TRANSFERENCE AND COUNTERTRANSFERENCE IN THE HERE-AND-NOW THERAPIES

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ABSTRACT: The various experiential, body-based, and other here-and-now therapies have been criticized for their insensitivity and naive handling of the dynamics related to transference and countertransference. How can approaches that emphasize the here-and-now recognize and work with larger patterns that only reveal themselves over time? This paper offers an overview to assist therapists who do not have classical training in attending to transference and countertransference phenomena. Moreover, it proposes that the here-and-now therapies, such as Hakomi, have specific advantages over psychoanalytically-oriented approaches for confirming or disconfirming observations regarding transference and for anchoring insights about transference phenomena not only into the client’s conscious awareness but also into the client’s perceptual framework and behavioral response set.

I vividly recall the first time I came to a gut-level appreciation of the way transference and countertransference operate. As a graduate student, I was being observed by my fellow trainees through a one-way mirror as I conducted an opening session with a man whom the intake team had described as belligerent and uncooperative. I charmed him. I showed so much empathy for his predicaments, so smoothly distanced myself from the counseling center’s administration policies, with which he was furious, and so sympathetically restated his frustrations, that his anger melted. After the session, I strutted back to the supervision group in the observing area, beaming with pride at my performance, particularly pleased about having outshone the infinitely more experienced intake team in enlisting this patient’s cooperation.

The supervising psychologist made mincemeat of my hubris. On the patient’s side, I was informed, it was a therapeutic blunder to smooth over difficult aspects of his interpersonal style rather than allow him to project onto the therapeutic arena his dysfunctional modes of perceiving and behaving (transference) so he might eventually come to recognize, understand, and consider modifying them. On my side, my need to dodge the patient’s hostility and have him see me as a nice guy also sparked memorable discussion, and my fear of having someone think badly of me was glaringly underscored. I came to recognize that these unacknowledged needs and fears had shaped the session far more than any therapeutic considerations. That was countertransference.

In transference and countertransference, the past lives on as a symbolic representation which unconsciously displaces one’s direct experience of the present. A present experience is overlaid with a constellation of assumptions and emotions rooted in the past. As Freud
once commented, “The patient does not say that
he remembers that he used to be defiant and
critical to his parents’ authority; instead he
behaves in that way to the doctor.” While
experiences from one’s past are at the core of
transference, the process is of course more com-
plex than a simple mirror reflection of the past
into the present. The memories and images are
shaped by various intrapsychic forces, such as
unresolved conflict or loss, as well as situational
factors, such as the therapist’s interpersonal style
of even pitch of voice.

Sheldon Roth, a psychoanalyst, uses the
well-known experiment where animals are
deprived of necessary vitamins as an analogy for
describing the manner by which transference
operates: “These vitamin-starved animals, when
offered an array of foods, gravitated toward those
that alleviated their deficiency. In an analogous
sense, what the patient primarily seeks in the
transference relationship will be those frustrated
elements of past life that have continued
unfulfilled into the present.”

To one degree or another, transference
and countertransference occur reciprocally, and
incessantly, in all relationships. A distinguishing
characteristic of the therapeutic relationship is that
transference and countertransference can be
brought into mindfulness and used as primary
sources of information rather than reflexively
accepted as irrevocable facts of the interpersonal
underworld.

The various here-and-now therapies have
been criticized for their insensitivity and naive
handling of the dynamics related to transference
and countertransference. If you stay in the mo-
ment, how do you recognize larger patterns that
only reveal themselves over time? Ironically, one
of the primary ways the more analytical therapies
enter the realm of the here-and-now is by attend-
ing to transference and countertransference. By
examining how the therapy is, moment by mo-
ment, recreating key themes in the client’s life,
themes that are larger than what might be recog-
nized in any given moment are uncovered. Con-
sider the following case, taken from a psychoana-
lytically-oriented introductory text:

A reasonable and rather rational
young woman begins therapy

with a fair degree of optimism,
energy, and enthusiasm despite
the presenting complaint of social
inhibition and occasional depres-
sion. I am at first seen as warm,
straightforward, and receptive, as
well as understanding and em-
pathic. By six months into
treatment the patient becomes
depressed, increasingly experi-
encing me as cold, unavailable,
and not understanding. When I
am verbally active I remind her of
her dictating, authoritarian, and
often violent father; when I
become quieter to combat this
reaction, I then seem like her
schizoid, distant, and apathetic
mother.

There seems to be no stance I can
take and win, and it is exactly this
that I communicate to the woman,
suggesting that this was the plight
she experienced in her home
environment. She is struck by this
empathic suggestion and can see
herself more clearly as she sees
the position she puts me into.

This helps her to understand,
provides a road map to help
structure her transference experi-
ence.

Greg Johanson has pointed out that in
Hakomi work, the curiosity that deepens the
exploration is elicited “when core organizing
beliefs are discovered which provide barriers to
effective, satisfying living.” These core organiz-
ing beliefs, which I refer to as “personal
myths,” are often starkly revealed when
transference occurs in the therapy. The trans-
ference that is acted out toward the therapist often
reflects core organizing principles of the client’s
guiding mythology. The basic strategy in working
through transference issues in psychotherapy
involves facilitating a shift in the client from an
acting out of the transference to becoming mindful
of the transference. James Masterson describes a
case where before this shift had occurred, the client "was angry and attacked me for not being interested in him or taking over the sessions for him. When the therapeutic alliance had been formed and he could see me realistically as his therapist, it became clear to him that those feelings of disappointment and anger in the sessions were not due to me. Once this was established, he could begin to explore the sources of those feelings in his past."

How does one facilitate the shift from an acting out of the transference to bringing about a mindfulness of the transference's role in the person's life? The classical approach involves the use of interpretation, an art whose requirements regarding observation, phrasing, and timing separate the experienced therapist from the unseasoned. Interpretation was once used to mean "making conscious something that was unconscious." But, over time, the use of the term has gained precision. According to Gregory Hamilton, "an interpretation is a comment that indicates that a present feeling, attitude, or behaviour is a repetition of a former one.... When most effective, interpretations delineate parallels between the infantile life, the present-day life, and the transference." He notes that the following interpretation, "You fear I will reject you if you are annoyed with me, just as you feared your mother would send you to your room for disrespectul behaviour" is more complete if the point is also made, "You are similarly afraid that your husband will leave you if you bring up your dissatisfaction with him." Thus, the parallels among the client's early life, the transference as evidenced in the therapeutic relationship, and the client's current life, would all be addressed.

Transference, interpreting it, and "working it through," are at the heart of psychoanalytically-oriented psychotherapy. Problem-solving around the client's immediate life concerns is seen as secondary to the core changes in the personality structure that may result from working through the transference. When the therapist retains, to an extent, the position of a "blank screen," there is little else for clients to do but project their inner world onto the therapy situation, and this transference often becomes thick and palpable. As it fills the room, analyzing it is an art. For the transference to unfold, be analyzed, and reach resolution, time is required.

There is, in fact, usually a rather humbling gap between introducing a pivotal interpretation of the dynamics of the transference and seeing significant change in the client's behaviour. Recall the woman described earlier, where, when the therapist was verbally active, the client responded to him as if he were her violent father, and when the therapist became quieter, the client responded as if he were her schizoid mother. In making the interpretation, the therapist noted that the client was unconsciously but effectively placing the therapist in the same sort of bind that the client was in when growing up. While underscoring that such an interpretation can help the client understand her own behavior, the therapist adds a sobering prognosis: "We must be perfectly clear that many why's and wherefores, for many years, will be necessary before there is a significant diminution of this isolation and depression-producing transference."

In fact, many dimensions of interpreting transference and countertransference are beyond the scope of this brief article. Sensitivity to the client's essential coping style, for instance, would dictate that for people diagnosed as borderline personalities the interpretation of the transference would take the form of confrontations about current behavior with less reference to past material than would be beneficial for people struggling with "normal" neurotic conflict. Similarly, an individual who might be diagnosed as having a narcissistic personality disorder is better helped by interpretations that focus on the person's grandiosity than on what shaped it. Another subtlety of the therapists's skill in interpreting transference involves an understanding of the psychological issues that attend the phase of childhood development being replayed.

An advantage of the here-and-now therapies is that they support a variety of potent techniques for anchoring transference insights not only into the client's conscious awareness, but also into the client's perceptual framework and behavioral response set. By working directly with systems that are usually outside of conscious awareness, such as underlying imagery and subtle bodily reactions to emotionally meaningful material, the client is able to more rapidly and more deeply integrate the insights that emerge.
from successful analysis of the transference. Among the experiential techniques that might be particularly useful in deriving and utilizing insights about the transference are: psychodramatic reenactments of childhood experiences which may have been prototypes of the transference; Gestalt dialogues that allow transference phenomena that were observed in the therapy to be experientially explored in the context of other relationships and/or formative experiences; imagery work with transference phenomena; Hakomi "probes"; working with client’s "subpersonalities"; Gendlin’s approach of focusing on “felt sensations”; the experiencing of “psychomotor structures”; and bioenergetics analysis of the psychodynamic functions of posture and body armorung. In any discussion of dissociative methods (age regressions, Gestalt splitting, etc.), it must be noted that when working with clients who have problems with dissociation, such as borderlines and schizophrenics, these techniques, if not completely contraindicated, should at least be used with great caution and sensitivity.

As with psychoanalytically-oriented therapies, all effective therapeutic work with transference begins with careful observation on the part of the therapist, including scrutiny of the therapist’s own gut reactions. A clue that transference may be occurring involves the sudden eruption of emotion, in the client or in the therapist, that seems inappropriate in timing or intensity, to the context in which the feelings arise. The data for formulating an interpretation about the transference, or an intervention to examine it, begins with the therapist’s self-monitoring of personal responses to interactions with the client. This often leads, regardless of the therapist’s orientation, to a hypothesis by the therapist about how what is occurring in the therapy may parallel what occurred in the client’s past or what is occurring in other areas of the client’s present life.

In the here-and-now therapies, there is an opportunity at that point to step out of the therapist-client focus and structure an experience that puts to a test the therapist’s hypothesis that there are parallels between specific behaviors observed during the therapy and the client’s childhood experiences. By psychodramatically recreating a situation from the client’s past, for instance, the therapist’s interpretation regarding the transference may begin to be vividly confirmed or disconfirmed. Notice how in the following vignette, excerpted from a session conducted by Ron Kurtz, a hypothesis is offered about the transference and is immediately confirmed experientially.

T: I notice that you re-word everything I say. I imagine as a child they didn’t let you have your own reality....

C: (Gets immediately emotional.) No, they didn’t. (In an emotional, slightly childlike voice).

T: (Switches to working with the child — a gentle, slow, caring voice.) Well, I can understand why that makes you so sad and angry.

C: (A definite shift to looking like a crushed child.)

T: So, you’re feeling pretty bad, huh. You needed someone to really believe in you, didn’t you.

C: (Nods.)

T: That’s really important, isn’t it?

The client’s characteristic though unconscious way of responding to the therapist is brought into consciousness with the therapist’s comment that links to childhood experiences the client’s need to reword the therapist’s statements. The interpretation is confirmed as the therapist, with considerable finesse, subtly transforms the therapy into an age regression where the client comes to understand the transference with poignant immediacy.

As a therapist begins to unearth the transference, the progression of tasks can be summarized as: observe, hypothesis, confirm, integrate. Observe carefully your reactions to the client and the client’s reactions to you. Be alert for
intense emotional reactions that seem somehow inappropriate, but also for the emotional undertow in even routine interactions, such as how the client greets you, relates to scheduling and fees, and how sessions are concluded. Any small blip on the radar screen of your inner surveillance system is worth noting. Hypothesizing involves thinking associatively (what does this observation remind me of?), analogically (if the client’s way of behaving is a metaphor, what might it symbolize?), and empathically (if the client does to her/himself what s/he is doing to me, what might that signify?). You are also likely to find new hypotheses emerging as you describe a particular session in your case notes or read over what has occurred during a series of sessions. In these first two tasks, the therapist’s role is essentially the same regardless of orientation, but the paths diverge in the manner by which analytically-oriented and experiencially-oriented therapists go about confirming their hypotheses and integrating the insights that are finally established about the transference.

Confirming or disconfirming hypotheses, along with formulating and reformulating them, can be thought of as the detective work that is the operating principle of all insight-oriented psychotherapy. The analytical approaches call for diligent observation as the therapist assiduously crafts a cogent interpretation. Here-and-now therapists can, as discussed above, draw upon lively techniques — such as age regressions, guided fantasies, and role plays — for confirming or disconfirming possible interpretations about the transference. The concept of the “Gestalt experiment” is a prototype for investigating observations of how therapist-client interactions are reflections of the client’s inner life. What is occurring interpersonally is used as a metaphor in structuring an experiment to examine what is occurring intrapsychically. Faced with a client whose martyrdom elicits the therapist’s anger, for instance, the experiment might involve having the client enact a dialogue between a self-punishing aspect of the self and a long-suffering aspect. The quality of expression in the dialogue will readily reveal the degree to which this particular formulation has currency in the client’s psychic economy. The empirical data that can be immediately derived from such structured interventions provides clues that, patiently gathered over time, may reveal subtle relationships among the client’s early life, psychological make-up, and the transference that is unfolding in the therapy setting.

Integration involves the anchoring of insights about the transference into the client’s self-understanding, perceptions, and behaviors. In classical analysis, this begins with introducing an interpretation that has been carefully distilled through the processes of observing, hypothesizing, and confirming. In experiential work, the spontaneous energy of the present moment can be experientially linked to longstanding dysfunctional thought and behavioral patterns, and opportunities can be created to experiment with new modes of action and new ways of interpreting events. The woman who put the therapist in a bind that was parallel to her childhood dilemma of having had an authoritarian father and schizoid mother could be helped to integrate insights about the ongoing role of her early predicament through a probe that causes her to become more mindful of the way she is organizing her relationship with the therapist to replicate her relationship with her parents; a time regression where her adult self visits her childhood self and validates the reality she is experiencing; or developing inner support for a subpersonality that can be called upon to assist her when she suspects this core conflict has been activated. The here-and-now therapies have in the past two decades been overlapping with cognitive-behavioral approaches (role plays are called behavior rehearsals; guided fantasy techniques are utilized in cognitive retraining) in offering increasingly precise methods for engineering such integration.

There is an important caution in using “experiential” techniques to work with transference issues. In a significant sense, the “here and now” way of analyzing the transference in psychoanalytically-oriented therapies — encouraging the transference to build and, face to face, confronting the client with straightforward, timely interpretations — is more direct than a “here and now” therapist’s working with the transference by creating a metaphorical structure to view what is hot and heavy in the room. Sometimes, when the relationship between therapist and client becomes intense and confusing, there is a temptation on the therapist’s part to take control and create, for
instance, a Gestalt enactment rather than to look
the person in the eye and talk about what is going
on. Like anything else, an “experiential” interven-
tion can be used to create distance when the
therapist is uncomfortable.

This brings us directly to the concept of
countertransference. How do you know if your
cue that transference is occurring — such as the
sudden eruption of strong emotions that seem
inappropriate in timing or intensity — is based
upon your projections or the client’s? The
psychodynamic processes are essentially the same
on either side of the coin, but our ability to
maintain an “objectivity” on this single issue is
one of the ways we justify our high fees. Among
the clues that the projections might be on the
therapist’s side are when the therapist is feeling a
distinct sense of helplessness, a need to control the
sessions or direct the client’s life, a fear of aban-
donment by the client, a need for constant rein-
forcement or approval from the client, or a desire
to cross the boundaries of the professional rela-
tionship. It is a rather delicate matter of judgement
and self-knowledge to determine when to bring
these concerns into the therapy relationship
through appropriate self-disclosure and when to
deal with them privately. Many psychoanalysts
see the core issue in training therapists as involv-
ing an understanding of the therapists’s coun-
tertransference issues and how to deal with them.
Again, a thorough discussion is beyond our scope
here, but the issue deserves not only frequent
consultation with your own observing ego but a
continual alert to discuss countertransference
concerns in supervision, therapy, or with a col-
league.

In summary, the “here-and-now” therapist
has access to potent interventions for exploring
transference phenomena, and for experientially
anchoring insights derived from that exploration
into the client’s ways of perceiving and behaving.
Compared to therapists with a psychoanalytically-
oriented background, however, most therapists
whose primary orientation is in the “here-and-
now” mode are not trained to emphasize the
unfolding of transference and countertransference
patterns. One purpose of this paper is to suggest
that holding such a focus is not only advantageous
to therapeutic outcome, but that “here-and-now”
approaches offer distinctive strengths for immedia-
ately confirming or disconfirming observations
about the transference and for utilizing those
observations for rapid therapeutic gain.

Regardless of approach, however, the key
to successfully working with transference and
countertransference issues is to remain alert. Ron
Kurtz tells the story of a worker who every
morning crosses a border checkpoint on his
bicycle.29 A guard, suspecting that the worker is
smuggling something, searches the worker every
time he crosses, but finds nothing. The worker, of
course, is smuggling bicycles. You may not be
able in any single session to reliably identify the
transference — the larger patterns the client is
acting out in the therapy setting — but over time,
as you remain alert for them, those patterns do
begin to reveal themselves. There may be no way
to know, based upon a single encounter at the
border, that the client’s scam is stealing bicycles,
but over time, as you realize that the person is
riding a different bicycle each morning, returning
on foot each evening, and that the local supply of
bicycles is dwindling, your curiosity might be
aroused.

I’ve had some 20 years now to think
about other ways I might have approached the
session described at the beginning of this paper,
which was so embarrassingly scrutinized by my
supervision group. Perhaps, were I more aware of
the transference and countertransference issues, it
might have unfolded something like this:

Client: (Arriving 10 minutes late,
smoking in a building with clearly
posted no-smoking signs, begins
loudly and angrily) I can’t believe
it! After telling those two damn
social workers at that stupid
intake session that I expect to be
seen by a psychiatrist, I get you!
You look like you’re still in
college! My ulcers are a real
physical problem and I want a
real doctor!

Me: Sounds like the evidence is
mounting for you, today and on
your first visit, that you’re not
going to get the treatment you
came here to get?
Client: Damn right! You think you can prevent me from getting more ulcers? Hah!

Me: Let me make a guess about your ulcers. You rush in here ten minutes late, disregarding the smoking regulations, and, although you have no real information about me, yelling at me because you’ve already decided I won’t be able to help you. Now let’s just suppose that there are parallels between the way you treat a professional whose only job is to help you and the way you treat your stomach, an organ that is closely connected with your emotions. If your stomach gets nearly as up-tight and constricted as I felt when you stormed into my office, we may already be finding some keys to preventing future ulcers....

While in the original session my interventions were limited mostly to placating and conciliatory statements, here, in my rendition of “Behind the One-Way Supervision Mirror II,” I am not yielding so much to my countertransference-based desire to be liked. I am responding more from my center. As a result, I am more able to recognize the client’s self-contradictions, and I can risk enough confrontation to get him to begin to examine what he is projecting, transferring, onto the treatment situation. Of course, I realize, we don’t always have two decades to center ourselves and formulate our interventions in tough clinical situations, but it does help to have a part of yourself always on the lookout for transactions between you and the client that have a whiff of smuggled bicycles.

REFERENCE NOTES


7. Roth, p. 32.
8. Roth, p. 22.
16. Roth, p. 22.
25. See, for instance, Chapter 6 of Feinstein & Krippner’s *Personal Mythology*, “Weaving a Renewed Mythology into Daily Life.”