Chapter 3 The Transference/ Countertransference Relationship

The transferential/ countertransferential relationship is the experience of unconscious wishes and fears transferred on to or into the therapeutic partnership.

> His life had been confused and disordered ... but if he could once return to a certain starting place and go over it all slowly, he could find out what that thing was. (F. Scott Fitzgerald, *The Great Gatsby*)

Introduction

In the previous chapter I discussed the working alliance as the basic foundation on which all other psychotherapeutic activities of a voluntary nature are based. In this chapter I will pay specific attention to what is understood by the transference/countertransference relationship; its origins; the views and expectations of it from both psychoanalytic and other approaches; its management and use in therapy, and what can happen when this relationship is interrupted or disrupted. It also examines different types of transference and countertransference exploring a variety of related categories. The summary in Table 3.1 has proved useful to clinicians from a number of different perspectives. The implications of transference/counter-transference dynamics for supervision in terms of parallel process from causal and simultaneous time-perspectives are also reviewed.

This chapter is not intended to be a comprehensive review of the literature on transference, countertransference or parallel process, but is a practical guide which may stimulate readers to review what they know and or investigate this fascinating area further. I consider it desirable to be willing to learn from multiple sources, and to develop the capacity to tolerate some of the ambiguities and paradoxes which necessarily attend increasing differentiation within the complex field of the alleviation of human distress.

The enormous literature on the subject of transference involves an

Table 3.1 Summary table of transference phenomena

This is an amended and updated version of the summary diagram which was originally published on p. 161 of Clarkson, P. (1992). *Transactional Analysis Psychotherapy: An Integrated Approach.* London: Routledge.

PROACTIVE TYPE	CLIENT TRANSFERENCE	PSYCHOTHERAPIST (COUNTER)TRANSFERENCE
Complementary (seeks identification)	• Client projects actual or fantasised Parent or caretaker's past • Client projects actual or fantasised past childhood	Psychotherapist complements client's real or fantasised projection as Parent or Child based on his/her own past or projects actual or fantasised past experiences of caretakers and children
Concordant (seeks identification)	Client projects client's past experience, feelings and fantasies	Psychotherapist experiences client's experience based on his/her own past
Destructive	Client's acted out or fantasised destructive past	Psychotherapist's past enacted in psychotherapy (therapist's transference) in destructive ways
Facilitative	Client's temperament, liking, style based on past experience	Psychotherapist's style and personal preferences
REACTIVE TYPE	**CLIENT COUNTERTRANSFERENCE**	**PSYCHOTHERAPIST COUNTERTRANSFERENCE**
Complementary (seeks completion) past	Client completes psychotherapist's real or fantasised projection	Psychotherapist experiences client's experience based on his/her actual or fantasised experiences of caretakers and children
Concordant (seeks identification)	Client experiences psychotherapist's denied Child or resonates empathically with therapist's experience	Psychotherapist experiences client's avoided experience or resonates empathically with client's experience
Destructive	Client answers psychotherapist's induced pathology	Psychotherapist accepts projected identification in destructive way
Facilitative	Client's responses to psychotherapist's preferences and style	Psychotherapist's responses to client's style or preferences

astonishing variety of contradictions, ambiguities and connotational disputes. However, it is also marked by a relative paucity of research. Depending on the place, the period of history, the prevailing fashion and the politics of different schools, analysts and therapists and their clients may experience completely different and even contradictory 'types' of transference. The number of 'types' and related phenomena decrease or increase depending on the author and their allegiance to a particular variety or sub-section of psychoanalytic or psychotherapeutic theory.

Many apparent theoretical inconsistencies result from confusing definitions and their application. Too often clinicians adopt the definitions associated with their particular school or brand of psychoanalysis. In this, they may forfeit flexibility and an opportunity for creative freedom which becomes possible when taking a wider-angled vantage point. We may need to give up or suspend the desire to be right, correct or 'error-free', since no dynamic discipline and certainly no creative engagement with the human condition can tolerate this. Such aspirations are often grandiose, handicapping and probably dysfunctional for any purpose other than doctrinal orthodoxy.

Neither is this chapter intended to be a substitute for careful reading of texts which are exclusively devoted to this subject, but to complement them. My intention is to provide an overview of the topic within a broad framework, comparatively balanced with discussion of other relationships. In much of psychoanalytic literature more attention is paid to the transference relationship than to any other. Therefore readers have full opportunity and encouragement to pursue subtle delicacies or nuancing of factional disagreements or to study the whole field with much more of a fine-tooth comb in other sources. My interest here is in widening the lens or creating new optical instruments, rather than studying down the microscope.

It certainly is true that, whether or not the psychotherapist engages theoretically or technically with any phenomenon which could fall under the transference rubric, effective and healing psychotherapy does take place. This includes a wide range of patients from those who are fundamentally impaired, such as those with schizophrenia, to the creative fulfillment of the individual in what Maslow (1968) would call the process of self-actualisation. Healing happens and people experience it as happening in many shapes and forms. People are healed or cured of their ills in witchdoctor's huts, in church halls, in operating rooms. History indicates that it has happened since the beginning of time. Myths tell how Hercules recovered from his madness through wandering the Earth. There are reports throughout the centuries that lepers have been repaired by touching the garment hems of kings or saints. To reduce this marvellous capacity to simplistic 'transference' is surely absurd. Clearly it is possible for people to get well and have insight without 'it'.

Yet transference is one of the ways we have found useful this century to describe one of the possible relationships in the space between doctor and patient. Even Freud, the father of psychoanalysis, vacillated about whether his approach was purely psychoanalytic and divorced from all other approaches to change, healing or cure; and whether it was actually intended to help.

Definitions and Descriptions

Origins

The etymological roots of both the Greek and Latin words for transference mean 'to carry across', so there is a sense of movement from one place to another. In its most ordinary use it is natural that information carries across from past experience into the future. People who cannot use memory in preparation for present or future coping are severely handicapped. This is because they cannot learn from experience. In this very wide sense it is important to recognise that transference is a ubiquitous, natural and necessary component of learning in most organisms who have survived up to this point in evolution. How conscious the organism or person is of using the past to inform future behaviour is of course completely open to conjecture, accident and interpretation. In this sense, thus, where transference is considered an unnecessary component of learning, anticipation is a synonym for transference. From this viewpoint, anticipation allows for rehearsal, planning and preparation.

When transference as a component of learning is explained to lay people they usually accept and understand the notion that we expect or anticipate similar experiences to those we have had in the past from similar places and similar people. Again, in this broad definition transference processes occur between husbands and wives, friends, teachers and pupils, workers and managers, citizens and government officials. In the healthy person or animal such transferences or anticipation are usually changed or updated in terms of here and now information.

> ... a critical issue is robustness: how well can a system withstand small jolts. Equally critical in biological systems is flexibility: how well can a system function over a range of frequencies. A locking-in to a single mode can be enslavement, preventing a system from adapting to change. Organisms must respond to circumstances that vary rapidly and unpredictably; no heartbeat or respiratory rhythm can be locked into the strict periodicities of the simplest physical models, and the same is true of the subtler rhythms of the rest of the body. Some researchers, among them Ary Goldberger of Harvard Medical School, proposed that healthy dynamics were marked by fractal physical structures, like the branching networks of bronchial tubes in the lung and conducting fibers in the heart, that allow a wide range of rhythms. (Gleick, 1988, p. 293)

If the organism is open to learning – healthy and robust – it will immediately start revising data as soon as experience begins to corroborate or contradict it. A trainee reports:

> I had a very humiliating teacher at school. When I walk into most teaching and learning situations I anticipate the same kind of put downs and shaming humiliation that I have experienced before at the hands of this teacher (and others) in learning situations before. I now have had experience that my current supervisor is different from the one I had at school. But I still anticipate a repetition of my early school trauma. I can feel it in tension of my neck muscles. However I can soon realise from watching how this supervisor relates to other people, as well as from how they relate to me, that they are not the same. Therefore I can behave in a different way and realistically begin to expect (transfer) different behaviours from this teacher in my adult life.

Transference in this sense has an intrinsic potential for evolutionary, adaptive response. A person can resist or refuse to learn, adjust to or update their anticipation or transferences in terms of emotions, perceptions or reactions related to here and now situations. In such a case they may continue to base their experience on the past. The healthy, adaptive use of transference can become an open system where information from the past is processed together with information from the present. Then it is no longer a symptom, but the vehicle by means of which symptoms can be undone. Not 'transferring' in this way is to be like a sandbank where every passing move wipes out the traces of the one before. However when our experiences are set in cement, there is no possibility for information to flow in new ways and to change according to changing conditions. There can be no adaptation to new circumstances and thus no evolution. This is when 'transference' becomes a problem to be solved rather than a means of solving problems – when it becomes chronic, long lasting, inappropriate, disproportionate and misplaced, it becomes a handicap rather than a help. This occurs when the person does not use transference as a hypothesis to be tested and changed if experience proves otherwise, but as a procrustean bed to fit current experiences into past patterns. Transference can be, for example, about people, places, situations, sounds and smells. If we think about this very deeply, the broad sense of transference is perhaps quite close to original reflex conditioning or associationist paradigms. More often it is used in the literature and in practice to refer to the replication of past patterns within the consulting room which makes their effective resolution possible.

In any psychotherapy therefore, whatever the orientation, transference may be allowed, invited, resolved, temporarily interrupted, avoided, or minimised, depending on the patient's diagnosis and needs, and the nature of the psychotherapeutic contract or agreement, and the clarity of boundaries (Clarkson, 1991c, f). Transference or countertransference phenomena are also proba-

bly the major contributions to ways in which the working alliance can be disrupted, impaired or destroyed.

Transference in psychoanalysis

Transference phenomena were initially regarded by Freud (1905) as interfering with the method of treatment he was developing. They became in time a vehicle for conducting psychoanalytic therapy (Freud, 1912a).

> By transference is meant a striking peculiarity of neurotics. They develop towards their physician emotional reactions both of an affectionate and hostile character, which are not based upon the actual situation but are derived from their relations to their parents. (Freud, 1935, p. 391)

The particular contribution of Freud lay in identifying and being willing to engage with the pathological aspects of transference. It seems that Breuer was the subject of an erotic, probably psychotic, transference which put him off the path of psychoanalysis. Breuer recoiled from the impact of excessive unrealistic feelings towards him from Anna O when she developed a phantom pregnancy in the course of treatment with him. He called it an 'untoward event' (Jones, 1953, p. 246). The same patient provided Freud with the basic impetus for constructing what subsequently became 'classical' psychoanalysis and a platform for all the multitude of ensemble players who continued variations on this theme.

Orr writes, 'From about 1930 onward, there are too many variations of the concept of transference for systematic summary' (1954, p. 625). Laplanche and Pontalis described it thus in 1988:

> For psycho-analysis, a process of actualisation of unconscious wishes. Transference uses specific objects and operates in the framework of a specific relationship established with these objects. Its context *par excellence* is the analytic situation.
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> In the transference, infantile prototypes re-emerge and are experienced with a strong sensation of immediacy.
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> As a rule what psycho-analysts mean by the unqualified use of the term 'transference' is *transference during treatment.*
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> Classically, the transference is acknowledged to be the terrain on which all the basic problems of a given analysis play themselves out: the establishment, modalities, interpretation and resolution of the transference are in fact what define the cure. (p. 455)

There is an enormous range of opinions concerned with *what* it is that is being transferred, ranging from patterns of behaviour, prototypes of object relation, affects, feelings and emotions, actual or fantasised and so on. Examination of different theories notoriously shows up different emphases. Of all approaches to psychotherapy those which consider themselves closest to psychoanalysis make the transference relationship the most important, if not the fulcrum on which the whole

of the therapeutic endeavour turns. Indeed it has been said that unless you are working in the transference relationship you cannot be said to be conducting psychoanalysis.

However, what transference is, how it manifests and what to do about it will be different depending on which historical period the psychotherapist is using. The *drive theory period of psychoanalysis* (Freud, 1935) was when transference was regarded as a help where it was positive or as a resistance where it was negative or seductive as well as a 'dangerous re-enactment of the past' (Hinshelwood, 1989, p. 448). During the *ego psychology period* (Federn, 1977d; Hartmann, 1939a, b; Weiss, 1950) transference was explained as 'evidence of impulses, instinct derivatives and the defenses against these' (Hinshelwood, 1989, p. 449) or the *object relations period* (Klein, 1984; Fairbairn, 1952; Winnicott, 1958; Kernberg, 1981, 1982) during which transference is viewed as a path of access to understanding internal objects.

> For instance reports of patients about their daily life, relations, and activities not only give an insight into the functioning of the ego, but also reveal – if we explore the unconscious content – the defences against the anxieties stirred up in the transference situation ... he tries to split the relationship to him (the analyst), keeping him either as a good or as a bad figure: he deflects some of the feelings and attitudes experienced towards the analyst on to other people in his current life, and this is part of 'acting out'. (Klein, 1984, p. 56)

Teaching, experience and understanding of transference and its manifestations and management change again during the *self psychology period* (Kohut, 1977; Wolf, 1988) where transference undergoes another transformation to fit the developing theories of the self and its objects in psychoanalytic theory.

If we think of the five relationships as being differentially emphasised in the different approaches it could certainly be said that the psychoanalytic interpretation of transference is strongest within the psychoanalytic approaches. However it is important to note that:

> It would therefore seem that transference as initially described by Freud is not an essential part of the therapeutic relationship ... numerous turns of phrase reveal that Freud does not look upon the treatment as a whole in its structure and dynamics as a transference relationship. (Laplanche and Pontalis, 1988, p. 457)

In its very particular way *transference in general* needs to be distinguished from transference phenomena which are idiosyncratic to the psychotherapeutic or psychoanalytic process. According to Rycroft (1972) all the patient's psychological phenomena and processes which refer to the analyst were derived from previous experiences. We can therefore define three emphases in the psychoanalytic use of the term transference:

- the emotional attitude of the client towards the analyst
- the displacement process
- its related state of the mind which:

> derive from previous figures in his life; by which he relates to his analyst as though he were some former object in his life; by which he projects on to his analyst object-representations acquired by earlier introjections; by which he endows the analyst with the significance of another, usually prior, object. (p. 168)
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> Transference may be paternal, maternal, oedipal, pre-oedipal, passive, dependent, oral etc., according to the object transferred and the stage of development being recapitulated; object or narcissistic according as to whether the patient conceives his analyst as an external person on whom he is dependent, whom he hates etc., or as a part of himself; positive or negative, according as to whether he conceives the analyst as a benign or malevolent figure. (Rycroft, 1972, pp. 168–9)

Cashdan (1988) differentiates four primary projective identifications which are displayed in the transference-countertransference field from an object-relations point of view: dependency, power, sex and ingratiation.

According to Detrick (1989), discovery of self-object transferences (Kohut, 1968, 1971, 1977), provide new, in-depth understanding of a variety of classes of psychological disturbance. Terms often proliferate into ambiguity. Amongst self-psychologist theorists Wolf provides a set of important definitions:

- *Self-object transference* is the displacement on to the analyst of the analysand's needs for a responsive self-object matrix, derived in part from remobilised and regressively altered editions of archaic infantile self-object needs, in part from current age- and phase-appropriate self-object needs, and in part from self-object needs mobilised in response to the analyst and the analytic situation.
- *Merger transference* is the re-establishment of an identity with the (self-)object of early development through an extension of the self to include the analyst in it.
- *Mirror transference* proper, in contradistinction to the idealising transference ... [refers] to the re-establishment of an early need for acceptance and confirmation of the self by the self-object matrix. [It] manifests as demands on the analyst (or defenses against such demands) to recognise, admire, or praise the patient.
- *Alter-ego transference* is the re-establishment of a latency need to see and understand, as well as to be seen and understood by someone like oneself.
- *Idealising transference* is the re-establishment of the need for merging with a calm, strong, wise, and good self-object. It may manifest as the more or less disguised admiration of the analyst, his character

and values, or by defenses against this transference, such as prolonged and bitter depreciation of the analyst.

- *Transference of creativity* is Kohut's (1976) term for the transient need of certain creative personalities for merger with a self-object while engaged in the most taxing creative tasks.
- *Adversarial transference* is the need to experience a supportive yet oppositional self-object relationship, an ally-antagonist self-object experience. The two-year-old who responds to all communications with 'No' is acting out a need to experience himself or herself as autonomous and to have his or her autonomy responsively accepted. (Wolf, 1988, pp. 186–7)

Wolf links these definitions to developmental phases in childhood recapitulated in psychoanalysis and suggests that the acceptance, empathy with and interpretation of such transferences are important, if not the most important, pillars of analysis with patients who fulfil diagnostic criteria for narcissistic or borderline personality organisation.

Transference in other approaches

Humanistic/existential approaches latterly have been addressing transference and countertransference issues more profoundly than in the past. As we have seen before, some therapists (for example, Levant and Shlien, 1984), some of the existentialists and some psychosynthesists historically do not recognise a phenomenon by the term transference. For them client behaviours, feelings, attitudes or fantasies in psychotherapy will not be interpreted or recognised as transference. The term 'transference' is not found in the indexes of major works on psychosynthesis. For many others, what is perceived as transference may be welcome or certainly 'allowed'. It does appear to be true that more and more practitioners are opening themselves theoretically and clinically to the recognition of how clients and patients repeat past patterns in relationship with their therapists and think about it more or less classically in terms of 'transference'. This has both positive and negative consequences, as will emerge.

To some theorists, in client-centred psychotherapy for example, 'transference is a fiction, invented and maintained by the therapist to protect himself from the consequences of his own behaviour' (Levant and Shlien, 1984, p. 153). Whether or not one agrees, considering the implications of this position is valuable food for thought – particularly for those who take 'transference' for granted, as if a theoretical term can be reified. Rogers dealt with the subject in 1951. He acknowledged the existence of transference attitudes in both analytic and non-directive psychotherapy. He thought that the client-centred psychotherapist 'attempts to understand and accept such attitudes, which then tend to

become accepted by the client as being his own perception of the situation inappropriately held' (Rogers, 1951, p. 218). He understood that psychoanalysts tend to transform transference *attitudes* into the full development of a transference *relationship* which usually leads to the development of 'a long-term dependent relationship, built up on experience of the psychotherapist as 'knowing more about me than I know myself'. Then there appears to the client to be nothing to do but to hand over the reins of his life into these more competent hands. This is likely to be accompanied by comfortable feelings of relief and liking, but also at times by hatred for the person who has thus become so all-important' (Rogers, 1951, p. 216).

Spinelli (1989) describes the position of phenomenological psychologists. They

> take issue not with the necessity and strength of what has been termed 'transference' but with the limited interpretation that has been given to it by psychoanalysts... [it] might be just as likely that the analysands are also 'testing' their analysts' claimed open-minded neutrality in their opinions of their patients (that is, their unconditional regard) in order to ensure the truth of such claims (*negative transference*), and also under other circumstances, are expressing their desire to continue to explore and maintain this unique, unusual and highly desirable relationship via whatever means the analysand has learned to employ when dealing with others who provide only conditional regard (*positive transference*). (Spinelli, 1989, p. 170)

The body of knowledge and theory which concerns learning and practice, as well as cognitive, emotional and behavioural approaches, does not really feature transference. The term is not listed in most of the indexes of cognitive behaviour therapy at all. Yet it is these approaches which, however it may be claimed, 'only provide symptom relief', alleviate suffering moderately fast and apparently effectively and experientially in many cases of excessive fear and depression (Smith *et al.*, 1980). Ryle, from cognitive analytic therapy, avows: 'I believe the relatively opaque interpretive stance of the traditional dynamic therapists is experienced by many patients as unhelpful and that conducting therapy on such terms can prolong dependency and block change' (1990, p. 220).

Samuels *et al.* (1986) within the Jungian tradition write about transference as follows:

> Jung separated transference into its personal and archetypal components.... *Personal transference* included, not only those aspects of the patient's relationship to figures from the past such as parents which he projects on to the analyst, but also his individual potential and his shadow. That is, the analyst represents and holds for the patient parts of his psyche which have not yet developed as fully as they might and also aspects of the patient's personality he would rather disown.
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> *Archetypal transference* has two meanings. First, those transference projections which are not based on the personal, outer-world experience of the patient. For example, on the basis of unconscious fantasy the analyst may

be seen as a magical healer or a threatening devil and this image will have a force greater than a derivation from ordinary experience would provide.

The second aspect of archetypal transference refers to the generally expectable events of analysis, to what the enterprise itself does to the relationship of analyst and patient. (pp. 19–20)

The way of acknowledging, describing or working with transference within a Jungian idiom again depends very much on which particular branch of the Jungian tree one looks. For those more closely identified with the incorporation of Kleinian psychoanalytic perspectives into or on to the work of Jung and his colleagues, transference is likely to play a much larger part than for those who are more classical and for whom the vicissitudes of childhood are but one dimension and not even always an important or necessary dimension of analysis or soul-making, to use Hillman's (1975a) term borrowed from Keats.

Many psychotherapists, whether or not their theoretical stance acknowledges, welcomes or allows for transference, notice that clients engage in forms of relationship which are repetitive, either in reality or fantasy, of patterns which they had experienced in their past. People may project into the therapeutic relationship all their unresolved child development issues and expectations. For example, if a patient suffered from being enmeshed (over-involved) with a mother it may be impossible for him to see or experience the psychotherapist as a separate person with an independent life outside the consulting room. As one said, 'I imagine that you only come alive when I ring the doorbell and that you wait in the cupboard for me until I come again.' For them, the psychotherapist is totally merged with their idea of themselves ('confluent' in gestalt terminology). Any experience that the therapist is different can be felt as an assault or an abuse. It can be said that the arrested or rudimentary self which has failed to differentiate from the caretaker hungers for a symbiotic partner. In therapy they may demand that the psychotherapist fulfils this fantasy of basic unity. Any break or failure of empathy or understanding is experienced as a betrayal or abandonment grossly at variance with the adult reality of the situation. Yet this break or betrayal may hold the very seed of genuine maturation (Hillman, 1975a; Estés, 1992).

Transactional analysts range in theory and practice across a broad spectrum. On the one hand there are Moiso (1985) and Novellino (1984) who intentionally and actively work with the transference. Schiff *et al.* (1975) wrote: 'Our policy is to accept the patient's investment of power (transference) to the extent we believe it is possible to utilise that power for their welfare' (p. 102). Their contested reparenting approach uses replacement model of reparative psychotherapeutic relationship, a radical departure from many other forms of psychotherapy. On the other hand, there are the Gouldings, who have stated:

We prefer, usually, not to invite a transference, although of course we do use ourselves. We are much more likely, however, to endeavor to keep out of the

> work, and to let the patient do his work against himself, by setting up dialogues, by keeping I–Thou transactions going, by saying 'any more?' instead of 'tell me'. Thus we hope that the patient, instead of resisting us, will resist himself, recognise the impasse when he gets to it, and either break through or stay stuck at the point of impasse. We prefer that he battle against his own internal Parent, instead of with his transferred 'parent', us. (Goulding and Goulding, 1978, p.210)

Finally, Smith (1991) argues persuasively in support of Langs that so-called transference phenomena are often more a function of the analyst's pathology or failure than a useful construct *per se*. He reviews astutely and entertainingly much of the field and follows with useful clinical applications.

Expectations

Transference and countertransference expectations can range over a wide area. On one hand, a psychologically unsophisticated client may be outraged at the suggestion that she would or could attribute, for example feelings about her parents, to the psychotherapist. Another version is when the client says, 'I know that I am expected to fall in love with my psychotherapist'. Or again, in dealing with psychotherapy trainees, their very knowledge or reading can precipitate a distortion, or even perversion, of the phenomenon. A client may be very quick to notice when he may be in twinship transference, or ridicule his desire to admire the psychoanalyst before this even has any opportunity to develop by laughing it off as an 'idealising transference'. So it is very important, either directly or indirectly as the situation demands, to explore the expectations or non-expectations in terms of transference and evaluate subsequent manifestations.

The transferential expectations of the therapist in particular become valuable grist to the mill. For example, a patient with a parent that was homicidal, judgemental, critical, weak or ill will probably at some stage surface the fear that the psychotherapist will use, abuse or neglect him. Of course it is not always so obvious. Frequently the patient may come with the grandiose fantasy that she has finally found someone whom she can trust and who will not let her down in the way which the original caretaker did (and all their stand-ins, such as lovers, husbands and employers have done since). However, embedded in this idealised transference can be the fear of being disappointed again or that any misbehaviour on the part of the client may precipitate the painful past relationship or even rage that someone can indeed be empathic, supportive and understanding *now* whereas the patient really needed it *then*. Sometimes to be listened to and cared for merely throws into painful relief all the past deprivations.

In ordinary relationships, or so-called transference in general, people often tend to repeat their most painful early relational patterns, for example marrying or rejecting one man after another; or finding themselves repeatedly in triangular relationships, feeling left out and victimised. In ordinary life however, the respondents tend to step into the projections and enter into a replay of the transferential traumas – if

not immediately, then as soon as boredom, crisis or appropriate life events set in. Given human susceptibility to projective identification or hypnotic induction, most people succeed in replicating their most painful early relationships in their adult lives. They may marry someone who appears sober, but whose life path quickly reveals blistering flirtations with dangerous criminal involvements or substance abuse.

Alternatively human beings can construct relational patterns, apparently exactly the opposite but based precariously on huge fissures of fear of repeated earlier damaging relationships. One client, instead of marrying a bullying tyrant like her father, married a paraplegic who would never have the opportunity to exercise physical violence. In working with couples I have frequently found that people can be fitted into unhappy, boring or tragic patterns in at least three ways.

- You can find or choose someone to fit the pattern, very simply finding an alcoholic husband to substitute for an alcoholic father.
- You can train the partner to fit the earlier pattern. By frequent nagging and lack of appropriate appreciation and feedback it is quite possible to train someone to become rebellious, resistant and resentfully withholding.
- If both these procedures fail, you are always free to interpret whatever someone else does to fit the pattern; so that even when your partner is loving, generous and forthcoming you may suspect perhaps they are just saying it to 'butter you up', doubt they mean it, or feel assured they probably say this to everyone. This turns a neutral or even positive situation into something negative, corroborating your expected scenario. The issue is not what you want but the power to elicit what you expect.

A more colloquial formula for transference combines the 'hoped-for-outcome' plus the 'expected disappointment'. It implies notice of the transference projection. The patient says: 'I hope that this time against all the odds I will find someone who will listen to me, but when I find out that he is so self-absorbed that he is only waiting for his turn to speak I recognise it in some way as what I just *knew* would happen.' So when I say the disappointment is expected I mean that when that payoff point happens and the woman cheats on him again – even after all her vows of fidelity , there is a sense of 'I knew it' – a sense of fit, because – 'I basically always expected it', or 'I deserved it'. The depth and longevity of the expected disappointment becomes clear at that point as if the person had always known and expected it – even though it had apparently been kept out of full conscious awareness until that moment.

As pointed out above, in ordinary life and particularly in mating or choosing partners for love, the force of the role induction, the implicit demand to complete the early scripted childhood *dramatis personae*, the mutuality of needs, frequently preclude anything but a replay. The

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difference between the therapeutic situation and the ordinary life situation is that hopefully the therapist does not succumb as easily to the hypnotic induction or the projective identification or the invitation to project an identification which the client may flag up time after time and in manifold disguises. It is the therapist's self-awareness, personal experience, their own analysis or psychotherapy, supervision and constancy of questioning which forms the rudiments of the resistance to collusion and patient experiencing again the depth and strength of their earlier painful relationships.

Diagnosis and Identification

Elsewhere (Clarkson, 1993, Chapters 9 and 10) I have pursued in considerable theoretical and clinical detail a classification and discussion of transference and countertransference phenomena concerning the introjection and replication of previous object relations in the psychotherapy (this is summarised in Table 3.1). This particular framework uses the ideas of identifiably separate intrapsychic egos in interpersonal relationship. In this object relations sense the ground of the anticipatory pattern of relationship based on past real or fantasised experience which the individual seeks to replicate with significant other people regardless of their individual, unique qualities, potentials or interactions of that current moment. Transference in this sense is thus that predisposition to particular relational patterns which are carried from situation to situation. The other person is not met freely as if for the first time. It is more as if the other person is met through a screen on which the person is projecting his or her own particular film. To the extent that such transference is 'updated' to the new situation, it can be seen as a functional adaptation.

Establishment of the Transferential Relationship

The ubiquity of transference

'Transference' is everywhere and unavoidable. Of course, if a word exists for a phenomenon and you believe in it, it becomes visible. We cannot distinguish all the varieties of snow for which the Inuit have names. For our purposes here in this section, we will accept its existence and ubiquity in psychoanalysis and therapeutic counselling psychology and while acknowledging the disputes, bracket them for a moment. What we do with it once we recognise it is equally important. The question for the practitioner is usually not about how to recognise or establish the transference/countertransference relationship, but how to manage it.

As we have seen in the definition section above, transference is either an epiphenomenon of learning or a displacement of affect from one situation to another. In this sense, human life is not possible without it. It can be described as a displacement from childhood patterns of loving which become regularly repeating patterns throughout life and which creates needs and expectancies directed towards people in a person's adult life. This is what Freud (1973) meant as the causes for transference in general. In this sense people are frequently and ubiquitously transferring from one situation to another and will certainly also do so within the psychotherapeutic relationship. If we accept that transference is a specific term to describe this kind of phenomenon we can see that transference is ubiquitous. If we confine its use to psychoanalytic or psychoanalytically oriented therapies it is still possibly just as impossible to escape the effects of the past's influence on the present. The consulting room, however, provides a container, a safe/dangerous space for its exploration, an alembic wherein which it can be concentrated, studied and distilled.

If one or both of the patient–analyst pair expects transference it is even less difficult to establish the transference/countertransference relationship. Since some amount of transference from past to present and future relationships appears to be an ever-present feature of human life, it is hardly possible to completely avoid its cognates in counselling and psychotherapy. However, its shape, nature, and intensity can be influenced, modified, or neutralised by the psychotherapist's appearance, context, and behaviour. The psychotherapist who wears a demandingly sexual aftershave cologne to a session with a patient who may be in the throes of, or defending against, an erotic transference, is bringing into the relationship substantial factors which have more to do with his own personality and background than is often spoken about. The patient may also be influenced by less obvious forces such as smells below the level of human discrimination, the therapist's dreams and fears, cultural tides and eddies, the political events of the world and so on.

There is often the illusion that transference can occur most effectively when the psychotherapist appears to maintain a stance of neutrality Psychoanalysts argue that neutrality in this sence is not supposed to evoke transference but to allow one to see it more clearly as the client's production, 'uncontaminated'. This is based on Freud's early admonition for the psychotherapist to be like a blank screen or a mirror (Freud, 1912b, p. 118). It is exemplified in some psychoanalysts' offices decorated in ten shades of beige with no personal items to communicate to their clients that they are individuals. There appears to be an idea sometimes that the modelling of blandness is most likely to evoke transference. However, Freud's own consulting room is strikingly rich, evocative and sumptuous. The majority of working clinicians' experience is that transference phenomena will manifest whether or not the psychotherapist has a Greek urn, a modern sculpture or a blank wall with the occasional certificate testifying to institutional compliance.

> The important thing about transference is that the potentiality in the patient for transference experience is mobilised and harnessed only by the analytic setting and by the analyst's behaviour, in which verbal interpretation plays a very mutative role. (Khan, 1974, p. 203)

Transference in general is thus likely to occur whether or not the other party invites, agrees or refuses it. We can regularly observe it in everyday relationships including, for example, marital partners who are often least likely to act as blank screens or clear mirrors for each other. It is the experience of most psychotherapists of whatever persuasion that clients or patients tend to project on them experiences, feelings, hopes or fears which are not related to them as people but more related to the client's past. As explained above, this kind of human learning set based on anticipation is normal and healthy.

In most cases experience proves that the psychotherapist does not have to be a blank screen in order for the patient to enter into a transference relationship. In fact, even some self-disclosing psychotherapists who pride themselves on their presence, openness or authenticity are used by clients and patients in ways which can be described as transferential. A very good example of this is the old film where the woman called Gloria interacts with both Rogers and Perls. In both of these interviews she experiences and expresses feelings towards them as if they were other than they are. These have more resemblance to what she experienced in her past (Perls) or what she had longed for as a little girl (Rogers). Indeed, particularly good examples of management of the transference are displayed by both these masters in their respective ways, although both would have been eager at that time to disclaim the idea of working with what we are here terming transference.

So, whether or not the practitioners invite it, phenomena which can be called transference (by observers, interpreters or theoreticians from other orientations) occur. The difference from ordinary life in the psychotherapeutic situation is not the difficulty or ease of inviting or eliciting the transference, but that it can provide the frame and the opportunity to explore it, to understand it and to work through it. The psychotherapist's mere presence in a consulting room is usually enough to create a potentially transferential space. Of course transference of a kind starts well before the meeting of patient and analyst. It often starts when a doctor or a friend recommends a certain analyst, over the telephone conversation to make the appointment, during the walk to the door through the car park; it may even involve the kind of front door encountered.

Optimal conditions

However, it is the conviction in much of the psychoanalytic canon that these special conditions which obtain in the consulting room of the

psychoanalyst are at the very least most likely to enhance or intensify the transference. **As we have seen some theoreticians reserve the term transference for this patient-analyst relationship only. Technically we can then speak of the development of a transference neurosis.** Classically the transference is invited by the fact that the analyst sits behind the patient who reclines on a sofa in such a way that they do not make eye contact. This tradition stems from Freud. Langs (1976) used to call it essential to the psychoanalytic frame.

'Allowing' the transference implies that the therapist can create a space wherein transferential feelings and fantasies may grow or flourish unhindered; neither watered nor pruned. The client may say 'I want to eat you up. I want to devour you'. The therapist may just let that statement rest in the therapeutic space for months or years before the patient may be ready to begin to work with some of the cannibalistic, patricidal rage he experiences but barely glimpses in dreams and fantasy preoccupations. It is a mistake of novice psychotherapists to intervene, interpret or dismantle transferential constructions early in the therapy without having built enough internal psychological scaffolding, so to speak, for the patient to support the systemically changing effects of a mutative interpretation.

Cox and Theilgaard (1987) explain the importance of temporarily relinquishing conventional interpretation in favour of the patient's need for supportive listening and for telling their own 'story' in their own words and images. They value and encourage spontaneous associations, allowing the patient to use their own metaphors, with their mutative power for affective release and increased insight. They use the metaphor of the story told by the patient until it loses its hold. Often they reply in kind supplying a quotation from Shakespeare or some other poet to elucidate, amplify and deepen emotion or insight.

Watkins has pointed out the similarity between hypnotic trance induction and invitation to the transference. As I point out later, this raises important conceptual, practical and ethical questions for the direction of influence and the power relationships which obtain in the psychoanalytic situation.

> The patient reclines on the couch and external distracting stimuli are removed – as in hypnosis. He is encouraged to turn his attention inward, to relax his conscious ego defenses, and to permit the seeping through of preconscious, and ultimately unconscious, material. The analyst in the meantime seats himself comfortably, places himself in a contemplative mood, relaxes his own conscious ego defenses and allows the communications of his patient to impinge upon his own unconscious – of if well analyzed, preconscious. In this twilight state of interpersonal relationship the two people give attention to their innermost feelings, the patient to his own, the analyst to both the patient's and his own. Would the psychoanalyst be horrified if the word 'hypnoidal' or 'light hypnosis' is used to describe the mental states of both parties?' (Watkins, 1954, p. 288)

Management of the Transference and Countertransference Relationship

The working through of the transference and/or the countertransference relationship is one of the most potent forms of changing human relational patterns. And the primary tool for this is the transference interpretation. This section considers the management of transference and countertransference phenomena. It is suggested that transference and countertransference (from both the patient's and the therapist's perspectives) function as an inseparable, systemic whole. For our purposes here though we will deal with transference and countertransference separately for a while.

The management of transference is a huge area about which many volumes have been written by Freud and his followers for example Greenson (1967) and Racker (1982). I will select some major pointers on which to focus for the purposes of this book and within the space allowed here. Greenson in particular made an enormous contribution in classifying transference both positively and negatively in terms of object relations, libidinal phases, structure and identification. He explained transference resistances as well as going into considerable detail about the technique of analysing the transference. He advised that the transference should be analysed when it is a resistance, when an optimal level of intensity has been achieved and when an intervention would add a new insight. He broke down the technical steps into demonstration of the transference, clarification of the transference, interpretation of the transference and working through of transference interpretations. For more specific details his *The Technique and Practice of Psychoanalysis,* Volume 1 (1967) is still highly recommended reading.

Nonetheless, there are still many questions left: how does a clinician decide when to encourage the transference, when to confront it, perhaps as Masterson or Berne would; whether to control its behavioural manifestations, or whether actively to ignore or dilute it?

Transference interpretation

As we know, in classical psychoanalysis, the analyst was conceived of as a *mirror* for the patient (Freud, 1912b, p. 118). The therapist's apparent detachment gave the patient the space to externalise her internal conflicts and the analyst's task was to analyse and interpret the transference. Interpretation was thus the analyst's primary technique for resolving the transference, and thereby the neurosis.

My intention here is to show how wide a range of understanding of interpretations and its use exist in psychotherapeutic thought and literature. A useful definition of interpretation is:

- Procedure which, by means of analytic investigation, brings out the latent meaning in what the subject says and does. Interpretation reveals the modes of the defensive conflict and its ultimate aim is to identify the wish that is expressed by every product of the unconscious.

- In the context of the treatment, the interpretation is what is conveyed to the subject in order to make him reach this latent meaning, according to rules dictated by the way the treatment is being run and the way it is evolving. (Laplanche and Pontalis, 1988, p. 227)

The analyst's skill and understanding of technical rules will determine the 'criteria, the form and formulation, timing 'depth', order etc.' (Laplanche and Pontalis, 1988, p. 228). Nonetheless these are subject to endless debates, disputes and differentiation throughout the theoretical concern and practical application of psychodynamic approaches to healing the psyche through insight.

> [Freud] elaborated a theory of immediate interpretation of the *here-and-now* which took the analyst outside these transference distortions and enabled the patient to introject an image that was more realistic – a mixture of good and bad. Thus the analyst, through interpretation, becomes a moderating influence that can ameliorate the internal situation and mediate between the unrealistic, archaic internal objects through forming the basis of a new internal object: less archaic, more realistic. These interpretations are mutative. (Hinshelwood, 1989, p. 20)

In his lectures from the Tavistock, Symington differentiates between three types of interpretation.

> I divide interpretations up into three classes: expressions of insight, of a unique moment of understanding; guesses necessary to keep the conversation going or moving in the right direction; and interpretations that have partial understanding, and are midway between an insight and a guess interpretation. (1986, p. 33)

Kernberg (1982) uses the term *genetic interpretation*, which is here understood to refer to the historic origins of transferential phenomena. He distinguished between such genetic interpretations and those that dealt with the transference as it affected the ongoing psychotherapeutic relationship. Thus the transference manifestation was dealt with, but not necessarily through a genetic interpretation. For example, rather than saying 'You're angry with me the way you used to be angry with your mother when you experienced her as withholding', the analyst would acknowledge the patient's anger in the here-and-now and reflect back that it seemed exaggerated. This approach developed in response to the danger of interpretations being experienced as persecutory. Moiso (1985) used a similar example to illustrate his approach to transference, which he called a psychodynamic TA therapy. 'Therapist: 'Maximilian,

you are not only discounting me professionally, but you are destroying the image of me that you carry within yourself. Don't do that and ask for what you want' (p. 200).

By allowing transferential projections to build, examples and evidence can accumulate to support and intensify an interpretation when the time is eventually right to make it. By thus allowing the transference, denial by the patient is less likely and recognition of patterns and insight is encouraged. It also helps in the development of a common language for referring to these patterns between the therapist and the client. Exploring and experiencing transferential patterns in their unique and exquisite detail should include physical, emotional, behavioural and cognitive manifestations. This forms the basis for interpretation.

Many Kleinians and Freudians would criticise interventions such as that of Masterson (1985) telling his patient that she should not intervene with her friend – 'You should try to make yourself think of a reason before you say something' (p. 21). Such interventions (chosen from many others in their work and other practising psychoanalysts) frequently focus on the external circumstances of the patient and sometimes even the very clear provision of information and life management skills, antitherapeutic if not mistaken. It is an orthodox assumption that any intervention which focuses on reality and not on the transferential relationship between analyst and patient interferes with the psychoanalysis. According to Malan, the aim of interpretation is exactly to effect new learning:

> ... interpretation, which is one of the therapist's most essential tools. In turn the aim of giving this insight is to enable the patient to face what she (or he) really feels, to realise that it is not as painful or as dangerous as she fears, to work it through in a relationship, and finally to be able to make use of her real feelings within relationships in a constructive way, thus changing maladaptive into adaptive behaviour. Moreover, the aim is also that the effects of this emotional learning should be permanent – i.e. that the patient should not only be able to deal with the immediate situation, but with similar situations in the future, in a new and adaptive way. (1979, p.3)

If, over a long time, the patient insists on seeing the psychotherapist in an unrealistic negative or positive way (based on past expectations of neglect, abuse or spoiling favouritism) it is vital that the therapist does not just respond by identifying with the projection. It is important that they have the freedom, capacity and intelligence to refuse to respond in kind. In loyalty and commitment to the relationship or working alliance he or she may say 'You are not trapped by me or with me. You are paying for a service and you are free to stop paying me for this service, if it is not to your satisfaction. This is different from when you were a child and you couldn't leave your parents' home.'

In achieving such resolution the psychotherapist uses experiencing, collecting evidence, analysing, confronting, recognising where the trans-

ference originates and why, cognitive understanding, emotional catharsis, and moving from reliving to remembering with the affective charge ameliorated. The psychotherapist also fosters the patient's skills in spotting transference reactions in future relationships, and coaches patients either to avoid situations that echo the original unmet needs or to be skilful in dealing with them – and knowing the difference between the two. The psychotherapist helps the patient develop reality testing – identifying for example the kind of people to whom the patient had repeatedly been attracted, and helping the patient to change his or her attractiveness patterns. The psychotherapist facilitates the patient to have new experiences with real relationships and real people, to begin to trust and expect such relationships, and to know what to do when something goes wrong. Any resolution of the transference is inevitably healing, since past damage usually resulted from an absence of a true and genuine, contactful relationship.

According to Cashdan:

> ... interpretation does not play a major part in object relations therapy. But this does not mean that interpretation has no place in the treatment process. It is simply that the emphasis on projective identifications and their modification favors the use of confrontation and other reactive techniques as the therapeutic interventions of choice. Although the therapist may interpret and communicate information, it is the restructuring of the relationship that is essential to lasting change. (1988, p. 136).

He then asks:

> How, then, do interpretations in an object relations therapy differ from interpretations in more traditional approaches? The answer lies in the nature of the issues that are highlighted. Within more traditional approaches ie those that are more oedipally directed, interpretive activities are apt to focus on issues of parental dominance, parent–child rivalries, and the discharge of libidinal tensions. In object relations therapy, the significant issues have more to do with threats of abandonment, rejection, and 'good' and 'bad' internalizations. (p. 137)

Of course, as we have seen, there are many interpretations of what object relations therapy is and any attempt to describe what all object relations therapists do (not only what they say) is as misguided as trying to describe what all gestalt therapists do. There are as many interpretations probably as there are practitioners calling themselves adherents of any particular approach. Even the values and views of theorists of supposedly the same school can be as contradictory as placing the object-seeking loving infant of Fairbairn (1952) in the same category (or crib) as the envious hating infant of Klein (1984)!

Alternative views

Of course interpretation, empathy, confrontation and the interruptions

of countertransference and life events are not the only ways to work with the transference relationship, but they are the primary ones.

> Plaut acknowledged that both schools of Jungian thought do agree that transference occurs and is important. However, the CSS (classical-symbolic-synthetic) method 'will deal with it by a mainly educative procedure centred on the elucidation and differentiation of archetypal contents' (p. 156).
>
> The adherents of ID (interactional dialectic), on the other hand (of whom Plaut is one): 'accept the projection in a wholehearted manner, making no direct attempts to help the patient sort out what belongs to him, what to the analyst and what to neither as well as to both. On the contrary, they will allow themselves to become this image bodily, to 'incarnate' it for the patient'. (pp. 156–7)
>
> Plaut went on to note that it is not simply a question of timing interpretation of transference phenomena, but 'a totally different attitude to the transferred image' (p. 157). The analyst who incarnates the image is doing so in response to the transference. The analyst should not state that he is incarnating the image in this way, but when he becomes aware of it the implication is that he must 'be able to recognise the boundaries of his own ego' (p. 157). (Samuels, 1985, pp. 199–200)

If one accepts the notion at all, it is clearly not really possible to avoid all manifestations of transference completely. Without much doubt however, it can be minimised by ignoring such indications, analysing the interaction, re-establishing or confirming adult reality testing, establishing clearer contracts or appropriate review of the working alliance.

For example, sometimes when a patient in a group is overwhelmed by feelings or fantasies evoked by the transference, the psychotherapist may intervene by working with someone else in the group and letting the first patient cry until he or she is better able to think. The psychotherapist may or may not make this explicit by saying what the patient is doing and why. Alternatively this can be interpreted in terms of the dependency transference of the whole group on to the group conductor.

Humorous exaggeration can be made of the patient's transferential moan, 'Oh, no one loves you, not even your psychotherapist!', or humorous confrontation: 'Of all my patients, your success is the one most likely really to damage me, is that it?' Humour obviously needs to be used with care, and only where a relationship is already established and the psychotherapist has some evidence of the patient's ability to enjoy and tolerate humour.

Refusing the parental role is another option. For example, if a patient asks the therapist's permission in a childlike way, the psychotherapist can respond 'What is stopping you?', that is, the psychotherapist refuses to be the granter of permission, and encourages the re-establishment of the working alliance. A version from Masterson (1983) is 'Why do you present yourself here like a helpless little creature who will run away if I shout?' (p. 41). The psychotherapist can also show how other patients are a resource, as well as referring patients to other patients for their support, and by using other group members to attract transference.

Hillman (1972) also questions the way most of us have been taught to think about transference:

> Transference has long been recognised as a demand for love; but this demand has usually been placed by analysis against too personal a background: the family problem and personal needs. Hence, the demand for love is never wholly acceptable. It is too much because its 'impossibility' is at root the incest desire. But, within the metaphor we are using, until my daimon has caught fire, I remain stuck in my transference and have legitimate need for the spark of another's eros for my self-development. The less the other can reveal his eros, the more I will demand it; for how else will my process be kindled? My own individuation impulse, my desire for psyche, must be ignited. This love for psyche – and not the analysis of 'transference reactions' – alone resolves the stuck transference. (pp. 109–10)

If the patient is so completely gripped by fear or rage for example (due to the transferred expectation that the psychotherapist cannot help him or her) that they threaten to leave, the psychotherapist may remind him, 'You have an opportunity now to work this through with me. Chances are that if you don't, you will continue to find or make other similar situations again and again. You can walk out on me now but you will walk on with the same problem in the future.' This can be seen as appealing to the working alliance.

Intentional interruption

There are many occasions where a psychotherapist may intentionally wish to interrupt the transference. This may range from attempts to deal with a transference reaction which has become psychotic or in a variety of other circumstances (Greenson, 1967). The guideline will probably be based on whether working in the transference is furthering the psychotherapeutic work or whether it has become temporarily or permanently dysfunctional.

When a patient is deeply in the throes of the physical and emotional expression of rage or grief towards the end of a session, the psychotherapist might remind the person that there are only ten minutes left. The clinician then may ask what the person needs before leaving or make a suggestion of what they may need to do in order to achieve some kind of closure. This is to avoid experiencing a precipitate abandonment which may be felt as punishment for fully experiencing and expressing the emotions of the self. When the therapist does this they are calling upon and therefore demonstrating that they believe there exists within the patient sufficient ego strength and coherent self-functioning to identify and strengthen the working alliance.

I can remember a supervisee bringing a client who was getting deeply depressed in a most unsatisfactory marriage without any hope or enthusiasm. Week after week for months she was withdrawn, sullen and miser-

ably angry with her analyst. She persisted in feeling that the analyst wished her to fail and never to be happy, in the same way that her mother had persisted in expecting only negative outcomes from her. The extent and vehemence of her distortions was becoming almost intolerable to both patient and psychoanalyst. For example, she had said that she believed that the analyst genuinely did not want her to get well and therefore she could see no point in continuing. After listening once again to further justifications for why she should feel negative about her analyst, the analyst leant forward closer to her and said quite loudly and firmly 'I am not your mother. I am on your side'. She went on to say to her emphatically and sincerely, 'I am not your mother. I support and approve your life. Do you want to work with me to continue this, or not?' She was shocked but also very relieved to have these two separate realities identified and confronted. Analyst and client shook hands on working together rather than working against each other; and the therapy progressed without much further ado to a mutually agreed successful outcome. Little (1986) reports a similar instance of even shouting in rage at her patient which led to a breakthrough in the transference. Of course many therapists have shouted at their patients – Freud, Perls, Laing amongst others.

To resolve it, the psychotherapist may allow the transference to develop, to become fully alive and yet be experienced as something alien to here-and-now reality. Then the psychotherapist may invite the patient to test reality through the use of his or her senses. 'When you were little, it is true that no one listened to you or paid you attention? Is that still true now? Look around the room, what do you see? People, yes. Are they looking at you? Do they seem to be listening? Are they paying attention to you? How can you tell?' At other times, or with other patients, the psychotherapist may encourage resolution of the transference through successful mastery of the developmental tasks.

Confrontation

Confrontation is a term which has become more used in psychotherapy recently particularly in psychoanalytic orientated psychotherapy. According to Masterson (1976), in working with so-called borderline patients confrontation is the principal therapeutic technique of the testing or resistance beginning phase. He does point out that confrontation will be needed throughout the therapy particularly when previously learned insights appear to have been forgotten. He writes:

> Confrontation, the principal therapeutic technique of this phase, throws a monkeywrench in the patient's defense system by introducing conflict where there previously had been none. The patient had been regulating his internal

> equilibrium or making himself feel good by acting out in ways that were harmful, but because he denied the harmfulness he felt no conflict. When the therapist points out the harm the patient can no longer act out without recognising the harm. Therefore conflict and tension are created. The patient can no longer act out freely without conflict. He has to recognise the cost of 'feeling good'. As the therapist brings to the attention of the patient's observing ego that which had been split off and denied, the patient often responds with anger at the loss of a mechanism which he had regarded as ego-syntonic. (pp. 100–1)

Confrontation is a strong technique and capable of destructive as well as constructive uses. Perls uses it, as does Berne; and even Rogers uses confrontation in respectively abrasive, analytic and gently loving ways with different patients depending on what their therapeutic needs are in terms of the transference at different stages of the relationship. According to Masterson again: 'it is not without its own dangers. The therapist must be able to be 'really there', empathic and 'tuned in' to the patient's feeling state in order for the confrontation to work. The confrontation must be faithfully wedded to the content of the patient's associations and the patient's feeling state' (1976, p. 101).

Empathy

Whereas interpretation of the transference has been the primary tool of psychoanalysis and psychoanalytically orientated therapy, there has been a comparatively recent awareness of the function and role of empathy in analytic practice. Of course empathy has been well established as a therapeutic modality since the beginning of the century at least in the work of Moreno (1946) and other precursors of the humanistic and existentialist movements in psychotherapy. The *Shorter Oxford Dictionary* defines empathy as: 'The power of projecting one's personality into, and so fully understanding the object of contemplation'.

Empathy within the psychoanalytic tradition now often seems to be associated with the work of the self psychologists, and has spread to some other sections of the psychoanalytic community. Empathy is the broader word but a review of the literature will reveal approximate synonyms, chief of which are empathic attunement (Stern, 1985; Rowe and MacIsaac, 1989) resonance (Weiss, 1950) and communicative matching (Masterson, 1985). Empathy is now a primary tool in analysis and is usually associated with the work of Kohut. It is regrettable that Kohut appears completely to ignore the enormous influence which Rogers brought to bear on the clinical uses of empathy, as well as his theoretical precedence. By 1951 Rogers had already written extensively about the use of empathy in psychotherapy, whereas Kohut's first publication on this topic appears to be 1959. In fact the first written usage of the word empathy as a therapeutic operation would appear to occur in the work of Jaspers – an existential psychoanalyst.

> Empathic understanding ... always leads directly into the psychic connection itself. Rational understanding is merely an aid to psychology, empathic understanding brings us to psychology itself. (1963, p.117)

This section is not intended to be a comprehensive review of the notion of empathy. I have however begun to address this theme here in this section (although it is discussed more fully later) because of its increasing acknowledgement in psychoanalytic work which focuses on the transference and particularly the countertransference. Kohut (in Elson, 1987) conceptualises it as a temporary regression of the analyst 'insofar as he merges, tentatively, into the other person in order to understand him' (p. 218).

I think it is an arguable issue whether empathy or affective attunement is not primarily a reparative operation rather than particularly indicated in the resolution of the transference or – more usually – considered as characteristic of the person-to-person interaction. (Of course, all these overlap and interpenetrate in the real situations.) For example, Masterson writes about communicative matching that 'the patients experienced these interventions as an acknowledgement and refueling of their real self ... to enable it to overcome its impairment and assume its capacities' (1985, p. 59). He also says, 'Communicative matching ... is an art, a matter of delicacy of fit and timing ... when combined with other therapeutic techniques... it provides the necessary added dimension to create the conditions for an optimum repair of the impaired real self' (p. 8). He thus here uses it with *reparative* intent.

A variety of terms are used to refer to the notion of *'einfühlen'* – to feel into another person's subjective world of emotions, images or fantasies. It is essentially different from interpretation in that there is a willingness to be affected by the client and a deliberate attempt to enter into the frame of reference of the patient, not from a position of superior knowledge, but from a position of open engagement.

Minkowski (1970) used the term *syntony* to express the vital contact with reality which is characterised by sympathy in terms of our relations with other human beings – a form of phenomenological projecting. Such 'visceral empathy' (Clarkson, 1994a) has been well documented by writers from other fields such as Watson (1973, 1984), who describes how plants will shrink from human hands that have recently been engaged in activities that are hurtful to other plants; for example, cutting the lawn.

> On my first visit to his office, Backster demonstrated this possibility very vividly by scraping a few living cells from the inside of his cheek and killing them in a glass dish by the addition of a drop of dilute sulphuric acid. At the moment of their death, Backster's favourite philodendron reacted with what, in a human subject, would be described as mild alarm. I repeated this test later with a potted plant and a blood sample of my own and found that I got a

> good response, but that the results were even more satisfying when I worked with a specimen of semen. Live sperm are perhaps the only part of a human body specifically designed to lead an independent existence outside the body, and might therefore be more likely to be put in a signal situation than cells from the inside of my cheek. Sperm seem to be more easily and more strongly alarmed, altogether more responsive than mundane red blood cells. And, quite apart from anything else, they are a lot more fun to collect. (Watson, 1986, pp. 40–1)

Understanding and empathy (or interpretation and support) need to go hand in hand. For example, Detrick appears to be under the impression that Kohut introduced the:

> concept of the basic therapeutic unit (understanding and explaining), [which] certainly implies that although it is essential for the patient to feel the analyst has grasped his experience, the analyst is under no obligation to agree with it or affirm its essential logic. (1989, p. 458)

However, as we saw earlier, these two therapeutic operations were in fact first identified and paired already in 1913 by Karl Jaspers (1963). In this, as in his apparent refusal to acknowledge the role of Carl Rogers, Kohut singularly seems to be building a system from within his own universe.

Is empathy reparative, used for understanding the patient or is it person-to-person sharing?

It seems important to differentiate, at least theoretically even if it may not always be possible practically, between uses of empathy or empathy-like interventions. When the empathic interventions are primarily made in order for the patient to use them in a replenishing way (Masterson, 1985) or in order to re-activate the natural developmental tendency (Kohut, 1971) it seems most clearly to relate, not to an understanding of the transference, but to an attempt to lay down 'self structures' or provide supplies, mirroring and other previously deficient experiences for the patient. **In these cases empathy may be used reparatively or in terms of what was developmentally-needed, eg. the self-object transferences which are calibrated to different developmental periods in a patient's life, as Wolf for example set it out in 1988. As I will show later, I think this is the primary operation of empathy in the person-centred approaches as exemplified by Rogers. For most human beings who have had deficiency experiences in terms of being listened to and understood for most of their childhood (and adult) lives, the therapeutic effect of the provision of these experiences must be due to reparation of some kind.**

Another function of empathy can be when a therapist shares with their client similar experiences, images or metaphors and this can act as

a bridge to the real relationship or the person-to-person relationship. I will return to this theme in Chapter 5. **The sense in which empathy seems to be most frequently used in dealing with the transference is that of pairing rational understanding (interpretation) with empathic understanding (emotional resonance). It can be said that it is supposed to support the client and build the working alliance in order to shore up the psyche in dealing with the working through of the transference.** For example, 'I can feel how distressed you are when you want to know more about my personal life and I refuse to discuss this with you. It is important for you to fully experience your reaction to this exclusion since this is so similar to the way in which your parents excluded you from their vital lives'.

The other major way in which empathy is used and understood is in terms of the countertransference. According to Tansey and Burke (1989) 'when empathy occurs, projective identification is always involved'. They continue, 'Empathy is the outcome of a radically, mutual interactive process between patient and therapist in which the therapist receives and processes projective identifications from the patient.' (p. 195).

> The power of understanding has been featured to account for the phenomenon called 'transference'. That use should not hide the point that it is this very power of understanding (not the transference, transference-love, or love itself) that heals. Understanding makes for healing and growth; misunderstanding makes for injury and destruction.... Understanding heals. It also makes one feel loved, or sustains love already felt, but the healing power is in the understanding. (Levant and Shlien, 1984, pp. 177–8)

Countertransference

Simply, countertransference usually means the therapist's feelings towards the client. **Countertransference is nowadays divided between what the psychotherapist brings – what can be termed proactive countertransference (really pathological psychotherapist transference on to the client) – and that to which the psychotherapist reacts in the patient often termed reactive or inductive countertransference. This differentiation separates two major kinds of countertransference depending on whether the psychotherapist is reacting to a patient or proactively introducing his or her own transference into the psychotherapeutic relationship.**

What Winnicott (1975a) called 'objective countertransference' (p.195) is here referred to here as *reactive countertransference* to emphasise that the psychotherapist is reacting accurately or objectively to the patient's projections, personality and behaviour in the

psychotherapeutic relationship. Winnicott's (1975a) 'abnormal countertransference' (p.195) is referred to here as *proactive countertransference* (psychotherapist transference) to emphasise the potential pitfalls that may result from the intrusion of the psychotherapist's unresolved conflicts into the psychotherapeutic relationship. As Novellino (1984) pointed out, the efficacy of this exploration depends on the ability of psychotherapists to separate their own personal material from their reactions to the patient's issues. **It will of course also be affected by the psychotherapist's ability and skill in separating out cultural and contextual issues such as the inevitable countertransferential conditioning which affects all therapeutic work with people who are different from us or defined as particularly different in a negative way by our societal expectations, rewards and narratives.**

Although the terms complementary and concordant are used by Freud (1920) and Racker (1982) to describe forms of countertransference rather than transference, they are used here to describe several other kinds of transferential phenomena. I also introduce in this context Lewin's (1963) terms *proactive* and *reactive* to designate whether the subject of the discussion originates the stimulus (proacts) or responds to (reacts) to a stimulus from the other. It is vital to remember that transference and countertransference phenomena are carried across not only in a verbal content but also in non-verbal ways through body language, smells, or atmospheric and contextual cues. Because the psychotherapeutic space is designed for the patient's interests and not the therapist's, the psychotherapist's proactive countertransference is usually viewed as detracting from the primary task.

'Counter-transference is here being defined as a non-pathological capacity of the analyst's affectivity, intelligence, and imagination to comprehend the total reality of the patient' (Khan, 1974, p. 206). Racker (1982) further distinguishes between 'complementary' and 'concordant' countertransference. In the former the patient projects aspects of his historical self on to the therapist so that the therapist is invited or induced to enact the role of the child in the past and the patient enacts the role of the significant parental other. The reverse can happen when the patient projects the parent role on to the therapist and then re-enacts the child role.

Reactive countertransference

Reactive countertransference describes those responses of the psychotherapist which are elicited by or induced in the psychoanalyst by the patient, and which specifically resembles the intrapsychic object relations patterns of the patient's historical or fantasised past. The psychotherapist may experience feelings, emotions, fantasies or behaviours which are evoked through processes

such as projective identification. Then the therapist finds himself or herself responding to the patient in a way which is not necessarily a version of the psychoanalyst's own personal issues. In this way it describes primarily a therapist's response elicited and in answer to the patient's expressed or unconscious needs.

> Countertransferences evoked by the patient's demands for self-object experiences are another subcategory of the countertransferences. Some therapists find their patient's insistent demands for a mirroring self-object experience intolerable, usually because it makes them feel impotent. Some therapists experience their patient's idealization of them as excessively stimulating to their own grandiose fantasies and either bear up with the discomfort or attempt to relieve their internal tension by some self-deprecatory comment. Many patients will feel painfully deprived of their need to have a self-object experience with an idealised other, and such self-depreciation on the part of the therapist is both antitherapeutic and anti-analytic. (Wolf, 1988, p. 144)

As explained earlier, reactive countertransference can be complementary or concordant.

- In a *complementary reactive countertransference* the therapist experiences the complementary response or the emotional, cognitive and behavioural responses which would complete or be complementary to the real or fantasised projection of the patient's historical past selves, ego states or historical epochs or the partners – the caretaker's or parent's regressive states.
- *Concordant reactive countertransference* seeks identification, confluence in gestalt, empathy, fellow feeling, resonance or empathic attunement or its variants in the others. This is the kind of reactive countertransference which is not necessarily based on the incompletions and developmentally distorting vicissitudes of the psychotherapist's life, but on what the patient is attempting to elicit – an Aeolian harp response – a literal emotional attunement to an affective or feeling state which is problematical or painful to the client. It is when we as therapists 'find' ourselves almost overwhelmed by feelings which are not felt as our own – perhaps the kind of urge to compulsive eating or bingeing which suddenly (usually temporarily) strikes many workers in hospital departments dealing with eating disorders until they understand, usually through their own therapy or supervision, the source, meaning and evocational purpose of their own experiences in terms of the clients who have turned to them for help and true understanding.

Proactive countertransference

Proactive countertransference is the term here reserved for those issues, feelings, atmospheres, dreams, fantasies, projections,

fears and desires introduced into the psychotherapy or the psychoanalysis by the psychotherapist himself or herself. 'Countertransferences proper manifested by the therapist are mainly based on the analyst's residual archaic self-object needs. By this I do not mean the normally expectable life-long needs for a modicum of mirroring, idealising, and other self-object experiences'. (Wolf, 1988, p. 144) Proactive countertransference can be complementary or concordant in the same way as all the other forms of transference or countertransference.

- *Complementary proactive countertransference* occurs when the psychotherapist complements the client's real or fantasised projection as the caretaker or child of the psychotherapist's own past. In other words the psychotherapist reacts to the client on the basis not of the client's reality, but on the therapist's own past which they are projecting on to the client.
- *Concordant proactive countertransference* occurs when the therapist imagines they are attending to the client's experience, but in fact they are replicating their own past. It is a kind of identification, but a false one drawing from the therapist's own unresolved issues.

Proactive countertransference responses can of course also be destructive or facilitative depending on whether the psychoanalyst or psychologist identifies with the projected identification or complies with the projective identification or induction to respond in a particular way.

Further Management and Use of Countertransference Phenomena

It is essential that the clinician be able to separate out proactive from reactive countertransference within this paradigm. Then it becomes possible and effective to use reactive countertransference as information about the expected or anticipated patterns of the patient, rather than confuse it with organismic data about the psychotherapist's own life or feelings or their own historical needs and expectations.

One hopes that psychotherapists will have resolved most of the major ways in which their own pathology or unresolved archaic experiences might interfere with their work with patients. However, since few of us fully resolve all of our personal issues completely and permanently, it is important that we at least understand ourselves enough to be able to identify and counteract our own pathological patterns, especially countertransferential responses based on unresolved issues from our own

past. More importantly, it is vital to know when and from whom we should seek help, confrontation, challenge or support at different stages and for different existential challenges in our personal and professional lives.

Of course, trainee and experienced clinicians ask, 'How do I know if it is my issue, the client's issue or the supervisee's issue?' A good rule of thumb is to begin by assuming that what is hindering progress or understanding is the practitioner's responsibility. This is most useful, because maximum change can perhaps be brought about in the part of the system for which therapists are 100% responsible – that is, in themselves.

It is certainly more pragmatic to place the emphasis on those areas where it is possible to achieve the maximum leverage or most efficient resolution. For this a figure–ground gestalt model may be useful. When the psychotherapist is actively engaging in the psychotherapeutic relationship with the patient, he or she can assume that most of the dynamics are contributed by the patient, and develop interventions from such a frame of reference. In other words, **at the moment of psychotherapeutic engagement in the relationship, it may be most useful to consider that patient transference and the psychotherapist reactive countertransference are most likely to provide the richest and most accurate options for intervention.**

On the other hand, the field most available for intervention is that of the psychotherapist when they are in supervision – even self-supervision. **Therefore, it may be most fruitful to consider hypothetically that most of the phenomena in the field are being caused by the therapist's proactive transference and the patient's reactive countertransference.** Let us then assume that the therapist's unresolved conflicts, confusions and deficits are causative in the therapy. Of course, it cannot be proven that either of these positions is accurate, or even likely. Clinical supervisory evidence, however, bears out that frequent alterations between these two viewpoints, with the emphasis on where the smallest intervention is likely to lead to the largest degree of shift in the problem, are exceptionally useful and effective for both the patient and psychotherapist.

Failures or Opportunities for Breakthrough

Absence of transference relationship?

Leaving aside such epistemological concerns, some patients appear not to develop a recognisable transference relationship. This may be because there is none, or because they are 'resisting' due to an inability or an unwillingness to engage with these aspects of the therapeutic process. It may also be a purely and determinedly defensive stance,

particularly with patients who have become 'couch smart'. This colloquial term refers to those patients who have either studied or read a lot about their psychotherapist's approach and who, often for narcissistic reasons, try to remain 'above' the 'textbook' reactions which apply to the ordinary and/or phobic patient population. Whether 'defensiveness' or resistance is ideological, endemic or iatrogenic I will leave for another discussion.

> The idea of a therapist as an architect of change can be abandoned without any trauma if we also abandon the correlated idea of a client resisting change. (McNamee and Gergen, 1992, p. 48)

It is possible there may not be the need to engage in a projected transference relationship because the patient sees the psychotherapist clearly as someone who is there to help, and they can use them purely and simply in this particular way. I believe this is indeed possible in some forms of short-term psychotherapy, in cognitive behavioural therapy or with specific contracts while a mild benign transference may operate with no harm and an important beneficial result – the kind of warmth which is potentially transferred to teachers and doctors who have been helpful. It may be possible in many other situations.

As I pointed out before, Freud separated out the analysable transference from this general positive expectation. We call this positive transference. We could call it an authentic recognition of the reality of someone's genuine and healthy helping intentions and effect. The presence of this kind of warmth or acceptance is apparently necessary for most successful human relationships. It is a question of whether it should be defined as transference since it may not be based on earlier positive experiences transferred from people in the past on to the present person (without evidence that such feelings or conclusions are genuine warmth and acceptance are warranted). It can perhaps also be described as a realistic or probabilistic expectation based on knowledge of the reliability of the person's own judgement and intuition. If someone consults a psychotherapist or psychologist, he or she expects the psychotherapist will be competent and helpful if they are properly qualified or well recommended. Pleasant or loving feelings towards someone who is helping you are not inappropriate, and I do not think they should be pathologised at the risk of stripping the fabric of humanity from healing. Klein (1984) indeed saw gratitude as the achievement of the mature personality or succesful analysand.

This expectation of help constitutes a reasonable expectation that specially trained professionals will possess and effectively use the skills they claim to have. In many such instances this level of positive expectation may be all that is necessary for the task of therapeutic change. As Jung, Freud and others have pointed out, sometimes it may not be necessary to enter a transferential relationship. This may be because the

person did not have a particular difficulty with a parent in the past, or because they had already transferentially resolved the tendency to project in other prior relationships, or the issues are of a different order. Difficulties in life may not necessarily derive from childhood experiences.

'Resistance' to transference

There are patients or clients who may not appear to enter the transference because they are unable or unwilling to engage. They may avoid doing so through the use of defence mechanisms, for example intellectualising or rationalising. An example is a patient in group psychotherapy who comments in a throw-away manner, 'Of course I should be anxious because the summer vacation is coming and I am supposed to miss you, but I don't!'. This could be resistance to the development of an abandonment transference which is then even more defended against because it is so thoroughly denied or repressed out of awareness. The psychotherapist may choose to confront such a rationalisation of denial (among many possibilities). The clinician could invite the patient to slow down and allow sensation and feelings, to breathe and re-own the emotion, and thus relive the earlier trauma of desertion. (This can happen through regression, hypnosis, or spontaneous reactivation of an earlier ego or self states.) In this way the person can re-experience the physical, emotional, cognitive and symbolic reality which is theirs in the relationship with the helpful 'other'.

For some analysts (e.g. Langs, 1976) any break of the therapeutic rule of abstinence (frustration of the patient's wish to be gratified by answering a question, for example) is considered destructive and a modification of 'the frame'.

> We could now even add that such self-revealing responses convey unconscious fantasies within the therapist, which would then complicate the interaction, the relationship, and the therapeutic outcome. They also reflect difficulties in the therapist's capacity to manage his own inner state. (p. 89).

Others (such as Symington from the Tavistock, 1986) would be more active, as judged appropriate: 'Transference is such a powerful emotional phenomenon that I do not think some acknowledgement of personal attitudes interferes with its operation' (p. 328).

Some examples of transference-inviting questions are: 'How do you feel as you say that to me?' 'How do you feel about me?' 'What do you think when I say that?' 'How am I like your mother?' 'What do you imagine I might do next? I imagine you think I will reject you? Tell me.' Facilitating the transference can be done passively (by being a mirror) or actively (by displaying emotion or behaviour similar to that which the patient is projecting, e.g. like a supervisee being late for an appointment with a patient who fears abandonment, and saying 'This is what you

were afraid would happen, and now it has happened'). Sometimes there is so little reality testing available that almost whatever the psychotherapist does, says, or is (or is not), is used by the patient to confirm his or her projections. 'You're not saying anything because you think I am useless and worthless' or 'You're just saying that so that you don't have to admit that you think I am useless or worthless.'

Another kind of resistance to the transference is displayed by people who have developed a more schizoid or autistic adaptation. Of course for such people it is technically transferential *not* to have a genuine interpersonal relationship, since this is probably what happened to them as children. People did not relate to them in ways which were beneficial to their growth, or sometimes did not relate to them at all. Parents may have been over-invasive, neglectful, or abusive of them or their siblings. They are, perhaps, transferring a fear that the psychotherapist may be as invasive or abusive as the original parent, and their withdrawal is part of the transferential relationship. However, it is sometimes necessary and humane to enter into the relationship and to risk approbation or fear in order to make the beginnings of a human, person-to-person relationship. Such patients can then begin to learn when and how to trust and how to protect themselves appropriately without cutting off from nourishing human contact.

> In analytic practice, our conceptions of change and of limitation affect the way we interpret a patient's approach to termination and to individuation as it arises throughout the course of treatment. In the psychoanalytic theory of technique, more emphasis is usually placed on the gathering of the transference than upon its dissolution. For much of the analysis, the patient may try to avoid the transference, since it re-evokes painful relationships, particularly the close relationship between two people. Transference works two ways to create a self-enclosed system: the analyst interpreting within the context of the transference will see himself as the representative of outside figures who are also used by the patient to represent the analyst. However, if treatment has proved helpful, the patient may begin to wonder how he will leave the analysis. What happens when the patient tries to place the analyst 'outside the area of omnipotent control' – that is, outside the transference of outside or past figures? I suggest that we label the class of interactions engaged in at this stage as 'the differentiating transferences'. (Hamilton, 1982, p. 284)

Of course, there are views, including mine, which hold that 'resistance' is but feedback on therapist-error! Jung (1935) insists: 'A transference is always a hindrance; it is never an advantage. You care in spite of the transference, not because of it' (p. 151).

Accidental interruption

No matter how careful one can be about preserving the 'frame of the psychoanalysis', surprisingly often the events and vicissitudes of life can

interrupt a transference relationship and bring in aspects of any of the others. Examples of interruptions that have interfered with the transference can be the publication of a book, meeting someone in a restaurant, becoming pregnant, appearing on television, moving consulting rooms or house. There is a dearth of well-established ways of thinking about or dealing with these kinds of events in our profession. Elsewhere (in the counterpoint of Chapter 8) I discuss examples and issues of this category at greater length.

Little (1986) – one of the first analysts to use reactive countertransference interpretations – describes a time when a patient accidentally met her at a concert.

> One day we had met by chance at a concert, and she found me afterwards in the musicians' room, to her great surprise. 'I didn't know you knew X' she said excitedly, and the next day discovered that she had meant 'What right have you to be here?'. From there it became possible to show her (as I had often tried to do) how she had been trying magically to control me and to have me with her everywhere. Much of her concert going had been to go with me, and finding me there in reality had disturbed her fantasy. (p. 71)

Position in an organisation and fame inside and outside the profession can seriously interrupt and influence, in unpredictable ways, the transference experienced in the consulting room. Such 'third party' transferences are under-researched, often concealed and often quite complicated to manage. Sometimes an appearance by one's analyst on television is enough to destroy the working alliance and provide grounds for termination of the psychoanalysis!

The negative therapeutic reaction

Failures in the transference/countertransference relationship which lead to destruction of the working alliance can be chronically eroding or acute and dramatic. Sometimes insufficient transference material can be mobilised because the relationship is either too personal or too devoid of evocative meaning for the patient (this is exceptionally rare), or the transference and/or countertransference is so strong or overwhelming that either due to the force itself or to the therapist's lack of experience and skill in management, it cannot be appropriately controlled or utilised. We are specifically here referring to the cases of psychotic transferences which manifest together with breaks in the working alliance, as threats or attempts (sometimes successful) to injure the psychotherapist, his or her children, and his or her property, or where the client may, for example, kill themselves in the belief that the psychotherapist had ordered them to do this. Perhaps the best and most useful book which investigates the causes and management of the negative therapeutic reaction is that of Seinfeld (1990).

The fact that transference is by definition regressive makes it particularly hard in the therapy of patients with borderline and psychotic symptomatology to keep the working alliance intact while developing the maximum scope for the development of transference fantasies and symbolic transferential enactments. Freud said that the neurotic builds castles in the air, but the psychotic lives in them. So, although the transferential nature of psychotic transference may be potentially therapeutic, a problem arises with the extent to which it undermines or destroys the working alliance. When a person believes that you are putting sexual fantasies into their head as a fact or whether they can distinguish the feeling, fear or fantasy that you may do that from the reality of the therapeutic relationship is what differentiates workable transference from unworkable transference. In the previous chapter we looked at the transferential, biological or archetypal phenomenon which I have called the vengeance of the victim. In these cases a psychotic transference can be said to take hold when it is repeatedly not amenable to interpretation, care and reality testing.

> But a neurotic can recognise the analyst as a real person, who for the time being symbolises, or 'stands in' for his parents, either as they actually were, or as he experienced them in his childhood, and he is accessible to verbal interpretation of the transference. Where the transference is delusional there is no such 'stand-in' or 'as-if' quality of 'authenticity', both the idealised parents and their opposites, or rather, the parents deified and diabolised, and also himself (the patient) deified and diabolised, for the analyst is assumed absolutely to be magical. To resolve the transference, the patient has to be enabled to bring together his love and his hate on to one person, to find both good and bad aspects of his analyst, his parents, and himself as human beings, and to know the difference between imaginative and objective reality. (Little, 1986, p. 83)

Kohut from self psychology also writes that **it is important to clarify the transferential aspects of analysis from other reality aspects – particularly if it seems there has been a misunderstanding or perceived failure on the part of the analyst:**

> If a patient tells me how hurt he was because I was a minute late or because I did not respond to his prideful (sic) story of a success, should I tell him that his responses are unrealistic? Should I tell him that his perception of reality is distorted and that he is confusing me with his father or mother? Or should I rather say to him that we are all sensitive to the actions of people around us who have come to be as important to us as our parents were to us long ago and that, in view of his mother's unpredictability and his father's disinterest in him, his perception of the significance of my actions and omissions has been understandably heightened and his reactions to them intensified? Clearly, it is the second response that provides the patient with a more accurate assessment of that aspect of reality with which we deal in psychoanalysis. And to insist that we tell him otherwise – that we should tell him with even the faintest trace of disapproval that he confuses the present and the past, that he mixes us up with his parents, and the like – is as misguided as to insist that our painters should go back to the medieval style and paint distant objects the same size as near ones. (Kohut, 1984, p. 176)

Criteria for Evaluating Effectiveness

It is usually considered that work in the transference /countertransference relationship vector is effective to the extent that there is sufficient replication of the original fantasised patterns in the psychotherapeutic relationship to provide here and now material to explore, justify, and work through the archaic patterns. There also needs to be sufficient investment in the working alliance, as well as curiosity about transference phenomena, to sustain interest and to maintain the investment in pursuing and undoing the meaning of repetitive transference patterns. Although this period in the psychotherapy may be short or extended, and it is therefore difficult to gauge its immediate effectiveness, its long-term effectiveness must be judged by the client's ability to be conscious of their transferential patterns, their ability to use this to increase their self-understanding, their ability to let go of these patterns and to develop alternatives and more satisfying relationships, and their ability to generalise a novel, fresher, and more satisfying precedent future-oriented relationship with all other aspects of their lives including their marriage, primary relationships, primary collegial and authoritative relationships.

In *Psychoanalysis Terminable and Interminable*, Freud (1937) explored the possibility of how an analysis can be said to be completed. He came to the conclusion that:

> Every analyst should periodically – at intervals of five years or so – submit himself to analysis once more, without feeling ashamed of taking this step. This would mean then, that not only the therapeutic analysis of patients but his own analysis would change from a terminable into an interminable task. At this point, however, we must guard against a misconception. I am not intending to assert that analysis is altogether an endless business. Whatever one's theoretical attitude to the question may be, the termination of an analysis is, I think a practical matter. Every experienced analyst will be able to recall a number of cases in which he has bidden his patient a permanent farewell *rebus bene gestis* [Things having gone well]. (pp. 36–7)

In terms of countertransference, the most important criteria for effectiveness are the ability and willingness to learn and to continue to learn how to separate out proactive from reactive countertransference, and to increase skills and opportunities to minimise the distorting effects of proactive countertransference as well as to enhance, refine, and develop skills, awareness, and abilities to utilise reactive countertransference for the benefit of the client in the psychotherapeutic relationship.

The primary avenues for this are personal psychoanalysis and supervision. By experiencing and exploring the parallel process in supervison, a clinician can improve vision, action and reaction. **Parallel process is the interactional field of the psychotherapist/patient**

field replicated in the psychotherapist/supervisor field. Any combination of patient and psychotherapist reactions to each other forms a dynamic field which is manifested in the supervisory relationship and variously referred to as parallel process. Understanding the shape and nature of the parallel process is not only useful when it gets in the way of supervision, but also for prevention, understanding, learning and relief.

I propose that parallel process is a way to describe the pattern of the patient-psychotherapist transference/countertransference relationship or the interpersonal pattern of the dyadic psychotherapeutic relationship.

Thus the categories and types previously discussed (Clarkson, 1991c, f) can be seen as the raw material for identifying parallel processes in terms of the interdependent field between patient and psychotherapist. Each category makes either the *patient* or the *psychotherapist* the focus of attention in order to facilitate exploration, understanding and intervention at a particular moment in the psychotherapeutic/supervisory process. However, it must be clear that such division is intrinsically arbitrary and never 'correct' or 'provable'. Patient and psychotherapist processes often interact out of awareness (unconsciously) in ways which may be mutually or differentially influencing each other 'hypnotically' (Conway and Clarkson, 1987).

It seems more accurately representative of the complexity of the patient/psychotherapist field to represent the different forces in it in a circular dynamic relationship to one another. As we know from physics, the idea that the observer can remain neutral and not influence the observational field is quite disproved (Herbert, 1985). Similarly, it seems obvious that we cannot unequivocally lay the responsibility on the patient for transferring 'on to the psychotherapist', *as if* that particular transference could happen with any psychotherapist. Equally it appears clinically correct that, for many therapists, patients present problems *as if* they are acutely aware of the vulnerable areas or developmental tasks of the psychotherapist, and sometimes they seem to work in some strange kind of tandem.

Often, as the trainee becomes more in touch with their negative transference in therapy, so the trainee's patients become more willing to express anger and disappointment to the trainee. To seek *first causes* in such a complex, dynamically interactive situation seems to be futile. It is more fruitful to recognise the co-occurrence of such phenomena and their prevalence in many clinical and teaching situations. This kind of phenomenon of simultaneity also occurs on large scales. Historical research reported by Koestler (1989) found a hundred and fifty examples of discoveries or inventions which were made independently by several persons at the same time. Perhaps it may even be beneficial to consider Jung's (1972, p. 36) concept of synchronicity (an acausal connecting principle) so that our models may serve our ends instead of

forcing our experiences to fit our perceptual prejudices or existing cognitive categories.

Because most of these processes are at the same time unconscious (or out of awareness) and extremely complex, it may be useful to think about the parallel process as being a *fractal* of the field, that is, as representing (even though in minute form) the structure of the larger whole (Gleick, 1988). No matter how small the size to which it is reduced, the essential features of the field will remain present and available for inspection. Following these analogies of fractals or even holons, it is possible to subject the dynamic interactional transference/countertransference field to investigation. However, it is important to avoid assigning first causes to either patient or psychotherapist, or trying to prioritise a particular transference reaction before a particular countertransference reaction in a sequence.

It is interesting to consider the possibility that a psychotherapist draws to himself or herself the kind of patients who are most useful for the therapist's development. There is growing and disturbing evidence from modern physics that unidirectional causality is a highly dubious notion in explaining physical (or psychological) events. In fact, it seems increasingly possible that everything is connected with everything else.

Herbert (1985) cites the work of John Bell, a theoretical physicist, as follows:

> Despite physicists' traditional rejection of non-local interactions ... Bell maintains that the world is filled with innumerable non-local influences. Furthermore these unmediated connections are present not only in rare and exotic circumstances, but underlie all the events of everyday life. Non-local connections are ubiquitous because reality itself is non-local. (Herbert, 1985, pp. 214–15).

Some Implications for Psychotherapy and Supervision

In the absence of proof of causality and directionality, it may be more useful and more congruent with the present state of our knowledge to assume that the phenomena of transference and countertransference are interconnected in ways which we do not yet understand. Mutual hypnotic inductions, which I understand as similar to projective identification from either or both the patient and psychotherapist, deserve intensive and long-term research – yet the clinical field is probably one of the very last which will open itself to rigorous scientific analysis, even supposing that we had the tools with which to do the studies.

The concept of *parallel process* is presented along with an analysis of these constituent parts of the interactional field in the psychotherapeu-

tic relationship. It is hypothesised that this interpersonal field is paralleled in the supervision process. It is further suggested that the mechanism for this replication is projective identification, conceived of as mutually interacting hypnotic inductions which occur out of awareness in the form of ulterior transactions. Therefore, because the meaning of a transaction lies in the communicative space between the dialoguing partners, it is postulated that a circular interaction serves as the dynamic field for what is called parallel process.

It is well known that therapists often behave in supervision in the same way the patient behaves in therapy. Thus, if a patient experiences a sense of helplessness and leans on the psychotherapist, the psychotherapist may feel the same helplessness as he or she leans on the supervisor, thus acting out in supervision a transient identification with the patient. This is called *parallel process* in supervision and *parallel process phenomenon* in treatment (Moldawsky in Hess, 1980, p. 131).

Doehrman (in Hess, 1980, p. 132) investigated this parallel process by conducting clinical interviews of patients, psychotherapists, and supervisors over a period of time. She concluded that the usual understanding goes only half the way. Rather, the supervisor stirs the psychotherapist, who then acts out with his or her patients. Thus, parallel process is not reflective alone – it works in both directions. This discovery has just begun to find its way into supervisors' work. It speaks to the complexity of the patient–psychotherapist–supervisor interactions and encourages a certain humility in supervisors.

As discussed in Clarkson (1991c, f), particularly with regard to reactive patient countertransference, patients may be responding to therapists' induced material. In the same way, supervisees may be part of a *projective identification process* initiated by supervisors, outside the conscious awareness of either. Hypnotists are familiar with such phenomena and, as discussed in Conway and Clarkson (1987), there are many situations where hypnotic inductions occur in every day life. Who is hypnotising who becomes a genuine and potentially disturbing question. What is clear is that this complex interactional process occurs in what Langs (1976) called the *bipersonal field*.

From chaos theory (Gleick, 1988) comes the image or metaphor of the fractal which shows self-similarity across scales – i.e. the wholeness of a phenomenon is maintained whether large or small and the size of influence does not relate to the size of the intervention. In other words large results can be obtained from very small and apparently insignificant causes and vice versa. If we take this metaphor into supervision, then the parallel processes as we encounter them there are explicable by nature's mechanisms of preserving wholeness. This works in a similar way to the fact that any one cell of a human body does not encode part of the whole, but the body of the person as a whole could be cloned

from any of its many varied cells. This is an invitation to an understanding of parallel process in psychotherapy and supervision, which is achieved by analysing the constituent parts of the interactional field of the psychotherapeutic relationship.

Finally, it is vital to remember that the story of transference is but one story among many, none of which can lay indisputable claim to knowledge and all of which have been and are being soundly contested:

> That knowledge cannot come from a theory such as transference, which has been a road block and a pointer in the wrong direction for almost a century. That knowledge may not come from any present version of psychotherapy, but rather from more neutral realms of cognitive, social and developmental psychology, to the ultimate benefit of a new theory and practice. (Levant and Shlien, 1984, p. 178)

Summary

Although these are ultimately conceived of as interacting as an inseparable systemic whole, for the sake of discussion **four categories of transferential phenomena have been delineated:**

- what the patient brings to the relationship (proactive transference)
- what the psychotherapist brings (proactive countertransference or psychotherapist transference)
- what the psychotherapist reacts to in the patient (reactive countertransference)
- what the patient reacts to as a result of what the psychotherapist brings (countertransference or reactive transference).

Any of these may form the basis for facilitative or destructive psychotherapeutic outcomes.

Table 3.1 is intended to offer the psychotherapist in training, as well as the experienced clinician and supervisor, one possible map by means of which to understand transference and countertransference in psychotherapy, counselling and the supervision of both. It has proved useful as a way of discriminating between different types of transferential and countertransferential phenomena. It can be used narrowly to only apply to the psychoanalytic situation or in a broad use of the term. I differentiate two categories in terms of transference at this point. Firstly, what the patient brings to the relationship (proactive transference) and secondly what the patient reacts to as a result of what the psychotherapist brings (patient-countertransference or reactive transference). Either of these may be facilitative or destructive to the psychotherapeutic outcome.

All of the figures encapsulate the fractal dynamic, ensoul the stories we spin and play for each other in the psychotherapeutic and supervisory process.

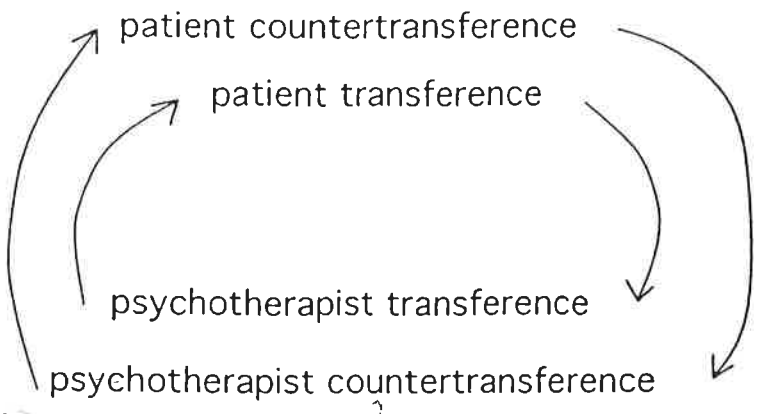

Figure 4.1 Parallel Process I

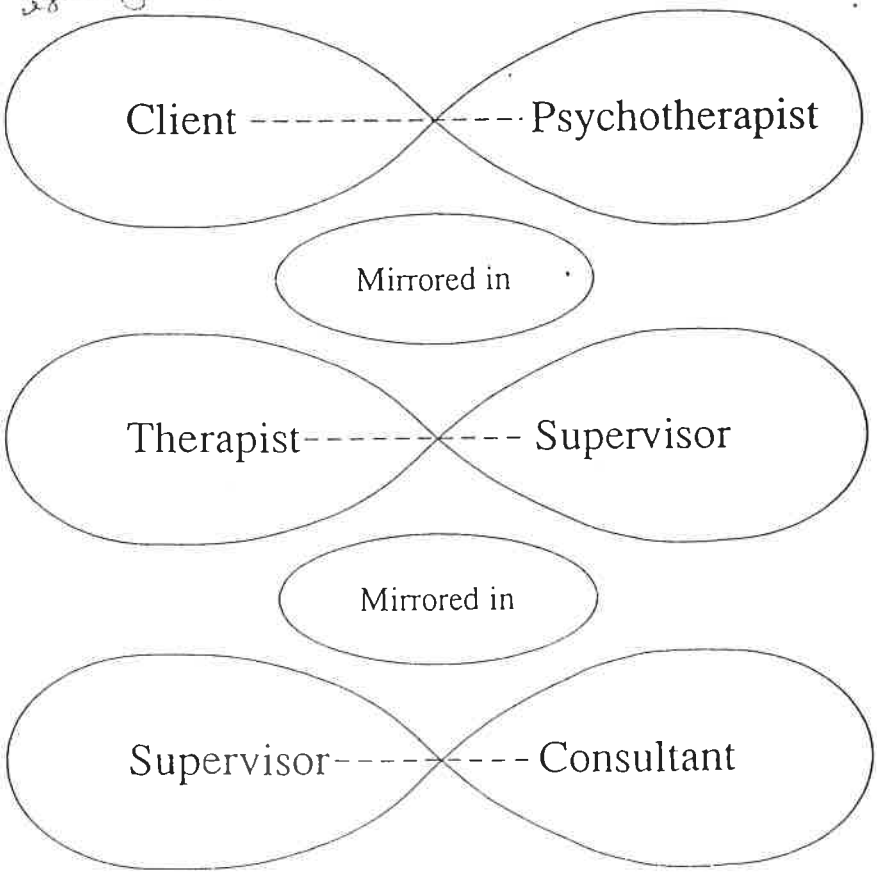

Figure 4.2 Parallel Process II

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Counterp

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This particular aspect of human nature to my mind deserves a great deal more attention than its current sparse and indicative indication in the theory and practice of transference understandings and psychoanalytic interventions. This is the way in which the transference/ countertransference dramas of individuals encode not a particular pathological repetitive function which can only be cured by an analysis which may be interminable, but a particular existential task or pattern which is the last and end result of the person's creative meaning making of the narrative of their lives.

In addition to the ones I have already mentioned in this 'text of texts', I am now thinking of Bly (1990), of May (1991), of Campbell (1976), of Estés (1992), of Bolen (1984), of Brinton Perera (1981), of Harré and Gillett (1994), of Gergen (1988, 1992), of Orbach (1986), of von Franz (1972), of Leonard (1989), of Wolf (1990), of Chambers (1990), of Bannister and Mair (1968), of Lacan (Benvenuto and Kennedy, 1986), of Goodman (1977), of Kelly (1955), of Erickson (Rossi, 1979), not to mention Lewis Carroll, Homer, Scheradzade – who told stories to save her life – and many others in the same service, along with all the other storytellers and poets always and everywhere. 'These approaches work with a part of the human psyche that is surprisingly neglected in many schools of therapy – the form-giving, meaning-making part, the narrator who at every waking moment of our lives spins out its account of who we are and what we are doing and why we are doing it' (Anderson, 1990, p. 137).

Counterpoint

Story as medicine, narrative to sing for the world

There is sex and death and then there are the stories. Eros and Thanatos are mute until the storytellers come and
make it organ tunes, brass bands, theatre, comic books, pornography, symphonies, robots, films, jokes,
advertisements, scientific papers, keynote speeches, love songs, rap, colours, costumes, history,
newspapers, *Dallas, Eastenders*, the *Clothes Show*, Oedipus, Psyche, rice paper origami, Churchill's fingers,
the family photograph album, a pressed flower, a memory told around a fireside on a beach glowing with
regret, a tirade of vendetta's blistering in a southern sun, a stage in a circle burning when the cannons rip the
awnings apart, a poster commemorating a battle, a bullfight, a bash. Until the stories are told, there is only
the thing itself without its history, without its cast, without its incidental

music. Until the vitality of its life is
distilled in the telling the construction of a bridge across a gorge cannot become the bones of a life. Until a
heartbreak is fashioned into pearls of remembrance, there is only the heartbreak.

At the macumba the eyes of Oxala spurt in a mess of chicken, shadows of talons sculpting shadows on a wall,
the smoke of pipes and forests burning, the drums are distant and calling , the dreamland needs us to
keep the world alive, so we keep walking and put the funeral flowers in the snow for the reindeer to eat and
leave a part of a room unpainted for God's perfection. In the quiet rooms, the hidden stony chambers, the
vat of earth in the Cornish soil, the stories are forged from the iron of bitter experience into the lightness of
a dream, a whisper of yesterday, a character long past its time for departure like a train that forgot to leave.

When you were born and when you were little and as these beads are strung into our existence we come alive
again when we went to the hospital and this happened and that and remember when you is my story
and your parents came from and their ancestors were and you can be proud that but we never talk about and
then what happens and what we will do next Christmas is the stuff our lives are made from and deprived of
the chorus, the other, the audience giving us back to ourselves we disappear unheard like the sound of
one tree falling in a wood which is nowhere.

Myriads of stories like the splintering corridors in amethyst, choirs of voices too loving or too still to know,
thundering insidiousness of all the attributions and proscriptions and contritions of a soul which may or may
not be mine, possessed by the ghosts of the past, a ventriloquist's doll draped over a wardrobe, a puppet
of barely flesh shaped by the hiding, the anthem, the sermon, the furniture and the food carving the very
crenelations of being and becoming and who am I if I am not their stories and they mine?

The how of the telling has more eternity than the what. The wine-dark sea or the woods of Dunsinane. The
keening against the silhouettes of mosques in torture or the work songs

bled out in painblinded endurance
and diamondbright brilliant exuberance in a field of cocoa, or tea or innocent sunpolished poppies. There
was a man who thought the whole world could be put in one part of one story – the middle part – and that
was a life. He told the story well and many believed him, but many did not.

There are legends and pictures of potato eaters and the scars of a famine streaked across the collective psyche
of a lyrical nation greened in suffering and song, there are children's pictures of flowers and butterflies
blooming from the lands and times of the killing ovens – they made music and the others lampshades from
their skins – and their light shines daily in the numbering and the roll call, the promise and the covenant, the
beckoning of justice and the burgeoning of pity and mercy and a certain granite-faced compassion.

And unicorns and snakes with feet and birds that waddled towards their end lovingly trussed in downy clouds,
and birdsnakes and houses on chickenfeet with dark horseriders breaking the dawn while the embers
brightened what little girls should know and when not to ask about what and how to fall asleep when your
sister is reading a book without pictures or conversations or your father's sacrifice to the winds for an easy
sea and a prosperous voyage with the Trojan whore.

To have authority is to write your own story and help them to live their own their way with their beat and their feet and the twistings of meanings and her-stories into the plaits of time and the resonances of cathedral bells and a whistling in the dark shrouded in fear and disgust, and what if they draw from the dreams of early times or far worlds or the whimpering sirens of war, without Physis suffering is just suffering and pain is just pain.