Phenomenological Inquiry and Self-functions in the Transference-Countertransference Milieu

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Abstract:

The article "Balancing on the 'Borderline' of Early Affect-Confusion: Part 2 of a Case Study Trilogy" serves as the basis for this rejoinder and collegial discourse. The organizing-functions of reparation, stabilization, regulation, and enhancement are described and placed within the transference-countertransference milieu. Examples of bifurcating client's questions to resolve transference are provided.

Key Words: relational psychotherapy, transference-countertransference matrix, attunement, relational-needs, organizing-functions, phenomenological inquiry, self-functions.

Response to Ray Little

Ray Little begins his commentary on *Balancing on the "Borderline" of Early Affect-Confusion: Part 2 of a Case Study Trilogy* by pointing out the importance of clear administrative contracts in managing the "boundaries" of psychotherapy. I offered to see Theresa twice a week and the opportunity to talk on the phone "if necessary" for only 5 minutes and no longer. "If necessary" was defined as calling to extricate herself from an argument or "crying spell" and primarily to make an additional appointment for the following day. This strategy eliminated the late night phone calls. It provided protection from emotional escalations and offered a relational-stability that had been missing in her life.

Ray, you mentioned in this commentary, as you also did in Part 1, that you would focus on the "present moment", in the "transference-countertransference matrix, honoring the defenses". You contrast this approach with how you imagine me as having a "focus on historical inquiry". My focus with Theresa was on the moment-by-moment dynamics between us and, simultaneously, her ever-

emerging internal experience. Working in the "present moment", with full internal and interpersonal-contact, is pivotal in tailoring the therapy to the client and effecting lasting change. When we facilitate full contact, memories will emerge but these memories, or the painful reluctance to experiencing the memories, always occur in the "present moment". We both seem to be stating that working in the here-and-now is indispensable. This is a central theme in *Beyond Empathy: A Therapy of Contact-in-Relationship* (Erskine, Moursund, & Trautmann, 1999).

In re-reading my case study I can see how you may have arrived at the impression that I was primarily focused on historical inquiry when I said, "for many sessions she was reluctant (at times unable) to talk about her childhood". Although historical inquiry is a significant aspect of any effective psychotherapy, the majority of my inquiry in this second year of Theresa's treatment was phenomenological. Perhaps I needed to emphasize that aspect more in my case presentation.

If, for the purpose of illustration, I were to ascribe a ratio to the various forms of inquiry, the ratio would be approximately ten or fifteen phenomenological inquiries to one or two transferential/ historical inquiries, back to seven or eight phenomenological inquiries. Then perhaps an inquiry or two about how she was experiencing our interpersonal relationship, another historical inquiry, more phenomenological inquiry, then two or three transferential/historical inquiries, and then one or two about how she coped, reacted physically, or what she concluded. Perhaps we would then return to several phenomenological inquiries, then, if appropriate, another relational-inquiry, and the ratio would continue. These inquiries may also take us to inquiring about vulnerability and the client's value of self. This is a constantly evolving co-creative progression.

The process of staying in the "present moment" occurs when we re-circulate everything the client says (whether it be about feelings, expectations, transferential reactions, historical experience) back to phenomenological inquiry. Interspersed with the many phenomenological inquiries about Theresa's affect, body sensations, fantasies, thoughts, associations, and how she made sense of her experiences, were *inquiries about how she experienced our relationship*. Some examples include: "What is it like when I ask you about your feelings?", "What do you experience inside when I look you in the eye?", "How so you experience my quietness?" Ray, I presume that these types of relational-inquiries are quite similar to what you might do. We use such relational-inquiries as we would use a delicate spice in cooking: in small portions to provide a subtle, penetrating flavor to the dish.

If I understand your meaning of "honoring the defenses", then I think I do what you are describing through acknowledgement and validation of the existence and importance of the client's interruptions to contact (internal and interpersonal) and

the various habitual ways of resolving relational disruptions – the archaic struggles for self-reparation and self-stabilization. I would like to have heard both how you honor the client's "defenses" and how you help them to dissolve those "defenses". How do you conceptualize "defenses", a psychoanalytic drive-theory concept, within the perspective of a relational psychotherapy? I wonder if the concept of "defenses" is incompatible with a developmental and relational understanding of human functioning.

Ray, you say that the "opening up of memories can be re-traumatizing, and make integration more difficult". I believe that re-traumatization may occur when the psychotherapist takes a "stand opposite the client". With an "opposite", confrontative and, at times adversarial, stand the client is once again left alone in his or her re-living of overwhelming memories – there is an absence of an "us". When we take a stand "alongside" the client we provide a new quality of a contactful relationship that strengthens internal security and allows for the traumatic memories to be integrated into a new sense of being and being-in-relationship.

With clients as neglected and traumatized as Theresa, my responsibility is to be an interested, involved, and caring psychotherapist who brings skills, commitment, and ethics to the therapeutic relationship. When I use terms such as "an alternative parent /object", I tend to miss the significance of the reparative relationship that is so essential for the client's healing from the wounds of cumulative neglect and trauma. It is important for me to remember that we are not merely an "alternative parent" or an "object"; we are real people involved in a healing process. That means being with and for our clients, respecting them, regarding them as valuable persons, supporting and celebrating them in their personal development, and loving them for who they are.

I disagree when you say, "I believe I would need to be seen and experienced as a bad object to enable the client to work through her grief and separate from me". Grief is more fully resolved in the presence of someone who is empathetic, attuned, and patient. Separation is much easier when there has been full interpersonal contact, a real sense of presence, and a celebration for what has been accomplished. If, in the separation, the client is experiencing the therapist as a "bad object" then something is amiss; either the therapist is out of contact with the client or the original relational disruption is not resolved. Such negative transference is an unconscious call for help in resolving intrapsychic conflict and achieving intimacy.

Response to Grover Criswell

Grover, you raise some challenging questions in your commentary on Part 2. The building of a constructive working alliance with Theresa (I think this is

what you call “positive transference”) was a major accomplishment in the first seven months and so central to providing an effective psychotherapy for clients with early affect-confusion. In building an effective working alliance with Theresa, I had two main focal points: security-in-relationship and affirming and valuing her.

Security-in-relationship requires more than verbal reassurance from the psychotherapist; it is in the client’s visceral experience of having her vulnerabilities respected and protected. Respect and protection come primarily from sensing that the therapist understands (or at least tries to understand). I took the position that whatever Theresa did had an important mental-organizing function or purpose, and, that the purpose was of value, worthy of my attention and our mutual exploration. The psychotherapist’s affirming and valuing the *function* of the client’s words, thoughts, feeling, and behaviors, without criticism or rejection, is central in accomplishing a constructive working alliance.

I never provided Theresa with a diagnosis but I did describe her affect experience and offered alternatives such as bringing her “troubled inner child” to therapy rather than crying helplessly or provoking conflicts with her coworkers and boyfriend. Together, in the first seven months, we discovered that many of her conflicts were rooted in her early relational experiences. You say that she seemed “compliantly dependent”; I think that she was beginning to feel understood and respected. I have had many clinical experiences, as you no doubt had as well, where it is better to have a client temporarily depend on a caring and involved psychotherapist than being dependent on archaic coping patterns such as Theresa’s engaging in conflicts at work, raging at her boyfriend, or collapsing into a sense of helplessness and long spells of crying.

Grover, I appreciate your comment:
“My understanding of “interpretation” in psychotherapy is that the therapist gives explanations only when the client is on the verge of making that discovery or insight himself or herself. We want them to take existential ownership in the search for meaning. We are helping them take the next step rather than expecting them to leap in response to our expectations. This would seem to be an important part of attunement. Otherwise, we may be experienced as giving them our version of the truth or to be imposing expectations of how they should view issues or be acting. This can place the client into the paradoxical dilemma of either being over compliant or defiant”.

The avoidance of potential “insight robbery” is why I make extensive use of phenomenological inquiry and focus on working with the emerging experience between us rather than relying on interpretation. In responding to an inquiry the client is continually discovering previously unthought and unarticulated aspects of his or her own experience. In working with the emerging interpersonal experience we are co-discovering our mutual unconscious process.

You capture the essence of a relational and integrative psychotherapy when you say, *"A key concept in the work is that of juxtaposition where the client is getting what she wants and needs but she is afraid to trust it. This was the springboard for much valuable work. While the work related to the mother's criticalness was one level, simultaneously the therapist is relating with her in sensitivity and affirmation. Her relational disturbances are being healed even as she has trouble trusting it. This is where I see the client moving from dependence toward interdependence, from affect confusion into self-acceptance".*

Grover, you end your commentary by wondering about the "five month break" in Theresa's psychotherapy. The summer recess was never longer than 12 weeks. After the initial seven months the client had no protest about the summer break because she had assumed that our therapy contract had come to an end. As our second year began we discussed my intended absence for the twelve weeks (she and her boyfriend were also going to be on an extended holiday) and she seemed comfortable. As the spring months approached the summer months Theresa voiced her discomfort in my being away. She was worried about getting into conflicts again. We talked about what she had discovered in our therapy together and I assured her that she was "in charge of her own life" and that she had "choice" in how to behave. She now had the internal resources to engage with people in a new and different way.

Response to James Allen

Jim, in your commentary you state, *"We might speculate that by being a container for her troublesome projections, and an observing caring presence, Erskine was a regulating process for her. By internalizing him, she contributed to her own self-regulating processes".*

I think that an attuned, developmentally responsive, and involved parent provides a young child with several mental-organizing functions that are originally relational in nature: reparation, stabilization, regulation, and enhancement. Over time, in the process of maturing and mastering developmental tasks, these mental-organizing functions gradually become autonomous self-directed functions. When there are cumulative relational disruptions in a child's life, when relational-needs are continually not satisfied, and when there is unresolved trauma, the child's sense of mental-organization becomes confused and disorganized and he or she prematurely learns to convert these relational-functions to self-functions. Later in life the person may then rely on these prematurely learned archaic organizing forms of self-reparation, self-stabilization, self-regulation, and self-enhancement to habitually manage problem-solving, health maintenance, and relationships with people. A repeated reliance on archaically organized self-functions interrupts internal and external contact in the present moment and leads to a myriad of relational and behavioral difficulties.

I am constantly watching to see if my clients are using either contextually mature forms of mental-organization and/or significant relationships to repair, stabilize, regulate, or enhance their sense of self. Or, are they relying on archaic forms of mental-organization? Theresa's helpless-crying and projections of abandonment are two examples of archaic attempts at self-reparation and self-stabilization. In an effective psychotherapy we create the quality of relationship wherein our clients can forgo using their archaic self-functions and temporarily transfer these organizing mental functions into the therapy relationship. I think this is what you are describing, Jim, when you say, "by internalizing him, she contributed to her own self-regulating processes".

I wanted to engage Theresa's introjected mother in a serious psychotherapy similar to what I have described in other publications (Erskine, 2003; Erskine & Trautmann, 2003; Erskine & Moursund, 2011; Morusund & Erskine, 2003). However, attending to Theresa's overwhelming sense of shame took precedence. Theresa's shame was the result of her mother's constant criticism and ridicule that gave the injunction: "Something is wrong with you". It seemed essential that we resolve her fear of ridicule and abandonment, her immobilized self-expression, and her compliance with Mother's definition before I attempted any interventions with the introjected mother. I wanted to be sure that she felt secure in relationship with me and that she had a much more solid sense of mature self-regulation and self-definition before I addressed her introjected mother.

Response to Masa Žvelc

Maša, you point out what I consider to be an important component of working relationally with the client's unconscious expression of affect-confusion when you highlighted the bifurcating of Theresa's direct questions. In an in-depth psychotherapy it is my responsibility to think beyond the apparent communication and have a broad-based perspective on the possible unconscious meanings in transactions and behaviors.

With bifurcating Theresa's question, I focused on both her felt sense of being in relationship with me and her unconscious archaic experience that gave rise to the question, "What does it mean if I don't believe your story about your mother hitting you, and what does it mean if I do believe you?" Her answers to both parts of the question revealed her disavowed affect and script beliefs, "No one is there for me" and "No one understands me". The bifurcated questions and her emotionally-laden answers expressed many implicit memories of neglect and relational deficits in her early childhood. This provided us the opportunities to explore how she coped, her body reactions, the conclusions she made, and the emotions she had in response to the ridicule, punishment, and emotional

abandonment. Such work led us to explore the various ways in which she was still using archaic strategies of self-reparation and self-stabilization.

Maša, your sense that something was missing is an important asset in discovering what is not being talked about in the psychotherapy. You say, "I stopped a little and curiously explored my sense of missing… And questions started to emerge: "What else happened to her? Is she avoiding something? What about her sexual experiences and development?"
These are wonderful questions that represent your curious mind and capacity to discover the un-talked-about, an essential quality for doing in-depth psychotherapy. I too explored this theme with Theresa through both circuitous and direct phenomenological and historical inquiries. There is no evidence of any childhood sexual abuse. She had a normal, but somewhat late, sexual development. There seemed no need to mention this in a case study that was already lengthy but I appreciate your raising such an important question. There is so much that I have not put into writing, such as several verbatim dialogues that would demonstrate our transaction-by-transaction interpersonal contact through which her unconscious experiences found verbal expression and meaning.

You say that the case study had "no signs of uncovering and verbalizing transference-countertransference matrix." Prior to your writing this comment, your previous five paragraphs identified, detailed, and illustrated a relational-psychotherapy that was a direct consequence of my careful attention to and use of transference and countertransference. This leaves me somewhat confused. I am always working within a transference-countertransference milieu; that is how I choose the nature of my phenonomological inquiries. For a more detailed example than what I provided in the written case of Theresa, please see the article "Integrating Expressive Methods in a Relational-Psychotherapy" (Erskine, 2010). I would like to have heard more from you about how you would have uncovered and facilitated verbalization of the transference.

Central to my ethical commitment is a constant introspection: 'What feelings, desires, history, or future dreams are being stirred within me? What are my own experiences as a parent and grandparent? What is the influence of all that I have read, films I have seen, and music that I know? What theories seem to be *experience–centered* rather than just speculation? How am I affected by other clients with whom I have worked?' I judiciously use the answers to this private inner questioning, along with the client's account, to form my series of inquiries.

I have discovered that with constant phenomenological inquiry clients have much less need to enact childhood experiences. With inquiry we are constantly discovering the client's inner process of affect, associations, implicit memory, past experiences, developmental needs that have been thwarted, and archaic organizing-functions that were formed to compensate for relational disruptions.

As I increasingly engaged Theresa with phenomenological inquiry and attuned responses, she became less driven to enact unconscious interpersonal conflicts.

I am constantly looking for the client's expressions of unconscious processes and transferences, not only in the enacted behavior or transactions that may reveal expressions of early development, but also in their escalations or immunizations of emotions; in their physiology and body movement; in their stories and metaphors; in their fantasies, hopes and dreams; in both their internal and external interruptions to contact; and in the emotional and personal responses engendered in me.

Masa, your last long paragraph is intriguing and has stimulated soul-searching and memories of my many encounters with Theresa. I think you may be reflecting a cultural difference and/or speculating from theory when you interpret the respectful phrase "It is my pleasure to be here for you" as inducing in the client the illusion "that he may be in love with her...this may be also mixed with sexual desires and fantasies". Nevertheless your confrontation is thought-provoking. In searching my own experience, I find that your comments do not reflect the quality of therapeutic relationship that I had with Theresa. It was my intention to neutralize Theresa's experience of "no one is there for me", and to convey to her that she is a person of value. Seeing her on a Sunday morning in an emergency session and saying those words was within the context of many months of Theresa remembering her mother's caustic comments and feeling worthless: "I'm unlovable", "I'm a piece of shit", "Something's wrong with me". If there is any concern about a transference-countertransference merger it may well be that I, at times, felt like a protective father or good uncle to a neglected, ridiculed, and physically abused little girl.

Although I did not think it was pertinent to write about it in my case study, a couple of sessions later I asked Theresa how she experienced my saying, "It is my pleasure to be here for you". I inquired extensively about what she experienced inside when I greeted her with those words. In this session she was able to identify that her comment "You do it for the money" was because she was "feeling so scared and ashamed of needing anyone". I made it a part of many sessions to inquire about how Theresa perceived the intricacies of our relationship. This is the essence of a relational psychotherapy.

A Short Conclusion

This has been a thoughtful and exciting dialogue with each of you: Ray, Grover, Jim, and Maša. I wish we were face-to-face so I could feel your emotional reactions, share with you my thoughts and feelings, describe more detailed memories of my interactions with Theresa, and hear much more from you about

how you treat similar cases. I look forward to your reactions to Part 3, *Relational Healing of Early Affect-Confusion.*

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