PSYCHOTERAPIA 1 (216) 2026
PAGES: 31–41
DOI: 10.12740/PT/217383

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INDIVIDUAL PSYCHOTHERAPY PATIENTS WHO WANT TO BECOME PSYCHOTHERAPISTS – ANALYSIS OF THE PHENOMENON CONCERNING THE THERAPEUTIC RELATIONSHIP

[1]Private practice

therapeutic relationship
dependent personality
features of a psychotherapist

Summary

In this article, I analyze a phenomenon that may arise during individual psychotherapy when a patient expresses a desire to become a psychotherapist. I understand identification with the psychotherapist and idealization of psychotherapy as an element of the therapeutic relationship that enables understanding the patient's dynamics. This phenomenon is likely to be more common in patients with an undefined, unformed self, with dependent features, and, on the other hand, in psychotherapists with narcissistic needs that are not met in their private lives, a strong need for power, and a weaker need for supervision of their therapeutic work. The article analyzes factors on the patient's side, the psychotherapist's side, and within the therapeutic relationship that connects them when the patient develops a desire to be like their psychotherapist. I describe the components of the therapeutic relationship; factors influencing the relationship; dependency and power within it, the mechanisms of identification and idealization; mechanisms that foster identification and idealization on the part of both the patient and the psychotherapist; and finally, the phase of therapeutic work involving the patient's achievement of psychological independence, with particular emphasis on the psychotherapist's awareness of the impact they have on the patient during psychotherapy.

Introduction

Today, there is a growing interest and curiosity about the workings of the human psyche, participation in psychotherapy, and psychotherapy as a path to professional development. The profession of psychotherapy seems tempting—respectable and lucrative, and the psychotherapist is perceived as someone who has acquired all the knowledge concerning the mysteries of inner life and is devoid of all worries. Although this is an idealizing perspective, it happens that patients—sometimes in mid-life—redefine themselves, discovering during psychotherapy their identity as a helper in understanding the intricacies of the psyche.

In this article, I would like to analyze the phenomenon in which, during the course of psychotherapy, a patient expresses a desire to become a psychotherapist. This desire may arise within a specific constellation of patient characteristics, therapist characteristics, and the therapeutic relationship between them. I will discuss the factors that influence the emergence of such a desire, how it can be understood in the context of the psychotherapeutic process of a patient who desires to become like their therapist, and what implications it may have for further psychotherapy.

Components of the therapeutic relationship

Components of the therapeutic relationship consist of: the working alliance, the real relationship, and the transference relationship, which includes both the patient's transference and the therapist's countertransference [1].

A working alliance is a covenant between the patient and the therapist to work together. The strength of the alliance depends on the extent to which the patient and the therapist agree on the goals of the therapy and on whether the tasks undertaken during the session will help achieve them. The strength of the alliance also depends on the experience of an emotional bond between the patient and the therapist. The relational dimension of psychotherapy encompasses the emotions and attitudes shared by the patient and therapist, as well as the psychological bond that connects them, based on these very feelings and attitudes. The patient's participation in building an alliance presupposes a desire for healing or growth, a willingness to undertake therapeutic tasks, a willingness or ability to form a bond and collaborate, and a sense of self-efficacy. Factors related to the therapist that influence the strength of the alliance include: empathetic understanding, a positive attitude, cohesion, a willingness to take appropriate responsibility for problems in the alliance caused by the therapist, relationships with objects from the past, persistent investment in the work, and commitment to the patient.

The real relationship is an objectively existing dimension of the relationship, relatively independent of transference and undistorted by it. It encompasses realistic perceptions and reactions, sympathy, mutual affirmation, and the I–Thou relationship. The more truthful and realistic the participants are toward each other, the better the therapeutic work and its effects will be. Patients seek a therapist who cares about them and likes them just as they are.

The transference relationship involves a repetition of conflicts with important people from the past in contact with the therapist [1]. The therapist's task is to understand the reality created by the patient and help them interpret it. A feature that helps the therapist manage countertransference is, above all, self-integration – a necessary condition for a proper relationship with the patient and for avoiding over – or under-identification, a key element in maintaining therapeutic boundaries, connecting with and separating from the patient, participating, and then distancing oneself and observing the patient from the sidelines. Other skills include anxiety management, cognitive skills, empathy, and insight into one's own self.

Factors influencing the therapeutic relationship

The quality of the therapeutic relationship always translates into the patient's ability to explore their own inner world [1]. Various authors [2–4] describe the factors shaping the therapeutic relationship, specifying those occurring on the patient's side and on the therapist's side. The former include, among others: understanding the importance of one's own influence on the psychotherapy process, the severity of the disorder, overall functioning, satisfaction with interpersonal relationships, attachment style, ego strength, intelligence, sense of control, expectations regarding the outcomes of psychotherapy, and preferences regarding therapeutic methods. A psychotherapist has no influence on the patient's factors; they can only understand them and recognize them as significant in the treatment process. Therefore, I would like to devote more attention to the therapist's role in building the relationship. Psychotherapists' awareness of their own limitations, or conversely, of their capacity to influence others, would be beneficial for patients and also helpful in training and professional work.

The psychotherapist shapes the therapeutic relationship through interventions such as facilitating the creation of new thoughts and actions, providing support, adopting a non-judgmental attitude, communicating understanding, demonstrating sensitivity, participating in the patient's experience, and paying attention to it. The therapist also influences the relationship through their qualifications and professional experience, age and gender, life stage and significant events in their history, as well as through their mental health, personality features, features related to social influence, directiveness, attachment style, compassion for the patient, expectations regarding the outcomes of psychotherapy, and adherence to the principles of its model. In her article, Kleszcz-Szczyrba [5] divides these factors into specific, therapist-related factors (personality, knowledge, self-therapy, supervision, experience) and nonspecific factors (demographic variables, organization of the therapeutic space, time management, personal life events, presentation and self-presentation). She also writes about the physical distance in the organization of the office, where dependent patients, with an increased need for contact, will strive to cross the physical boundary by moving closer to the therapist, and an excessively comfortable spatial arrangement may encourage excessive closeness.

Dependency and power in the therapeutic relationship

The therapeutic relationship is fundamentally about helping. It is asymmetrical, involving a suffering patient who needs help and an experienced, qualified psychotherapist tasked with helping them. The therapist-patient relationship resembles a parent-child relationship and is a relationship of dependence [4]. A psychotherapist can function as a parent, authority figure, master, or teacher. Patients strive to develop and become like their therapists – internally integrated. They want to achieve peace, gain knowledge, self-control, and self-confidence. They desire to know what their therapist understands and do what they do. Over time, a relationship based on dependence becomes unnecessary for the patient as they learn new ways of thinking and acting, becoming their own therapist. At this point, psychotherapy can end.

It is important to remember the importance of psychotherapy in shaping the patient's identity. Therapists of all theoretical orientations exert influence on their patients, regardless of the key role assigned to the therapeutic relationship in a given modality. There is a power imbalance between the patient and the psychotherapist. Openly acknowledging this power and then using it has the best possible impact on therapy and reduces the risk of abuse. The therapist's task is to guide the patient to a state in which they have enough strength to cope without them [6]. However, it is not the therapist's task to mold people in their image and play a dominant role in their lives [7]. Freud wrote that "the education of the patient should lead not to identification with us, but to the liberation and realization of his essence" [7, p. 94]. Awareness of the power a psychotherapist has in a therapeutic situation allows for avoiding abuse.

Identification and idealization in the therapeutic relationship

Identification is a neurotic, secondary defense mechanism of the ego [8]. It is a normal element of psychological development. It involves a transition from immature forms of introjection to deliberate, not fully conscious desires to partially resemble another person. Identifications become a form of enrichment of the self by adopting various traits of admired individuals; they create a sense of self and one's place in the world. None of us function without identifications, but sometimes they are vague and cause an inner emptiness [6].

Freud distinguished between non-defensive identification, motivated by a simple desire to be like a valued person, and defensive identification, related to a perceived threat from a powerful person. In many cases, both elements are present [7]. In the therapeutic relationship, the psychotherapist should accept the fact that they are an object of identification for the patient and skillfully support the patient so that the patient can build their own identity, independent of the therapist. It is through the mechanism of identification that psychotherapy leads to such change. The ability to identify with new objects creates a force that can heal emotional suffering. The quality of the emotional relationship between the patient and the therapist correlates with the effectiveness of therapy more than any other factor [8]. Gabbard [9] indicates that therapeutic change can occur through the internalization of the therapist's functions, the formation of a representation of the therapist that the patient consciously uses, and through the internalization of the therapist's emotional attitudes. The patient becomes their own therapist, able to think about their inner experience in the same way as the therapist. The relationship with the therapist is then no longer necessary for further development, and the psychotherapy process can be terminated.

The idealization mechanism, a primary defense mechanism of the ego, involves attributing ideal traits to others in order to avoid fear, contempt, jealousy, or anger [9]. Idealization is a developmental mechanism that serves to cope with anxiety and is associated with the belief that there is someone who has control over everything. Psychological unification provides a sense of security [8]. Renouncing idealization would involve the initiation of the process of separation and individuation.

If idealization did not occur during adolescence, it is important to work through it during therapy. The patient gradually experiences disappointment with the therapist and learns to accept their limitations, leading to the emergence of a multidimensional image of the psychotherapist [6]. The asymmetrical nature of the therapeutic relationship, in which the therapist does not disclose their own personal matters, fosters the process of idealization [1]. Idealization may be signaled by a feeling of discomfort or satisfaction, which evokes the patient's admiration for the therapist. Revealing countertransference feelings at the appropriate time and being authentic and kind will reinforce the psychotherapist's image as a living and present participant in the relationship, without unnecessary self-disclosure.

Excessive identification with the psychotherapist and their idealization, expressed in the desire to be a psychotherapist, can be understood as an expression of the patient's difficulty in separating, discovering their own self, distinct from the therapist's self, and as a way for the patient to avoid feeling like a separate person who can freely explore their desires. This may stem from a lack of closeness and a desire to remain dependent on the psychotherapist [1]. Such attitudes should be treated as a transitional phase, not as a disruption of the relationship, but from a diagnostic perspective as a manifestation of the patient's inner world, fears, and needs.

Patient mechanisms contributing to excessive identification and idealization of the psychotherapist

The personality defense mechanisms described above—identification and idealization—are crucial in the functioning of personalities with dependent traits [10]. Below, I will discuss the mechanisms on the patient's side that contribute to excessive identification and idealization of the psychotherapist: fixation of the drive in the oral phase, symbiotic character structure, guilt, suppression of one's needs and feelings, and the inability to accept care from the psychotherapist.

The perpetuation of the drive in the oral phase leads to identification with the caregiver, an inability to care for oneself, and a simultaneous fantasy of becoming a caregiver for others. Individuals with dependent traits emulate those with whom they are in relationships, partially adopting their identities to gain strength, competence, and self-confidence. This provides emotional stability, meaning in life, and a sense of significance. Separation and individuation become difficult, and the patient fears being separate and independent.

The symbiotic character structure stems from the patient's life history, in which, as a child, the patient was used to fulfill the plans of his caregivers [11]. As a result, pathology of identity develops – the externally imposed identity becomes inauthentic or incomplete. Contact with others is based on dependency and entanglement. The self is formed through incorporation, idealization of others, or identification with them, rather than through a more mature process of internalization. Natural attempts at separation are blocked or actively punished by parents due to their own fear. Excessive importance is placed on the

patient's natural ability to empathetically reflect others. Over time, a sense of security can be achieved only through reflecting others.

Modell [cited in: 11] distinguished two types of guilt: separation guilt and survivor guilt. Separation guilt occurs when the patient believes that leaving home, being different, defying their parents, or developing in a way unattainable for them will harm them or even destroy them. Survivor guilt involves the belief that if one has something good, it is at the expense of someone else who has been deprived of it. Family unity is maintained by the pathology of dependency, mutual obligation, and the denial of autonomy, and what is considered love is, in reality, an exploitative and possessive attachment. The experience of such strong dependency causes a weakened sense of self and a lack of awareness of one's own desires. Symbiotic guilt makes it impossible to care for oneself; one must care for others.

In the desire to become a psychotherapist during one's psychotherapy, I also see a suppression of one's needs and feelings. After all, being a therapist is not about caring for oneself, but for someone else. This desire reflects a continued family delegation to serve others, a difficulty in caring for oneself, and remaining in the role of a patient. Those who expressed a desire to become psychotherapists during psychotherapy were characterized by difficulty in seeing their own mental life. In their family systems, they had extensive experiences of caring for others, serving them at their own expense, and were neglected by their parents. In this sense, the idea of being a psychotherapist, i.e., treating others, would be a continuation of self-abuse. In countertransference, anger may arise that the patient is not working on self-change and that supporting them in developing this idea would mean supporting their self-neglect.

I also believe that the patient's desire reflects their inability to accept care from a psychotherapist—the patient wants to heal themselves through studying psychotherapy. Their past experiences with caregivers who expected subordination and suppressed their independence leave them distrustful of the psychotherapist's ability to protect them and help them flourish.

Psychotherapist's mechanisms contributing to excessive identification and idealization by the patient

In the therapeutic relationship, we support patients' autonomy while simultaneously meeting their symbiotic needs for support and a point of reference, kindness, and connection. These needs are particularly strong in people who did not experience closeness and warmth in childhood. They can be easily exploited by authority figures [11]. Below, I will discuss mechanisms on the psychotherapist's side that foster patient identification and idealization, such as: a sense of power and influence, the therapist's lack of self-disclosure, the influence of the therapist's family life cycle, narcissistic gratification, and the maintenance of therapeutic boundaries.

Kottler [12] writes about the modeling influence of the therapist's personality and how the therapist's status creates a sense of power. By teaching patients how to apply therapy

to themselves, we gradually transfer this power to them. To be able to place demands on patients, we must be integrated physically, emotionally, and intellectually. An effective therapist is, above all, someone who is kind, cares for others without exploiting them, does not make others dependent on themselves, and teaches them how to learn on their own. Of course, identifications vary depending on the therapeutic system, and some are planned interventions. However, in this article, I attempt to describe cases that lead patients astray by repeating patterns of dependence on significant others.

When choosing to work as a psychotherapist, we choose an occupation that, by definition, is characterized by a sense of self-detachment. We are present with the patient, not revealing information about our lives. However, the psychotherapist's lack of self-disclosure can foster idealization on the patient's part. Although we are constantly revealing ourselves, for example through office decor, clothing, or speech style, we do not talk about ourselves [6]. Often, patients do not know whether the therapist is married, or even, if they wear a wedding ring, whether it is just jewelry. They do not know whether the therapist has children or how they manage in their private life. They may see diplomas on the walls, testifying to success and education, and when passing other patients, they may fantasize about the therapist's popularity and expertise. To avoid excessive idealization, one might consider the number of diplomas hanging on the office wall, limiting them to the key ones confirming the qualifications that we are required to present. Freud warned psychoanalysts against succumbing to the temptation to present themselves as wonderful saviors, healers, or prophets [8]. This applies to honesty in presenting patients with the potential prognosis, the effectiveness of therapy, and self-presentation on a website advertising one's practice. Excessive idealization in the therapeutic relationship leads to a diminishment of the patient. This idealization can be reduced by making oneself more real [6], through a gradual "disenchantment," which allows the patient to accept human limitations but also avoids premature fear that the therapist is just like everyone else and cannot be regarded as a source of support.

For the treatment of patients, our own disorders are the greatest danger [13]. The effects of therapy depend not only on the type of diagnosis and the psychotherapist's knowledge, but also on the psychotherapist's mental health.

A very interesting aspect is the influence of the psychotherapist's family life cycle on their work. The authors highlight how satisfying relationships in private life allow for the fulfillment of the psychotherapist's narcissistic and symbiotic needs through positive emotional experiences within the family. However, depending on the developmental stage of the psychotherapist's family, circumstances may still exist that foster stronger identification with the therapist and their idealization. The approaching empty nest phase, when the therapist experiences separation from their own child, may tempt them to become excessively close to the patient and make it difficult for them to cope with the patient's separation. Idealizing transference may also be reinforced when the therapist experiences a desire to be the perfect parent and enters into competition with the patient's parents. When a therapist lacks a family of their own or has unsatisfactory relationships with loved ones, there may be a risk of fulfilling their emotional needs in their relationships with patients.

In our professional work, we experience narcissistic gratifications stemming from our role as psychotherapists [14]. We work all day with patients to whom we are very important and who may idealize us. Regardless of our competence, patients feel that their role is to admire the psychotherapist if they value the relationship [15]. We are not fully aware of the extent of our power, and the therapeutic situation reinforces a sense of grandeur and unconscious fantasies of our own omnipotence. Spending time with people for whom our professional activities are of little importance, or being the parent of a young child, can provide a good balance to narcissistic omnipotence. Narcissistic abuse of the patient's desire for identification remains a professional taboo [8].

Another important mechanism that maintains the therapeutic relationship within a framework in which positive therapeutic work can take place is the maintenance of boundaries, which ensure a predictable and consistent therapeutic experience. Boundaries minimize the risk of role confusion and the danger of exploiting the patient. Disruptions in patient and therapist boundaries can significantly impact the relationship [1]. When boundaries are not clearly defined, they become blurred, and the patient cannot distinguish between themselves and the therapist. This is facilitated by an unclearly formulated therapeutic contract, or worse, the lack thereof: an imprecise division of patient and therapist roles and undefined work goals, which overall create ambiguity in the therapeutic situation. The opposite of this condition is isolation, when boundaries are too rigid and the patient experiences no contact with the therapist. This occurs when the therapist fails to show kindness to the patient and fails to present themselves as an authentic, present, and vibrant participant in the relationship. Therapist behaviors that contribute to unhealthy boundaries include objectifying the patient in order to meet their own needs (e.g., power or intimacy) rather than the patient's needs, as well as impulsive behaviors on the part of the therapist. It is important to distinguish impulsive behaviors from spontaneous behaviors related to caring for the patient. Spontaneity is an asset in clinical work.

Achieving independence by the patient

The condition for an integrated, stable ego and good object relations is a good internalized object. Integration means living fully, loving, and being loved by internal and external objects [16]. Kohut emphasized that in the therapeutic relationship, the therapist should serve as a self-object for the patient, allowing the patient to utilize this self-object in the process of their own development [17]. The therapist must also respect the patient's need for idealization and address this defensive strategy in a way that brings the greatest benefit to the patient [15].

In a family system characterized by symbiotic forces, the patient was rewarded for not being different from their family of origin and punished for being different and having different desires. This is repeated in the relationship with the therapist: the patient tries to become like the therapist out of fear of the therapist's anger if they were to strive for independence; they crave the therapist's praise and try to please them, assuming the role

of a disciple and continuator of the therapist's work. The focus of therapy then becomes the patient's discovery of their own autonomy. True autonomy means not having to submit to anyone and being able to follow one's own internal compass [18].

There are three forms of autonomy: self-determination, independent action, and self-control [18]. Discovering and developing the self involves re-recognizing one's own abilities, talents, and interests, and seeking one's identity within oneself rather than in another person. The role of the psychotherapist in this context is to support the patient in expressing the emerging components of their authentic identity and to address the anxiety caused by the threat of separation – patients with dependent traits fear separation, for example, the end of therapy. Patients with an undefined self lack well-regulated, goal-directed aggression. Instead, the idea that aggression is harmful and dangerous is reinforced, and that becoming an adult through aggression is forbidden. As a result, development is inhibited. However, it is precisely aggression that drives separation. The therapist's task is to help the patient develop the behaviors necessary to mobilize, express, and regulate aggression and hostility, which will serve to separate and differentiate themselves from their family of origin while maintaining satisfying relationships with others.

In well-conducted therapy, differences in competence are not exploited to build hierarchical relationships, but rather to minimize differences in knowledge and skills. This creates closeness between therapist and patient while also motivating learning and development, allowing the patient to develop an independent personality.

The therapist's task is to invite the patient to enter "adulthood," in which the therapist plays the role of a father: he represents the wide outside world, talks about what excites him, assuring him that it can be achieved; provides gratification, while remaining careful in emphasizing his own importance.

Conclusions

The phenomenon in which a patient develops a desire to become a psychotherapist during the psychotherapy process can be understood as a mechanism of the patient's dependence and inhibition in the development of their identity. The psychotherapist becomes another person with whom the patient over-identifies and whom they idealize, which is an expression of the patient's fear of individuation and of defining their desires and aspirations. It is helpful to examine whether the patient exhibits dependent personality traits and engages in excessive identification with other close people. When observing countertransference feelings, it is worth paying attention to those that emerge when the patient relates to the therapist and expresses a desire to be like them. It is then worth asking oneself whether, beneath the initial self-satisfaction and self-admiration, there emerges a feeling of discomfort and the sense that this is not the patient's authentic self, but rather an attempt to borrow the therapist's self. Then, work can be undertaken to draw the patient back to their inner self, where they may be experiencing emptiness, lack, and ambiguity.

For psychotherapists, the phenomenon of excessive identification and idealization by patients is fostered by maintaining an overly-positive self-image and experiencing a sense of superiority in relationships with patients. In such situations, regular and ongoing supervision, regardless of educational level, is invariably helpful, as is maintaining a personal life balance that provides satisfaction and meets needs, enabling better conduct of the challenging therapeutic work.

Although psychotherapy itself is not intended to train future psychotherapists, it can contribute to providing support and assistance, and the patient's recovery allows him or her to begin working for the benefit of others.

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