

DOCUMENT RESUME

ED 453 480

CG 030 961

AUTHOR Habicht, Manuela H.
TITLE Interpersonal Processes in Psychoanalytic, Cognitive Analytical and Cognitive Behavioural Therapy.
PUB DATE 2001-01-00
NOTE 20p.
PUB TYPE Information Analyses (070) -- Reports - Evaluative (142)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Cognitive Processes; *Counseling Theories; Counselors; *Interpersonal Competence; *Mental Health; Personality Theories; *Psychiatry; Psychotherapy; Therapists
IDENTIFIERS Countertransference; Freud (Sigmund); Transference

ABSTRACT

The aim of the review was to compare interpersonal processes in psychoanalytic therapy, cognitive analytical therapy, and cognitive-behavioral therapy. Since the emphasis is on psychodynamic therapy, Freud's conceptualization of the phenomenon of transference is discussed. Countertransference as an unconscious and defensive reaction to the patient's transference is explored. The importance of both interpersonal processes for therapy outcome is explained and views of different authors on transference as well as countertransference are covered. Emphasis is placed on the operation of transference in psychoanalytic therapy as well as how transference is dealt with and resolved. Cognitive analytic therapy is defined briefly and identifying as well as reciprocating transference is explained. Varieties of countertransference as defined by Ryan (1998) are explored and similarities between modeling and countertransference reactions are demonstrated. There is evidence of interpersonal processes such as transference and countertransference in all psychotherapies. Since these processes originated in psychoanalytic therapy, it is suggested that non-psychoanalytic oriented therapists be probably at a higher risk of unrecognized countertransference due to a lack of personal therapy. (Contains 43 references.) (Author/JDM)

Interpersonal Processes in Psychoanalytic, Cognitive Analytical and Cognitive Behavioural Therapy

Manuela H. Habicht

Abstract

The aim of the review was to compare interpersonal processes in psychoanalytic therapy, cognitive analytical therapy and cognitive-behavioural therapy. Since the emphasis is on psychodynamic therapy, Freud's (1915/1958) conceptualisation of the phenomenon of transference is discussed. Countertransference as an unconscious and defensive reaction to the patient's transference is explored. The importance of both interpersonal processes for therapy outcome is explained and views of different authors on transference (Gelso & Carter, 1985; Brammer & Shostrom, 1982; Cerney, 1985 and Ehrenreich, 1989) as well as countertransference (Little, 1951; Blanck & Blanck, 1979, Gelso & Carter, 1985 and Langs, 1974) are covered. Emphasis is placed on the operation of transference in psychoanalytic therapy as well as how transference is dealt with and resolved. Cognitive analytic therapy is defined briefly and *identifying* as well as *reciprocating* transference is explained. Varieties of countertransference as defined by Ryan (1998) are explored and similarities between modelling and countertransference reactions are demonstrated. There is evidence of interpersonal processes such as transference and countertransference in all psychotherapies. Since these processes originated in psychoanalytic therapy, it is suggested that non-psychoanalytic oriented therapists be probably at a higher risk of unrecognised countertransference due to a lack of personal therapy.

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

- ☐ This document has been reproduced as received from the person or organization originating it.
- ☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PERMISSION TO REPRODUCE AND
DISSEMINATE THIS MATERIAL HAS
BEEN GRANTED BY

M. HABICHT

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)

1

2

BEST COPY AVAILABLE

1. Introduction

The humanistic approach to psychotherapy has put the therapeutic relationship center stage; it is seen as the primary vehicle promoting psychological growth and healing. The success of such a relationship is grounded in essential human qualities such as empathy, congruence, and genuine positive regard (Kelly, 1997). The establishment of a warm, supportive and empathic environment between client and therapist has been widely embraced, by various schools of therapy, as an essential ingredient in psychological healing. For instance Stiles et al. (1996) found that this variable was ranked highly (second in the list of 19 treatment techniques or interactions) by both psychodynamic and cognitive-behavioural therapists.

This paper will focus on the therapeutic relationship and describe different interpersonal processes that facilitate change in therapeutic interventions such as psychoanalytical, cognitive analytical and cognitive behavioural therapy. One of the interpersonal processes discussed is the concept of transference. The concept of transference is seen by many as Freud's greatest discovery in the area of psychological intervention (Fine, 1990). Not only is this construct pivotal in virtually all systems of psychodynamic and psychoanalytic treatment, but theory and research suggest that transference is operative and important in non-analytic treatments as well (Adelstein, Gelso, Haws, Reed & Spiegel, 1983; Gelso & Carter, 1985, 1994; Rhoads & Feather, 1972; Ryan & Gizynski, 1971). Countertransference has shown to be an important interpersonal process in psychodynamic as well as cognitive analytical therapy as well. However literature that refers to transference and countertransference reactions in cognitive behavioural therapy is virtually non-existent. The following review demonstrates the importance of the above interpersonal processes in different therapies and presents evidence for similarities between them and modelling in cognitive behavioural therapy.

2. Interpersonal Processes in psychoanalytic therapy

One of the distinguishing and central technical features of psychoanalytically oriented psychotherapy (subsequently referred to as dynamic therapy) is the interpretation of transference. Freud (1912/1958) originally described transference as "stereotype plates" or representations of early interpersonal relationships, which influence perceptions of current relationships. His conceptualization of the phenomenon of transference thus implied two components: a structural component referring to a mental representation of interpersonal relationships and a procedural component referring to the application of this mental representation to guide interpersonal perception. Regarding transference as a process, although Freud noted that transference could emerge with equal intensity outside of therapy as in it, his own emphasis was on transference to the therapist in particular. Strachey (1934) also elaborated on the importance of transference and outlines a process in which transference interpretations are capable of reversing the patient's "neurotic vicious circle".

Freud (1910/1959) first introduced the term countertransference to refer to the analyst's unconscious and defensive reactions to the patient's transference. Because he viewed countertransference as having uniformly adverse effects on therapy, Freud was "almost inclined to insist that (the analyst) shall recognize this countertransference in himself and overcome it" (pp. 144-145). Subsequent writers broadened Freud's classical definition of countertransference to refer to all of the therapist's reactions to a client, whether those reactions were conscious or unconscious, in response to transference or to other phenomena (e.g. Fromm-Reichman, 1950; Heimann, 1950, 1960; Little, 1951, 1960).

2.1. The importance of transference and countertransference in psychodynamic therapy

Gelso and Carter (1985) suggested that a transference relationship occurs with all types of psychological intervention, regardless of the length of treatment. Brammer and Shostrom (1982) described transference as a type of projection of the client's past or present unresolved and unrecognized attitudes towards authority figures and love objects. Cerney (1985) wrote that transference occurs on an unconscious level and also that not all reactions or feelings towards the therapist can be labelled transference.

Because transference interpretation has been regarded as a hallmark of a technique of dynamic therapy, both term transference and interpretation have received considerable attention in the literature. Unfortunately, they have assumed a variety of meanings over the years. In regard to transference, there has been a disagreement about what it encompasses and whether additional concepts such as therapeutic alliance or real relationships are required to account for the patient's reaction to the therapist (Ehrenreich, 1989).

Classical analysts typically assume the anonymous stance and engage in very little self-disclosure and maintain a sense of neutrality, because they are attempting to foster a transference relationship, in which their clients will make projections onto them.

Therapists believe that if they say little about themselves and rarely share personal reactions, whatever the client feels towards them is largely a product of feelings associated with other significant figures from the past.

Transference is the unconscious shifting to the analyst by the client of feelings and fantasies, both positive and negative, that are displacements from reactions to significant others in the client's past. Malan (1976) emphasised the importance of linking the patient's reactions to the therapist and reactions to parental figures in the area of brief psychodynamic therapy. Gill (1982) has also written extensively about the importance of transference interpretations, but with a different technical emphasis. He advocates that priority is given to exploring the here-and-now transference reaction to the therapist rather than linking the reaction to its original sources. Strupp and Binder (1984) have taken a similar position in regard to short-term therapy.

Transference allows the clients to attribute to the therapist "unfinished business" from these past relationships. The treatment process involves their reconstruction and reliving of the past. As therapy progresses, childhood feelings and conflict begin to surface from the depth of the unconscious and clients regress emotionally. Some of their feelings arise from conflicts such as trust versus mistrust, love versus hate, dependence versus independence, and autonomy versus guilt or shame.

Mann (1997) pointed out that transference takes place when clients resurrect from their early years intense conflicts relating to love, sexuality, anxiety, hostility, and resentment. Then those are brought into the present. The client re-experiences them, and attaches them to the therapist. The client might see the therapist as an authority figure who punishes, demands, and controls. Hostile feelings are the product of a

negative transference, but clients might also develop a positive transference and, for example, fall in love with the analyst, which to be adopted, or in many ways seek the love, acceptance, and approval of an all-powerful therapist.

Freud's insights regarding erotic transference and its link with resistance were first described in his remarkable "Observations on Transference Love" paper (Freud 1915/1958). Here he concluded, among other things, that the quality of love expressed by patients in analytic treatment was for the most part the same love that is expressed in everyday life. What primarily differentiated the two forms of love was that love expressed within analysis was closely tied to resistance. By this, Freud meant that the patient expressed romantic and sexual feelings for the analyst as a psychological defense against remembering painful experiences from the patient's past, that is, dangerous oedipal striving for the parent. The patient experiencing his or her longings for the analyst is real, keeps the focus on the here and now and towards the expression of free association and therapeutic progress.

Relevant for the author's clinical practice is Freud's conclusion that a subgroup of patients were untreatable. Freud (1915/1958) was referring to the group, all of whom were women, when he made his often quoted comments about certain female patients who demonstrated "elemental passionateness" (p. 166) and were "accessible only to 'the logic of soup, with dumplings for arguments' " (p. 167). These patients failed to face the reality of their erotic feelings as resistance and so led Freud to conclude that they were not suitable to psychoanalysis.

If this psychodynamic approach is to produce change, the transference relationship must be worked through. The working-through process consists of exploration of unconscious material and defenses, most of which originated in early childhood. Working through is achieved by repetition of interpretations and by exploring of resistance. It results in a resolution of old patterns and allows the client to make new choices.

Compared to Freud, who viewed countertransference as having uniformly adverse effects on therapy, Little (1951) wrote, "If we can make the right use of countertransference may we not find that we have another extremely valuable, if not indispensable tool?" (p.33). Another, as yet unnamed perspective has emerged in defining countertransference. This perspective distinguishes the extent to which therapist reactions are grounded in reality of the therapeutic relationship, defining

countertransference as irrational reactions emanating from unresolved issues within the therapist (Blanck & Blanck, 1979; Gelso & Carter, 1985; Langs, 1974).)

2.1.1 The operation of transference

It can be seen that the source of transference tends to be both maternal (general) and paternal (typical) (Gelso et al. ,1999). Both changes in the therapy structure and events in the client's outside life typically stimulate the development of transference. Gelso et al. (1999) point out that regarding to changes in structure, the most common changes were increases in therapy fees, shifts in frequency of visits, and shifts in settings or office. Another domain under which transference operates pertains to client dreams and fantasies about the therapist.

2.1.2. Dealing and resolving transference

Therapists typically deal with transference by using traditionally psychoanalytic strategies such as focusing on the immediate relationship, offering interpretations around the transference, and raising questions aimed at fostering insight. Gelso et al. (1999) point out that other factors such as the working alliance, real relationships as well as intellectual and emotional insight also play a major role in the facilitating the resolution of transference.

Mann (1997) described the case of Mrs A, who is in her fifties as an example of dealing and resolving transference.

"She came to psychotherapy after the recent death of her father which evoked anxiety and depression in her. Her profession took her into repeated contact with the dying and their relatives. Until her father's illness she had found this a satisfying job which she did very well. Since his death she had been unable to go to work.

At first she wanted to speak about her job and her father's death. He had been suffering from a senile dementia and she had nursed him while he was dying. His behaviour had been very difficult: he repeatedly confused her with his wife; he exposed himself and would make overtures for her to get into bed with him on the ward. This was difficult in itself, but also stirred memories from the past.

Gradually she revealed more of her history. Both parents were violent to each other, and the mother was violent to all children. Father had not

physically abused his daughter, but had used her for his voyeuristic pleasure: he would watch her take a bath until she was quite grown-up or force her to pose naked while he drew her. When she once tried to lock the bathroom door he had burst in saying, 'What is so special about your body that nobody can look at it?' This only stopped after her protests in early adolescence." (Mann, 1997, p.18-19).

Mann (1997) described Mrs. A's married life as unsuccessful with several divorces. She tried to marry men that were very different from her father. When she talked to Mann and spoke with a mesmerising intensity that would just keep his attentions, he would consider that to be transference replay of the past. The client reported that in all of her sexual experiences none of her husbands has seen her naked. Mann considered revealing her innermost secrets - being psychologically naked - a form of transference, because the client had learned that "she has concealed herself from the prying eyes of those who would take advantage of her (father and husbands)" and this would no longer be necessary in the therapeutic relationship, because the therapist would not take advantage of her (Mann, 1997, p.19)

2.1.3. Problems with transference

Cutler (1958) found that the content of client's material frequently elicited countertransference reactions. Whereas some triggers can be considered objective and factual (e.g. the client discussed death, therapy was interrupted for several weeks), most triggers were the result of the therapists' subjective perceptions. For example, countertransference was stimulated by the therapists' phenomenological evaluations of the progress in therapy, appraisals of the client, comparisons of the client to others, or perceptions of a certain level of emotional arousal in the client or therapist.

2.2. Cognitive analytical therapy: A definition

Ryle (1990, 1995) describes cognitive-analytical therapy (CAT) as a time-limited integrated psychotherapy. It emerged as a formal psychotherapy method in 1990 and was developed with the aim of providing psychotherapy within the National Health Services. As the name suggests, the model integrates a wide range of theory and practice (psychoanalytical, cognitive and behavioural) yet retains a distinct method. A central feature is the reformulation of the patient's problems in terms of procedures, defined as repetitive goal-directed sequences of perceptions and beliefs, predictions, and appraisals, actions, or roles, the consequences of enactment, notably the responses of others and the evaluation of the consequences. The process of reformulation in cognitive analytical therapy is intended to facilitate a work-oriented therapeutic alliance (Ryle, 1990). A full description of the method is beyond the scope of this paper (see Ryle, 1990), but the main distinguishing features of CAT are the joint descriptive reformulation of the patient's problem and their active participation in therapy (normally 16 weekly sessions).

2.2.1. Interpersonal processes in cognitive analytical therapy

Ryle (1998) examines interpersonal processes such as transference and countertransference from the theoretical viewpoint of cognitive analytical therapy. Transference, countertransference, and projective identification are understood in terms of reciprocal role procedures (Ryan, 1994). The patient enacts one or other pole of a particular reciprocal role pattern producing pressure on the therapist to enact the reciprocal role. Countertransference is understood as the therapist's awareness of this or their tendency to respond to this pressure. Ryan (1998) states that the concept of transference implies that the patient has an inappropriate or misguided perception of the therapist. This perception will be manifested in the fact that much of what patients do or say, at least early in therapy, is the representation of one or other of their repertoire of problematic procedures. These manifestations may take form of overt acts (being silent or late, for example) or of statements such as idealising or rubbishing the therapist). Ryan (1998) distinguishes two main forms of transference. The patient either seeks to deny differences and takes on the therapist's role and characteristics (*identifying transference*) or he/she seeks from the therapist a response that matches one of his or her (harmful) reciprocal roles (*reciprocating transference*). Roles are seen to incorporate beliefs, values, memories and affects in association with

patterns of behaviour and expectation. In theory, every role described in the repertoire may be enacted by the patient in relation to the therapist or may be induced in, or perceived to be played by, the therapist. The reformulation provides, therefore, a comprehensive list of potential transference-countertransference interactions.

Ryan (1998) points out the existence of two different types of countertransference as well. He describes the *elicited countertransference* as a response to whatever role the patient is playing. He differentiates this type from the therapist's *personal countertransference* that derives from his or her own array of role patterns. The existence of *identifying* and *reciprocating countertransference* are pointed out as well (Ryan, 1998). He points out that it is important to recognise reactions, such as the induction of feelings in the therapist that are associated with one or other roles in the patient's repertoire, as belonging to the patient. Ryan (1998) points out that they provide a basis for accurate understanding and should be discussed with the patient, especially when they represent unacknowledged or unmanageable feelings. It makes them more acceptable because they are shared and named. Emphasis is placed on the fact that the "therapist cannot know what it is that the patient cannot feel: and for example, the anger evoked in a therapist by a story of abuse may be his or hers and appropriate but may never been experienced by the patient. In such cases it is better to present the feelings as one's own than to claim knowledge of what is 'in the patient's unconscious', or to make assertions about possible origins (Ryle, 1998, p.306-307)".

2.3. Interpersonal processes in cognitive-behavioural therapy

Transference and countertransference are present in cognitive-behavioural therapy as well. Watkins (1983) identified the following five transference patterns in counseling including cognitive behavioral therapy:

1. *Counselor as ideal.* The client sees the therapist as the perfect person who is doing everything right, without flaws. When clients elevate the therapist, they usually put themselves down.
2. *Counselor as seer.* Clients view the therapist as an expert, all-knowing and all-powerful. They look to the therapist for direction and might remain dependent.
3. *Counselor as nurturer.* Some clients look to the therapist for nurturing and feeding, as a small child would. The therapist may get lost in giving sympathy and feeling sorry for the client and become a nurturing parent. In the process, the client never learns the meaning of personal responsibility.
4. *Counselor as frustrator.* The client is defensive, cautious and guarded and is constantly testing the therapist. In this case it is essential that therapists avoid reacting defensively, a response that would further entrench clients' resistance.
5. *Counselor as nonentity.* In this form of transference the client regards the therapist as an inanimate figure without needs, desires, wishes, or problems. If therapists depend on feedback from their clients as the sole means of validating their worth as therapists, they may have difficulty managing cases in which this phenomenon exists.

However transference is not used at all to facilitate change. The avoidance to act on a reciprocating countertransference that was evoked by the patient's direct or non-verbal communication can be seen as modelling. It is important in cognitive-behavioural therapy as well, to recognise the pressure to reciprocate, or to note the inevitable inadvertent reciprocation all therapists are at times induced to supply. It serves to illustrate the extent to which the patient has actively sought confirmation of the damaging patterns and it opens up the possibility of exploring other possible ways of proceeding. The therapist's job here is straight forward – not to join the “dance” but to model different behaviours.

The terms modelling, imitation or social learning have been used interchangeably. They describe one of the interpersonal processes used in cognitive behavioural therapy to implement change. All refer to the process by which behaviour of an individual or a group acts as a stimulus for similar thoughts, attitudes, and behaviours

on the part of observers. Bandura (1969, 1971a, 1971b, 1977, 1986) has emphasised the role of modelling in the development and the modification of much of human behaviour. He outlines three major effects of modelling. First is the acquisition of new responses or skills and the performance of them. This observational-learning effect refers to integrating new patterns of behaviour based on watching a model. The therapist can act as a model in training of verbal and motor skills for autistic children. The second effect of modelling is an inhibition of fear responses, which occurs when the observer's behaviour is inhibited in some way. In this case the model that performs an inhibited fear response either does not suffer negative consequences or, in fact, meets with positive consequences. Examples include models that handle insects and do not get hurt. The third effect of modelling is a facilitation process of responses, in which a modelling provides cues for others to emulate. The effect is to increase behaviours that the individual has already learned and for which there are no inhibitions.

Several types of models can be used in therapeutic situations. A live model can teach the client appropriate behaviour, influence attitudes and values and teach social skills. For example therapists can model the very characteristics that they hope their clients will acquire. Through their actual behaviour during sessions, therapists can best teach self-disclosure, risk taking, openness, honesty, compassion and the like. Therapists are constantly serving as a live model for their clients - for better or for worse! In addition to modelling desired behaviours and attitudes, therapists can also adversely influence their clients by modelling rigidity, lack of regard and respect, fear, rudeness, boldness and aloofness. This might happen as a result of an unrecognised countertransference. As pointed out earlier the therapist's personal countertransference derives from his or her own array of role patterns. Personal therapy and supervision aim to make such responses quickly recognised and controlled.

Multiple models are especially relevant to group cognitive-behavioural therapy. The observer changes attitudes and learns new skills through observation of successful peers. Modelling is also part of other treatments, particularly those involving role-playing, in which the therapist may rehearse and enact alternative behaviours.

As mentioned before modelling is used in the treatment of autistic children. The essential feature of autism is that the child's ability to respond to others does not develop within the first thirty months of life. Even at that early age, gross impairment

of communicative skills is already quite noticeable. The child's vocalisations are reinforced by the therapist until they occur very frequently. Then the therapist acts as a model and the child will be rewarded for imitating the sounds produced by the therapist, and simultaneously punished for meaningless sound. Here modelling is combined with reinforcement. When imitation is established, children are taught to label everyday subjects using the same modelling approach.

Modelling in combination with flooding and response prevention can also be used as part of the treatment of obsessive-compulsive disorders. A client who has the obsessive thought that he might be contaminated with germs spends four hours a day washing himself. In therapy, he first watched the therapist to contaminate herself with dirt (modelling). He then was urged to rub dirt and dust all over himself (flooding) and endure it without washing it off (response prevention). After about a dozen sessions of covering himself with dirt and dust sitting there without washing it off, the thoughts of contamination diminished and the washing ritual no longer occurred in his daily life.

Modelling can be done in a way so that the client observes the actions of the therapist consciously and is able to repeat them. The demonstration of relaxation techniques such as autogenic training and abdominal breathing are just two examples. Modelling can also be used to demonstrate appropriate interpersonal skills. These skills are displayed constantly as part of the therapeutic intervention and can be internalised by the client and used in an environment outside of therapy. For example clients who participate in an anger management program usually have a low frustration tolerance and below average problem solving skills. When a client gets angry during a session the therapist can model an appropriate response and the client will benefit by learning that the behaviour modelled is useful in solving the conflict. The therapist can also use role-playing to teach social or interpersonal skills acting as the model to teach appropriate behaviour. D'Zurilla & Goldfried (1971) emphasise the usefulness to patients of learning to imitate appropriate models when learning problem-solving strategies and Mahoney (1974) maintains that it can be useful for the therapist to "think out loud" to give patients a good model of the kind of cognitive-mediation skills that can be used in dealing with difficult situations.

3. Conclusion

While all forms of psychotherapy require effective therapeutic relationships the example of Mrs A. should have made clear that the client/therapist relationship is of vital importance in psychodynamic-oriented interventions. As a result of working through the transference situation, Mrs. A acquired insights into her unconscious psychodynamics. One could argue that the therapist in the case of Mrs. A acted as an appropriate model to teach her that revealing her "innermost secrets" would not hurt her. However the emphasis was on reliving the past, the inclusion of emotional experience as well as working through the transference with repetitive interpretations. The lenses through which therapists see the world largely dictate whether and when countertransference is stimulated. It is recommended that therapists check their lenses continually to heighten their self-awareness and enhance their ability to recognise stimuli that are likely to trigger countertransference. In fact, research indicates that therapists' awareness is inversely related to countertransference behaviour and is critical to managing countertransference (Latts & Gellso, 1995; Van Wagoner et al., 1991).

It appears as if most countertransference reactions affect the emotional distance between therapist and client. Some reactions predictably draw the therapist and the client closer together (e.g. identifying or empathising with the client) whereas other reactions push the therapist and the client further apart (e.g. blocked understanding, boredom). However negative feelings seem to be unpredictable in their effect on the distance between therapist and client. For example, some therapist may react to their anxiety by withdrawing from the client (Hayes & Gelso, 1991), whereas other may respond by increasing their involvement with the client (Gelso et al., 1995). Therefore it can be concluded that countertransference contributes to the constant dance that occurs between client and therapist of drawing nearer or moving apart, of "joining and disjoining" (Perls, 1947, p.22), of "merging with and separating from" one another (Gorkin, 1987, p.80).

Many of the ideas incorporated in the model of transference-countertransference in cognitive analytical therapy have been expressed in a different form in psychodynamic intervention. Leiman (1997) and Bollas (1987) have pointed out that transference communication may represent different voices addressed to different figures represented by the therapist. Cognitive analytical therapy uses psychological and everyday language rather than notions based on fantasy (such as projection,

introjection and internal objects) and clarifies the distinction between identifying and reciprocating countertransference. In contrast to psychodynamic Ryan (1998) points out that it will be appropriate to recognise identifying countertransference reactions and discuss them with the patient and present them as one's own response rather than to claim knowledge of the patient's unconscious thoughts and feelings. Cognitive analytical therapy bases itself on phenomena that can be observed, described and refined with the patient's cooperation. The client will understand the continuing influence of intrapsychic and interpersonal procedures and it is asserted how every act or communication is addressed to another person or to a part of the self.

Transference and countertransference reactions can be observed in cognitive behavioural therapy as well. The potential effects of transference, as shown in the examples, clearly demonstrate why all therapists must be aware of their own needs, motivation and personal reactions. If they are unaware of their own dynamics, they may avoid important therapeutic issues instead of challenging their clients to understand and resolve the feelings they are bringing into the present from the past.

Most therapists in Australia follow a cognitive behavioural orientation and it is the author's impression that many of them do not recognize transference and countertransference reactions or ignore their presence. Cognitive behavioral oriented therapists rather reflect on transference reactions by identifying the behaviour and exploring the underlying emotion as well as the automatic thoughts associated with it. They are usually less aware of their countertransference reactions and it is the author's view that they are more likely to experience reciprocating countertransference. Similarities between modelling and working through a transference reaction can be clearly seen. The interpretation of the transference from an analytical perspective (the client is angry because he feels rejected for not being able to have an additional session with the therapist this week) helps the client to gain an understanding of the origin of his behaviour and emotion and at the same time models a process that the client can follow in similar situations. If looked at from a cognitive behavioural perspective the therapist models a process of problem resolution by exploring the underlying automatic thoughts that led to the anger outburst. Although therapists must be aware of the possibility of transference, they should also be aware of the danger of discounting the genuine reactions their clients have towards them.

The review clearly shows evidence of transference and countertransference reactions in psychodynamic, cognitive analytical and cognitive behavioural interventions. Psychodynamic as well as cognitive analytical therapists use these interpersonal processes to facilitate change, whereas cognitive behavioural therapists should be aware of these patterns but use other specific factors such as modelling to influence treatment outcome.

4. References

- Adelstein, D.M., Gelso, C.J., Haws, J.R., Reed, K.G. & Spiegel, S.B. (1983). Client change factors predictive of continued growth after brief, time-limited counseling. (In C. Gelso & D. Johnson (Eds.), *Explorations in time-limited counseling and psychotherapy* (pp. 115-128). New York: Columbia University, Teachers College Press.)
- Bandura, A. 1969. *Principles of behavior modification*. New York: Holt, Rinehart & Winston.
- Bandura, A. 1971a. *Psychological modeling: Conflicting theories*. Chicago: Aldine-Atherton.
- Bandura, A. 1971b. Psychotherapy based upon modeling principles. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change*. New York: Wiley.
- Bandura, A. 1977. *Social learning theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Bandura, A. 1986. *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Blanck, G & Blanck R. (1979). *Ego Psychology : Psychoanalytic development psychology*. New York: Columbia University
- Brammer, L. & Shostrom, E. (1982) *Therapeutic Psychology*. Englewood Cliffs, NJ: Prentice Hall.
- Cerney, M. (1985). Counselor Verbal Interaction, Non-verbal behaviour modification. *Journal of Abnormal Psychology*, 78, 107-126.
- Dzurilla, T.J. & Goldfried, M. R. 1971. Problem solving and behavior modification. *Journal of Abnormal Psychology*, 78, 107-126.
- Ehrenreich, J.H. (1989). Transference: One concept or many? *Psychoanalytic Review*, 76, 37-65.
- Fine, R. (1990). *The history of psychoanalysis*. New York: Continuum.

Freud, S. (1959). Future prospects of psychoanalytic psychotherapy. (In J. Stachey (Ed. and Trans.). *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 87-172). London: Hogarth Press. (Original work published 1910)).

Freud, S. (1958). The dynamics of transference. (In J. Strachey (Ed. and Trans.) *The standard edition of the complete psychological works of Sigmund Freud* (vol. 12 pp. 99-108). London: Hogarth Press. (Original work published 1912)).

Freud, S. (1958). Observations on transference love. (In J. Strachey (Ed. and Trans.) *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 157-171). London: Hogarth Press. (Original work published 1915)).

Fromm-Reichman, F. (1950). *Principles of intensive psychotherapy*. Chicago: University of Chicago.

Gelso, C.J. & Carter, J.A. (1985). The Relationship in Counselling Psychotherapy: Components, Consequences, and Theoretical Antecedents. *The Counseling Psychologists*, 13, 155-243.

Gelso, C.J. & Carter, J.A. (1994). Components of the psychotherapy relationship: their interaction and unfolding during treatment. *Journal of Counseling Psychology*, 41, 294-306.

Gelso, C.J., Fassinger, R.E., Gomez, M.J. & Latts, M.G. (1995). Countertransference reactions to lesbian clients: The role of homophobia, counselor gender, and countertransference management. *Journal of Counseling Psychology*, 42, 356-364.

Gelso, C.J., Hill, C.E., Mohr, J.J., Rochlen, A.B. & Zack, J. (1999). Describing the Face of Transference - Psychodynamic Therapists' Recollections About Transference in Cases of Successful Long-term, Therapy. *Journal of Counselling Psychology*, 46, 257-267

Gill, M.M. (1982). *Analysis of transference: Theory and technique* (Vol. 1). Madison, CT: International Universities Press.

Gorkin, M. (1987). *The uses of countertransference*. Northvale, NJ: Jason Aronson.

Hayes, J.A. & Gelso, C.J. (1991). Effects of therapist - trainees' anxiety and empathy on countertransference behaviour. *Journal of Clinical Psychology*, 47, 247-290.

Heimann, P. (1950). On countertransference. *International Journal of Psychoanalysis*, 31, 81-84.

Heimann, P. (1960). Countertransference. *British Journal of Medical Psychology*, 33, 9-15.

Kelly, E.W. (1997). Relationship-centered counselling: A humanistic model of integration. *Journal of Counseling Development*, 75, 337-345.

Langs, R.J. (1974). *The technique of psychoanalytic psychotherapy*. (Vol. 2). New York: Jason Aronson.

Latts, M. G. & Gelso, C.J. (1995). Countertransference behaviour and management with survivors of sexual assault. *Psychotherapy*, 32, 405-415.

Little, M. (1951). Countertransference and the patient's response to it. *International Journal of Psychoanalysis*, 32, 32-40

Little, M. (1960) Counter-transference. *British Journal of Medical Psychology*, 33, 29-31.

Mahoney, M. J. 1974. *Cognition and behavior modification*. Cambridge, Mass.: Ballinger.

Malan, D.H. (1976). *Toward the validation of dynamic psychotherapy*. New York: Plenum Press.

Mann, D (1997). *Psychotherapy - An Erotic Relationship: Transference and Countertransference Passions*. New York: Routledge.

Perls, F.S. (1947). *Ego, hunger, and aggression*. New York: Random House.

Rhoads, J.M. & Feather, B.F. (1972). Transference and resistance observed in behaviour therapy. *Journal of Medical Psychology*, 45, 99-103.

Ryan, V.L. & Gizynski, M.N. (1971). Behaviour therapy in retrospect: patients' feelings about their behaviour therapy. *Journal of Consulting and Clinical psychology*, 37, 1-9.

Ryle, A. (1990) *Cognitive Analytic therapy: Active Participation in Change*. Chichester: John Wiley.

Ryle, A. (1995) (Ed). *Cognitive Analytic therapy: Developments in Theory and Practice*. Chichester: John Wiley.

Strachey, J. (1934). The nature of the therapeutic action in psycho-analysis. *The International Journal of Psycho-Analysis*, 15, 127.159.

Strupp, H.H. & Binder, J.L. (1984). *Historical Background: Overview and critique. Psychotherapy in a new key*. New York: Basic Books.

Styles, W.B., Statrup, M. et al. (1996). Therapist intentions in cognitive-behavioural and psychodynamic-interpersonal psychotherapy. *Journal of Counseling Psychology*, 43, 402-414.

Van Wagoner, S.L., Gelso, C.J., Hayes, J.A. & Diemer, R.A. (1991). Countertransference and the reputedly excellent psychotherapist. *Psychotherapy*, 28, 411-421.

Watkins, C. E. (1985). Countertransference: Its impact on the counseling situation. *Journal of Counseling and Development*, 63, 356-359.



U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)



Reproduction Release

(Specific Document)

I. DOCUMENT IDENTIFICATION:

Title:	Interpersonal Processes in Psychoanalytic, Cognitive Analytical and Cognitive Behavioural Therapy		
Author(s):	HABICHT, Manuela H		
Corporate Source:	Deakin University, Geelong Australia	Minor Project	Publication Date: January 2001
Paper			

II. REPRODUCTION RELEASE:

In order to disseminate as widely as possible timely and significant materials of interest to the educational community, documents announced in the monthly abstract journal of the ERIC system, Resources in Education (RIE), are usually made available to users in microfiche, reproduced paper copy, and electronic media, and sold through the ERIC Document Reproduction Service (EDRS). Credit is given to the source of each document, and, if reproduction release is granted, one of the following notices is affixed to the document.

If permission is granted to reproduce and disseminate the identified document, please CHECK ONE of the following three options and sign in the indicated space following.

The sample sticker shown below will be affixed to all Level 1 documents	The sample sticker shown below will be affixed to all Level 2A documents	The sample sticker shown below will be affixed to all Level 2B documents
<p>PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY</p> <p>_____</p> <p>TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)</p>	<p>PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE, AND IN ELECTRONIC MEDIA FOR ERIC COLLECTION SUBSCRIBERS ONLY, HAS BEEN GRANTED BY</p> <p>_____</p> <p>TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)</p>	<p>PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY</p> <p>_____</p> <p>TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)</p>
Level 1	Level 2A	Level 2B
<input checked="checked" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Check here for Level 1 release, permitting reproduction and dissemination in microfiche or other ERIC archival media (e.g. electronic) and paper copy.	Check here for Level 2A release, permitting reproduction and dissemination in microfiche and in electronic media for ERIC archival collection subscribers only	Check here for Level 2B release, permitting reproduction and dissemination in microfiche only
<p align="center">Documents will be processed as indicated provided reproduction quality permits. If permission to reproduce is granted, but no box is checked, documents will be processed at Level 1.</p>		

I hereby grant to the Educational Resources Information Center (ERIC) nonexclusive permission to reproduce and disseminate this document as indicated above. Reproduction from the ERIC microfiche, or electronic media by persons other than ERIC employees and its system contractors requires permission from the copyright holder. Exception is made for non-profit reproduction by libraries and other service agencies to satisfy information needs of educators in response to discrete inquiries.

Signature: <i>Dr. Manuela H. Habicht</i>	Printed Name/Position/Title: Dr. Manuela H. Habicht
Location/Address: 5 Goodman Court, Woomba QLD 4350, Australia	Telephone: +61 412 6330281 Fax: +61 7 33022392
	E-mail Address: 100104.2743 Date: 14.06.01

III. DOCUMENT AVAILABILITY INFORMATION (FROM NON-ERIC SOURCE):

If permission to reproduce is not granted to ERIC, or, if you wish ERIC to cite the availability of the document from another source, please provide the following information regarding the availability of the document. (ERIC will not announce a document unless it is publicly available, and a dependable source can be specified. Contributors should also be aware that ERIC selection criteria are significantly more stringent for documents that cannot be made available through EDRS.)

Publisher/Distributor:
Address: N/A
Price:

IV. REFERRAL OF ERIC TO COPYRIGHT/REPRODUCTION RIGHTS HOLDER:

If the right to grant this reproduction release is held by someone other than the addressee, please provide the appropriate name and address:

Name:
Address: N/A

V. WHERE TO SEND THIS FORM:

<p>Send this form to the following ERIC Clearinghouse:</p> <p style="text-align: center;">ERIC Counseling and Student Services Clearinghouse P.O. Box 6171 201 Ferguson Building University of North Carolina at Greensboro Greensboro, NC 27403-6171</p> <p style="text-align: center;">ATTN: Processing Coordinator</p>

However, if solicited by the ERIC Facility, or if making an unsolicited contribution to ERIC, return this form (and the document being contributed) to:

ERIC Processing and Reference Facility
Computer Sciences Corporation
4483-A Forbes Boulevard
Lanham, MD 20706
Telephone: 301-552-4200
Toll Free: 800-799-3742
FAX: 301-552-4700
e-mail: ericfac@inet.ed.gov