

# 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 administra-

tive 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.<sup>1,2,3,4,5</sup> 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."<sup>6</sup> While experiences from one's past are at the core of transference, the process is of course more complex 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."<sup>7</sup>

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 moment, 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 attending to transference and countertransference. By examining how the therapy is, moment by moment, recreating key themes in the client's life, themes that are larger than what might be recognized in any given moment are uncovered. Consider the following case, taken from a psychoanalytically-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 depression. I am at first seen as warm, straightforward, and receptive, as well as understanding and empathic. By six months into treatment the patient becomes depressed, increasingly experiencing 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 experience.<sup>8</sup>

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."<sup>9</sup> These core organizing beliefs, which I refer to as "personal myths,"<sup>10,11</sup> are often starkly revealed when transference occurs in the therapy. The transference 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.”<sup>12</sup>

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.”<sup>13</sup> 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.”<sup>14</sup> 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 disrespectful 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.”<sup>15</sup> 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 whys and wherefores, for many years, will be necessary before there is a significant diminution of this isolation and depression-producing transference.”<sup>16</sup>

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”;<sup>17</sup> working with client’s “subpersonalities”;<sup>18</sup> Gendlin’s approach of *focusing* on “felt sensations”;<sup>19</sup> the experiencing of “psychomotor structures”;<sup>20</sup> and bioenergetics analysis of the psychodynamic functions of posture and body armoring.<sup>20</sup> 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.<sup>22</sup> 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?<sup>23</sup>

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 experientially-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 pro-

vides 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;<sup>24</sup> 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.<sup>25</sup>

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” intervention 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 clue 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 abandonment by the client, a need for constant reinforcement or approval from the client, or a desire to cross the boundaries of the professional relationship. 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 involving an understanding of the therapists’s countertransference 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 colleague.

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 immedi-

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.<sup>26</sup> 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.

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25. See, for instance, Chapter 6 of Feinstein & Krippner's *Personal Mythology*, "Weaving a Renewed Mythology into Daily Life."
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