Chapter 26

Transference and Countertransference as Interpersonal Phenomena

An Introduction

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Transference, for Interpersonal analysts, refers to the unconscious transfer of experience from one interpersonal context to another. It refers, in other words, to the reliving of past interpersonal relations in current situations. The concept of transference, thus, is a fundamental expression of the Interpersonal psychoanalytic conviction that “the patterns of our later interpersonal relationships are formed in our early lives, repeated in our later lives, and can be understood through the medium of their repetition” (Fromm-Reichmann, 1950, p. 4), particularly in the mutual aspects of the patient-analyst relationship.

Interpersonal theorists traditionally have warned, however, against an exclusive focus on the “repertorial characteristics” of the analytic relationship, for this, in their opinion, leads to a neglect of the therapeutic significance of the vicissitudes of the actual or “real” patient-analyst relationship. Historically, Freud, in the belief that the analyst could be a “blank screen,” thought all of the patient’s reactions (attitudes and feelings) toward the analyst were transference. As Fromm-Reichmann (1950, 1959), Thompson (1950), Crowley (1952), and other seminal Interpersonalists later pointed out, however, patients’ analytic attitudes inevitably represent “a blending of transference and realistic appraisal” (Thompson, 1950, p. 100). As contemporary Interpersonal analysts further emphasize, the clinical course of transference relatedness itself always represents an integral of the past and the present, invariably incorporating in its clinical structure aspects of the analyst’s actuality (Wolstein, 1959, 1975; Searles, 1965, 1979).

In the clinical situation, as in everyday life, one’s experience is always a complex amalgam of transference-related and nontransference-relatedness. Interpersonal and intrapsychic processes are inevitably complex and constantly shifting amalgams of these relational dimensions (Fiscalini, 1988). The transference-countertransference relational dimension and what Fiscalini calls the “consensually valid or actual relationship” (what is often termed the “real relationship”) are, therefore, separable only conceptually. As Fromm-Reichmann (1950) notes, “transference” and “real” feelings are inevitably intermingled, and “this fact is among the causes for the complexity of... disentangling and correctly recognizing all of a patient’s transference reactions” (p. 101).

Freud’s original view of transference phenomena as occurring only in the analytic situation and as characterizing all of patients’ analytic relatedness (Grey and Fiscalini, 1987), while no longer held by most analysts, even by Freudians, historically has left a lexical imprint. Though the term “transference” generally refers, in its more delimited analytic sense, to the irrational repetition or carryover of the past into the present, it also is used to refer, more broadly, to all of a patient’s relatedness in the analytic relationship or, most broadly, to that analytic relationship itself—hence, the terminological ambiguity of the concept of transference as it is currently used.

Countertransference, whose study has followed that of transference, has had an even more complicated history of analytic meanings. Conceptions of countertransference have ranged on a continuum from the narrow—the analyst’s reaction to the patient’s transference—to the very broad—the totality of the analyst’s reaction to his or her patient. Interpersonalists vary in their definitions of countertransference, from those who use the term inclusively (e.g., Chrzanowski, 1977, 1979; Stern, 1987) to refer to all of the analyst’s feelings or attitudes—rational, irrational, and irrational—to all of a patient’s feelings or attitudes toward the patient to those (e.g., Fromm-Reichmann, 1950; Crowley, 1952; Thompson, 1952, 1956; Fiscalini, 1988, 1991) who generally limit their meaning of the term to more or less correspond to Thompson’s (1952) definition of it as “the transferring of irrational aspects of the
an analyst's personality to the relationship with his patient" (p. 162). Contemporary Interpersonalists, whether they employ a broad or narrow definition of countertransference, view it as transference's reciprocal, that is, as the same psychic process. In Wolstein's (1975) words, "countertransference, as psychic experience undergone during psychoanalytic therapy, is no different from transference" (p. 78). In actual practice, Interpersonalists have tended variably to widen or narrow their definitions of countertransference, at times using the concept in its more delimited sense to refer to irrational transference or countertransference and relatedness, and, at other times, using the term, as is often done with transference, to refer most broadly to the entirety of analytic relatedness. As Fiscali (1990) points out, however, the "totalistic" concept or definition of countertransference as referring to all feelings or attitudes (conscious or unconscious, rational or irrational, normal or neurotic) held by the analyst toward his or her patient employs such a broad and all-inclusive reference that it becomes somewhat confusing, if not meaningless. Mendelson (1991) similarly criticizes the totalistic or overly inclusive use of the term transference.

The definitional difficulty is addressed in Sullivan's (1940) concepts of "parataxic" and "parataxic distortion." In his concept of parataxic distortion, which subsumes the processes of transference and countertransference as irrationality that applies to either the patient or the analyst, Sullivan addresses the bidirectionality of transference process. In the differentiation of parataxic distortion and parataxis lies a conceptual distinction between irrational (or distorted) and arational (or intuitive and creative) unconscious experience and relatedness.

Nevertheless, despite the definitional complexities of the concepts of transference and countertransference and their methodological merits of the concept of parataxic distortion, contemporary Interpersonalists generally retain the terms transference and countertransference to refer to transference integrations and in this way maintain a logical continuity of reference with the traditional psychoanalytic theory of unconscious experience and its interpersonal transfer.

**TRANSFERENCE, PARATAXIS, AND PARATAXIC DISTORTION**

Parataxic distortion—relating to others in terms of some illusory personification or fantasy of who or what they are—and transference both refer to irrational attitudes toward others based on previous interpersonal experience, but they reflect different theories of psychological development and functioning (Thompson, 1956). Sullivan used the new term, parataxic distortion (or connected in any logical fashion. Various experiences which arc related to one another are

Thus, Sullivan (1940) asserts that "when we talk professionally with a person—whom I shall now call 'the patient'—the speech behavior occurs in a sense including the two of us and an indefinite and shifting group of illusions and impressions as to each other" (pp. 92-93; italics added). These parataxic distortions, or illusory "me-you" patterns, which, as Sullivan notes, are such a complication in interpersonal relationships, clearly refer to the transpersonal dimension of human living. Thompson (1950) notes, however, that the concept of parataxic distortion is a broader one than that of transference (at least as originally defined by Freud) in that it refers more inclusively to projections of dissociated aspects of the self (what Fiscali [1990] calls the "introspective transference") and character defenses as well as illusory personifications of others (viewing contemporaries as childhood figures)—that is, the transference or illusory displacement of instinctual wishes. Despite this expansion in meaning, Sullivan, in his concept of parataxic distortion, essentially retained the phenomena that are today usually called transference or countertransference.

Sullivan (1958) referred more broadly to parataxis as one of three modes of human experience, developmentally intermediate between the more primitive prototaxic and the more advanced (more nearly logical) syntaxic modes of symbolization. Parataxis, in this sense, includes irrational (prelogical) intuitive processes, along with irrational and distorted experience (Mullahy, 1970; Schecter, 1971; Fiscali, 1985). Parataxic symbolization is the primitive, primary process type of cognitive organization, what Arieti (1967) calls the "paleological mode of thinking," that carves the experiential substrate for the process of prototaxic distortion or transference. Transferences or countertransferences, particularly in their irrational or arational aspects, may also be carried by prototaxic processes. As Mullahy (1975) notes, great masses of early experience can be revolved and revolved in subgroups (i.e., by the analyst) or groups of either prototaxic or parataxic symbols. Thus "new" interpersonal situations can be lived parataxically or prototaxically, as if they were, in fact, very old situations. In contrast to the indeterminate, "cognitive," and arational or prelogical protocognitive processes of prototaxic thought, parataxic symbolization is characterized by rudimentary distinctions in experience. Mullahy points out that with the development of the parataxic mode of symbol activity, the original undifferentiated wholeness, oneness, of experience is broken. But the "parts" of the various aspects of the various kinds of experience are not related or connected in any logical fashion. Various experiences just happen together, or not, as the case may be. They are concomitant. The young one cannot yet relate his experiences to one another or make any logical distinctions among them. Expressed in another way, experiences which are related to one another are

Parataxic symbol activity and its linguistic substrates, autistic symbolization, thus are "arbitrary, highly personal, unchecke/ tested" (Mullahy, 1945, p. 254) constructs. Parataxic symbolization is, in other words, a primitive, prelogical process of association in which associative meanings are essentially private and personal, rather than logical (Grey, 1979). Mullahy (1945) points out that parataxic processes are thus well suited for carrying transference or countertransference experience. Mullahy further notes, however, that they are also adapted for conscious therapeutic use. As Sullivan (1958) observes, they can all carry the ability, throughout life, to relate via these primitive (and intuitive or creative) modes of "prelogical" experience (Tauber and Green, 1959).

Parataxic processes, both as irrational (i.e., transferential or parataxically distorted) and as rational (creative or intuitive) experience, constitute an important dimension of the interpersonal analytic field. Schecter
Interpretation and Transference Distortion

In recent years, several Interpersonal or Interpersonally oriented analysts with a perspectivistic or relativistic epistemology have questioned the traditional concept of transference as distortion (Levenson, 1972, 1982a, 1983; Gill, 1982a, 1983; Gill and Hoffman, 1982; Hoff, 1983, 1992; Stern, 1985, 1987, 1992). In their contemporary critiques of the "blank screen" concept (Blatt, 1928a, 1983) and Hoffman (1985) emphasize that all transference communications are, in some way, related to the "here-and-now" analytic interaction and always include a plausible interpretation of the analyst's experience by the patient. Thus, both Gill and Hoffman view patients' transference experiences of the analyst as plausible interpretations or constructions of him or her, rather than as distortions or pure projections. Transference, then, is defined as selectivity in awareness or rigidity in perception, rather than as distorted misattributions. Hoffman (1983) argues that, in principle, transference operates much like a "Geiger counter," thus requiring a selective sensitivity to certain facets of the analyst's personality and subjectivity, it also operates, distortedly, to emphasize inappropriately this facet over others equally important and give it undue selectivity or, even, exaggerate its very quality—for example, experiencing the analyst's annoyance as violent rage or his or her confusion as inarticulacy. The analyst is, as it were, interpreted in terms of a "narrow or reductive context." Transference distortion is also implicit in the use of what may be called "improbable contexts"—the inappropriate (mis)assignment of other's behaviors or attitudes to irrelevant or unlikely reference frames, meaning schemata, or categories. The analyst's behavior or attitude may be subject to plausible but impossible interpretation. For example, the patient may plausibly interpret an analyst's咳augh at a certain juncture in a session as a sign of restive boredom or unconscious anger, when it may be much more likely that the analyst is simply recovering from a cold or, even if the analyst is irritated or bored, that these feelings are related to the patient in more complex or different ways than the patient imagines. In other words, the concept of transference as distortion is implicit in the common observation that there are always varying degrees of plausibility which are never impossible but are improperly assigned meaning. Some interpretations of experience or behavior seem more probable (less distorted) than others.

For Interpersonalists, interpretive "truth" or understanding of transference and countertransference derives from social consensus, with interpretive authority shared by the patient and analyst. This interpretive egotism and perspectivism, which are generally characteristic of contemporary Interpersonalists (even though they vary in their epochological leanings), thus require neither that the analyst's interpretive "truth" must rule nor, as some would have it, that the patient's interpretive "truth" must rule. Interpretations of transference and countertransference, like the clinical phenomena themselves, ultimately become interpersonal (social) constructions, even though they originate in private and uniquely individual experience (see Wolstein, 1959, 1985). They are formed and formulated both personally and interpersonally.

The perspectivistic epistemologies of many contemporary Interpersonalists emphasize the inherent ambiguity of clinical events. (Stern, 1985) pointed out, however, that constructivism or perspectivism need not imply solipsism. As Stern puts it, "Constructivist epistemology does not require relativist ontology" (p. 205). In other words, our coherence theories (that are paleo-relativistic or epistemologically) are circumscribed by some fit with, or correspondence to, "reality," although we may not be able to "know" that reality exists or is an "artifact".

This interpretive relativism is an argument against analytic authoritarianism as well as a critique of the concept of analytic impersonality or anonymity (the "blank screen" concept) and the methodology of the "principle of isolates," the notion that natural phenomena or events can be studied in "pure" form in a vacuum (Grey, 1979). The concepts of the analytic situation as an interpersonal (or intersubjective) field and of analytic interpretation as socially constructed meaning do not, however, require, as Gill, Hoffman, and Levenson suggest, rejection of the concept of transference as irrational or inappropriately distorted or, at least, that transference is not contaminated and not narrowly equated with "pure" projection or misattribution.

Transference reactions may be anchored in patients' plausible, or even permanent, present experiences of their analysts' conscious or unconscious experience; however, these reactions are also invariably distorted, in some way or another, and thus interpreted that is by past experience. A distortion is implicit in the unbalanced perceptual rigidity and attentional selectivity that frequently, perhaps invariably, characterize transference experience (Gill, 1982b, 1983; Hoffman, 1983). The analyst is rigidly seen in set ways, and no other. The patient may focus rigidly on a particular quality in the analyst's attitude or behavior and, moreover, may emphasize or exaggerate its pervasiveness or prominence in the analyst's total relatedness. Distorted relatedness is inherent in patients' transferrentially exaggerated responses to analyst's attitudes or behaviors. Patients may plausibly or validly see or sense hostility or disapproval or some other quality in their analyst's attitude but exaggerate, misjudge, or even misread its emotional amplitude, motivational intensity, unconscious meaning, or psychic role or importance in the analyst's personality. In other words, transference distortion may manifest itself in the "contextualizing" of analytic data. Of course, what is said here of transference applies equally to countertransference experience.
Transference distortion is exemplified perhaps most centrally in the emotional carryover of childhood responsiveness in analytic self-experience. It is not unusual for patients accurately to appraise facets of their analyst's personalities—their hostility, contempt, dependency, withdrawal, coldness, and so on—but these same patients distort the emotional import of these aspects of themselves and experience their analyst's traits with all the intensity or meaning experienced in past childhood relationships. It is not surprising that one's analyst is similar, or even nearly identical, in significant respects, to one's childhood parents in fact, no longer. It is not surprising that the child of one's childhood, except in transference distortion. The distortion of the transference reaction lies, then, in the meaning or significance attributed to the analyst's attitude or behavior (i.e., seeing the analyst as having the same power and significance in one's life that one's parents had when one was an infant or child), not in the attribution or projection of imaginary attributes.

These are seen broadly, the concept of transference as distortion seems clinically valid. In one way or another the unresolved interpersonal situations of one's past invariably structure, limit, confine, color, narrow, warp, skew, or complicate one's views or interpretations of one's parents or other adults, one's one's present relatives.

Transference and countertransference, in Zephopolou's (1960) phrase, are both "situationally oriented and characterologically conditioned" (p. 4)—a dialectical interplay of present and past, fact and fiction. The past shapes itself to the present, as that present is shaped by the past. As Wolstein (1975) notes, "regardless of his psychoanalyst's professional facade, the patient, if he is capable of such perception, gradually comes to perceive aspects of his psychoanalyst's unconscious experience as if it were his own. The psychoanalyst would wish it, or cooperatearily (p. 84). The patient is responding to something real, here and now, and in that measure his response cannot be judged as being simply distorted" (p. 83). Transference or countertransference distortions, as noted earlier, define a continuum of irrational or illusory relatedness, ranging from slights skews in analytic experience to gross, psychotic-like warps in analytic relatedness. Patients' views or interpretations of their analysts and analysts' experiences of their patients vary in their degree of "artificial creation." Nevertheless, transference or countertransference symbolizations, as they begin to take form, always reach out into the analytic present as if they simultaneously reach back into the patient's or analyst's past (Wolstein, 1959).

**TRANSFERENCE AND COUNTERTRANSFERENCE: PSYCHOLOGICAL ORIGINS AND FUNCTIONS**

For Interpersonal relations theorists, as for many analysts today, transference or countertransference relatedness is seen to originate in the interpersonal dynamics of character and adaptation, not, as classical psychoanalytic theory suggests, in the blind impatience of an infant "compulsion to repeat." Transference and countertransference have their interpersonal origins, then, not in the repressive pull of the repetition compulsion, the blind instinctual "compulsion to repeat," the infantile experience or state of being, but in the defensive dialectics of the needs for interpersonal security and personal satisfaction or fulfillment (Shapiro, 1985).

Interpersonal relations theory, in its repudiation of the primacy of instinctual dynamics and in its influential role in the "interpersonal turn" in psychoanalysis, with its focus on the intricacies of analytic character, resistance, and the self, offers a more sophisticated and interpersonalized understanding of Freud's original view of transference as a form of "resistance against remembering." For Interpersonalists, the meaning of transference, or parataxically distorted, experience, in particular, and all repetitive behavior, in general, is found in the interpersonal dynamics of anxiety and the concurrent defensive operations of the "self-system."

The individual, according to Interpersonal theory, learns or internalizes characteristic patterns of feeling, thinking, and behavior during the course of his or her interpersonal development. These attitudes and unconscious assumptions, learned earlier living, are then unconsciously carried into, or transferred onto, all "new" situations by a process of what Singer (1965) calls "pathological generalization." In other words, transference represents the universal human tendency to generalize about, and to adapt to, one's world on the basis of previous experience (Singer, 1965; Chzranowski, 1977; Singer, 1985). In this sense, transference is akin to what Plaget describes as the "stimulus generalization or response generalization in the course of learning." Put in Interpersonal psychoanalytic terms, "parataxic distortions ... develop from the early but essentially non-sexual interactions with significant people. One develops ways of coping with these people and others to resemble, later, characteristic ways of transference or interpersonal integrations" (Thompson, 1950, p. 109). As Sullivan (1954) notes, parataxic distortions are one of the central ways in which the "personality displays before another of its gravest problems" (p. 27).

Individuals, because of their experience with anxiety and interpersonal disapproval, develop a self-protective system of interlocking security (defense) operations, precautionary signs and signals of what is required, expected, and acceptable, and the identification of unconscious beliefs and assumptions—the self-systems—designed to keep all "new" experience consonant with previous experience (Sullivan, 1953, 1955, 1956; Sullivan and Dulieu, 1965; Sullivan, 1971). Interpersonal therapists, and other defense operations, one is able to avoid, ignore, or deny new experiences that are incongruent or discordant with "transferred" expectations and attitudes, thus ensuring the parataxic, or transential, similarity of "new" and old interpersonal situations. As Mullahy (1945) observes, through processes of selective instillation, through the instrumentality of parataxic symbols, "attitudes ... not favorable to the prevailing "me-you" patterns are not discriminated" (p. 271).

Thus, transference, or repetitive behavior in general, is not an automatic biologic compulsion, for the tendency to repeat relatively rigid patterns of behavior, as in transference or countertransference relatedness, is not an innate drive but rather the social "product of interpersonal forces" (Thompson, 1986, p. 57).

In this sense of transference as attempted adaptation to one's interpersonal world, Thompson (1953) asserts, "if we attempt to understand character and transference in interpersonal terms, we must keep in mind that both have similar origins as well as performing similar functions" (p. 25). Consequently, the interpersonal relations, analytic and otherwise, of an individual with a predominantly hostile character structure, for example, will be characterized by a mode of interpersonal behavior justified by, or adequate to, an earlier situation, or situations, where the significant people were hostile and did ridicule him. The patient has a hostile and derogatory self—why? Because his experience, or a great part of it, with the significant people who took care of him in early life, taught him, convinced him, that he was a person to be ridiculed, ill-treated, abused. And since he consequently dislikes, or even hates himself, even though he may partially disguise it from himself and others, he must therefore dislike, or be hostile toward others, and this becomes inevitable for him to expect hostility in the new situation [including the analytic one], one which is for him closely on the model of earlier situations [Mullahy, 1945, p. 271].

Transference and countertransference, however, are expressed not only in characterologically determined unconscious patterns of apprehension and anticipation—in "pathological compartments" of transference or parataxic "blueprints" derived from interpersonal experiences (Singer, 1965)—but also in intended or unintended reenactments of the original transference or parataxic "blueprints," imaging or anxiety-producing interpersonal situations. As Cohen (1952), Thompson (1950, 1956), Singer (1963, 1982b), and Feiner (1979), among others, point out, patients (or analysts), either by virtue of the characterological operation of their defensive attiudes or by unconscious provocations, pressure others, including their analysts (or patients), in a number of nonverbal ways to behave or react like the significant adults in the person's earlier life. Thus, patients (or analysts) not only transferentially reexperience their earlier anxious interpersonal experiences, but also interactively re-create or bring them about with their analysts (or patients) and others in their life. In such ways, later life experiences reinforce the individual's original transference pattern. Consequently, "the old way of reacting seems to be automatically repeated" (Thompson, 1950, p. 57), when, actually, it is actively re-created over and over again. Transference becomes a self-perpetuating phenomenon. In this sense, Levenson's (1982a) proposition that transference is inevitably "real"—an interactional replica of earlier situations—becomes valid. Noting the close clinical relationship between anxiety and parataxic distortions—that the analytic emergence of transference and
countertransference patterns are generated and conditioned by conscious or unconscious anxious experience arising from a multitude of different sources in the whole field of the patient's psychic life (Cohen, 1952, p. 69)—Cohen (1952 and Wolstein 1954) offer operational or functional definitions of transference and countertransference in terms of anxiety and defensive adaptation. As Singer (1965), too, emphasizes the defensive and self-protective function of these "pathological generalizations": transference and countertransference distortions are efforts to secure the patient—self and others—not only in safety and predictability. As Singer (1965) notes, "A particular world image is maintained through transference and attempts to dissolve it are resisted because it provided reference points for the patient and aided him in anticipating and avoiding anxiety" (p. 266).

Singer observes, further, that in the analytic situation: "the development and maintenance of parataxic distortions and transference reactions is occasioned by the patient's despair about an alternative, by . . . alding doubt that people [including the analyst] are capable of behavior which is at variance with the generalizations he has developed about the way the world is" (p. 265).

Thus, parataxic, or transferential, generalizations are pathological attempts to perpetuate a rigidly uniform view of the world in which all of life is conditioned by conscious or unconscious varied sources in the whole field of the patient's psychic life. For example, all people, including one's analyst, may be seen as rejecting and critical, not just one's actually rejecting, critical parent. Particular and personal early experiences are distorted into terms of one's own life experience. For example, all people, including one's analyst, may be seen as rejecting and critical, not just one's actually rejecting, critical parent. Particular and personal early experiences are distorted into terms of one's own life experience. For example, all people, including one's analyst, may be seen as rejecting and critical, not just one's actually rejecting, critical parent. Particular and personal early experiences are distorted into terms of one's own life experience. Thus, for example, the clinical rigidity of a transference pattern, its resistance to analytic change, depends on "the number of situations the patient has encountered in his life which forced him to develop his particular system of beliefs . . . . The more massively and early in his life the patient has encountered insistence on self-restriction, the more readily will he accept his developed . . . . all parataxic generalizations" (Singer, 1965, p. 265; italics added).

Transference and countertransference patterns are not, however, static processes; they are always in dynamic flux, always open, even if only minimally, to the future as well as to the present (Wolstein, 1954, 1977; Chrzanowski, 1977). Thus, clinically, patients' transferential analytic relatedness represents a developmental integral of their experience, not simply a pristine reliving or repetition, a frozen replica, of the original traumatic situations that set the transference train of events in motion. Even if the transference picture is largely interpersonally connected with the residuals of the earliest situations, it includes more recent elements, or interpersonal experiences, which modify it or elaborate upon it in varying ways and to varying degrees (Cooper, 1974; Kagan, 1950; Wolstein, 1954, 1977; Singer, 1965; Chrzanowski, 1977, 1979).

Thus, Interpersonalists do not view transference and countertransference as compendial of the narrow classical sense of a literal reliving of a specific childhood conflict—"an emotion or attitude transferred unaltered from some earlier situation" (Thompson, 1953, p. 25; italics added)—but indeed as the clinical expression of a complex characterological integral of life experience. Chrzanowski (1977), for example, poits that transference phenomena are epigenetic and include experience from all phases of the life cycle. Transference patterns, in other words, are inevitably modified or altered throughout one's interpersonal development. As Thompson (1950) points out, although

early patterns of behavior, developed in reaction to the personalities of the significant people of our early childhood, are very strong and very important, . . . some modification of these early patterns must be made. The resultant pattern of experience with other people throughout childhood and even in adult life . . . the original patterns are the core of subsequent behavior, but this core can be altered constructively or destructively by subsequent life experience" (pp. 56-57).

Adult experience, as Mullaly (1945) observes, tends to be pyramidal, built upon and conditioned by previous experience. In this sense, all living is "colored" or marked by earlier experience. Nevertheless, interpersonal processes, including transference and countertransference, are not only recurrent and repetitive in nature but also emergent—"they not only reproduce the old, they also reconstruct it in new and changing ways" (Wolstein, 1954, p. 38). Herein, of course, lies the possibility for analytic change, self-transformation, and psychic reconstruction.

Transference and countertransference patterns are not only complexly structured but also are complexly interrelated with one another; as Riech (1943) notes, they form "interconnecting, overlapping reference frames" (p. 42). Riech notes, "one has to realize that one pattern connects with another—the whole making a tangled mass that only years of analysis can unsnarl" (pp. 40-41). Ultimately, it is the complexity, not simply the rigidity, of human experience and character that makes its analytic transformation such a lengthy and often unpredictable process.

TRANSFERENCE, COUNTERTRANSFERENCE, AND THE INTERPERSONAL FIELD

A central premise of Interpersonal psychoanalytic theory is that each participant in psychoanalysis is involved as part of an interpersonal field in processes that invariably affect, and are affected by, that field of experience. From this basic conception of the analytic situation as an interpersonal field derives the contemporary interpersonal view of transference and countertransferences as compendial of and compen­

All contemporary interpersonal analysts, however, else they may differ, view the psychoanalytic relationship as a dyadic system in which participants and field can exist and mutually influence one another. Transference and countertransference patterns are seen as mutually formed experiences jointly created by both analytic participants, rather than as exclusively endogenous expressions of either participant's closed or encapsulated intrapsychic world. In other words, transference invariably shapes, and is revealed in, the analytic's countertransference, and, conversely, the analytic's countertransference partly shapes, and is revealed in, the
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... goes on in the [analytic] interview" and that analysts "should never lose track of the fact that all the patients are not simply 'eavesdroppers' but have 'more or less exactly addressed'" (p. 19) to them.

The view that the analyst is a participant, rather than a nonparticipant, observer corrects this black and white, either/or distinction, especially in psychoanalytic data, including transference phenomena. First of all, it recognizes the perspective nature of the analytic situation, that the analyst (as well as the patient or analyst) inevitably sees the other (and himself or herself) from some personal perspective. There is, in other words, no such possible observational stance as neutrality (Wolstein, 1959, 1977; Levenson, 1972, 1983; Spiegel, 1977; Hoffman, 1983; Stern, 1987, 1992). Perhaps even more important, however, is the interactional principle inherent in the concept of participant observation: the observer, in his or her way of observing, inevitably affects the observed, and the observed inevitably affects the participant-observer's observing. In other words, transference and countertransference are participatingly generated: they are inevitably field processes, reciprocal aspects or poles of an interactive, experiential field. The analyst is not, and cannot be, a "blank screen"; transference and countertransference are inevitably both artificial and procrustean. The analyst's role as that of an "observant participant" (fromm, as Sullivan, 1949) woefully put it, refers to the analyst's "skill in participant observation in the unfortunate patterns of his own patient's living, in contrast to merely participating in such unfortunate patterns with the patient" (p. 12). Implicit, but undeveloped, in Sullivan's formulation is a concept of the analytic patient's living as a concept of the analytic patient's living as an analytic participant-observer, where in the interactional experiences of transference and countertransference patterns and the clinical centrality of their coordinated inquiry. This radical possibility in transference-countertransference analysis, however, was elaborated and developed by a later generation of Interpersonal theorists. Nevertheless, Sullivan (1954), in his concept of the analyst as an expert participant-observer, firmly planted analytic consciousness in the concept that the entering analyst has an inescapable, inextricable involvement in all that...
collaborative endeavor on the problem at hand the alteration of the patient's behavior, verbal or otherwise, is a transference distortion, the emergence of parataxic communication in the therapeutic situation" (p. 196). Cohen (1952) defines countertransference in similar operational terms: "when in the patient-analyst relationship, anxiety is aroused in the analyst with the effect that communication between the two is interfered with by some alteration in the analyst's behavior (verbal or otherwise), then countertransference is present" (p. 235).

Represented in these concepts of coparticipant observation, too, are Ferenczi's (1926, 1932/1988) earlier far-reaching and influential ideas on mutual psychoanalysis.

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