Is it possible to integrate humanistic techniques into a transference–countertransference perspective?

by Michael Soth

Soth, M. (2004) “Integrating humanistic techniques into a transference–countertransference perspective” – A Response to ‘Humanistic or psychodynamic – what is the difference and do we have to make a choice?’ by Lavinia Gomez

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This was written as a response to a brilliant and helpfully clarifying article by Lavinia Gomez 'Humanistic or psychodynamic – what is the difference and do we have to make a choice?', which tackles this difficult theme in a non-dogmatic and fairly comprehensive fashion. I do, however, argue against one of her conclusions, based on a different interpretation of what we might mean by 'containment' and 'enactment'.

Dear Lavinia,

I am responding to your article in ‘Self & Society’ which I enjoyed reading. I found it inspiring because it both clarified things for me and got me reflecting about where I stand on these questions as well as thinking further about the finer differences and inherent vicissitudes.

Thank you for formulating the issues regarding the humanistic-psychodynamic debate so clearly and helping us forward with an important discussion. These recurrent questions, conflicts and polarisations have the potential to keep all of us psychotherapists stewing and running around in circles, or to galvanise us into a position from which we can make a concerted contribution to a social situation which is badly in need of psychological depth understanding.

I agree with much of what you say, e.g. that the divisions do not at all neatly line up and that “things are more complicated than they might appear” (i.e. than they might appear from within the traditional polarisation between humanistic and psychodynamic approaches).

I found the distinctions and conceptualisations you propose (‘alongside’ and ‘opposite’ therapeutic positions) useful, and you succinctly draw out the essential differences and entrenched misunderstandings, and do not get caught in the standard polarisations. I was relieved and delighted to read your comments arguing against “the therapeutic process as the internalising of a new parental figure”, which is a notion that has long bothered me. Your research into Ferenczi and how the early polarisations within psychoanalysis pre-figure the humanistic-psychodynamic debate I found interesting - a background that deserves to be widely known.

And your concluding discussion on ‘containment’ is, in my view, essential to any attempts at clarifying the differences and possible areas of integration between humanistic and psychoanalytic approaches. In order to take the discussion further in this direction, I would like to offer the following comments.

Whilst I agree with large parts of your article, as a fellow traveller in working within these productive and as you clearly say: inescapable - tensions, I also find myself disagreeing with some of your statements; some of them, I think, may actually be getting in the way of developing more precisely the notion of ‘containment’.

I wholeheartedly agree that ‘containment’ is a crucial notion around which a lot of learning across the approaches can happen, and maybe some degree of integration. For that purpose we obviously need to do justice to the notion of ‘containment’ mainly as a relational process (which I think you do unequivocally). To me, that implies a process that cannot be achieved or ‘engineered’ unilaterally by the therapist. I emphasise this because as soon as we are talking about ‘containment’ as one (or even the) transformative factor in therapy, there is always the danger that people then latch onto it, trying to turn it from a psychological, relational and essentially uncontrollable notion into another literal, normative, objectifying goal.
As soon as I grasp at it, wondering how to ‘make it happen’, turning it into another therapeutic objective (or NVQ) to pursue and legislate around, psyche - and containment of anything unconscious - is out the window.

I see you as trying to avoid this danger by talking about it as “crossing many ordinary dichotomies of thought”, “above all an exchange” and using terms like “nebulous”, “mysterious”, “enigmatic”.

However, as a therapist in the Body Psychotherapy tradition, I would prefer to talk about ‘containment’ not as a vague and elusive notion, but in holistic terms as a body/mind process. If we take the mother-infant dyad as the prototype of all containment, infant observation and modern neuroscience are increasingly telling us just how interlinked emotional and relational processes are with physiology, brain chemistry and anatomy. Emotional attunement and mirroring (as important ingredients in the complex process of ‘containment’) depend on dyadic interactions which seamlessly reach from biochemical to hormonal to vegetative to muscular processes through non-verbal exchanges right to symbolic and mental communication.

Why should we not think about the client-therapist relationship in the same way?

**This is what I would like to propose as a first step:** attending to the relationship as a body/mind process.

When we do this, it becomes apparent that containment is paradoxical: in order for containment to occur, it needs to break or get lost; in order for the working alliance to exist, it needs to fail. The recognition of containment as inherently paradoxical is my second proposition. Although it is a precious, transformative process when it happens, I think we agree that containment cannot be achieved by will or strategy: it can not unilaterally be made to happen.

However, I propose that embracing its paradoxical nature creates a phenomenological ‘clearing’ in the psychotherapeutic wood which often we cannot see for the trees. If we can attend phenomenologically to the detail of its paradoxical manifestation in the relationship moment-to-moment, how containment seems present one minute and gone the next (i.e. the dialectic of its coming-into-being and its destruction), I think it is possible to be very precise about it as a relational body/mind process.

This is not the space to go into detail about this, but for starters this would involve attending to parallels between the complex web of inner relationships / object relations (i.e. the subjective, emotional world of psyche) and the complex matrix of body/mind relationships (spontaneous and reflective processes) in both client and the therapist, including the autonomous nervous system (ANS) of both.

The subtlety of the relational process as a body/mind exchange was not recognised at the time when the classical analytic rules of abstention originated (which were - as you describe so well - partly a reactive and reactionary move, anyway). With a more precise awareness of ‘containment’ as a relational body/mind process, I believe we can lift some of these restrictions against ‘active techniques’, but with provisos and conditions. One of my main disagreements, therefore, is with your formulation of therapeutic constraints and dangers in a way which effectively rules out ‘non-interpretive’ techniques if one is trying to acknowledge and work with the transference. This is not at all to dismiss your warnings against the dangers and confusions arising from Ferenczi-style humanistic attitudes and “multi-positional approaches” - I agree with your misgivings. I have no doubt that, traditionally, humanistic values, intentions, strategies, interventions have been used to side-step the transference - often with disastrous results. You are very clear about how such a stance gratifies the therapist by enacting the positive, idealised object (“Ferenczi tried to be everything to his clients: not just a stand-in for their ancient transference hopes, nor simply an equal partner alongside them as they struggled, but also the parent of their dreams” which “he and they thought they needed”), as was Freud who accused Ferenczi of trying to be “the better mother” than himself.

If we recognise - as you describe - the importance of “providing an empty relational space in which the unconscious dynamics can take form”, i.e. the importance of allowing ourselves to be constructed as an object by the client’s unconscious, we realise that in significant ways the therapist is not free to choose at all. That is, of course, an insight which the humanistic tradition - with its emphasis on choice, potential, responsibility and agency - has been struggling with (and against) very hard over the years.

In my view, most humanistic approaches still carry shadow aspects of their original protest against psychoanalysis, manifest in the implicit assumption that the therapist is free to ‘choose’ - free to choose such therapeutic variables as the most effective techniques, the most appropriate stance, intervention or ‘treatment strategy’ or the mode of relationship (e.g. reparative, authentic, transferential, working alliance, etc).

All of these notions are frequently used in a fashion which suggests much more ‘freedom of choice’ for the therapist than I think exists. Often, such
apparent freedom of choice is oblivious of, ignores or vastly underrates the extent of the transference or boils down to the - in my view: omnipotent - assumption that the therapist can override or overcome the transference.

I agree with you that as humanistic therapists we are not free to ‘choose’ to ‘pick’n mix’ stances (to work from an ‘opposite’ stance and then to ‘choose’ techniques which are intended to create an ‘alongside’ alliance).

But then I don’t think any therapist who recognises transference at all is ever really free to do anything. If I have the slightest inkling about the extent of the transference and want to avoid playing into or against it altogether, I would have to be sitting there in a catatonic state after two minutes because nothing I do or do not do is outside the transference (as you demonstrate so eloquently in your example of depriving the client of oxygen). So in my view restricting myself in any way (theoretically, technically) is not, in itself, the answer to recognising the dangers of the transference.

So whilst I agree that the therapist’s notion that they are free to ‘choose’ has disastrous consequences, I just do not agree that these dangers are inherent in the techniques themselves, but in the stance, attitude and frame of mind in which we - I include myself in this - have traditionally used them. Humanistic techniques have rarely been used within a framework which fully appreciates the extent of the transference.

Therefore, I do not agree with your statement: “If the therapeutic route we choose is through the ‘opposite’ position, we are confined to a psychoanalytic approach of some kind, because this is at present the only theory which explains what happens if we do this.”

We are confined to psychoanalytic technique only if the only other alternative is an attitude which believes - or implicitly acts as if - the therapist’s intention can override the transference. If we recognise (and surrender to the recognition) that the therapist’s intention to place themselves ‘alongside’ is not necessarily being received by the client or may be misconstrued, whatever our technique, the practical/technical questions become less polarised (and less relevant).

But even psychoanalytic technique (e.g. Object Relations approaches which “eschew non-interpretative interventions”) does not get us out of this conundrum (as I am sure you are well aware): I may be intending to direct my interpretation at the client’s ‘adult ego’ (or whatever we want to call it because that’s the part that is supposed to be making use of my verbal offering), but a moment later I realise that the client took it as a criticism. I offer the interpretation because I am assuming a degree of ‘alongside’ working alliance which I then find out does not actually exist, or not sufficiently.

The actual alliance is a rather mixed and fragmented bag, depending on the client’s unconscious more than on my intention: maybe it was only an unconscious part of the client - as betrayed by a spontaneous gesture, a subtle contraction - that registered criticism, even whilst consciously they were agreeing with the interpretation, saying: “yes, that’s very true”.

Clearly, in this moment it is not up to me to ‘choose’ to be ‘alongside’ or ‘opposite’. Does that make me give up interpretation altogether as a technique?

No, it just means that I must disabuse myself of the naive belief that it is up to me to choose anything in a quasi-medical, apparently separate, pseudo-objective fashion. It just means: I can never simply assume that what I say or do - regardless of my particular therapeutic intention and rationale (psychoanalytic or humanistic) - is having the intended effect, or is only having the intended effect (and no other effects), or - for that matter - is having any therapeutic effect at all. Indeed, it could be argued that most interventions have both therapeutic and countertherapeutic effects at the same time. The more powerful an intervention, the greater its potential for transformation and the greater the danger that it will also threaten containment.

It is the claim and perspective of Object Relations (as I understand it) that all therapeutic thinking, feeling, reflecting, contemplating, strategising etc. (whatever the technique or approach) arises relationally, and therefore needs to be reflected upon in terms of transference and possible projective identifications. In simple terms: I can never be sure who (or what) it is within the dynamic that is generating a therapeutic impulse within me, and therefore, I cannot know in advance whether it will be ‘therapeutic’ or not. The proof of the pudding is in the eating.

The Object Relations perspective helps us realise that our therapeutic intentions and reflections are ‘over-determined’ and have several, sometimes contradictory, meanings: all questions regarding our therapeutic diagnosis or agenda, all therapeutic impulses to create any effect or ‘choose’ any type of relationship (‘alongside’ or ‘opposite’) are - in your words - “constrained” by the transference and arise in relation to it.
In this perspective, what matters more than the particular technique is the way the client’s unconscious receives and experiences it - that is as true for interpretation as for any of the multitude of ‘humanistic’ interventions. So to throw out the baby of the plethora of ‘humanistic’ techniques with the bathwater of ‘humanistic’ naivety á la Ferenczi is, in my book, not consequentially following through our analysis of the constraining effects which the transference has on the therapist in any orientation, stance or technique.

I do not usually like polarising around the issue of touch in psychotherapy (and I certainly resist Body Psychotherapy being reduced to its special techniques, including touch), but as it is the most controversial non-interpretative intervention, let’s take it as an example.

Even if I touch a client (and there may be all kinds of ‘humanistic’ approaches offering me different kinds of rationale for it), I do not necessarily have to lose sight of the transferential enactments which are also going on. Even if the client inevitably misinterprets touch through the transference, even if it does engender unfulfillable longings and promises (which are there, anyway), even if touch has the opposite effect from that intended or expected (as can happen with an interpretation), even if the whole psychotherapeutic field fantasises about touch as automatically gratifying, there is nothing to stop me attending to the phenomenological detail of the actual relational experience: what does it actually feel like? How is it actually being received, regardless of how it was intended?

Touch can be as multi-faceted, ambivalent, duplicitous, hostile, invasive, controlling as any verbal statement - in my view, there is nothing about touch that makes it inherently simple or gratifying, other than everybody’s longing for it and idealising fantasies about it (and that includes humanistic and psychoanalytic practitioners). I am not actually arguing for or against touch at this point, but am trying to de-construct simplistic assumptions about it.

I suggest that in principle we can use any technique as long as we do not believe that we can omnipotently achieve our intended outcome (however worth while that outcome may be and however directly - according to the textbook - the technique ‘should’ lead to it).

The possibility of therapeutic transformation, in my view, does not inhere in any therapeutic model or technique. Precisely because any model or technique can (and does) acquire a counter-therapeutic effect or function in the relationship, I conclude that the potential for transformation inheres in something beyond theory or technique (i.e. maybe in the - as you call it - “nebulous” notion of containment, see below).

If we pursue the notion of transference to its conclusion, I therefore claim that it is possible to use any technique, as long as we do not believe it to be therapeutic in and of itself, and as long as we are attending to its countertherapeutic effects (i.e. transferential re-enactments). These effects are not a function of the therapist’s choices or intentions (who are themselves subject to transferential pressures), but a function of the unfolding transference process and its containment.

As a consequence of all of the above, it seems to me, therefore, that you contradict yourself by saying...

- on the one hand that the “true division in psychotherapy is more practical than theoretical”, and that working from within the ‘opposite’ position necessarily requires refraining from active techniques which cloud the therapeutic space
- and on the other hand that containment has nothing to do with technique.

If you formulate containment as the crucial ingredient in transformation, then it seems to me that the true division is between containment and its opposite: you repeatedly make it clear that the greatest therapeutic danger is an acting into or an acting out of the transference (e.g. when you talk about “powerful and primitive expectations are lasered on to the therapist, who is expected not just to understand but to fulfil them. Disappointment then appears as anything from a horrendous betrayal to an imminent threat to her [i.e. the client’s] continued existence”). Such transference or countertransference enactments occur when the therapist mistakenly believes in the therapeutic effects of their behaviour and intervention whilst being oblivious of the simultaneous countertherapeutic effects.

In my view the true division is between containment and re-enactment, and I think there is a lot of mileage in formulating the psychotherapeutic endeavour as a paradoxical journey between the Scylla and Charybdis of containment and re-enactment.

An important ingredient in the transformative experience of ‘containment’ is the therapist’s surrender to their helplessness in the face of the transference; and, equally, the therapist’s surrender to being in conflict, torn between conflicting therapeutic impulses.
Precisely because I recognise the validity of your statement that “there is no final answer to the dilemma we are faced with as therapists” (i.e. between ‘alongside’ and ‘opposite’ positions, or - as I would prefer to say - feeling torn between containment and re-enactment), I can become interested in that never-ending dilemma in the moment: do I follow my impulse to respond spontaneously, reactively (and what some people might call: authentically), as if I am just (naively) responding to any human being, as if the transference was not there OR do I follow my impulse to respond in recognition of the transference and all the constraints, complications and double-takes which that involves? And what happens when I recognise that usually both sides of my conflict (i.e. both my spontaneous impulse and my self-conscious hesitation) mirror the client’s internal world (i.e. that I am drawn into enactment either way), and that I am trapped either way?

If we accept that it is not up to the therapist to ‘choose’ to be either ‘alongside’ or ‘opposite’, but that the client’s total experience of the therapist is a mixed bag of usually conflicted fragments (partially ‘alongside’ versus partially ‘opposite, partially conscious versus partially unconscious), then our own internal conflict as therapists gives us the most immediate route into the fullness of the “characteristic relational quagmire”. The therapist’s ongoing, moment-to-moment dilemma becomes the heart of the therapeutic position (rather than any theory or technique which are all only grist to the mill). Beyond recognising that “taking either to an extreme carries grisly therapeutic hazards”, and accepting that the dilemma cannot be eased by a priori technical restraints (i.e. the avoidance of certain techniques), I can now say that I do not want this dilemma eased, anyway, because it is the foundation of my work.

As I’ve written elsewhere, I am working towards an holistic body/mind formulation of countertransference in which the body (i.e. both the client’s and the therapist’s body) “rather than being used as a gratifying or cathartic therapeutic shortcut which avoids the intensity of the transference, can be seen to constitute an avenue into the full experience of the transference/countertransference process and its relational sources in early development”. What helps me perceive the ways in which the therapist a) intends to be ‘alongside’ or ‘opposite’, and b) in which ways the client actually experiences the therapist ‘alongside’ or ‘opposite’, is my attention to the spontaneous body/mind relational process - along the lines of your proposition: “Body Psychotherapy might foster a somatic dimension to our awareness of ourselves and the client”. Maybe all I am arguing for is already contained in that sentence.

I remember that TV advert which claims that 93% of communication is non-verbal - I would prefer to make those count, rather than restricting myself to squeezing the last drops out of the remaining 7%. Containment, in my view, does not come about through the therapist’s intention or choice of a particular stance or avoidance of particular techniques. It requires something more difficult and paradoxical than that to profoundly affect the therapist’s presence (which - as you describe and I agree - is a crucial ingredient in containment).

If we do not want to leave notions like ‘containment’ or the ‘quality of the relationship’ amorphous, I think a more paradoxical formulation of containment along with attention to the transference-countertransference process in body/mind terms give us access to a huge, and often neglected, chunk of the therapist’s presence.