# A THEORETICAL EXPLORATION OF THE CONCEPTS TRANSFERENCE AND COUNTERTRANSFERENCE FROM A PSYCHODYNAMIC, AN INTERPERSONAL AND A CYBERNETIC POINT OF VIEW

by

ETHELWYN ELEONORE REBELO

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The aim of this study is to explicate the concepts transference and countertransference from the psychoanalytic, interpersonal and cybernetic perspectives. Commonalities and differences in definition are described. The notion that transference and countertransference provide the therapist with objective interpersonal information concerning the patient or client system is explored. It is pointed out that whilst, according to the tenets of second-order cybernetics, objective interpersonal information is not possible, transference and countertransference analysis, nevertheless, according to this viewpoint, provide the therapist with a double description. Such a description may influence the therapist's interpretation or understanding of the system at hand and be a component then also of the co-constructed, therapeutic reality of the therapist and patient or client.

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# CHAPTER 1

## INTRODUCTION

> Transference is the manifestation of the morbid habits of the patient towards the psycho-analyst. Let us take the case of the neurotic who was terrified in childhood by a brutal schoolmaster. He has more or less completely forgotten the painful scenes in which he figured. In the course of analysis he will manifest inexplicable attacks of terror towards the physician. (Dalbiez, 1941, p.211)

As is suggested by Dalbiez's (1941) description and as will be shown by the theory to be discussed in chapters 2 and 3 of this dissertation, the concept of transference is an important aspect of psychoanalytically-based therapy. This is so because it is in the transference that the patient is understood to bring the "morbid habits" (Dalbiez, 1941, p.211), which govern his or her problematic relationships to therapy.

Transference is not the domain of the patient alone. Therapists also experience transference, although in their case it is termed countertransference. Countertransference, defined as "the analyst's projection on to the client of emotions which originated in his or her own personal history" (Bootzin, 1980, p.iv) may influence the therapeutic process substantially.

Implicit in this definition is a view of countertransference as a negative force which hampers psychotherapy. From an alternative perspective, however, countertransference may be regarded as a source of information which contributes positively to the therapeutic process. Such a perspective has been espoused by Racker (1968) and Kiesler (1982a) and is discussed in chapter 5.

Transference and countertransference are concepts developed by Freud in his psychoanalytic theory. For Freud, our inner life was to be seen as a battleground beset by tense struggles between competing forces (Byrne & Kelley, 1981).

This battleground was divided into three levels or states: the conscious, the preconscious, and the unconscious. The conscious level consists of present perceptions and thoughts; the preconscious level includes past memories which are more or less available to consciousness when required; and finally, the unconscious level consists of all the past events, present impulses, desires and unacceptable images of which one is not aware (Byrne & Kelley, 1981).

All these present impulses, desires and unacceptable images of which one is not aware constitute the id. Essentially, the id represents primitive animal instincts which are threatening to the superego and hence, cannot be expressed in an unleashed way. The superego represents the internalization by a person of the values and moral codes of a society. Another word for superego might be conscience. The id operates in accordance with the demands of the pleasure

principle which may be understood as the demand for immediate satisfaction of bodily needs. The aim of the id is, therefore, to obtain pleasure and avoid pain. The ego, within the conscious and preconscious levels, on the other hand, acts to gain the same pleasurable ends in accordance with the requirements of reality. It is the task of the ego, therefore, to mediate between the demands of the id and the constraints of the superego (Byrne & Kelley, 1981).

The ego reacts to threat from the id by defending itself by means of various defense mechanisms. One of these defense mechanisms is displacement. It occurs when an unconscious impulse is directed towards a person or object other than the one upon which it was initially focussed. When it occurs in psychotherapy, this phenomenon is then termed transference (Hjelle & Ziegler, 1976).

As a consequence of displacement, the threatening or forbidden id impulses deriving from problematic relationships are, in the transference, forced to be discharged in a constant manner upon the therapist (Hjelle & Ziegler, 1976). Hence Dalbiez's (1941, p.211) description of "morbid habits".

If one understands the transference to be some sort of repetition in therapy of the patient's "morbid habits" (Dalbiez, 1941, p.211), then the concept has a central role to play in the various interpersonal approaches. Clearly "morbid habits" could be abstract metaphors used to indicate maladaptive interpersonal or interactional styles.

These interpersonal approaches focus on observable interactions among people rather than the inner workings of the psyche. Little attention was, however, paid to the concepts of transference and countertransference within the interpersonal movement until the 1980's. That such concepts should finally be utilized is not surprising since the role of the therapist in influencing the patient's interactional patterns or "morbid habits" is emphasised by this approach (Swart & Wiehahn, 1979).

The interpersonal perspective also sets a great store on the role of present factors in generating maladaptive patterns of behaviour. Whilst it may be acknowledged that a person's problems have originated in early childhood, the effective causes today are understood to reside in his or her present interactions. These present interactions are important, not only in terms of the reinforcement they provide for problematic behaviours, but also in terms of the meanings, fantasies and wishes that they generate (Wachtel, 1987). Clearly then, transference, as an analysis of an interaction within the particular context that is the therapeutic setting, has much to offer the therapist or theorist adopting an interpersonal approach.

Such a theorist is Anchin (1982), whose view of transference is described in detail in chapter 2. Whilst, another interactional theorist, Kiesler's (1982a) identification of countertransference as an "impact message" (p.275), implicit in the patient's interaction with the

therapist, is discussed in chapter 5.

Like Anchin (1982) and Kiesler (1982a) above, theorists representing a cybernetic paradigm have also attempted in recent years to describe these concepts within the premises of their perspective. The two that shall be mentioned in chapter 8 of this dissertation are: Colson (1985), who wrote of transference and countertransference patterns in psychoanalytic group therapy from a family systems view; and Mendell (1981), whose view of transference is that it functions as a barrier to change in a group system.

Essentially, cybernetic epistemology is founded upon the principle that a human system is a self-corrective organisation of feedback (Watzlawick, Bavelas & Jackson, 1967). The principle of feedback refers to a process wherein a part of a system's output is reintroduced into the system as information about the output. Such feedback may be either positive or negative. Negative feedback is responsible for maintaining homeostasis in the system, in that the information is used to decrease the deviation from a set norm. In the case of positive feedback, the information acts as an amplification of this deviation, so that positive feedback is associated with change (Keeney, 1983).

If positive feedback is not to lead to unchecked escalations within a system or dissolution of the system, it must be subject to higher order controls. As Keeney (1983, p. 71) points out: "In general, for the survival and co-evolution of any ecology of systems, feedback processes must be embodied

by a recursive hierarchy of control circuits." One might take as an example here the boy, whose father physically abuses him. The initial feedback is provided when the child goes to school, where the teacher notices his bruises. As these are severe and interfere with the child's capacity to concentrate in class, the teacher reports the matter to the principal of the school. The principal, in terms of another level of feedback, contacts the child protection unit of the police force. Yet a higher level of feedback occurs when, the child protection unit, acting in accordance with the dictates of the law, lays a charge on the father of the child. This discourages him from hurting his child any further, or, in other words, escalating his abuse of the boy.

When one views feedback only as it occurs to maintain homeostasis on one level, one is speaking in terms of first-order cybernetics. Inclusion in one's perspective of higher levels of feedback brings one into the domain of second-order cybernetics. Hence, a view which takes in only the boy and his abusive father within their family system is a first-order cybernetic view. A view incorporating the effect of the actions of the schoolteacher, the principal, the child protection unit and so on, is a second-order cybernetic view.

It is evident from second-order cybernetics that the therapist, by virtue of his or her interaction with members of a system, becomes, at a higher level, also a part of that system. One cannot, therefore, speak of influencing a system, without acknowledging that the system then "feeds back" to

influence the therapist (Hoffman, 1981). The therapist's observations and descriptions of a family system are, thus, not to be categorised as disinterested and objective information, but rather as feedback within that system. This implies that it is not possible to observe human systems objectively or to describe them, without, in the process, changing them.

The result of all this is that it is not only important to describe the system, but also to describe the describer, as a missing aspect of the description (Varela, 1989). Following from this, first-order cybernetics as the cybernetics of observed systems has been distinguished from second-order cybernetics which is defined as the cybernetics of observing systems (Howe & Von Foerster, 1975).

Up until the early 1980's, most cybernetically-premised therapy assumed a separation between the the system that was being observed and the observer. It was, accordingly, of a first-order level. Hence, research proceeded on the assumption that "objectivity" and therefore certainty, was possible (Tomm, 1983). With the possible exception of the Milan School who came to recognise that families may have their own solutions to problems, treatment was problem-focused. It was largely based on the assumption that the therapist stood outside or above the observed system in treatment. From that position it was expected that he or she would fix and control it in a technological sense. The premise uniting both researchers and clinicians was the belief

that objective reality "out there" was accessible to observation and description (Tomm, 1983).

Second-order cybernetics, however, embodies the constructivist notion that description is a "construction" of the observing system. According to this perspective, the characteristics of the observer determine what he or she will observe (Hoffman, 1981). Objective reality may exist but it is not accessible to human observation. Hence Varela's (1989) point that it is important to describe both the system and the describer of the system.

The problem is that, whilst one might expect the above formulation to advance information about the system in question, one would still be unable to obtain objectivity, since, to obtain objectivity, the describer of the describer would also need to be described, and so on. If one was to go for objectivity, where would one draw the line?

The above process of description is, obviously, impossible. Hence, it has been advocated by people such as Varela (1989) and Maturana (1980) that we abandon "representation" and bracket objectivity as the central concept for understanding cognitive mechanisms. In other words, once one accepts that our observations are not representations of a reality out there, then we can no longer lay claim to objectivity. The notion of objectivity is inextricably linked to the possibility of a person's observations and perceptions mirroring that reality. The implication of abandoning both these concepts is that

transference and countertransference can no longer be viewed as reliable sources of interpersonal information in a therapeutic setting.

Clearly the bracketing of objectivity, as Varela (1989) and Maturana (1980) suggest, is at odds with approaches based on first-order cybernetics, for instance that of Haley (1964). According to Haley, change occurs as a result of the therapist, as a separate entity or system, joining the observed system and altering it through the way he or she perceives it and therefore interacts in it. It is also at odds, with the psychoanalytic view which propounds that there is such a phenomenon as insight.

Perhaps, however, interpersonal information and objectivity are overvalued concepts in the systems of meanings concerning human relationships that is psychotherapy? It is enough, one might argue, that, as particular forms of description, transference and countertransference change that which is described? The very action of the therapist in describing particular forms of behaviour within transference analysis and in conveying that description to the patient or client must, as positive feedback, inevitably change the behaviours of that patient or client.

It is necessary now to turn to the origin of the particular form of description that is transference analysis.

# CHAPTER 2

## TRANSFERENCE IN INDIVIDUAL PSYCHOTHERAPY

### The Origin of the Concept Transference

From as early as the eighteenth century it had been observed that the relationship between therapist and patient played a significant role in effecting outcome (Kovel, 1978). However, little conceptual attention was paid to this phenomenon until the advent of Freud, who first identified a transference relationship in the case of Anna O. (Jones, 1957). Langs (1981) has argued that Freud's conceptualization of this dimension of the treatment relationship is perhaps the most fundamental of his contributions.

But what was this great contribution? As Kovel (1978) points out, it was nothing more nor less than the observation that Freud's patients tended to treat him in ways approximating earlier relationships - often as a parent. At first, Freud considered this an impedance to the process of therapy, a resistance to treatment, because the attitudes revealed were not only irrational, but often hostile. Yet even the loving feelings that were generated appeared to be problematical initially. Although these feelings motivated much work on the part of the patient, they soon enough became obstacles to change, insofar as change would result in giving up the "neurosis" and hence also fantasies surrounding the wish for the analyst's love (Freud, 1924, p.214).

Eventually Freud (1924) adopted a more balanced view. True, transference was a resistance, but it was also the "neurosis" actualized .

In his essay on "Neurosis and Psychosis", Freud (1924) explains that the transference neurosis comes about as a result of the ego, at the command of the superego, forbidding an id impulse. The ego defends itself against this impulse by repressing it, causing the impulse, in turn, to force itself upon the ego by way of a compromise. The impulse is then discharged upon a substitute, permitted object. In other words, the direction of the impulse becomes displaced from its original object to an alternative object that is acceptable to the superego and ego. This alternative, acceptable object is the therapist in the transference neurosis. Transference is, therefore, representative of "[the ego in] conflict with the id in the service of the super-ego and of reality" (Freud, 1924, p.214).

Thus, in the transference, a patient's forbidden id impulses are permitted a compromised realization. Hence, as Mills, Bauer and Miars (1989), referring to Freud's work, point out, "careful attention to the unfolding relationship between patient and therapist [offers] an arena in which conflictual patterns of action and reaction [can] be identified, examined and modified" (pp. 338-339).

Clearly then, if for Freud (1917), psychoanalysis was to be effective, it was to include both the nurturance and the careful dissolution of transference. Transference was the very beast to be grappled with and in its successful resolution lay the key to successful therapy. This is further illustrated in a letter to Jung in which Sabina Spielrein pointed out that:

> Freud would never, never argue that the transference to the doctor [was] not simultaneously an attempt at adjustment. Why should he? Even if the patient transfers all his infantile attitudes (wishes) to the doctor, it is simply obvious that he learns in the process to adjust his infantile attitude to reality. (Carotenuto, 1984, p.85)

He, furthermore, came to view transference as generally present from the beginning of treatment. As a positive emotion it would, as mentioned earlier, act to motivate the patient to pursue psychotherapy. On the other hand, transference became a resistance either when the patient's affection and underlying sexual need for his or her therapist became so strong that it provoked a reaction formation. Alternatively, it might also become a resistance if the patient's impulses were predominantly hostile instead of affectionate (Freud, 1917).

With regard to the form assumed by these impulses in the transference relationship, Freud (1917) cautioned as follows:

> Suppose we succeeded in bringing a case to a favourable conclusion by setting up and then resolving a strong father-transference to the doctor. It would not be correct to conclude that the patient had suffered previously from a similiar unconscious attachment of his libido to his father. His father-transference was merely the battlefield on which we gained control of his libido; the patient's libido was directed to it from other positions. A battlefield

need not necessarily coincide with one of the enemy's key fortresses. (p.509)

The term "libido" was used by Freud to refer to the energy force by which the sexual instinct is represented in the mind (Hjelle & Ziegler, 1976, p. 28). Hence, the sexual instincts or impulses of the patient referred to in the preceding excerpt of Freud's might be directed, more primarily, at a need to challenge authority figures in order to escape from an unconscious fear of castration.

## An Orthodox Definition of Transference

Subsequent psychoanalytically-based theorists have not always been able to agree with all the aspects of Freud's conceptualization of transference (Rank & Ferenczi, 1925). Despite varying points of view, some of which shall be discussed later, Freud's discovery, nevertheless, remained an integral consideration in any psychoanalytically-oriented, psychodynamic therapeutic endeavour. Psychodynamic therapy, according to Kovel (1978), refers to any therapy which assumes an interplay of forces within what is understood as the "mind".

Greenson (1965), considering the various usages of the concept within the field of psychodynamic therapy, attempted to create an orthodox definition of the concept. He, accordingly, defined transference as: "the experiencing of feelings, drives, attitudes, fantasies, and defenses towards a person in the present which are inappropriate to the person and are a repetition, a displacement of reactions

originating in regard to significant persons of early childhood" (p. 156).

Greenson (1965) was reasonably successful in that, according to Ehrenreich (1989), his definition has been widely accepted. It is based on the following three assumptions, all of which owe their existence to Freud's earlier theoretical work:

1. Transference is inappropriate to the present situation;

2. It implies a repetition of a past reaction; and

3. Transference arises idiosyncratically from a particular early experience of the patient.

Clearly, therefore, for Greenson (1965), work with transference in any psychodynamically-oriented therapy is founded on the premise that feelings, attitudes and behaviours generated in therapy are to be investigated in order to understand and modify a patient's historically-based, characteristic manner of relating to significant people in current life. It is also founded upon the assumption that such behaviour may be viewed objectively and independently of any countertransference-based perceptions.

## Transference Resolution

The means of dissolving the transference was perceived at first as twofold. Firstly, the analyst or therapist sought not to gratify the transference wishes directly. Secondly, transference wishes were to be resolved through interpretation or telling the "truth" about the meaning of what was taking place (Freud, 1979).

In this regard, use was made also of dreams as the indirect expressions of transference wishes (Dalbiez, 1941). Such interpretations involved conveying to the patient that his or her feelings did not derive from the present situation, but that they were a repetition of a past event. The significance of that past event, in its determination of the patient's present psychic structure, would then be analysed. For example, a patient, whose early life experiences were filled with a sense of isolation and abandonment might experience strong feelings of anxiety and rejection at the prospect of terminating her sessions with her therapist. On exploration, it might also emerge that this particular patient tends to cling to members of her family and to colleagues at work and that she is strongly lacking in self-confidence. The patient's emotional response to leaving her therapist, as well as her dependency needs and poor self-concept, could then be interpreted as deriving from her earlier sense of isolation and her fear of abandonment.

Hopefully, as a result of these therapeutic interventions (also known as transference analysis), transference feelings would gradually grow into what Kovel calls "a new edition of the infantile neurotic text" (1978, p.81).

As Kovel (1978), moreover, points out: "Transference wishes are stirred up willy-nilly, whether the therapist cultivates them or not, but the form they assume depends greatly upon what the therapist does" (p. 82).

Some of the principles on which the therapist's technique came to be based, may be enumerated as follows (Mills et al., 1989). They are to:

1. work with the interpersonal manifestations of conflict;

2. utilize naturally-occurring positive transference to strengthen the therapeutic alliance;

3. strive for an emotional experience of the transference relationship;

4. confront transference behaviour early in therapy; and

5. make use of the "Triangle of Insight" (p. 342) - the total interpretation of transference should connect the patient's current life situation with experience in the transference and in past life.

## Changing Conceptualizations of Transference and Transference Resolution

As is evident from the principles discussed in the previous section (Mills et al., 1989), the current life situation of the patient came also to be considered in the practice of transference analysis. This is due to later work conducted by the Neo-Freudians which resulted in some changes in the conceptualization of transference and the practice of transference analysis (Ehrenreich, 1989). In fact, the notions of transference and countertransference have inspired a significant degree of both theoretical and practical analysis and revision.

Rank (Rank & Ferenczi, 1925), for example, came to the conclusion that the orthodox emphasis on historical lessons learned from transference analysis did not result in significant change. He therefore attempted to improve treatment by focusing on the use of the therapy situation as a present experience rather than as a reincarnation of the past. Hence, he advocated an emphasis on the "here and now" of interaction, rejecting an investigation of the historical antecedents of an emotional problem - unless it highlighted a dynamic currently at work within the therapeutic relationship. An example of such an instance might be a transference-based attachment to the therapist, where the patient, whose father abandoned the family, relates to the therapist as a father-figure.

According to Rank's (Rank & Ferenczi, 1925) conceptualization, then, the analysis of transference was directed, by and large, at the elucidation of present rather than past conflicts. Rank, therefore, would also have viewed the above

example of transference as possibly representing the patient's present need to abdicate responsibility and his or her present feelings of vulnerability.

Fifty years later, another useful contribution to transference analysis and its resolution was made by Malan (1976). He shall not be discussed in any detail, except to mention that he re-emphasised the importance of examining both positive and negative feelings. Negative feelings, in particular, were to be identified and worked through in order to help the patient tolerate such feelings for other people.

Through the years, various psychodynamic theorists and pratitioners have utilized the concept of transferene in various ways (Mills et al., 1989). Both Rank (Rank & Ferenczi, 1925) and Malan (1976) assumed, like Greenson (1965), however, that demarcating certain behaviour as transference, was an objective enterprise.

## Anchin's Interpersonal Perspective of Individual Transference Factors

Rank (Rank & Ferenczi, 1925) and Malan (1976) are just two of a multitude of significant psychodynamic theorists to have engaged in a diversity of conceptualization and description of transference and its therapeutic resolution. Exponents of the interpersonal perspective, have, as has been mentioned in chapter 1, also recently generated conceptualizations of transference and its therapeutic resolution.

By focusing on the interpersonal manifestations of what psychodynamic theorists would view as intrapsychic conflict, Anchin (1982) has described the patient's idiosyncratic, inappropriate behaviour in terms of the concepts of "interaction sequence, interpersonal pattern and interpersonal style" (p.109). The concepts of interaction sequence, interpersonal pattern and interpersonal style define various units of behaviour. This behaviour is exhibited in the patients' interactions with classes of other people and is thus fairly enduring across similar situations. Significantly, Anchin reflects little uncertainty, in his work, regarding the possibility of any lack of objectivity in selecting and describing these units of behaviour.

For Anchin (1982), these three concepts may, accordingly, be described as follows:

> An <u>interaction sequence</u> refers to a time-bound series of concrete behavioral exchanges which have cognitive and affective concomitants, while the <u>interpersonal pattern</u> represents a regularity among these processes that may be extracted from this and other sequences.... The concept of <u>interpersonal style</u> represents still another level of abstraction, beyond that of the interpersonal pattern. Specifically, it encompasses the idea that across the range of specific self-defeating patterns that a patient plays out with significant others over the course of his or her day-to-day sequences in specific situations, there is a central theme running through a

great many of these patterns. (p.109)

The sequences, patterns and styles described by Anchin (1982) may, accordingly, be organized around the patient's goals of enhancing his or her feelings of acceptability and self-worth. Successful in the past, they may be less successful at present, resulting also in emotionally painful and destructive consequences.

## Replacing Unsuccessful Interpersonal Styles

Anchin (1982) points out that it is the therapists' task, irrespective of his or her conceptual framework, to help the patient to change his unsuccessful interpersonal style, or set of behaviours with other behaviours more suited to helping him achieve a happier and more gratifying existence. In order to accomplish this it is necessary to observe the patient in interaction - and to delineate both the content and process of interaction sequences. For Anchin:

> The process of identifying specific self-defeating consequences incorporates, among other options, (1) underscoring the nature of others' reciprocal understanding vis-a-vis the patient; (2) labelling the relationship messages implicit in these countercommunications; (3) drawing out negative implications of these countercommunications for the patient's self-definition and feelings of self-worth; (4) clarifying

> the manner in which his or her rigid patterns and others' characteristic countercommunications impede gratification of important human needs, wants and desires; and (5) explicitly linking these consequences to the patients' dysphoric affective states. (p.123)

As is evident from the above discussion, Anchin (1982) does not distinguish between the sequences, patterns and styles exhibited by the patient in relation to others, on the one hand, and those exhibited in relation to the therapist, on the other hand.

He does, however, emphasise the effect of context on the interpersonal styles of individuals. As such, his work may be viewed as an interpersonal description of the concept transference. As will be evident from a discussion of cybernetic epistemology, it is also compatible with Bateson's (May, 1977) theory of learning, to be examined in chapter 8.

Given then, the various ways in which transference may be identified and utilized in the service of effecting behavioural change, the question that arises is, what happens when the therapeutic situation is extended to include more than two protagonists?

# CHAPTER 3

## TRANSFERENCE IN GROUP PSYCHOTHERAPY

In the last 30 years or so, the practice of group psychotherapy has increased both in popularity and scope. Essentially, group psychotherapy refers to "any one of a number of approaches... in which psychological problems are played out and worked through in a small group over an extended period" (Kovel, 1978, p.337). Two psychodynamically-oriented theories of group transference shall, therefore, now be discussed briefly.

The first, psychoanalytically-based, structural model (Saravay, 1985), links transference behaviour dynamically to group developmental stages. The second approach, formulated by Yalom (1975), connects transference behaviour to the idiosyncratic psychological and interpersonal concerns of each member.

Before discussing the structural model, it is essential at this stage to describe its progenitor's, namely Freud's, understanding of groups.

### Freud's Conceptualization of Groups

Freud's understanding of groups was rooted in the conceptualization of two types of emotional connection operating simultaneously (Bocock, 1983). On the

one hand, there was members' acceptance of the leader as their collective conscience (superego) and object of respect (ego-ideal). On the other hand and as a result of this process, it posited that group members regress from viewing each other as a source of emotional and instinctual gratification, to the point where they relate purely in terms of a sense of identification with each other. Freud viewed this regression (in object relations) as inspired by anxiety arising from a shared oedipal transference directed at the leader who represents the common ego-ideal or object of respect.

An oedipal transference is a transference based on behaviour understood, in terms of psychoanalytic theory, to have emerged with the activation and resolution of the oedipus conflict. Such resolution occurs when the child, at about age four or five, represses his or her love for the opposite sex parent and develops an identification with the same sex parent. An oedipal transference is therefore one in which the group leader is viewed as a parent, or collective conscience of the group, and forbidden love object simultaneously (Hjelle & Ziegler, 1976).

It is, then, the process of transference that creates bonds between individuals and hence the development of a group. The notion of bonds founded upon members' mutual sense of identification (ego identifications) forms one of the foundations of the psychoanalytically-based structural model (Saravay, 1985). A by-product of this notion is, furthermore, the assumption that groups function as coherent, interdependent wholes, that the transferences of each member are connected to processes taking place in the group at large.

For Freud (Bocock, 1983), therefore, group transference was oedipal in origin. The regression in object relations to ego identification was accordingly inspired by anxiety arising from the nature of the group bond with the leader.

This theory of oedipal anxiety was, however, later challenged by the discovery that small groups could be organised around preoedipal transferences (Saravay, 1985). Examples of such transferences include oral-dependent, oral-aggressive, anal-retentive and anal-aggressive types of behaviour. An anal-aggressive transference, for instance, might be characterised in terms of group members perceiving the leader primarily as an object to be possessed or controlled.

Given such preoedipally-based behaviour, a new explanation therefore had to be found for the regression to ego-identification responsible for uniting group members.

## The Structural Model

The new explanation for the regression to ego-identification responsible for uniting group members was provided by a new structural model of groups. This model assumes that the bond of ego-identification between members is an adaptive regression permitting simultaneous libidinal attachments between group members (Saravay, 1985). As mentioned earlier, Freud used the term "libido" to refer to the energy force by which the sexual instinct is represented in the mind. A libidinal attachment is consequently a sexual attachment (Hjelle & Ziegler,

1976).

This bond of ego-identification between members is also not necessarily the effect of anxiety arising from a shared oedipal transference directed at the leader. The structural model is able to account for the phenomenon of group development containing a variety of transference phases. These phases may then arise, not only from the oedipal stage, but from any of the stages of infantile development (Saravay, 1985).

Such phases might include, for example, a movement from a characteristically oral-dependent group transference, through an identification around anal-retentive transference wishes, to the final activation and resolution of an oedipally-based transference (Saravay, 1985). This means that, initially, group members might express the wish, either overtly or covertly, to merge with the leader, and might relate to each other in a gullible and dependent way.

Resolution of the above oral-dependent type of transference might then mark the movement towards an anal-retentive transference phase (Saravay, 1985). At this point, members are likely to respond to feelings of uncertainty, perhaps generated by the frustration of earlier transference wishes, by withholding information from the leader, keeping silent and by forming an identification between members based on a culture of orderliness, punctuality and consensus. At such a stage, it is expected that disagreement and debate is unlikely to be tolerated.

Finally, it would be hoped that the successful resolution of the above anal-

retentive transference phase would allow the group to move towards an oedipal transference (Saravay, 1985). In such a transference, the leader, as a fantasised parent, represents an ego-ideal or superego. It would then be expected that members would cope with the feelings of rivalry for the attention of the leader, and the anxiety this generates, by becoming more cohesive. The resolution of this phase might then signal the advent of more mature behaviours on the part of group members and the ultimate termination of the group. Thus they would learn to postpone gratification of their desires in the group and to respond constructively to each other's problems and to criticism.

The group, therefore, develops along transference phases generated by the various stages of infantile development. In this way, the group re-enacts certain significant developmental conflicts in an individually-inclusive manner. For this reason, group transferences are intersystemic, linking each member's id, ego and superego. As Saravay (1985) succinctly puts it:

> Congruent self-representations in the members' ego give expression to a shared unconscious wish arising in their ids, whose object, the leader, is represented in their ego-ideals and superego. Thus, group transferences require the participation of the id, ego and superego, and the components of the transference represented in each system must be derived from the same developmental stage conflict. (pp.202-203)

Saravay (1985) thus argues that, since the group is bound amongst itself and to the leader according to components of the same prevailing group transference, then both bonds are derived from the same developmental stages. Hence, also, these two ties advance or regress in concert with each other. Defenses derived from other stages and incorporated in the transference are likewise subordinated to the purposes of the conflictual theme present at that time.

For instance, as mentioned in the preceding section, group members might identify around oral-dependent transference wishes on the one hand, expressing, on the other hand, the desire to merge with the leader who is unconsciously represented as the mother of the group. With the unconscious merger of members with the leader, the group itself then becomes the unconscious symbol of the mother or breast (Saravay, 1985).

Clearly, however, as Foulkes and Anthony (1957) have pointed out, each member brings to a group certain conflicts and issues that are idiosyncratic. Inasfar, therefore, as the group process is able to incorporate common fantasies and conflicts, each member is able to participate fully. When the manifest content of group discussions fail to engage group members, they begin manipulating each other in the service of their own latent interests, until some sort of a compromise is achieved. This compromise is then organised around a particular developmental stage conflict with its attendant transference and, as such, forms also the culture of the group. Both therapist and group member are thus, inextricably linked to the group transference phase.

## Yalom's Theory of Transference in Group Psychotherapy

Unlike the structural model (Saravay, 1985) described above, Yalom's (1975) theory of transference focuses almost exclusively on the bond between group members and the leader. For Yalom, in contrast to the more psychoanalytically-based structural model, transference factors are not connected conceptually to a group developmental stage.

Whilst the structural model (Saravay, 1985) is based purely on psychoanalytic principles, Yalom's (1975) approach is, on the other hand, founded upon a mixture of interactional and psychoanalytically-based, psychodynamic principles.

Briefly, interactional principles assume an exchange of messages and a reciprocity between persons. A central proposition is that an individual's behaviour is always to be understood as a sequential response to the behaviours of others (Swart & Wiehahn, 1979).

Psychodynamic or dynamic principles, assume, as mentioned earlier, an interplay of forces within the unconscious (Kovel, 1978). The unconscious may, therefore, be likened to a battleground in which conflicting psychic forces strive for domination, as was described in chapters 1 and 2. Behaviour then represents the result of this conflict. A greater emphasis is placed, according to this view, on a person's underlying motivations, feelings and conflicts (Smith, Sarason & Sarason, 1978).

For instance, Yalom (1975) conceives of transference distortions arising

from the following psychodynamic manifestations:

> the displacement of affect from a previous object. For example, as in the case of a patient responding to a female therapist with the same emotions initially directed at his or her mother; feelings of conflict toward authority, feelings of conflict toward authority, dependency, autonomy, rebellion etc, which become personified in the therapist, and the tendency to invest the therapist with superhuman characteristics in order to use him or her as a shield against existential anxiety - an example here might be that of the patient who views his or her group therapist as some sort of god who can solve all the problems of existence. (pp.199-212)

The said distortions, may, however, also be based on members' explicit or intuitive appreciation of the great power of the therapist. Yalom (1975) points out that the leader's presence and impartiality are essential for group survival and stability, his power being founded on his freedom to expel members, add new members and to mobilise group pressure against anyone he wishes. The unequal interaction between group leader and member, described by Yalom, thus forms the most fundamental breeding ground for the evocation of transference.

Such an unequal interaction may be defined in terms of Bateson's (1979) conceptualisation of "complementary interaction" (p.117). Bateson conceived of a complementary interaction as an interaction based on the maximization of

difference. As such, each party's behaviour is different from, but complementary to that of the other party. In the above instance, the therapist's behaviour is different from that of each group member: the therapist's behaviour conveys leadership, strength, and power, whilst group members tend to respond, in most instances with an acceptance of the therapist's power.

As in the case with individual therapy, for Yalom (1975), therefore, provided a therapist assumes the responsibility of leadership in a complementary interaction, transference will occur. The issue is thus not the evocation, but rather the resolution of transference. This is a departure from the classical approach which was concerned primarily with the evocation and consequent interpretation of its genetic roots (Ehrenreich, 1989).

The transference having accordingly been evoked, Yalom (1975) then goes on to caution:

> There are some patients whose therapy hinges on the resolution of transference distortion; there are others whose improvement will depend upon "interpersonal learning" stemming from work not with the therapist but with another member, and there will be many patients who choose alternate therapeutic pathways in the group and derive their primary benefit from other curative factors. (p.217)

Furthermore, Yalom (1975) indicates that:

> Attitudes toward the therapist are not all transference based: many are reality based and others are irrational but flow from other sources of irrationality inherent in the dynamics of the group. (As Freud knew, not all group phenomena can be explained on the basis of individual psychology.) (p. 217)

The essential point to be made for the purposes of this account is that, as mentioned earlier, individual transferences may, according to this perspective, originate in diverse psychodynamic processes and contextual factors such as interpersonal relationships. Unlike the structural conceptualization (Saravay, 1985), they are, moreover, not conceptually linked to the developmental stages of the group or, thus, to identification processes between members.

For Yalom (1975): "If the therapist maintains flexibility, he may make good therapeutic use of irrational attitudes towards him without at the same time neglecting other functions in the group" (p.217).

In fact, Yalom (1975) emphasizes the importance of transference resolution for the purposes of good "therapeutic uses" (pp.202-203), which largely include interpersonal learning. He also, like Saravay (1985), assumes that a therapist is able to objectively know the interpersonal and intrapersonal dynamics of his or her clients.

Having obtained information regarding transference-based interpersonal and intrapersonal dynamics, transference resolution may, according to Yalom

(1975), be facilitated both by "consensual validation" and by increased "therapist transparency" (p. 211). The former technique involves assessing the consensus of members' opinions or feelings associated with the therapist. Members are encouraged to compare their perceptions with one another and reality testing is thereby enhanced. The latter technique refers to the therapist's gradual and calculated self-disclosures. This fosters members' opportunities to confirm or disconfirm their impressions of the therapist. As with consensual validation, transparency amplifies reality testing.

Yalom (1975) describes the behaviour of the therapist towards increased transparency as behaviour which encourages members to deal with him as "a real person in the here-and-now" (p. 203). As such, the therapist also treats any feedback members offer him with respect, indicating his willingness to examine his blind spots, to expose his feelings, and to acknowledge or refute motives or feelings attributed to him.

Ultimately, however, as calculated self-revelation, transparency is subject to the therapeutic needs of members and to the dynamics of the group process. Timing is an important issue that has to be considered. A revelation which may be appropriate and useful at one point may be hopelessly

# CHAPTER 4

# COUNTERTRANSFERENCE IN INDIVIDUAL PSYCHOTHERAPY

As was indicated in chapter 2, Anchin (1982) advocated that the therapist analyse the self-defeating consequences of a patient's interactional style as this is manifested in others' reciprocal countercommunications. Clearly, one way of doing this is to examine the therapist's own internal responses, or countertransference, to the messages transmitted by the patient. Implicit in Anchin's work, therefore, is the view that the therapist's emotions and attitudes towards the patient are likely to be generated by the patient's interactional style, irrespective of how apparently irrational these emotions and attitudes might appear to be. This emphasis on the interactional style of the patient is something of a deviation from the classical psychoanalytic understanding of countertransference. This deviation will be discussed in the following section.

## The Psychoanalytic Understanding of Countertransference

In a letter to Annie Pink, a patient whom he later married, Reich (1988), one of psychoanalysis' early disciples, passionately described what he understood to be his countertransference feelings towards her in the following way:

Your health improved steadily; only occasionally was there distortion,

> stemming from the recent denial which you had to experience in order to gain complete health. And the joy I took in you grew from week to week; I had long exceeded the bounds of interest which a male physician is allowed to take in a female patient if he himself is to remain free of conflicts and capable of further work. It was not easy for me these last few months, Annie Pink. But I wanted, yes, I first had to make sure that you were healthy. And just as you struggled with the transference, I struggled with "countertransference" - I was surprised that you hadn't noticed. (p.173-174)

As with Freud (1979), Reich (1988) perceives countertransference feelings as interfering with "further work" (p. 173-174). This was so because countertransference, as the experience of intense feelings on the part of the therapist for his or her patient, was seen to hamper the former's objectivity. The task of the therapist was understood to be, in terms of psychoanalytic theory, to identify internal areas of conflict as these were released in the patient's style of interaction. In order, however, for the therapist or analyst to be able to identify these areas of conflict in the patient, he or she had to be as objective as possible.

Countertransference affected this objectivity. It was this principle that led to the still commonly-held notion that analysts or therapists should themselves undergo analysis or therapy in order to make themselves aware of their emotional vulnerabilities as these might be expressed in countertransference (Kovel, 1978).

## Countertransference as an Impact Message

Kiesler (1982a), in contradiction to Greenson (1965), and the psychoanalytic approach discussed in the preceding section, tends to emphasise present rather than past relationships in his analysis of "impact messages" (p.274) which the therapist experiences in relation to the client. Implicit, however, in his analysis, is an understanding of countertransference or "impact messages" as the effect on the therapist of the client's transference. Kiesler's (1982a) focus is thus on the client-therapist relationship, irrespective of the form of therapy. He makes no separate distinctions with regard to group or family therapy.

Briefly, Kiesler (1982a) uses the term "impact message" to represent the engagement or pull the therapist experiences in transaction with a client. Whether the client is seen individually or in a group does not appear to matter. These engagements may affect the therapist's emotions, action tendencies, cognitive attributions and fantasies in relation to that particular person. Interestingly, unlike the classical definition, the genesis of countertransference lies, for Kiesler, essentially with the client. Implicit also in Kiesler's identification of the "impact message" is the premise that such identification can be relied upon as objective information.

In contrast to Racker (1968), who will be examined in the following chapter, Kiesler (1982a) does not view all clients as inducing countertransference-based responses in their therapist. When a therapist, however, finds himself or herself experiencing an "impact message", it encompasses all of the therapist's

responses to that particular client. This is, as shall be seen in chapter 5, also true for Racker's (1968) conceptualizations.

For Kiesler (1982a), signs that the therapist is being engaged or "pulled" in a certain way by a particular client, include:

1. The therapist noticing that there is a repetitive pattern to his or her internal responses;

2. The client's interruption of his or her previous baseline of pursuing understanding and change; and

3. The therapist's awareness that he or she is off his or her usual baseline in therapy.

For Kiesler (1982a), being "off baseline" might be manifested as:

> talking more or less than usual, liking or disliking a client more intensely, feeling particularly brilliant or dull with a given client, and so on. At times the therapist may find himself tending to avoid or to emphasize certain topics regardless of the client's interest. Or the therapist may notice his own anxiety at particular moments with his client. (p.283)

Kiesler (1982a) accordingly advocates that, after the therapist realises, that he or she is being engaged in a particular idiosyncratic way, he or she, firstly, interrupts the complementary response. Secondly, by making use of appropriate techniques, the therapist is to help the client to discontinue his or her distinctive

evoking style. Finally, the therapist is to metacommunicate with the client about the "impact message" (p.286).

Kiesler (1982a), places a great deal of emphasis on the therapist's metacommunication of the "impact message". He, in fact, makes use of the "impact message" in much the same way that Racker (1968), as we shall see, utilises a complementary identification, that is, by identifying the impact of a client's particular style of interaction on significant others. Here, metacommunication clearly also mirrors the use of the interpretation of transference in psychoanalytic therapy.

Kiesler does, however, caution that whilst the client is productively working on some other aspect of psychotherapy, metacommunication assumes less of a priority.

For Kiesler (1982a), metacommunication involves the following:

1. telling the client both the positive and negative engagements he or she experiences with the client;

2. pursuing the extent to which the client intended to elicit that effect from the therapist;

3. identifying the self-definitional and relationship claim the client is intending to impose on the relationship;

4. pinpointing with the client the exact pattern of verbal and nonverbal behaviours which produced the impact;

5. analysing the client's extratherapy relationships with significant others in terms of the identified evoking style of the client;

6. modelling, rehearsing and reinforcing alternative, more successful and flexible client interpersonal styles to be used with persons in his life;

7. using the therapeutic relationship to model and reinforce the metacommunicative process itself for the client to use with important persons in his life.

The client thus learns to talk directly with significant others about their relationship communication.

# CHAPTER 5

## COUNTERTRANSFERENCE IN GROUP PSYCHOTHERAPY

The classical definition of countertransference viewed the phenomenon as encompassing purely those aspects of the therapist's reactions reflecting his or her supposedly unresolved conflictual concerns. It was thus a deviation on the part of the therapist from viewing the patient objectively to viewing him or her subjectively. Hence, countertransference was a therapy trap (Brabender, 1987). Furthermore, as was the case with Wilhelm Reich and Annie Pink (Reich, 1988), the feelings inspired, according to this notion, were, generally, of great intensity. In recent years, however, definitions of countertransference that include and encompass all of the therapist's reactions to the client have been proposed by both Kiesler (1982), from an interpersonal perspective, and Racker (1968), from a psychodynamic point of view.

### Racker's Definition of Countertransference

Like Kiesler (1982a), Racker (1968) did not view countertransference as a trap, incorporating only the therapist's unresolved issues. For Racker,

countertransference embraces the entirety of the therapist's unconscious and conscious reactions to both his or her transferential and reality needs and to those of group members. In other words, the group therapist, adopting this perspective, as with that of Kiesler (1982a), cannot differentiate his or her feelings and behaviours in terms of those that are supposedly countertransference-based and those that are not countertransference-based. He or she may, however, distinguish between "concordant and complementary identifications" (Brabender, 1987, p. 551).

Briefly, a "concordant identification" (Brabender, 1987, p.551) occurs when the therapist identifies with an aspect of the group member's self-representation. As Brabender, quoting Racker, points out, it is based "on resonance of the exterior in the interior, on recognition of what belongs to another as one's own ('This part of you is I')" (p. 551). For Brabender, an example of such an identification is the situation where members of a group might be making a great many statements suggesting helplessness and impotence to the extent that the therapist begins to feel ineffectual. This experience on the part of the therapist can, then, be classified as a concordant identification.

A "complementary identification", on the other hand, is established through the "therapist's resonance with an object in the patient's world" (Brabender, 1987, p. 553). As an example, Brabender cites the patient who complains constantly and repetitively of others' rejection. When the therapist begins to feel annoyed and desirous of getting rid of the patient, a complementary identification has been achieved.

According to Racker (Brabender, 1987), complementary identification may occur as a result of several interpsychic dynamics. Two, however, are particularly significant. Firstly, such an identification may occur in response to the patient's activity of projective identification with the therapist. In the example of the patient who complains of others' rejection, this might be that of a disengaged, uninterested mother figure. Secondly, it may occur as a defensive manoeuvre on the part of the therapist to avoid a concordant identification. Again, in the previous example, this might be manifested in the therapist's own unconscious expectations of rejection at the hands of others. Thus, in such instances, a complementary identification may be assumed to be in avoidance of a concordant one.

However, the opposite also holds true. The therapist who nurtures empathy to escape being angry with a patient is, as Brabender (1987) indicates, using a concordant identification to escape a complementary one.

The point here is, as Roth (1981) indicates, not to feed a particular type of identification exclusively, but to be able to oscillate flexibly between the two. Clearly, they both have their therapeutic uses: concordant identification is a great resource towards achieving an understanding of both the conscious and repressed aspects of the patient's life. A complementary identification, as an object of exploration between therapist and patient, can help the latter to recognize the impact of his or her style of interaction on significant others. Irrespective of whether the identification is concordant or complementary, it is essentially a fount of reliable, objective information for the therapist about the

patient or client.

Significantly also, although Racker's (1968) classification is essentially descriptive , it includes, in its conceptualization, both present and past interpersonal events as the basis for the patient's relationship with the therapist. This is in distinction also to Kiesler (1982a) who, as has already been mentioned, tends to emphasise present relationships.

# CHAPTER 6

## THE FAMILY THERAPY MOVEMENT'S REJECTION OF TRANSFERENCE AND COUNTERTRANSFERENCE

Both the psychoanalytically-based, psychodynamic approaches and the interpersonal approaches discussed above, assume that both transference and countertransference reactions are located in the individual. Whilst interpersonal paradigms have long been associated with family therapy (Kiesler, 1982a), this has not been the case with classical, psychoanalytically-based psychotherapy (Guerin, 1976).

In the 1950's, at the time of the development of the family therapy movement, psychoanalytic psychotherapeutic principles prohibited the collection of a family in one room for the purposes of treatment (Guerin, 1976). One of the main reasons for this was the belief of most psychoanalytic theorists that if psychotherapists were to see a family together, the presence of relatives would contaminate each member's transference reactions (Guerin, 1976).

The espousal of a cybernetic perspective, to be discussed later, by several significant proponents of family therapy, presented these psychotherapists with an alternative way of viewing both problematic behaviour and the tasks of the

therapist in its treatment.

Of most significance for the purposes of this dissertation was the fact that family-focused, cybernetic theorists such as Jackson and Weakland (1961) rejected the theory of transference (Guerin, 1976). Such theorists, attempting to make use of the principles of communication theory and of cybernetics in their work, assumed that transference was the inextricable fruit of psychoanalytic psychotherapy and, therefore, irrelevant to their purposes (Jackson & Weakland, 1961).

This attitude is illustrated by an article on conjoint family therapy, in which Jackson and Weakland (1961), on the basis of certain assumptions of communications theory, rejected the application of the concept of transference to family therapy. They indicated that the inappropriate feelings that family members may have for their therapist might be better explained in terms of unfulfilled expectations. These expectations may be caused by ignorance, misinformation or such explanatory concepts as "All men are ...." (p. 32). Both transference and countertransference were, furthermore, purely a manifestation related to the inactivity prescribed by psychoanalytic treatment. Family therapy, on the other hand, contained more activity, thus militating against the creation of a context in which the patient was able to create a framework "embroidered" with "past personal references" (pp. 32-33).

Thus, the concepts of transference and countertransference were largely deleted from both the family therapy movement and its cybernetic epistemology. The new emphasis which developed focused on viewing the patient's symptoms

within the context of family interaction patterns. This was founded upon the creation of a new epistemology within which to understand and conceptualize that which was being observed: an epistemology derived from cybernetics and communications theory (Guerin, 1976).

This epistemology is illustrated, inter alia, in the work of Andolfi, Angelo, Menghi and Nicolo-Corigliano (1983). In a publication entitled Behind The Family Mask, Andolfi et al. describe the individual and the family as two systems in evolution: both systems containing and accommodating the dual needs of family unity and independent individual growth. Family unity, on the one hand, and independent individual growth, on the other hand, are both separately implicated in the family system's movements towards either instability or stability. For Andolfi et al., the family may be seen as a system in constant transformation. Internal and external pulls for change require that family members assess their relationships with each other and constantly reevaluate the balances in the family between unity and the independent, separate growth of each respective member. When individual growth is suppressed in the service of unity, "pathology" is likely to result. A pathology which then serves to maintain the equilibrium and functioning that the system has achieved. An example might be that of the family in which the adult children are not encouraged to date or form romantic attachments in order to ensure that they do not leave home. If they are to leave home, their parents might be forced to confront their incompatibility and separate.

In 1985, Colson made use of Andolfi et al's (1983) theory of family pathology in his analysis of transference and countertransference patterns in

psychoanalytic group therapy.

Colson's (1985) use of the above theory shall be examined in chapter 8 of this dissertation. At this stage it is important to point out that its compatibility with the concepts of transference and countertransference suggest that the rejection of the latter concepts by people such as Jackson and Weakland (1961) was not a necessary consequence of their acquired, cybernetic epistemology. The failure of these theorists to develop the notions of transference and countertransference within their epistemological domain may, however, also be possibly explained in terms of their failure to recognize the semantic plasticity of these concepts. This plasticity has been exploited both by the interpersonal models discussed above and by more recent cybernetically-influenced theorists such as Colson (1985) and Mendell (1981) to be discussed further in chapter 8. These theorists moulded the concepts of transference and countertransference to fit in with their respective paradigms. This is possible also because neither the concept of transference nor that of countertransference is unavoidably founded on a lineal and dualistic way of thinking. The problem with lineal and dualistic thinking as these are manifested in certain approaches shall be discussed in the following section.

# CHAPTER 7

## BATESON'S CYBERNETIC EPISTEMOLOGY

### The Problem with Lineal Thinking and Dualism

Lineal thinking involves thinking in terms of A leads to B, B leads to C and so on. Bateson (1979) defines it as follows:

> Linear is a technical term in mathematics describing a relationship between variables such that when they are plotted against each other on orthogonal Cartesian coordinates, the result will be a straight line. Lineal describes a relation among a series of causes or arguments such that the sequence does not come back to the starting point. The opposite of linear is nonlinear. The opposite of lineal is recursive. (p. 242)

According to Bateson (Hoffman, 1981) then, lineal thinking, with its inherent identification of cause and, therefore, blame, is a one-sided, atomistic way of perceiving elements which are, in fact, interconnected in a relationship. Thus, A

acts on B, but then B, in turn, acts on A. In the world of human activity, such relationships are organised into "systems" (p.342), which may be defined as an order of people and processes in dynamic interaction.

Dualism, in this context, involves drawing an arbitrary boundary line between the parts of a system or between a system and one of its parts. Such thinking also is incorrect for Bateson (Hoffman, 1981). In describing the etiology of behaviour, people and the human systems of which they are a part are not to be treated as distinct entities.

With the exception of the structural model of group therapy (Saravay, 1985), the psychoanalytically-based approaches and also the interpersonal approaches to transference and countertransference are dualistic in that the behaviours of therapist and client are not viewed as necessarily reciprocally connected. Clearly, transference and countertransference, viewed non-dualistically, should be seen from a perspective which includes the therapist and client in a recursive interaction. Viewed non-dualistically, transference, and countertransference are the linked halves of a relationship.

Transference behaviour is bound, in terms of its psychoanalytic conceptualization, to the patient's system of meanings and classes of solutions. With transference resolution and its attendant metacommunication, and in the therapist's awareness of countertransference factors, the therapist responds analytically, both to the patient's responses to him or herself and to his or her earlier responses to the patient, respectively. The patient too, in transference

resolution, is forced to examine his or her initial responses to the therapist. Therapist and patient are then forced to re-evaluate their responses to each other and the premises underlying these responses.

With reevaluation, both, hopefully, alter their respective systems of meanings and, in the patient's case, his or her class of solutions. Hence, the patient's view of the therapeutic relationship and of interpersonal relationships in general is likely to change.

Furthermore, the solutions that then emerge are likely to derive not only from a different perspective on interpersonal relationships but also from a different class of solution. In other words, the solution is obtained within an altered frame of meanings, bound by different premises. Such an altered perspective is founded upon a double description in which the patient has a view of: a) how he or she viewed the therapist and b) of how the therapist viewed him or herself in relation to the patient.

Double description, according to Bateson (1979) and Keeney (1983), is an epistemological tool by means of which one is enabled both to generate and to discern different orders of pattern and relationship. Bateson (1979) compares it to the synthesis and depth provided by a binocular view in contrast to a monocular view. In Bateson's words:

> The binocular image, which appears to be undivided, is in fact a complex synthesis of information from the left front in the right brain and a corresponding synthesis of

> material from the right front in the left brain. Later these two synthesised aggregates of information are themselves synthesised into a single subjective picture from which all traces of the vertical boundary have disappeared. (pp. 79-80)

The point to be made is that when one makes use of double description and when one views human behaviour non-dualistically, the focus of concern moves away from the personal system, and its internal conflicts, to the relationships or ecology of interpersonal transactions at hand. It is argued that the patient to emerge from a psychoanalytically-based form of therapy is likely to have gained some greater understanding of such an ecology. Although, such an understanding may be partly submerged beneath a wider concern with the personal system.

In any event, when we commit the above-mentioned errors of lineal and dualistic thinking, of splitting the object of explanation into parts and pieces and speaking separately, for example, of the group and the person and of one part causing something in the other, we are guilty of chopping up the ecology. According to a cybernetic approach, there is an interdependence between these parts.

This interdependence implies that a person's behaviour is inextricably connected, as a system, to the groups within which he or she functions (Bateson, 1979).

## The Importance of Context

The groups in which an individual functions and their suprasystems would be seen by Bateson (1979) as the contextual background of the person's behaviour. May (1977) illustrates Bateson's emphasis on the importance of context with the following anecdote:

> The first time I ever met Gregory Bateson was at Mills College, where he was a member of the discussion panel at a lecture I delivered. After the lecture the audience and I were arguing back and forth, as fruitlessly as is generally the case, about how freedom develops in the child in America. Gregory roused himself on the platform to volunteer, "The child develops freedom in the context of the family." Since then I have found the word context emerging in all kinds of forms in Bateson's thinking. (pp. 84-5)

According to Bateson (May, 1977), the patient in transference views the analyst in a particular context and, thereby, obtains meaning from the otherwise unknown situation. Hence the patient will respond to the analyst as a daughter, son or whatever.

In the interests of a contextual awareness, Bateson (Keeney, 1983),

furthermore, argued repeatedly that clinicians were to view the world through the lens of a cybernetic epistemology. Such an epistemology involves seeing the universe as an organisation of multitudes of interdependent, hierarchical systems, of which one of the smallest might be the animal cell.

In addition to understanding the function and organisation of the cell within the context of an animal organ, a cybernetic epistemology also provides a way of understanding psychological symptoms and pathology in the following way. For Bateson (Keeney, 1983), all systems were understood to be organised through processes of change. This means that, in a human group system, an individual's behaviours and the group's sequences of interaction are constantly changing. One could not, however, understand fluctuations within the individual without looking also at the wider fluctuations of the group system.

The so-called healthy individual's systemic organisation is characterised by a balanced repertoire of alternating behaviours and emotions which are then represented by the ever-changing, adaptations of the group organism to the wider social context.

The members of a group situated within a context which is, for some reason, seen as pathological, will then achieve systemic organisation in a pathological way. This might be done, for example, by escalating a particular emotion or behaviour in the group. In this way, an initial discouragement would become a clinical depression. According to Bateson (Keeney, 1983), this was related to the observation that each member of a distressed family would be likely to have different forms of escalating behaviour. The family organism or system

achieves organisation and homeostasis by balancing the escalations of each member.

Clearly, when one refers back to the structural model of group psychotherapy (Saravay, 1985), one can only conclude that it too shares certain core assumptions in line with a cybernetic epistemology. Firstly, the therapist is very much a part of the semantic organisation of the group or system. In other words, in terms of the group transference, he or she is associated with members' perceptions of the group process and the meanings formulated. In reciprocal fashion, the therapist is also both influenced by and an influence upon group dynamics as these are manifested in each transference phase. Furthermore, in true Batesonian fashion, individual and system are inextricably connected in that the dynamics of each group member and the dynamics of the group as a whole are seen to be isomorphic.

As is the case with the structural model, the shift towards a cybernetic epistemology involves attending, therefore, to the ways in which families or groups are organised as systems. This entails focussing not solely on the individual but on the entire context (May, 1977).

Bateson's attention to context resulted in some further fruitful insight into processes of learning (May, 1977). Before we, however, delve into Bateson's conception of interpersonal learning, it is, perhaps, necessary that we be reminded of what Freud had to say in this regard.

# CHAPTER 8

## TRANSFERENCE AS LEARNING

### Freud's Understanding of Interpersonal Learning and its Relation to Transference Analysis and Resolution

According to Freudian theory, the constitutional foundation of personality structure and development is termed the id. The id, which is largely unconscious, refers to all that is inherited, present at birth, fixed and, therefore, not susceptible to learning. The demands of the external environment, often in conflict with those of the id, result in the development of the ego. The ego functions to mediate between the demands of the id on the one hand, and the internalised demands of the external environment, termed the superego, on the other hand. When learning takes place, then, it takes place at the level of the ego (Hjelle & Ziegler, 1976).

The ego, or the conscious self, makes use of defense mechanisms which function to repress and make unconscious, id impulses unacceptable to the superego. Transference is, in fact, as mentioned in chapter 1, the fruit of a particular defense mechanism called displacement. With displacement, the expression of an impulse (deriving from the id) is redirected from a more

threatening object or person to a less threatening object or person (Hjelle & Ziegler, 1976).

With the analysis of transference, the therapist reveals to the patient the original object of the emotions that have been displaced and the significance of that object for the patient and his or her interpretations of the world (Hjelle & Ziegler, 1976). Implicit, then, is the notion that interpersonal learning is brought about when a person is made aware of the tension between the external environment, represented by the therapist in the above instance, and the influence of his or her internal world on its interpretation. In other words, the patient becomes aware that the premises which govern his or her interpretation of the environment are questionable.

Such a formulation of interpersonal learning is more or less compatible with Bateson's "deutero-learning", a term used to describe a higher order of learning in which the person learns to learn (Ruesch & Bateson, 1951, p.202). For Bateson (1979), learning consists of three components, namely stimulus, response and reinforcement. These three components form the context of learning in which the response maintains the stimulus and the reinforcement maintains the response. Furthermore, in Bateson's (1979) words: "Response by learner reinforces the stimulus provided by teacher. And so on" (p.147). When the learner obtains a view or double description of this process, deutero-learning takes place. As Bateson puts it: "there is a learning of context...this learning of context springs out of a species of double description which goes with relationship and interaction"

(p.148).

## Bateson's Understanding of Interpersonal Learning and its Relation to Transference Analysis and Resolution.

Bateson, writing together with Ruesch (Ruesh & Bateson, 1951), believed that interpersonal learning, as deutero-learning, takes place when a person perceives a change in the rules governing his or her interpersonal environment. For example, such learning might take place in a work situation, with the arrival of a new boss with original ideas as to how the particular company or department in question should be run. As the employees perceive a difference in the demands placed on them and their response to these demands and so on, so interpersonal learning with regard to the behaviour of their new boss, their old boss and themselves will take place.

It was, furthermore, Bateson's proposition that the context within which learning takes place contributes to the development of the character structure of the subject or individual (Ruesch and Bateson, 1951). As he or she learns to learn, he or she develops expectations of and ideas about the context in which the learning takes place. According to this conceptual framework, we may therefore expect a Pavlovian subject to:

> [E]xpect a world in which he has no control over the good and evil which may befall him; he will try to know when they are coming, and

> he can take appropriate visceral precautions, readying his body for the food or pain. He can, so to speak, look for omens to tell him when the disaster will come, but it will not occur to him that he can do anything about the disaster, except within his own body. (p. 216)

Thus people, for Bateson (May, 1977), carry with them an understanding of the world and an interpretation of it based on the type of context within which significant interpersonal learning took place. Drawing on Bateson, we can say that this understanding and interpretation determines their character structure. Their character structure, in turn, influences their interpretation of the world. This understanding and interpretation then becomes reflected in the nature of the transference. Thus a person whose significant interpersonal learning occurred in a context in which he or she was constantly attacked by significant others may develop a character structure in which he or she presents as the perpetual victim. Transference behaviour might then manifest as the expectation that the therapist will in some way punish or harm the patient.

Most importantly, however, in line with Bateson's epistemological biases, there is an interaction between the person and the context of learning (May, 1977). This means that when the context changes and the subject has to learn to learn new rules, he or she develops propositions about contexts in the process. This Bateson called "Learning Two" (May, 1977, pp.86-87). May explains Bateson's viewpoint in the following way:

"Now the context itself changes. The premises on the basis of which one learns now shift. Contexts which are new to the learner may induce such learning. One 'learns to learn' in a new way" (pp. 86-87).

An example of this type of learning would be that which occurs with the change of context that is the psychodynamic psychotherapy situation. As the psychotherapist, analysing the transference, comments on the patient's idiosyncratic, inappropriate behaviour, the person's view of the context and all the facts he or she has learned, take on a new meaning. In a private conversation with May (1977), Bateson described transference and transference analysis as follows:

> The analysand brings to the analysis old ways of perceiving a relationship to a senior male. He perceives and acts to the analysis in terms of this old (now obsolete) Learning Two. By "analysis of the transference" he is pushed to replace the old Learning Two with a new Learning Two, and to discover <u>about</u> Learning Two. (p. 87)

The above description relates to a cybernetic understanding of transference reactions in the context of individual psychotherapy. But what of a cybernetic understanding of transference in the context of group therapy?

## Transference and Countertransference in Group Psychotherapy

### Transference and Countertransference as Scapegoating.

In 1985, a paper was published in the International Journal of Group Psychotherapy in which the author attempted to apply a cybernetic perspective of family dynamics to psychoanalytic group psychotherapy. Like Andolfi et al. (1983), this author, namely Colson, described healthy families as providing the kind of holding environment which allowed their members to differentiate and advance in life. Rigid families, on the other hand, were characterised by the maintenance of fixed roles which sheltered family members from the fear that change and differentiation would provoke disintegration and inevitable death, both to the individual and to the family. The emergence of an identified patient then served to direct the focus of family members onto the problem member and away from their own needs for differentiation, as the following excerpt from Colson (1985) illustrates:

> Pathological forms of protectiveness and scapegoating are both involved in which the symptomatic individual maintains an enmeshment with the family which saves them from anxieties associated with change. The lower the level of differentiation among

> the family members, the more severely disturbed the symptomatic family member will be. Also the lower the level of differentiation, the greater the difficulty for all involved in extricating themselves from the rigidly defined roles which maintain the family enmeshment. (p. 505)

Within the group therapy system, any point of change or stress, such as the progress of a member, was likely, according to Colson (1985), to produce a problem in the form of a particular member selected for scapegoating by the group:

> This process is analogous to the disturbed family's unconscious selection of one of their members to be the family "problem", thereby placing one person in the focus of attention and concern and saving the others from facing difficult issues in their own lives and in their relationship with one another. (p.507-508)

The dynamics of a therapy group are, furthermore, derived from each member's family system. For Colson (1985), then, "[a]ttention to such dynamics is facilitated by [a] thorough knowledge of each patient's family background and by sensitivity oneself to the variety of ways in which differentiation may be inadvertently discouraged" (p.513).

Once together therefore, the therapy group forms a new system wherein, in

times of stress, members are likely to make use of interpersonal patterns which are derived from their present family systems and which are consequently designed to maintain stability.

Colson (1985) appears to view transference as referring to the interpersonal patterns of relating which each member brings to the group from his or her present family system. These then become particularly represented in the scapegoating of a certain member who becomes the problem patient of the group "family". Transference, according to this view, pervades all the group relationships, both those directed at the therapist and those between members. Furthermore, as with psychoanalytically-based models, the group as a dynamic unit, is founded upon transference factors. Clearly, then, Colson's formulation, is non-dualistic in that the therapist is implicated in the group process.

With regard to countertransference, Colson (1985) offers a vignette illustrating how a particular patient reproduced certain interpersonal patterns of relating derived from his family in the therapy group, and the countertransference-based collusion of the therapists. He then makes the point that:

> The primary technical error is the tendency for the therapist, in the guise of appropriate technique to unconsciously collude with a scapegoating process, thereby discouraging differentiated growth. The result is that group members remain stuck in rigidly defined roles precluding for each the experience of alternative relationship paradigms. (p.513)

Implicit in the above quotation is the notion that the therapist is able to observe the dynamics of the group with objectivity, that objectivity is possible. Whilst the therapist may view aspects of the group process subjectively, this is only as a consequence of countertransference factors. He or she must, however, be objective in order to perceive problems and to encourage differentiation.

With this paper, Colson (1985) undoubtedly makes a valiant attempt to describe transference and countertransference in terms of Andolfi et al.'s (1983) conceptualization of differentiation and cohesion. This conceptualization, in turn, is based on the cybernetic notions of change and stability. A possible caution is that it is uncertain that growth is always connected to differentiation. For example, one could argue that an individual might experience his or her identification with a particular group as intensely meaningful and enriching because he had always perceived himself to be isolated from others. This individual's psychological growth in the direction of increased sociability and interpersonal trust would be unlikely to provoke a stressful reaction in terms of scapegoating behaviour in the other members of the group system.

Whilst Colson (1985) implicates mechanisms of transference and countertransference with scapegoating behaviour, like the proponents of the psychoanalytic structural model, he also makes it clear that the group, as a dynamic entity, is founded upon transference factors. Another theorist, Mendell (1981), isolates only its effect as a transient impediment to change.

## Transference as an Impediment to Change

For Mendell (1981), operating also from a cybernetic orientation, transference, as a mode of interaction inherited from a problematic, other system, is to be viewed as a temporary barrier to change. Hence, it is imperative that the group therapy leader, who is both an agent of stability and an agent of change, confront any manifestations of transference in the group.

In the therapist's capacity as a catalyst for change (Mendell, 1981), he or she must not only challenge transference behaviour, but also preserve his or her personal autonomy. This is important because it is his or her external, independent outlook which serves as an outside point of reference for the group. From this point of reference, the group system may acquire new information and be energized to new capacities. It is important to emphasise here that the therapist's perceptions of group behaviour are viewed by Mendell as new information for the group. The use of the word, information, must be taken to mean the input or feedback introduced into a system. In this context, the use of the word, 'information', does not necessarily imply that some value of truth or objectivity is attached to it, as may be the case concerning its use in other contexts.

For Mendell (1981), the group is energized to new capacities in terms of the regulation of both the boundaries defining the group system and those

boundaries defining the therapist's own personal subsystem. Such regulation may be carried out through the setting of ground rules. A ground rule might be, for example, that members do not interrupt each other. Whatever these rules are, they are intended to nurture constructive communication and to erase the destructive modes of interaction, known as transference behaviour, originating in other systems.

Clearly, however, the implication of all this is that boundaries are manifested both outwardly, in interaction, and inwardly, in interpretation. As interpretation, the therapeutic maintenance of boundaries may then possibly mimic traditional forms of transference analysis.

## Transference as a Sum Relationship

Mendell (1981) describes a systeming relationship as one in which the boundaries between members are permeable to information from each party.

In a sum relationship, on the other hand, a one-way boundary exists, controlled by one party (Mendell, 1981). We might describe the boundary in such a situation as being semi-permeable, or open only to information being imparted from the controlling party. Hence, the situation arises where the controlling party is unable to include, in interpretations of the other, any notion contradicting that controlling party's basic premises or assumptions of the other. In a sum relationship, therefore. the controlling party does not perceive incoming messages, but seeks rather to transmit information. An example here would be

the autocractic employer, in a work situation, who perceives his or her employees in a fixed fashion and does not pay much attention to what these employees have to say about themselves, each other or the job at hand. For this employer, his or her employees are purely incompetent or diligent workers, to be interpreted merely according to their capacity or incapacity to follow orders.

Transference, as a phenomenon, is a sum relationship for Mendell (1981) since the patient's interpretation of the therapist is manifested in an interactional style deriving from his family system. As transference persists, incoming, constructive information necessary to bringing about a change in interpretation is blocked from entering the group system. Mendell does not elaborate on the interactional mechanisms through which the therapist is prevented from introducing information into the group. We might expect, however, that these are to be found in the controlling party or person's interpretations of the therapist's or group leader's messages.

At the point that the controlling person or party is made to see the inaccuracies of his or her interpretation and the transference is resolved. This explanation is consistent with the understanding of interpersonal learning, as formulated by both Freud and Bateson. Speaking from the point of view of a cybernetic epistemology, this event may also be described in terms of information from the therapeutic system entering to catalyze the individual member and, hence also the group of which he or she is a part, towards change.

Further change then becomes possible with the nurturance of systeming relationships between group members and the consequent interchange of

information and energy. The implication of this is that as the group changes, the group therapy leader and his or her subsystem also receives input from the group and is also inevitably altered.

# CHAPTER 9

## CONCLUSION

Second-order cybernetics, discussed in the introduction to this dissertation, elaborates on the bond between therapist and patient or group and also on connected problems with the notion of objectivity. Both of these factors, that is, the bond between therapist and patient, and the issue of whether objectivity and, therefore, information regarding a relationship is possible, are germinal to any discussion of transference. It seems clear that the notion of information implies that of objectivity, in any context aside from a discussion of cybernetic processes, where it seems to be synonymous with input.

If human experience is understood to be immersed in subjectivity, how can a therapist ever be certain that the messages he or she believes to be emanating from a relationship, do not, in fact, derive solely from the workings of his or her own consciousness.

The psychodynamic perspective, the interpersonal point of view, and the approaches discussed above, assume the possibility of objective description on the part of the therapist. This is perhaps, with the possible exception of Mendell (1981) whose cybernetic account of group processes is premised on the notion of feedback deriving from the therapist or group members. This feedback is viewed

as input which is not necessarily purely subjective or objective. Any assumption, however, that objectivity is possible is, as has been mentioned earlier, in conflict with the basic tenets of second-order cybernetics.

If we bracket objectivity, and hence, interpersonal information, as has been suggested by, for instance, Varela (1989), the therapist dealing with the issues of transference and countertransference consequently has the following options.

The first is, as has been indicated in the introduction, to dispense with the notions of transference and countertransference. After all, every perception is subjective and idiosyncratic. To delineate certain behaviours as more subjective and idiosyncratic in origin than other behaviours, as is considered the case with transference, is arbitrary and a question of degree. Furthermore, as regards Greenson's (1965) criterion of appropriacy: who is to decide as to what is and what is not appropriate?

The second option is to proceed as if objectivity and, indeed, objective interpersonal information were possible (Golann, 1987). For Golann one may appeal to consensus for a notion of relative accuracy, thus acknowledging recursiveness and subjectivity without abandoning descriptive standards and methods. In elaboration, he states that, "[o]ne possible solution to the difficulty of describing ambiguous and
complicated interactional events is to separate observation from explanation while attempting to achieve reasonably detailed, disciplined descriptions" (p. 339).

The therapist utilizing this option would then view transference and countertransference as labels for descriptions of his or her view of the client-

therapist relationship.

Unfortunately, this proposition of Golann's (1987) is in itself problematic. Firstly, any perception or description is, as Bateson (Ruesch & Bateson, 1951) amongst others has pointed out, epistemologically-based. For Bateson, perception is founded upon difference, upon the distinction between figure and ground. The identification of figure is arbitrary and influenced by epistemology. We, therefore, cannot separate observation or description from explanation, as Golann (1987) proposes. Secondly, Golann's utilization of consensus as an arbitrator between opposing perceptions is also a problem. It should be remembered that there was once consensus that the earth was flat.

This being so, and if we are to accept, as Golann (1987) does, that subjectivity is inevitable, therapy becomes a description or co-construction of reality between the therapist and patient or the group leader and group members.

The therapist can no longer believe that he or she offers the patient or group member objective information as to his or her interpersonal functioning with any certainty. Concepts such as transference and countertransference may only be defined as the avowedly subjective descriptions of the therapist's view of his or her relationship with the client. This is not to imply, however, that the therapist is not able to offer change to the patient or client. Such change, as has been pointed out earlier in this work, will come riding on the back of any description the therapist or client makes.

It is interesting to note, in this regard, that Racker's (1968) totalistic classification of countertransference is more compatible with a constructivist

perspective than is Kiesler's (1982a) formulation of impact messages. From the constructivist perspective and from Racker's (1968) point of view, countertransference is not a trap the therapist falls into, but an inevitability. Both of these perspectives assume that the therapist's responses to the client are unavoidably subjective. Racker does, however, appear to assume that the therapist is able to stand back and analyse his or her identifications in order to obtain information or objectivity.

Despite cross-paradigmatic compatibilities such as that between Racker's (1968) approach to countertransference and that of the constructivists, most attempts to incorporate a notion of transference within either an interpersonal or cybernetic model, would be forced to deviate somewhat from Greenson's (1965) psychoanalytically-based definition of transference. The focus of this deviation is essentially founded on the idea that transference arises idiosyncratically from a particular early experience of the patient or client. Both the interpersonal and cybernetic perspectives do not locate problems in living as being based necessarily in the crucial early stages of life, as do most psychoanalytic perspectives, with some exceptions, for example Rank (Rank & Ferenczi, 1925). Indeed, such problems are generally seen to be manifestations of present relationships.

As representative of present relationships, the identification of transference and countertransference can nevertheless convey to both the constructivist and the non-constructivist therapist alike, some subjective indication as to the patient or client's reality and the nature of his or her problems in living.

Both transference and countertransference are, then, useful therapeutic concepts because they provide the therapist with a view of the interpersonal style and issues around differentiation that accompany a particular patient or client as he or she negotiates different contexts. When this information is combined with the patient or client's view of others and others' view of the patient or client, as is the case in group psychotherapy, a double description and a richer sense of the system and its ingredients are obtained.

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