THE THREE TRANSFERENCES

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Introduction

Transference is one of those things in psychology that everyone has something to say about. The problem is however that many people have differing definitions of transference. Therefore when they talk about transference they are often talking about different things. As they have the same label - "Transference" - people assume they are talking about the same thing and thus disagreements are rife and at times bitter. So if you are ever having a discussion with others about transference it is wise first to work out if you are actually talking about the same thing!

Others have stated this point before:
Silverberg(1948) says that transference has been defined as either being
1) the whole relationship between two people
2) only a bit of repetition

It is pleasing to see that one of the main articles on Transactional Analysis and transference makes this distinction as well (Carlo Moiso(1985)). He notes that in transactional analysis transference has been correlated with life scripts and on the other hand transference is connected to the analysis of specific transactional stimuli and responses. So transference is connected to a whole life script and at other times it is seen as a specific transaction.

The whole relationship:

This means that when you enter into a relationship with another person then the whole way you begin to think, feel and act is determined by what you have learnt about relationships in the past - mainly from your parents in childhood.

A bit of repetition:

A good example of this is how Eric Berne talks about the transference transaction. So in this instance transference is not the whole relationship but a single transaction commonly called the transference transaction.

Transference transaction

The supervisor transaction is a type of transference transaction.

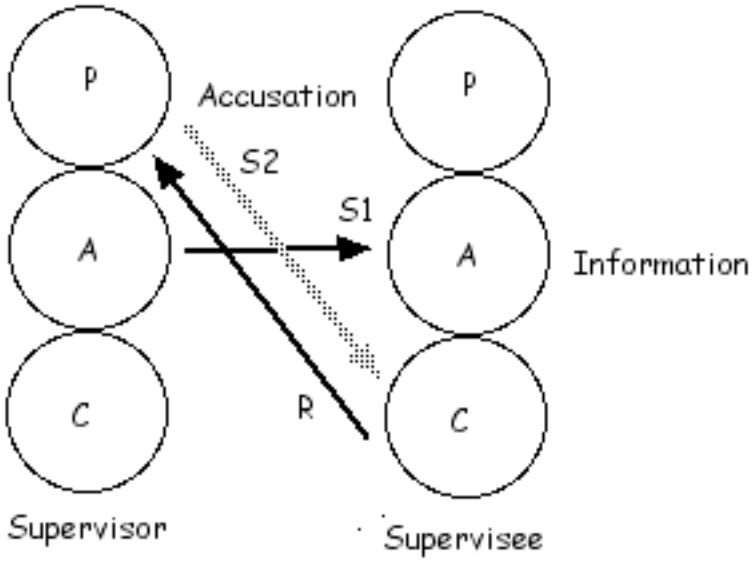


Diagram 1.

This is a transference transaction - a crossed transaction. The supervisee mistakenly sees the supervisor as a parental figure and will react to that person in the same way that they reacted to their mother or father as a child. So in childhood when a child was told it had done something wrong it often felt bad or angry, sad and so forth. So if a supervisor has to tell a supervisee they have done some wrong or needs to be improved (Stimulus 1) the supervisee will often feel the same way. So information may not be perceived as being information but seen as an accusation (Stimulus 2). Consequently the supervisee does not respond back to S1 but to S2 with either rebellion or compliance (Response 1).

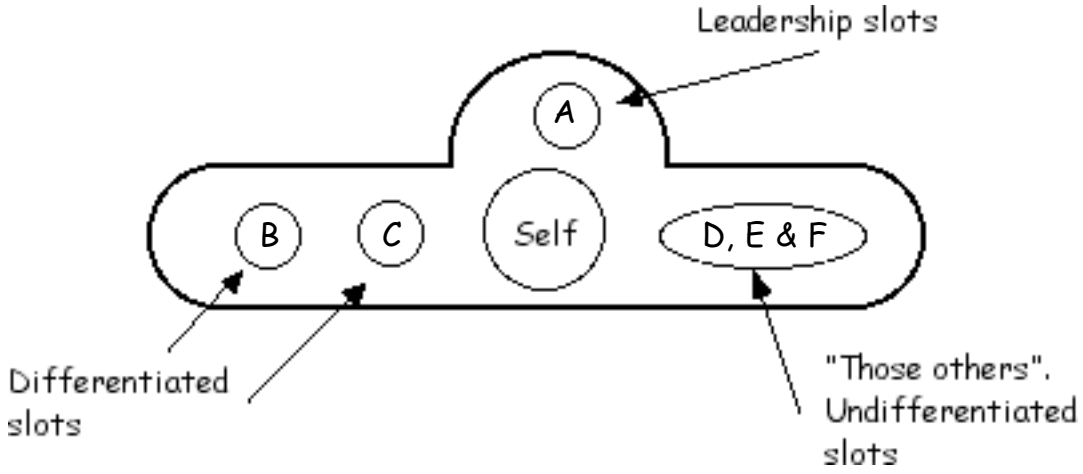
So as you can see - transference - in this instance are just a single transaction that gets repeated over and over again. This is often called game playing. It is definitely not the whole relationship. So 'curing' the transference in this instance is quite easy. The supervisee simply strengthens the Adult ego state and responds from that rather then the Child ego state. So with this definition transference is seen as a 'unhealthy' thing that needs to be avoided and it is possible to relate without transference.

Where transference is seen as the whole relationship 'cure' is far less clear. It also raises the issue of can you have a relationship that is free from transference or do all relationships have transference with healthy and unhealthy transference being the main point.

So in discussion with others it would seem wise for the discussants to make sure they have defined transference the same way or the discussion is doomed to go around and around in circles.

The three transferences

Eric Berne in his book 'The structure and dynamics of organisations and groups' developed a diagram called the "Group Imago Diagram" (Berne (1963)). This he referred to as the private structure of the group and is shown below in diagram 2.

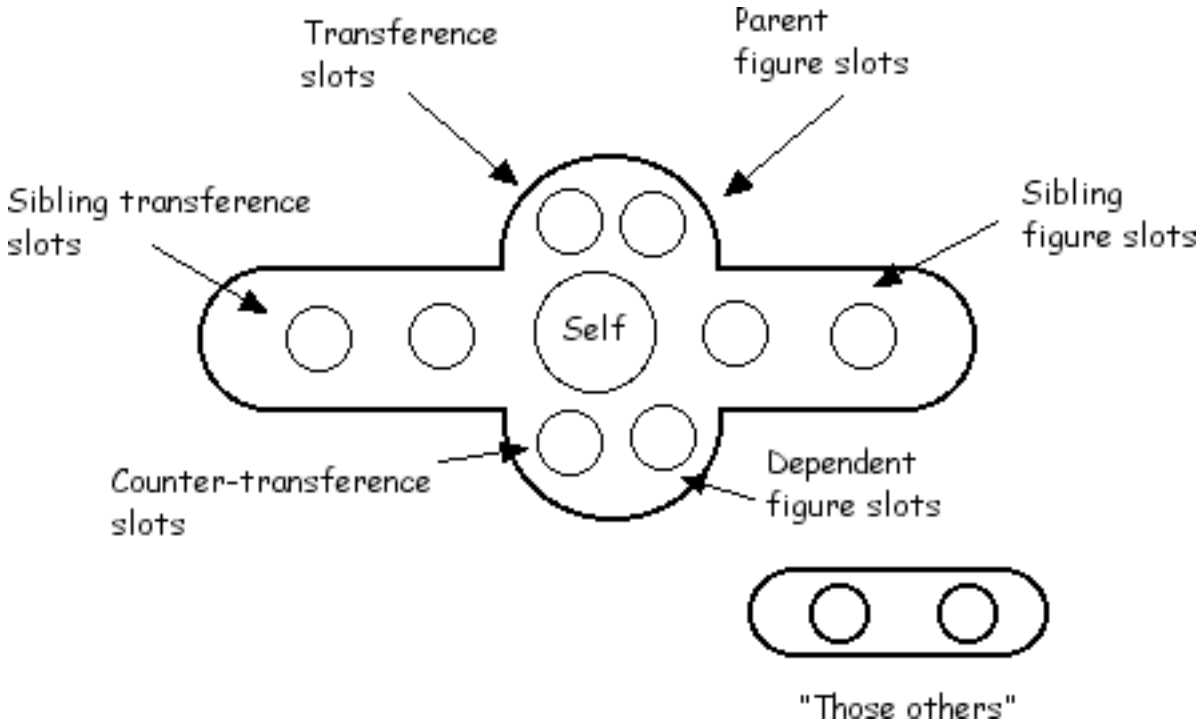


Group Imago Diagram
Diagram 2

Every person in a group has one of these. It shows how they position themselves in relation to others. They may see someone in the leadership position (slot) and others in peer or equal slots (Differentiated slots). Then there will be others who are just 'there' and have no significant psychological meaning for the person. So for these people there is no emotional investment whereas for the differentiated ones there are emotional reactions. These emotional reactions occur from the past experiences of the person. So these are the ones that the person will transfer onto. Particularly the person in the leadership slot.

So the individual (Self) develops these slots or images in childhood and carries them around and as he meets new people some will transferred into the various positions (slots). Those others who do not 'fit' will remain in the 'Others' position.

Tony White(1985) expanded this diagram into the "Script Imago Diagram" and it is shown below in diagram 3:



Script imago diagram
Diagram 3

Again we have the self in the middle and then we have others placed in various positions in relation to the individual. We have others as either:

1. Transference figures (Parent figures)
2. Sibling-transference figures (Sibling figures)
3. Counter-transference figures (Dependent figures)

The transference figures we perceive as those who are in some way more powerful or psychologically potent than us. The sibling-transference figures are seen as our peers on an equal basis and the counter-transference figures are those who we see as having less power or less psychologically potent than ourselves. It must be remembered that this is the person's private view of the world not the public or formal view. For example, your boss at work is in the formal transference slot. However in your own mind that may not be so at all. If you have a close friendship with him you may in fact perceive him as an equal figure. Or if you see him as needy or incompetent you may see him as a dependent figure or less psychologically potent.

This imago is developed in childhood and provides us with a set of 'images' or prototypes for relationships that we will carry around with us in our lives. Whenever we develop an attachment to someone then we will classify them into one of these 'images' and transfer our past onto the the person in the here and now.

There are some common factors that people will tend to use to categorise others into one of the 3 types of transference.

* Economic factors: Parents have economic control over children. Employers have economic control over employees and as a result an employee is likely to see the employer as a parental figure. Logically the employer is likely to see the employee as a dependent type figure.
* Legal factor: Parents have legal control over children. Those who have legal control over others such as judges, police and umpires are likely to see the underlings as dependants and vice versa the other way around. Whereas two policemen of equal rank will tend to see each other as sibling figures of equal potency.
* Information factor: Parents have more information than children. So in adulthood when you come into contact with an 'expert' such as a doctor, lawyer, psychologist you will tend to view that person as a parent figure at least in those circumstances. Again two lawyers will tend to see each other as equals.
* Nurturing factor: Parents nurture children. So if one goes to see a counsellor who is nurturing then the client will tend to see that person as a parental figure and the counsellor will tend to see the client as a dependent figure.
* Individual personal factors: despite all the above there maybe other things which make your perception of another person different than what it is expected to be. For instance the way a person looks, has their hair done, they way they speak or gossip you have heard about them may remind you of someone from your childhood and thus you will tend to slot that person into a particular image of that 'old' figure regardless of how many formal controls they may have over you.

Regarding treatment the goal is to transform or create new slots or images in the client's script imago. If the client had a mother who never listened to her ("Don't be important" injunction) then she will develop transference figures in the here and now who either do not listen to her, or she perceives them as not listening to her. As she forms a transference relationship with the therapist the client will begin to gain reinforcing memories of when the therapist did not listen to her and ignore or forget those times when the therapist did listen. Thus the client will recreate the same relationship with the therapist in the here and now that she had with her mother in the past. This is sometimes called the transference neurosis: the same quality of relationship is recreated by the client in the counselling room.

Working with the transference the therapist confronts the transference neurosis by a variety of means and over time the client will begin to create a new slot or image. As it becomes more practised by the client experiencing being listened to it gains in its strength and the other slot of not being listened to begins to fade. Consequently the client will then begin to form new types of relationships with others where she feels listened to and the new imago image is created. In this sense

'cure' is achieved.

For those training to be psychotherapists, one of the gaols is to create a dependent figure or counter-transference slot that represents a healthy way of relating to clients. So when new clients arrive they are perceived in a way that will allow the therapist to relate to them is a health promoting way. A counter-transference issue will evolve when the client for some reason is slotted by the therapist into a dependent figure slot that is unhealthy . Thus the therapist will relate to that client in a way that confuses the treatment.

<u>How the three transferences develop</u>

How do the images or slots in the script imago develop?. How do we create them in childhood so that when can transfer them onto others in adulthood? This is one of those things in psychology that looks relatively clear on the surface but as you look in more detail it gets more complicated.

These slots or images are somewhat like muscles. When constantly used they grow and become strong and vital. If they are not used they tend to atrophy. They can never completely die away, yet when not used for long periods of time they can become quite insignificant.

It is probably safe to say that the images develop within the first decade of life and will become fully formed when four conditions are met.

1. The child observes how others relate (modelling). The more affect laden they (the model) are the more powerful the effect. If a girl sees her mother relating to others in a nurturing way then that girl will develop a slot or image of dependent figures or counter-transference figures that are related to with the Nurturing Parent ego state. If a boy sees his father relate to his peers in a competitive way then he will be forming slots in his script imago with sibling-transference figures that are competitive in nature.

2. The child get stroked for particular types of relating. If the young boy is given lots of attention and strokes for being competitive with his peers then he will develop strong sibling-transference slots that are again competitive in nature. If a girls is stroked for taking charge and being critical of others then she will tend to develop counter-transference images that are critical and controlling in nature.

3. Attributions also play a role here. If a young girl is told "You are the nurturing one" that will encourage her development of counter-transference images where she sees them as requiring nurturing. If a young boy is told, "He is the fun loving one of the children" then he is likely to develop sibling-transference slots that are of that nature.

4. The child can practice the relating style first hand. This is often done through play. Psychologists have long recognised that humans and animals use play as

a way of learning how to be with others. Practising how to be.

This is the most important of the four conditions for without actual practice in childhood the slot formation will be retarded. For instance if a mother strongly models nurturing behaviour but then the child has no opportunity to practice such behaviour first hand with others then that 'image' will tend to remain dormant and unpractised. Children can often find a way however. For instance girls playing with dolls is a modified version of practising first hand. It is not as strong as with a real life person but it is better than nothing.

This of course highlights the problem for the only child in a family or children who are raised in some form of isolated environment. Their options for practice are limited. In this way the best thing parents can do is:

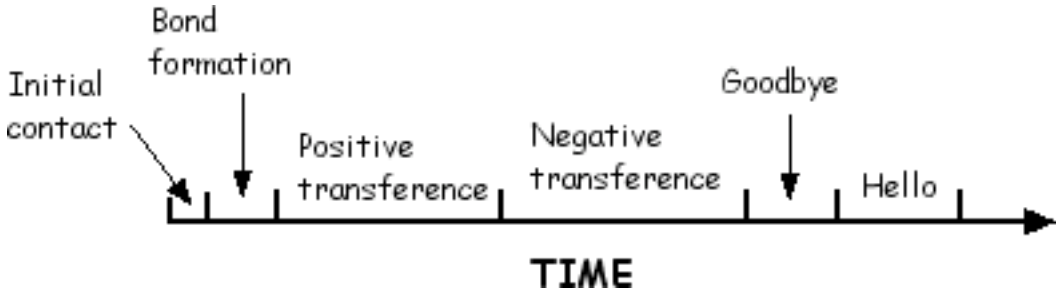
* Provide good role models
* Provide the offspring with access to a variety of other children/people of their own age and different ages
* Remain aloof during the practice. Don't play for them.
* Stroke healthy relating

This will allow for the formation of the most healthy transference, counter-transference & sibling-transference images.

Positive and negative transference

Whilst the process of positive and negative transference technically occurs in all relationships that gain some degree of emotional depth, it is most notable in the client-therapist relationship. To explain this I will follow what Freud(1966) said about how the transference relationship between client and therapist alters over time.

If a person enters counselling and ends up working through the transference relationship with the therapist then there are 6 stages in which that relationship progresses. Diagram 4 below.



Changes in the transference relationship
Diagram 4

Initial contact

All relationships including the relationship between client and therapist

begins with the initial contact stage in diagram 4. The two individuals meet for the first time and at this point they are only acquaintances with no emotional bond between them. It should also be noted however that at this point most clients will have the therapist to some degree in the transference or parental slot in the script imago.

To understand this consider what confronts the client even before they have walked in the door. The client has asked the therapist for help, so the client makes an appointment - the therapist decides what times he is available and usually the client has to fit in with that. The therapist decides finishing and starting times, how long treatment will run for, what form the treatment will take, how much the client will pay, how payment is made, if there are any coffee breaks, their length, what coffee will be drunk and what food will be eaten, the therapist defines the ground rules and in some cases the the therapist may have legal control over the client such as in court ordered treatment. As you can see an awesome set of circumstances that will inevitably effect the client's perception of the therapist.

This initial contact stage is where the two parties begin to sort out where they fit for each other in their script imagoes. At this stage the slotting or psychological understanding of each other is brittle and fragile. There can be considerable changes as the client and therapist get to know each other better. That is, as they begin to form a bond or attachment. As any counsellor will know there are those clients who you just click with and there are others who you do not. This can be explained by the script imagoes of both connecting. The therapist fits well in one of the client's script imago images and the client fits well in one of the therapist's script imago images. So the connection between them has a 'natural' feel or a feeling that they understand each other.

Bond formation

As the contact continues the bond or attachment between the two increases. It should be noted however that the client-therapist relationship is unique in this way in that it is not an equal relationship as say are friends or partners can be. The therapist has more emotional meaning to the client than the other way around or at least that is how it is meant to be. Put somewhat crudely the client needs the therapist more than the therapist needs the client for their emotional well-being.

This is similar to what happens with a parent and a child. It is without a doubt devastating for a parent when a child dies but it is not in the same league of devastation for a child when a parent dies. So the client will develop a more important attachment than the therapist.

Some therapists and therapeutic theories will actively resist attachment development on the therapist side. They believe that the treatment must be clinical and one should stay out of it personally. Obviously forming an attachment means it

is getting personal. So they try and keep distant from the client in this way and to keep their own humanness out of the counselling.

This also applies for some trainers who believe that if you are training a person to be a transactional analyst then you cannot also be their therapist as well. The usual reason given is that the attachment achieved in therapy will confuse the teaching relationship. To my mind this is a silly flat rule to have. There are people who I have as clients who I would never enter into a training relationship with and vice versa. Then there are many others who benefit greatly from it both ways - clients who become trainees and trainees who become clients. It seems likely that those who just have a flat rule indicates some counter-transference issues on the therapist's or trainer's behalf so they need to create a organisational boundary to deal with it.

Positive transference

Once the attachment is beginning to form many move into what Freud called the positive transference. He states that during this time the patient develops a special interest in the therapist where the patient's relationship is most agreeable. Changes in the patient seem to occur swiftly and appear to result from what the doctor says.

There may be the disappearance of peripheral problems. For instance the person looses weight, gives up smoking, their sexual relationship improves or they start sleeping better when these were not the main presenting problems. The therapist must treat such changes with caution and be careful to avoid diagnosing them as 'real' changes as they can quickly disappear when the next stage appears.

However I am not suggesting that these changes are fake or manipulative for some reason. Instead in this stage of positive transference the Free Child of the client sees hope for finally resolving the needs and wants they have had for their whole life. For example a person who always felt not understood by mother or father may see in the therapist some who is finally going to understand them and thus their lifelong unmet need is finally going to get met. Thus a great deal of hope is engendered and such spontaneous changes can result along with a positive attitude by the client towards the therapist.

Negative transference

Alas the positive transference stage comes to an end as the client moves on. Freud also spoke about this at some length. The change from positive transference to negative transference can be quite rapid and he states that all the spontaneous cures of the positive transference stage are "blown away like spray before the wind" (Freud(1966)). It is typified by feelings of negativism, resistance and anger or conflict in the client. The client who once thought you the therapist could do no

wrong in a strong positive transference all of a sudden sees you as the enemy and a poor therapist who does not know what he is doing. As a consequence difficulties arise in treatment such as arguing over appointment times, missing appointments, breaking agreements, questioning what the therapist is doing, arguing over money and so forth. The client may start smoking again or sleeping poorly again and the therapist may get the blame for that also.

As with all transference it is imperative that the therapist does not take it personally. If they do then difficult counter-transference problems will arise within the therapist. It maybe very nice for the therapist to hear in the positive transference stage that they are 'the best thing since sliced bread' and that the client loves you. Unfortunately they don't because how can they love you when they do not know you. They only know you in a very specific way in the counselling room and very little about your personal habits or ideas and the whole rest of your life. The client does not love the therapist but loves what they believe the therapist to be.

Fortunately the same applies for negative transference. When the client views you in a very dim light it's not really you, but what you represent to them. You are an image in the client's mind and script imago that is being transferred from the past onto the here and now. Again the client does not know you.

This negative transference is the beginning of the separation which some move through relatively easily and some others struggle with tremendously. In the positive transference the bond or attachment is being built up and the client gains the therapeutic value from such a healthy attachment forming. Then it all turns around with the negative transference where the bond is being broken down and the person is separating and moving away. This is similar to what happens with teenagers who develop a negative attitude to their parents, they are also breaking away.

As diagram 4 shows the positive transference precedes the negative transference. I discovered early on in my study of transference that it is usually more productive to drag the negative transference into the positive transference stage. As I say to trainees sometimes: in the positive transference the client puts you on a pedestal and then in the negative transference they shove you off and at times the fall can be painful. It seems wiser for the therapist to take charge and jump off the pedestal in their own way and in their own time.

So during the positive transference I will ask questions of the client like:
"What is there about me that you do not like?"
"What have I done that has irked you or annoyed you?"
A situation may arise where I as the therapist miss an appointment or am late for some reason. When such a circumstance arises I will focus on it to allow the client to be aware of and understand their negative reactions to me because of the event.

(Please note that at this point I am often asked the question, "Do I create such situations for the reasons I just mentioned?" My answer is a resounding, no. To go down that path would be most counter-therapeutic for obvious reasons.)

By bringing the negative transference into the positive transference stage the process is speeded up and does not allow the mistaken image building by the client in the positive transference to become too big of a problem. In this sense it keeps the relationship between the client and the therapist more real.

Good-bye

Eventually the therapist looses the emotional value that they once had for the client and at that point the client says good-bye and moves away. Some do it abruptly and others move away in a stepwise fashion. Other people in the client's life start to take on much more emotional importance to them as the therapist becomes less and less important. For most this is the last time that the client and therapist see each other. On the odd occasion there is post therapy contact usually because the client is in the counselling field anyway and they run into each other as a matter of course.

Hello

If there is post therapy contact then the client and therapist have to say hello to each other in some form. This is usually harder for the client than it is for the therapist because the therapist had more emotional significance for the client than the other way around. So some sensitivity in relation to this on the ex-therapsit's behalf is probably called for.

Conclusion

In this article I have examined some aspects of that very diverse subject called transference. In particular I have shown that the historic way of viewing transference and counter-transference as the only two types of transference is incomplete. There is indeed a third type of transference called sibling-transference. This is done by expanding Eric Berne's group imago diagram into the script imago diagram.

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