ljubav i rad: OLI integrativna psihodinamska psihoterapija* [The capacity for love and work: OLI integrative psychodynamic psychotherapy]. Belgrade, Serbia: Beoknjiga.
- Jovanović, N. (2025). *Razvoj bazičnih emocionalnih kompetencija u OLI. integrativnoj psihodinamskoj psihoterapiji* [The development of basic emotional competencies in OLI integrative psychodynamic psychotherapy]. Belgrade, Serbia: Kreativna knjiga & OLI Centar.
- Jovanović, S. (2025). Method of working on the maturation of introjects in psychotherapy [Conference presentation]. XX Summer School of the Eurasian Confederation of Psychoanalytic Psychotherapists, Moscow, Russia.
- Karasu, T. B. (2001). The advanced practice of psychotherapy. *Harvard Review of Psychiatry*, 9(3), 118–123.
- Kernberg, O. F. (1975). *Borderline conditions and pathological narcissism*. New York, NY: Jason Aronson.
- Killingmo, B. (1989). Conflict and deficit: Implications for technique. *International Journal of Psycho-Analysis*, 70, 65–79.
- Klein, M. (1940). Mourning and its relation to manic-depressive states. In *Love, guilt and reparation*. London: The Hogarth Press.
- Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psycho-Analysis*, 27, 99–110.
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Krivzov, J., Hannon, D., & Meganck, R. (2021). Approaching psychotherapy case studies in a metasynthesis: Deficit vs. conflict in treatment of medically unexplained symptoms. In M. Borcsa & C. Willig (Eds.), *Qualitative research methods in mental health* (pp. 37–63). Cham: Springer.
- Mahler, M. S., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant*. New York: Basic Books.
- Racker, H. (1968). *Transference and countertransference*. New York: International Universities Press.
- Sugarman, A. (1995). Psychoanalysis: Treatment of conflict or deficit? *Psychoanalytic Psychology*, 12(1), 55–70.
- Yilmaz, M., Türkarslan, K. K., Zanini, L., Hasdemir, D., Spitoni, G. F., & Lingiardi, V. (2024). Transference interpretation and psychotherapy outcome: a systematic review of a no-consensus relationship. *Research in Psychotherapy: Psychopathology, Process and Outcome*, 27(1).