

Processes of Separation and Termination in Short-Term Dynamic Psychotherapy A View of Therapists' Transference in These Processes

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Abstract

The termination phase in short-term dynamic psychotherapy (STDP) is of paramount importance for treatment success. This phase consolidates the difficulties that both therapist and patient experience surrounding the pains of separation and loss. In this article, I discuss the personal characteristics required of the therapist in order to engage successfully in short-term dynamic psychotherapy. I also address the various types of countertransference that may arise in the therapist due to his or her own unconscious defenses, which may be especially activated during the phases of separation and termination. I present excerpts from two treatments that illustrate some expressions of countertransference and their impact on termination. I hope thereby to encourage therapists to examine their attraction to - or avoidance of - short-term treatment, and in so doing, deepen their self-awareness as well as broaden their therapeutic repertoire.

Keywords: Therapeutic Repertoire, Time Limited, Separation, Countertransference, Transference

1. Introduction

In short-term dynamic psychotherapy, the beginning of treatment is also the beginning of its ending. The shadow of termination is cast even upon the selection of patients suitable for this modality, and subsequently colors the various stages of treatment - not only the final phase. In this article, I address what is distinctive about termination in STDP and focus primarily on the transference and countertransference processes that occur in the minds of both therapist and patient. In my opinion, these processes influence therapists' motivation to choose or not to choose STDP as part of their repertoire.

In the termination of a short-term treatment of a supportive nature—typically intended for individuals in crisis or those with limited ego strength—the threat of separation is softened through various means. For example: gradual reduction in session frequency, guidance on using the knowledge and insights gained, and mention of the therapist's accessibility in future times of difficulty. By contrast, in standard short-term dynamic psychotherapy, the patient is encouraged to experience the current pain, sadness, and anger emotionally, and to link them with significant past losses and

separations. Of course, the experience of termination, alongside the emotional processing related to separation, occupies an important place in any long-term dynamic therapy. However, in the latter, an enduring sense of “timelessness” often predominates, enabling the deferral of the topic and even the denial of the reality of ending for many years.

Borman and Gorman, in analyzing the ideal values characteristic of short-term versus long-term therapists, note that viewing treatment as having a “timeless” quality - requiring patient expectation for change—is one of the central values of the dynamic therapist who treats over the long term [1]. Conversely, in STDP there is a deliberate emphasis on real time—actual, finite time. Termination is often predetermined, and this fact, with its existential implications, is mentioned and even emphasized at every stage of treatment [1]. Thus, the termination phase in STDP is crucial, and at times may determine the success or failure of the therapy [2,3].

Short-term dynamic psychotherapy is intended from the outset for individuals with good ego strength. Mann recommends accepting into brief treatment only those capable of tolerating high affective

intensity [4]. Malan, Sifneos, and others likewise emphasize criteria for selecting patients suitable for brief therapy [5,6]. These are individuals with a good level of ego organization and robust ego capacities—assessed already in the initial evaluation. Another parameter desirable to examine at the outset is the candidate's prior experiences with relationships, separations, and mourning. The mere existence of conflicts in this domain—such as past abandonments or traumatic losses - does not constitute a counterindication; however, it helps the therapist anticipate what to expect during treatment. Mann argues that, via the transference to the therapist, the patient will re-experience a reunion with or separation from a disappointing parent toward whom he or she feels ambivalence and guilt [4]. Reprocessing painful affects with the therapist's empathy and interpretations enables renewed growth, both during termination and thereafter. In this sense, STDP constitutes a condensed version of the processes of attachment, individuation, and separation. Rank views the predetermined ending as a catalyst that confronts the patient with dependency issues and maternal fixations [7].

The goals of STDP are necessarily limited. Whereas in long-term therapy there exists at least the wish and illusion of resolving all problems, here the treatment is limited by definition and revolves around a single central issue—the resolution of the topic chosen as the focus—with the arena of change, as in any dynamic treatment, located first and foremost within the treatment itself, namely the therapist–patient relationship. Among the various developers of STDP, differences emerge particularly regarding the emphasis given to the termination phase and its processing. Some, like Malan, maintain that the central conflict should be reactivated toward the end, with termination serving as an opportunity for renewed integration [8]. Malan even recommends setting a termination date during the evaluation phase and dedicates the last quarter of treatment to separation. At the same time, he argues against overvaluing termination as if it were a basic principle. Patients who are not dependent will take what they need from treatment and will manage with minimal separation pain.

Davanloo recommends a flexible approach in which treatment length is based on the patient's ego strength—that is, between 5 and 30 sessions [9]. Davanloo emphasizes that individuals who have suffered significant losses at critical stages of development will often respond with mourning at termination. For such patients, termination requires a kind of bifurcation into two foci: one addressing the originally selected central issue, and a second devoted to processing the affects associated with past significant losses—hence his argument to allocate treatment time for preparation and affective work. Wolberg differentiates between patients with significant losses in their histories—who require a substantial period for processing the emotions that arise—and those for whom losses are not a highlighted issue, or those who are nondependent, distant, or avoid deep engagement with the therapist [10]. Bauer and Kobos note that viewing termination as an opportunity to address separations and losses facilitates the separation processes for both therapist and patient [11]. Termination thus acquires a cognitive significance as a kind of “learning experience.” This is also

important for countertransference, as it functions as an “antidote” to the therapist's grandiose sense of his or her importance in the patient's life.

Sifneos appears to be the outlier among STDP therapists. He emphasizes the positive nature of termination, describes it as an anxiety-arousing component, and refers to his method as “anxiety-provoking brief psychotherapy.” He avoids fixing a termination date in advance but informs his patients that the treatment will be brief. He highlights collaboration in achieving goals, the positive achievements, and the enjoyment derived from them. The achievements he emphasizes include increased autonomy and self-esteem. For him, the termination date is set when there is a sense of progress in the problem identified as the initial focus. He seeks to create a positive balance between sadness and disappointment and the joy and satisfaction surrounding accomplishments. Sifneos underscores the need to avoid what he terms “regressive dependency,” and explains termination and separation difficulties primarily as deriving from pregenital issues [6]. In his view, carefully selected patients do not present such problems; he accomplishes this through early screening out of patients struggling with merger and loss issues rooted in early maternal relationships.

James Mann organizes his entire method around themes in which time constitutes the central problem; the length of his treatment is rigidly fixed at 12 sessions [4]. In his understanding, patients find it difficult to accept real temporal limits, which relates to conflicts around separation and individuation as well as the need to confront death and life's finitude. He believes that issues arising around separations and loss are not merely global but more accessible than Oedipal problems. Mann notes patients' tendency to deny the approaching end during treatment, but asserts that it is the therapist's role to prevent avoidance and denial. Negative feelings toward the therapist, he argues, take on the intensity and patterns the patient once experienced toward objects who frustrated and hurt him. Mann was the first to discuss and emphasize the resistance to separation that may also arise on the therapist's side [12]. Yet, according to Mann, active and appropriate engagement with these feelings - without extending treatment—remains essential. Only thus, he contends, can the therapist be internalized as a positive figure and as a substitute for the original ambivalently perceived object. Such internalization is vital and enables better adaptation.

It appears that differences in the emphasis on the nature of termination and its processing reflect not only theoretical divergences but are also influenced by the therapists differing personalities, the primary significance of separation and loss in their early experiences, and the defensive organizations they developed. The question arises whether there are indices for the self-selection of therapists suited to this approach. It seems that therapists for whom this method is suitable are those for whom this form of treatment evokes emotional issues of a different intensity than those arising in other therapists. I will illuminate several such issues:

Therapists drawn to STDP by constructive motivation—those who believe in the advantage of interventions that are as economical as

possible in relation to patients' natural development. They are also attuned to the regressive effects and potential for excessive dependency, or other negative possibilities of long-term therapy, such as regression and the creation of overdependence or even addiction to treatment. In contrast, there are therapists for whom STDP unconsciously serves as an escape from the threat of long-term attachment, with the depth, commitment, and patience such treatment requires. In other words, for some therapists, the attraction to STDP serves unconscious defenses, while the value-laden arguments serve merely as rationalizations. There are also therapists who refuse to engage in STDP even after learning the method. Vinokur and Desberg and Shefler noted the difficulty of convincing therapists - especially experienced ones - to adopt this form of treatment [13,14]. Beyond the challenge of learning a new method and the flexibility it demands, less conscious reasons for such refusal appear to exist. For example: the difficulty of repeatedly attaching and separating, with short intervals between, or the difficulty of repeatedly taking an active part in highly intensive experiences that such treatment entails.

A therapist's emotional response to STDP also varies according to the organizational context of practice. In public clinics or health insurance settings, the therapist may face pressure and patient anger as termination approaches. Such a therapist may find himself or herself battling guilt over "abandoning" a still-needy patient to his or her fate. The therapist may also struggle with internal feelings of anxiety and helplessness at being required to perform an impossible task. Glick, in his work on forced termination, highlights the patient's experience that, at some level, the therapist "threw" him away [15]. Stern writes about the danger forced termination poses to the integrity and essence of the therapeutic process, as it undermines the reciprocity required in the therapist-patient relationship and diminishes the patient's value as a person aware of his or her needs [16]. Depending on personality structure, the therapist may react with anger and displacement of blame onto the system, or develop defenses such as rationalization, dissociation, or emotional distancing from patients. Such an organization tends to exacerbate internal questions of personal and professional identity among therapists. Forced termination may amplify doubts regarding the value of one's therapeutic work and one's capacity to help people.

Therapists working in such frameworks may be at risk for rapid and pronounced burnout, according to Stern. By contrast, therapists employed in private practice or in clinics that allow greater flexibility in treatment length and adaptation to patient needs operate from a fundamentally different stance. In such centers, following assessment, STDP may be offered as the treatment of choice, with the belief that it fits the patient. It may be presumed that this stance is communicated to the patient who, even if expecting something else, perceives a message of personalized attention to his or her needs. Choosing brief treatment fosters a positive therapeutic alliance, but does not preclude the full range of transference feelings toward the end of treatment and separation. Moreover, such feelings are part of the regression so common at the end of any dynamic therapy and certainly do not prevent the emergence of various forms of countertransference on the therapist's part.

2. Therapist Issues with Separation and Loss

The difficult struggle with separation and loss may also stir unresolved issues in the therapist. The therapist may also find it hard to separate from the patient and thereby struggle to assist the patient in focusing on the problems of separation. The therapist may be undergoing his or her own crisis due to a personal loss or the death of a loved one, leading the therapist to sink with the patient into exaggerated mourning, or to use the patient's difficulties as an instrument for processing his or her own grief. Another possibility is that the therapist attempts to evade the subject of separation by encouraging the patient's defenses against processing the termination. Long-term treatment, together with the sense of "timelessness" it allows, affords a more comfortable feeling of safety and mutual indulgent closeness.

For some therapists, engaging in STDP and in serial attachments and separations may represent a repeated attempt to work through a personal trauma. In certain cases, a therapist's brief treatments may assume the character of a recurring nightmare, akin to post-traumatic states. In such instances, therapist and patient repeatedly experience oppressive feelings of threat, abandonment, and loss, with no capacity to develop new coping responses. The therapist's needs to process loss and grief may at times lead to projective identification onto the patient, eliciting in the patient premature reactions of mourning, anxiety, or defensive behavior that derive from the therapist's disavowed needs. Therapists' needs, of course, vary. A therapist who has sufficiently worked through grief, abandonment experiences, and losses—through successful personal therapy - may at times prefer long-term treatments that require sustained commitment and "long breath." In practice, much depends on the therapist's life stage. I present this in somewhat exaggerated form, as many therapists concomitantly practice various modalities. The ability to engage flexibly in different forms of treatment according to patient needs suggests a richness and flexibility of personality that are hallmarks of a more mature and balanced self.

2.1. Difficulties with Satisfaction and Joy about Accomplishments at Termination

STDP has a rewarding aspect. Focus, intensity, and time limitation often yield rapid and marked changes. Patients sometimes feel renewed strength, release, and even a fresh start. In contrast to patients, the therapist—perhaps due to his or her own failures and limitations—may struggle to share in the patient's joy; envy may occasionally arise. The therapist may then dampen the patient's enthusiasm, highlight unresolved problems, and even withhold due affirmation. A therapist with narcissistic disturbances may experience the patient's achievements as his or her own. Of course, some realistic sense of accomplishment is natural and constitutes one of the rewards of our therapeutic work. Gorkin writes that such conduct by the therapist may lead the patient to harbor doubts that his or her achievements are not truly his or her own, may even evoke a sense of a false self, and can prompt the patient to sabotage therapeutic gains in an effort to destroy the therapist's "create on [17]."

2.2. Difficulties with the Therapist's Struggle for Perfection

Some therapists with narcissistic vulnerabilities cannot tolerate any degree of failure. A therapist may justify—especially vis-à-vis the internal critic—the fact that treatment results are not perfect by rationalizing that the self-imposed constraints of brief therapy constituted an impossible task from the outset. Such a view helps allay the anxiety aroused by imperfect treatment or termination. In therapists with narcissistic issues whose defenses derive from a grandiose self, the patient's expectations for a magical solution to all problems may trigger the therapist's omnipotence. As if saying to oneself: "What others could not achieve in years of psychoanalysis with this patient, I will accomplish in 15 sessions." Such a therapist may pressure patients to achieve beyond their capacity, ignore the patient's individuality and difficulties, or embellish and magnify partial gains as great successes.

2.3. Addressing Countertransference Phenomena

In most countertransference phenomena I have encountered, the issue was not the mere existence of the therapist's difficulties but the lack of awareness of them and their emergence within treatment. When the therapist is aware, the chances of dealing successfully with the issue—even in relation to patients—improve. Deep and sensitive supervision can help therapists identify countertransference reactions as early as possible, thereby preventing stuckness and therapeutic failures. Recognizing countertransference may signal to the therapist the presence of analogous difficulties in the patient; an aware therapist can then use his or her personal experience to help the patient give expression to concealed feelings. Such a therapist will be less defensive and more empathic in the therapeutic relationship. This is true whether the difficulties involve separation and loss, perfectionistic strivings, or individuation challenges rooted in fantasies of perfect symbiotic fusion.

Self-insight also has limits. As Schafer writes, the striving for perfection and for solving all of the patient's problems in a short time is linked to early fantasies of omnipotence that led some of us to choose the helping profession: the hope to be powerful where once helpless, to be a rescuer where once destructive, or to serve as a substitute for a bountiful breast instead of a small, dependent, needy infant [18]. Another way to address the wishes and feelings that live and remain active in the therapist's mind—even when conscious—is to share the therapist's feelings during the terminal phase. Gorkin suggests that the aware therapist share with the patient his or her sorrow at the ending of treatment [17]. In his view, such sharing is not only human but therapeutic. Karin Maroda likewise supports explicitly addressing countertransference with the patient as part of a successful termination [19]. In my view, in doing so, therapist and patient mutually acknowledge the patient's attainment of maturity, autonomy, and a sense of equality—integral elements of therapeutic achievement. It also must be borne in mind that at times the therapist will need to respect the patient's need to avoid excessive closeness that might be created by revealing the therapist's countertransference. At times, it is appropriate to maintain a certain distance, if that is the patient's wish, even toward termination.

2.4. Case Vignette

Uri (pseudonym), 25, was diagnosed with a personality disorder featuring hysterical traits and dependency. He experienced severe anxiety with somatic manifestations, especially around issues of relationship, separation, and autonomous functioning. Uri was born with a defect that impaired eating and swallowing, requiring extensive medical intervention; he was therefore overprotected by his mother and underwent psychological treatments in childhood. He sought help during a severe crisis stemming from a dependent and problematic relationship with a girlfriend and difficulty separating from her. In the evaluation phase, it was clear that he did not meet the criteria for brief therapy - particularly due to limited ego strength and self-cohesion. Nevertheless, a focused 12-session treatment was decided upon in the hope of helping him overcome the current crisis and enabling a meaningful experience of separateness and individuation. The focus was formulated based on an experience at ages 8–9: his mother spoon-feeding him. Uri recalls hearing friends arriving to visit; he felt embarrassed and therefore began eating by himself. Yet, when they left, he reverted to the infant role his mother assigned, and even felt comfortable there. I said to Uri: "Deep down you know you possess strengths and can eat on your own, but the fear of losing protection and love continues to arouse anxiety; you are afraid you will not hold up."

During treatment, Uri organized himself and made significant moves toward an independent life. He separated from his girlfriend and withstood the separation; he slightly reduced his dependent ties with his mother, progressed at work, and more. Some symptoms—such as dizziness and fainting—disappeared. However, as termination approached, regression occurred—a phenomenon common in all dynamic treatments. I, however, felt dissatisfaction and impatience with Uri's demanding and dependent behavior toward me and his family. I felt he was not progressing adequately and was not using the strengths I believed he had; even by the planned termination, he would not reach the level of independence I expected. It seems I had succumbed to an omnipotent wish to effect dramatic change in a short time, projecting onto him my own needs for autonomy and somewhat "forgetting" the initial assessment data. Reality jolted me when Uri arrived at the emergency room with overwhelming panic on a day he knew I was not working, and he did not report he was in my care. When I processed my anger and disappointment over this "collapse," I realized I had overemphasized both his and my wishes and had not given sufficient attention to the terror of the approaching separation. In so doing, I had pushed him back into the role of the "sick" one who cannot be left because he requires ongoing support and constant care—a role well-rehearsed from childhood. Adjusting my emphasis—especially moderating my inflated expectations—enabled Uri to reorganize and complete treatment, with the understanding that he might return in the future for another phase of therapy to take a further step.

2.5. Second Case

Tamar (pseudonym), 29, an only child of older parents who are Holocaust survivors. The parents are in conflict, do not live together, yet continue to embitter each other's lives without being

able to separate definitively. Tamar was always caught between them, though primarily recruited by the mother to her side, with the father depicted as violent, hostile, and distant. At 18, Tamar distanced herself from home, completed military service, studied music, and settled in Jerusalem. She made a modest living teaching music. For years she avoided relationships with men; over the past two years, she began a turbulent relationship with a South African partner, and they now lived together. Tamar sought help when her mother, who lives in the coastal plain, fell ill and demanded extensive attention, accompanied by great demands and many accusations toward her. When Tamar dared meet her father—who suddenly expressed a wish to reconnect—the mother reacted with rage and accused Tamar and the father of plotting to kill her. Tamar felt her mother controlled her through her victimhood—operating “by remote control”—and sought help.

Already by our second meeting, we formulated the focus as “finding the appropriate and optimal distance from the mother and developing coping strategies against her intrusiveness and coerciveness,” so that Tamar could indeed help her but without overinvolvement, maintaining boundaries that would allow her freedom and a life of her own. Treatment length was set at six months, comprising 23 sessions. A trusting relationship formed quickly. Tamar showed very high motivation and worked in treatment by processing emotional experiences from past and present. We addressed Tamar’s difficulty in withstanding the mother’s pressure and intrusiveness and recognized how hard it was for her to develop autonomy without the heavy burden of guilt toward her mother. The mother construed every step toward Tamar’s separateness as betrayal. Gradually, however, Tamar became more assertive with her mother, more proactive at work, and fought her inner pessimism, which we both understood as an internalization of her mother’s attitudes. She began to trust her capacity to build a marital relationship and motherhood, whereas previously she felt “this just isn’t for me.”

When the precise termination date arose for discussion, the problem emerged that her partner - whom she was very attached to - was about to leave the country around the time of termination. I deliberated whether I was overburdening her precisely when she faced a painful separation from her partner; I feared she would not withstand these two “abandonments.” After discussing it with her, we set our final session for one week after his planned departure, thereby extending treatment by two weeks. Throughout treatment, Tamar evoked in me a great deal of affection. I enjoyed our relationship, her rich inner world, and her investment in therapy. Despite her fears, Tamar expressed confidence and curiosity about using what she had gained in treatment in the future. She moved to a separate apartment from her partner and created a place of her own. Tamar displayed courage and resolve in her individuation process; within me, however, a strong need arose to protect her from further traumas of abandonment.

When termination day arrived, it turned out that her partner’s departure had also been postponed by a week; thus, our final session coincided with his flight. I felt filled with anxiety and guilt

about “leaving” her on such a day and even considered offering an additional session. It seems I was projecting onto Tamar my own difficulties in coping with abandonment and loss. Here, Tamar’s behavior reminded me that the therapeutic focus we had worked on had been well internalized: she found the appropriate distance from her partner just as she had from her mother. She said goodbye to him at home without accompanying him to the airport. Tamar arrived punctually for our final session and used it fully. She presented me with a beautiful gift—an art drawing she herself had made—thus expressing her capacity to find an appropriate distance from me as well, while maintaining distance from my needs for overprotection and softening the separation.

3. Summary and Discussion

The two cases presented each exemplify how the therapist’s personality, experiences, and defensiveness find expression through countertransference and shape the way treatment is conducted. At termination—which serves as a touchstone for the success of STDP—this influence reaches its peak. The termination phase acquires varied meanings for different patients, depending on their developmental stages or the central conflicts that surfaced in treatment. In my view, the extent to which a therapist emphasizes the importance of termination processes reflects, beyond theoretical orientation, the degree of significance the therapist attributes to issues such as separation, death, loss, and individuation—as these are mirrored in the therapist’s inner world, early experiences, and defensive organization.

Resistance to engaging in STDP and the preference for exclusively long-term treatment should not be understood solely as a theoretical stance about personality structure, the time required for structural change, and the gradual resolution of transference neurosis. Additional factors contribute: the therapist’s values, indoctrination processes and difficulty learning new methods, alongside conscious and unconscious personality factors with which the therapist must contend, especially in the termination phases of any brief treatment [1,13]. In Israel, following legislative changes and the implementation of national health insurance, the importance of acquiring knowledge and skills that enable significant change within limited time has increased. This will allow many therapists to learn the method and experience both its advantages and its limitations. I would also emphasize the importance, in supervision, of addressing the multiple and complex facets of countertransference that may arise among trainees. Therapists should be helped to identify and address these phenomena. Only thus can therapists use their personal experience constructively and effectively, and help patients more quickly with their difficulties.

References

1. Budman, S., & Gurman, S. A. (1988). *Theory and Practice of Brief Therapy*. New York: Guilford.
2. Strupp, H., & Binder, J. (1984). *Psychotherapy in a New Key*. New York: Basic Books.
3. Hoyt, M. F. (1979). Aspects of termination in a time-limited brief psychotherapy. *Psychiatry*, 42(3), 208-219.
4. Mann, J. (1986). The Core of Time Limited Psychotherapy:

-
- Time and the Central Issue. In S. Budman, *Forms of Brief Therapy*. New York: Guilford.
5. Malan, D. (1976). *The Frontiers of Brief Psychotherapy*. New York: Plenum.
 6. Sifneos, P. (1987). *Short Term Dynamic Psychotherapy: Evaluation and Techniques*. New York: Plenum.
 7. Rank, O. (1936). *Will Therapy*. New York: Knof.
 8. Malan, D. (1978). *Exploring the Limits of Brief Psychotherapy*. In H. Davanloo, *Basic Principles and Techniques in Short Term Dynamic Psych*. New York: Spectrum Press.
 9. Davanloo, H. (1980). *Short Term Dynamic Psychotherapy*. New York: Jason Aronson.
 10. Wolberg, L. (1980). *Handbook of Short Term Psychotherapy*. New York: Thieme Straton.
 11. Bauer, G. P., & Kobos, J. C. (1987). *Brief therapy: Short-term psychodynamic intervention*. Jason Aronson.
 12. Mann, J. (1973). *Time Limited Therapy*. Cambridge Mass: Harvard University Press.
 13. Winokur, M., & Dasberg, H. (1983). Teaching and Learning Short Term Dynamic Psychotherapy. *Bulletin of the Menninger Clinic*, 47(1), 36-52.
 14. Shefler, G. (1994). Interaction between time limited therapy and research. In G. Shefler, *Time limited therapy*. Magnes.
 15. Glick, R. A. (1987). Forced terminations. *Journal of the American Academy of Psychoanalysis*, 15(4), 449-463.
 16. Stern, S. (1993). Managed Care, Brief Psychotherapy and Therapeutic Integrity. *Psychotherapy*, (2), 135-148.
 17. Gorkin, M. (1987). *The Uses of Countertransference*. New Jersey: Jason Aronson.
 18. Schafer, R. (1973). The Termination of Brief Psychoanalytic Psychotherapy. *International Journal of Psychoanalytic Psychotherapy*, (2), 135-148.
 19. Maroda, K. J. (1991). *The Power of Countertransference: Innovations in Analytic Technique*. John Wiley & Son.

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