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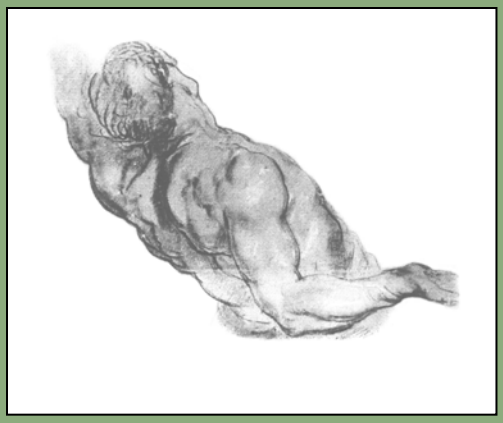

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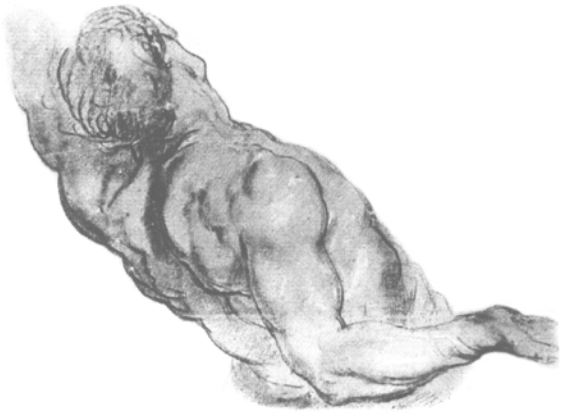

USABP Mission Statement

The USABP believes that integration of the body and mind is essential to effective psychotherapy, and to that end, its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity. (revised October 1999).

Transference and Countertransference in Organismic Psychotherapy

Anna Maria Bononcini & Mauro Pini

Abstract

The article deals with the concepts of transference and countertransference as used in the field of Organismic Psychotherapy, focusing attention on the relationship between its theoretical model of reference and technical repertory. Organismic Psychotherapy, as conceptualized by Malcolm Brown, is characterized by systematic attention to everything occurring at the somatic level during the sessions: the therapist is trained to identify the relationship between what s/he experiences physically and what the patient expresses both verbally and non-verbally. Furthermore, the therapist must be capable of transforming his/her own psychic wounds into a vantage point for the observation of the client. This enables him/her to empathize with the client's wounds in a process that eventually leads the latter to self-actualization.

Keywords

Organismic - Transference - Countertransference - Malcolm Brown

> *If you want to find out anything from the theoretical physicists about the methods they use, I advise you to stick closely to one principle: don't listen to their words, fix your attention on their deeds. To him who is a discoverer in this field, the products of his imagination appear so necessary and natural that he regards them, and would like to have them regarded by others, not as a creation of thought but as given realities.*
>
> *Albert Einstein (1933)*

From organismic theory to its clinical practice: scenes from a difficult marriage.

One of the more controversial topics in Organismic Psychotherapy, a body-oriented approach introduced by the American psychologist Malcolm Brown (1979, 1990), concerns the status of its metapsychological constructs. The question of whether organismic concepts like "endoderm", "the closed cortico-spinal circuits", "the four being centres" or "the full embodied soul grounding" (Brown, 1990, pp. 312-315) are to be considered as metaphors, concrete psychophysiological processes or bodily events, constitute a still unresolved issue, one much debated within the Italian Society of Organismic Psychotherapy (SIPO).

In more general terms the question is a very old one, going back to when the philosopher Kant used the term the "thing-in-itself" to indicate the fundamentally unknowable nature of objects in the material world, opposing this concept to reality as it appears to the mind - the object as *phenomenon.*

The modern history of psychology, with its difficulty in establishing itself as an independent discipline, has been distinguished by the elaboration of divergent theoretical approaches to the understanding of human behavior and personality. These systems often show incompatible ideological orientations concerning the human being: it is the realm of psychological speculation, aimed at gaining knowledge of the ultimate determinants of the human condition, an area far beyond the experiential field of clinical data. Rather, the modern psychodynamic perspective tends to stress the influence of the subjective experience of the author on the theorization process behind meta-psychological models (Atwood & Stolorow, 1993; Carotenuto, 1998). Given this background, the age-old problem of the relationship between metapsychology and clinical practice is anything but resolved (Klein, 1976; Reppen, 1985; Fabozzi & Ortu, 1996; Goldberg, 2000).

In psychotherapeutic practice, as Reich affirmed in the first chapter of his major work Character Analysis (1933), the psychotherapist is faced every day with situations which often cannot be adequately dealt with by recourse either to the theoretical knowledge acquired during training or to clinical experience alone. The problem could be seen as one of how to establish the possibilities and limitations of the application of theory to clinical practice. For a psychodynamically oriented therapist, the time and place of the therapeutic enterprise are those shared with the patient in the bi-personal field provided by the setting (Gill, 1994; Carotenuto, 2003). On the other hand, if the therapist cannot rely on a comprehensive theoretical model, he/she will encounter insuperable difficulties of orientation within the complexity of the intrapsychic and interpersonal vicissitudes involved in treatment.

This is just as true in the case of Organismic Psychotherapy since its "paradoxical" theoretical guidelines, similar to those of Gestalt Therapy (Zerbetto, 1994), advise against the use of any theoretical reference point in the sessions, in order to concentrate exclusively on the *here-and-now* of the relationship. But in this case too, it must be emphasized, we are talking about an option regarding the *theory of technique* and not about simple adherence to an assumed "objective reality", or to use Kantian terminology, to the "thing-in-itself".

Even Jung (1910), while insisting that "theories in psychology are the very devil", recognized that the clinician in some measure needs such models, both for their heuristic value and as a guideline. The therapist is always armed with a series of theoretical reference points (Holt, 1989, 2003), however much his training may have discouraged him from taking too much interest in them, as in the organismic approach.

This leads us to ask what, in the last analysis, determines a cure or, if preferred, what stimulates the process of *self-actualization* as conceived by humanistic psychology. Is it the theory of reference, the knowledge of a repertory of techniques, or the relationship that the individual therapist is capable of establishing with the patient? And, since it does not seem reasonable to insist on making a choice among these - the school followed being simply the result of personal choice - what is the relationship between the personality of the therapist and the theoretical knowledge acquired during training, and in what way might this influence the therapeutic relationship?

The meeting between therapist and patient: from psychoanalysis to psychotherapies of a humanistic orientation.

More than any other discipline, psychoanalysis is concerned with the study of the relationship between therapist and patient. The terms transference and countertransference, coined by Sigmund Freud himself, represent the classical constructs that psychoanalysis uses to describe what happens in the bi-personal field of the setting. Despite the fact that the meanings attributed to these definitions have evolved constantly over the years in the psychoanalytic literature, they continued to be considered as two essential components of the terrain of contemporary analytic technique (Pine, 1998; Power, 2000). In recent times, transference and countertransference have tended to be redefined in terms of an all-embracing meaning, instead of in the narrower sense understood by classical psychoanalytic theory (Eagle, 2000a). In particular, the concept of transference has changed. Today it no longer defines the distortions and projections of the patient with regard to the analyst seen as a blank screen; rather it approaches the idea that the transference reactions of the patient are a response to plausible readings of signs that inevitably escape from the analyst. The underlying idea is that no one can truly function as a blank screen, including analysts: consequently the transference-countertransference interaction is considered a fundamental aspect of therapeutic action. (Eagle, 2000b; Jones, 2000). At the same time, countertransference is no longer seen as an obstacle to analysis but rather as an indispensable tool. As Carotenuto wrote (1986), it represents a kind of "Kant's dove" for the analytic enterprise.

The various body psychotherapies of a humanistic orientation, which include that of Malcolm Brown's organismic approach, have embraced some notions derived from the psychoanalytic theory of object relations. Yet, with the advent of humanistic and experiential forms of psychotherapy in the 1960s, therapists have tended to minimize the role of transference in treatment (Glickauf & Chance, 1998); consequently, the theme has received scant attention by the organismic, with some exceptions (see: Moselli, 1990; Downing, 1995).

Organismic Psychotherapy recognizes that the relationship with the caregiver is one of the primary needs of human beings. If such a need is unfulfilled in the child by a mother incapable of carrying out the functions of "holding" properly, it is regarded as being *the* cause of all subsequent problems. It can reasonably be claimed that the client-therapist relationship is not less important in the organismic approach than it is for the theorists of object relations (Mitchell, 1988; Smith, 2000). In Brown's thinking, the capacity of the therapist to feel empathy for the experiences of the patient is fundamental to the efficacy of the therapeutic act and an indispensable precondition for the application of whatever body-oriented methods are chosen (Brown, 1990).

Nevertheless, it is equally important that the problem seems to be elsewhere. Psychoanalysts, whether they adhere to drive theory, attachment theory, or Kohut's self psychology, possess a wide range of tools (concepts, precepts, speculations, instructions, the analysis of his/her own transference carried out previously, etc.) which give them access to a map which lays out, however crudely, the most difficult areas of the territory. The holistic-organismic tradition, however, from the historical contributions of Goldstein and Angyal, to the positions of Rogers, Maslow and Brown has not yet carried out a sufficiently systematic investigation of the therapeutic relationship.

Several authors agree that the analysis of transference and countertransference involves a wide range of techniques (Gill, 1982; Gorkin, 1987; Stolorow, & Atwood, 1989; Jones, 2000). Humanistic psychologists have always shown a certain reluctance to use the term "technique" because it suggests a kind of aseptic mode of approaching the patient that is thought to be inadequate and ineffective with respect to the aims of therapy, which are to encourage *self-actualization*. Precisely because of this methodological reluctance, Organismic Psychotherapy does not believe in dictating therapeutic protocols to be followed uncritically without taking into account the subjective positions of client or trainee. An aspiring organismic psychotherapist is trained to develop an approach founded on an awareness of his/her physical and mental experiences that would include the overcoming of the neurotic defense mechanisms, which inhibit *self-actualization*, thus obtaining an overall restructuring of the personality rather than the curing of any given symptom.

Transference and Countertransference in Organismic Psycho-therapy

> In order to examine the distinctive features of the organismic approach to the therapeutic relationship, we intend to keep to psychodynamic concepts as a means of comparison. More precisely, the terms transference and countertransference will be used in their widest sense, which does not refer exclusively to the more or less pathological factors arising from the client's or the therapist's past life. Transference refers to everything that happens to the client in his/her relations with the therapist, either at the conscious or at the unconscious level, whereas countertransference is the situation mirrored in the therapist (Carotenes, 1988).

The systematic attention given to bodily sensations, both of client and of therapist, is the element that differentiates organism psychotherapy as a therapy, from exclusively verbal psychotherapies. The therapist is expected to identify the relationship between his/her bodily experiences and what the client expresses both at a verbal and at a non-verbal level; the mental dimension is not therefore the only area of investigation of the relationship, but must necessarily be integrated with information coming from non-verbal behavior. The therapist, furthermore, puts trust in the "wisdom of the organism" of the client, that is, in his/her capacity for self-healing: the task of the therapist is to encourage an awakening by overcoming neurotic defense mechanisms.

This confidence guides organismic psychotherapists in their work and has consequences for their way of being within the therapeutic relationship. The attitude to take in the encounter with the client is one designed to accept, accompany, mirror and give back what happens in the *here-and-now* of the session, at a mental and physical level. It is taken for granted that this should be achieved without colluding with the neurotic ploys brought into the relationship by the client as part of his/her defense mechanisms. Using organismic terms, these ploys express the closed "cortico-spinal circuits" (Brown, 1990, p. 313); that is to say they are a modality of psychic function isolated from the totality of the organism operating in the service of the false self. The concept has some significant similarities with Winnicott's (1949) definition of "mind-psyche".

For psychodynamically-oriented therapists, a relevant problem in this field is one of being aware of what is being projected onto the patient, avoiding either colluding or clashing with him/her (Shafer, 1983; Gorman, 1991) - not an easy matter for anyone. How can this be achieved? What can help us in the choice of the most suitable therapeutic strategy for that particular individual, or more realistically, to realize quickly when we are navigating in treacherous waters? The organismic psychotherapist initially supplied very few answers and Malcolm Brown's way of seeing the question seems only to have been modified in recent times.

Here is what Brown (1990) writes in Chapter Six of his book on the evolution of the therapeutic relationship: "The wise body psychotherapist….always perceives and relates to the client from his own alive and intact primary dynamic feeling centres….the therapist's half-conscious/half-unconscious cultivating of a therapeutic relationship thus rests upon the final flowering of his-her own primary dynamic feeling capacities in their more advanced stages of individual transformation"(p. 221).

These statements may provoke a shiver of apprehension: who will ever be capable of so much? Taking these affirmations too seriously would result in a superhumanization of the organismic psychotherapist. At the same time the statements say very little about the risks and difficulties of the relationship. We know that choosing to dedicate oneself to a profession (that of therapist) which involves being face to face with emotional suffering for many hours every day, can only spring from an attempt to heal one's own "wound" and hence to enter into contact with the most problematic and painful parts of one's own past; the important thing is, as Carotenuto suggests (1988, 1998), to be capable of transforming this wound into a window, a privileged observation point making it possible to lead the client out of the tunnel of neurosis. There is no indication of a guideline beyond ourselves to tell us when we are sufficiently restored to health and, if we look into ourselves, it may be that the road to becoming "good-enough" therapists would seem to us to be like an ascension towards the status of demigods. This is not to everyone's satisfaction. Not everyone feels they have the appetite for such a thing.

A systematic reflection on the theme of transference/ countertransference in Organismic Psychotherapy may be hindered by the fear of encouraging a cold mental attitude, devoid of empathy toward the patient. To alleviate this concern, however, in a seminar dedicated to the practice of psychotherapy after the age of sixty, Brown (1992a) states:

> Let me to ferret out a few more of these unnatural and demanding costs upon one's soul. The most pervasive one is that, to the extent that you must give your whole being and soul to those who tend to either over-idolize or imprint themselves upon you in the form of their idealized projections and identifications, you are forced by circumstances to adopt a mirrored self image that is too falsely lofty, too exaggeratedly exalted, and one-sidedly slanted towards behaving as if you were perfect….the nature of the unconscious interpersonal transference is such that it tends to absorb and swallow up into a enormous web the psychotherapist's own self-image during the course of his or her conscientious efforts to identify empathically with the point of view of the patient. We are both seduced and forced unwillingly…. to acquire almost a superhuman set of

> imaginative and feeling sensibilities that are indeed partly real but also partly fabricated and artificially created….we have no choice but to mirror for them a kind of fully functioning perfection of beingness and at the same time an other-worldly spiritual saintliness ….If the therapist must maintain his role as a superior human being and wise savior he also cannot tolerate facing or opening himself at any level to the patient's negative transference (Brown, 1992b).

Brown rightly warns the therapist of the risk of unconsciously building a messianic image of himself to the point of encouraging the client in his need to project superhuman images and powers onto the therapist. He recognizes a series of professional risks to do with the yoking of the unconscious projections of the client to the equally unconscious self-image that the therapist may be cultivating. Again, the terms transference and countertransference are used here, as they would be understood in psychoanalysis. Brown recognizes, furthermore, the existence of negative transference and the need for the therapist to deal with it. This latter aspect is no small matter because, practicing a style of therapy based on Rogers' assumptions of the empathy and the unconditional acceptance of the client, one might legitimately suspect that the organismic psychotherapist might be distracted enough to forget that the negative components of transference are always present and that, as Reich (1933) reminds us in his systematic research on this topic, they should be dealt with, as should the positive and idealizing aspects. The classic studies of Schafer (1983), Kernberg (1984) and, more recently, those of several French psychoanalysts, Maugendre (2000), Kaswin-Bonnefond (2000) and Porte (2000), confirm this assumption.

Organismic Psychotherapy shares with Jungian analytic psychology the conviction that the modalities that are used to approach mental suffering essentially reflect the personality and unresolved conflicts of the therapist (see: Carotenuto, 1986, 1988, 1998, 2003), who operates more as an artist than as a scientist, since the only instrument he has available for practicing his profession is himself, his personality. However, there are substantial differences between holistic-organismic notions and Freudian theory. Whereas Freud had an essentially deterministic vision of humanity, linked to late nineteenth century scientific tradition, Brown's organismic approach has its origin in Rogers and Goldstein's (1934) assumption that each individual has within him/herself the potential conditions for healthy and creative development and that the failure to realize this potential, the cause of mental problems, is attributable to negative environmental influences (Hall & Lindzey, 1978). The risk is that this optimistic vision of humanity may lead to blaming the most unpleasant and worrying aspects of our personality on the system of the false self and thus on the conditioning of the external environment that has not accepted us as it should have, rather than on our basic nature. The consequences of this can be a tendency to give less importance to these aspects, at least in writing and in theory with some important exceptions within the organismic approach.

In her master's thesis, Katherine Ennis Brown (1987) compares various aspects of organismic and Jungian theory, in particular that part of the personality that analytic psychology calls the "shadow" and that Jung himself (1917) describes with the following words in his "Psychology of the Unconscious": "By shadow I mean the "negative" side of the personality, the sum of all those unpleasant qualities we like to hide, together with the insufficiently developed functions and contents of the personal unconscious. " (Brown, 1987, p. 38).

Ennis Brown in this and later writings (1995), agrees with Jung in considering the unveiling of the shadow elements as a necessary step, although a painful one, towards self-knowledge. This is an indispensable aim for any psychotherapy, because the shadow contains a lot of human potential which is needed for self-actualization. There is a lot of strength, a lot of energy in the shadow that we need to have at our disposal so that life does not find us defenseless. Various factors make this process of integration problematic: the extremely emotional and unconscious nature of shadow elements that makes them difficult to deal with, the archetypal basis of some of them, and the defensive tendency which makes us project them outside ourselves. Furthermore: the archetype of the shadow is the devil and

> The discovery of our shadow forces us to contemplate anew the problems of good and evil. If we take up the challenge, it becomes an inner, moral struggle between collectivity and individuality, which can shake our perceptions of ourselves to the core (Ennis Brown, 1987, p. 40)

Ennis Brown's conception is not at all the same as the philosopher J.J. Rousseau's idea of the "noble savage" (Rousseau, 1755), whose innocence can only be compromised by contact with an unhealthy civilization. Ennis Brown affirms that the aim of the psyche is not the achievement of a condition of perfection, but to become "whole", which involves regaining possession of precisely those parts that have remained in shadow. This means that among the guidelines for the therapist, whose official task is to share part of the journey towards the integration of personality with the client (Carotenuto, 1992) until he is able to carry on the journey alone, are the following:

> Theories and knowledge may help the therapist to understand the patient and to question what is happening between him/herself and the patient, but they are not helpful in establishing a relationship between them. It is

> the therapist's ability to perceive and relate to the psychic reality of the patient that will provide the contact ground of the relationship. On this ground, they will meet, and there the conscious and rational intentions, which both have brought to the encounter, will be modified by the unconscious and irrational aspects of their personalities (Ennis Brown, 1987, p. 123).

These statements reveal a way of interpreting the relationship between theory and practice, between knowledge and experience that may clarify some of the questions raised earlier, in the first part of this essay. Theoretical knowledge is not there to serve the client but the therapist. It helps the former to understand, to examine what is happening within him/herself, in the other person and in the relationship. From a modern cognitive-constructivists perspective it can be said that a theoretical frame of reference has the adaptive function of giving structure to the experience, providing an orientation and a form of knowledge of the world from different aspects of the environment (Neimeyer, 2002). It is taken for granted that it is the responsibility of the informed psychotherapist not to abuse this knowledge in his/her relations with the client, being helped in this by the paradoxical theoretical instruction, already discussed, to leave theory out of the sessions.

One of the most useful tools in pursuing this aim will be the acquisition, through training and adequate experiences, both of the development of an awareness of one's own emotional reactions to the expressions of the client, and the capacity to maintain the awareness of these reactions during the course of the relationship, however inconvenient and difficult this may turn out to be. It is the constant activation of the physical-emotional level (or of countertransference) in the therapist that makes it possible to keep theory to him/herself, when needed, without evading the relationship.

Guidelines

Brown's suggestion made recently at a recent seminar held in Bologna when asked about what emotional attitude was appropriate for the therapist to "Keep your ego out of the consulting room!", should be taken as an invitation to avoid the arrogance of thinking you know better than the client what s/he needs. However, this suggestion cannot be taken to mean that the "good-enough" therapist is one who transforms him/herself into a sort of passive sounding board for the emotions of the other person, completely neutral and without personal characteristics. Otherwise, with each client every therapist would have the same opinions, the same emotional reactions; we know that in reality this simply does not happen. "The fact that the famous "wound-window", writes Carotenuto (1998), "is different for each wounded person, and the mental landscape that can be discerned and investigated through that opening is different, not just for each client, but also for each therapist" (p. 105).

Although capable of empathy, no psychotherapist can feel what goes on in the client's organism better than client. This comment might seem superfluous, but it has become a part of the common language of body-oriented psychotherapists to say: "I feel the client's sadness, or anger or stomach-ache" that it should be remembered that the stomach that hurts is that of the therapist. What the therapist experiences in the session is (also) a very personal reaction to the other person and to what that person is experiencing on a physical, emotional and mental level. It is therefore important that professional therapists train themselves in self-awareness and that they be able to recognize what aspects of their psyche and organism are most involved in the client's problems. This is necessary in order to be alert to the risk that transference might lock on to some ancient, incompletely resolved psychic conflict, as suggested by Ennis Brown that could take the therapist on a collision or collusion course which would compromise the favorable outcome of the therapy.

If the therapist is able to use this recognition as an indicator of the type of process the client is going through, s/he may be able to help the latter to develop and, if possible, to modify the process. The goal is, however, anything but easy to achieve; the very projections of which the therapist is an object may seem so extraneous, that s/he thinks: "this thing is not mine, it does not belong to me!".

The eminent neuropsychiatrist, Paul Schilder, came across an unusual phenomenon (Kauders & Schilder, 1922). While at work, using the techniques of hypnosis with a masochistic client, he felt decidedly sadistic reactions and feelings arise in himself and he was convinced that these were neither a product of his past nor of anything to do with his life at the time. Schilder deduced that such feelings were unconsciously "evoked" by the client: reactions that coincided with those of the client. Schilder did not give a name to the phenomenon he had discovered and wrote about it a couple of times (surprised that his account did not create a sensation) and, underlining the fact that countertransference was not sufficiently recognized in the psychoanalytic literature, called for an investigation into how the therapist's emotions could become complementary to those of the client.

Schilder's invitation fell on deaf ears until the fifties, when psychoanalysts began to be interested in the phenomenon. In recent years it has received a lot of attention and has been given a variety of labels: induced countertransference, provoked countertransference or projective counter-identification (Downing, 1995). Many phrases that one hears in conversations between therapists (e.g. "what I am feeling now is what the client felt in childhood in his/her relationship with the mother", or, "….what the mother felt in her relationship with the client") seem unnatural and exude a kind of perplexing supernatural aura. This mechanism, defined by Melanie Klein

(1946) as projective identification reveals what is there in the therapist and not what is in the client or in the client's mother. Schilder was detecting his own sadism, evoked by the client and by the process they were experiencing. If he were not capable of having sadistic feelings there would have been nothing to "bring out". In other words, the wider the range of emotions, feelings, devils and wounds that the therapist has acquired through his/her personal history, the greater will be the resonance s/he is capable of providing and, in the last analysis, the greater the success of his work.

To return to Organismic Psychotherapy, Ennis Brown stressed that the process of recognition and assimilation of projections is a fundamental part of therapeutic work. The power and the role of the mechanism of projection go way beyond what can finally be usefully made explicit and brought to the client's consciousness during psychotherapy to the extent that they become in some way part of the very tissue of the therapeutic relationship itself. It is a characteristic of the contents of the unconscious that they are projected onto the "other", independently of their quality, positive or negative, archetypal elements included. The combination, often paradoxical, of rules and permissiveness, and the encouragement of communicative behavior which is as open as possible, strongly characterize the therapeutic relationship and encourage projections and transference. Yet because of the very position s/he occupies, the client "does not know". It is not only a question of ignorance, for example, of the psychotherapeutic process but a lack of emotional knowledge, of oneself and of the other, of the feelings and bodily reactions that are progressively evoked and that, surprisingly, manifest themselves in the course of the relationship.

Every time we face a situation that is not already firmly enough part of our experience, we automatically (and unconsciously) have recourse to a mechanism of projection. The psyche does not easily tolerate losing itself in a meaningless void and in its *orror vacui* tends to decode the ambiguous stimuli it is exposed to in terms of what it knows already, as is well-known to psychologists who use projective techniques, in particular the Rorschach test. Thus, for example, we all know that some people tend to interpret any physical contact as having a sexual connotation, because this is the only meaning already known and consolidated by experience. This unfortunate assumption seems to be made with some frequency in people who have been sexually abused (Lawry, 1998). The main function of projection concerns both the defense against unacceptable unconscious content and against an intolerable sense of inner void, this latter being a situation of indifference that is disturbing for its absence of recognizable reference points. What the individual uses to fill this void has to do with his personal history. If this has been difficult, it will reinforce the distortion of reality, giving it extraordinarily persistent characteristics.

Whoever undergoes psychotherapy discovers that the journey of growth and healing, as it gradually allows him/her to "retell" his/her own personal history (Shafer, 1992), involves a gradual re-appropriation of the psychic material projected (also) onto the figure of the therapist, material which anyway had given structure, however negative, to his/her way of being in the world. Consequently, s/he will find him/herself inevitably facing an emotional and/or existential void, which among other things, it would be better not to fill with content coming from the therapist. We accept, therefore, Carotenuto's advice (1998) aimed at the "sorcerer's apprentices": "Remember the warning you must have heard many times from your high school teachers: "Don't prompt! Whoever prompts does damage to himself as well as to the class-mate he would like to help" (p. 110).

This part of the process will be facilitated all the more if the therapist is capable of recognizing this special kind of inner void and can tolerate it together with the other person without attempting to do anything to fill it, until a new vision of the world and of him/herself arises in the client, together with a new repertory of strategies for coping with his/her psychic wounds.

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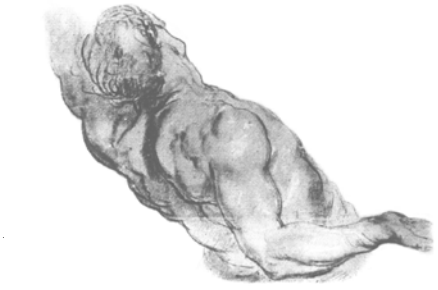

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