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Patient Use of AI and its Implications for Transference-Countertransference Dynamics

Artificial intelligence is beginning to appear in the analytic space—not only as a topic but, at times, as something that can become part of the patient's psychic reality. Analysts may need to adopt a sustained, clinically grounded stance toward this phenomenon—one that recognizes initial defensive reactions and preconceptions, yet is not determined by them. Drawing on clinical observations, it explores how patients' use of large language models as digital confidants can shape transference: from easing the articulation of thoughts held behind the "second censorship," to producing insights that are dissociated from affect. The focus is not on whether AI produces valid interpretations, but on how the analyst receives and metabolizes AI-mediated communications within the transference–countertransference field. Feelings such as rivalry, irritation or protectiveness may offer valuable analytic data, reflecting both the analyst's vulnerabilities and the patient's unconscious enactments. In some treatments, AI may be positioned as a third figure in the analytic dyad, evoking triangular tensions and bringing latent conflicts to the surface. These moments can provide clinically relevant information about internal object relations. Such material should be taken seriously and engaged with as part of the analytic process, rather than being avoided or downplayed—consciously or unconsciously—by the analyst.

- Keywords: Artificial Intelligence, Large Language Models, Transference-Countertransference Dynamics, Therapeutic Relationship, AI as Third, Digital Confidant, Algorithmic Echo

Introduction

The integration of interactive digital technologies like Large Language Models (LLMs) into patients' lives presents a unique challenge to psychoanalysis. While the field has previously contended with the psychic impact of technological shifts, AI introduces a seemingly interactive, non-human "other" that can become profoundly enmeshed in the patient's internal world. The aim is not to

revisit polarized appraisals of AI, but to address a more delimited clinical question: how patients' AI-mediated communications enter and affect the transference–countertransference field.

Two key perspectives are explored here:

(1) The patient's experience: How patients utilize AI in relation to their therapy, its impact on them, the quality of "insights" derived from conversations with AI, and, crucially, its influence on their relationship with the analyst and on transference dynamics.
(2) The analyst's role and experience: How analysts contend with the presence of AI in the therapeutic field, what novel countertransference reactions this may elicit, and the questions it raises for their own practice and professional identity.

The aim here is not to precisely establish general principles—given the distinct ways different patients and analysts, based on their personality, will relate to AI—but rather to open a space for critical reflection and dialogue concerning the challenges and transformations AI may introduce into the therapeutic relationship.

Patient's digital confidant

The entry of artificial intelligence (AI) into the daily lives of our patients represents a significant phenomenon that often resonates within the psychoanalytic consulting room. I increasingly encounter patients who, between sessions, utilize these technologies for various purposes related to their therapeutic process. Some, for example, recapitulate the content of a session in dialogue with AI afterwards, attempting to "sort out their thoughts" or seeking

further information on topics that were broached. I have also experienced patients uploading their own session notes to AI and requesting an analysis; others use it to "test" different interpretations of their experiences or dreams. Alternatively, some, in their frustration, ask AI for specific advice on what to do about their problems (which their psychoanalytic therapist has declined to provide). It is not uncommon for a patient to arrive at a session stating: "I was thinking about what you said, and then I discussed it with AI, and I realized that..." or "AI offered me an interesting perspective on my problem..." These examples illustrate some current uses, and the ways patients engage with AI in relation to their therapy will undoubtedly continue to evolve with the technology itself. Such interactions, when a patient actively introduces a "digital confidant" into the therapeutic space, in my view, significantly influence and will continue to influence psychoanalytic practice, and their impact merits closer psychoanalytic reflection.

Patients may utilize AI in numerous ways that impact the process of psychoanalytic therapy. This paper will primarily focus on instances of use wherein the interaction with AI leads to the experience of having gained a new insight.

When I first began to notice similar uses of AI, my initial hypothesis was that these digital interactions functioned as a kind of self-referential loop. From this perspective, AI would simply mirror, merely reflecting the patient's own thoughts back to them–nothing more. It would provide only an illusion of understanding, wherein the patient essentially engages in a dialogue with themselves, as if looking into a mirror. This perspective initially suggested that AI brings nothing fundamentally new, merely reflecting what is already known

to the patient in some way. (As I will discuss later in the context of the analyst's countertransference, this initial interpretation may have also been shaped by my own reactions to this new phenomenon.)

However, closer observation and accumulating clinical experience with patients led me to a partial reconsideration of this view.

> Vignette: The patient, Mr. F., a middle-aged man, was the eldest son of a highly successful but emotionally distant father, a renowned academic, and an anxious, over-involved mother. He often spoke of a lifelong feeling of never quite measuring up to his father's intellectual standards, while simultaneously feeling suffocated by his mother's worries. In his clinical presentation, he had long struggled to establish a stable romantic relationship, which he consciously and intensely desired. He repeatedly described a pattern wherein women he was interested in rejected him, or those who showed interest eventually turned out to be "complete lunatics" (his words). Mr. F. consistently, albeit politely, rejected my interpretations suggesting a possible unconscious fear of closeness and intimacy. He insisted that he was doing his utmost for a relationship and felt no such fear; rather, it seemed that admitting such a "weakness" would be shameful for him. After several months, he came to a session with renewed energy. Somewhat sheepishly, almost apologetically, he mentioned that between sessions he had shared some of his reflections with an AI system and "chatted" with it about it. "This thing told me," he began hesitantly, "that I might be afraid of women, and that's why I subconsciously choose unavailable ones, or those with whom it then

> becomes hell. I found it... well, interesting." He was taken aback by this interpretation, coming from an impersonal entity, yet at the same time, it seemed less threatening for him to consider it than when it came from me. I noticed a subtle irritation rising in me when he compared the AI's phrasing with mine, as if he were evaluating which of us offered the "better" interpretation. This small competitive spark surprised me; I saw how easily I could slip into the same struggle for authority that he seemed to enact with intimate others. Becoming aware of this reaction helped me somewhat approach his enthusiasm with more curiosity than defensiveness, and the session regained a tone of exploration. It was as if the AI had helped him overcome his shame, which prevented him from admitting to another person (the analyst) thoughts perceived as embarrassing or revealing. In this session, for the first time, he conceded the possibility that there "might be something to it." This "admission," facilitated by AI, opened a space for deeper exploration of his fear in subsequent analytic work, where it gradually became possible to address more extensively the shame that had presumably previously prevented him from accepting this idea from the analyst. This, in turn, gradually led to a greater capacity to experience shame in the transference towards me.

Mr. F.'s use of AI highlights a distinction central to Yirmiya and Fonagy (2025): authentic, human epistemic trust versus the quasi-trust afforded to nonhuman systems. The analyst's live interpretation activated Mr. F.'s epistemic vigilance—an understandable defense against relational risk. By contrast, AI, lacking reciprocal intentionality, does not trade on intersubjective trust; it can

nevertheless elicit quasi-trust and even credulity. This allowed him to rehearse the challenging idea cognitively before risking it in the human dyad. The return to the analyst constituted the pivotal therapeutic act—a moment of encountering whether the relationship could offer authentic, intersubjective validation—thus mitigating two opposing risks: psychic equivalence (taking the AI's suggestion as objective fact) and pretend mode/hypermentalization (keeping it as an affectively empty, intellectualized 'insight').

The epistemic dynamics described by Yirmiya and Fonagy concern the relational field—the patient's tentative opening to knowledge offered by another mind, or its simulation. Yet the same movement has an intrapsychic counterpart. This distinction between authentic human trust and non-human quasi-trust helps clarify what internal thresholds are crossed when AI allows the patient to tentatively voice thoughts that would otherwise remain inhibited.

AI can, in this sense, be understood as a tool that, for some patients, helps articulate and externalize contents from the domain described by Joseph and Anne-Marie Sandler (1984, 1994) as the 'present unconscious' (a concept akin to Freud's notion of the preconscious). This present unconscious contains thoughts and feelings that, although not deeply repressed, are kept out of full consciousness by the so-called 'second censorship'–a mechanism protecting the individual from shame, embarrassment, or a sense of absurdity. This was likely the mechanism at play in Mr. F.'s initial difficulty in accepting the interpretation directly from me, as the AI interaction seemed to temporarily bypass the shame associated with revealing 'foolish' or socially unacceptable aspects of the self. Thus, it may be easier for patients to explore certain lines of thought with AI, whose patient-perceived nature—whether currently experienced as impersonal

and non-judgmental, or characterized differently in the future (e.g., as highly empathetic or, conversely, provocative)—can temporarily weaken the pressure of this second censorship or elicit other specific responses. The patient may experience AI as a safer space for the initial formulation of themes that they might otherwise conceal from the analyst–potentially perceived as an external representative of this censorship–or simply not allow themselves to emotionally acknowledge during contact with them. It may be precisely the absence of a direct human gaze and expectations that allows thoughts, which would otherwise remain below the threshold of conscious verbalization, to find their initial form. The question remains, however, what type of "awareness" can emerge from such an interaction if it lacks a crucial dimension of the psychoanalytic process: its manifestation in the transference and the associated affective experiencing of the insight. If the patient uses AI to "bypass" potential shame or anxiety they might feel in relation to the analyst, this may lead to the verbalization of certain contents, but simultaneously to the avoidance of their emotional processing precisely within the context of the therapeutic relationship, where these emotions could be explored and understood by a living human being.

The moment a patient brings "insights" gained from interaction with AI into the analytic session can profoundly influence the traditional therapeutic dyad. AI may come to function as a kind of “third” element in an imagined relational triangle, comprising the patient, the analyst, and artificial intelligence. At this point, it is important to clarify that the notion of AI as a “third” in the analytic situation is used here in a primarily structural and Oedipal sense. AI enters the patient–analyst dyad as an external object, generating a classical triadic

configuration in which dynamics of rivalry, loyalty, jealousy, or exclusion may be enacted. This understanding differs from Ogden's concept of the analytic third (2004), which refers not to an external figure but to a jointly created intersubjective field–a third subjectivity that emerges from within the analytic dyad itself. While AI may at times become symbolically located within this shared analytic field, it does not constitute an analytic third in Ogden's sense; rather, it functions as an object around which Oedipal and triangulated transference–countertransference configurations can become more visible. This triangular situation strongly evokes what Faimberg (2005) calls the "narcissistic dimension of the Oedipal configuration." Before the classical Oedipal conflict described by Freud (1924/1961) can even be worked through, the patient is often caught in an all-or-nothing logic: either occupying the phallic position of the one-who-knows, or falling into humiliating exclusion. For Mr. F., whose internal father was experienced as a brilliant but excluding figure, accepting an interpretation from the analyst-father would have meant narcissistic defeat. AI offered a third route: he could encounter the same idea without submitting to the analyst, thus preserving narcissistic integrity while still enacting the rivalry.

Occasionally, AI may function as a catalyst, enabling specific latent aspects of a patient's conflicts or transference patterns to manifest more explicitly or in a novel form. This newly emerged dynamic and its impact on the analyst will be discussed in more detail in the following section. While AI may help to render visible certain aspects of the patient's internal world, it cannot engage in the embodied, emotionally committed relational process through which meaning is ordinarily co-created with another mind. As Yirmiya and Fonagy (2025) point

out, AI lacks genuine emotional presence, reciprocal intentionality, and affective commitment—conditions necessary for the emergence of authentic epistemic trust. Nevertheless, it must be acknowledged that patients can indeed bring insights from their conversations with AI into the analysis, where they can subsequently be worked through within the transference relationship.

While I approached the patient's use of AI primarily in terms of shame avoidance and epistemic trust, it may also be viewed as reflecting a developmental need rather than merely a defensive maneuver. For some patients, interacting with AI may serve a transitional function that supports psychological growth. Using Margaret Mahler's (1974) theory, AI may temporarily function as an intermediate space supporting separation without full emotional withdrawal from the analytic bond. The patient's playful engagement with AI can also be viewed, in Winnicottian (1980) terms, as taking place within a transitional (potential) space — an intermediate area of experience, sustained by sufficient trust, that is neither wholly internal nor external. In such a neutral, non-challenged area, creative exploration and new forms of symbolization can emerge without endangering the analytic bond. Through this space, he could momentarily think and speak in his own voice while keeping the analytic relationship intact — a movement that later made it possible to articulate dependence and rivalry more openly within the transference.

Regarding the use of AI as a confidant, another dimension concerning the patient needs to be mentioned. In my experience, patients are generally aware of the risks associated with sharing their most personal non-anonymized information on the servers of commercial companies that own AI. However, the risk of danger is either completely dissociated, or it is treated as a kind of

adrenaline-fueled risk–much like a smoker who is aware of the risks of smoking but hopes to evade them, or for other reasons refuses to engage with the associated dangers. This does not mean, however, that strong persecutory feelings associated with this act are not present in the back of the person's mind. This dissociated risk and the potential persecutory feelings linked to it can provide further material for therapeutic work.

The Analyst in the Algorithmic Age

The presence of artificial intelligence in the lives of some of our patients, as discussed in the previous section, not only transforms their experience of and relation to the therapeutic process but also can place new and complex demands on the psychoanalyst. The entry of a "third" in the form of AI into the consulting room–whether explicitly through the patient's communications or implicitly as a presence in their mental world–resonates within the analyst's internal space and can activate a wide spectrum of countertransference reactions. These reactions, though potentially unsettling at first, constitute a valuable therapeutic tool if recognized and processed by the analyst.

As I indicated earlier, moments when patients brought in "insights" gained from AI interactions initially evoked a certain displeasure in me. I felt frustrated when the focus in the session shifted from our joint exploration of my interpretations to discussions about AI outputs. At times, I likely found myself in a position where I perceived AI as a rival who, at least from some patients' perspectives, offered "better" or faster answers. I sometimes had the feeling that for patients, AI was an idealized object capable of cleverly answering everything and always available. The analyst can thus easily find themselves in an imagined "contest" for interpretive authority, which can lead to feelings of irritation, frustration, or

even anger—someone uninvited is "intruding upon" my analysis with the patient! I can imagine that for some analysts, this might even awaken, for example, feelings of anxiety about their own inadequacy. Similarly complex countertransference reactions can be evoked by the awareness that the patient often entrusts their most intimate data to commercial platforms. The analyst may be tempted to warn the patient against uploading their data to external servers, placing them in a dilemma: how to avoid adopting the position of a potentially critical superego that might reinforce the patient's persecutory fantasies, while simultaneously reflecting on their own protective feelings activated by this situation. In such moments, I believe it is important to recall Heimann's (1950, p. 83) warning that communicating the analyst's own feelings to the patient could, in some cases, be more of "a confession and a burden to the patient," and that the analytic task is rather to understand the meaning of the patient's actions and the analyst's reaction to them.

The recognition, processing, and utilization of such feelings, instead of unconscious enactment, are crucial for maintaining a functioning analytic frame and for a deeper understanding of the patient's internal world. Indeed, these feelings may signal not only the analyst's own vulnerabilities but also reveal unconscious aspects of Oedipal dynamics enacted by the patient. They might be analogous, for example, to a situation where a patient who, in secondary school, perceived their father as the primary intellectual authority, encounters a teacher who profoundly captivates them. This can challenge the father's privileged position, naturally affecting their mutual relationship. My initial perception of AI as merely a "mirror" of the analysand's thoughts, as I mentioned, may thus have been partly influenced by these unwelcome, insufficiently reflected

feelings I experienced in the countertransference–essentially, it was an attempt to downplay the significance of a "competitor" who was disrupting my work and partially usurping my position. In the spirit of Heimann (1950), this can be understood not merely as a simple reaction to technology, but as a complex countertransference phenomenon that is, to some extent, the patient's creation, wherein the patient unconsciously "uses" AI to evoke specific feelings in the analyst that reflect their own internal conflicts and personal history. Confrontation with the patient's use of AI often demands arduous work from the analyst on their own countertransference. However, in facing the "algorithmic third," this work can ultimately be psychoanalytically very beneficial for both the analyst and their patient. The primary question, therefore, in my view, is not whether insights generated by AI are valuable or not, but rather how the analyst is able to process such interactions for the benefit of the therapeutic process. In this respect, Racker's (1957) distinction between concordant and complementary countertransference offers a useful lens for understanding what such processing entails. My irritation could be seen as a complementary identification with the patient's internal father figure—the distant intellectual authority whose position is challenged by a rival. Recognizing this identification allowed me to use the countertransference affect not as a personal reaction but as analytic data, clarifying how the patient unconsciously positioned me to re-enact his internal rivalry.

Conclusion

Advanced interactive technologies, encompassing various forms of artificial intelligence, can, in some cases, become active co-creators of experienced reality and interpersonal dynamics within our consulting rooms. As I have

attempted to demonstrate through selected clinical observations, the presence of AI may offer a novel pathway for the externalization of internal conflicts for certain analysands, while also introducing complex countertransference challenges that call for analytic self-reflection. Paradoxically, it is precisely the confrontation with a non-human "third" that may, in some instances, aid us in achieving a deeper understanding of the patient and their modes of relating. It is important to avoid either demonizing or uncritically embracing AI. In my opinion, we should maintain our analytic stance, from which we can reflect with an open mind on its influence on psychoanalytic practice. This approach, I believe, may prove crucial for psychoanalysis as it navigates the evolving technological landscape.

Patient Anonymization

The clinical vignette is based on therapeutic practice; however, identifying details have been altered, omitted, or composited from multiple cases to ensure that no individual can be recognized by others or by themselves, in accordance with the journal's anonymization policy.

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Disclosure of interest

The author reports there are no competing interests to declare.

Data availability statement

This conceptual paper is based on existing literature and the author's clinical and theoretical reflections. As such, data sharing is not applicable as no new empirical datasets were generated or analyzed in the course of this study.

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