TRANSFERENCE AND COUNTERTRANSFERENCE

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As rapport is an overworked word with counselors, so is transference among psychotherapists. Indeed, the indiscriminate use of these terms has led to their being considered to be, to some extent at least, synonymous. In this indiscriminate use of the term, transference is applied to the total relationship between the therapist and client. This total relationship is, however, sometimes referred to as "analytic rapport," to distinguish it from transference.

The varied use of transference is the result of differing opinions, or disagreement, as to what it really is. French (2, p. 73) writes that "there is a good deal of confusion as to what transference really means." Macalpine (32), in a comprehensive discussion, states that "there are no clear-cut definitions and many differences of opinion as to what transference is." She suggests that "transference is not fully understood; if it were, it could be stated simply and clearly."

In this chapter it is our purpose to describe the phenomenon of transference as it has developed in psychoanalysis, and to relate it to certain psychological concepts. Its significance in the client-centered approach to counseling and psychotherapy will then be considered, and a discussion of countertransference will conclude the chapter.

THE NATURE OF TRANSFERENCE

The concept of transference owes its origin to Freud. Freud first became aware of the relationship which he later described as transference when he was using the technique of hypnosis with his patients. A female patient, upon awakening from the hypnotic trance, threw her arms around him (17, pp. 47-48). Freud felt this to be "a false connection" to the person of the analyst. Later he used the term "displacement of affect" to refer to this phenomenon.

Freud defined transference in various, though essentially similar, ways. In one place (18, p. 139) he states that transferences "are new editions or facsimiles of the tendencies and phantasies which are aroused and made conscious during the progress of the analysis, but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment." Later definitions of other psychoanalysts are similar. Nunberg (38) states that "transference may be said to be an attempt of the patient to revive and re-enact, in the analytic situation and in relation to the analyst, situations and phantasies of his childhood." Lagache (29) specifies the situations of childhood as parent-child relationships in his definition: “Transference is generally defined as a repetition in present-day life, and particularly in the relationship to the

analyst, of various emotional attitudes developed during childhood within the family and especially towards the parents." Hoffer (24) offers a somewhat more technical definition: “The term 'transference' refers to the fact that people when entering into any form of object-relationships and using objects around them for instinct gratification and for protection against anxieties (as a defense) *transfer* upon their objects those images which they encountered in the course of previous *infantile* experiences, and experienced with pleasure or learned to avoid (pleasure-pain principle)." Finally, French (2, p. 73) stresses the inappropriateness of the patient's behavior, stating that “by transference we mean an irrational repetition of the stereotyped reaction patterns which have not been adjusted to conform to the present situation."

Transference, then, is not the total relationship between the analyst and the patient. It is only a part of it, that part which is irrational, i.e., not justified by the nature of the objective situation, or the actual behavior or personality of the analyst. The irrational reactions of the patient are repetitions of reactions to earlier figures, especially to parents or parent surrogates, in the patient's life. The repetition is usually “explained” by the concept of the repetition compulsion postulated by Freud to explain behavior not in accordance with the pleasure principle. (Lagache (29), recognizing the lack of explanation in the repetition compulsion, suggests that it is related to the Zeigarnik effect, or the fact that interrupted tasks are better remembered, and taken up again more actively, than completed tasks. Similarly, unresolved infantile conflicts are reopened in the analytic relationship.) Affects and emotions, conflicts, attitudes, wishes, fantasies, and ideas originally directed toward earlier significant figures are displaced onto, or transferred to, the analyst.

While there are some analysts who would prefer a broader definition of transference, most agree with the definition just given. Most would limit transference to the irrational behavior of the patient toward the analyst. But recently there have been a number of analysts who have raised a question about how much of the presumed irrational behavior is actually irrational. It has usually been held that transference reactions are not related to the analytic situation or the analyst's behavior, but arise spontaneously within the patient. Freud (17, p. 76) wrote: "It must not be supposed, however, that transference is created by analysis and does not occur apart from it. Transference is merely uncovered and isolated by analysis." Again, he states (16, p. 382) that ". . . we do not believe that the situation in the cure justifies the genesis of such feelings." Ferenczi, Sandor, Rado, and others of the classical or orthodox analysts accepted this point of view. Alexander (1, p. 46) states that transference behavior occurs "without the analyst's giving any provocation."

The analyst has traditionally been considered as a mirror, a neutral, objective, anonymous figure. In the last few years, however, it has become recognized that this conception of the analyst cannot be maintained. Macalpine (32) was among the first to point this out. She regards the transference as being induced from outside the patient, by the analytic situation and the analyst's behavior. She notes that Freud himself once stated that the analyst “must recognize that the patient's falling in love is induced by the analytic situation," though he never elaborated or followed up this statement.

Macalpine (32) specifies the elements of the analytic situation which create an infantile setting and a threat to the patient to which the patient adapts by regression to an infantile state, which is the transference. These features include: (1) the curtailment of the object world, by the use of the couch, which limits vision, even leads to closing of the eyes, and requires an infantile posture; (2) the constancy of the environment, which fosters fantasy; (3) the fixed routine which is reminiscent of infantile care; (4) the lack of response from the analyst, which is a repetition of infantile situations; (5) the interpretations on an infantile level; (6) the reduction of ego function to a state intermediate between waking and sleeping; (7) the diminished personal responsibility in the analytic sessions; (8) the elements of magic, infantile in nature, in the patient-physician relationship; (9) the liberation of fantasy from conscious control in free association; (10) the authority of the analyst inherent in the situation; (11) the disillusionment of the patient's expectation that he will be dependent on and loved by the analyst, leading to regression; (12) the inability to select and guide thoughts, a facet of infantile frustration; (13) the frustration of every gratification by the analyst, leading to regression; (14) the resulting divorce from the reality principle, and regression to the pleasure principle. These conditions cannot help but produce regression to an infantile state. As Spitz (53) puts it, the patient is forced into the position of a child. Waelder (56) points out that the patient is in the position of a child coming for help, and that by exposing the most intimate aspects of his life he is put "in the position of the child that is nude in the presence of adults" (see also Schmideberg [51]*).*

From this point of view, the transference is the patient's adaptation to a real situation, an adaptation that demands regression to an infantile level. Macalpine (32) thus defines transference as a “person's gradual adaptation by regression to the infantile analytic setting."

Transference, then, is the result of the nature of the analytic situation, and thus can be induced or controlled by the behavior of the analyst. As Greenacre (21) states it, "The [transference] relationship is an artificial one, arranged and maintained for the definite purpose of drawing the neurotic reactions into sharp focus and reflecting them upon the analyst and the analytic situation." Nevertheless, the patient contributes to the development of the transference by a readiness and willingness to adapt to the analytic situation. He comes to the analyst for help, thus placing himself in the hands of the analyst, accepting a dependent position. Moreover, he regresses easily because, presumably, the origins of his conflicts lie back in the infantile experiences.

If the transference is induced, or at least fostered, by the analytic situation, then it would appear that it could be controlled, or even avoided, by the therapist. This is essentially the approach of Alexander and French (2) in their brief psychoanalytic therapy. Transference, in the technical psychoanalytic sense which has been discussed above, is not inevitable in psychotherapy, and may be undesirable in many cases. Alexander and French agree that it is possible for a patient to find permanent relief from symptoms by using the therapeutic relationship in a rational, realistic way. Transference is avoided, or controlled, by decreasing the patient's dependence on the therapist--less frequent interviews is one way which they suggest. Other ways presumably would include dispensing with the couch, having the patient face the therapist, keeping interpretations on a current level, abandoning the technique of free association, etc. One of the techniques of Alexander and French is for the therapist not only to avoid being a blank screen to whom the

patient transfers attitudes and feelings, but to have the therapist take an active role, in which he behaves toward the patient in a way opposite from the way the father, or other authority or traumatic figure, treated him. Presumably, however, such a situation, while it may be psychoanalytic therapy (since it is based on psychoanalytic dynamics or personality theory), is not psychoanalysis (1, p. 161). The main work of psychoanalysis is considered to be the analysis of the transference. Zetzel (62) suggests that in spite of differences of opinion regarding transference, "analysis of the infantile oedipal situation in the setting of a genuine transference neurosis is still considered a primary goal of psychoanalytic procedure. An essential difference between analysis and other methods of therapy depends on whether or not interpretation of transference is an integral feature of technical procedure." Transference, then, while first seen by Freud as constituting a resistance to analysis, was also recognized as an asset in that it brought into therapy the essential, original, and basic conflicts or neurosis. The difficulty of this analysis of the transference accounts for the length of psychoanalysis, and for what have been called interminable or unending analyses (2, 37). Macalpine (32) feels that the resolution of the transference is not understood, and that it actually must resolve itself after analysis.

There are analysts, however, who do not accept the infantile origin of the transference relationship (26, 28, 46, 54), or indeed that all neuroses or emotional disturbances originate in infantile conflicts. Horney (26) is probably the most outspoken advocate of the position that transference is not a reaction to the past, but an expression of the patient's present personality and conflicts. Glover (20) also suggests that "the patient displaces on the analyst all he has ever learned or forgotten throughout his mental development." It appears that Ferenczi and Rank (14) anticipated the position of Horney. They felt that since much of the child's early experience occurs in the preverbal period, it could not be recollected and verbalized. They therefore proposed analysis of the existing transference without the necessity of the recollection and re-experiencing of childhood conflicts, or the so-called lifting of infantile amnesia.

Dependence on the analyst is the result of basic anxiety, according to Horney. Interpretation in terms of infantile patterns, she warns, has three dangers: (1) it contributes to the dependency, since it doesn't touch the underlying anxiety, and thus counteracts the goal of therapy which is independence; (2) the analysis as a whole may become unproductive; and (3) there may be insufficient elaboration of the patient's actual personality structure. The purpose of analysis is the understanding of present personality trends, not of their relationship to childhood. She raises the interesting question if in analysis "love is a feeling which is only transferred from an infantile object to the analyst, is it perhaps true that all love is transference, and if not, how can we distinguish between love which is transferred and love which is not?" (26, p. 162).

Horney recognizes that the patient reacts to the therapist in terms of his own conflicts and needs, his own personality patterns, rather than entirely in terms of the therapist's objective personality and behavior. This, however, is not transference as it is defined by orthodox psychoanalysis. The question which she voices raises an important point--is all transference behavior neurotic, and if not, when is it not? This problem is perhaps related to the confusion between the transference relationship and the transference neurosis. It is difficult to find a distinction between them, but the terms are not always used interchangeably. Some limit the use of transference to the transference neurosis. French gives definitions for both terms, but they

appear to be identical (2, ch.5). Irrational elements in the patient-analyst relationship are termed neurotic, yet the transference is defined as irrational behavior. Macalpine (32) defines the transference neurosis as the adapted, regressed condition, the end point of transference prior to its working through. The question still remains, however, as to whether the transference relationship is entirely an abnormal, neurotic phenomenon.

TRANSFERENCE AND GENERALIZATION

That transference is not limited to the analyst-patient relationship has been recognized by a number of psychoanalysts. The definitions by Lagache (29) and Hoffer (24) implicitly recognize this. Nunberg (38) specifically states that "transference occurs also in other than psychoanalytic therapies," and further states that the transference of infantile experiences into reality and acting them out is not limited to the transference situation, but is "a tendency to establish identity of old and new perceptions." Greenacre (21) similarly suggests that a dependency relationship, and thus transference, will develop in any situation where one person is seeking help from another, trained person. Thompson (54) begins her discussion of transference with the statement: "Transference was not created by psychoanalysis. As long as human beings have had relationships with each other, there have probably been irrational elements in those relationships. These irrational elements have been especially marked in the attitudes toward those upon whom a person is dependent. Therefore, one sees it in all situations where one of the two people is in a position of authority in relation to the other." As French (2, P. 72) reminds us, "all behavior is patterned upon the past, is based upon experience," so that all behavior has past, or unreality, referents as well as present, reality referents.

This suggests a relationship between transference and what has been dealt with under the concept of "transfer of training" in psychology. The similarity in terms, while perhaps purely coincidental in their origins and development, is significant. Transference is behavior which is affected by past experience; it is reacting in a new situation on the basis of habits learned in a previous situation. Even the use of the terms positive and negative to apply to both transference and transfer of training is parallel. In positive transference the patient reacts appropriately to a helping figure, and the relationship is facilitated because of this application of past learning. In negative transference, as in negative transfer of training, the patient reacts inappropriately to the present reality situation using behavior learned in another, differing situation.

All adult behavior is based in part on previous learning. In a new situation, reactions are not entirely random or trial and error in nature, but are chosen from the repertoire of learned behavior and are more or less appropriate to the situation. The individual tends to respond as he has in the past to similar--or better, to similarly perceived--situations. His behavior is appropriate or inappropriate, depending on the similarity of the new situation to past ones, and on the accuracy of perception of the individual. In other words, individuals tend to generalize from previous learning. Transference, then, is a special case of the phenomenon of generalization. Miller (34) has suggested this in an interesting paper.

Now it is true that generalization may be faulty; the perception of the new situation may be false. (This situation will be discussed in the following section.) But it also happens that adequate

generalization may not occur because of the interference of persistently established behavior reactions. Such reactions are the basis for Freud's concept of the repetition compulsion. Failure to generalize from appropriate earlier experiences, or failure to learn to react as the present situation demands, may be due to the persistence of inappropriate responses which have become fixated in the individual's behavior. This is the neurotic paradox described by Mowrer (36), the persistence of "behavior which is at one and the same time self-perpetuating and self-defeating" (36, p. 487), a contradiction of the law of effect or the theory of reinforcement. This is not the place to evaluate resolutions of this paradox, which led Freud to the repetition compulsion. But the work of Maier (33) is suggestive. He found that, when forced to face an insoluble problem, rats developed rigidly fixed patterns. And, as suggested above, and in an earlier chapter (Chap. 7), behavior is determined by the *perception* of the situation, rather than its “real" characteristics. This leads to a consideration of some of the determinants of perception.

TRANSFERENCE, PERCEPTION, AND PROJECTION

The influence of needs upon perception has long been recognized in common sense psychology. Extreme hunger and thirst lead to preoccupation with food and drink, and even to mirages, which are false perceptions. Only recently have psychologists investigated this area, however. Among the earliest studies were those of Sanford (49, 50) and Murphy and his students (30, 42, 52). Since 1947 Bruner (10, 11, 41) has stimulated a great deal of work on this problem, including a symposium published by Blake and Ramsey (6). Although there have been controversies over some of the methods and procedures, there seems to be no doubt that personal values and needs affect perception. (For a recent review of this work, see Jenkin, Noel. Affective processes in perception. *Psycbol. Bull.,* 1957, 54:100-127.)

The mechanism by which needs and values affect perception is called projection. Projection has been used in a number of different ways. In a technical psychoanalytic sense, projection is the attribution, ascription, or attachment to another person of motives, desires, wishes, attitudes, etc., which belong to, but are unacceptable to, oneself. It is thus reacting to one's own dynamic tendencies as though they belonged to someone else, and is an unconscious, defensive process.
Projection is used in other ways, however. Several discussions of transference have employed the term. Nunberg (38), for example, discusses transference as a projection of the image of the father on the analyst. Zetzel likewise (62) writes that the analyst is viewed "as a substitute by projection for the prohibiting parental figures." Greenacre (21) also uses the term. The use of projection by these writers is not consistent with the usual psychoanalytic definition given above. Schmideberg's (51) example of a child's fear of attack by the analyst as a projection of her own sadism is in agreement with the definition, however. Since the sadism is not actually present in the analyst, this is a transference reaction. But transference is, as Paulsen (40) points out, more than projection as it is usually defined in psychoanalysis. The viewing of the analyst as the father, or other authority figure, and endowing him with the attributes of these figures, is displacement rather than projection.

But the term projection is frequently used in a broader sense. Freud himself defined it once as follows:

“The projection of inner perceptions to the outside is a primitive mechanism which, for instance, also influences our sense-perceptions, so that it normally has the greatest share in shaping our outer world. Under conditions that have not yet been sufficiently determined even inner perceptions of ideational and emotional processes are projected outwardly, like sense perceptions, and are used to shape the outer world, whereas they ought to remain in the inner world.” (*The basic writings of Sigmund Freud.* A. A. Brill (Ed.) New York: Random House, 1938, p. 857. Quoted in reference 3, p. 1.)

Thus broadly defined, projection would appear to include displacement, and thus transference. It is also in this broad sense that projection has been used to apply to certain tests, such as the TAT and Rorschach. In projective techniques, the subject responds to the test stimuli in terms of his own perceptions as influenced by his motivations, attitudes, and drives. The meanings or interpretations which he attributes to the stimulus are projected into it. In this sense, all perceptions, since they are influenced by these inner factors, involve projection. The perceptions of the therapeutic interview and of the therapist are no exceptions. What the client sees in the therapeutic situation depends in part on the personal meanings which he projects into it.

Estes (13) states that there are two objective conditions which determine whether a personally significant recurring experience or situation will be responded to realistically, in terms of its objective characteristics. These are its clarity or absence of ambiguity, and its consistency. The characteristic of ambiguity is the structured-unstructured dimension in projective tests.

Bordin (7, 8) has provided an excellent treatment of ambiguity as a dimension of psychotherapy. He defines ambiguity as the stimulus configuration which is vague and incomplete, and in which no clear-cut response is predetermined. Ambiguity "is that attribute of a stimulus situation by virtue of which its demand character on different persons is different" (8, p. 138). In the therapeutic relationship the therapist may define or structure the situation in varying degrees. The more unstructured, or ambiguous, the situation, the more opportunity it gives for projection by the client, or for structuring it in terms of his needs, values, and conflicts.

The psychoanalytic situation is highly ambiguous, as both Estes (13) and Bordin ((7, 8) point out. The analytic rule of free association--"tell me everything that comes to your mind"--carries no restrictions. The analyst is silent for long periods, giving the impression of a blank screen. In the orthodox use of the couch, he is out of view of the patient and therefore not present as a reality in the visual field of the patient. These conditions maximize the opportunity for projection on the part of the patient, for the development of irrational or unrealistic perceptions--in other words, for the development of transference. Whether the transference involves infantile regression, or is of the type described by Horney, depends upon how the analyst structures the situation. Where the situation is structured as one where infantile, regressed behavior is demanded, it is inaccurate to label this behavior as purely transference, or due to projection; it is a realistic response to the situation. The fact that the patient does regress, however, indicates the presence of unresolved infantile conflicts. Presumably, if this is the case, patients who are unable to adapt to an infantile relationship may not have such conflicts.

Bordin (7, 8) lists as one of the functions of ambiguity this eliciting of the client's conflicting feelings, and states that this is identical with the concept of transference. The eliciting of these emotions enables the therapist to understand the client better. Finally Bordin suggests that by being ambiguous the therapist provides a background against which the client's irrational feelings become clear and come into awareness.

Both Estes and Bordin warn that ambiguity tends to arouse anxiety. The latter warns against inexperienced counselors using it in extreme form. Although he feels that client-centered therapy is less ambiguous than psychoanalysis, he claims that he has seen inexperienced counselors, in the effort to be nondirective, become involved in intense relationships fraught with danger to the client. While this may be possible, most beginning counselors are unable to achieve such ambiguity, since, as Bordin also points out, an ambiguous situation is anxiety-provoking to the therapist.

Faulty generalization, or the persistence of fixed, inappropriate behavior, may be a matter of the "false" perception of the situation. This “false" perception arises on the basis of the individual's values, needs, or unresolved conflicts. But it is also a function of the ambiguity of the situation or stimulus. The motive behind these false perceptions which lead to nonadaptive behavior are not entirely clear. These behaviors are commonly regarded as defense mechanisms. The phenomenological point of view adopted in this book would suggest that such behavior represents efforts toward the preservation of the self in the face of threat. Threat, it has been suggested (Chap.7), leads to withdrawal and reduction in the variabilityof behavior. Under threat, the individual's perceptions are more strongly influenced by his needs.

Estes advocates the avoidance of ambiguity, apparently feeling that clarity and consistency are conducive to differentiation and accurate experience. "To the extent that the therapist and the therapeutic task and situation are clear and consistent, to that extent the client should progressively respond to the therapist realistically. To state the principle more generally, when a contemporary, recurrent situation is clearly and consistently differentiated from earlier situations to which it at first gets assimilated, a perceptual conflict is instigated. And it tends to be resolved realistically" (13). The clear differentiation of the present therapeutic situation from the earlier infantile situation is one of the techniques used by Alexander and French (1). Ambiguity, or transference, then, is not only unnecessary, but undesirable in psychotherapy. Estes feels that client-centered therapy is a clear, consistent therapeutic situation.

TRANSFERENCE AND CLIENT-CENTERED THERAPY

The psychoanalytic transference does not often occur in client-centered therapy. The client-centered therapeutic situation is such that it does not foster transference. It is less ambiguous than psychoanalysis--the client sits up, facing the therapist; the rule of free association is not applied; and there is perhaps less silence on the part of the therapist in the early interviews. Nor does the client-centered relationship foster an attitude of dependence in the client. The therapist does not assume, or imply, either by actions or words, that he is a superior or authority figure. The whole atmosphere of the client-centered situation encourages and fosters independence in the client, rather than dependence. Even the avoidance of interpretation contributes to this development of independence in the client (47, pp. 214-215). Most therapies stress the need for the therapist's understanding the client better than the client does himself, keeping at least one

step ahead of the client. Wyatt (61) relates this to transference: "Transference can only develop when the therapist has succeeded in showing that he understands the patient more effectively than the patient does himself." This attitude, Rogers feels (47, pp. 215-216), leads to loss of self-confidence in the client, and to a dependent relationship.

Another factor fostering the transference is a threatening situation. Therapy in general, including psychoanalysis, has commonly been held to be a nonthreatening situation. Nevertheless, the analytic situation, as detailed by Macalpine (32) contains threatening elements. She relates this threat and insecurity to the regression which is an essential of orthodox transference. Analysis, by fostering, even forcing, regression and dependence, creates resistance and conflict, if only regarding the dependent-independent needs of the client. And as we have seen, ambiguity is threatening, leading to anxiety. Client-centered therapy, on the other hand, is less threatening and more secure, with its avoidance of interpretation, less ambiguity, and encouragement of independence rather than dependence and regression.

Transference, then, develops in a situation where the therapist is a superior, authoritative figure, and the client is made to feel inferior and childlike. A dependence of the client on the therapist naturally results. A threatening and insecure situation fosters regression and leads to defensiveness (resistance), which encourages projection and misperception of the actual situation.

Transference can and does develop to some extent in many client-centered therapy experiences, however. It will be remembered that transference is a function of the client and the situation. To the extent that client-centered therapy is ambiguous, transference may and does develop. Clients may be more or less "ready" to develop a transference relationship. This readiness is perhaps related to the nature and severity of their maladjustment or disturbance. As Rioch (46) points out, strong, repressed feelings seek emotional discharge or expression regardless of reality. Even in a relatively clear and unambiguous situation, the client with strong emotional attitudes will tend to project them into the situation. A highly dependent client may be ready, even desirous, of a transference relationship and convert the therapist into a father figure. Rogers (47, pp. 197-217) refers to transference "attitudes" in connection with client-centered therapy.

When transference attitudes, or a transference relationship, do develop in client-centered therapy, what does the therapist do? The analyst, as has been indicated, analyzes and interprets the relationship, as he does other productions of the patients. As the analyst treats transference as he does other responses of the patient, so the client-centered therapist accepts and understands these attitudes and feelings just as he does any other attitudes of the client (47, p. 203).

This handling of transference attitudes in the atmosphere of client-centered therapy appears to lead to relatively rapid recognition by the client that their origins are within himself, rather than in the therapist or in the therapeutic situation. That is, in a secure, nonthreatening, relatively unambiguous or reality-oriented situation, the client is led to recognize that projection (or displacement) is occurring. Reality, though inconsistent with the original perception, can be accepted. Rogers gives some illustrations of this (47, pp. 201-213). In some severely disturbed

clients, where there is present a strong internal threat to the self, projection may be greater and more persistent.

The point of view of client-centered therapy regarding transference is as follows: (1) transference is not a necessary condition for psychotherapeutic personality change; (2) in the client-centered approach, the orthodox psychoanalytic transference does not develop; (3) transference attitudes do often develop, but are handled as are other attitudes expressed by the client.

If the transference, with its regression to an infantile, dependent level, is not necessary for therapeutic change, then does this mean that maladjustment does not originate in infancy? Or does it rather mean that it is not necessary to uncover and analyze these origins, to recover infantile amnesia? The latter would seem to be the more tenable position. This is the position of Horney and other neoanalysts, who are concerned with current interpersonal relationships. If, then, client-centered therapy and neoanalytic therapy are similar in concentrating on current adjustment problems, how do they differ? Why is it that in one approach the transference relationship is strong and is considered to be an essential factor, whereas in the other approach it is not? It appears that the nature of the therapeutic situation still differs, in the same way in which client-centered therapy differs from orthodox psychoanalysis. The analytic situation, even in the case of the neoanalysts, appears to be one in which a dependence on the therapist is fostered, if by no other technique than that of interpretation, even though Horney criticizes the dependency of orthodox analysis.

Finally, then, how does client-centered therapy differ from brief psychoanalytic psychotherapy as advocated by Alexander and French (2), where transference is not involved? In this latter approach, transference and dependence are avoided or controlled. Nevertheless, the basic technique is interpretation, coupled with role-taking and other activity on the part of the therapist, which would appear to lead to the development of a dependency even if not the orthodox transference. And the relationship is still apparently one of superiority-inferiority, with the therapist being an authority. The total picture of brief psychoanalytic therapy is one of the therapist keeping ahead of the client, outthinking, outwitting, and outguessing him, actively directing and manipulating him.

As has been suggested earlier, all behavior is based on past experience, as well as being influenced by the present situation. The client's behavior is thus a mixture of irrational, projected elements--errors in perception and/or generalization--and of realistic reactions. The separation of these two elements is difficult, if not impossible, even though French (2, chap. 5) insists that the transference neurosis and reality adjusted behavior are mutually exclusive. It would appear to be difficult for a therapist to determine whether the client's reactions are in some cases responses to his (the therapist's) actual personality, or to projections upon the therapist. Heimann (23) cautions that "the analyst has to consider the reciprocal fact that his own personality, no matter how much he controls its expression, is perceived and reacted to by the patient." It is difficult for the therapist to be aware of his own personality sufficiently well to know whether the client is reacting to him as he is or as he is misperceived, particularly since every reaction combines the two. Only a true mirror will give back a true reflection. The apparent error of psychoanalysis in

insisting that the transference is entirely a spontaneous reaction of the client would indicate how easy it is to misinterpret the client's behavior. This leads us to a consideration of countertransference.

COUNTERTRANSFERENCE

Compared to the discussion of transference, there is relatively little concerning countertransference. Perhaps, as Racker (44) suggests, neglect has been due to the rejection by analysts of their own problems, problems surviving the didactic analysis which Freud originated as a result of his discovery of countertransference. The assumption was that countertransference was not present unless the analyst was not completely analyzed; if the analyst felt he should not have countertransference attitudes or feelings, he would suppress them. This assumption has now given way to the recognition that countertransference is present in all analytical situations. The development of interest in the countertransference has come perhaps as a result of the recognition that the analyst is not, and cannot be, neutral and objective, a mirror or a screen. Nor is the analyst, however well analyzed, free from transference reactions to the client. Racker (44) refers to the analytic myth "that the analysis is an interaction between a sick person and a healthy one." When the analyst ceased to be a blank screen for the patient, the patient ceased to be an abstract problem screen to the analyst, and became the object of stronger feelings.

As transference consists of irrational reactions of the patient to the therapist, so countertransference consists of irrational reactions of the therapist to the patient. This is included in most definitions of the term. However, like transference, countertransference has been variously described and defined (12, 15, 19, 31, 39, 44). As transference has been applied to all the reactions of the patient to the analyst, so countertransference has been used to include all reactions of the analyst to the patient. Racker (44), in a comprehensive discussion of countertransference, accepts it as "the totality of the analyst's psychological responses to the patient." Heimann (22) also agrees with this definition. At the other extreme, it has been limited to "repressed elements, hitherto unanalyzed, in the analyst himself which attach to the patient in the same way as the patient transfers to the analyst affects, etc., belonging to his parents or to the objects of his childhood; i.e., the analyst regards the patient (temporarily and varyingly) as he regarded his parents" (31). However, there has been less tendency to restrict countertransference to this reaction than there has been to restrict the definition of transference. Possibly the cases in which the analyst reacts to the patient as if the patient were his father are rare, certainly much rarer than the reverse. This is to be expected in view of the fact that the analyst is often, if not usually, older than the patient, and, if not older, is an authority figure because of his profession and status, at least in the eyes of the patient. It is curious that little attention has been given to the situation in which the analyst views the patient, irrationally, as a son.

Most discussions of countertransference clearly state, or imply, that the transference reactions of the analyst to the patient are few and weak compared to those of the patient to the analyst. This may be so in analysis, if not in other forms of therapy. It is perhaps to be expected, since the analyst has been analyzed himself, and is presumably more mature, if not older, than the patient. Berman (5) states that because of the training analysis, the attitudes and emotional responses of the analyst will be less intense and shorter in duration than those of other persons.

Nevertheless, the extent and significance of the emotional reactions of the analyst to the client have been increasingly recognized, and although these reactions vary in nature, they have tended to be included as countertransference reactions. There have been several discussions by psychoanalysts, including those of Heimann (22), Little (31), Reich (45), Cohen (12), Gitelson (19) and Racker (43, 44), which are of value to all therapists. Although transference appears to constitute less of a problem in other therapies than in analysis, countertransference, broadly defined as unwarranted or excessive attitudes or emotional reactions toward the client, is a significant problem in all therapies. This has already been touched upon in Chapter 3, when we discussed the influence of the therapist's needs upon the therapeutic relationship as an ethical problem. It is not possible to deal exhaustively with the problem here, and the reader is encouraged to consult the articles on countertransference referred to in this section.

We shall, however, give some consideration to how the therapist can recognize and deal with his own emotional reactions in therapy. Like transference, countertransference is viewed by analysts as being both a danger and an asset. Though it would appear to be more often a hindrance, recently it has been viewed as a help, but its use has not been adequately described or explored.

Since the needs which the therapist may be satisfying in the therapeutic relationship do not usually reach awareness, how can the therapist become aware of them? Sometimes, of course, they are accompanied by strong or clear feelings. This suggests that the therapist should examine any strong or unusual emotions arising within himself during therapy. The development of a strong liking for or dislike of the client should be examined. On the one hand, the therapist may be identifying with the client, so that empathy has become sympathy. On the other hand he may be irritated and impatient at the lack of progress of the client, which may be threatening his concept of himself as a successful, competent therapist. Reactions of love or hate may or may not be related to the actual personality or behavior of the client, but in any case they should be examined.

Again, strong emotional reactions of the client should not be accepted automatically or interpreted as transference reactions. The therapist should examine himself to see if his own personality or behavior has aroused the reaction. Since we see what we want to see, in therapy, as in other situations, it is too easy to attribute the client's reactions to the transference rather than to examine them in terms of one's own personality and behavior. The therapist may be projecting his own ideas and needs into the client's behavior. Benedek (4) points out that the client may make valid responses to the therapist as a person, which the therapist labels as transference because to accept them would compel him to give up his position as an impersonal agent, or screen.

We see then that both the client's and therapist's emotional reactions must be examined in terms of being reality responses to each other and must be understood as such for progress in therapy. Cohen (12) suggests in this connection that "perhaps the loss of the feeling that communication is going on is the most commonly used signal which starts the analyst on a search for what is going wrong, a search which begins with himself. She suggests a useful definition of

countertransference for all therapists: "When, in the patient-analyst relationship, anxiety is aroused in the analyst with the effect that communication between the two is interfered with by some alteration in the analyst's behavior (verbal or otherwise) then countertransference is present." She classifies anxiety-arousing situations into three categories. The first includes situational factors, or reality events, in the analyst's life, including the need for success or recognition as a competent therapist. Current problems or frustrations would also be included here, as well as fears of failure, or of a psychotic break or suicide of the patient. The second category includes unresolved neurotic problems of the therapist. The third consists of the communication of the patient's anxiety to the therapist, by verbal or nonverbal means.

The presence of countertransference attitudes may thus be identified by anxiety to which the therapist should be alert. Cohen's signals of anxiety are useful, and are included, slightly reworded, here:

1. Unreasonable dislike for the client.
2. Inability to empathize with the client, who seems unreal or mechanical.
3. An overemotional reaction to the client's hostility.
4. Excessive liking for the client.
5. Discomfort with the client; dread of sessions with him.
6. Preoccupation with client's behavior trends, including fantasying about responses to the client.
7. Difficulty in paying attention to the client, with mind wandering to personal affairs, or drowsiness.
8. Beginning appointments late or running over the established time.
9. Getting involved in arguments with the client.
10. Defensiveness or vulnerability to the client's criticism.
11. Repeated misunderstanding of the therapist by the client, or disagreement with his responses.
12. Provoking affect in the client.
13. Over-concern about the confidential nature of his work with the client.
14. Sympathy with client regarding his treatment by others.
15. Feeling impelled to do something active for the client, such as giving advice or suggestions.
16. Appearance of the therapist in the client's dreams as himself, or the appearance of the client in the therapist's dreams.

When the therapist recognizes the presence of excessive or unjustified emotional reactions to a client, what should he do about it? Most discussions of countertransference regard it as detrimental to therapy. As Alexander expresses it, "So far as the countertransference is concerned, the prevailing view is that the analyst's own emotional reactions to the patient should be considered as a disturbing factor. It is a kind of unavoidable impurity" (1, p. 82). The goal, then, is to minimize this impurity. This is the purpose of the training analysis. The aim is to attempt to approach the ideal of the analyst as a blank screen, with the analyst's personality minimized if not eliminated, so that the patients reactions can be, as purely as possible, transference reactions. The analyst, therefore, should be aware of his countertransference reactions in order to control them, in the attempt to achieve objectivity and a neutral, detached

attitude, even though "this detached attitude is, of course, studied and not quite spontaneous because even the well-analyzed therapist retains certain characteristic reactions to other persons" (1, p. 85). But “quite often the analytic process becomes stymied on account of the inexperienced student's lack of ability to control his spontaneous countertransference attitudes" (1, p. 89). Alexander continues: "The analyst should attempt to replace his countertransference reactions with attitudes which are consciously planned and adopted according to the dynamic exigencies of the therapeutic situation" (1, p. 93). Though a completely objective attitude is unattainable, it should be striven for, even though the result is a studied, controlled relationship rather than a spontaneous one.

This point of view regarding the handling of countertransference attitudes has been questioned recently, and Alexander himself recognizes the possible potential value of a different approach to the use of countertransference. This new approach is based on the fact that actually the countertransference cannot be controlled by the therapist. It is not easy, or perhaps possible, for the therapist to conceal his emotional reactions from the client. The reactions are sensed by the client. The personality of the therapist cannot be kept out of therapy by control or role-playing.

Some analysts have stressed the use of the countertransference as a tool or instrument in psychotherapy (e.g., 4, 12, 22, 31, 44, 58). Cohen (12) and Racker (44) suggest that understanding the origins of countertransference attitudes may aid in understanding the client's transference. Benedek (4) and Little (31) suggest that the countertransference be analyzed, the latter suggesting that the analyst discuss his countertransference reactions with the client. There is little, however, of a very specific nature regarding the actual use of countertransference as a tool.

Of more significance, perhaps, are some reports of experiences resulting from the actual expression of the therapist's emotions in the therapeutic situation. Weigert (58) gives an illustration of the expression by the therapist of disappointment and anger in therapy, without the loss of good will toward the client. Alexander (1, pp. 90-91) reports that "an inadvertent expression of my resentment against the patient's provocative attitude had an unexpected therapeutic result." When the patient said: "Do you deny that you dislike me and do you call it analysis being impatient with your patient?" the therapist admitted the dislike, while pointing out that the patient's behavior was unconsciously calculated to make him disliked. Alexander, however, regards this as a loss of the control which is so important in psychoanalytic therapy. He considered the favorable results in this case only an accident. Only by chance would a spontaneous expression of a countertransference reaction be beneficial.

Weigert (58) feels that the countertransference can be used as an instrument for determining the progress of therapy. The resolution of the countertransference permits the analyst to be emotionally more free and spontaneous with the patient, until "The analyst is able to treat the analysand in terms of equality."

But why should not the therapist be free and spontaneous throughout the therapy? This attitude toward the therapist's participation in the therapeutic relationship, perhaps first suggested by Ferenczi, but opposed by Freud, is being expressed again by the Sullivanian school of

analysts. Thompson (55) writes that "The analyst need no longer feel defensive about being natural and spontaneous."

Warkentin (57) gives some illustrations of the introduction of the therapist's feelings, including aggression, into therapy, stating that "on occasion it is even helpful when the therapist offers directly his aggressive or negative as well as his positive attitude to the patient." He suggests that "the patient may more readily accept the therapist's positive feeling, when there is no withholding of other emotions as they are experienced by the therapist." He reports the case of a school teacher, giving an "excellent history," to whom he said: "You are beginning to irritate me with your empty smile and friendliness; I wish you felt free to be more honest with me." This may seem to be inconsistent with the attitude of acceptance and a nonthreatening therapeutic atmosphere. Possibly in extreme form it is, even though it is based on sincerity and frankness. Warkentin appears to use the method as a technique with selected patients, and stresses that there must be no question of the genuine acceptance of the patient, and that the statements must be an honest expression of the therapist's emotional experiences at the time.

Possibly the control of countertransference attitudes introduces an artificial element into therapy, contributing, as does the classical transference on the part of the client, to the length of analysis. The control of the countertransference may be an important element in the development of the transference, and in the establishment of an authority-dependency, superior-inferior relationship.

Rogers (48) recently has raised a similar question regarding the participation of the therapist. He uses the term "congruence" to cover in effect what has been considered to be freedom from countertransference, or awareness of the therapist of his true emotional reactions. "Thus, if he is experiencing threat and discomfort in the relationship, and is aware only of an acceptance and understanding, then he is not congruent in the relationship, and therapy will suffer. It seems important that he should accurately 'be himself' in the relationship, whatever the self of that moment may be." Then he continues, "Should he also express or communicate to the client the accurate symbolization of his own experience? The answer to this question is still in an uncertain state. At present we would say that such feelings should be expressed, if the therapist finds himself persistently focussed on his own feelings rather than those of the client, thus greatly reducing or eliminating any experience of empathic understanding; or if he finds himself experiencing some other feeling than unconditional positive regard" (48, pp. 49-43).

The therapeutic relationship is a complex one. Both therapist and client are reacting to each other in terms of varying degrees of reality, and projection, or transference. Each is reacting to the other in terms of perceptions and misperceptions, and to the perceptions and misperceptions which the other has of him. It is no wonder then, that the relationship is complex, and its analysis difficult and often confusing. It is no wonder that misunderstandings develop in the relationship.

A necessary condition of therapeutic change is the presence of understanding, which is based on successful communication. Anything which clears the channels of communication is therefore desirable. The therapist must continually keep in mind the necessity for

communication and mutual understanding in deciding what he shall introduce into the therapeutic situation in terms of his own feelings and reactions. It would appear that where the suppression or control of these feelings impedes communication, they should be expressed in some form. It is possible that spontaneity on the part of the therapist is an important aid in developing and maintaining a condition of communication and understanding.

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