CHAPTER 1: INTRODUCTION

This research uses the qualitative approach of Grounded Theory to explore how psychoanalytically oriented therapists think about and work with what have been called "extra-therapeutic transferences." It is a study of the subjective experience of therapists listening to clients talk about the transferences that people form in their lives outside of the therapy setting.

The Problem and Background

As a psychoanalytically oriented therapist, I struggle to integrate theory and practice, to reconcile disparities between what I do and what I think I should be doing. What I read in professional literature and hear at conferences emphasizes how therapists work with the transferences that emerge in treatment. Transference is defined as an aspect of the therapist-client relationship that develops when significant relationships from the client's past are re-capitulated and repeated, or "transferred" to the therapist. Freud, Strachey, Gill, and other psychoanalytic theoreticians argue that meaningful therapeutic change occurs only through recognition and clinical use, mainly through interpretation, of this therapeutic transference.

However, my clients, and I believe those of other therapists, spend much of their time in therapy exploring relationships with people other than their therapists. They talk emotionally about interactions with their partners, children, other family members, friends, co-workers, other drivers on the road, and even phone company workers who showed up late. Similarities between current and past relationships may and may not be transferential, but when current relationships are emotionally intense,

repeat patterns, or appear to carry elements of the past, I consider that they have transferential dimensions. Talking about them in therapy seems to be helpful to clients, but because of the emphasis on interpretation of the therapeutic transference in psychoanalytic theory and training settings, I question spending so much time talking about clients' outside relationships.

I have wondered how other therapists come to terms with the apparent contradiction between the extent to which clients talk about people outside the therapeutic relationship and the emphasis in psychoanalytic theory on the curative role of transference and its interpretation. How do therapists think about and use the material that emerges when patients describe transferential relationships outside of the therapy relationship, the so-called extra-therapeutic transferences?

Inconsistencies between theory and practice are common and can lead to confusion on the part of therapists. In his examination of Freud's case reports and autobiographical accounts Reuben Fine (1989) observed that there was a "considerable discrepancy between [Freud's] theory as stated in his theoretical papers and the way in which he did conduct his analyses" (p. 494). For example, although Freud wrote about the analyst as a blank screen and his followers sought to follow his teaching, Freud, in his own practice, did not maintain this stance. The discrepancy between theory and practice is further illustrated in the following contemporary anecdote: a colleague told me about her collaboration with a well known analyst on a case where he saw the man, and she saw the man's wife. Her patient told her some things the analyst had said to the man concerning his relationship with the wife, and my colleague asked the analyst about it later. His comments to the man had sounded very direct and non-analytical, but right-on. The analyst replied: "Of course I said those things. I am an analyst when my door is open, and when my door is closed I do what I think can be helpful."

In the literature I found other examples of individual therapists who discovered their own ways to describe working clinically with the extra-therapeutic transferences, but no systematic investigation or higher level conceptualization of this phenomenon exists. Though psychoanalytic theory provides thoughtful and useful guidance for clinicians on the recognition and use of transference in the therapy setting, it has little to say about clinical use of extra-therapeutic transferences. When discussed at all, within contemporary as well as traditional psychoanalytic literature on transference, extra-therapeutic transference interpretations are deemed less helpful than transference interpretations. They are often considered mistakes resulting from therapists missing or avoiding the "real" transferential implications in the material (Strachey 1934; Heimann 1956; Gill 1979; Wallerstein 1995). These authors maintain that when patients talk about outside relationships it is a defensive displacement of ideas or affect that belong in the transference—splitting, or resisting the experience of transference with the therapist because the experience might be painful or threatening. As Merton Gill (1979) states, "The most commonly recognized disguise [of transferential feelings towards the therapist] is by displacement [where] the patient's attitudes are narrated as being toward a third party"(p. 273).

Since the tendency is to view patients' discussions of outside relationships as a manifestation of the therapeutic transference or as a form of resistance to treatment, psychoanalytically oriented psychotherapists lack theoretical guidance if and when they work directly with extra-therapeutic transference material. If therapists are "doing what is useful" with their clients, but continuing to talk the talk of mainstream psychoanalytic theory, that is, if there is a mismatch between practice and theory, the theory needs to be reconsidered in order to be optimally useful to clinicians.

The over-emphasis on therapist/client transference and transference interpretations as the key to treatment may exclude from consideration the possible benefit to clients of talking with their therapists about outside relationships, having those transferences considered on their own terms, and gaining the benefit of insight and understanding derived from discussing and interpreting extra-therapeutic transferences, even though such experiences may have great immediacy for the client.

The few commentaries I found that do discuss the significance of extra-therapeutic transferences (e.g.,Fine, 1989; Halpert, 1984; Kivowitz, 1990; Ornstein, 1990) suggest that material from the client's outside life provides important affective material that is not necessarily available in the analytic situation itself and *must* be interpreted in reference to the client's outside relationships, independent of whether it relates to the therapist/client transference.

The purpose of the study is to discover how therapists think about the impact on patients of relationships that occur outside the clinical setting, what relevance they attach to the discussion of outside relationships within the psychotherapy process, and what technical use they make of this material in their conduct of therapy. Do psychoanalytically oriented therapists consider outside relationships as phenomena to be worked with directly to address clients' views of themselves and their relationships or only as they relate to the primary therapeutic transference? While acknowledging that the concept of transference occurring between patient and therapist is of central importance to psychoanalytic theory, the focus of this study will be on how psychoanalytically oriented therapists make use of extra-therapeutic transferences and whether they integrate it with their understanding of the concept of transference. Such an inquiry could add a dimension to our theoretical understanding of an important and undervalued therapeutic phenomenon, extra-therapeutic transference.

The Research Question

The following questions are addressed in my research: How do psychoanalytically oriented psychotherapists conceive of and make use of clients' presentation of outside relationships? Do they see clients' outside relationships in terms of the concept of transference? What theoretical concepts guide psychoanalytically oriented psychotherapists as they listen to clients' presentation of outside relationships?

This qualitative study focuses on the subjective experience of the therapist, using a Grounded Theory approach (Glaser & Strauss 1967). The data consists of in-depth interviews with psychoanalytically oriented therapists who were asked to consider their practice with regard to extra-therapeutic transferences. The "constant comparative method" of qualitative data analysis as described by Strauss and Corbin (1990) was used to analyze data from the study.

Clarification of Terminology

I will differentiate between the uses of several terms that overlap within the psychoanalytic literature. The most general meaning of "extratransference interpretation" refers to interpretation by the therapist of *any* clinical material that does not directly relate to the therapist/client transference, such as the repetition of traumatic experience in dreams and symptoms, the denial of a parent's psychosis or alcoholism, or the manifestation of early separation anxiety in adult insomnia or fear of death (Blum, 1983). An occasional, and quite different use of the term "extratransference" in the literature refers to interactions that occur between patient

and therapist outside the therapy setting. This latter meaning is not relevant to the present study.

The "extra-therapeutic transferences" under study here are a subset of extratransference phenomena that may be interpreted and that do not necessarily relate to the therapist/client transference. This form of extratransference phenomena, the "extra-therapeutic transferences," concerns relationships with significant people in patients' lives that have transferential aspects.

The terms "client" and "patient" are used interchangeably in this study, as are "therapist" and "psychotherapist," "analyst" and "psychoanalyst." "Extra-analytic transference" is also used interchangeably with "extra-therapeutic transference."

Theoretical Framework: The Psychoanalytic Concept of Transference

This study questions the parameters of the concept of transference in psychoanalytically oriented clinical practice. A brief discussion of how the term "psychoanalytically oriented psychotherapy" is understood within psychoanalytic theory and practice, as well as an overview of the concept of transference, will provide a context in which the research questions will be explored.

Psychoanalysis and Psychoanalytically Oriented Psychotherapy

Among therapists who identify their theoretical orientation as psychoanalytic there is a wide range, from psychoanalysts who train in institutes that require them to undergo training analyses and control cases, to therapists who learn psychoanalytic theory and practice through study and supervision and who may or may not undergo

personal psychoanalysis. Psychoanalytically oriented psychotherapy is guided by psychoanalytic principles, but does not meet all the criteria for psychoanalysis.

There is a large body of literature addressing differences between psychoanalysis and psychoanalytically oriented psychotherapy (e.g., Bibring, 1954; Gill, 1984; Rangell, 1981; Wallerstein, 1983). In terms of practice, however, the range of difference between theories – Kleinian, Kohutian, Lacanian, Relational, Freudian, Jungian, etc. – may be greater and more significant than the range of differences in technique between analysts and other psychoanalytically oriented therapists. For purposes of this study, elements common to the practice of psychoanalytically oriented therapy are more important than distinctions between schools of psychoanalytic thought.

In Freud's (1912) formulation, psychoanalysis was the treatment of choice for neurotic patients. The analytic process brings meaningful mental and emotional content from the patient's unconscious into consciousness in order to promote insight, self-awareness, and freedom from painful and restrictive psychological symptoms. Post-Freudian schools of psychoanalysis apply the analytic approach to a wide range of diagnostic categories in addition to neuroses, such as narcissistic and borderline personality disorders.

Examples of elements common to psychoanalysis, and to a lesser degree common to psychoanalytically oriented psychotherapy, are the following: it is assumed that unconscious processes contribute to psychopathology, that past experiences influence present-day experiences, and that patients will resist aspects of the psychoanalytic process that seem to threaten their habitual ways of being and interacting; the relationship between patient and analyst is expected to take on importance during treatment; the patient is encouraged to talk freely while the therapist

remains relatively quiet and relatively neutral, responding to material brought out by the patient; interpretation (particularly of the transference, but also of dreams and other material) is the analyst's primary intervention; sessions occur several times a week and go on for several years. In analysis the patient usually lies on a couch, with the analyst sitting out of sight, to encourage the patient's staying with his/her own processes and associations. Psychoanalytically oriented psychotherapy is generally conducted with the therapist and the patient sitting in chairs, facing each other, and the frequency of sessions is usually once, or sometimes twice, a week.

The participants chosen for this research are psychoanalytically oriented psychotherapists, but not psychoanalysts. The study addresses itself to the practice of psychotherapy that is based on psychoanalytic theory, but that does not meet all the structural criteria of psychoanalysis. A further study, based on an inquiry into the clinical use of extra-therapeutic transferences in psychoanalysis, might yield different results.

The Psychoanalytic Concept of Transference

All approaches to psychotherapy recognize the importance of a positive relationship between therapist and client so that the work of therapy can progress. But more than any other approach to therapy, psychoanalytic theory attends to the *transferential* aspect of the therapy relationship.

The basic concept of transference is a simple idea that accounts for the carry-over, or transfer, from past relationships to current relationships. Otto Fenichel (1945) noted, "It is a general human trait to interpret one's experience in the light of the past" (p. 30). The form that it takes in psychoanalysis and psychoanalytically oriented psychotherapy is that the patient's perceptions and feelings that were present in earlier

life and relationships are heightened by the analytically oriented therapy situation and are frequently transferred to the therapist. Freud found that neurotic patients in psychoanalysis would begin to treat him in a manner similar to significant figures from their past. This experience reached its most intense form in the transference neurosis. Emergence of the transference neurosis brought into focus feelings towards the analyst that originated during the period of the patient's Oedipal Complex. Interpretation of the repressed Oedipal conflicts transferred onto the analyst relieved neurotic symptoms. In current psychoanalytic theory, transference is no longer limited to the transference neurosis per se, but has been broadened to include the gamut of feelings the patient has towards the therapist that are transferred from significant emotional relationships in the past.

Theories regarding the transference help clinicians understand the source of this material in clients' lives and also prescribe a therapeutic stance or techniques to bring the intensity of the transference to bear on treatment. The very structure of psychoanalysis and psychoanalytic psychotherapy is designed to facilitate an intensification of transference in the relationship between therapist and client. Many schools of psychoanalytic therapy have developed since Freud's time, each making use of transference in ways that reflect the theory itself, with its particular understanding of etiology and cure. Depending on the school of psychoanalytic theory, the transferential aspect of the therapy relationship may reflect such elements as previous relationships, patterns of relating, unmet developmental needs, or internal conflict. Options for handling the transferences that emerge in treatment include the therapist's silent awareness and observation of it, other activities such as the therapist choosing to alter his/her behavior towards the client based on the type of transference, and verbal interpretation of it. Whether a particular transference is actively interpreted or remains

in the background, the skill with which the clinician is able to understand and use transference phenomena is the key to effective treatment and therapeutic change.

Classical explanations of psychoanalytic cure stress the over-arching importance of interpreting the transference (Strachey 1934). Effective interpretations of transference phenomena in the analytic setting, i.e., those that bridge the past and the present, are believed to be the most powerful therapeutic intervention.

CHAPTER 2: LITERATURE REVIEW

The focus of this study is how psychoanalytically oriented therapists listen to their clients' presentation of outside relationships and how they use that clinical material. The first section of my review of relevant literature will be a historical overview of the concept of transference in psychoanalytic theory and practice, followed by a section on the literature that addresses the concept of extra-therapeutic transference. I will then review the literature that defines psychoanalytically oriented psychotherapy, concentrating on distinctions outlined by Robert Wallerstein (1965, 1986, 1995). In the final section I will summarize several empirical studies that relate to aspects of the research question and methodology.

The theoretical framework for the study relies on three concepts: transference, extra-therapeutic transference, and psychoanalytically oriented psychotherapy. Concepts to be discussed—transference, interpretation, and insight—are part of the basic language of psychoanalytic theory, a language that continues to be used as though it were a common language, despite significant variations in meanings and use of these terms among psychoanalytic schools of thought. In addressing the confusion that can result when confronted with different understandings of commonly used words, Joseph Sandler (1983) described the phenomenon as the "elasticity" of psychoanalytic concepts. He refers to the way meanings become stretched to accommodate changes in use, to allow different schools of psychoanalytic therapy to speak the same language. Recognizing the elasticity of concepts also helps account for differences between publicly expressed meanings (such as those used in writing and conferences) and more private meanings (such as those used in the consulting room). Implicit in the present research study is an interest in exploring how therapists handle differences between

their understanding of concepts in the (public) context of a psychoanalytic theory with which they identify, and how they use those concepts in (private) practice.

Transference

In this section, I review development of the psychoanalytic concept of transference from classical Freudian, ego psychological theory, and contemporary psychoanalytic theories. I undertake such an extensive review of this literature, first, because this is the literature that defines the theoretical orientation of the study's participants, and second, because I am exploring the potential usefulness of the neglected concept of the extra-therapeutic transference. This concept rests on and is contrasted with an understanding of what is generally meant by transference in psychoanalytic theory.

Freud and the Classical Psychoanalytic Theory of Transference

Sigmund Freud observed how people read their present experiences through lenses that were shaped in the past. His understanding of transference began with recognizing it as " a universal phenomenon of the human mind . . . [that] dominates the whole of each person's relations to his human environment" (1925, p. 76). Only gradually did Freud come to appreciate how the transference phenomenon, intensified by the structure and process of psychoanalysis, becomes the key to analytic treatment and cure.

Freud initially thought the patient's dreams and free associations in analysis would be sufficient to cure neurotic patients. Repressed conflicts, which the analyst interpreted, would move analysis towards cure through insight. Other than the positive transference that helped create trust and rapport, when transference phenomena arose,

Freud thought of them as resistances or obstacles to treatment. The unexpected termination of Dora's treatment in 1901 opened Freud's eyes to the importance of attending to the transference. He concluded that his failure to analyze Dora's transferential reactions to him had led to a premature termination of her analysis. He made the same observation about a case of his colleague Josef Breuer who failed to recognize a female patient's transference love towards him (Freud, 1925, pp. 46-47). "Transference, which seems ordained to be the greatest obstacle to psychoanalysis, becomes its most powerful ally, if its presence can be detected each time and explained to the patient" (1905). In reviewing the case in his Postscript to his paper on Dora, Freud talked of his growing understanding that "all the patient's tendencies, including hostile ones, are aroused; they are then turned to account for the purposes of the analysis by being made conscious, and in this way the transference is constantly being destroyed" (p. 139).

Although other types of transference may be present, the most relevant for Freudian treatment is the "transference neurosis" (Freud, 1914). The less important are, first, the general and positive type of transference that Freud understood to occur in any doctor-patient relationship, involving a feeling of trust that facilitates therapeutic progress. The second is a "transference reaction" that Brian Bird (1972), in a later elaboration of Freud's theory, described as "the means of displacing feelings and attachments from one object to another, and of repeating the past in the present" (p. 281).

The transference reaction is distinguished from the complex, and particularly Freudian notion, called the transference neurosis, an artifact of the psychoanalytic process. According to Freud the transference neurosis is the defining characteristic of a successful analysis. During the psychoanalytic process a transference neurosis would

emerge when the analyst becomes the object of transferred sexual and aggressive feelings once reserved for the patient's parents. Conflicts from the core of the patient's neurosis would become activated within the relationship to the therapist, and working through genetic components of the transference neurosis would be the primary therapeutic activity. Bird (1972) said:

> I come to represent some complex of the patient's neurosis or some element of his ego, superego, drives, defenses, etc., which has become part of his neurosis. I do not, however, represent as such, actual persons from the past, except in the form in which they have been incorporated into the patient's neurotic organization. (pp. 281-282)

As the transference neurosis is played out with the analyst and interpreted, the patient recognizes internal conflicts previously kept from consciousness. The traditional analytic structure—frequent sessions, neutral analyst, patient on the couch, free association—encouraged regression and intensified the development of the transference neurosis. Freud's statement at the end of "The Dynamics of the Transference"(1912) suggests the power and immediacy of analytic work in the transference:

> The struggle between physician and patient, between intellect and the forces of instinct, between recognition and the striving for discharge, is fought out almost entirely over the transference-manifestations. . . they, and only they, render the invaluable service of making the patient's buried and forgotten love-emotions actual and manifest; for in the last resort no one can be slain *in absentia* or *in effigie*. (pp. 114-115)

Although in the early years, Freud believed that analysis of the transference would lead to a complete resolution of the neurotic conflict both within and outside the analytic relationship, he later became less optimistic. In "Analysis Terminable and Interminable"(1937) he talked about successful treatment not so much in terms of a permanent resolution of the transference neurosis, but "to secure the best possible

psychological conditions for the functioning of the ego; when this has been done, analysis has accomplished its task" (p. 268).

Despite his eloquence when describing the power of the transference in such passages as those quoted above, and the fact that he discussed transference in a number of his lectures and papers (1912, 1915, 1920/1952, 1937), Freud did not write extensively on the *technique* of working with the transference (Bird, 1972; Fenichel, 1945; Macalpine, 1950; Strachey, 1934).

Psychoanalytic Technique Reg arding Transference

Followers of Freud elaborated on psychoanalytic technique regarding transference. Most notable was James Strachey (1934), who introduced the concept of "mutative interpretation." In his and in all subsequent discussions of the hierarchy of useful psychoanalytic interventions, interpreting the therapeutic transference ranks high, and interpreting or working with extra-therapeutic transferences ranks low. Before discussing Strachey's elaboration on transference interpretation I will discuss interpretation and insight, complementary processes that characterize psychoanalytic treatment and promote structural change in the patient.

Interpretation: What the Analyst Does

Interpretive activity on the part of the analyst is a hallmark of psychoanalytic technique. Simply stated, "interpretation involves the explanation of the meaning of behavior in terms of past or present relationships" (Basch, 1980). Interpretations may apply to resistances, defenses, wishes or fantasies, warded-off impulses, superego

reactions, identifications, and similar matters, where unconscious meaning attaches to manifest thought (Stone, 1981). In addressing the lack of systematic guidance relating to psychoanalytic technique and the theory of technique, Karl Menninger (Menninger & Holzman, 1973) described interpretation as including all the ways that the analyst verbally assists the patient in understanding him/herself better: insight giving, clarification, confrontation, synthesis, the pointing out of connections, implications and meanings that that might elude the patient, reminding the patient of things he forgot he had said, discrepancies, self-contractions, and so forth.

Edward Bibring (1954) identified a hierarchy of five "basic therapeutic principles." He referred to suggestion, abreaction, manipulation (by which he meant the mobilization or redirection of emotional systems in order to expose the patient to new experiences; he did not mean advice or guidance), insight through clarification, and insight through interpretation. The interpretive process, as opposed to an interpretation per se, may include a number of these steps.

Bibring went on to describe how each of the techniques within his hierarchy resulted in particular types of changes in the patient:

> Thus suggestive techniques result in suggestion (in the sense of induced irrational beliefs)[e.g. to help the patient face reality]; abreactive techniques bring about relief from acute tension through emotional discharge; manipulative measures correspond to a number of curative agents which may be outlined under the general heading 'learning from experience'; and finally the techniques of clarification and interpretation which produce the corresponding types of insight which we propose to call insight through clarification and insight through interpretation. (1954, p. 746)

For Bibring, clarification is a process of reflecting and restating what the patient has said in order to facilitate the patient's self-awareness and increase his or her ability to verbalize more complex experiences. Interpretation refers exclusively to increasing awareness of previously unconscious material: unconscious defensive operations and

impulses, hidden meanings of behavior patterns, etc. In a further elaboration Roy Schafer (1983) calls interpretation a "creative redescription" that helps organize the patient at conscious and unconscious levels.

Interpretation is the psychoanalytic therapist's way to convey his or her understanding of the patient to the patient. This understanding develops through the therapist's introspection, intuition, and empathy, together with his or her cognitive and rational gathering and organizing of data from the patient's history and productions in the therapy setting.

The Role of Insight as Curative: What Goes on in the Patient

Complementing the therapist's interpretive activity is the patient's acquiring insight, a process involving both cognitive awareness and affective experience. From a psychoanalytic perspective, insight is the key to structural change within the patient. Harold Blum (1980) says that

> Interpretation leading to insight is the specific and most powerful agent of the psychoanalytic curative process. . . . insight propels the psychoanalytic process forward and is a condition, catalyst, and consequence of the psychoanalytic process . . . [i]nsight does more than make [the unconscious] conscious; it establishes causes, meanings, and connections. (pp. 41, 51)

According to Menninger (1973), as patients acquire insight, there is a lessening of repression and more of their own inner life can become available. Insight is both a means and the goal itself. Insight is the patient's recognition of a number of interlocking ideas: (a) that the current feeling, attitude, or behavior is of a pattern, (b) that the pattern originated in his or her past, is present in contemporary reality situation relationships, and in the analytic relationship, (c) that there were reasons for the pattern to be established, though those reasons may no longer be relevant, and (d) that the repetition of neurotic patterns contains elements that are problematic for the patient or others in his life

(pp.151-152). "Insight is the simultaneous identification of the characteristic behavior pattern in all three of these situations [childhood, contemporary situation, analytic situation], together with an understanding of why they were and are used as they were and are" (p. 152).

Strachey's Concept of the Mutative Interpretation

James Strachey's influential paper, "The Nature of the Therapeutic Action of Psycho-Analysis" (1934) attends more specifically to interpretation of the transference and has remained a reference point for all students of psychoanalytic technique since it was first presented. He coined the phrase "mutative interpretation," referring to a transference interpretation that goes far beyond making the unconscious conscious. The mutative interpretation provides what he calls a "breach in the neurotic vicious circle" (p.143). This occurs as the patient becomes aware that his response to the analyst is inappropriate, that the analyst is, in fact, a new object and that previous views of the analyst were distortions. The interpretation must be specific, detailed and concrete; it must be emotionally immediate and directed at what Strachey calls the "point of urgency"; the patient must experience it as something actual. Strachey's position has continued to be an ideal for many psychoanalysts. In a later section I will discuss Strachey's position with regard to interpreting extra-therapeutic transferences.

Reaffirming the Value of the Mutative Interpretation

Horacio Etchegoyen (1983) reaffirms Strachey's position as an ideal for psychoanalysts in his paper entitled "Fifty Years After the Mutative Interpretation." According to Etchegoyen, Strachey provided theoretical principles to support Freud's (1912) statement that one could not vanquish an enemy *in absentia* or *in effigie*. The

enemy here is the unconscious dynamic that comes to life in the transference. Bringing Strachey's position into the perspective of a psychoanalytic community influenced by object relations theory, Etchegoyen adds that the analyst's attitude of empathy and objectivity is a necessary pre-condition for the mutative experience. "Mutative interpretations laid the foundations for the future explanations which promoted insight and working-through to the position of main theoretical instruments of today's psychoanalysis" (p. 458). Etchegoyen also reaffirms the traditional view, expressed by Strachey, that extratransference interpretations are not mutative. The only value that Strachey and Etchegoyen place on the extratransference interpretations (including extra-therapeutic transferences) is tactical or preparatory, paving the road for transference interpretations.

Many others have contributed to expanding on the concept of interpretation in psychoanalytic treatment, especially interpretation of the transference. I have limited my review to only a few of the major contributors in order to provide a foundation for examining the literature on extra-therapeutic transferences.

Refinements and Reconceptualizations of the Psychoanalytic Concept of Transference

Transference remains a cornerstone of psychoanalytic psychotherapy since Freud's original conceptualization and through the many theoretical and technical modifications that contribute to contemporary psychoanalytic theory. But two major changes have necessitated a broader view of transference than Freud envisioned. First, psychoanalytic therapy sought to treat patients who were not neurotic. Second, the idea of the analyst as blank screen, or objective observer, was eroded and supplanted by

various relational or intersubjective views of the therapist's role. There is a rich and fascinating body of literature reflecting changes in theory and technique, but I will limit my discussion to a brief description of selected schools that are likely to have influenced the psychoanalytic practice of participants in my study.

Each theoretical framework makes use of transference in ways that reflect the theory itself, with its particular understanding of etiology and cure. For example, for Freudians, what are analyzed within the transference are manifestations of internal, unconscious conflicts and drives, against a backdrop of psychosexual stages of development, most importantly, manifestations of the Oedipal Complex. The contribution of ego psychology to classical psychoanalysis was making the ego itself a legitimate object of study. Within the transference, interpretation and analysis of conscious and unconscious ego mechanisms and defenses would be integrated with the analysis of unconscious drive manifestations (A. Freud, 1966). For Kleinians, what is particularly analyzed within the transference are manifestations of primitive states of aggression, greed, and so forth, as well as mechanisms by which the patient attempts to deal with these painful states, against a backdrop of paranoid-schizoid and depressive positions (Heimann, 1956; Joseph, 1985; Klein, 1952). For self psychologists, what is analyzed within the transference are manifestations of selfobject failures, against a backdrop of the development of a cohesive sense of self (Elson, 1986; Kohut, 1977, 1984; Ornstein, 1990; Schwaber, 1985; Shane & Shane, 1992; Wolf, 1988). Contemporary relational and intersubjective theories do not view transference as one directional, but understand it to be derived from a mutual process that includes conscious and unconscious input from both therapist and patient. What is analyzed, then, includes the relational or intersubjective context (Hoffman, 1985; Mitchell, 1988; Stolorow & Atwood, 1992).

Given all of these models, James Fosshage (1994) offers an example of an integrative redefinition of transference. According to Fosshage transference is "the primary organizing patterns or schemas with which the analysand constructs and assimilates his or her experience of the analytic relationship" (p. 265). For Fosshage an adequate concept of transference must account for developmental strivings as well as for pathological repetitive patterns. Traditionally these strivings have not been put under the transference umbrella because they are not, strictly speaking, repetitions of the past.

I anticipated that participants in this research study would have been trained in the classical and ego-psychological approach to therapy as well as some version of contemporary, more relational schools of thought. The following passage by Stephen Mitchell (1988), who has synthesized a wide range of theories, provides an example of a relational approach to working with the transference in therapy:

> The analyst becomes the various figures in the analysand's relational matrix, taking on their attributes and assuming their voices; the analyst and the analysand gradually rewrite the narrative, transforming those characters in a direction which will allow greater intimacy and more possibilities for varied experience and relatedness. One never stands completely outside the transference-countertransference configurations; instead, one struggles continually to emerge from them. As constricting transferential constraints are clarified through interpretive activity, the newly won relational positions themselves take on new transferential meanings which carry with them their own constraints. (p. 296)

Despite the shift within contemporary psychoanalytic theories towards mutual, relational, or bi-directional models, and despite the more flexible views on what constitutes analysis and psychoanalytic psychotherapies, definitions of transference and interpretation in the analytic setting still center almost completely on the transference *within* the therapy relationship. While Strachey's description of the mutative transference interpretation, set in the context of a one-person psychology, may not fit literally into the conceptual framework of contemporary psychoanalysis, the principal expressed in his

concept still prevails. The affective immediacy of an interpretation of the transference within the therapy relationship is still thought to make it the most effective therapeutic technique. Working interpretively with transferences that occur outside the therapy relationship is not considered to be mutative.

Contribution of Merton Gill Towards Reconceptualizing Transferences

Merton Gill (1979; 1982; 1983; 1984), a major voice within the American psychoanalytic community from the 1940s to the 1990s, concerned himself with developing an expanded view of the transference. During his career his theoretical orientation moved from ego psychology towards the interpersonal. He argued that old-school analysts take too narrow a view of the transference: they do not pursue transference vigorously enough, nor do they take into sufficient account the impact the analyst has on her or his patients. Arguing against thinking of the analyst as a blank screen, Gill claims that the analyst always does something on which the patient's perception is based. Since there is always some connection to the actual analytic situation, it is possible to interpret any transference with immediacy. Gill maintains that it is less important to connect transference interpretations to historical antecedents than to call attention to the here-and-now manifestation in the analytic situation. Focusing on the past or on other non-transferential material is often a form of avoidance or resistance. He observes that both patient and analyst tend to avoid recognition of here-and-now transference manifestations because to do so is disturbing to both of them.

In Gill's view of analytic treatment the transference is everything, and everything is transference. He goes much further than Strachey in criticizing other types of interpretative activity. While, for Strachey, these other activities provide the groundwork leading up to mutative transference interpretations, for Gill they are impediments to the

process of analyzing the transference. Insofar as one of the tasks of this research study is to evaluate the potential usefulness of a concept such as the extra-therapeutic transference, Gill's arguments must be addressed, both within the literature review and in my final chapter.

Critiques of the Centrality of Transference Interpretation

An overemphasis on or over-idealization of the mutative value of transference interpretation may obscure awareness of the therapeutic value of other aspects and activities involved in psychoanalytic therapies: the non-transferential aspects of the analytic relationship, the patient's exploration of unconscious fantasy material unrelated to the transference, and interpretation or non-interpretation of extratransference phenomena. The literature reviewed here reflects theoretical positions that may influence study participants in their practice of psychoanalytically oriented psychotherapy, enlarging their repertoire of techniques beyond that of strict interpretation of the transference.

Using the Relationship Versus Interpreting the Transference

How is it that some patients seem to benefit from an ongoing relationship with a good therapist, even though the therapist may never interpret the transference? While the role of interpretation has been central throughout the history of psychoanalysis, there have always been advocates for attending to the role of the affective relationship between patient and therapist. The ideas of Ferenczi (1930/1955, 1933/1955), Alexander(1933; Alexander & French, 1946), Winnicott (1958, 1965), and Bion (1977) sparked decades of heated controversy and are embedded in such concepts as the "real relationship," the "therapeutic alliance," the "working alliance," a "corrective emotional experience," the containing or

holding aspects of therapy, "transference cure," re-parenting, and supportive therapy. While empathy in Kohut's (1977) theory of self psychology has a number of functions, it includes a healing aspect similar to these concepts.

There is also a body of literature discussing the differences, and whether there are significant differences, between something that might be called a *real* relationship and the transference. To even outline the similarities and differences between these concepts goes beyond the scope of this review, but they are fully reviewed by Robert Wallerstein (1965). It is sufficient to this discussion to note the ongoing debate regarding the role of the therapeutic relationship in effecting change. In addition to chronicling the theoretical debate, Wallerstein conducted research that shows the lasting benefit of what have been termed supportive techniques in psychoanalytic therapies, including use of the non-transferential aspects of the relationship. This amounts to a significant challenge to views that transference interpretation is the only key to structural change.

Those who argue for the curative value of the therapeutic relationship place it at the heart and center of psychoanalytic psychotherapy. They do not speak to the use of extra-therapeutic transferences. Some form of the concepts listed above will likely be familiar to the participants in my research study and may be important to their ideas of how therapy works.

Non-Interpretive Techniques

Interpretation, especially of the transference, may be the most highly valued of psychoanalytic techniques, but therapists also employ a variety of techniques in their practice, verbal and non-verbal, that are therapeutic and that may not relate directly to the transference at all. Strachey (1934) himself acknowledges that

> The fact that the mutative interpretation is the ultimate operative factor in the therapeutic action of psycho-analysis does not imply the exclusion of many other procedures (such as suggestion, reassurance, abreaction, etc.) as elements in the treatment of any particular patient. (p. 159)

Bibring's (1954) basic therapeutic principles—suggestion, manipulation, abreaction, clarification, interpretation— became part of a larger discussion within the American psychoanalytic community regarding differences between psychoanalysis and psychotherapy. Within the context of that discussion, therapeutic activities, other than interpretation which leads to insight, were devalued because they were not analytical, but Bibring's list is an example of an attempt to conceptualize the other activities going on in psychotherapy. Significantly for this study, his list does not mention interpretation of transferences outside of the analysis or therapy.

While still asserting that interpretations are the distinctive analytic technique, Leo Stone (1981) affirms the value of non-interpretive elements in analytic treatment, implicitly calling into question the tendency to view mutative interpretations of the transference as the only decisive analytic element. He places particular emphasis on the usefulness of clarification, one of Bibring's (1954) hierarchy of therapeutic principles. His main focus, however, is on the subtle, non-verbal elements inherent in the analytic structure and the analyst's attitude, tone, timing, empathy, listening skills, and so forth.

Harold Stewart (1990) incorporating British theories of Winnicott and Balint, both of whom worked with very regressed patients, maintains that there are roads to psychic change other than the mutative type of transference interpretation. He describes non-interpretive but powerful therapeutic responses, especially with regressed patients, such as long silences that allow the patient to remain in a dreamy state while in the analyst's presence.

Interpretation of Extratransference Material

Interpretation of any clinical material that is not directly related to the therapist/client transference is referred to in the literature as extratransference interpretation. The extra-therapeutic transferences under study here are a subset of extratransference phenomena that may be interpreted and that do not directly relate to the therapist/client transference. Extra-therapeutic transferences concern the transferential dimension of relationships with significant people in patients' lives, apart from the therapist. Literature specifically addressing the clinical use of extra-therapeutic transferences will be reviewed in a later section.

Examining the role of extratransference interpretations provides a context for questioning the exclusive emphasis on transference interpretation and the transference neurosis in effecting cure. Leo Stone moderated a panel discussion on the value of extratransference interpretation at the 1981 American Psychoanalytic Association's Meeting, and raised the following questions which are central to those I am studying:

> Are interpretations elicited by other issues superfluous? Or diversionary? Or feeble? Or possibly just ancillary? Is material from other sources indispensably informative, providing a matrix for the transference emergence and understanding, and in that sense alone, useful? Or can such interpretations contribute in themselves to significant 'structural change'? Or do they sometimes include effective transference references via the principle of multiple appeal? (reported in Halpert, 1984, p. 137)

In response, Harold Blum (1983) states that the transference neurosis is only an ideal construct, unlike what really occurs in analysis. As the adult neurosis is *never* entirely within the transference, the analyst must pay attention to other relationships as well in order to fully discover the patient. "It is impossible to do analysis purely on the basis of transference without attention to current conflicts and realities and without reconstruction of the past in which the transference is rooted"(reported in Halpert, 1984, p. 142). "A 'transference only' position is theoretically untenable and could lead to an artificial reduction of all associations and interpretations into a transference mold and to an idealized *folie a deux*" (Blum, 1983, p. 615).

Blum (1983) also observes that the relationship between the transference and the extratransference is exceedingly complex. He stresses the complementarity and synergy of working with the extratransferences as well as the transference to the therapist.

Extratransference interpretation is not necessarily non-transference, but it does not deal with the transference to the analyst. Extratransference interpretation may include transference to objects other than the analyst, the real relationship to the analyst or other objects, or may refer to the sphere of external reality other than the psychic reality of transference fantasy (Blum, 1983, p. 591). In a similar vein, Leo Rangell, who was also on the 1981 panel, says:

> To the generally accepted formulation that transference recapitulates the developmental history and brings the neurosis into the eye of analysis, I offer the proposition that the transference itself is not sufficient to contain and yield up the crucial events in the complex development of an individual neurosis. I. . . think of any number of instances . . . where I would understand the patients only incompletely and have a very inadequate concept of their neurosis from listening for and confronting the transference alone. (1981, pp. 675-76)

In a later article, Harold Stewart (1990) refers to three aspects of the patient's environment – the world in which the patient presently lives, the world of the patient's past, and the patient's relationship with the analyst. In addition to classical transference interpretations that concern the third aspect, extratransference interpretations concern the patients' relationships to the first two aspects of their environment. "The extratransference interpretation . . . is related to the patient's object relations and environment outside the analytic situation. This topic has been relatively neglected in the analytic literature, which has rightly centered on the transference and transference interpretations" (p. 63).

Nathan Leites (1977), in a scholarly paper entitled "Transference Interpretations *Only*?" suggests that the psychoanalytic community is preoccupied with seeing everything in terms of transference and discounting experiences in therapy that are primarily about non-transference phenomena. He makes this relevant comment:

> In the classical conception of transference the patient was really concerned with the major persons in his childhood when addressing the analyst. More recently, the patient has come to be viewed as apt to be unconsciously engaged with the analyst while ostensibly absorbed in somebody else…Formerly, the perceptiveness of the analyst was to reveal the parent behind himself; now he may discover himself behind the parent or spouse. (p. 275)

Other Critiques of Centrality of Transference Interpretation

In her review of Merton Gill's work, Janet Malcolm (1984) raises issues that can be applied more generally to the centrality of transference interpretations. She argues that Gill's overemphasis on here-and-now interpretation of the transference leaves little room for free association and psychoanalytic exploration of the unconscious. She says Gill doesn't allow enough silence (he attacks old style analysts for their sadistic, long silences) "The analysis remains frozen in the present" (p. 18).

The questions raised by Thomas Szasz (1963) regarding the primacy of transference interpretation are part of a broader critique of classical psychoanalysis. He points out that transference analysis privileges the analyst's view of reality and may involve judgments about the patient's view of reality, which may or may not be shared by the patient. He also points out that not all of a patient's responses to the analyst are transferential, but may be responses to what is *really* going on, and furthermore, that analysis of transference can be a defensive maneuver for the therapist, protecting her from the impact of the patient's personality. While Szasz's position is less foreign to current psychoanalytic practice than it was in 1963, it is still an important reminder of the potentially negative effect of power imbalances built into conventional and even contemporary analytic thinking.

Extra-Therapeutic Transferences

I have divided my review of the literature on extra-therapeutic transferences in psychoanalytic psychotherapy into two sections. In the first section I look at literature reflecting the traditional position that extra-therapeutic transferences are not intrinsically valuable foci. In the second section I review literature that argues for, and illustrates, the clinical usefulness of extra-therapeutic transferences.

Devaluation of the Curative Potential of Extra-Therapeutic Transferences

Despite the attention given to extratransference activities, as in Strachey's (1934) comments and the 1981 panel on extratransference interpretations reviewed above, there is little ongoing discussion of the specific phenomenon of extra-therapeutic

transferences. The very absence of literature addressing the issue of extra-therapeutic transferences, which is noted in a number of sources (Blum, 1983; Fine, 1989; Haas, 1966; Leites, 1977; Ornstein, 1990; Stewart, 1990) is evidence that extra-therapeutic transferences are relegated to matters of little analytic value, if they are discussed at all.

When mentioned, in contemporary as well as classical psychoanalytic literature, extratransference interpretations, including interpretations of extra-therapeutic transferences, are generally viewed either as building blocks leading up to meaningful transference interpretations, or as mistakes. When therapists make such interpretations, they are thought to have failed to address the defensive displacement of ideas or affect that belong in the transference and thus to miss or avoid the real transferential implications (Strachey 1934; Heimann 1956; Gill 1979; Wallerstein 1995).

Along with other non-mutative techniques, extra-therapeutic transferences are thought to fall into Strachey's building block category.

> The acceptance of a [mutative] transference interpretation corresponds to the capture of a key position, while the extratransference interpretations correspond to the general advance and to the consolidation of a fresh line which are made possible by the capture of the key position…oscillation of this kind between transference and extratransference interpretations will represent the normal course of events in an analysis.(Strachey, 1934, p. 158)

Strachey maintains that extratransference interpretations cannot be mutative because they are not immediate and urgent. They might provide relief and reassurance, but run the risk of shoring up defenses rather than analyzing them.

Merton Gill (1979) agrees with Strachey that the affective immediacy of a transference interpretation in the here-and-now leads to insight that is unavailable with other types of interpretation. He argues, further, that it is a serious error to neglect the transferential implications in *everything* that a patient says and does. Gill views

extratransference material, including extra-therapeutic transferences, as disguised references to the transference, primarily through the defenses of displacement or identification. It is displacement when the patient's attitudes are narrated as being toward a third party; it is identification, when the patient attributes to himself attitudes he believes the analyst has toward him. Gill is explicit in his point: " I believe that less is accomplished if one gives priority to interpretations of transference outside the therapeutic situation and of genetic material at the expense of facets of the transference within the therapeutic situation" (1984, p. 173).

Clinical Value of Extra-Therapeutic Transferences

Commentaries on the clinical value of extra-therapeutic transferences and illustrations of their use in clinical practice come from voices within the mainstream of psychoanalytic thought and/or not identified with any particular school, as well as some who are identified with self psychology and intersubjectivity. In reviewing this literature, I wondered if analysis of the data collected in this research study could shed some light on why particular schools of psychoanalytic thought might be more or less likely to find value in the clinical use of extra-therapeutic transferences.

Perspectives From Mainstream Psychoanalytic Theory

It seems there have always been a few who have brought up arguments for interpreting extra-therapeutic transferences. Edward Glover (1955) reports that at a 1933 meeting to discuss Strachey's paper on the mutative transference interpretation, Ernest Jones "felt the author's attitude to extra-transference interpretation to be rather too nihilistic"(p. 279). Particularly in the early stages of analysis, Jones said, "emerging Id-

impulses may be really directed to people other than the analyst" (p. 279) and in such situations non-transference interpretations could also be mutative. Reporting the results of a questionnaire he gave to a group of psychoanalysts in 1938, in response to the question on transference analysis, Glover said:

> The balance of opinion appeared to be definitely in favour of analyzing transference 'throughout', 'constantly', 'whenever interpretation is possible', etc. One holds 'only transference interpretations effective' . . . . One answer referred to the need to analyse 'all' transference manifestations, i.e. extra- as well as intra-analytic situations . . .(p. 305)

In his own later writings on interpretation of transference, Glover said he does not "exclude the therapeutic effect of 'extra-transference' interpretations at any stage in the analysis" (p.279).

Although there have been numerous isolated comments regarding extra-transference interpretations, the most significant discussion of the topic took place in 1981 at the meeting, mentioned earlier, of the American Psychoanalytic Association in New York, moderated by Leo Stone. In the proceedings reported in Halpert (1984), Stone counters the position that extratransference interpretations have no independent therapeutic value. He maintains that important affective material is not necessarily available in the analytic situation itself and *must* be interpreted in the patient's outside life.

> There are situations in which transferences themselves may spontaneously occur in the patient's immediate life without evident processing through the analytic situation, and interpretation of these transferences can provide significant contribution to the psychoanalytic process beyond their immediate therapeutic effects. (p. 138)

Carl Adatto (1989) reviews Freud's position on various aspects of the transference, including the role of extra-analytic transference interpretations, in light of current analytic findings and techniques. He re-examines the ideal of the unfolding transference neurosis, concluding that it is an ideal for analysis that is seldom met.

Despite his adherence to a conventional view of the importance of transference interpretation, in discussing his case illustration Adatto says:

> Analysis of extra-analytic transferences are quite important, as the patient associates to and focuses on transferences to individuals other than the analyst. To have interpreted the woman's transference to her child, or the man's transference to his previous analyst, at a given point in the analysis, as a transference resistance to me in my opinion would have been not only incorrect, but also tactless. (pp. 522-523)

And in a clinical example, he says:

> The analysis of her relationship with Mary was important because through understanding of what functions of her own she had assigned to Mary, and of the defensive aspects of the transference to Mary, she was able to analyse her characterological problems. Her transference not only to me but to others such as Mary, her husband or mother had to be examined There was no shortage of affect when she was dealing with transferences not related to me. (p. 522)

L. Haas (1966) works from a classical psychoanalytic model, based on drive/conflict and ego defenses. Yet he observes that the value of analyzing and interpreting the behavior of patients towards other persons is less appreciated in theory than in practice. He describes a case where there is a full-blown transference experience outside the analytic relationship that was worked through at length within the analytic setting, while the patient's transference reactions to the analyst were mainly superficial. Haas suggests that one reason for depreciating extra-therapeutic transference interpretations may be the perception that others, in contrast to the analyst, are mutual participants with the patient in interpersonal relationships. Since the analyst is not seen as a mutual participant, it is assumed that transference within the analytic setting can be more clearly delineated. Haas disagrees with this formulation, and claims that the partner's interaction with his patient "does not alter or controvert the transference nature of the patient's behavior" (p. 424).

Ludwig Haesler (1991) also challenges the conventional approach towards extra-therapeutic transferences. He speaks of extratransference interpretations, but the interpretations in his case example are in reference to extra-therapeutic transferences.

He remarks on the conspicuous absence of attention to extratransference interpretations within the debate about the theory and technique of psychoanalysis, maintaining that analysts daily give interpretations having to do with situations and relationships outside the analysis, as well as transference interpretations. He says, "this need not necessarily be immediately regarded as a displacement or flight from the transference" (p. 463). Haesler sees extratransference interpretations as complementary to transference interpretations. They are not independent of each other, but neither should the one be "exclusively and artificially reduced to the other" (p. 475). For Haesler, transference and extratransference spheres involve the same sorts dynamic relational configurations the patient has structured and manifests both within and without the analysis.

> The elaboration of specific relational structures in the there and then and in other material from the patient's associations . . . opens up prospects over the here and now and thereby permits integration of the extratransference and transference spheres as affective experience in the here and now . . . In this way, one of the spheres is not split off from the other, which would artificially split the patient's experience, nor is there any forced artificial reduction exclusively to the transference dimension. (p. 475)

Most significantly, he maintains that to force material from extratransference experiences into the transference dimension restricts the free unfolding of the patient's material and affect.

Reuben Fine (1989) puts forth the idea of an "analytic triad." His argument is that there are *always* two transferences, one to the analyst and one to an outside person, who may change from time to time during the course of an analysis. Working through the transference to the analyst cannot be done properly without also working through the extra-analytic transference or transferences. Comparing the two transferences is helpful, as is the understanding of the importance of other triadic patterns in a patient's life. Fine re-examines several published cases, including Kohut's Analysis of Mr. Z.(1979), and points

out the existence of highly charged transferences to people other than the therapist. When these transferences are examined, together with the transference to the therapist, historical and present-day dynamics are brought to light. He concludes that "Transference remains a central concern of the analytic process, but it should be extended to *all* transferences, not just to the analyst" (p. 502).

Alexandra Kivowitz (1990) also proposes a triadic view of the transference. She points out that "In individual, dynamically-oriented psychotherapy, the expectation has been that 'transference' would manifest itself dyadically . . . . Departures from this have been considered deviations from the expectable psychoanalytic mode" (p. 75). Rather than viewing patients' introductions of "others" into the therapeutic setting as resistance, she suggests it is a way for patients to involve therapists in understanding and helping them with the complexity of human relatedness. The examples Kivowitz cites are of patients who "may have had inordinate difficulties with (at least) one important person (loss to death, mental or physical illness, separation) and may have failed to receive good-enough help with this from another important person" (p. 74). Therapists' own needs to emphasize their importance to patients through the centrality of the therapist-patient relationship may block a more complex understanding of triadic dynamics in a patient's outside life. In one of her case illustrations, Kivowitz describes how her patient's preoccupation with talking about her lover was a means for her to help the therapist understand how she needed relationships with both mother and father and needed not to be asked to choose one or the other (p. 82).

Perspectives From Self Psychology and Intersubjectivity Theory

Self psychology and intersubjectivity theory rely on a particular understanding of transference. Kohut introduced the concepts of selfobject needs and selfobject

transferences to account for the different quality of transference that emerges with patients who suffer from narcissistic or other types of self disorders, in contrast to neurotic patients. As will be discussed below, selfobject transferences occur in outside relationships, as well as in the therapy relationship, and can be usefully interpreted in treatment. The intersubjective model (Stolorow & Atwood, 1992) added a second dimension to the concept of selfobject transferences. Within that model, transference experiences shift between the selfobject dimension, when the patient "yearns for the analyst to provide selfobject experiences that were missing or insufficient during the formative years" and the repetitive dimension, "which is a source of conflict [wherein] the patient expects and fears a repetition with the analyst of early experiences of developmental failure" (p 24).

Anna Ornstein (1990), a self psychologist, discusses the interpretation of transferences manifested in relation to selfobjects other than the analyst. Her particular point is:

> The working through of these personality features requires that the analyst be attuned not only to the transferences in relation to herself, but also to those transferences that patients have developed in relation to other important people in their lives. It is in response to the transferences in relation to key people in the patient's current emotional environment (primarily spouses) that pathological defenses will be called into action when they no longer are in the context of the analytic relationship. (p. 42)

Other people in a patient's life are not as likely as the analyst to respond empathically to the patient's unappealing narcissistic behavior. Outside relationships may truly recreate early, traumatic relationships, in part because of the patient's lack of awareness and empathy towards others. One of Ornstein's patients, after years of therapy, did not manifest the problematic behavior patterns that had been present earlier in the transference, though he still manifested these patterns with his wife, without much insight. After a long period of working within the primary transference, Ornstein actively interpreted the transferences occurring with his wife, and helped him gain

insight into what was being repeated in that relationship. Her concluding remarks are: "I believe future clinical reports would have to include such interpretations, since they are regularly being offered but not reported and their place in clinical theory has so far not been carefully examined" (p. 57).

James Fisch (1994) makes a point similar to Ornstein's—that analysis of the extra-therapeutic transference allows access to dynamic material that must be worked through and that may not be available within the primary transference. Fisch opines:

> Many valuable psychotherapies are actually conducted in this manner [analyzing selfobject failures in extra-therapeutic transferences], and have been for a long time, but . . . analytically oriented therapists and supervisors have been reluctant to speak of it in public for fear of being labeled superficial and non-analytic. (p. 77)

Fisch credits self psychology with providing a model that legitimizes this kind of therapy because it does not rest on conflict and aggression. His case illustrates the primary use of extra-therapeutic transference interpretation that focused on the patient's relationship with his estranged wife as a failed selfobject transference. In this case feelings towards the therapist were not the center of the therapy, though they deepened as the patient responded positively to the fact that his therapist was able to help him work through the extra-therapeutic transference.

Douglas W. Detrick (personal communication, May 2, 2002) proposes the construct of "compensatory transference" referring to extra-therapeutic transferences during analytic treatment. Theorizing from the perspective of self psychology, he maintains that once the empathic bond has begun to remobilize the therapeutic transferences, outside relationships may become colored by that experience. In other words, everyday interpersonal experiences may take on the role of expressing remobilized childhood experiences (i.e. therapeutic transferences and not defensive displacements of intratherapeutic expression). These outside experiences become

available for interpretation within the therapy setting directly, analogous to transference interpretations within the therapeutic relationship. Detrick points to a case example of the compensatory transference in Heinz Kohut's *The Restoration of the Self* (1977).

James Fosshage (1994) incorporates ideas from self psychology and intersubjectivity theory in his model, noting that an adequate concept of transference must account for both developmental strivings and pathological repetitive patterns. Fosshage refers to Ornstein's (1990) case report, described above, and agrees with her that it is quite possible that a particular analyst might not directly elicit all of a patient's primary problematic organizing principles. A patient's discussion of extratransference material may or may not have direct bearing on the analytic relationship. Fosshage claims that his reconceptualized model of transference (which is elaborated more fully in an earlier section of this chapter) can bridge analytic and extra-analytic relationships. Citing Stone and Rangell, who were participants in the 1981 panel on extratransference interpretations, Fosshage reiterates that the "complexity of human relations and the vast range of experience outside the analytic scene . . . cannot be condensed into one relationship without losing the richness and variety of extra-analytic experiences" (p. 276).

David Shaddock (2000) works with individuals in long-term, analytically-oriented therapy, and also sees those individuals in conjoint sessions with their partners. Based on his intersubjective systems model, he synthesizes individual and couples work, using the transference between partners as a powerful tool for insight and change. His understanding of the couple dynamics (and transferences) enhances the work in individual, as well as conjoint, sessions. Shaddock maintains that in individual treatment therapists too often minimize the impact of a client's relationships outside of therapy. Working through

the transference and developing a new relational experience with the therapist may not be sufficient to alter old relational patterns that are still being reinforced in the client's relationship with his or her partner.

Psychoanalytically Oriented Psychotherapy

Since the participants in my study are psychoanalytically oriented psychotherapists, this section will provide background for what is meant by the term "psychoanalytically oriented psychotherapy." I rely primarily on the work of Robert Wallerstein (1965, 1986, 1995) and his colleague, Lester Luborsky (1984), who wrote a guide to the practice of psychoanalytically oriented psychotherapy for practitioners, researchers, and supervisors. Wallerstein has devoted his career to questions having to do with psychoanalytic psychotherapy vis-à-vis psychoanalysis, maintaining this focus in his empirical research and in his exhaustive review of the major writings and debate concerning this issue. At the Menninger Foundation in 1954, Wallerstein and Luborsky were part of the group who designed the Psychotherapy Research Project, a 30-year study that Wallerstein summarized in *Forty-two Lives in Treatment* (1986). I will describe that project in more detail below. In this section I will first review Wallerstein's and Gill's theoretical positions regarding differences between psychoanalysis and psychotherapy, then summarize the approach outlined in Luborsky's manual for conducting psychoanalytically oriented psychotherapy.

For many years, the fact that mutative transference interpretations were considered the defining characteristic of psychoanalysis meant that other forms of psychotherapy were just that, psychotherapy. The distinction was that analysts interpreted the transference and therapists manipulated the transference. According to Wallerstein's (1995) review, by the 1950s there was a general consensus within the psychoanalytic

community that psychotherapies derived from psychoanalytic theory—which at that time meant the theories of Freud and ego psychology—offered the possibility of effective treatment for a broader range of pathology than psychoanalysis. However there were many debates about how far from psychoanalytic technique one could venture and still be thought of as effecting structural change. One aspect of the controversy centered on the question of how the real relationship with the analyst impacts treatment. The question was whether intentional use of the real relationship (i.e. Bibring's (1954) suggestive and supportive elements) meant that the treatment model was no longer analysis. There developed, as Wallerstein puts it, a "majority consensus" that a continuum of supportive-expressive psychotherapies existed. Psychoanalysis was the most expressive and relied most heavily on interpretation. An intermediate form of expressive psychotherapy made use of analytic concepts and interpretive techniques. Supportive forms of therapy used suggestive techniques that were not considered psychoanalytic, though they might be effective.

Since the mid-50s, with the introduction of new theoretical models, the distinctions between psychoanalytic psychotherapy and psychoanalysis are blurred even further. George Allison, at the 1992 meeting of the American Psychoanalytic Association, spoke of the widely held idea of a spectrum, along which "the quantitative mix of kinds of interventions changes . . . from the most expressive-analytic end (for the normal neurotic patients) to the more suggestive-supportive end (for the sicker than neurotic patients) and that somewhere conceptual boundaries do get crossed" (as cited in Wallerstein, 1995, p. 537.

Merton Gill (1982, 1984), mentioned above as a key figure in the dialogue concerning the technique of transference analysis, also addressed the differences between psychoanalysis and psychotherapy. Complementary to his broadening view on

transference manifestations in the here and now, Gill moved away from the majority consensus regarding distinctions between psychoanalysis and psychoanalytically oriented psychotherapy, de-emphasizing external factors such as the frequency of sessions and use of the couch as necessary conditions for analysis. According to Gill, a therapy is psychoanalysis if the therapeutic, interpretive focus remains with the transference. It is unnecessary to wait for regression and the emergence of a transference neurosis, as Freud had advised, since there are significant elements of transference in the room from the first moment of treatment. As the therapist interprets transference experiences, the transference dimension is heightened and becomes even more available. From Gill's perspective many forms of psychotherapy that do not meet the conventional criteria for analysis would still be psychoanalysis.

Throughout the discussions relating to similarities and differences between psychoanalysis and psychoanalytically oriented psychotherapy there remains a staunch commitment to the centrality of transference interpretation as a hallmark of "psychoanalytic," whether that be psychoanalysis or psychoanalytically oriented psychotherapy. Clinicians who subscribe to one of the current schools of psychoanalytic therapy, or to an integration of various schools of psychoanalytic therapy, whether those clinicians be analysts or therapists, are expected to attach great importance to the transference. They may not be bound to the older views regarding "mutative interpretations of the transference," since the widened view of transference allows for a greater variety of means to bring consciousness of transference manifestations into the analytic relationship.

Lester Luborsky (1984) operationalized the supportive-expressive psychoanalytically oriented psychotherapy model used at the Menninger Clinic. "Supportive" refers to techniques associated with direct forms of support in the therapy

relation. Supportive aspects mostly derive from the treatment structure and refer to aspects of therapy reflected in patient's experience of treatment and the relationship with the therapist as helpful. While not primarily aimed at providing understanding or attending to the transference, supportive aspects do contribute to the patient's insight. "Expressive" refers to techniques associated with understanding what the patient expresses. According to Luborsky, these are "standard psychoanalytic interpretive techniques," guided by manifestations of transference (pp. 10-12).

According to Luborsky, the curative process in psychoanalytically oriented psychotherapy is an integration of elements that are supportive, and others that are expressive: self understanding (through expressive, interpretive techniques), the helping alliance (through supportive techniques), and incorporation of the gains , e.g. through internalization of therapist, especially in the working through of the meanings of termination. Luborsky goes on to divide the therapist's activity into four steps: (a) listening openly to the patient, (b) understanding the patient's intentions and their consequences, especially as they relate to the main symptoms and themes of central relationships, including relationship with therapist, (c) responding by telling the patient what the therapist has heard and understood, and (d) returning to listening.

Luborsky (1984) charges the therapist with the task of identifying the main relationship themes that will be focal points of therapy by understanding the patient's symptoms in the context of relationships, attending to shifts in the patient's "states of mind," and by attending to each sphere of the relationship triad, which consists of "current relationship of patient and therapist in treatment, current relationships outside of the treatment, with family, friends, co-workers, et al., and past relationships, especially with the parental figures" (p. 110). When possible, the therapist's response should deal with a facet of the main relationship problem and relate it to one of the

symptoms the client presents (p. 121). As Gill said, "Of the three spheres, attention to the current relationship of the patient and therapist has the greatest potential for therapeutic impact because their interaction is played out in the 'here and now'"(cited in Luborsky, 1984, p. 112).

To conclude this discussion of what constitutes psychoanalytically oriented psychotherapy and how it differs from psychoanalysis, I refer to Wallerstein's current position, which presents a useful working definition of psychoanalytically oriented psychotherapy. It is noteworthy that the many parenthetical comments and qualifying remarks in this statement reflect the continuing ambivalence within the psychoanalytic community regarding such distinctions:

> I see psychoanalysis simply as the therapy that rests centrally (though not exclusively) on…the effort to systematically analyze, in so far as one can . . . the psychoanalytic interaction and all the suggestive elements that enter into it. I see psychoanalytic psychotherapy (varyingly supportive and expressive) as resting partly, where possible, on an interpretive-analytic base, but also, in varying degrees, depending on the characteristics and needs of the particular patient, on many other kinds of (supportive) technical interventions. (2000, p. 202)

I expect that the participants in my research study, who identify themselves as psychoanalytically oriented psychotherapists, would be comfortable with Wallerstein's (2002) description of their approach. I also expect they would generally agree with Luborsky's (1984) description of the psychoanalytic psychotherapy process—an integration of supportive and expressive techniques that recognizes the importance of transference manifestations in the therapy relationship.

Empirical Research Studies

While I found no empirical studies that specifically looked at the clinical use of extra-therapeutic transferences, the three studies that I review here are relevant to the current research, particularly in that they undercut commonly held assumptions about

the exclusive reliance on transference interpretations for psychoanalytic cure. They also point to discrepancies between theory and practice with regard to the use of interpretations of the transference and other phenomena. I review Robert Wallerstein's (1986, 1995) reports of a long-term study comparing psychoanalysis and psychotherapy, Victoria Hamilton's (1993) empirical study of analysts' approaches to transference interpretation, and Carol Tosone's (1993) research into the relationship between patients' psychopathology and therapists' interpretive activity.

Wallerstein's Report of the Psychotherapy Research Project

The stated purpose of the Psychotherapy Research Project was "to learn more about the nature and effectiveness of the everyday clinical work of the large, prominent clinical community gathered into the group private practice of psychotherapy and psychoanalysis, in conjunction with a psychoanalytic sanatorium" (Wallerstein, 1986, p. 5). The project began in 1954, at the Menninger Foundation, under the leadership of Robert Wallerstein, and continued for 30 years. Addressing, among other things, the differences between psychoanalysis and psychoanalytic psychotherapy, it posed the following questions: "(1) *what* changes actually take place in psychoanalysis and in psychoanalytic psychotherapies (the outcome question)? and (2) *how* do those changes come about or how are they bought about, through the interaction of what factors or variables (the process question)?" (Wallerstein, 1995)

Forty-two patients were divided into three treatment groups: psychoanalysis, expressive psychotherapy, and supportive psychotherapy on the basis of in-depth clinical assessments (interviews and multi-faceted clinical evaluations as well as psychological tests). These groupings were based upon assumptions about which treatment modality would be appropriate for a given patient profile.

All therapists were trained in psychoanalytic methods and were experienced in both expressive techniques that were directed towards analyzing the defenses, resistances and transferences, such as uncovering, interpretive, or insight-aiming, and supportive techniques that were directed towards strengthening the defenses, such as ego-maintaining or ego-building. The length of treatment was expected to be at least two years and might be indefinite.

Assessment of changes in patients was based on comparison of initial evaluations with the following types of data collected at the completion of treatment: interviews with and retesting of patients; interviews with family members, therapists and hospital staff; and therapists' or analysts' progress and process notes. No data was collected during the treatment, nor were therapists or patients aware of the research during the treatment. In this way the researchers hoped to achieve a "naturalistic" approach, one which did not disturb or influence the process of treatment.

One of the research goals was to test the "guiding assumptions of the theory of psychoanalytic therapy – that is, the sets of theoretical and the derived technical propositions that guide our understandings of how psychoanalysis and psychoanalytically based psychotherapies operate to bring about change" (Wallerstein, 1986, p. 53). The researchers expected to find that treatments in the psychoanalysis group would consist of mostly expressive techniques, and that lasting, structural change in the patients would result. They expected to find that treatments in the supportive psychotherapy group would consist of mostly supportive techniques, and that changes in the patient would be less extensive and less enduring. Results from treatments in the expressive psychotherapy group were expected to be intermediate.

The preliminary data consisted of the comprehensive case formulations drawn from multi-faceted, in-depth clinical evaluations of patients. These were the basis for

treatment recommendations, predictions, and treatment group assignments. Further data was collected at the time of termination, consisting of written documentation, interviews with patients, and re-testing of patients. At the time of termination the researchers also collected the therapists' or analysts' progress notes, which in some cases were brief periodic summaries and in other cases were extensive process notes from every session. Assessment of change in the patients was based on the data collected at the time of termination, including interviews with patients, family members, therapists, and hospital staff, as well as psychological tests that were compared to the battery of tests given prior to treatment.

It was found that predicted differences between the three models did not hold up. Treatments that purported to be expressive, in fact, included many supportive change mechanisms. "Real treatments in actual practice are inextricably intermingled blends of more or less expressive-interpretive and more-or-less supportive-stabilizing elements" (Wallerstein, 1983, p. 26). Wallerstein concluded that the study calls into question the assumption that the only route to stable and enduring personality reconstruction is through psychoanalysis via mutative interpretations, insight, and "true" structural alterations in the ego. Further:

> . . .treatment changes brought about by way of supportive techniques (and presumably <u>without</u> full intrapsychic "conflict resolution" and concomitant achieved insight) have turned out often to be substantially much more stable and enduring over prolonged time spans that we initially anticipated. (p. 17)

With regard to the questions addressed in the present research study, Wallerstein's conclusions lend legitimacy to clinical activities such as interpretation of extra-therapeutic transferences in effecting lasting structural change.

Hamilton's Study of Varieties of Transference Interpretations

Focusing specifically on transference, Victoria Hamilton (1993) studied analysts' approaches to transference interpretations, looking for the correlation between their stated views on various types of interpretations and their theoretical orientation. Hamilton also explored how analysts represent their work to themselves, "their internal working models of their beliefs and clinical practices" (p. 69).

Hamilton interviewed 65 British and American psychoanalysts from varying theoretical orientations, asking them to discuss 27 dimensions of transference interpretation. Transcripts of the interviews were rated by independent judges. She also used a questionnaire to rate the influence on analysts' of the orientations with which they identified themselves. A statistical analysis of both forms of data "revealed significant correlations between specific dimensions of technique, declared theoretical orientation and the degree of influence of important thinkers in the training or local culture of each analyst" (1993, p. 68).

With regard to therapists' internal working models, Hamilton pointed out that unlike other studies, which attempt to correlate analysts' stated beliefs and tape recorded sessions with patients to discover the relationship between theory and practice, her study, by only talking with therapists about their beliefs, "represents an intermediate step between theory and practice." In her opinion, "At present, we do not have terms to cover the area lying between higher-level theories (metapsychology), avowed theoretical orientation, technique as learned and developed from teachers and colleagues, and interpretive practices" (1993, p. 77).

Hamilton (1993) draws on the 1991 work of Samuel Stein, asserting, with him, that the role theory plays in every analyst's practice can be very unobtrusive, but powerful. Stein illustrates this point by a discussion of Kohut's two analyses of Mr. Z,

treatments that were very different because of the shift in the analyst's theory that "soaked through cognitive, perceptual and affective processes in the analyst" (Stein, cited by Hamilton, p. 78).

Hamilton's study shares with mine the focus on therapists' subjective experiences of their clinical work. Both studies also look at theoretical perspectives on the relationships between different kinds of transference interpretations. In terms of the content of my research question, Hamilton's most relevant finding was that that analysts who worked from a more relational framework "found little value in the distinctions between either transference and extratransference phenomena or the transference and the 'real' relationship" (1993, p. 73).

Tosone's Study of Interpretive Activity Correlated With Patients' Psychopathology

Carol Tosone (1993), in a qualitative study entitled *Impact of the Level of Patient Functioning on the Content and Frequency of Therapist Interpretation,* addresses the theoretical and clinical assumption that therapists vary the frequency and content of interpretations, particularly transference interpretations, depending on the level of the patient's functioning. Her interest was to discover whether therapists do, in fact, follow recommendations in the literature. Is it true that therapists do more interpretative activity with higher functioning patients and more supportive activity with lower functioning patients?

Archival material from the University of Pennsylvania, from therapies conducted by experienced psychoanalytic psychotherapists, was the data source for this study. Independent judges counted the number and categorized the type of

interpretations from transcribed audiotapes of treatment sessions of 38 patients who were depressed and who were seen in short-term psychoanalytic psychotherapy.

In her analysis, Tosone (1993) sought to provide in-depth understanding of the interpretative process by examining the content of interpretations. She differentiated between the objects of interpretation: therapist, parents, significant others, self, siblings, and unspecified. She also considered temporal aspects of interpretations: childhood and adolescence, past, present and future. A response was categorized as an interpretation if it met one or both of the following criteria: (a) therapist explains possible reasons for the patient's thoughts, feelings and/or behavior; (b) therapist alludes to similarities between the patient's present circumstances and other life experiences.

In reviewing the literature Tosone (1993) found support for the theoretical principle that transference interpretations (both what she calls genetic and here-and-now types) are more powerful and effective than extratransference interpretations (where the therapist is not the object). Her research asks whether this difference is borne out in practice. Tosone bases her definitions of the three types of interpretation in her study on the concepts of Freud (1937) and Gill (1982). An extratransference interpretation is "an interpretation which does not involve the transference and which pertains to the past or present"(Tosone, p. 11). A genetic transference interpretation is "an interpretation which links present feelings, conflicts, and behaviors toward the therapist with their childhood roots." A here-and-now transference interpretations is "an interpretation which addresses the relationship between the therapist and patient in the treatment setting" (Tosone, p. 11).

Tosone's central hypothesis, that therapists would modify content and frequency of interpretation based on the level of patient functioning, was not

supported. She found, however, that therapists made more extratransference than transference interpretations for both lower and higher functioning patients. In her discussion of theoretical and clinical implications, Tosone notes that her findings indicate a de-emphasis on transference interpretations and an emphasis on extratransference interpretations, pointing to "discrepancies between theory and practice: that is, therapists do not always follow the recommendations in the literature, particularly in regard to the analysis of transference" (1993, p. 87). Her findings bring into question the "generally acknowledged belief that interpretation is core to the psychoanalytic process and that analysis of the transference is a central feature of psychodynamically oriented technique" (p. 85).

Tosone's (1993) study, like Wallerstein's (1985, 1996) Psychotherapy Research Project, gives empirical support to the value of techniques such as extra-therapeutic transference interpretations, which have been devalued in the psychoanalytic literature pertaining to treatment. She concludes that a gap exists between theory and practice with regard to interpretative activity in psychoanalytically oriented psychotherapy, which is one of the questions explored in the present study. The present study takes Tosone's findings further, using distinctions she made, but focusing specifically on extra-therapeutic transferences. Unlike Tosone's study, whose aim was to find correlations between types of interpretive activity and patients' diagnoses, the emphasis of the present study is to explore therapists' thoughts about the role of extra-therapeutic transference phenomena in their clinical practice.

The studies I have cited explore the intersection between psychoanalytic theory and practice relating to interpretive activities, some focusing on therapists' subjective experience about the way they practice, and some including the concept "extratransference interpretations" among the constructs they consider. None,

however, has isolated the concept of "extra-therapeutic transference" for consideration, nor examined therapists' attempts to account for their actual practice of working clinically with the extra-therapeutic transferences, whether or not it is integrated with their psychoanalytically oriented theoretical orientation.

CHAPTER 3: METHODS AND PROCEDURES

The purpose of this study is to discover how therapists think about the transferential aspect of relationships that occur in patients' lives outside the clinical setting. The central questions are: How do psychoanalytically oriented psychotherapists conceive of and make use of clients' presentation of outside relationships? Do they see these relationships in terms of the concept of transference? What theoretical concepts guide psychoanalytically oriented psychotherapists as they listen to clients' presentation of outside relationships? In this chapter on methodology I shift from what led up to the research question and perspectives gleaned from psychoanalytic literature to the processes and techniques that guided my study of the phenomenological data.

Design

My approach to the research was qualitative. The focus of the study is therapists' subjective experiences as reported in open-ended interviews that invited their thoughts and feelings about the process of conducting therapy. A qualitative approach to research is particularly appropriate for analyzing data derived from participants' personal experiences, allowing the quality of those individual experiences to be retained in the analysis and interpretation. A qualitative approach is also appropriate for understanding a neglected or insufficiently elaborated theoretical area of thought, such as the concept of extra-therapeutic transference within the framework of psychoanalytic theory.

Qualitative research does not rely on statistical or quantifiable procedures or hypothesis testing, but uses, instead, other systematic methods and procedures to collect, code, and analyze data and to generate theory from the data. The specific qualitative

methodology that guided the data analysis aspect of my research is Grounded Theory, developed by Barney Glaser and Anselm Strauss (1967) and further described by Anselm Strauss and Juliet Corbin (1998). *Grounded* refers to establishing the basis for concepts in data; *theory* refers to "a set of well-developed categories (e.g., themes, concepts) that are systematically interrelated through statements of relationship to form a theoretical framework that explains some relevant social, psychological . . . or other phenomenon" (Strauss & Corbin, 1998, p. 22).

The grounded theory researcher begins with an area of inquiry or study, and allows the theory to emerge from the data, rather than beginning a project with a preconceived theory in mind. The approach goes beyond description of phenomena through the organization and categorization of data into increasingly complex conceptualizations and levels of abstraction. The methodology of grounded theory combines well with the semi-structured interview style described by Elliot Mishler (1986) to provide an overall approach where findings and theoretical conclusions stay close to phenomenological data from which they are derived.

Participants

Nature of the Sample

In keeping with the research questions to be addressed and the study's qualitative design, the sampling was purposeful and focused on a small number of information-rich cases. Michael Quinn Patton (1990) describes information-rich cases as "those from which one can learn a great deal about issues of central importance to the purpose of the research . . . whose study will illuminate the questions under study" (p. 169).

The size of the sample was planned to be between 7-11 participants. Patton (1990) states that "qualitative inquiry typically focuses in depth on relatively small samples" (p.

169). The number of participants is determined by whether sufficient information has been gathered to do justice to the subject in question, or "to the point of redundancy," a phrase attributed by Patton to the 1985 work of Lincoln and Guba (cited in Pattton,1990, p. 185). When the purpose of the research is to maximize information, "the sampling is terminated when no new information is forthcoming from new sampled units" (pp. 185-86). Grounded Theory advises that data be gathered "until each category is saturated" (Strauss & Corbin, 1998, p. 212). There is a dynamic relationship between data collection and analysis—analysis of the data from early interviews may influence the form of subsequent interviews and/or point to the need for additional, unanticipated interviews. "Sampling often continues right into the writing because it often is at these times when persons discover that certain categories are not fully developed. Then, data gathering functions in the service of filling in and refining" (p. 214).

I strove for maximum variation in the sample by selecting participants from different professional fields and theoretical orientations. The aim of maximum variation sampling is to discover central themes that cut across a great deal of participant variation. A small sample of great diversity yields "high-quality, detailed descriptions of each case, which are useful for documenting uniqueness, and important shared patterns that cut across cases and derive their significance from having emerged out of heterogeneity"(Strauss & Corbin, 1998, p.172). To maximize variation in a small sample, the researcher must identify diverse characteristics or criteria for constructing the sample.

Criteria for Selection

To be included in the present study, participants had to be experienced psychotherapists and identify themselves as psychoanalytically oriented. "Experienced"

means that therapists have been in practice at least 10 years, a length of time which should allow them to have developed their own style of practice and be able to reflect on their clinical work. Therapists who are psychoanalysts were not included in the study, which is limited to "psychoanalytically-oriented psychotherapists."

I did not control for gender, age, or other demographic variables. To maximize variation I included representatives of the various mental health professions that are licensed in California: psychiatrists, social workers, clinical psychologists, and marriage and family therapists. I selected participants from different theoretical schools within the framework of psychoanalytic psychotherapy. I attempted to maximize variation in these areas of licensure and theoretical schools in order to have the broadest view of how psychoanalytically oriented therapists address the central questions.

Recruitment

I recruited participants through recommendations from colleagues, and from the memberships of professional organizations in the San Francisco Bay Area. I sent a letter describing the research project (see Appendix A) to colleagues, asking them to recommend potential participants. (When I began my research, the institute name was the California Institute for Clinical Social Work, which is how the name appears in the appendixes. In January, 2005, the name was changed to The Sanville Institute.) I also put an advertisement in the newsletters of The Psychotherapy Institute in Berkeley, and the Santa Clara Valley chapter of the California Association of Marriage and Family Therapists (see Appendix B), briefly describing the research project, and asking interested therapists to contact me by phone or email. I then sent a letter to prospective participants whose names I had received, or who contacted me directly. The letter (see Appendix C) included a description of the research project and its

methodology, and was accompanied by the consent form for potential participants to review (see Appendix D) and a brief screening questionnaire (see Appendix E). I telephoned the participants I selected for inclusion and set up a time and place for the interview. Had there been therapists who were interested in participating that I do not include, I would have sent them a letter thanking them for their interest (see Appendix F).

Data Collection: The Interview

Data for the study was collected through semi-structured interviews. Mishler (1986) describes this type of research interviewing as a form of discourse that involves two people, and that relies on context and mutually constructed meaning.

> Rather than serving as a stimulus having a predetermined and presumably shared meaning and intended to elicit a response, a question may more usefully be thought of as part of a circular process through which its meaning and that of its answer are created in the discourse between interviewer and respondent as they try to make continuing sense of what they are saying to each other. (pp. 53-54)

An open-ended interview is the most appropriate tool to gather the type of information sought in this study, i.e., the thoughts and other subjective experiences of therapists about an aspect of their own clinical work. According to Patton (1990),

> The purpose of open-ended interviewing is not to put things in someone's mind (for example, the interviewer's preconceived categories for organizing the world) but to access the perspective of the person being interviewed. We interview people to find out from them those things we cannot directly observe. . . . Qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit. (p. 278)

Procedure

I planned to interview each participant once, for about an hour, in the setting they preferred—either their office or mine. I tape recorded the interviews and then

transcribed them. An interview guide consisting of a set of topics and probe questions helped me insure that certain questions would be covered during the interview, but the interview guide was only for my own use. It was not intended to direct or shape the interview.

Before beginning the tape-recorded interview, I reviewed the purpose of the study and issues of confidentiality with the participants and had them sign the informed consent, a copy of which they had received prior to the interview. I initiated the interview by inviting participants to begin to talk about their thoughts and experiences related to the research topic; after that, the interview followed the direction set by the participants. A semi-structured interview of this sort should be relatively spontaneous, reflecting the participant's own narrative, process, and flow of thoughts in response to the central research questions. If I wanted to ask about something that did not come up spontaneously during the interview, or if I wanted the participant to clarify or elaborate on something they had brought up, I asked my questions at what seemed to be appropriate points in the interview, hoping not to interrupt the flow.

The Topics of the Interview Guide

The preliminary interview guide (see Appendix G) consists of a list of topics and probe questions designed to help me attend to areas of inquiry that would shed light on the research questions. Early interviews may suggest additional topics and probe questions that could be added to the interview guide for subsequent interviews. Although the topics are presented here in a certain logical order, during the interview there was no need to follow any pre-conceived order of questioning. Whether and in what order questions are asked was entirely dependent on how the interview proceeds.

After the participant gave consent to proceed with the interview and we discussed whatever questions he/she might have had about the project, I began the interview with an introductory statement about the research question. I then asked the participant to begin by talking about his/her initial reactions and thoughts about this question. As the interview proceeded, I referred to the topic areas below.

Participant's Theoretical Orientation and Description of Current Practice

This topic area had several purposes. First, it established what the participants meant by identifying themselves as "psychoanalytically-oriented psychotherapists." Second, since an important aspect of this study concerns a potential gap between psychoanalytic theory and practice, questions in this topic area brought into focus the groundwork for discovering disparities between theory and practice. Furthermore, this area of inquiry allowed each participant to create the personal, theoretical and practical context for our discourse. I asked about participants' education and clinical training and inquired into current continuing education and consultation, as well as other influences on their approach to clinical work.

Participant's Understanding and Use of Particular Psychoanalytic Concepts

This topic area explored in more depth the relation between theory and practice in the participants' experience. In the literature, concepts of transference, interpretation, and insight are hallmarks of psychoanalytic practice. One aspect of the current study is to discover whether psychoanalytically oriented psychotherapists do subscribe to and make use of these concepts, and if so, how they integrate these concepts in their clinical practice.

Integrating the Concept of Transference in Practice

A question central to the present study is whether psychoanalytically oriented therapists view clients' presentation of outside relationships through the lens of the transference. This topic area was designed to focus on participants' understanding of transference. Do they value the concept only as it applies to the therapy relationship or do they value its usefulness when applied to a broader range of phenomena?

Examples of Extra-Therapeutic Transference in Participant's Clinical Experience

I asked participants to discuss examples from their practice of clients talking about outside relationships. My responses to their case examples were directed towards helping participants reflect on their own intellectual and affective processes that guide them when they work with clients' presentation of outside relationships. I did not introduce the term "extra-therapeutic transference" until the end of the interview. I was interested in learning about the participants' own ideas regarding this phenomenon, without naming a concept which may be new to them. At the end of the interview I introduced the term "extra-therapeutic transference," as it is defined in the psychoanalytic literature, and asked for the participants' reactions to the usefulness of this concept.

Other Theoretical Concepts, Apart From Psychoanalytic Concepts, That May Guide Practice

Since psychoanalytically oriented psychotherapists may not find sufficient guidance from psychoanalytic theory when it comes to working with extra-therapeutic transference phenomena, this topic area allowed for an exploration of other guiding principles that these therapists might use. Exploring this area was meant to encourage experienced

therapists to reflect on their own theories of therapy, even when those explorations might take them beyond the theories with which they consciously identify.

Participant's Development as an Independent Thinker

Experienced therapists will have developed their own ways of thinking and working that augment their formal training and take into account the setting in which they work, as well as their personalities and experience, holding on to some elements of favorite theories and letting go of others. In particular, I was interested in the ways psychoanalytically oriented psychotherapists may have made some internal translations or adjustments of psychoanalytic techniques to fit their way of practicing. By addressing this topic area I hoped to learn about how experienced therapists have found their way into their own style of practice and how they get support and validation for that style. Attention to this topic might uncover gaps between psychoanalytic theory and practice, along with therapists' individual attempts to deal with any such gaps

Data Analysis

I analyzed material from the interviews according to the "constant comparative method" described by Strauss and Corbin (1990,1998). Asking questions and making comparisons permeates the Grounded Theory approach. Questioning is the medium for data collection and a tool for understanding the data that has been collected. A Grounded Theory researcher asks what something in the data is or what it means, and considers qualities belonging to categories he or she already knows about in order to begin to make sense out of the phenomenon under study. The process of making such comparisons will suggest new questions to ask oneself to deepen and broaden

understanding of the phenomena under study, and move from the particular to the more general and abstract. In the Grounded Theory approach, analysis of the data begins as soon as the initial data has been collected, in contrast to other approaches where all of the data is collected prior to analysis. Thus, the process of making comparisons influences the process of collecting data and may suggest further questions to be asked in interviews, based on the evolving theoretical analysis. When new data comes in, further comparisons are made. Other tools involved in analyzing data, such as the different types of coding to be discussed below, assist in this process of asking questions and making comparisons, and eventually in theory generation.

Procedure for Data Analysis

Data analysis began with listening to the audiotape of each interview to get a sense of the participant's unique "voice" and to summarize the themes that stood out. Then the audiotape was transcribed. As more interviews were conducted and their audiotapes reviewed, I began to make comparisons between them, noting both the uniqueness of each and generalities that emerged. As mentioned above, emerging categories may suggest the need to collect more data until all relevant categories are saturated.

The primary tools for analyzing data within the grounded theory approach are a series of coding procedures that facilitate theory building from the particular phenomenon to more abstract and interrelated conceptualizations and categorizations. The different types of coding—open, axial, and selective—do not take place in a linear, sequential manner, but operate concurrently.

"Open coding" refers to the process of breaking down the data and examining it closely, looking for similarities and differences. Transcripts of the interviews were

examined line by line, looking for collections of phrases and words that seemed important, looking for clusters of related phrases, while also paying attention to general themes. The work of open coding is to name concepts, define categories, and develop those categories in terms of their properties and dimensions (Strauss & Corbin, 1998, p. 103). "Axial coding" refers to the process of reassembling data that was broken down in open coding, relating categories to sub-categories to arrive at more precise and complete explanations about phenomena, and adding depth and structure to categories (pp. 124, 142). "Selective coding" integrates and refines categories and their relationships to one another, moving towards a theory. Data from many cases is reduced into concepts and sets of relational statements that can explain the phenomenon in question. By this point in the analysis, a central category has emerged and becomes a focus for further theoretical construction (p. 145).

Presentation of the Data

I will present the data in two chapters. The first consists of a summary and overview of the data analysis and findings. I describe the participants, being careful to protect their anonymity, noting their common features and variations, and I describe the categories and sub-categories that emerged through coding and organization of the data, with illustrations from the data.

The final chapter is devoted to a discussion of the study's implications and significance, as well as its limitations. At this point I will discuss how the patterns that emerged in the data analysis relate to the research questions and to the literature.

Reliability and Validity

Reliability and validity are the criteria commonly used to evaluate experimental or other quantitative types of research. Though they are less useful in the evaluation of qualitative research, these two concepts are so associated with rigor in science that they cannot be ignored. Reliability concerns the accuracy of the measuring instrument or procedure: does the measuring procedure yield the same result on repeated trials? Can other researchers reproduce the experiment? Validity concerns whether the study measures what the researchers set out to measure. Are a study's findings generalizable? Validity refers to the rigor of the research design and also the extent to which researchers take into account alternative explanations for any causal relationships they explore (Howell et al., 2003).

Considering its research goals and its methodology, qualitative research needs to be evaluated on its own terms. However the concepts of reliability and validity can be adapted to address the design and scope of qualitative research. Strauss and Corbin (1998) consider the reproducibility aspect of reliability in qualitative research, and argue that another researcher who follows the same procedures for data collection and analysis will come to "the same or very similar theoretical explanation about the phenomenon under investigation" (p. 267).

Since generalizability is not the goal of qualitative research, with regard to validity it is more relevant to ask if results are transferable than if they are generalizeable (Howell et al., 2003). Strauss and Corbin point out that qualitative research builds theory through "the language of explanatory power" rather than through generalizability. "The real merit of a substantive theory lies in its ability to speak specifically for the populations from which it was derived and to apply back to

them" (1998, p. 267). In the present study the population from whom I derive theory and for whom that theory should hold "explanatory power" consists of psychoanalytically oriented psychotherapists in the San Francisco Bay Area. However, though its precise findings are limited to this particular population of psychotherapists, the study may have broader relevance through its suggestions concerning the relationship between psychoanalytic theory and practice.

Donald Polkinghhorne's (1987) discussion of validity in qualitative research centers on whether findings can be trusted and used as the basis for decisions. To be valid, the research conclusion "inspires confidence because the argument in support of it has been persuasive . . . .The degree of validity of the findings of a phenomenological [or other qualitative] research project, then, depends on the power of its presentation to convince the reader that its findings are accurate" (p. 38). Mishler (1986) comments that it is less a question of absolute truth than "assessment of the relative plausibility of an interpretation when compared with other specific and potentially plausible alternative interpretations" (p. 112).

CHAPTER 4: RESULTS

This study explores how psychoanalytically oriented psychotherapists think about the clinical process when their clients discuss outside relationships in the therapy setting, and considers the relevance, for clinicians, of the theoretical concept of extra-therapeutic transferences. I expected that therapists who identified themselves as psychoanalytically oriented would attach importance to the concept of transference, referring to the relationship between client and therapist, which they did. I also expected participants to report that clients talk a lot about relationships in their lives outside the therapy setting, which they also did. Since my review of the literature had yielded little in the way of commentary on the clinical use of this material in psychoanalytic therapy, I wondered how participants would talk about it from their actual practice and whether they would apply the concept of transference to these outside relationships. If participants did apply the concept of transference to clients' outside relationships, would it be as an aspect of the therapeutic transference or as extra-therapeutic transferences that have clinical value on their own terms?

I collected data for the study from hour-long, open-ended interviews with ten therapists, recorded on audiotape and later transcribed. I began the interviews by explaining that I was interested in understanding how psychoanalytically oriented therapists thought about what was going on in therapy when their clients talked about the relationships in their lives, and then invited participants to tell me what they thought about this topic. I knew from discussions I had had with colleagues while I was formulating the research question that I would be asking people to focus on their work

in an unfamiliar way. For example, one participant seemed to immediately understand what I was asking, and began by paraphrasing my question as follows: "Well, let's see. A man comes in and he starts talking about his wife and the quarrels he has with her and all, and, uh, what am I thinking about and how does that influence what I do?". Other participants expressed uncertainty about what I was interested in, feeling the question I asked was vague and broad.

Psychoanalytically oriented therapists are accustomed to discussing their work in terms of transference and counter-transference, and I was asking them to shift their focus to an aspect of practice that they may not have articulated. Without imposing too much structure onto the interviews, I brought up questions from the Preliminary Interview Guide (see Appendix G) in order to help the participants focus on the aspect of their work that I was interested in – i.e. their thoughts and feelings about what is going on in therapy when clients talk about outside relationships. I encouraged them to bring up case examples and asked more questions when they did bring up cases that included the phenomena in question. Participants did express many interesting thoughts about the clinical significance of clients talking in therapy about their outside relationships, which will be described later in this chapter. None of the participants was familiar with the phrase "extra-therapeutic transference" though they recognized its applicability to the phenomenon when I introduced the concept towards the end of each interview.

I will begin this chapter with a description of the participants. Next I will give a brief introductory overview of the findings, and finally present the findings, grouped according to the following major categories: Participants' Development of Their Own Theories of Therapy, Participants Listen on Several Levels at Once, The Role of the Therapeutic Transference, and The Role of the Extra-Therapeutic Transferences.

Participants

The ten participants were experienced, psychoanalytically oriented psychotherapists from each of the licensed mental health professions in California: two marriage and family therapists, four clinical social workers, three psychologists, and one psychiatrist. There were seven women and three men. One participant was African-American, the others Caucasian. All were in private practice in the San Francisco Bay Area: five from the East Bay, four from the Peninsula, and one from Marin County. In addition to practicing as psychotherapists, most participants supervise and consult with therapists in training. Some also teach and write in the professional community.

One interview was not recorded because the audio equipment failed so I had only the summary notes that I wrote after the interview. I have included this participant in the demographic description here, and incorporate her contribution to the study in a general way, even though I'm unable to use verbatim passages. For purposes of the data analysis, I used nine transcriptions of interviews.

Throughout this chapter I will refer to the individual participants as "Participant A," "Participant B," etc. to protect their anonymity and confidentiality. To help distinguish one from another within the study, I provide the following list. The description for each participant includes gender, type of license, years in practice, and stated theoretical orientation:

> Participant A is a male psychologist who has been in practice for 49 years. He said his orientation was psychodynamic, object relations and existential. He is influenced by Bion. He started out from a training that was classically psychoanalytic and still adheres to the major principles. He has done a lot of group therapy. He described himself as becoming more relaxed about using his own reactions and responses to guide him in therapy as his career progressed.
>
> Participant B is a male psychologist with 40 years in practice. He described his theoretical orientation as post modern and constructivist. He also has experience

with more expressive and body therapies. Though he was trained in traditional psychoanalytic theory, he claims to have rejected it in favor of being a strict constructivist. He is more interested in being authentically himself than in adhering to any particular theoretical approach.

Participant C is female social worker. She has practiced for 23 years. Her stated theoretical orientation was eclectic, psychodynamic, and relational. She has a solid background in social work and psychoanalytic theory but has learned to trust herself to "do her own thing" in practice. Her work with parents and children has made her more aware of the importance of the real relationships in peoples' lives.

Participant D is a female social worker who has spent 28 years in clinical practice. She said her orientation was psychodynamic/intersubjective. Her social work training had a psychodynamic emphasis which is still how she works, but she has become more flexible and believes that different people need different types of treatment. She has also incorporated a spiritual dimension into her work.

Participant E is a female social worker with 30 years in practice; her theoretical orientation is psychodynamic, object relations, relational, etc. Her original training was in community based social work and exposure to traditional psychoanalytic theory, but she thought her development as a clinician came later, through workshops and consultation she sought out on her own. She uses constructivist concepts similar to those of Participant B, but integrates them seamlessly with other psychoanalytic concepts.

Participant F is a female psychologist who has been in practice for 12 years. She said her orientation was broadly psychodynamic and Control Mastery. She felt she had good training in psychoanalytic theory in her social work program and was practicing in that style when she was introduced to Control Mastery. The more she learned about it the more she appreciated it as a flexible approach that was a good fit for her. She likes that the approach is more about what patients need than trying to make one theory fit for everyone.

Participant G is a female marriage and family therapist. She has been in practice for 21 years and stated that her theoretical orientation was psychoanalysis and object relations. Her original training was in family therapy but she went on to study in several postgraduate training programs in order to learn about psychoanalytic psychotherapy. She is one of the two participants who practices psychoanalysis, but she described herself as a "small a" analyst since her analytic training has not been in an accredited psychoanalytic institute. She likes teaching.

Participant H is a female marriage and family therapist with just 3 years in practice. She described her orientation as relational, eclectic and transpersonal. She was somewhat self-conscious about her lack of clinical experience and eager to improve her work and knowledge of theory. She is very engaged with her clinical consultation. Her background includes having lived in several countries, counseling experience from another setting, and an interest in her own spiritual development that affects her understanding of clients' issues.

> Participant I is a female psychiatrist who has been in practice for 26 years. Her stated theoretical orientation is self psychology, but she has also been quite influenced by Jungian theory. She was originally trained in a classical psychoanalytic model that she found cold and unhelpful, for herself as an analytic patient, as well as for her own patients. The fact that she has found it very helpful to actually meet clients' partners gave her a particular interest in the research question.
>
> Participant J is a male social worker with 25 years in practice. He said his theoretical orientation was psychoanalytic, object relations, particularly neo-Kleinian. His original social work training gave him a broad psychodynamic background and he is now about to complete a psychoanalytic training program. He does both psychoanalysis and psychoanalytic psychotherapy. He has a great deal of experience working with children and adolescents and uses his knowledge of developmental theory, which he also teaches in an academic setting.

My criterion for "experienced" therapists was that participants had been in practice at least ten years. Nine met this criterion. Their years of experience ranged from 12 to 49, the average length of practice being 28 years. I included one participant who had been licensed for only 3 years, though she had previously been a counselor in a related field. Since I assumed people who had been away from their original training for many years would no longer adhere strictly to the theoretical approach they first learned, I thought the perspective of a participant closer to her original training would add to my understanding of how therapists develop their own ways of working and reflecting on their clinical work.

In my recruiting materials (see Appendixes A and B) I specified that research participants be "psychoanalytically oriented psychotherapists," but I discovered that many of the participants were uncomfortable calling themselves "psychoanalytically oriented," even though, from my perspective, they seemed to be exactly that: therapists with a solid background in psychoanalytic theory, making use of basic psychoanalytic concepts and techniques such as unconscious dynamics, transference and counter-transference, interpretation of dreams and other unconscious material. Participant B said he didn't think he was appropriate for my study because he was not

"psychoanalytic," despite the fact that he has written extensively about psychoanalytic theory and that these principles appeared important to his work when he talked with me. Some people expressed discomfort calling themselves psychoanalytic because they were not analysts and their practice was not limited to psychoanalytic techniques. Some expressed discomfort because they had identified themselves with one or another offshoot of psychoanalytic theory, such as post-modernism or constructivism, which meant, to them, they were no longer psychoanalytic. Five of the participants said they were "psychodynamic." I had intentionally not used the word psychodynamic in the recruitment materials because I thought it was too vague, but I discovered that for many people it is a description with which they are much more comfortable than psychoanalytic and it seems to mean, for them, what I thought of as psychoanalytically oriented. On the other hand, Participant G said she thought psychodynamic was a sloppy label that "includes everybody from the most superficial counseling kind of people . . . whose work is really very much problem solving oriented . . . maternal hand-holding" to psychoanalytically oriented therapists.

I inquired into participants' specific theoretical orientation, both in the questionnaire I sent them (see Appendix E) and during the interview. Participants G and J said in the questionnaire that their orientation was "psychoanalytic or psychoanalysis." Participant J is in training to become an analyst, and Participant G has had considerable analytic training. They talked about both psychotherapy and analytic cases. The other theoretical orientations that participants stated in their questionnaires and/or elaborated on during the interviews were: object relational, relational, existential, intersubjective, "broadly psychodynamic," Control Mastery, self psychological, Jungian, transpersonal, postmodern, and constructivist.

Despite the fact that some participants had expressed confusion about the research question, they were all very cooperative with the interview process. They were thoughtful and reflective in considering aspects of their work not usually articulated. I was interested in discovering if there might be a gap between theoretical orientation and actual practice, with regard to the use of the extra-therapeutic transferences. If such a gap existed, I wondered if it would be perceived as a problem. It did not seem to be a problem for the participants. They openly described the way they worked, including times when they did not have a ready theoretical explanation for a particular intervention, and seemed confident and comfortable with their own styles of working. The only one expressing a lack of confidence was the most newly licensed, who was eager for opportunities to learn more about psychoanalytic psychotherapy. Any doubts she may have felt about her own expertise did not involve the question of extra-therapeutic transferences. All of the participants were very engaged in talking with me about the unique paths they had taken that brought them to this point in their professional lives. They seemed to enjoy their participation in this project, and thanked me for asking questions they had not been asked before. Several spoke about how our conversation had helped them clarify their own thinking.

Overview

The findings of this study reveal the complexity that underlies therapists' listening to clients as they talk about relationships in their outside lives. Today, these therapists understand and listen differently to clients than how they were taught in their original training settings. Professional training in psychoanalytic theory and technique and continuing education, as well as personal influences such as interests in social issues and their own psychotherapy experiences, provide the theoretical context in

which participants consider the process of psychotherapy. They are seasoned clinicians who have developed their particular styles of working and their own theories of therapy. Their professional identities evolved during a period when the field of psychoanalytic psychotherapy was shifting from a one-person, ego psychological model towards models that incorporate a more interpersonal, relational, and intersubjective approach to theory and practice, and the participants' development reflects this shift. In considering why they do what they do with their patients, they rely on their own sense of what is really healing and what will be most useful in the context of a particular therapy.

Participants were completely unfamiliar with the concept of extra-therapeutic transference, but when I had explained what it meant it made sense to them in terms of their clinical work.

A major category of findings was that therapists listen to their clients on several levels at once. At a very basic level, listening respectfully as clients talk about relational experiences in their lives contributes to building an atmosphere of trust and safety in the therapy relationship. The therapist also listens for the affective dimension of communication, both verbal and non-verbal. The therapist hopes to gain an understanding of the client's world and relational patterns in the client's history and present life. At another level, the therapist is listening for unconscious themes that may be expressed symbolically or metaphorically in the stories the client tells. Finally the therapist listens for the emergence of themes relating to the therapeutic transference. The fact that therapists are able to listen on several levels at once is relevant to those findings that address the relationship between the therapeutic transference and the extra-therapeutic transferences.

This study investigates these two kinds of transference, the therapeutic transference and the extra-therapeutic transferences. The findings show that psychoanalytically oriented therapists continue to place great importance on the role of the therapeutic transference, even though the concept of the transference, along with other psychoanalytic concepts, has gone through considerable re-definition in the past thirty years.

The question of when to interpret the therapeutic transference is complicated for the participants, as it has always been for psychoanalytic therapists. A client's ability or readiness to look at what is going on in the therapy relationship is associated with deepening work, which is valued by therapists, and which they contrast with supportive work. Despite their differences from one another and their criticisms of classical psychoanalytic theory, the participants all appreciate those moments when the relationship between client and therapist feels alive in the room, and they see those moments as having great therapeutic value, so that they always listen for that possibility.

With regard to the extra-therapeutic transferences and their relation to the therapeutic transference, the findings reveal that participants simultaneously hold two positions. One is that there is a hierarchy in which extra-therapeutic transferences serve the therapeutic transference. The other position is that the two types of transference operate in parallel, both important and complementary to each other. All but one of the participants expressed both positions. In many of their clinical examples they showed that important therapeutic work happened in terms of outside relationships and was not a manifestation of the therapy relationship. If participants hold the belief that the most important therapeutic work happens within the therapeutic transference but see that interpreting the extra-therapeutic transference can

lead to deep insights and therapeutic progress in the patient, I would expect this to constitute a condition of cognitive dissonance. Cognitive dissonance refers to discomfort felt because of a discrepancy between what one already knows or believes, and new, irrefutable information. But participants did not seem conscious of a contradiction between the two positions or to experience discomfort. It may be that the concept of listening at many levels at once and the fact that different dimensions of the therapy process shift between foreground and background may adequately contain otherwise contradictory positions, or that the concept of doing what is most useful for the patient may override other theoretical assumptions.

Findings

I will discuss my findings in four sections. The first section focuses on how participants developed their particular ways of working and thinking about the therapeutic process. It elaborates on the previous description of participants and provides a context for considering their discussion of the various components of the research question. The second section organizes participants' comments in terms of how they listen to clients on several different levels, simultaneously. The third section examines participants' thoughts about the concept of the transference and its role in their practice of psychoanalytic psychotherapy, including their considerations of when and if they interpret the therapeutic transference. The fourth section focuses on participants' thoughts regarding the concept of the extra-therapeutic transference and the relationship between the extra-therapeutic transferences and the therapeutic transference.

Participants' Development of Their Own Theories of Therapy

Findings presented in this section relate to the participants' growth and development and their views on the changing world of psychoanalytic psychotherapy. I was very interested in hearing from participants how they think the therapy process works and how they arrived at these ways of thinking; in other words, what had contributed to the development of their own theories of therapy? Findings related to the participants' own theories of therapy provide a foundation for later sections which focus on the participants' description of what they think is going on in therapy when their clients are talking about relationships in their outside lives.

Personal Growth and Therapy

Participants talked about the influence of their non-professional interests and activities. Many referred to having been a part of "the sixties" and the importance of their social and political activism. Several had been involved in public education. Other interests and activities they said had great importance for them were literature, spirituality, their own families, and their personal therapies. In the words of Participant E:

> My conversion to doing psychoanalytic psychotherapy was a long one because I, you know, I grew up in the early 60's, everything was very political . . . I was interested in changing the world. Then maybe the community. And finally it got down over 35 years to maybe if I could have an impact on one person I would be happy, but I mean it starts in this more global way. But . . . now, all of this has become part of training analysts psychoanalytic programs as well, culture, class, race, all of that has become, you know, that was part of our [social work] education from the get go, you know, the impact of poverty, impact, you know, the family systems and all of that . . .

Almost all the participants talked about the importance of their own therapy or analysis in terms of their personal growth and how they practice. Several gave examples of how experiences with their own therapists influenced the way they practice:

> I have had a few therapists in my life and some of it made an enormous difference to me, uh, but it was the quality of my relationship with them and the quality of who they were that opened possibilities for me to open those parts of myself, that kind of thing . . . that were really powerful for me. (Participant B)
>
> Let's just say yeah, [her therapist validating the relevance of her religious beliefs] helped me feel okay about bringing that into my own practice. And really, I think he's been very groundbreaking with me in terms of looking at things in a different way, taking it out of the traditional psychodynamic theory. (Participant D)
>
> [He was] someone who considered himself Jungian…but is technically very self psychological and so I think much of the way I started working with people came out of my experience with him and the sense of my really feeling held and nurtured and really understood . . . . It basically became very spiritual. (Participant I)

It was clear to the participants that how they practice as therapists is, to a large extent, the result of who they are, their own personalities, value systems, inner work, and life experiences.

Shifts in Theoretical Positions

The participants' careers span the period of time when psychoanalytic thinking shifted from a one person, intrapsychic model where the therapist is thought to be objective and neutral, towards a more relational and interpersonal model that recognizes the importance of therapists' subjectivity. Most of the participants described their early training as psychodynamic or psychoanalytic, with a foundation in ego psychology. A few began in training programs they called eclectic. There were, in effect, two scenarios: those who felt their background in ego psychology had been too narrow, and who sought to broaden their clinical framework, and those whose early training felt unsatisfying because it was too shallow and who sought to deepen their clinical framework. In either case all of them moved towards a style of working that incorporates ways of thinking that differ from their original training. They learned

about other theoretical perspectives through advanced training programs, individual reading, study groups, consultation, workshops, and conferences.

The shift is illustrated in participants' stories of their professional development and in the way they described how they work now. Participant C said: "I'm trying to think what model I get that from. More relational, probably, umh, I just use myself and my experience with people." From Participant B: "I'm very subjective in my work. I don't try to be objective. I just try to understand, be aware of my own subjectivity as much as I can and know that it's me and that's what they get."

Most of the participants had considered the possibility of training in psychoanalysis at some point in their careers. Participant J is currently attending a local psychoanalytic institute and intends to become an analyst. Participant G has had advanced training in psychoanalysis. She did not go for "full analytic training" because of the expense. The rest of the participants, for one reason or another, have not pursued formal analytic training. Participant A, a psychologist, said he would probably have gone for analytic training except that in those days, when he got his PhD, only MD's were admitted to psychoanalytic training. In hindsight he thought it was good that he had not done that training because it freed him to explore a variety of approaches. Others expressed ambivalence about analytic training, such as the following comments by one of the social workers, Participant E:

> In my own decision not to [go for advanced training] . . . I had to come to terms with my own, uh, you know, it's like internalized homophobia or internalized…anti-Semitism, or anything like that. . . . It's a kind of self-hate, you know, you're not as good if you're not an analyst. . . . Especially in the Bay Area because there are all these analytic training programs.

Participants commented on how their thinking has changed over the years with regard to basic psychoanalytic concepts and techniques, and how they think the

psychoanalytic community itself has changed. Expressing her view of the contemporary psychoanalytic community, Participant D said:

> It didn't feel to me like it did in the 70s and 80s . . . when it was more like, uh, "you the therapist are not doing a good job unless you're interpreting the transference between, you know, the patient's transference to you, if you're not doing interpretation of that all the time then you're not very good." I mean it just doesn't feel that way.

Participant I expressed her objection to the lack of relatedness in the classical approach:

> Actually I've stopped going to the more traditional psychoanalytic [presentations]. . . but I used to get enraged. I used to be enraged because I felt uh. . . I felt that the distancing between the analyst and the patient was hurtful, and it was a dishonoring of the connection between them.

At another point, she elaborated on her perspective:

> In the classical analysis . . . saying that everything is the patient, you know, we're the blank slate—I don't believe that at all—but I do feel that how I am in the room with them is how I, how I relate to them is, in part, is the center of the field.

In addition to describing their ideas about therapy in relational and object relational terms, several of the participants used language of constructivism to explain to me how they understand clients' experience, the therapy process, and concepts such as transference. Participant A's description of how experience is constructed is a good illustration:

> I think I get constructed by my experience and in constructing, constructed by my experience I construct the world I'm experiencing. And there's obviously an interplay between those two. And so when I start talking about my relationship to somebody I'm obviously putting that person into the framework of my experience. Now, I guess that's transference but it's not the unconscious identification of the patient with an authority figure, although that happens too, obviously.

How participants think about the role of basic psychotherapeutic concepts and techniques such as the unconscious, transference, interpretation and insight reflects their theoretical orientation. Participant G said: "I don't know if I've changed, changed my ideas about that so much. Uhm, I'm like sort of the standard issue British

School ideas about the transference, uh, it's in everything all the time, really anything could be understood as [being transference]." Others talked about how their thinking has changed. In the words of Participant E:

> But it [transference], the notion has been, it's just not my experience, but from general, from the field, it's been uh expanded, or maybe it was always there, to include the way in which people are constructing their world view out of those experiences and that is how the world is experienced.

Interpretation and insight are still important psychotherapeutic concepts for the participants, who discussed them in the context of contemporary psychoanalytic theory. A later section in this chapter focuses on how participants think about the role of the therapeutic transference and will pay more attention to the question of interpreting the transference. At this point the examples are intended to highlight the more general question of the shift in emphasis on the basic psychoanalytic concepts and techniques of insight and interpretation. Participants understand insight to be an experience that involves an integration of affect and cognition. What the therapist chooses to interpret is a function of the therapist's theoretical orientation. Some sounded quite traditional:

> I do think that that is the therapist's job, to be able to bring, help the client get to some understanding of it, and that means interpreting…. [Interpretation] would be an explanation from or an attempt at understanding, how the therapist understands something that has transpired with that client. uh…something like that. Pretty simple….I think that insight grows with interpretations, that what you're trying to do is to help the person come to the insight. I think that people are, when I make an interpretation, when I'm saying something that's at a point where I think the person is right on the edge of getting it, you know and they just need a little help, they just need like a little upward push and then that's where the interpretation is, it's kind of a little upward push and then it all comes together. . .You can see that they've gotten it. And that's the insight. (Participant D)

> I'm frequently likely to interpret on the basis of my perception of where the person I'm dealing with places himself in the world. . . . It's really based in part on what he's saying, part on my knowledge of his past and this and that. (Participant A)

Others expressed their reservations about the usefulness of traditional psychoanalytic interpretations:

> Well I do it [interpret] all the time. Do I really think it makes a big difference? Uhm, every once in a while, every once in a while, and I think they're rare, you make the right interpretation, you get that 'OH' kind of insight from the person and it really can be integrated. (Participant I)

> I think genetic interpretations should almost always, almost always come from the patient. . . . but I think for me to introduce genetic interpretations is almost always a sign that I'm anxious and trying to nail something down. (Participant G)

> Well, I do interpretations, but they're suggestions of ways to seeing it or what I think might be . . . I think it's important to connect things for people when you see connections . . . Secondly it's a form of enhancement for them because I'm really sharing what I'm thinking and feeling about their situation. And third, it gets it out of my head so I can go on. (Participant B)

The participants' professional growth and development reflect development going on in contemporary psychoanalytic thought, nuanced and integrated by the individuals themselves.

What Is Really Healing?

The question of what is really healing is at the heart of any therapist's theory of therapy. Participants talked about what their patients need from them and from the therapy process and what they, the therapists, should be doing to facilitate their patients' progress and healing. Some reiterated, in their own words, basic tenets of psychoanalytically oriented therapy, such as the importance of analyzing unconscious material and the process of working through:

> I think that's the defining quality of analytic work, is the intention to stay attuned, to the unconscious emanations. (Participant G)

> Repeated experience, is, I think, what moves you forward . . . if he gets the words [through an interpretation] then the repeated experience may help him look at, understand what he's doing, it may get into his guts a little bit. (Participant A)

Participant J talked primarily about how the therapy process is structured, unconsciously, by and around the transference. He works with that awareness in a variety of ways, confident that what the patient needs help with will gradually emerge.

Many of the participants emphasized the healing relationship more than particular psychoanalytic techniques. For Participant F, creating conditions of safety, a Control Mastery concept, is most important for healing. Others talked of how they psychologically hold their patients and create safety:

> Having the session be the sanctuary where people can really feel understood and held in a loving presence opens up the way for all kinds of healing and trusts and insights and connectedness in the transference. (Participant I)

> I mean I really feel that what comes out of the therapy is, comes out of the relationship and it's not who you are and what theory you have [studied]. (Participant C)

> I think that what's helping her the most is our relationship. It seems that I've been holding it, her mother transference, uhm, her mother who was lacking being protective. (Participant H)

In describing what they thought patients needed from therapy, what would really help them in their lives, the participants talked of self acceptance and about patients having more choices or options. New experiences with the therapist are thought to be a factor in achieving these goals:

> Maybe help their view, or see their reactions in a broader context . . . you help people feel much more self aware. . . help them be a little more buffered by getting some distance or maybe not taking everyone's reactions quite so seriously, literally. (Participant C)

> People use therapy in very different ways. But I think . . . they get to inhabit a lot of parts of themselves that they're not able to actually act out in the world and inhabiting those parts, with somebody else . . . they are able to increase them and change them . . . and I think that makes future interactions a lot better. (Participant B)

> I think talking about it in the interpreting and connecting is helpful to her. I think it gives her, uhm, self acceptance, self understanding, and more compassion and it helps her to be less judgmental about her behaviors and by accepting her feelings she has more choices. (Participant H)

Several also discussed their belief that attending to the spiritual and psychosomatic dimensions contributed to patients' growth and healing.

Do What Is Useful

Participants talked about how they sometimes do things that may not be "psychoanalytic" but are helpful to their patients, particularly to improve the quality of patient's outside relationships. They described interventions such as: self disclosure, offering guidance to a patient, giving a patient direct feedback about the impact they have on others, inviting a patient's partner to come in for a few sessions with the patient, and seeing a patient in both individual and couple sessions. In some of their examples they described techniques they had come to believe were beneficial, even though they didn't fit what they thought of as a psychoanalytic model. They might or might not have systematically integrated these techniques into their own version of a theoretical model. Other examples they described were more spontaneous interventions, things the therapist did or said in the moment, without forethought.

Although for the most part the participants seemed self confident and comfortable with their style of practicing, in talking about these implicit gaps between theory and practice they sometimes sounded like they were answering to a set of community standards. Talking about seeing patients with their partners:

> Sometimes I see couples, then I see them individually and I don't have any problem with that. It's never been a problem, but it's supposed to be a problem because you're supposed to develop a transference with one and then not . . . . But I still work with the transference with me with those people, especially when I see them individually. . . . I think the individual stuff is deeper, in some ways. (Participant B)

> And sometimes I will break my, all my rules, and work individually with each one as well as doing couples therapy. (Participant I)

Talking about self disclosure:

> And I do that in careful ways, but I would, I do quite a bit of it, actually, when I think it would be useful . . . and then I watch very carefully to see what happens. . . . You feel you're kind of uh like you're not supposed to do, but then you find it so effective and so I've gotten a lot more comfortable with that and really noticing what happens, afterwards. (Participant C)

Talking about guidance:

> But my experience is, in fact, that that [the transference] sometimes is not the most important aspect of the therapy . . . the therapist sometimes has to take the role of uh kind of more of a guiding role, less of a blank slate role and more of an opinionated role. As I have grown up. . . as a therapist, that has become more of my position . . . that there, that uh, that in fact people come for something and that they have faith and belief that you can offer them something and that sometimes to be a traditional blank slate is not what I think people necessarily need. (Participant D)

Participants also described, unapologetically and sometimes humorously, their own deviations from how they were trained or what they view as common standards of practice. In these instances their interventions did not seem to be integrated with their overall theory of therapy or therapeutic style, but had seemed useful at the time. In this excerpt from our interview Participant G talked about when she confronted a patient ("Q" refers to the researcher):

> There's a blind spot that she has and she can't see how provocative she can be. So, you know, and now that's not strictly analytic but I might say to her, "It sounds like you're. . . . Could that be having a . . ."
> Q: Not particularly analytic because?
> G: Well, I'm basically staying in the conscious realm there.
> Q: And so why would you do that?
> G: I don't know. It just seems . . . it seems, I think that I was impatient, like, duh, that was better? (both chuckle) I don't know. I mean it doesn't strike me as particularly good work, I don't think it's, you know, a capital crime, but . . .
> Q: It sounds like useful.
> G: Yeah, I guess I thought that at some level.

In other instances, participants explained how they had learned through experience what would be most useful for their patients, and interventions they described seemed well integrated into their therapeutic style. Here are two examples from Participant I that illustrate the importance of being true to what one has learned

through experience. In this first example she described her shift towards working more interactively:

> I: I am not at all passive in this process. I work interactively.
> Q: Has that always been true?
> I: It wasn't true in my [training]. but uh my experience was nothing happened. (laughs) Patients didn't get any better and—it didn't seem to make sense to me, so early on in my practice I started to interact more.

Then she talked about how useful she finds it to meet a patient's partner:

> Well it's interesting that you should ask that because I'm struck lately by how . . . how incomplete my, as a therapist, my understanding and knowledge of what's actually going on in those relationships can be from just hearing the uh words from the patient by herself. When I have brought in the spouse . . . to get another view it's, it's often so different that I'm finding myself to be doing more of that stuff.

By this point in their professional lives, participants have been exposed to many systems of thought that they have integrated with their earlier training. How they work with their clients, and how they think about their work with clients, is shaped by these theoretical influences as well as the participants' personalities, values, personal growth and life experiences. When they talk about what they think is healing or useful for their patients, they express some fundamental aspects of their own theories of therapy. The remaining categories will elaborate on their theories of therapy, especially with regard to how they make clinical sense out of clients talking about outside relationships.

Participants Listen on Several Levels at Once

When clients talk about relationships and interactions with people in their lives, participants are listening at several different levels, and with several purposes. They pay attention to content and process, trying to understand what kinds of problems the client has and what kind of response he or she needs. They listen to affective communication, verbal and non-verbal, tracking affect states in themselves as well as in the client. They are trying to diagnose or assess clients and to understand about the social and cultural context in which they live. Participants listen to the concrete information as well as unconscious or symbolic communication. Clients' presentation of outside relationships may suggest repeating patterns in their lives and transference themes. Therapists choose what level to put into words at any given point in the therapy.

Participant G explained the listening process as occurring on three levels: listening as one human being to another, listening with evenly hovering attention for unconscious themes to emerge, and listening for the state of the transference:

> So basically I'm talking about three kinds of ways of listening, there's kind of the listening one human being, one subject to another subject, "you're worried about your doctors." Or "You're resentful about having been treated badly," or grateful that you were treated well, or whatever it is, "and you want me to know that because I'm important to you as another human being that you have a particularly intimate relationship." So there's that level of listening. Which is, which has to be part of the work although it sometimes can feel as if it is a resistance. And sometimes it is. The other, then there's what I would call Freudian listening which is that you're listening with evenly hovering attention so that the [states that determine] the parapraxes, the recurring images, the peculiar inconsistencies, through, through the telling itself the unconscious can be revealed . . . over a long period of time. It doesn't happen . . . instantaneously. So it can be taken just as dream response if you want. And then there's kind of [inaudible] which is that you're listening for derivative material that reveals the state in the here-and-now transference.

I will build on her categorization as I present participants' thoughts and comments about their different ways of listening to clients.

Listening as One Human Being to Another

All of the participants spoke to the fact that clients need to talk about their outside relationships in therapy, and that it is important to let them talk, even though they may also be resisting feeling or talking about something deeper. In a tone that conveyed her respect for the humanity of her clients, Participant C said, "I mean I take what they're saying very seriously." Listening as one human being to another contributes to building trust and building a therapeutic relationship. Participant B talked in terms of how it helps him engage with his patients:

> I think I identify with all the people, I try to. I find ways that I can imagine myself in their shoes. Like when I'm reading a good book or something, only more so because it's, it's you know it's real. and uh sort of trying it on or something. . . . I'm interested in relationships. I think those are the main things going on with people.

Participant J talked of how important it is to stay with his patient's account of an interaction even though he was very aware of the aspect of her reporting that revealed her defensive patterns and transferential implications:

> You know, in a way there's, there were different levels we could talk about that on, but we stayed with that, her upset at this meeting with … for most of the session, most of the session….I felt it was very productive, uh, but I also had to pay attention to the fact that she sometimes gets, even during that description, into these [familiar states of self hate and isolation].

Just listening to whatever the client chooses to talk about, which often is their outside relationships, is a basic and valuable therapeutic stance.

Listening for Affect States

As therapists listen to their clients' words, they are also attending to the affective or feeling dimension of the communication, tracking changes in affect states, and noting incongruities between affect and the stories clients tell. Participant G remarked that "what affectively becomes enlivened in the room" is where she thinks her attention should go. Therapists listen to clients' verbal expression of feelings, observe the nonverbal behaviors and body language, and also pay attention to their own feelings which can provide clues about clients' unconscious or disavowed affective experiences. Beyond just listening for or noticing affect states, therapists' activities become important for clients in terms of affect regulation, identification of feelings, integration of affect with cognition, and making connections between feelings in one context and another. Participants gave many examples of their awareness of the affective dimension in clients' outside lives, within the therapy relationship, and within themselves.

The following excerpts illustrate how participants include the affective dimension in their portrayal of clients' outside relationships.

> We've already started talking about his, uh, his contempt for his wife and, uh that is so contradicted by other descriptions of her and start looking at some of the contradictions and some of his anger at her that he's feeling, that that's a reaction to something which is that she makes him feel like he isn't a man. (Participant J)

> I'm thinking about a woman who has gone from one relationship to the next . . . and has felt like a victim, has felt criticized, attacked, unloved. (Participant I)

> She admitted to feeling very sexual towards her father and, in growing up, of the eroticism in the relationship that she really didn't know what to do with and had all kinds of feelings about – guilt, anger, frustration, longing and I think she has transferred that in the relationship with a man. (Participant H)

> It feels like it's more about the tension between the two of them. (Participant H)

Participant C told a long story about a teenage patient who had made great progress, partly because of her relationship with a mentor at school. She described how the girl and her father seemed at different stages of her therapy:

> There was a whole period where she was failing in school and the father was just distraught . . . she was just terrified with the whole social situation at school. . . and she just sort of shut down. . . she's now kind of able to . . . experience herself differently and a lot of excitement about that . . . And the father's softened up, funny enough, now that she's getting A's instead of F's. . . He can relax a little bit. And she can start to see also that it was out of his anxiety, it wasn't because he thought she was a horrible kid.

Participants spoke of clients' affect in reference to the therapy relationship or the therapy process, alluding to the therapeutic transference and the healing relationship. They notice when clients feel safe:

> So here is a different situation where he could, this is what he was saying, that he could take a small risk with expressing one small dissatisfaction and see how that would go. (Participant H)

> . . . in those moments they're the most vulnerable, real moments in the therapy because you're not just talking about something outside of. . . . You're sharing it between us and so that's, those are the times when the greatest work can be done. (Participant I)

Participants notice when clients experience painful or distressing affect in relation to them, as in this excerpt from Participant A , who also brings up his own affective response to the client.

> He could get annoyed with me—I, as I've gotten older, sometimes drift off during hours, especially if I feel a barrier being put up against me . . . . He could get angry with me about that, but basically I had to stay up on the pedestal and that's why he got angry when I'd drift off.

There were many examples of clients' affect states in the therapy setting, which sometimes reflect the degree of emotional contact that clients have or are able to tolerate in the therapy relationship: "She's very embarrassed about being so dependent on me" (Participant J); "I feel so nervous" (Participant H quoting her client); "She's pleasant with me, she cries, she shares feelings, she's upset, she talks, she shares really

crazy things, and all that stuff, feelings she had. . . " (Participant B); "She'll get into these very preoccupying states, preoccupied states of mind about it, and then the details will just flood the room" (Participant J); "She's very frightened of being more involved . . ."(Participant J); and

> But there hasn't been any feel of anything between us that's, uh….has any…none of the qualities of the intimacy, the degree of intimacy we have, have had a quality of strain or extra stuff, or stuff hidden, or manipulation, or it hasn't felt any of that. Uh, it's sort of a benign thing. (Participant B)

Finally, participants use their own emotional responses to help them understand what their clients may be feeling or what may be going on in the therapy relationship. As participant A says, "If something is going on…I'm liable to consult what I feel, and understand that in terms of what's happening in the room, and I won't necessarily interpret it." Participant G speaks of the process of tuning in to oneself:

> I mean you go with where your attention is drawn, overdrawn. And you … use your own responses, which can be at any, any part of yourself—it could be heart responses, it can be emotional responses, it can be the bodily responses, anything in the sensorium, all of that can be used as a place to register responses from him.

The following excerpts illustrate how participants' experience their own affect states and make use of their awareness:

> But when I'm with this person I'm feeling kind of on edge, uncomfortable…it's like when this particular woman is talking to me I don't get a sense of really feeling who she is. There's something missing. (Participant D)

> She sometimes gets . . . into this very deep kind of . . . depressive stance where I start to feel quite helpless and there's nothing I can do to, you know, break into her uh this sort of cocoon that she's wound around herself. (Participant J)

> He's tricky in the sense that he doesn't appear to suffer very much,…But there is something that feels empty about all this. And I think that there is a kind of suffering in him (Participant G)

It is clear that the affective dimension of communication is very important for participants when listening to their clients.

Trying to Understand the Client's World

Participants are committed to understanding their clients—who they are and what their problems are. Participant F said she listened from a variety of viewpoints, but that it is all about understanding the client. Among other things, she is listening for what the client thinks about him or herself, and what kind of person she or he is. What clients say about their relationships, and the way they say it, helps therapists assess clients and formulate treatment plans. Participant E said this very clearly:

> I guess the first thing that comes into my mind is that when people talk about their outside relationships they're bringing into the therapy in a demonstrable way where the difficulties are, whether it's characterological or relational, or whatever, that it's the, it's the way in which, I mean, sort of, that you learn who they are, where their strengths are, where their kind of difficulties are, and that could be, it's the template for understanding their history.

In similar terms, Participant H said:

> I think it's very helpful for clients to bring material that's about them in relation to other people. I think it gives me a sense of what is it that they want to understand more about themselves, what bothers them, what they're struggling with, what they're hoping to gain or what they're hoping to become.

The following example illustrates the breadth of information that can be gleaned about a patient when she talks about her marriage:

> So a woman comes in and says her husband is cold, doesn't love her, and so on and so forth, and it's clear that she's a woman who wants to be responded to in a certain kind of way and it's clear to me that she steps on her own lines and gets in her own way and comes over to the man's controlling because she's stopped trying so hard to get what she wants… (Participant A)

As psychotherapists, the participants are always listening for information that will increase their understanding of clients' experience of self, and self in relation to the world.

Listening for Repeating Patterns in Relationships

When clients talk about a specific interaction or relationship, the participants wanted to understand how it might fit with a pattern of other relationships in the client's life, and, at a deeper level, how it might reflect an underlying, unconscious relationship template. As Participant I remarked, "I would look for patterns, if it's a common theme, and especially if there's any kind of genetic history that would make it likely that they would have certain kinds of pain." Participant D emphasized the historical element, how history is contained in the present, and how that concept affects the way she listens:

> I guess when a person comes in and generally talks about their relationships I am, uh, the first kind of thing I think about is the history, and how whatever they're talking about might be related to their history. You know, which comes from, looking at history of course comes from a psychoanalytic, psychodynamic kind of perspective . . . the history always applies to the present. . . and so when I think about what happens to her in her relationships I'm thinking about her history and the difficulties she had as a, you know, growing up, and her relationships.

The comments of Participant H show the importance of trying to understand, through listening to clients talking about relationships, how their relationship templates have developed:

> Well, I'm interested in what is it that's being repeated here, what are the patterns that are being repeated and uhm how did those uh patterns, how were they internalized, what is that, how did they get settled, how did they get started, how did those beliefs take hold, how come that happened that this person believes that?

She said, about a different client, "Well, I, I think that both. I think that she's re-enacting more at a concrete level, many different ways, but also re-enacting the neglect of the mother." Awareness of the repeating patterns or templates that shape patients' relationships informs many of a therapist's interventions.

Listening for Unconscious Themes

From the psychoanalytic perspective, the unconscious plays an important part in relationships and patterns of relationships. At one level participants are always listening for clues from the unconscious that will lead to making connections and deepening understanding as therapist and client explore the symbols and metaphors in all sorts of material that comes up, including the client's presentation of interactions and relationships. Participant G described her way of listening with "evenly suspended attention" for "some words, some phrases, some thought, something that gives it, gathers emotional weight. It becomes, it emerges, a phrase . . . so it's what affectively becomes enlivened in the room."

She went into more detail about how she might listen to a client talking about outside relationships with this kind of attention, wanting to pick up on both the repeating relationship patterns and other unconscious themes:

> At the same time I also know that those, those reports from the external world can be taken as associations and that they're very useful uhm from an analytic point of view in that they uhm, if you listen long enough you get patterns, you get, uhm, you get emanations about the unconscious, uh, through those reports.

Several participants noted that they listen to a client talking about outside relationships in the same way that they listen to dreams, focusing on unconscious themes and away from the concrete, literal narrative:

> I almost looked at it as the people from the other family as being parts of her self, you know, just like in a dream. That's the way I look at it, as if it were a dream. . . .It is her story about these people; I don't know how it really happened with those people, but, so it must mean something. (Participant H)

Participant J spoke in very similar terms, about how his work with an adult patient was like therapy with a child, where he would understand the child's play to be a metaphor for other themes:

> Then again, what I'm doing in my mind is I'm saying, I play around with it in this way I think 'I don't know if he has a wife'; it's like play material all this stuff that's alive; it's the same kind of stuff. I'll stay within it a lot, it's just, it'd be like a

> dollhouse with him, and he's got this wife and he says 'look what's going on in this house?'

Attending to unconscious meaning is a hallmark of psychoanalytic work, and was represented in the way participants talked about listening to their clients' presentation of everything, including outside relationships.

Listening for the Emergence of Transferential Themes

Finally, participants talked about how they always wonder if there is a transferential aspect to the stories clients tell about their interactions with others. As I will discuss again in a later section, there is quite a range in how participants talked about the relative significance of the content, i.e., clients talking about relationships in their outside lives, and its possible connection to the therapeutic transference.

Clients talking about outside relationships may attune the therapist to how the therapeutic transference will develop in the future. Participant F said she thought the same things would be likely to happen with her as happen outside the therapy and gave an example of how she would expect a client who is meek in her relationships with others to react to the her in that same way. She wants to hear what her client will need or fear from her. Several others spoke of how listening to what the patient tells them about outside relationships attunes them to what may come up in the therapy relationship:

> And it's also a place, the way in which [I begin to learn] what the issues are going to be in the therapy, in terms of our relationship, so it's sort of the predictor…it's sort of the organizer of the past, it's the uh, it's the medium. (Participant E)

Participant D, in describing a patient whose account of her experiences did not ring true for her as the therapist, said:

> D: I expect to find some difference coming to her, I expect something to, you know, like the little chink in the armor, I expect it to appear.

Q: With you?
D: Yes, with me. It's just a matter of when.

At other times clients' talk of outside relationships may resonate with transference themes that are already occurring in the therapy. It may even be an indirect expression of material that primarily relates to the therapeutic transference, such as: "So I'm always looking at that [the historical references] and then I also look at how it relates to me and what is their relationship with me" (Participant D), or:

> What I would hope that I would be doing, which I would strive to do, I would always be wondering in my mind if there's relevance here. But I may or may not bring it in, but I, I look—I think it has—I don't think everything is about me. (Participant E)

Participants are always attending to multiple levels of the therapeutic process. At one level they just listen to what their clients tell them about their experiences with others, listening as one human being to another. Beyond just being good listeners, they are attuned to the affective dimension of clients' communication. Their clinical training and experience has prepared them to discover rich significance in what clients tell them, to understand their clients' personalities and social context, the patterns in their relationships, and the unconscious themes of their inner worlds. Listening to clients talk about outside relationships may also alert participants to issues in the therapy relationship.

The Role of the Therapeutic Transference

Examining participants' theoretical understanding and clinical use of the concept of transference was central to the research question. In this section I limit my presentation to participants' views on transference as it pertains to the client/therapist relationship. I have called this concept the therapeutic transference, in order to differentiate it from the universal and the extra-therapeutic transferences, but participants refer to it simply as "the transference." Sometimes participants talked about the relationship between therapist and patient rather than the transference, or used phrases such as "when it is happening in here" to refer to the therapy relationship. I have decided to include their discussions of the therapy relationship with discussions of transference, even though it could be argued that these are separate concepts.

All the participants agreed that the therapeutic transference is a very important dimension of therapy, sometimes to be interpreted, sometimes not. But they did not agree on just how important or central it is. Not only did participants differ from one another in how they thought about the role of the therapeutic transference, but also individual participants expressed different points of view. Sometimes they talked about the therapeutic transference as if it were the primary focus of psychoanalytic psychotherapy, and at other times they pointed out dangers in overemphasizing the transference. A similar range of differences will show up when I present participants' thoughts on the relationship between the therapeutic transference and the extra-therapeutic transferences. The fact that participants are listening at several levels at the same time means that they can listen for the transferential dimension but let it remain in the background.

It's All Transference

Participants used phrases like "it's all transference," referring both to the universality of transference in life, and to a way of understanding the therapy process. The following remarks, from three different participants, illustrate the idea of transference as a universal phenomenon, not restricted to the therapy setting:

> I think everything is about transference. I mean you can even say it's about transference to God, you know. And then the next level is related to our parents, and we were disappointed by them because nothing they do could be God, and then we start passing it on to the next and the next and the next. So I think the relationship with the analyst is not really any different from all those relationships. Everything's about transference. (Participant I)

> I mean on the broadest level I think everything is transference. That is that we're all distorting everything based on what's happened to us in the past…That's what it is, that's all. (Participant B)

> That is, I think about these things as experiences that become constructions about the world, so that in that broad sense it's all transference. (Participant E)

Others meant by "it's all transference" that anything or everything occurring in the therapy could be construed as a manifestation of the therapeutic transference. Participant J, who is in analytic training, expressed this most strongly, saying "Well, I guess I what I would say is that I do believe that the hour is structured unconsciously by the transference." He elaborated as follows:

> [The patient's telling a story] has both an independent existence – and I understand that, it's not that the patient's problem is me, that the transference to me is what they're in treatment for, but I do think it's got, it's structured, that the session, the telling me about the dog, is structured unconsciously as an experience of the transference. And that's the way I orient myself to the material, mainly.

For others the idea that everything occurring in therapy is a manifestation of the transference seemed to be an ideal, but not one that gave as much coherence to their work as in the example above. Participant A said he would like to be the kind of

therapist who saw everything as being about the transference, but that other theoretical models and his own experience had led him to a different therapeutic style:

> Basically I would like to be able to practice the way the Tavistock people do where everything they say has reference to me, regardless of whether it is about history or about current events. I don't practice that way.

Deepening the Work

Many of the participants associated working with the therapeutic transference with doing deep psychological work. As psychoanalytically oriented therapists, they believe in the value of working with patients at deeper levels, and hope to do more than supportive therapy whenever possible. As examples of work going deeper, they described times when a patient stopped "externalizing" and began to see how he or she contributed to their own problems, and when patients were able to pay attention to what was happening in the therapy relationship. Participants think about educating patients with regard to the therapy process and encourage patients to wonder about deeper layers of themselves and their experiences. The following description, from Participant E, shows how she hopes her patients will be able to work with the therapeutic transference:

> People have to learn to be, in therapy… I try to take say something like that in the beginning, when they first come in, that I'm very interested in what happens in the room, between us, that I'll, although I know it's hard sometimes to bring it up, I'm very open to hearing about their experience of me, then say, for instance, if they have reactions to [something I say or do] and that I'm going to try to ask them. So I sort of forewarn a little bit.

Factors such as the structure of the therapy and client readiness can facilitate or hinder the deepening process.

Structure of therapy.

Frequency of sessions and length of treatment are associated, in participants' minds, with deeper work. They like to do long term work with patients, and to see their patients at least once a week. Even those who did not have analytic training thought it would be easier to do deeper work in psychoanalysis, and to keep the focus on the therapeutic transference, because people are seen four or five times a week. Participant J, who does do analysis, explained how he thought the structure of analysis enables patients to do deeper work:

> Most people I see come more than once but there's still a few people come once a week. Uh, and there is a difference, I mean, I think it's, uh, I think the people who have a lot more support, who come 4 or 5 times a week, I mean it's so much easier to work in transference and I, I uh, I think it also, in analysis you invite a much stronger relationship and then the weekend break, I mean for some people, people come 5 times a week, the weekend's a very big deal. If you come one time a week the weekend is, it's not, uh…I think the material is still structured by the unconscious and by the transference but I think it's a bit different, I mean I, I think it's a little bit, I think I focus less on [the transference].

Participant G, who also does analysis, expressed a different point of view. She questioned whether it is the traditional structure of analysis that deepens the work. She said:

> I used to think you really couldn't call it analysis if somebody's sitting up facing you and you're only seeing them once a week. I'm not sure that's true anymore, I actually think it has to do with—how you're listening, and how you're functioning as a pair and what you're listening for and what you're talking about.

Participants from all the different theoretical perspectives talked about how they thought they could do deeper work with clients when the clients came more often and when they stayed in therapy. They expressed frustration over such things as the downturn in the economy and the influence of the managed care model that contribute

to patients not being able to come to therapy more often and to their expecting a problem-solving approach from their therapists. Participant C said:

> (Referring to the internal map a client brings to all relationships) I think it's really important [in] deep work, hm, I find it a lot easier to work that way when I'm seeing people more often, and that's one of the things I feel sad about, with kind of cutbacks in the economy, is that I'm doing so much more of every other week and it's just generally a lot more catch up. I'm just seeing people less intensively hm so I don't, but it's always a, I mean it's always there, you're doing the same thing, hopefully and conceptualizing the same way even if it's less often, but it's just harder to use in therapy, to talk in terms of the relationship.

She came back to the issue of long-term therapy later in the interview:

> I mean that's kind of the joy in long-term work, when you work with people that externalize a lot and then they see how, the benefit of looking at their part. They actually can make shifts and changes in themselves more easily than changing the other person.

Client readiness.

Being able to accept transference interpretations is associated, in the minds of the participants, with a client's readiness to do deeper work. Even under the best of circumstances, when a patient is assessed as having the capacity to benefit from psychoanalytic psychotherapy, is able to have frequent sessions and to stay in treatment as long as necessary, the process of deepening the therapeutic work is gradual and depends on the establishment of trust and a sense of safety. Participant J described this gradual process:

> I think this is the part which takes a while to kind of gather up in terms of talking about, making interpretations of the transference. It takes a while to get into that mode and it takes a while for it to kind of gather.

Therapists must take the patient where he or she is and follow the patient's lead. Patients sometimes need the therapist to stay with them at the level of the immediate problems that brought them to therapy, as Participant A described:

> . . . because the current anxieties and the current need to deal with them may overwhelm him so that he has to come and talk and talk about them and there's not much room to enter. Now if he stays in therapy long enough, obviously we can get into things.

Along the same lines, Participant E talked about how the work with one of her clients had deepened over time, meaning that the client was now more able to work in the transference, while previously she had only been able to talk about her marriage:

> Actually when I think about her, and that's a good example, the beginning phase she couldn't have tolerated working in the transference so it was very much about her and her husband and she externalized a lot.

The participants brought up the importance of timing their interpretations, and their understanding that patients would let them know, one way or another, if they were ready to "go deeper." As Participant J put it, "I think patients know very clearly when they are, you know, what they are ready to know, what's the maximum sort of emotional contact you can make with the patient." Participant A gave a more detailed example, adding that it is impossible to put into words how he decides on the timing:

> Well I don't try to bring it in the appointment very early. I try to get at what underlies his sensitivity to being cheated, and then sometime when it seems to be an appropriate time – and don't ask me how I know that – uh, I'll say that I wonder how much you feel cheated in here, and uh if my timing is okay we'll get into a discussion, and if my timing isn't okay, 'oh, you're great, doctor, nothing like that here', so I'll come back to it in a month or so.

Some patients cannot, or will not, do the deeper kind of therapy work. Participants could not necessarily explain why that was, but said things such as "we all have those kinds of patients who aren't very aware, or are resistant to talking about the relationship"(Participant E). Participant C said more about this puzzling phenomenon:

> There's certainly patients that I don't work as much in the relationship and it would be interesting to do a study of why certain patients can fall into that so easily and others, no matter what you try, they'll just look at you puzzled (laughing) "Why, why are you asking me what I think, you know, is going on in here?"

In the following example Participant E was trying to help her patient overcome her resistance to doing deeper work. The implication here, and in the comments of several other participants, is that supportive therapy is not "deep":

> Well it's very difficult because—she wants uh everything to sort of be okay, in her life. She tends to pull for sort of supportive psychotherapy and I'm struggling to try to move the therapy forward a little and so that's, it's not exactly painful but it's close to that, because I'm working very hard to try to sort of help her open up to herself and to look at herself and she's working very hard to not.

Interpreting or Not Interpreting the Transference

Participants certainly expressed their belief in the value of transference interpretations, and gave examples, such as the following, a case where Participant B interpreted the therapeutic transference:

> Well I have one client who's forever thinking I'm disapproving of her…And we talk about that, and we talk about how her family always criticized her and so forth, and there was a scarcity of love and contact in her family and they all elevated themselves by pushing the other one down. Criticizing. And she expects that from me, sort of, that she's not enough, that she's not good enough.

Participants also talked about situations where they would not interpret. Even though they notice and think about the significance of the therapeutic transference and the dynamics that are being played out in the therapy relationship, participants do not necessarily talk about it directly with a patient. A number of factors enter into their decision to interpret or not to interpret manifestations of the transference. Participant A makes the point that the positive transference should be left alone, not interpreted, a point that has been widely accepted in psychoanalytic practice.

> He was doing a lot of good work on the basis of the transference. . . trust in me, wish to come up and be a good patient and all the rest of that, and to go into the, uh reflection of me as an idealized father would have turned him away from what he was working on. He might have agreed, he might have even been able to amplify it, but it would have had no therapeutic effect at that point.

Several participants talked about the difference between interpretations in the transference and interpretations of the transference. Participant J explained this difference to me. Categorizing interpretations in this way keeps everything, including clients' presentation of outside relationships, in the realm of the therapeutic transference:

> So interpretation of the transference would be, say somebody comes in and they say uh I was really anxious this weekend because my dog got out of the house and I couldn't find her for a day and a half and I was scared to death. And it's the weekend break . . . so within interpretation of the transference would be to say something about what, on another level that we were talking about the relationship with me. And the experience of the absence . . . And interpretation in the transference would be uh something along the lines of I certainly understand how frightening that would be. You've let me know how attached you are to this dog, and how frightening it was.

In deciding on whether it would be helpful to interpret the transference, participants brought up other elements or concepts that guided them. In this example, Participant G was more concerned with tracking the patient's unconscious processes than the transference per se:

> Well it's not that there isn't transference—there can't not be, I think the transference is always there—but it's not where his attention or my attention, it's not where the unconscious process takes us. . . . my job is to get attuned to him, uh, and to try to pick up the drift of his unconscious in my unconscious.

Several participants said they were less likely to interpret the therapeutic transference with adolescents than with adults because of their ideas about what adolescents need from treatment. Participant J said that because of their developmental stage, he didn't think adolescents could work in the transference in the same way adults can. Working with adolescents it is more like play therapy, where he stays in the metaphor:

> I tend to shift in my thinking a lot when I do work with adolescents. I think it's still very much there in terms of the function they're wanting me to provide, but I don't, uh, we talk about it but it's not the same invitation to regress in the transference the

> way with an adult patient . . . I don't emphasize it as much, frankly. I tend, probably, to go a little bit in the other direction, of not pulling as much for it.

Participant C also talked about how she was less likely to interpret the therapeutic transference with her adolescent patients than with adults, but the reasons she gave were not about staying in the metaphor but about the helpfulness for adolescents of interpreting extra-therapeutic transferences that arise in relationships with peers and other adults in their lives.

Many of the participants talked about how interpreting the transference, when it is done insensitively, is reductive and can be harmful to patients. These examples come from the two participants with analytic training:

> There is just the reality of the outside world that people, everybody needs to talk about . . . and I think always to just reduce that to a psychoanalytic category and a theoretical construction is inhuman . . . so I don't actually believe in that kind of practice. (Participant G)

> Clearly doing that prematurely is, uh, you know, makes you a persecuting object. . . . It's too overwhelming; I think people let you know in their responses to interpretations whether. . . (Participant J)

Overemphasizing transference interpretations could be harmful in the sense that it gives too much importance to the therapist's role:

> [While transference interpretations can be powerful] the idea that the therapist knows what it is and he's bringing it to the client's attention …is not true. And it doesn't do the client a big service to have them think that, uh, the therapist sees the real truth and they're going to tell you it and then when you learn it, learn to see it, you'll be tuned, calibrated to go out . . . (Participant B)

Or it could be harmful in the sense that it means other important issues in the patient's life are being neglected, as Participant C noted about a case presentation she had heard:

> [The therapist was] presenting a man she'd worked with and he was having severe problems with a partner and it didn't seem like she was relating very, sort of back and forth between their relationship and the partner, it seemed mostly to be in relationship to her, and uh I felt, you know, that this man's relationship might be

> down the tubes while they were analyzing and I've seen this happen with colleagues, where they've been kind of stuck in a very deep transference and completely obsessed and absorbed by it. And the marriage just goes down the tubes. And so I feel that's kind of a, it's a, unfortunate.

In discussing how it might be damaging to clients to interpret the therapeutic transference, Participant F talked about clients with separation issues or a very intrusive parent. To try to get such a client to focus on the therapeutic transference can recreate the earlier experience and re-traumatize the client. She gave several case examples where her attitude towards the clients and way she structured the therapy was determined by her understanding of what they needed from her. She felt she was always making use of the transference, but not necessarily by interpreting it.

When deciding whether to interpret the therapeutic transference or not, therapists are guided by complex theoretical principals, but even more importantly, by their understanding of who their clients are and what they need from them.

Impact of the Here-and-Now Transference

During most of the interviews there were points when the participants seemed particularly enlivened, talking about those times when therapist and client recognize the therapeutic transference because of something that just happened between them. In these instances they echoed Strachey's (1934) description of the mutative transference interpretation (see Chapter 2), though they were less interested in making connections to the historical, genetic roots than in staying with the here and now experience within the therapy relationship: "I don't necessarily privilege those [genetic interpretations] but I certainly do privilege process interpretations in the here-and-now, things that are going on between us" (Participant E).

One explanation that was given for wanting to be able to work in the here-and-now transference was that it meant the therapist had access to information, through his or her own self awareness and countertransference, that wasn't there when the patient was describing relationships with other people. Here is a case illustration, from Participant E:

> If she comes in five minutes late and is anxious and I sincerely feel this is her time, I don't have any judgment about it, she's sort of handling a lot of different things, and she's human, she's going to be a few minutes late sometimes. But if she comes in really anxious and I explore that with her and she thinks maybe I'd be angry, I know I'm not angry. She tells me it's happening with someone else, I don't know if they're angry or not.

Another explanation had to do with the immediacy and intensity of the experience when it is "in the room." The following example, from Participant I, conveys the tone that was present in many of the participants' comments, a tone of deep appreciation for the interpersonal moment.

> Well, I see what's happening, you know, putting aside the fact that we're two human beings, I see what's also happening as . . . in those moments they're the most vulnerable, real moments in the therapy because you're not just talking about something outside of. . . you're sharing it between us and so that's, those are the times when the greatest work can be done.

Participant I talked here about the special quality of those interpersonal moments when the therapeutic transference is alive in the room. She was, however, highly critical of the classical analytic model, and at other points in the interview she downplayed the importance of transference interpretations. She was like other participants who questioned an overemphasis on transference interpretations, but affirmed the value of the mutative transference interpretation, from an updated, relational perspective. These participants were able to hold both points of view regarding the value of interpreting the therapeutic transference, without any apparent discomfort.

The participants reported that there are some cases where they have to work in the transference. To not do so would be a treatment failure, as described in the following passages from three different participants:

> I have many of my patients where the work is just really about what's going on here-and-now . . . in this kind of enclave, this, of the relationship between the two of us, everything exists. (Participant G)

> Now with her I know what that's about, it's all transference. [The client talks incessantly about food and her weight] and she will uh, will finally get to what it means in the transference, because that experience can't be explained in terms of the food she's eating. . . and she'll get into these preoccupied states of mind about it and then the details will just flood the room. And with her it's, you know, it wouldn't be helpful for me to stay within the metaphor of just what she's eating. (Participant J)

> It depends on the people. With some people, with some people I, you couldn't not do it. I don't, I don't even have to bring it up, they are already focused on me, either they're idealizing me or it's—actually if it's a mirroring kind of thing I might not, I might not even bring it up. But if it's an idealized transference and, or an eroticized transference, then it becomes really necessary for me to, uhm, honor the fact that they're having those feelings and that yes we are two human beings in a room, but to also help them see that whatever's going on between us is also, it's like a mirror or projection that's going on inside of them. (Participant I)

> And the anxiety about my break that's coming up this week, uhm, the preoccupation with what I do, what I think about them or what do they think about me, uhm, underlying raging or mourning or whatever. It's really potent, right there, and not to attend to that would be sort of silly. And to insist on viewing all that material as dream work, would be, it just doesn't work. (Participant G)

Regardless of current theoretical orientation, the participants are very attuned to the important role of the therapeutic transference in their work.

The Role of the Extra-Therapeutic Transferences

The main focus of this research study was to inquire about what therapists think is going on in treatment when clients talk to them about the relationships and interactions in their everyday lives. What does this material mean for participants in terms of their clinical theories, and how do they make use of it in the therapy setting?

Previous sections have shown how these experienced, psychoanalytically oriented therapists/participants listen to the material that their clients present on several different levels at once, and how they think about and make use of the psychoanalytic concept of transference. At this point I will present findings that pertain specifically to the *phenomenon* of clients talking about outside relationships, to the *concept* of the extra-therapeutic transferences, and to the relationship between the therapeutic transference and the extra-therapeutic transferences.

The participants all agreed that clients talk a great deal in therapy about their outside relationships and that this material is very important. They made inferences about their clients from what and how they reported about their relationships with other people. None of them had heard the terms extra-therapeutic transference or extra-analytic transference. I asked them to reflect on the phenomenon of clients talking to them about outside relationships, and introduced the concept of extra-therapeutic transference only towards the end of the interview. By that time it made sense to them, though at first several of them thought it meant something else, such as: " Well I think it's sometimes called the real relationship, is that what you're talking about?"(Participant G); "You mean where the patient is transferring something from the analyst, transferring from the analyst onto another person?" (Participant I). Even after I introduced it, several of them got the words mixed up: "So, I think that's an interesting concept. Extra…transference" (Participant C). Most of the participants, however, responded positively to the concept, as I will describe later in this section.

Participants' views on the relationship between the therapeutic and the extra-therapeutic transferences fell into two sets. I call the first set a hierarchy, where the therapeutic transference is foremost and extra-therapeutic transferences are of only secondary importance. I call the second set parallel concepts, where both therapeutic

and extra-therapeutic transferences are important and complementary to each other. With the exception of Participant J, all of the participants took both perspectives. I tried to divide the participants into two groups, based on my overall impression of their perspectives, comments they repeated in the interviews and particularly their accounts of their clinical work, but when I reviewed the transcripts more carefully I found that individuals I categorized as having a hierarchical view said, at times, that the concepts of the therapeutic transference and the extra-therapeutic transferences operated in parallel, for example this comment by Participant H, whose overall position was that there is a hierarchical relationship between the two types of transference: "It's like a complement . . .Although they look very different . . . in the outside or in the room, but it's really working with the same." I also found that individuals I categorized as holding the concepts as parallel said, at times, that the extra-therapeutic transferences are secondary to the therapeutic transference, for example this comment from Participant C, whose overall position was that the two types of transference operate in parallel: "I think I always try to kind of match up whatever issues they're having with other people to what I've observed in the way they're relating to me." So while I did find two positions with regard to the relationship between the therapeutic and the extra-therapeutic transferences, I did not find that individual participants consistently took one position or another, except for Participant J.

Participants' views regarding the relationship between the two types of transference can be expressed as a continuum, as illustrated in Figure 1. At one side is the extreme hierarchical position: everything that happens in treatment is structured by the therapeutic transference. At the other side is an opposing view, that the therapeutic transference is an over-rated concept. Along the continuum are sub-categories that show different relationships between the two types of transference: (a) the therapeutic transference is

most important and too much attention to extra-therapeutic transferences detracts from the main work, (b) listening to extra-therapeutic transferences may provide clues for what is happening within the therapeutic transference, (c) the two types of transferences are both important and complement each other, (d) sometimes one is more important and sometimes the other, (e) there are times when extra-therapeutic transferences should be the focus without reference to the therapeutic transference, and (f) there are times when it is a mistake to focus on the therapeutic transference. The middle range corresponds with the perspective that the two types of transference operate in parallel.

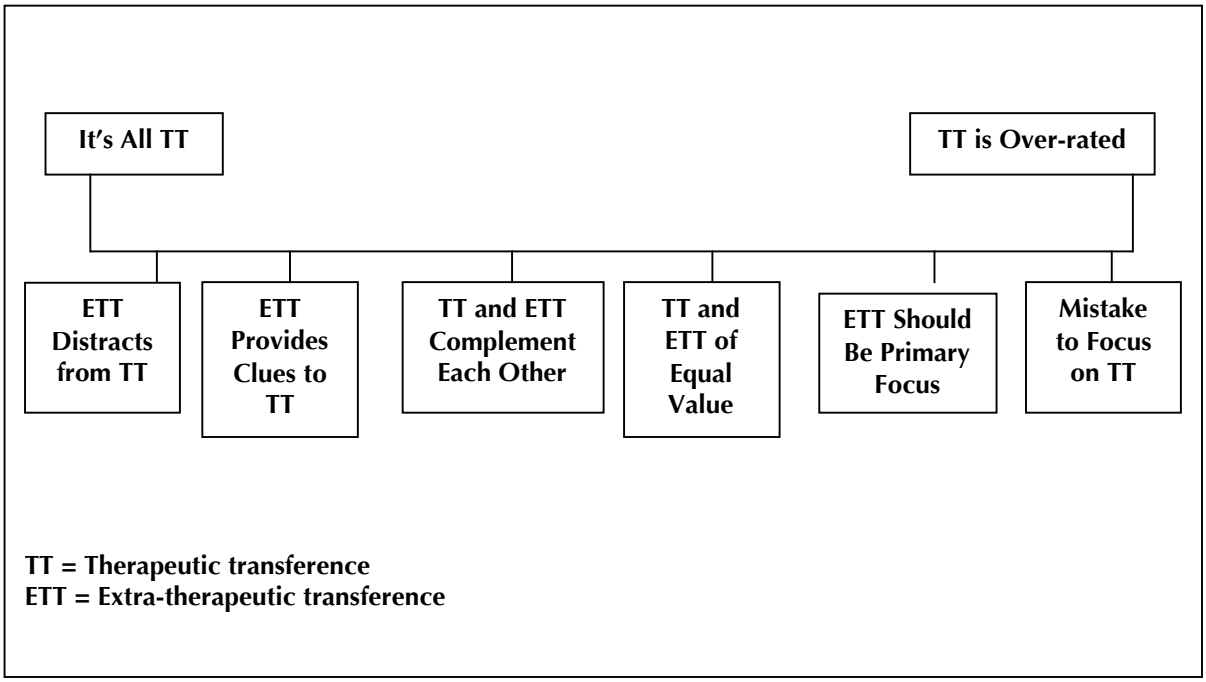

FIGURE 1: Range of Views Regarding the Relationship Between the Therapeutic Transference and the Extra-Therapeutic Transferences

Hierarchy of Transferences

From a hierarchical perspective, talk about outside relationships is no different than any other kind of clinical material; it is in the service of the therapeutic transference. Although the therapist talks with clients about outside relationships and may even interpret outside transferences, the therapist is always thinking about the therapeutic transference. Lasting changes in the patient's outside life are thought to be more the indirect result of work within the therapy relationship than direct interpretive work on outside relationships. A familiar idea for psychoanalytically oriented therapists is that working within the therapy relationship, or therapeutic transference, provides new experiences that will benefit patients in their outside relationships. As Participant D said when talking about the therapeutic transference: "I think that that relationship becomes kind of the model for outside relationships so that if you can resolve things with the therapist then hopefully it gives you kind of a template to begin resolving things elsewhere."

From this perspective the therapist is likely to assign a defensive function to the patient's talking about outside relationships in the therapy setting. Participants mentioned how talking about outside relationships can be a displacement, a form of resistance to deeper work, a distraction to the therapist. It can also be an indication of acting out, as noted by Participant E: "Something can happen here and it's going to get replayed out there, just because it's too, maybe frightening to have it in here." Participants thought clients' talking about outside relationships was sometimes defensive, but not necessarily. No one thought that it was good clinical practice to routinely confront patients' defensive presentation of outside relationships. As with all clinical material, deciding how and when to interpret transference experiences, or defenses against awareness of transference experiences, requires clinical skill and sensitivity to the patient.

Participant J was consistent in describing his work as all being structured by the therapeutic transference. He acknowledged that while there are transferences in all relationships, and that people present those transferences in the material they talk about in therapy, for his part, he is always thinking about the therapeutic transference, why and how the patient is telling the stories to him. As I presented in an earlier section, he was one of the participants who distinguished between interpretation "of" and interpretation "in" the transference. The following illustrates his thinking, and is also a good example of participants listening on several levels at the same time, in his case the manifest and latent levels. Here he does not emphasize the defensive aspect of talking about outside relationships:

> I don't think his relationship to the baby is going to be a transference to me that's displaced. . . . At the same time what he tells me in a session with me about the baby will be about him being my baby too, you know so it means I'll listen to it in both ways so I don't think he'll ever really talk about this baby except about his transference to the baby, but whatever he chooses in his time with me to tell me that will be very influenced by the fact that he's sitting with me. So, it's really both.

In other situations he described how patients talking about outside relationships might be a displacement away from the therapeutic transference which is threatening to them, as in this example:

> [After] breakthroughs in their ability to get close to you they, you see an increase in defenses and so there's increased amounts of displacement on or you know displacements to the body or to stories about other people and uh that are much easier to talk about than the relationship with me.

Others also described how it is easier for patients to talk about outside relationships than to deal with their feelings towards them, especially in the early stages of therapy. Participants, such as Participant H in the following passages, said they would discuss those outside relationships with clients, but in their own minds they would be wondering what was going on in the therapeutic transference:

> I certainly do that [talk with clients about their outside relationships], that would probably be uh, that's the bulk of how I work. What I started saying is that I constantly keep it in mind, like I put it on a little shelf in my mind, in my psyche, and, because I think that's the most useful, really truly for the person. I believe that's where the feeling . . . the transformation [is], but I'm aware there's a lot of resistance for that and people are not always ready or not interested and sometimes they really just want to understand themselves with that other person.

At a different point in the interview she added that there is healing power in the immediacy of a mutative transference interpretation:

> The way I work and the way I hear your question is that when I'm with a client and sit and listen to them and listen to their story and imagine their relationships to other people I also at the same time constantly keep in mind and wonder about how I can use that material to include it in our relationship, you know, with the hope that I can bring that material back to the room between us in our relationship and you know the goal would be to provide them with an immediate uh experience versus just you know understanding what's happening with them in relation to other people.

Participant E talked about how the outside relationships can interfere with the deeper work of therapy, including work with the therapy relationship itself. She was describing a case where her patient was in a destructive relationship with her daughter:

> With her it's very hard for me to remember that this [the patient talking about her children] also could have something to do with the therapy, because I get very involved in that thing with the kids . . . I'm very concerned. . . . it was very worrisome, and so, you know, then I could have really focused on that and lose track of what's happening in the therapy and trying to help. Now obviously they're all related, but there is a way in which that sort of goes away, the deeper work.

From the perspective of a hierarchical relationship between the therapeutic and the extra-therapeutic transferences, participants are always thinking about the therapeutic transference. Extra-therapeutic transferences may give them clues about the therapeutic transference, may represent a defense or resistance, but do not have clinical value on their own terms.

Transferences in Parallel

From the perspective that the two types of transferences operate in parallel, participants used both to understand the internal world of their patients and effectively help their patients, integrating clients' talk about outside relationships within the therapeutic *process* that includes the therapy relationship. They used the therapeutic transference to help them understand the extra-therapeutic transferences and they used the extra-therapeutic transferences to help them understand the therapeutic transference.

They also talked about situations where the extra-therapeutic transferences were alive in the therapy office and were the focus of therapy, without reference to the therapy relationship or therapeutic transference. Their expanded appreciation of the concept of transference, incorporated in relational, self psychological, intersubjective and interpersonal psychoanalytic theories, and their years of personal and professional experience, gave them a framework for integrating the therapeutic and extra-therapeutic transferences.

Participants talked about the relationship between the therapeutic and the extra-therapeutic transferences as "the same," "complementary," "background and foreground," without implying a hierarchical relationship between the two types of transferences. In the following passage Participant E has been telling me about a case where there were similar patterns in the patient's family history, in her current relationships and in the relationship to the therapist:

> E: What do I think about it? I think about it as [inaudible] sort of the same thing. . . . Well, I use, I'm always using one to understand the other, I guess.
> Q: both ways?
> E: Yeah, yeah. I mean certainly, I mean theoretically I always think about what happens between us as the mirror or reflecting what happens outside. But sometimes it's the other way around too, because if she's talking, obviously, if she's talking about something with somebody then I'm thinking about what she's feeling in here. [inaudible] so it does go both ways. But I think if we think about transference and what that is, and not just historical, genetic kinds of transference,

> but any kind of transference that happens, where we've constructed a world according to our, our [inaudible] then that's going to get played out here, along with everything else, so how could it not?

When thinking of the two types of transference as operating in parallel, participants gave examples of how they would work with both the therapeutic and the extra-therapeutic transferences, using both to help clients become more aware of themselves and patterns in their relationships. Participant C talked about working with a client who had young children. Sometimes the focus was on the therapy relationship and at other times they talked in depth about the client's relationship with her children. She said, "I think they both can be immediate in different ways and I think a child relationship stirs up so much primitive, kind of early feelings in parents, and uh so I think it's rich."

Participant H told me how she came to know different sides of her patient's inner experience through listening both to his talking about his relationship with a woman and the participant's own experience of the client's relating to her:

> (She describes how her client met the woman in question) So I think there's a lot of transference in, onto the person that, you know, bringing that person, uh, you know, could be reliving the same experience that he had with his mother and the same feelings of wanting to protect her and being useful and uhm being rather undemanding and being hyper vigilant and uhm and really totally neglecting his needs, these are really, you know, that's, to me that's more clear transference on . . .

Then a little later she chuckles as she talks about the therapeutic transference:

> His transference towards me, uhm, even though he more idealizes me there's a lot of transference about, uh, expecting me to rescue him, you know, to have a different outcome than he had with his mother, and we are now in a stage where, uh, it's really annoying for me, because he's able to really be as demanding as he would like to be and that means uh, "you know I really really want to see you as soon as possible, but I'm not available tonight and I really can't come tomorrow and uh you know so Saturday morning, I think you said that sometimes on Saturday morning you're working, right? And I feel so nervous, so . . ."

Participants talked about how there are times when the therapeutic transference is in the foreground and times when the extra-therapeutic transferences are in the

foreground, maybe because of a decision on the therapist's part as to what to interpret, but maybe, as noted by Participant C, just because there are phases in the therapy: "I think that long term relationships with clients, they go through phases where the issues are more between and then sometimes they're more out there, but they don't, they can fluctuate back and forth in different periods." In the next example, Participant G describes how letting the therapeutic transference remain in the background can facilitate the patient's talking about outside relationships and other material:

> I think that many people, many patients, uh, use you as a background object. I don't think that we're always used as the primary object or the, the object that is most in need of analysis. I'm a background object for many people, they use me as the whole, as the thing that contains the work so that associations can flow.

Thus, in contrast to the way they talked about a hierarchical relationship between the two types of transference, participants also took the position that the therapeutic and the extra-therapeutic transferences operate in parallel, complementing each other, both having intrinsic clinical value.

Using the Extra-Therapeutic Transferences

The participants brought up a number of situations where they thought it was more important to stay with the extra-therapeutic transferences than to pull for work within the therapeutic transference. As I mentioned earlier, they all talked about the need for staying where the patient is, following the patient's lead, and timing transference interpretations sensitively and appropriately. But they went further than that, saying that sometimes it would be missing the point to focus on the therapeutic transference, just as it would be to pull for a transference interpretation from any material where the connection is tenuous. To illustrate, Participant B said to me:

> But I mean you and I are talking about all these people and we could just talk about our relationship and what we're feeling in this room at this moment but we wouldn't be covering where your life and your world really is that much. And it might change you, but I don't think there's that much developed between us.

Several others said, in the same vein:

> No, I mean I would very much be alarmed if someone came, I mean it's fun to work in the relationship but I feel like we have to relate it to other relationships they're in. It's more useful. (Participant C)

> I don't think everything is about me. I do think that because we are who we are in a sense that we can find the links easily but hum, the notion of displacement takes it to yet another level because then it's like, it's kind of like it or not that if something not being experienced in here and so it has to be experienced out there, but I actually think those things are really being experienced out there and they're important and they're relevant and it may be similar or may also be experienced in here and so we could make that link. (Participant E)

> I don't need to become the most important person. I mean if I see somebody twenty years old they're not gonna get, it's unusual they're going to have a big romantic transference for me, but if they're having these five drug dealers and their father was some, you know, there's something to talk about there that's really important, uh, and much more available in that context than it is with me. But if it's more available with me, that's great. (Participant B)

> So it makes sense to stay with that, to really, I mean could sort of yank it into, "well, maybe your concern, maybe these say, these dreams are some anxiety because you've been missing sessions with spring break and then I'm going to miss some sessions," we could have done all of that, feels like a therapeutic cliché to me. It doesn't feel real and alive. (Participant G)

Participant G went on to talk about how much she liked to work with negative transferences in the therapy relationship, but:

> It just doesn't make sense to me when somebody's coming in telling me about this girlfriend that they've now just turned into a devouring monster that we wouldn't be interested in that. Would we want to turn that into something that's here-and-now between us? Well, we could do that, but that's not the material, that's my theory. I want to stay in the material.

Participant C talked about the importance of the extra-therapeutic transferences in this criticism of a case presentation she once heard:

> It seemed so uh internal and limited, just to look at the transference in the relationship, that I felt like this person could use help dealing with the husband and

> the kids and life! And I felt like, I feel sometimes it's uh maybe so self-absorbed on the part of the therapist to—I don't know quite the right word for it—indulgent? Or something, or narcissistic? On the part of the therapist to kind of keep eliciting everything in terms of the response, the responses to the therapist.

It was in their own case examples that the participants showed most clearly their belief that interpreting the extra-therapeutic transferences can be very helpful for clients. Some were very ordinary sounding clinical situations, such as Participant D's description of when her interpretations make connections between issues occurring in the client's current relationship and her family of origin:

> The person I'm thinking about has, she, it's a woman who has issues with her husband, uh and there's some weeks she misses talking about it, but there are, you know, mostly she does talk about it, and when something happens in the household then it comes up even later. So, what I think is that uh, I actually think with her that it's not a uh necessarily an issue with me, that it's not necessarily a transference issue with me, I think, when I think about her, I think about her history and I think about she grew up and I think that she uh chose someone who would keep her in the same position in her life even though she's a grown up woman now, she's in the same kind of position that she was as a child. And that that has become so familiar and comfortable for her that she has decided on a relationship that repeats that and than in her struggle now to be different, because I think she's now beginning to want to be different, that's what calls up the a lot of the conflict with this person, it's because she's struggling against that uh traditional position that she's been in.
> Q: And would you say those kinds of things to her, I mean would you be making . . .
> D: Yes.
> Q: . . . interpretations, comments like that?
> D: Yes. I would say it to her. I'd say, "Oh, does that remind you of, your, you know, you told me something five weeks ago about your father that kind of reminds of that, what do you think?"
> . . . .
> Q:. . . . and not viewing it as necessarily a displacement of something between the two of you or?
> D: No. Not necessarily. I'll look at that. I'll think about that, uh, but it just, how can I tell you, it just seems clear (both laugh). It's clear. It's just clear that that's where it is.

Participant C described how she worked with an adolescent whose father was critical and judgmental. The patient had a very positive relationship with a teacher who came to be a mentor for her. The therapist supported the patient in being able to use this more positive mentor relationship to change a negative relational pattern that was

linked to her father, "and sort of be able to experience herself differently with this man who was her mentor, and got more confidence."

Participants illustrated how they focus on the extra-therapeutic transference rather than on the therapeutic transference because the intensity is in the extra-therapeutic transference. Participant B remarked that this client's "fears are raging in other places so much." The excerpt also gives another example of genetic interpretation of the extra-therapeutic transferences:

> B: She just broke up with her husband who became very much like her father, at the end. And the trauma of that really sent her off in a lot of ways, and she hadn't realized that she had re-triggered that earlier trauma, and helping her realize that, and see the connections, helps her bring her life under control, that she's not just crazy.
> Q: And would that have come into her relationship with you as well?
> B: No, because I don't think there's ever that degree of intensity between us. It's sort of a benign thing and it isn't really, she doesn't really probably see me fully as another person so much. I'm a therapist, I'm there, I'm a nice man, an older man, so you know, it's sort of benign, she trusts me, mostly, uh, and the, we could work on the level of distrust she has, but the distrust doesn't seem that bad, and it's so strong in other places. Her fears are raging in other places so much and I don't want to make myself the center of attention, you know, uh, that would seem, uh, I don't know, I don't feel a need to, I don't think that's the way to help.

Participant G talked about a client who repeatedly finds himself in dysfunctional relationships with women. She said, "he's working out the transference stuff with the women in his life." She has found it very useful to work within those transferences:

> And he likes Pygmalian kinds of relationships and then he marries the Pygmalian and the next thing you know, they turn into Mother! Well, it's, you know, that's where the action is, for him, right now.

Talking about the same client a little later in the interview:

> I'm not thinking that at this point the payload is in terms of the here-and-now transference kind of work. I think the payload is much more in the unconscious revealing of self through his concerns about these women and uhm with everything . . . He brings in a lot of dreams and so it's not hard with him to work this material as if it were dream material as well as the actual themes.

Participants' Reactions to the Concept of the Extra-Therapeutic Transference

Although none of the participants had heard of the concept of the extra-therapeutic transference, it made sense to them when I introduced it towards the end of the interviews. They could see that it gave a name to phenomena that clearly exist, the transferences of everyday life. Many of them also saw that working directly with extra-therapeutic transferences, without reference to the therapeutic transference, had an important place in their work. A case description from Participant D that I excerpted in the previous section had as its focus the phenomenon of her client talking about outside relationships. Later in my interview with Participant D, after I had introduced the concept of the extra-therapeutic transference, she reflected back on this woman and on another client she had told me about, a man estranged from his children, and thought about the usefulness of the concept of extra-therapeutic transference to her two cases:

> Well I just think uh . . . if he could understand that the historical piece and the repetitive nature of what he was living in then, it might be very helpful. And I think it would be helpful for the therapist, it would be helpful for me and other therapists to have some uh concept or name to assign to that. You know, when you have uh when you are able to put together what you do with an idea or concept or name, then it in some ways it legitimizes it, so for people who are not comfortable with what they're doing it would probably be very helpful.

She had a very favorable response to the concept of the extra-therapeutic transference:

> If I'm understanding you correctly, it's everywhere. I mean when you're doing therapy it's like everywhere and it's nice to be able to conceptualize it . . . I guess it would give uh, a concept to what a lot of people seem to be doing.

Participant H used similar words in her response: "It's helpful for me, it feels like it solidifies, you know, it clarifies."

Others responded positively, but their tone said "of course" rather than "that's a helpful new concept." When I asked Participant A what he thought about the concept and whether he thought therapists focused on it, he said: "I think we do. We

just don't label it." Participant C answered, when I asked if the concept made sense to her: "Yeah, sure. Very. I mean people transfer on their partners." And Participant G, responding to my question as to whether she thought it would be a useful concept to have around:

> I think so. I don't see how you could operate without it. Otherwise you are doing nothing. I mean, luckily, we don't have to choose, you know, all of these ideas and these ways of working are available to us on any given topic.

Participant J recognized what I meant by the extra-therapeutic transference and identified it in his practice, referring to a patient we had talked about earlier as having had transference towards his wife, but he put it in the context of "working in the transference":

> Seems to me it's a kind of central idea, I mean that it's, that people talk a lot about uh, in terms of the focus for interpretation? Yeah. It's, I do think of it along those same lines though that it's, you know, you're still, the transference, you're interpreting in the transference and that the transference can be to anybody. To the girlfriend or to the boss or to the new baby.

The participants seemed interested in discussing this topic with me, even when they thought my initial question too vague and worried that they didn't know where I wanted them to focus their attention. In this passage Participant E connected several levels of what we had been talking about, expressing her reaction not just to the concept of the extra-therapeutic transference, but to my having asked her to think about what was going on in therapy when her clients talked to her about the relationships in their outside lives. She brought it back to a question of how we listen:

> E: So, just like what we try to do for our patients you're doing for us, which is to make the unconscious kind of [talking over each other]
> Q: Or at least saying whether, yeah, would that help or labeling things that are going on.
> E: Yeah. Well no, this has been interesting because when you say well how do you think about it, I don't know, no one ever asked me that question before. How do I think about it? I don't know.
> Q: Well on the one hand it is so, it's so kind of mundane.

E: (Chuckles) Uh huh. It is and it isn't. That's exactly right. Because it is the bulk of the work. It's what they come in with, it's what they want to fix, and it's what we're listening to, and it's just a question of how we listen.

CHAPTER 5: DISCUSSION

In approaching this study I was interested in what psychoanalytically oriented psychotherapists think is going on when their clients talk about relationships with people outside the therapist's office. What do therapists hear in this material, how do they think about it, and what do they do with it? I wondered if the concept of transference, so central to psychoanalytic theory, extended to their work with clients' relationships outside the therapy office, or if the clinical relevance of transference was limited, in therapists' minds, to something that occurs within the therapeutic relationship.

The research questions became: How do psychoanalytically oriented psychotherapists conceive of and make use of clients' presentation of outside relationships? Do they see clients' outside relationships in terms of the concept of transference? What theoretical concepts guide psychoanalytically oriented psychotherapists as they listen to clients' presentation of outside relationships?

The answer to the first part of the research question—How do psychoanalytically oriented psychotherapists conceive of and make use of clients' presentation of outside relationships?—depends, not surprisingly, on the context. Participants talked about many factors that would influence their response to this type of material, including, but certainly not limited to, their theoretical orientation. The answer to the second part of the research question—Do they see clients' outside relationships in terms of the concept of transference?—is not so obvious. Participants are accustomed to thinking of transference as referring to what goes on within the therapy relationship. None of them applied the term transference to outside relationships. When I asked them if they thought the term could apply, they said yes, but it is clear that it's not a familiar way for them to think.

There was also no obvious answer to the third part of the research question—What theoretical concepts guide psychoanalytically oriented psychotherapists as they listen to clients' presentation of outside relationships? Participants thought that sometimes clients' talking about outside relationships was a manifestation of the therapeutic transference, and psychoanalytic theory of therapy applied. Yet they all described cases where they worked directly with extra-therapeutic transferences as well, and had no systematic or coherent theoretical rationale. Participants listen on many levels at once, and respond to clients where they think there is the most immediate access, where their interventions will have the most impact in terms of clients' insight, self-awareness, understanding, or affect state. They hope to facilitate change, offer clients more options in their outside lives, and it is from this stance that they attend to clients' presentation of outside relationships.

Underlying the research questions was my interest in considering the relevance of the concept known as extra-therapeutic transference, which is discussed in a rather small body of literature (Adatto, 1989; Blum, 1983; Fine, 1989; Fisch, 1994; Fosshage, 1994; Haas, 1966; Haesler, 1991; Halpert, 1984; Kivowitz, 1990; Leites, 1977; Ornstein, 1990; Stewart, 1990). I was also interested in investigating what I thought might be a discrepancy between psychoanalytic theory and practice. Findings from the study add to understanding how the concept of extra-therapeutic transference has clinical value, and how it relates to the concept of the therapeutic transference. The findings also suggest that there *is* a discrepancy between theory and practice with regard to the role of extra-therapeutic transferences in psychoanalytically oriented psychotherapy

In the sections that follow, I will first summarize the results according to their major categories and sub-categories. In subsequent sections on interpretation of the results I will focus on how the findings demonstrate the concept of extra-therapeutic transferences in psychoanalytic psychotherapy and suggest a discrepancy between theory and practice. I

will discuss how participants seemed to handle this apparent discrepancy, through their use of a contemporary relational psychoanalytic framework, through their ability to listen on many levels at once, and through their commitment to doing what is useful for their patients. Some references to the literature review will be interwoven in this discussion, but in the section on the relevance of the findings to the literature I will connect topics from Chapter 2 to the results, and consider how a self psychological psychoanalytic model can accommodate the concept of extra-therapeutic transference. Finally I will discuss limitations of the study and suggestions for future research.

Summary of Results

I grouped the findings into four interrelated categories: Participants' Development of Their Own Theories of Therapy, Participants Listen on Several Levels at Once, The Role of the Therapeutic Transference, and The Role of the Extra-Therapeutic Transferences. The latter two categories address the research questions directly, focusing on how participants conceive of the therapeutic transference and clients' presentation of outside relationships. The point of looking at how participants came to develop their own theories of therapy was to provide a context for understanding their thoughts about the therapeutic and extra-therapeutic transferences. Listening to clients on several levels at the same time turned out to be an aspect of the psychoanalytic psychotherapeutic stance that allows therapists to register both types of transference within content that is focused on clients' outside relationships. I will briefly summarize the findings in these four major categories and their sub-categories.

Participants' Development of Their Own Theories of Therapy

Participants described their individual paths to becoming the therapists they are today, acknowledging the influence of their own personalities, personal growth and therapy, value systems, and life experiences, as well as theoretical and clinical influences. Most learned psychoanalytic theory from the perspective of ego psychology and went on to educate themselves about other perspectives through advanced training programs, individual reading, study groups, consultation, workshops, and conferences. They incorporated concepts from relational, interpersonal, self psychological, intersubjective, and constructivist psychoanalytic models. Their current theories of therapy are implicit in how they think about what is really healing. While they still found relevance in basic tenets of psychoanalytically oriented therapy—such as the importance of analyzing unconscious material, the process of working through, insight, and the technique of interpretation, especially of the therapeutic transference—they rejected any mechanical or rigid adherence to such techniques. They value the healing power of the therapy relationship itself and believe new experiences with the therapist help clients become more self aware, self-accepting, and have more choices in life. Participants rely on what they have learned from experience, as well as from theory. They described interventions they find useful for their clients, but they don't think these interventions are "psychoanalytic," such as offering guidance, inviting a client's partner to come in for a few sessions, giving a client direct feedback about the impact they have on others, and self-disclosure. In some cases they systematically integrated these types of interventions into their own theory of therapy, while in other cases they made no attempt to theoretically account for what were spontaneous responses.

Participants Listen on Several Levels at Once

The second major category of findings shows how therapists are always listening on various levels when their clients talk about outside relationships. First the participants recognize that people just need to be able to talk about what disturbs them, which often means talking about troubling relationships. Listening to them is a basic therapeutic stance. Participants are attuned to patients' affect states and to their own as they listen to patients. They want to understand more about their clients than what the concrete stories tell, to imagine the world their clients live in and to assess their clients' experiences of self and functioning in the world. They are particularly interested in clients' relationship patterns, listening for connections between stories the client may be telling and connections to history or other places in the client's current life. They deepen their understanding of clients by listening, as well, for clues from the unconscious; the way a client talks about a certain relationship or interaction may suggest symbols and metaphors that relate to significant themes in the therapy. Yet another level of listening is in reference to transferential themes. Participants said they always wonder if there is some allusion to the therapy relationship in the stories clients tell about their interactions with others.

The Role of the Therapeutic Transference

Examining the participants' theoretical understanding and clinical use of the concept of transference, referring to both therapeutic and extra-therapeutic transferences, was central to the research question. The third major category of findings addresses the role of the therapeutic transference in participants' clinical thinking and practice. Participants all agreed that the therapeutic transference is a very important dimension of therapy, sometimes to be interpreted, sometimes not, but their opinions

as to just how important it is were complex and varied. The participant who is a candidate in an analytic institute represented the perspective that everything in psychoanalytic psychotherapy is a manifestation of the therapeutic transference. Others were aware of that perspective as an ideal, but said that's not the way they practice. They do, however, associate working with the therapeutic transference with doing deep psychological work, and are less satisfied if they're only able to do what they think of as supportive therapy. They noted factors that facilitate or hinder the deepening process: frequency of sessions, length of treatment, and client readiness.

They frequently made reference to the question of when and whether to interpret the therapeutic transference. Even though they notice and think about the significance of the therapeutic transference and the dynamics that are being played out in the therapy relationship, participants do not necessarily talk about it directly with a patient. They felt that to interpret the therapeutic transference insensitively is reductive and can be harmful to patients. At times, however, interpretation of the therapeutic transference is definitely indicated, such as when the client is clearly focused on the therapist, or in the case of the here-and-now transference when therapist and client become aware of the therapeutic transference because of something that just happened between them. In the context of the immediacy and aliveness of the shared experience, such transference interpretations are powerful for both people, and participants think it promotes the most meaningful kind of insight. When deciding whether to interpret the therapeutic transference or not, therapists are guided by complex theoretical principals, but even more importantly, by their understanding of who their clients are and what they need from them.

The Role of the Extra-Therapeutic Transferences

Findings presented in the final major category pertain to the role of the extra-therapeutic transferences: to the *phenomenon* of clients talking about outside relationships, to the *concept* of the extra-therapeutic transferences, and to the relationship between the therapeutic and extra-therapeutic transferences. Participants affirmed that their clients do talk a lot about their outside relationships and provided numerous case examples. Although they were unfamiliar with the term extra-therapeutic transference, their case examples illustrated the concept when clients' experiences of relationships were colored by previous experiences and/or repeated old relationship patterns. I looked closely at what role participants thought these extra-therapeutic transferences had in the therapy process, how participants worked with them, and what kind of connections they made between the therapeutic and the extra-therapeutic transferences. The results, based on the case examples and what participants had to say about the therapy process, were complicated and seemed to reflect contradictory views. To summarize, I called one set of views the hierarchical perspective, in which interpretation of the therapeutic transference is what facilitates therapeutic change, and interpretation of other material, including extra-therapeutic transferences, is secondary, in the service of the therapeutic transference. From the hierarchical perspective, clients' talk about outside relationships is likely to be thought of as a form of displacement or resistance. I called the other set of views the parallel perspective, meaning the two types of transference are both useful and complementary to one another and that there are times when it is correct to interpret the extra-therapeutic transference on its own terms, with no connection to the therapeutic transference.

Interpretation of Results

The Concept of Extra-Therapeutic Transference

When psychoanalytic psychotherapists listen to clients talking about outside relationships, they perceive that the significance of this material is layered. They may respond to one or more layers. The results of this study show that interpretation of the transferential aspect of outside relationships is one of their responses, though participants were not aware of the technical concept of extra-therapeutic transference.

Participants had a moderately positive reaction to my introduction of the concept of extra-therapeutic transference. While some saw that it could be helpful to have a name for something they do, others saw no need for yet another concept. It would be interesting to see if therapists would find it a more useful concept if they had time to reflect on it and think about it as they worked. For the present study I only spent one hour with each participant, and waited to introduce the term until late in the interview because first I wanted participants to tell me in their own words about the phenomenon of clients talking about outside relationships.

I think their previously held ideas about transference may have been an obstacle to participants seeing the need for a concept of extra-therapeutic transference. Psychoanalytic psychotherapists are committed to the particular meaning of transference that refers to something happening within the therapy relationship, what I have called the therapeutic transference. In that sense transference is a highly valued, or perhaps even idealized construct, as some have suggested (Blum, 1983; Halpert, 1984; Leites, 1977). No matter what clients are talking about, participants said they listen for possible references to the therapeutic transference and consider how they might make an appropriate interpretation. While noting that a given treatment, or

phase of treatment, might not be organized around the therapeutic transference, it seemed clear that their preference was for working with the transference, especially in the here-and-now. They were particularly energized when they told me about cases where the transference was "in the room" and they were able to explore the immediate experience with their clients. They were less interested in making the type of classical transference interpretation that involves genetic reconstruction, which is consistent with their interest in contemporary relational and intersubjective psychoanalytic models of the therapy process.

Their adherence to the centrality of the concept of the therapeutic transference may get in the way of their being able to *think about* transferences occurring in outside relationships as powerful transferences that can, and maybe should, be analyzed. What they *do*, however, is interpret those outside transferences by bringing to clients' awareness the way they experience old feelings in current important relationships, the repeating patterns in their relationships, their own resistance to changing those patterns, and so forth. It is more of a conceptual problem for therapists than it is a practical problem. They know about a more general meaning of transference as something that occurs in all relationships, and they commonly work with those transferences from clients' everyday lives, but they haven't made the connection that becomes clear when the concept of extra-therapeutic transference is introduced.

Discrepancy Between Theory and Practice

There is evidence, anecdotally and in the literature, of a discrepancy between theory and practice with regard to the interpretation of extra-therapeutic transferences, and the results of this study provide further evidence. In the introductory chapter I recounted a story that bears repeating, of the psychoanalyst who said, in reference to

the fact that he spoke directly to his analytic patient about his relationship to his wife, "I am an analyst when my door is open, and when my door is closed I do what I think can be helpful." His rather off-hand comment points to a challenge inherent to any empirical study of how theory and practice inter-relate. For many reasons clinicians may not give an accurate account of what goes on behind their office doors. British psychoanalyst Edward Glover (1955) noted the problem in his 1938 empirical study of psychoanalytic practice. He attempted to learn what analysts really do by means of a questionnaire on psychoanalytic technique, with questions based on difficulties frequently raised by students in analytic training. Commenting on his study, he said, "It has at least the merit of being the first and moderately successful attempt to penetrate the curtain of uncommunicativeness behind which psycho-analysts are only too prone to conceal their technical anxieties, inferiorities and guilts" (p. vii). The implication here, and elsewhere, is that therapists are uncomfortable talking about what they do if they cannot easily fit it into the context of a coherent theoretical school of thought. Joseph Sandler (1983) made a similar observation:

> The investigation of the implicit, private theories of clinical psychoanalysts opens a major new door in psychoanalytic research. One of the difficulties in undertaking such research is that posed by the conscious or unconscious conviction of many analysts that they do not do 'proper' analysis (even though such a conviction may exist alongside the belief that they are better analysts than most of their colleagues). (p. 38)

James Fisch (1994) relates the problem to the specific question addressed in my study, considering how therapists interpret extra-therapeutic transferences but don't talk about it:

> I am of the opinion that many valuable psychotherapies are actually conducted in this manner [interpret extra-therapeutic transferences], and have been for a long time, but that analytically oriented therapists and supervisors have been reluctant to speak of it in public for fear of being labeled superficial and non-analytic. (p. 77)

Trying to understand how actual practice corresponds with theory is even more problematic with psychoanalytically oriented therapists than with analysts who are more clearly identified with their theoretical schools, training institutes, and collegial networks. Most of the participants in the present study, like most psychoanalytically oriented psychotherapists, do not belong to psychoanalytic institutes. They rely on theory that is mainly taught in the context of analysis and must figure out how it applies to their own practice where they see patients once or twice a week, sometimes for short periods, and where they also draw on other clinical approaches that are not psychoanalytic.

The participants are primarily clinicians, not theoreticians. While three of them were quite at ease when talking theoretically—the two with analytic training and one who has written a book on psychoanalytic theory—the others seemed somewhat self-conscious when I asked them to talk about the theory behind their work. Their discomfort was partly the natural anxiety anyone would feel when being interviewed, by a stranger, on audiotape. I suspect they also felt some concern about exposing a lack of theoretical understanding or inability to articulate theory. A further concern, in keeping with the comments of Glover (1955), Sandler (1983), and Fisch (1994), might be that they're doing something they fear would not be sanctioned by their peers. This concern was expressed in little jokes and disclaimers they made about particular interventions.

The results of this study do highlight differences between theory and practice with regard to the role of interpreting extra-therapeutic transferences in psychoanalytic psychotherapy. Participants' theoretical orientation favors the centrality of working with the therapeutic transference, but in practice they do not limit themselves to transference interpretations; they do many other things that they believe are of benefit

to their clients, including interpretation of extra-therapeutic transferences. The perspective that there is a hierarchy in which extra-therapeutic transferences serve the therapeutic transference is consistent with participants' theoretical allegiance to the centrality of the therapeutic transference. The perspective that the two types of transference operate in parallel, both important and complementary to each other, is more consistent with participants' actual practice.

If such a discrepancy exists—i.e. if therapists actively interpret the transferential aspects of outside relationships but psychoanalytic theory of therapy only recognizes the effectiveness of interpreting transferences within the therapy relationship itself—then the concept of extra-therapeutic transference might address that discrepancy and help clinicians account for the benefit to patients of examining how old experiences color and replay in current interactions and relationships. It might make it easier for them to talk about this aspect of their clinical work with consultants or colleagues. They do not currently have a coherent theoretical explanation for the role of extra-therapeutic transferences in psychoanalytic psychotherapy. Why haven't they, or the field in general, addressed this discrepancy?

How Participants Handled the Apparent Discrepancy

I have argued that the results of my study suggest a discrepancy between theory and practice with regard to the value of extra-therapeutic transference interpretations, a discrepancy that is also implied by participants holding both the hierarchical and parallel perspectives on the therapeutic and extra-therapeutic transferences. The theory of cognitive dissonance (Festinger, 1957) tells us that humans are uncomfortable when they perceive internal inconsistencies and that they try to establish harmony or consistency between cognitions, or beliefs. But with the exception of some joking

disclaimers, the participants did not appear to be uncomfortable describing their work with clients' outside relationships, or the fact that they might interpret transferential aspects of those relationships without reference to the therapeutic relationship. I will discuss some thoughts here about how these therapists, and perhaps others like them, deal with what appears to be a discrepancy, without experiencing a sense of cognitive dissonance.

The fact that participants were able to handle the apparent discrepancy does not mean that there is no discrepancy, or that the discrepancy is insignificant. Joseph Sandler discussed this issue in his paper "Reflections on Some Relations Between Psychoanalytic Concepts and Psychoanalytic Practice" (1983), and his comments helped me understand what was going on for the participants:

> The fledgling psychoanalyst will bring with him into his consulting room what he has learned from his own analyst, from his supervisors and other teachers, and from his reading. He will carry in his head the theoretical and clinical propositions that he has gathered from these various sources, and these propositions will be, for the most part, the official, standard or public ones. The human mind being what it is, *he will continue to underestimate the discrepancies and incongruities in the public theories and will learn to move from one part of his theory to another without being aware that he has stepped over a number of spots in this theory that are conceptually weak* [italics added]. (pp. 37-38)

Sandler goes on to describe how experienced therapists acquire a reserve of other "partial theories, models or schemata" that they call on in practice.

> That they may contradict one another is no problem. They coexist happily as long as they are unconscious. They do not appear in consciousness unless they are consonant with what I have called official or public theory, and can be described in suitable words. Such partial structures may in fact represent better (i.e. more useful and appropriate) theories than the official ones, and it is likely that many valuable additions to psychoanalytic theory have come about because conditions have arisen that have allowed preconscious part-theories to come together and emerge in a plausible and psychoanalytically socially acceptable way. (p. 38)

The study participants were able, as Sandler describes, to underestimate the discrepancies and incongruities in their theories of therapy.

I speculate that a relevant background issue is the shift within psychoanalytic theory. Contemporary models, with constructs such as relational or interpersonal field, self objects, matrix, and mutual construction, while they do not explicitly address extra-therapeutic transferences, do implicitly diffuse the distinction between therapeutic and extra-therapeutic transferences through their increased emphasis on the interpersonal. I think the clinicians in my study, practicing in a community where these models are accepted, feel there is room for them to do such things as working directly with clients' outside relationships, more room than there would have been in the past, when Freudian and ego psychological models were dominant, and transference was thought to be a more discreet clinical phenomenon.

Sandler (1983) notes that the elasticity of concepts explains how terms can be stretched to accommodate changes in meaning and use, as has happened with the concept of transference. He says, "Elastic concepts play a very important part in holding psychoanalytic theory together" (p. 36). How far can concepts stretch without losing their usefulness? The argument is made by some, as it has often been made during the evolution of psychoanalytic theory, that what is going on in contemporary psychoanalytic theory is more a schism than a shift, that the differences between competing models are too great for them to be integrated into a single theory. Clarity and specificity are blurred in the attempt to make theory more inclusive.

The fact that transference can be construed as such a big and flexible concept, may be one reason participants did not feel the need for a separate concept to account for transferences in outside relationships, but it also means there is a lack of differentiation between therapeutic and extra-therapeutic transferences. Differentiating one from the other allows for sharper thinking about the meaning of clients' outside relationships and the clinical relevance of extra-therapeutic transferences.

The results point to a second factor that allows therapists to handle the apparent discrepancy, which is that they listen on many levels at once. The multi-dimensional listening process serves to contain what might otherwise be experienced as contradictory or confusing lines of thought. When a client is talking about an outside relationship, the therapist may hear references to both therapeutic and extra-therapeutic transferences, as well as learning about the client's intrapsychic life, cultural context, affect state, intellectual functioning, and so forth.

A third factor that emerged in the study that allows therapists to handle the apparent discrepancy is their commitment to doing what is useful and healing for their clients. It is a principle that seemed to take precedence over specific theoretical concepts or psychoanalytic theories of technique for most of the participants. It was demonstrated in their examples of self disclosure, offering guidance to a patient, giving a patient direct feedback about the impact they have on others, inviting a patient's partner to come in for a few sessions with the patient, and seeing a patient in both individual and couple sessions. It was also demonstrated in their examples of interpreting extra-therapeutic transferences.

These strategies—listening at many levels and doing what is useful—may allow therapists to work comfortably with both types of transference, but they mask the actual discrepancy that exists between theory and practice. Theory and practice should inform each other, but in the case of participants' work with the transferences from clients' everyday lives, there is no generally accepted theory to inform practice. To the degree that well-thought-out theories advance the practice of psychotherapy, the concept of extra-therapeutic transferences should be revisited.

Relevance of the Findings to the Literature

Transference and Participants' Theoretical Orientation

Since the theoretical framework for this research study relied on three concepts —transference, extra-therapeutic transference, and psychoanalytically oriented psychotherapy—I began the literature review by looking closely at these concepts. They relate to the theoretical orientation of the participants and their understanding of psychoanalytic thought. Most participants' original training was along the lines of classical psychoanalytic thinking of the time: Freud and ego psychology. Freud (1905, 1912, 1915, 1920/1952) identified transference as a key element in psychoanalysis. Others elaborated on the technique of working with transference, particularly James Strachey (1934), who established the standard of mutative transference interpretation, and ego psychologists (e.g., A. Freud, 1966) added to the prevailing psychoanalytic model of the time. Participants' current theoretical orientation, practice, and their use of transference derive, as well, from contemporary models of psychoanalytic psychotherapy in which transference has been reconceptualized. They are influenced by object relations (Heimann, 1956; Joseph, 1985; Klein, 1952; Winnicott, 1965), by self psychology(Elson, 1986; Kohut, 1977, 1984; Ornstein, 1990; Schwaber, 1985; Wolf, 1988), by intersubjectivity (Shaddock, 2000; M. Shane & E. Shane, 1992; Stolorow & Atwood, 1992), by constructivism (Hoffman, 1985), and by relational psychoanalysis (Mitchell, 1988). Several participants also mentioned the influence of Jungian theory on their practice. I did not attempt to review Jung's theory, or his views on transference, because it is such a different model than the others I included in my review of the literature, but some of Jung's ideas have certainly been assimilated into the eclectic practice of psychoanalytic psychotherapists that is represented by the participants. In particular, several of the participants mentioned the importance of a

spiritual dimension in therapy and brought up Jung's ideas in that context. The development of participants' thinking about the process of psychoanalytic therapy and the concept of transference—from the time of their original training, through decades of clinical experience and further education—involves an increasing emphasis on relational patterns within and outside of the therapy.

I highlighted the contribution of Merton Gill (1979, 1982, 1983, 1984; Wallerstein, 2000) earlier, with the intention of addressing his arguments in my discussion of the study's findings. Gill maintained that analysis of the here-and-now transference is what makes treatment psychoanalytic, either in analysis or psychotherapy, and that the immediacy of connecting a patient's experience to what is happening in the room with the therapist is more important than connecting to historical antecedents. In terms of the findings of this study, Gill's position is that "it is all transference." and corresponds to one side of the range of perspectives *vis a vis* the relationship between the therapeutic and extra-therapeutic transferences. (See Figure 1.) The participant in analytic training comes close to sharing this perspective, but the other participants reject Gill's extreme position. The idea that everything is transference was appealing to some of them as an ideal, but not as a guide for their real practice. Yes, they might always wonder about possible connections to the therapeutic transference and be pleased when opportunities came up to work with the here-and-now transference, but they do not systematically work the transference in the way Gill recommends. Furthermore, they consider it presumptuous for a therapist to think that everything the client says is about the therapist.

Many of the participants talked about how the therapy relationship itself is what heals patients, emphasizing the empathic, affective connection rather than verbal interpretations of transference. Though not the focal point for this research study, the

fact that participants brought this up is a reminder that the question introduced by Ferenczi (1930/1955, 1933/1955) and Alexander (1933, 1946) is still present in the psychoanalytic community: is there healing power in the therapy relationship itself, or is it just a "transference cure" when patients seem to get so much benefit from the relationship? Attributing importance to Winnicott, Bion, and Kohut, participants expressed their belief in the power of the affective relationship with the therapist. The relative importance of the relationship itself versus transference interpretations was not studied.

I reviewed literature that questioned the overemphasis on transference interpretation in teaching and writing about psychoanalytic technique. These authors looked at the role of non-interpretive techniques in psychoanalytic treatment (Bibring, 1954; Stewart, 1990; Stone, 1981; Strachey, 1934), and of interpretation of extratransference material (Blum, 1983; Halpert, 1984; Leites, 1977; Stewart, 1990). Participants' description of their practice included a variety of interventions other than strict interpretations, in agreement with this literature, and added weight to the argument that too much emphasis on the centrality of transference interpretation can obscure the way patients in psychoanalytic psychotherapy are helped by activities and interventions not focused on active interpretation of the therapeutic transference.

Extra-Therapeutic Transferences

The fact that none of the participants had ever heard of the term extra-therapeutic transference is consistent with the lack of attention paid to this concept in the literature. When mentioned, in contemporary as well as classical psychoanalytic literature, interpretations of extra-therapeutic transferences are thought to be, at best, building blocks that lead to meaningful transference interpretations, and at worst, a

failure on the part of the therapist to interpret defensive displacement of ideas or affect that belong in the therapeutic transference (Gill, 1979; Heimann, 1956; Strachey, 1934; Wallerstein, 1995). There is a small body of literature that takes into account the value of directly interpreting extra-therapeutic transferences in psychoanalytic treatment (Adatto, 1989; Fine, 1989; Fisch, 1994; Fosshage, 1994; Haas, 1966; Haesler, 1991; Halpert, 1984; Kivowitz, 1990; Ornstein, 1990). These papers cover both theory and practice, from a variety of theoretical orientations. I recall Leo Stone's remarks:

> There are situations in which transferences themselves may spontaneously occur in the patient's immediate life without evident processing through the analytic situation, and interpretation of these transferences can provide significant contribution to the psychoanalytic process beyond their immediate therapeutic effects. (as cited in Halpert, p. 138)

The results of my study agree with Stone's statement. Participants described their own clinical experiences of working interpretively with clients' outside relationships, though they lacked a theoretical concept for this important aspect of treatment. They knew it to be helpful to work directly on the experience of outside relationships, but did not think to expand their notion of transference to include this as a separate phenomenon.

In analyzing the study results I explained that participants held two positions with regard to the relative importance of therapeutic and extra-therapeutic transferences: the hierarchical perspective and the parallel perspective. The hierarchical perspective is in keeping with the literature that ignores extra-therapeutic transferences entirely or considers them only as manifestations of the therapeutic transference. The parallel perspective is in keeping with the literature that affirms the necessity and value of interpreting extra-therapeutic transferences, independent of the therapeutic transference. Figure 1 illustrates a range between these two perspectives that reflects participants' comments about extra-therapeutic and therapeutic transferences both being important, complementary, and best understood together.

Many of the authors reviewed also talk about a complementary relationship between the two types of transference. Later in this discussion I will take up more specifically the question of how the concept of extra-therapeutic transference can be integrated into psychoanalytic theory.

Psychoanalytically Oriented Psychotherapy

The criteria for inclusion in this study was that participants be experienced psychotherapists and identify themselves as psychoanalytically oriented. The phrase "psychoanalytically oriented" caused difficulty. I had reviewed literature that defined psychoanalytic psychotherapy and compared it to psychoanalysis and other forms of psychotherapy (Gill, 1982, 1984; Luborsky, 1984; Wallerstein, 1965, 1983, 1986). The participants had just the kind of training and experience I was looking for and that qualified them as psychoanalytically oriented in terms of this literature, but I found they were hesitant to call themselves psychoanalytic for one reason or another. Some seemed to think the term was reserved for analysts. These are sophisticated, highly experienced therapists, aligned with contemporary schools of psychoanalytic theory, but they seemed more comfortable saying they are "psychodynamic," than "psychoanalytic." I had avoided the term psychodynamic in my description of the study because I thought it was too vague.

I was puzzled that participants would be uncomfortable with the label psychoanalytically oriented, and wondered it I'd missed something by reviewing only literature that was out of date. It happens that Nancy McWilliams (2004) published a book on psychoanalytic psychotherapy since I began the research study, an ambitious and pragmatic book that emphasizes a flexible "psychoanalytic mental set" rather than particular rules or techniques and looks for common principles underlying current

psychoanalytic models of treatment rather than advocating a particular theory. With regard to differences between psychoanalysis and psychoanalytic psychotherapy, she thinks therapy has "more modest goals" than analysis and her classification basically agrees with Wallerstein's (1983, 2000). She uses the terms psychoanalytic and psychodynamic interchangeably.

> I prefer to envision a continuum from psychoanalysis through the exploratory psychodynamic therapies in which transferences are invited to emerge and be examined in light of the client's history then the transference-focused or expressive treatments that zero in on the here-and-now use of pathological defenses, and finally the supportive approaches . . . I regard the analytically influenced therapies not as a poor substitute for the real thing but as valuable in their own right. (pp. 14-15)

McWilliams' (2004) language and style are similar to that of the participants in this study. Many of the processes she describes as characteristic of psychoanalytic psychotherapy are similar to how the study participants described their ways of working and thinking about their work: valuing the affective connection that contributes to a healing relationship, expecting transference reactions to emerge in relationship to the therapist and interpreting the therapeutic transference, listening at various levels, doing what is useful for clients even when that means interventions that are not psychoanalytic, and relying on intuition and experience. McWilliams does not, however, shed any light on the question of why participants would resist calling themselves psychoanalytically oriented. Nor does she address the question of interpreting extra-therapeutic transferences.

Empirical Research Studies

The three studies I reviewed (Hamilton, 1993; Tosone, 1993; Wallerstein, 1986, 1995) explored the intersection between psychoanalytic theory and practice relating to interpretive activities. Their findings undercut commonly held assumptions about the exclusive reliance on transference interpretations for psychoanalytic cure and point to discrepancies between psychoanalytic theory and practice with respect to interpretive activities. They do not isolate the concept of extra-therapeutic transference. By highlighting the practice of interpreting extra-therapeutic transferences, results of the present study add to conclusions of earlier research that challenge assumptions about the exclusive role of therapeutic transference interpretation.

Incorporating the Concept of Extra-Therapeutic Transference Into Psychoanalytic Theory of Therapy

The results of this study show how psychoanalytically oriented therapists do, at least sometimes, interpret transferences from clients' outside lives and believe that it is helpful for their clients, but that they have no separate theoretical explanation for this aspect of their work. They rely on other factors as an implicit rationale: the confidence they feel in their clinical judgment that comes from many years of experience, their ability to listen to clients on many levels at the same time, and their commitment to doing what they believe will be helpful for clients. A theory that reflects how followers actually practice may be more helpful than one that does so only partially, but psychoanalytic theories of therapy have largely ignored the concept of extra-therapeutic transference.

In my search for relevant literature on extra-therapeutic transference I found seven papers that gave in depth case examples (Adatto, 1989; Fine, 1989; Fisch, 1994;

Haas, 1966; Haesler, 1991; Kivowitz, 1990; Ornstein, 1990), and a number of psychoanalytic writers who spoke in a more general way about how extra-therapeutic transferences should be acknowledged as having a role in therapeutic change (Blum, 1983; Halpert, 1984; Stone, 1981). The authors of these papers come from different schools of psychoanalytic thought and each argued persuasively that extra-therapeutic transferences should be analyzed in certain cases. Though I wondered if the results from my study would suggest that a particular theoretical orientation might be more amenable to incorporating the concept of extra-therapeutic transference, I did not find any pattern among the theories represented in the study. I think any psychoanalytic model of therapy could recognize the usefulness of extra-therapeutic transference if the concept of transference were elaborated. As Fine (1989) noted in the conclusion of his paper:

> In any case, it becomes clear that the concept of transference should be enlarged and expanded from that occurring in the analytic (or therapeutic) situation and those occurring in all the other life situations. Transferences are universal, and which ones are to be analysed depends on the circumstances of the case and the material produced by the patience. Thus there are in everybody multiple transferences. . . . All of these require careful investigation. (p. 503)

Self psychology, because it involves a significant reconceptualization of transference through the delineation of selfobject transferences, provides an example of how a theory of psychoanalytic therapy could incorporate the concept of extra-therapeutic transference. Ornstein (1990), Fisch (1994), and Fosshage (1994) go beyond clinical illustrations of the use of transferences from patients' outside lives and begin to put their analysis of extra-therapeutic transferences into a more systematic theoretical context.

Anna Ornstein (1990) explains that selfobject transferences occur in all intimate relationships when wishes and fears are triggered that emanate from unmet and

traumatized childhood needs. The therapist's empathic immersion in the patient's subjective world allows for the recognition of extra-therapeutic selfobject transferences, as well as recognition of selfobject transferences arising within the therapy relationship. In her case example, she describes how her patient had worked through many of his issues within the therapeutic transference with an analyst who was empathically attuned to him, but his wife, who was not, after all, focused entirely on understanding him, continued to trigger defensive, pathological responses in him. Ornstein helped the patient by actively interpreting the extra-therapeutic transference to his wife, and the patient made great progress. Hers is similar to cases that participants in my study described, when there was much more affect available around a marital relationship than the relationship to the therapist, who was experienced as an ally or a benign presence.

Ornstein's (1990) patient was in psychoanalysis and she argued for the importance of analyzing the extra-therapeutic transference to his wife. James Fisch (1994), however, sees the role of extra-therapeutic transferences as particularly important in the practice of psychoanalytic psychotherapy. Interpreting extra-therapeutic transferences is an example of the kind of modification of technique that he claims is needed when moving from a theory of psychoanalysis to psychoanalytic psychotherapy.

Fisch (1994) highlights another important concept from self psychology, the need for interpretations to be "experience near," and looks at how interpretation of an extra-therapeutic transference to his patient's estranged wife stays close to the patient's subjective experience and is very helpful. His description reminded me of how one of the participants in my study talked about needing to stay with the patient's affect, which led to interpreting outside the therapeutic transference. "Experience near," like

Strachey's (1934) "emotionally immediate," speaks to the importance of interpreting where the patient feels the most affective intensity, whether or not that intensity relates to the therapeutic transference. Experience-near transference interpretations can take into account an expanded concept of transference that includes both therapeutic and extra-therapeutic transferences. Fisch also points out that, because of its emphasis on the emergence of developmental needs (that arise in both therapeutic and extra-therapeutic selfobject experiences) rather than internal conflict, self psychology provides a model that can legitimize an analytic focus on patients' outside relationships.

Self psychologists are attuned to the emergence of new as well as repeated dimensions in the transference, and both dimensions can occur in extra-therapeutic as well as therapeutic transferences. Fosshage (1994) criticizes what he calls the "displacement" model of transference and looks instead at how repetitious relational configurations or schemas oscillate between foreground and background. At times they are not operative in the analytic relationship but may be operative in extra-analytic situations. The two types of transference can be complementary, as well. Fosshage describes how a self psychologist listens empathically to a patient describing a painful, abusive experience that occurred in an outside relationship. The therapist is attuned to the validity of the painful extra-therapeutic transference experience. Feeling heard and understood, the patient has a new relational experience within the therapeutic transference and might also come to a deeper understanding of the extra-therapeutic transference experience. It would be a mistake to assume the outside experience was a disguised reference to the therapist. Fosshage concludes that "the complexity of human relations and the vast range of experience outside the analytic scene . . . cannot be condensed into one relationship without losing the richness and variety of extra-analytic experiences" (p. 276).

Limitations of Study and Suggestions for Future Research

The study is limited by the exclusion of psychoanalysts. I chose to focus on the experience of psychoanalytically oriented psychotherapists because I wanted to understand how they distill from psychoanalytic theory associated with psychoanalysis, concepts they can use in their practice of psychotherapy. The central research questions could also be asked of psychoanalysts—how do they make use of the extra-therapeutic transferential material that arises in psychoanalysis? It might even be that the discrepancy between theory and practice would be more obvious in analytic practice than in psychoanalytically oriented psychotherapy where other adaptations of psychoanalytic theory are necessary. I think such a study would be best undertaken by a researcher who was trained as an analyst.

The study is further limited by geographical constraints. Participants are all in the San Francisco Bay Area, primarily involved in education and clinical training that is locally available. Further research in other locales, where other psychoanalytic theories might be more prevalent, could build on the present study's interest in the question of whether some schools of psychoanalytic theory are more useful than others in addressing extra-therapeutic transference phenomena.

A final limitation in the study arises from the fact that I spent only one hour with each participant and introduced them to an important concept that they had never heard of. What I got was just their first reaction to a complex idea. I chose not to introduce the concept of extra-therapeutic transference until the end of the interview because I was most interested in learning how participants would spontaneously

describe their experience of working with clients' outside relationships. If they had time to consider or reflect on the concept of extra-therapeutic transference, the results might have been different. Further research could involve a follow up study that included a second interview or written materials that would acquaint participants with the concept of extra-therapeutic transference prior to the single interview. It is possible that therapists might find extra-therapeutic transference a more useful concept if they had time to reflect on it and think about it as they work.

APPENDIX A

RECRUITMENT LETTER TO COLLEAGUES

Whitney Daly van Nouhuys, MS
Marriage, Family & Child Therapist
License # MFC 16677

661 Live Oak Ave., Suite 5
Menlo Park, CA 94025
(650) 325-3676

813 San Diego Road
Berkeley, CA 94707
(510) 525-8983

Dear

I am about to begin the data collections phase of my doctoral dissertation at the California Institute for Clinical Social Work, and am writing to ask your help in recruiting participants.

My qualitative study is about the clinical use of transferences from everyday life in psychoanalytic psychotherapy. It will address the question of how psychoanalytically-oriented psychotherapists think about what is going on in therapy when clients talk about outside relationships, and what theoretical concepts are useful to therapists in this aspect of their work.

I am looking for a small number of experienced psychotherapists from any of the mental health professions who identify themselves as psychoanalytically oriented, but who are not psychoanalysts. I will spend about an hour with each participant in an unstructured interview that I will tape record.

Can you think of someone who might be interested and appropriate for this study? If so, you could either tell them about it and suggest they contact me, or give me their names and contact information and I will get in touch with them directly.

My address and phone number are at the top of this letter. I can also be reached by email at wvn@wandd.com. Please let me know if you have any questions.

Sincerely,

Whitney van Nouhuys, MFT

APPENDIX B

RECRUITMENT AD FOR NEWSLETTERS

Ad submitted to newsletter of the Santa Clara Valley Chapter of California Association of Marriage and Family Therapists:

SEEKING PARTICIPANTS FOR RESEARCH STUDY. I will interview experienced psychoanalytically-oriented therapists concerning their thoughts about clients' presentation of outside relationships in therapy. If you might be interested, or would like to hear more, please contact me. Whitney van Nouhuys MFT, doctoral candidate at California Institute of Clinical Social Work. (650) 325-3676, or wvn@wandd.com.

Ad submitted to newsletter of The Psychotherapy Institute in Berkeley

SEEKING PARTICIPANTS FOR RESEARCH STUDY. I will interview experienced psychoanalytically-oriented therapists concerning their thoughts about clients' presentation of outside relationships in therapy. If you might be interested, or would like to hear more, please contact me. Whitney van Nouhuys MFT, doctoral candidate at California Institute of Clinical Social Work. (510) 525-8983, or wvn@wandd.com.

APPENDIX C

LETTER TO PROSPECTIVE PARTICIPANTS

Whitney Daly van Nouhuys, MS
Marriage, Family & Child Therapist
License # MFC 16677

661 Live Oak Ave., Suite 5
Menlo Park, CA 94025
(650) 325-3676

813 San Diego Road
Berkeley, CA 94707
(510) 525-8983

Dear

[for individuals who have contacted me directly: I appreciate the interest you have expressed in participating in the research study I am conducting. for individuals whose names I have received from a colleague: I was given your name by _____ because (s) he thought you might be interested in participating in a research study I am conducting] I am writing to give you some information about the study and to invite your participation.

I am a doctoral candidate at the California Institute of Clinical Social Work. The question I am exploring in my research study is how psychoanalytically oriented psychotherapists think about the phenomenon of clients talking in therapy about their outside relationships. I am interested in understanding what thoughts and theoretical concepts guide therapists in this aspect of their work.

Participation in the study means that I will interview you for about an hour, at a time and place that is convenient for you. I will tape record the interview. I might also follow up with a brief phone call if I need clarification of something that we discussed. If you choose to participate, I hope you will find the process to be helpful in clarifying your thoughts about the aspect of practice being studied and your own theoretical assumptions. I will be happy to send you a summary of the study results is you wish.

I will treat the information you give me as confidential and will protect your anonymity, as well as that of any clients you discuss during the interview. I have enclosed a copy of the consent form for you to review and which I will ask you to sign at the time of the interview.

If you would like to participate in this research project, please complete the brief questionnaire and return it to me in the enclosed self-addressed envelope as soon as possible. I will then be in touch with you regarding the possibility of your participation.

I hope this project is of interest to you. Please feel free to contact me at one of the above phone numbers or at wvn@wandd.com if you have any questions.

Sincerely,

Whitney van Nouhuys, MFT

APPENDIX D

CONSENT FORM

I, _____, HEREBY WILLINGLY CONSENT TO participate in the study on how psychoanalytically-oriented psychotherapists' conceptualize the phenomenon of clients' talking in therapy about their outside relationships. This doctoral research project will be conducted by Whitney van Nouhuys, MFT under the direction of Sylvia Sussman, Ph.D., principle investigator and faculty member, under that auspices of the California Institute for Clinical Social Work.

I understand the procedure to be as follows:

A one hour audio-taped interview will occur in a confidential setting to be arranged between myself and the researcher. I will be talking about my thoughts and feelings as an experienced, psychoanalytically-oriented therapist listening to clients' talking about their outside relationships.

I am aware of the following potential risks involved in the study:

The possibility exists that I might experience emotional discomfort . Should that happen, I will be able to contact the researcher who will make provisions for me to receive professional help, up to three sessions, to resolve issues related to participation in the research study, at no cost to myself.

I understand that I may withdraw from the study at any time. I understand that this study may be published and that my anonymity and confidentiality will be protected – that is, any information I provide that is used in the study will not be associated with my name or identity.

Signature

_____Date_____

- -

If you would like a copy of the results of this study, please provide your name and address:

Name _____

Address_____

APPENDIX E

PERSONAL INFORMATION FORM

Name_____

Address _____

_____

Telephone (day)_____(evening)_____

Email address_____

Profession and year of licensure:

Social Worker_____

Marriage and Family Therapist _____

Psychologist _____

Psychiatrist _____

What is your theoretical orientation? _____

_____

APPENDIX F

LETTER TO PROSPECTIVE PARTICIPANTS WHO ARE NOT INCLUDED IN STUDY

Whitney Daly van Nouhuys, MS
Marriage, Family & Child Therapist
License # MFC 16677

661 Live Oak Ave., Suite 5
Menlo Park, CA 94025
(650) 325-3676

813 San Diego Road
Berkeley, CA 94707
(510) 525-8983

Dear

Thank you very much for the interest you have shown in the research study that I am conducting as a doctoral candidate at the California Institute for Clinical Social Work. At this time I have recruited enough participants to begin the study and will not need to schedule an interview with you. If it becomes necessary to interview additional people I may contact you again to see if you would still be interested and available.

If you would like to know about the results of my study when it is completed, feel free to contact me.

Thank you once again for your interest.

Sincerely,

Whitney van Nouhuys, MFT

APPENDIX G

INTERVIEW GUIDE

Introduction

Thank you so much for agreeing to this interview and to being a part of my research project. As you know, I am interested in hearing your ideas about working with your clients' presentations of outside relationships. Clients in therapy talk a lot about other people, and their interactions and relationships with other people. I'm hoping you can help me understand some of the ways in which psychoanalytically oriented psychotherapists make use of this material, and what theoretical concepts guide them. I'd like to hear about how you think about this aspect of your work. As we talk, I encourage you to bring up examples from your practice that will help me understand how you work and how you think about the work. Let's begin by your sharing your initial reactions and thoughts about this question.

Participant's Theoretical Orientation and Current Practice

1. Type of practice, kinds of patients. Couples?
2. Your understanding of "psychoanalytically-oriented"?
3. Elaborate on questionnaire re theoretical orientation
4. Education? (include training and continuing education)?
5. Supervisors or mentors? Their theories?
6. Other influences on your practice??

Participant's Understanding and Use of Particular Psychoanalytic Concepts

1. Psychoanalytic concepts that you consider important.
2. How do clients change?
3. Insight?
4. Interpretation?
5. Transference?

Integrating the Concept of Transference in Practice

1. How do you *use* transference?
2. Changes over time in your understanding and use of transference? Why?
3. Do you think about client's outside transferences?
4. Relate to primary transference or not?

Examples of Extra-Therapeutic Transference in Participant's Clinical Experience

1. Ask for case examples or vignettes illustrating outside relationships in therapy.?
2. If participant says they think differently or do different things with different people, explain differences. How decide different reactions?
3. Change over time re thinking about or using outside transferences?
4. [At the end of the interview] There is concept called extra-therapeutic or extra-analytic transference. Have you ever heard either of those terms?
5. [still at the end of the interview] Some people who write in the field of psychoanalytic theory discuss the value of interpreting extra-therapeutic transferences as a way to get at aspects of clients' lives that you might never be able to get at within the therapist-client transference. What do you think about that idea?

Other Theoretical Concepts That May Guide Practice

1. Times when psychoanalytic theory doesn't explain enough?
2. What else would help clients in their relationships, using the vignette or case example?
3. Affect on individual work when therapist also works with couples or families? Theories for couple and family therapy

Participant's Development As an Independent Thinker

1. Reactions to psychoanalytic literature and case presentations? How integrate in your practice?
2. Where do you look for support for your own point of view as a threrapist??
3. Community of peers?
4. More professional education to help you integrate theory and practice? Especially with respect to the relationship between analysis and therapy?

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