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Transference: the Metaphoric Relationship between Patient and Therapist

In the last chapter we considered various active psychotherapeutic methods. We will now consider an additional major source of understanding and of change: the relationship that develops between patient and therapist. In getting to know any other person we are guided by our previous experience of people and, as each of us has had a different experience, each develops a personal set of assumptions and expectations. We differ, for example, in how far we tend to see others as weak, friendly, trusting, humorous, patient, strong, controlling, threatening, or destructive. We also differ in how we see these and other traits to be connected to each other. For one person, strong others may be seen as threatening; for another, they may be perceived of as reliable; for one person, friendly people may be seen as weak or stupid; for another as trustworthy. These differences are expressions of what one could call different implicit theories of relationships linking our perceptions of individuals to our repertoire of relationship scripts. On meeting a new person, we perceive their qualities, more or less accurately, and attribute other qualities to them on the basis of our particular scripts, and then act as seems appropriate in terms of our particular aims and available means. Much of the suffering of neurotic people can be attributed to the particular implicit theories of personality which guide them in their relationships.

It is in our emotionally significant and less structured relationships, such as those with friends and lovers, rather than in relationships with, say, shop-assistants or policemen, that our individual expectations and our personal repertoire of perceptions and responses play a powerful role. Moreover, in such relationships we tend to have chosen people, although not always consciously, who seem familiar and ready to play through the drama of relationship according to the plot for which we are already rehearsed; this process of selection serves to confirm the "rightness" of our beliefs.

There are, however, surprises; surprises of two sorts. The first arises from the fact that our consciously recognized version of ourselves and of what we seek in others is seldom the whole story; much is left out, and there is often a counter-plot implying quite other needs and expectations. The sources of these limitations and divisions in the self have been discussed earlier, in Chapter 5. The second sort of surprise is based upon the fact that what we perceive in the other person, and the pattern of relationship which we expect, may not correspond with their identity and their intentions. In this mismatch between the template of our expectations and assumptions, and their surprisingly different assertions and realities, we are presented with the opportunity to modify our system of understanding. Because such learning is difficult, we will often prefer to lose the relationship or try to bully the other into fitting the prescription we offer; but sufficiently strong and sure others who can stand their ground and refuse to be so reduced offer us a real possibility of change. The failure of our mental schemes to assimilate their reality, and the failure of our habitual relationship scripts to evoke the expected reciprocation, force us to enlarge our ideas about the limits of our being, and about what we want and can expect from others, and give us the opportunity to develop more complex and less inflexible scripts.

This understanding is crucial to therapy, for the psychotherapist can be a person who offers these two sorts of surprise. By giving the patient the opportunity to manifest and recognize his own contradictions, and by not accepting his invitations to confirm his assumptions, he can offer a unique opportunity for change.

The process of engendering a relationship that can expose these contradictory wishes, while gratifying none of them, is a central method of psychoanalysis and the main source of psychoanalytic understanding. In the orthodox analytic setting, the patient lies on the analyst's couch, usually for several hours a week, and the analyst is both literally invisible and personally opaque. This method tends to maximize the patient's sense of helplessness and dependency, and serves to make manifest the less respectable and more infantile aspects of his nature. In psychoanalytic terms, this situation is designed to create a regressive, dependent transference. The resolution of this by interpretation and working through is the central therapeutic method of psychoanalysis. Transference is defined as the patient's partly or wholly unconscious tendency to view the psychotherapist in illusory ways determined by his own expectations and wishes, rather than on the basis of the actual behaviour and characteristics of the analyst. Forms of transference, however, occur in settings other than that prescribed by orthodox analysis, including many situations where it is not recognized. The transference which occurs in less rigidly defined treatment situations where, for example, patient and therapist sit in view of each other and where the therapist's interventions may not be exclusively interpretive, may also be utilized therapeutically. I have argued earlier (in Chapter 6) that the psychoanalytic assumption that the orthodox psychoanalytic role is a neutral one seems doubtful; for many patients, the inaccessibility and remoteness feels hostile and may mirror their own inability to stay in touch with others. Such patients may struggle through

to the recognition that the analyst is offering care but, in my view, the way to this recognition need not in most cases be made so hard.

The idea of transference is now fairly generally understood, but often in the somewhat crude version that "patients look for parent substitutes in their therapist". The description "metaphoric relationship", proposed in the title for this chapter, is suggested to avoid such simplification. The world "metaphor", from the Greek, is equivalent to the Latin-derived word "transference", but the different sense conveyed by the two words in English points to a distinction which I would want to make. To say that a patient has "transferred" an attribute or expectation from a parent to his therapist seems to describe a relatively crude and simple act, whereas to say that a patient uses the therapeutic situation, consciously or unconsciously, to experience and enact metaphorically various "as if" versions of his sense of himself and of his wishes, needs and expectations, implies, I think correctly in most cases, a more creative and delicate use by the patient of the opportunity provided by the therapist.

Metaphor is meaningful because the structures of meaning expressed metaphorically correspond to the structures of meaning being explored. One skill of a therapist, therefore, is to allow his patients to use the relationship as a stage on which to play out versions of his scripts, especially those felt as unacceptable or not fully known. Another therapist's skill is to recognize and use fully those small-scale interactions that take place on the therapeutic stage to illustrate the higher-order scripts which are responsible for the patient's life difficulties.

At this point it should be noted that not all that takes place between the patient and the therapist is at the potentially more obscure level of metaphor. The meeting of patient and therapist is a real event, recognized by both as serving a particular purpose, and each inevitably presents the other with a sample of himself. What particular sample of himself the patient offers will, in part, be rooted in the obvious and real nature of the therapist: for example, as older person to younger patient, as white therapist to black patient, or as male therapist to female patient, or the reverses of these; and these realities must be fully acknowledged in understanding what transpires, and may set a limit on what can happen. Within such limits, however – and the limits will be wider to the extent that the therapist can convey his openness to possibility – the individual patient's self-presentation will reveal his particular formations and his particular limitations that stem from his history. As therapy proceeds, such samples may be selected, consciously or unconsciously, as being related to the larger themes, and patient and therapist may develop together a mutually understood symbolic process.

There is one other aspect of the situation that determines which samples of himself a patient brings; namely, the fact that the patient is in need and the therapist is offering help. This inequality, and the anxiety, shame, or anger so easily generated in our culture in adults by the recognition of their dependency, means that some of the experience of the patient in therapy is always difficult to acknowledge. The manifestation of these less acceptible aspects is usually, initially at least, partial and indirect, and is often apparent to the therapist before it can be

consciously named or acknowledged by the patient. The process of unfolding the more difficult aspects of the truth about himself is helped by the therapist's basic acceptance of the patient, and by the sense of sdafety engendered by his feeling understood. The patient's statements, silences, dreams, or demeanour, will usually acceptance of the patient, and by the sense of safety engendered by his feeling understood. The patient's statements, silences, dreams, or demeanour, will usually combine some concealment with some expression; the therapist needs to clarify and make explicit what is being hinted at, and to imply permission for the expression of the difficult thoughts and feelings that he suspects to be present.

In many treatments, the transference serves to illuminate particular issues, or provides further experience of problems which have already been faced in other relationships; but in some this metaphor becomes the dominant factor and the relationship with the therapist carries the weight of the central issues of the patient's life. In some way, unconsciously chosen but allowed by the therapist's conveying his understanding of it, the basic issues of the self are raised: who am I; am I allowed and, if so, on what terms; can I give or receive love; is my anger too dangerous to admit? Along with this, concealed or forgotten aspects of the self and the blocks that prevent change become focused upon that encounter, and may be lived through there to a different conclusion for the first time.

In these more total metaphoric relationships, the therapist needs to be deeply sensitive if the patient is to be spared humiliation, and if he is to learn from the process. This involves the total acceptance of the reality of the patient's feelings, coupled with a clarity and delicacy in exploring their origins and meanings. The patient feels "as if" the therapist is someone other than, in reality, he is, but there is nothing "as if" about the feelings. Provided the therapist has established his genuine human commitment to the patient, the patient can accept the therapist's non-reciprocation of the extremes of love and hate that may be experienced and can, in time, come to value the real care offered (which is therapy) above the more dramatic feelings experienced and the more dramatic responses sought. This process, whereby needs and desires are recognized only to be abandoned, is both painful and strangely liberating. In the remainder of this chapter, we will look at examples of how meetings between patient and therapist can be used in this way. We will start by considering the manifestations of transference in the treatment of Anne and David.

David

David was seen on seven occasions before a gap of some months; because of this and the plan for later group therapy I did not emphasize the transference relationship. It was discussed around two themes: firstly, through my early recognition of his difficulty in accepting the patient role, which was linked with his more general tendency to adopt the care-giving role in his relationships. The second issue was in anticipation of the end of treatment. The experience of being alone after Patricia had left had been a painful one, which he had needed to go through. When, in the

sixth session, it became apparent that he had forgotten the date of our next meeting, I felt that this was probably the result of him not wanting to think about yet another defection, although when I said this he did not accept that is was true. At the seventh session he was given a further appointment 5 weeks later for which he arrived a day late, and it may well be that his failure to meet, which could not be remedied at that time, was an expression of anger or the need to avoid the feelings around the termination of treatment.

Anne

In the case of Anne, as we have seen, transference issues came up at the very start of therapy over the issue of trust. As she developed more trust, the basic pattern of the relationship was characterized by her feeling safe with, and working hard for, me as a good parent. While my "good parent" role was helpful in encouraging Anne towards more self-care, the recognition of mixed feelings was important and, as therapy proceeded, she became more able to be both present in the session and to experience her negative feelings more directly; she was able to shed tears for the first time. As the long break in treatment approached and as she recalled many painful memories, Anne experienced much sadness and some anxiety, but she developed a confidence that she was managing, and she contrasted this sense of "work in progress" with her previous need for everything to be perfect and totally under control.

FOUR EXAMPLES OF TRANSFERENCE UTILIZATION IN TREATMENT

We will now look at some other examples of transference which illustrate the various ways in which it may play a part in treatment.

Peter

Peter was referred for treatment by his tutors because of his failure to complete written assignments. After he had been in treatment for some time he agreed to record, anonymously, an account of the understandings he was gaining of his work difficulty, for my use in a conference for teachers on learning difficulties. The following excerpts are from this recording. It illustrates a recapitulation in treatment of the work difficulty and his growing understanding of the relationship of this recapitulation to his work difficulty and to crucial events in his childhood.

> I made an appointment to record this material yesterday but, due to reasons that are not of great significance, like lying in bed in the morning, I failed to turn up and I am recording it a day late. This may not, at the outset, seem very relevant, but you will see the significance of it. My problem first occurred during the Christmas vacation; I had been working fairly well during my first term and had produced one or two pieces of work of good quality. During that first vacation, when we had a normal amount of reading and writing to do, I experienced a total work breakdown. I knew that some students who showed a certain amount of superficial early promise "blew their fuses" when they came to do real work at University, and I assumed that my relatively good grades had exhausted what little intellectual ability I possessed. With this theory in mind, I went to the Dean, not to apply for treatment, but tell him that it would probably be better for the University and for myself if I were to leave. The Dean evidently realized that, although I may have had problems, they didn't lie in the field of intellectual exhaustion, and he recommended that I should discuss the problem further with somebody else . . .
>
> In my early therapy sessions, I described what happened when I worked: how I would spend a great deal of time sitting with my books and trying to read, to such an extent that where I was living I acquired a reputation for being something of a swot; but for myself, I think I spent most of my time dreaming and going round and round in my mind why I wasn't working, what was going to happen if I didn't work, and how it would be if I did, and how greatly I would achieve, if I did; and I lived altogether in a sort of fantasy world in which I was the conquering hero or was sinking slowly lower and lower to the gutter. I felt I was being unfairly insulated against the coldness and hardness of the world, but that sooner or later it would all catch up with me and I would get my desserts and be seen for what I really was – a rather miserable failure.
>
> Well, what we discovered in the interviews was that all these work difficulties, which had been present since I was at school, were in part reactions to significant male figures. At this stage, perhaps, the thing will fall into perspective when I say that from childhood I have not had a father; he committed suicide when I was seven, and now, in treatment I have found what I had in a vague way suspected: that I hadn't known at all what that had meant . . .
>
> It seems that one of the major things I have been seeking has been some kind of retribution, as if I had been responsible for, and actually was being punished for, my father's death. At school, I had attempted to achieve that first by being very aggressive, bringing down the retributory wrath of the authorities, but the need was evidently not assuaged; so I had switched to being compliant to an extreme degree but then, instead of bringing down the direct wrath of the authorities by deviant actions, what I did was to fail 'O' levels, to fail one of my 'A' levels, to fail my Oxford and Cambridge Entrance, and almost to fail to get a University place . . .
>
> It was the year after I was born that my father became chronically ill. I think I had a real problem with him as, in becoming ill, he seems to have returned to the infantile situation, so that both he and I were like male infants demanding our mother's love. My mother's great need for love to be given in return was turned on her children, especially on me, her only son, and I think I felt the pressure of that over-demand for love from her. In my therapy there was a process of becoming consciously aware of what was going on and of what the situation had been in the past with regard to my father and mother. Underneath that, my subconscious seemed to lag behind so, although I was aware of what sort of syndrome was operating, it continued and still continues, to some extent, to operate.
>
> I also react, but not so much now, to the doctor as a mother, a sort of symbolic mother whom I need and love, but who is demanding things from me. I react to him also as a father figure, and I want to express aggression to him, and I react to him in the same way as I had wanted to react to my father but, as a child, I had learnt that anger to fathers made them die. While, on the one hand, I wanted him to drop dead, on the other hand to express aggression was to have him do so. So, this aggression had to be expressed non-verbally, in lateness for appointments, by not turning up for the recording session yesterday, it had to be expressed in forgetting to bring the dreams I had remembered and written down to talk about, just as it had been expressed in not writing essays for tutors. I also reacted to my doctor as an invader because, although

distorted, the structure I had built up was, while frightening, yet in a sense safe and secure, and the doctor was someone who was going to come into my squalid but known mental situation and change it. So, while I wanted it changed, to do so meant a painful experience, it meant exposing myself to new feelings which I also saw as painful, and for this reason, too, I resisted the doctor and wanted to express my aggression to him.

So, this is how the process of recovery seems to be operating. Although the mean line of the graph of progress is constantly upwards, the actual line is one of advance and regression, although in general the regressions are never so far back as the previous ones; so, although I wanted to assert myself, wanted to express my personality and my individuality, and my aggression against the doctor by refusing to come to the appointment yesterday, nevertheless I have recorded this today.

Charlotte

Charlotte, already described in Chapter 8, was a young woman incompletely recovered from anorexia nervosa, still suffering from marked food preoccupation, with phases of binge-eating and vomiting, and suffering from depression and difficulties in close relationships. The treatment included the use of active techniques, notably self-monitoring, but transference interpretations played an important part on some occasions. The first occasion was at the end of the first assessment session, when I suggested that she was scared of her wish for total care, and was hence having great difficulty in accepting any care at all. This same fear was important in understanding her relationship dilemmas. In the ninth session, I suggested that her indirectly expressed anger with me was linked with the way in which she seemed to perceive me as demanding that she should behave well as a patient, in which she saw me as being like her mother. In the twelfth session, following a break in treatment, she arrived announcing that she was arranging to consult a nutritional expert, a move which I saw as representing a denial of the understanding she had achieved of the meaning of her symptoms and, hence, as representing an indirect, unacknowledged act of hostility towards me; it was also an attempt to escape from the dependency which she had allowed herself. From the fifteenth session to termination at the twenty-first I repeatedly returned to the theme of the approaching termination and of her apparent incomplete ability to acknowledge the fact of it or the feelings about it. These difficulties were seen as linked with her frequently repeated pattern of relationship, a cycle of denied need, fear of closeness, cutting-off, symbolized and magically controlled by her anorexia, gorging, and self-induced vomiting.

In the cases of Peter and Charlotte, there were many similarities between the patients' behaviour in the transference and their behaviour in some relationships in the world outside. In the next case we will consider, the expression of the issues was less direct, representing a metaphoric recapitulation (unfortunately without resolution of the difficulties experienced in life) rather than a repetition.

Nora

Nora was a young woman who consulted for the second time at the age of 25. Four years' previously she had consulted with depression and a sense of not being in control of her life, related to the recent experience of a frighteningly intense emotional involvement with a girlfriend. Two assessment interviews at that time suggested that these problems reflected a harsh, denigrating attitude towards herself, and an inability to allow herself full expression or achievement, due to guilt at having rejected her family's strong religious beliefs. She had accepted referral for group therapy at that time, but had only attended two group meetings. When she returned, at 25, she reported feeling better about herself in general, seeing herself as more in control of her life, and her main complaint was one of persistent sexual difficulty. She had never had an orgasm despite the recent experience of a profound and prolonged relationship with a man who was currently abroad. This relationship had not been ended but she was now involved in a second relationship which was also intense, but was similarly incomplete sexually. She had consulted at a time when she was only available for treatment for 3 months, and I had been uncertain about whether to offer treatment, or not. When I said, at the third session, that we would see what we could do in the time available, she countered by saying that she now felt she would not proceed. I interpreted this response as representing her need to control by withdrawal, and linked this with her previous leaving of therapy, with the fearful experience of over-involvement with the girlfriend, with her current ambiguous commitment to two men, and with her sexual problem which represented, I felt, a defensive absenting of herself at the point of sexual commitment. This defensive control seemed characteristic of many of her relationships, although it alternated in some instances with placatory behaviour followed by resentment. These themes were explored over five further sessions, two sessions having been postponed by her. She dealt with her two-man problem by arranging to go abroad away from both for a further year, and postponed her last session; she failed to contact me for an alternative time.

Win

Win had 30 therapy sessions over the last 18 months of her University career, the reason for seeking help being a morbid obsession with death, panic attacks, many psychosomatic symptoms, and depression. In the course of her treatment, her self-attacks, her symptoms, her fears, and her self-diminution reduced in intensity, and her tendency to see destructive attacks from others, which were based on projection, was much lessened. Termination was accompanied by sadness and by the feeling that she was not ready to leave. Follow-up contact was arranged but, for geographical reasons, this was infrequent. Over the ensuing 15 months, however, she wrote a number of letters in which she expressed very fluently her sense of "unfinished business", and described eloquently the painful experience of living through the resolution of a powerful transference which had clearly not been adequately dealt with at the time of termination. In Win's early letters she was preoccupied with her sense of loss and with her awkwardly conveyed shame at having sexual feelings for me.

> Sometimes lately I've wanted to feel that you were hurt like me, but I expect it's some odd wishful thinking. I am not clear why I want to produce pain in you when you took so much of it away from me. So now I'll come on to the other reason for my feeling that you would be ashamed of, or angry with, me. What a pity that I can't think of any other way to put it down that doesn't sound absurd, especially since it's simply that I want you physically as well as the other ways . . . . Nothing I can think of consoles me. It makes me very angry with you for making me feel it, and with me for feeling it . . . .

Later (4 months after ending) she went through a period of great desolation, described as follows.

> Some nights ago . . . . I suddenly, for no reason I could see, began to feel worse than ever before. I can't explain exactly what it was but the end result was quite different to anything experienced at other times. (I no longer seem to have the death fears.) I became quite convinced that I was the only living thing left on earth. I went frantically calling the cat to be able to hold on to a breathing, living creature. I couldn't find it, and ended up watching the cars go by to reassure myself. Since then, I came to hate everyone for not wanting me. By the time I wrote to you I had worked up 100% hate. I hardly knew where it all came from. Then, for some completely unknown reason, everything lifted like a fog. No delirious happiness, nothing excessive, just a nice, calm, reasonable peace. My boyfriend says that he won't leave me and he wants to stay. I think I was relieved most of all to know how much I wanted him to, rather than whether he wanted me . . . .

Two months later she was able to write as follows.

> It is hard for me to write, for although I know where to end I hardly know where to begin, so I'll start by saying what I intended to leave to the end, which is a very simple and, to you at least, obvious statement that I know I must become alright without you. I am afraid of becoming whole since, paradoxically, unity also means apartness . . . .

In her next letter she explained how difficult it was to name her feelings for me without risk of distortion or of my being reductive.

> I consider that I have loved a few people before, although my boyfriend is the only person of whom I have said it. None of these feelings encompass the kind of thing I feel towards you, nor even in their own way were they so strong. I swear that if these people went from my life I would grieve, but that I would see an end to it. Perhaps I am doing myself a rather twisted injustice, but what I mean is that I cannot see an end to grieving now, and the pain does not seem justified by the cause . . . .

Two months later she described how the pain of ending had initially felt like the appropriate punishment by her "gaoler" (her name for her self-destructive and self-restrictive parts):

> Now, when I should feel peace, when I can grow away instead of being pushed away as I felt it was, I wait to be punished . . . .

These issues were referred to over the ensuing months, with increasing self-assertion, and finally, 15 months after the formal termination, she was able to write her last letter.

> I wasn't intending to write to you but as I put down in my diary my version of what I was thinking and feeling, I found I was posing a question to which I didn't have the answer. Since it is a question about you, I am turning it into a letter. Something happened which in itself isn't very important, but which made me very depressed. After a week of being down, I found myself crying and not able to stop. This went on for about 3 hours, during which time all the feeling I had had for you and all the sadness that went with it returned. I thought it had disappeared but it was only buried. And yet, it wasn't the same depression or the same pain, and this time I could see through that state into the time beyond it. The next day I felt rather better and in a week quite strong and recovered. I began to dismantle the particular problem and to reason it out in the light of what I had learnt from you. Reasoning is always a good sign for me because I can only do it when I'm not afraid. The reasoning itself wasn't very wonderful or profound but the meaning it holds for me is. I tried to think of the pattern of the things you've said, and put them in order, not to regiment them but to make them stand still and be looked at. It made sense. I found myself trying to see you away from what I wanted, in the past, to force you to be, so I will try to tell you what you mean to me now. First, I can't, and probably never will, understand why I had to go away that first time before I was ready. I felt like a ghost going from your room, as though I had ceased to exist. I hope there is no worse feeling to be experienced. Sometimes I think you might have been surprised at how really bad I felt, but of course I couldn't ask you if you knew. I hope you didn't because it would have made you very cruel. I couldn't believe that. Well, I came back and I wrote, and if I was persistent, unreasonable, and a nuisance, it was at least partly your fault. Nevertheless, you were good to me. You were always there and comforted me, and later you let me be angry with you which I badly needed to be. I could really have smashed you sometimes. You were still there, and answered my letters despite my idiocies and spite and the difficulties. When I reflect on my foolishness now, it doesn't please me, but it doesn't upset me as before. It's just a part of what I was, and am now, in different forms. It doesn't govern me. Then I went through a phase of wanting to be without you, being afraid to try it. This took the form of me managing and being independent and you being hurt and upset without me. As I wrote, I realized that it was this question I was posing, and this fear was still hanging about. So this letter is just a way of discovering if my independence, which seems to me to have become a bit loud and aggressive in my last letter or two, was hurting you or not. I have been so happy lately, and still am, and it took some misery to bring the question to my attention. I don't think there are any more questions. Puzzles perhaps. With love from Win"

A DISCUSSION OF THE FOUR EXAMPLES

We will now consider the last four examples in terms of the PSM. In the case of Peter, the transference relationship was a repetition of a pattern recognizable in his relationship to tutors and teachers for many years, and bearing traces from his earlier relationship with both parents. He consciously sought high achievement and worked appropriately until nearing success or completion, at which point he stopped. These self-engendered failures were both acts of defiance (historically having the meaning of not doing what mummy wanted) and invitations to punishment (historically a kind of baring of the throat to the fathers who, in the fantasy generated by his own father's death, would not survive or permit his direct anger and maybe not even his success). He was trapped into the dilemma "either compliant or defiant" and success was prohibited by a snag; in psychoanalytic terms, these were manifestations of anal and oedipal issues. In treatment, he

alternated between compliance and defiance and he finally chose to end therapy himself, a decision which probably included both elements of defiance and some proper assertion of autonomy. Symbolically, being able to go off on his own terms, feeling that he had made progress and yet had left me neither punishing nor punished, was a challenge to the snag. His problems were not completely resolved, however; throughout his undergraduate and postgraduate career, which was ultimately a successful one, he repeatedly failed to obey the letter of the law, and in particular was often late in submitting work.

In the case of Charlotte, the basic dilemma she showed in her relationships, and repeated in the transference, was one of being either controllingly withholding, or involved and out of control. This was parallelled in her attitude to food, in which she was either meticulously self-depriving and self-controlling, or greedy, binging, and out of control. Clearly this dilemma, in psychoanalytic terms, relates to the early oral issues of trust and dependency. The transference interpretations I gave her were fully accepted intellectually, and she became much less food-obsessed and much more able to express her feelings, but she remained a waxing and waning presence and, as with Peter, treatment had mitigated rather than fully resolved the basic dilemma.

When Nora missed her last appointment, I felt that she had been untouched by treatment, having simply re-enacted her controlling, withholding script with me. Her sexual problem was an expression of an existential one in which basic trust in others was lacking and the integrity of the self was felt as in jeopardy. While these issues point to a developmentally early origin for her difficulties, it could be that the very competent strategies she had evolved for remaining safe constituted the main reason for the persistence of this pattern. Some weeks later she wrote that the sessions had been "an introduction to a series of valuable explorations which I hope somehow to continue . . . they have without doubt unravelled a little of the internal confusion and I can sense an allayment of some of those suicidal fears." So, while the therapy remained as incompletely consummated as her sexual relationships, some shift may have been initiated.

For Win, the living through of the transference relationship was the whole point of therapy, and most of the crucial work was done after the end of regular sessions, by letter. The continuing source of Win's troubles was her harshly self-critical and self-punishing "gaoler", which was slowly mitigated by my becoming both the object of her love and desire, and an alternative and kinder judge. (In psychoanalytic terms, as described by Strachey (1934) and discussed below, I was the object of her id drive and a quasi replacement for her superego.) The sexualization of the transference can reflect an inability to hold onto the metaphoric quality of the relationship (a sign of severe pathology) or it may represent a resistance to the work of therapy. In Win's case, however, it seemed to be no more than the intense manifestation of what was primarily a powerful maternal transference, in which the basic issues of trust, and separation without damage to either, were eventually lived

through. It was a painful experience, but by the end she had clearly achieved a much less conflicted and kinder attitude towards herself.

DISCUSSION

In terms of the PSM, the metaphoric relationship of patient and therapist offers an opportunity for the patient to engage in a relationship in a situation with special possibilities which can allow the expression of aspects of the self normally concealed or unrecognized. Patients can be expected to relate to the therapist in terms:

(a) of their general relationship scripts;
(b) in terms of scripts selected on the basis of their initial construction of the therapist, for example as authoritarian or maternal, and;
(c) in terms determined by the actual evolution of the therapeutic relationship.

Whatever is manifest in these ways may be usefully commented upon by the therapist. As regards (a) and (b), the patient's perceptions and actions may reflect narrow, inflexible scripts which have served satisfactorily in the past, with or without the addition of the defensive strategies such as repression and denial, or the distortion of projection. The patients' usual procedures may be manifest in a range of tactical level acts and experiences, both in everyday life and in the transference, which can be seen by the therapist to reflect the terms of higher-order scripts of which the patient is not aware. These higher-order scripts can be described by the therapist, and such descriptions are accepted and found useful by patients. As regards (c), the evolution of the transference will be shaped in part by the realities of differences in status (self-exposing, help-seeking patient, more or less un-self-revealing, help-giving therapist), in part by the particular style of the patient and therapist, and in part by whatever it is that the patient's needs determine. The therapist's offer to the patient, of non-critical listening and the absence of conventions of logic or politeness, communicate the particular privileges of treatment, which allow the patient to experience and enact aspects of himself that are normally concealed. In particular, childhood-based feelings, and meanings normally hidden or guarded against, may find expression even if regression is not actively fostered, because of the safety that can be established in the therapy situation, and as this safety and the therapist's acceptance are understood, riskier and more anxiety- or guilt-arousing issues can be presented. Not everything that develops in the transference relationship is regressive or shameful, however; often the patient's real wish is for the therapist's recognition of his capacity to be effective and to love.

Transference, a psychoanalytic concept ignored by other schools, is the subject of an enormous and often confusing literature within psychoanalysis. Sandler *et al.* (1973), in discussing the evolution of the concept, propose that it should be distinguished both from the treatment alliance and from those traits that are equally manifest in other relationships. In this view, transference is a unique process evoked

by the treatment situation and characterized by the development of specific illusions about the analyst and by attempts to provoke particular responses from the analyst, in ways representing the repetition of aspects of past relationships. However, Sandler *et al*, also concede that such distortions and manipulations may occur, though without being recognized, in non-treatment situations, so that this proposed, exclusive classification is not entirely satisfactory.

In the evolution of psychoanalytic practice, the interpretations of the transference has become the central, for some virtually the exclusive, intervention. For a specific and highly influential paper on this subject, we can turn to Strachey (1934) who approaches his issue with considerable detail and clarity. Strachey retraces the evolution of Freud's thinking from an early concern with the recognition of unconscious desires and drives to his recognition that "as analysts, our main task is not so much to investigate the objectionable unconscious trends, as to get rid of the patient's resistance to it." The energy for this task of overcoming resistance was seen to come from the transference:

> Instead of having to deal as best we may with conflicts of the remote past, which are concerned with dead circumstances and mummified personalities, and whose outcome is already determined, we find ourselves involved in an actual and immediate situation in which we and the patient are the principal characters, and the development of which is to some extent at least under our control; but if we bring it about that, in this revivified transference conflict, the patient chooses a new solution instead of the old one, a solution in which the primitive and unadaptable method of repression is replaced by behaviour more in contact with reality, then even after his detachment from the analysis, he will never be able to fall back into his former neurosis.

Transference analysis has as its main aim the modification of the superego. Strachey, influenced by Klein, sees the superego in the infant as built up out of a vicious circle of re-introjecting projected oral aggression. This circular process (anything but a merry-go-round) begins with the child's destructive feelings for the frustrating mother; these are projected into, and then experienced as coming from, the mother, and by this means a mutually sustaining savage id and savage superego are built up. In the normal child, the balance of positive feeling emerging around the genital stage is supposed to relieve this vicious circle, but in the neurotic it persists and will be manifest, evidently or latently, in the transference relationship with the analyst. The "mutative interpretation" which, in Strachey's view, is the essential instrument of change in psychoanalysis, recognizes and names both the violent, forbidden impulse, and the violent defence against it, and relates this polarization to the confusion seen to exist between the analyst as he really is and the "archaic phantasy object" projected onto him in the negative transference, Such interpretations are effective because the analyst has become the object of the patient's id drives and the quasi replacement of his superego; the repetition of interpretations of this process leads to the permanent modification of the patient's superego.

On the basis of this account, Strachey, and psychoanalysts in general, insist upon the need for "neutrality" on the part of the analyst because "it is a paradoxical fact

that the best way of ensuring that his ego shall be able to distinguish between phantasy and reality is to withhold reality from him as much as possible." It is argued that any act of the therapist will be experienced by the patient, unconsciously, as representing either an invitation and hence heightening id pressure and provoking increased superego repression, or as a punishment and hence heightening superego pressure. It will thus inevitably feed into the savage id–superego vicious circle. If this point is taken as true, the proposal to combine transference analysis with active methods, which is a central proposition of this book, is clearly absurd.

I think one has to accept that any act of the therapist may have a powerful meaning to the patient, and if a strong transference relationship has developed this will include meanings articulated at a primitive level. What I am not so clear about, however, is whether there is any way of being with an analyst for 5 hours weekly, at considerable expense, that does *not* accord to him a powerful reality. The analytical argument is really for the provision of a particular kind of presence; that of a literally and personally invisible, largely silent and withholding, deliberately opaque, occasionally speaking, and implicitly helpful presence. Such a presence may be appropriate for some patients, but I cannot see that it is necessarily so for all; it will have very different meanings according to the patient's history. For some, and especially for those previously exposed to, or themselves operating in, similar controlling and withholding ways, it can represent sterile mirroring, or can be sensed as persecutory. (Perhaps the preoccupation of Kleinian theory with schizoid–paranoid phenomena and the predilection of Kleinians for violent language stems from their patients' reactions to this opaque stance?) Moreover, the personally inaccessible analyst, when he does speak, offers a form of interpretation which throws into question at a very fundamental level the patient's self-understandings. I cannot believe that these somewhat Olympian pronouncements, even if accurate, are not at times experienced as powerful challenges to the patient's reality sense, even though Strachey says that "the patient's ego is so weak, so much at the mercy of his hidden superego that it can only cope with reality if it is administered in minimal doses and these doses are in fact what the analyst gives him in the form of interpretations." I find myself doubting both the description of the interpretation and of the patient implied in this passage. Those neurotics with clearly weak egos (the borderline cases and narcissistic personality disorders) seem to do rather poorly in classical analysis. Those who do well are the healthier ones, most of whom have shown an ability to cope with some areas of their lives, and many of whom have demonstrated considerable strength and courage in surviving past bad experiences, and in managing the conflicts and pressures they impose upon themselves. Some of the ego weakness apparent on the couch may be a weakness induced by the couch.

Further questions about this model of change are raised by a more recent brief paper addressed to the same general issue. Khan (1970) argued that the major problem that faces the analyst, especially with the more sick patient, is not his

"authentic illness" (by which he means, I think, the condition capable of description in classical psychoanalytic terms) but rather the patient's "practice of self-cure". This practice of self-cure, Khan argues "is rigidly established by the time he reaches us. To treat this practice of self-cure merely as resistance is to fail to acknowledge its true value for the person of the patient". I would personally extend this somewhat backhanded recognition of the patient's capacities by suggesting that, if we look at how most neurotic patients live their lives, we will often find their problems are not primarily those of a beleaguered ego crushed in the vicious circle of savage id–superego conflict, but are rather those of people operating with a set of strategies somwhat less adaptive than those of their neighbours. Most of these strategies will, however, have served well enough in the past; the inadequacy of them at this point in time has been exposed by their failure to cope with new situations or by the recognition that they are restricting growth. Although to some extent the neurotic person's strategies will differ from those of his neighbour in that they are more concerned with ego-defence (that is to say, they will involve more restrictions on awareness or action), many of his difficulties are the result of ways of thinking and acting which were once, but have now ceased to be, effective. These ineffective ways are often easily visible to the therapist, and, once named, are recognized without resistance by the patient. If the therapist names these strategies clearly, and perhaps uses some of the active methods discussed in Chapter 8, he will often find that the patient's weak and beleaguered ego turns out to be remarkably resourceful. Given a conceptual tool, "it" will get on with the job. Moreover, as "it" becomes more effective, "it" becomes stronger and less in need of defence or, as I prefer to say, as the patient gains a sense of greater control, capacity, and value, his need for strategies which distort reality and limit action is reduced. The classical analytic technique has left analysts and their patients ignorant of the effectiveness of all the more direct means of help because analytical theory rules them out, and imposes on the patient a passive and regressed role.

In my experience, the early sharing of accurate descriptions of faulty procedures and of active methods does not prevent the development of transference or the possibility of working with it, although the transference itself will have fewer regressed and paranoid features.

This is not to say that active methods should always be applied; there are patients for whom the right to shape and explore what can be done with the therapist, is very important, and to whom active methods can seem intrusive or irrelevant. A less active approach is often appropriate for the patient who has been unable fully to mourn a past loss; the therapist, by becoming the metaphor for the lost person, allows the process of loss, repeated with the termination of therapy, to be gone through to completion. In this way, those scripts designed to deny the reality of the loss, or diminishing the value of the lost person, and hence of the self in relation to the lost person, can be revised.

Gallwey (1978) has contributed a useful consideration of the transference with special reference to the problems of aim-restricted psychotherapy, by which he

means therapy conducted once weekly or for a limited period. In his discussion he notes that quite primitive pathology may be present in the transference without any general regression taking place. He relates this possibility to the mechanism of splitting, contrasting this with the previous analytic ideas in which such primitive pathology would always seem to be the result of regression to earlier modes. In terms of the procedural sequence model, these primitive transference involvements represent unintegrated relationship scripts, the avoidance of which may have dominated the actual form of relationship experienced by the individual. In Gallwey's view the issues of deprivation, limitation, and loss are particularly central in the management of aim-restricted therapies of this sort, and not all patients are able to cope with those problems on once-a-week treatment. He stresses the importance of early recognition of the problems and early involvement between patient and therapist, saying:

> Patients in weekly psychotherapy with whom one does manage to make good early contact can get into the stride of the work in such a way as the times in their weekly sessions take on a regularity characteristic for themselves . . . so that their internal "clock" seems to regulate the experience appropriate to its meaning with extraordinary facility.

The difficulties of time-restricted therapy may be more those affecting the confidence of the therapist than those of the patient because:

> . . . It is much easier to lose track of the reality of the importance of oneself and the work for the patient's unconscious, and become slipshod, particularly if the patient is improving . . . or is effectively concealing his feelings. It is a very pronounced thing about transference work that however much evidence one gets that, when correctly carried out, it militates against regression and makes patients less dependent upon oneself in a clingy, infantile way, the impingement of disturbed dependency within the transference . . . inevitably leads one to the feeling that one should not attempt to contact it for fear that it will be exacerbated. The very reverse is in fact the case . . .

This paper, which includes sensitive clinical examples, also includes an appropriate warning against bad transference work.

> There is one common shortcoming, however, and that is for therapists not only to shy away from examining and endeavouring to interpret the transference, but to believe they are making transference interpretations, when they are forcing the material into a mother/father/sibling constellation, and relating it ad hoc to themselves. Such facile constructions are sometimes combined with implications that the therapist represents an ideal authority. The combination of banality and pseudo-superiority is at its best ineffectual and exasperating . . .

The closing words from this paper will serve to close this discussion also, as they summarize the situation very clearly:

> . . . I think we intuitively know that the responsibility of involvement in the transference is unique, and once one has made contact at an intimate level of understanding, then the therapeutic effectiveness that it enhances cannot be easily set aside. However, if there is fair contact with one's own weaknesses, support from

colleagues, and involvement with other people's work, then there is immense interest and satisfaction to be had from the utilisation of the most sensitive and informative of all psychological instruments.

10

Instructions, Constructions, Interpretations, and Strategies

In the last three chapters, the selection of patients, the setting up of therapy, the establishment of its goals, the place of active methods, and the use of the transference have been considered. It has been argued that therapists must know how to create a situation in which patients can reveal their troubles and know how to make sense of, and reframe, these troubles. Beyond this, they need to have certain practical skills at their disposal which they can teach patients to use in the pursuit of self-knowledge and self-control, and they should be familiar with and, in some contexts, able to use, the transference. In the present chapter, further attention will be paid to what therapists say and do, and to the question of planning the strategy of the treatment.

It should be emphasized at this point that, in my view, psychotherapy involves more than techniques: it is the skilful use of the human encounter. The development of closely specified treatment methods and the production of standard treatment manuals have served to introduce some rigour into the field of training and outcome research, but such treatment packages, fortunately, are still delivered by human therapists of all shapes and sizes, in very different contexts. In my own practice, while drawing upon some of the specific techniques of cognitive and behavioural workers, I never conduct therapy on lines restricted to any one such approach, and the foundation of treatment is always a sharing with the patient of my overall understanding.

The aim of a therapeutic programme is to obtain maximum impact with minimum means. One of the main contentions of this book is that this is best achieved by the early elaboration of treatment goals in the form of high-level explanations or hypotheses about the patient's self-perpetuating faulty procedures. In this, the approach differs from both psychoanalysis and behavioural therapies, where the emphasis is more upon detail: in psychoanalysis, through attention to the minutiae of recollection, fantasy and the transference; in behaviourism by the careful microanalysis of small units of behaviour. In both these approaches,