Linda was feeling intense guilt about her decision. As we rehearsed what each would say to their son, it became evident that Pete could not give the information without angrily blaming Linda. Therefore, it was agreed that Linda should be allowed to tell him first. This was carried out and reported on in a session that was very emotional for all of us, as we moved toward ending. Both individuals said they found the termination phase of the therapy helpful, but Pete acknowledged that he still had his hopes up every time they came for a session. The decision to stop therapy was a painful one for him. They were each offered referrals for individual therapy.

It is difficult to summarize technique by describing only a few cases. However, some of the differences between working with couples and working with individuals have been highlighted in the above examples, including: the possibility of different agendas in starting treatment; the ability to see the relationship *in vivo*; the richness and complication of having another individual contribute to the therapeutic interaction; the need to balance airtime and attention; the unique opportunity to work on an individual issue within the couples context; and the more active involvement of the therapist. The ending phase, which leads to termination, has its own special characteristics in this milieu. Before discussing this phase, it will be helpful to examine in greater detail the issues of transference and countertransference as they are manifested in psychoanalytic couples therapy.

Chapter 5

Transference(s)

As we have seen, psychoanalytically-informed couples therapy has borrowed from and elaborated on many ideas from psychoanalysis and from individual psychoanalytic psychotherapy, including the unconscious and mechanisms of defence. In terms of the concepts of transference and countertransference, the couples therapist is dealing with multiple, interacting partner-to-therapist and partner-to-partner transferences and countertransferences. In this chapter, the concept of transference will, somewhat artificially, be sifted out from the concept of countertransference for the purpose of highlighting its special properties in this milieu. The vagaries of the countertransference will be the focus of the next chapter.

> Every beginner in psycho-analysis probably feels alarmed at first at the difficulties in store for him when he comes to interpret the patient's associations and to deal with the reproduction of the repressed. When the time comes, however, he soon learns to look upon these difficulties as insignificant, and instead becomes convinced that the only really serious difficulties he has to meet lie in the management of the transference.
>
> (Freud, 1915a, p. 159)

The concept of transference has been hailed in psychoanalysis as everything from the greatest obstacle to the treatment to the most important and facilitative aspect of it. In either case, the understanding and analysis of transference

phenomena have always been at the very centre of the therapeutic endeavour for psychoanalytic therapists. Different schools of psychoanalysis emphasize different aspects of the definition and the manifestation of transference. Traditionally, the meaning of transference was the displacement of a whole series of positive and negative psychological experiences from the patient's past onto the person of the therapist. Those were the days when the therapist was considered a neutral observer, a blank screen onto which the patient could rather easily project their fantasies, wishes, desires, and fears from past relationships. Earlier, Greenson (1967) said that for a reaction to be considered transference, it must have two characteristics: it must be a repetition of the past and it must be inappropriate to the present. We also know that transference does not only occur in therapeutic situations but is ubiquitous.

The thinking about transference has gone through several iterations since Freud's day, as the concept of a two-person therapy has taken hold. The analyst's role in the creation of the transference, not only their "real" personality characteristics, but their mood, desires, needs – conscious and unconscious – are seen as inevitably part of the result. We repeat Renik's (1993) catchphrase of the "analyst's irreducible subjectivity" as a mantra.

It is not a new assumption that the marital relationship rests, at least in part, on expectations and perceptions that have been transferred from one partner's earlier significant life experiences to the other. To the extent that such "transferences" are gratified or corroborated, the marital relationship may be satisfactory. However, as has been referred to earlier, at least two unsatisfying eventualities can occur: one or more key expectations are sorely disappointed, the partner eventually turning out to be the reverse of what they appeared to be during the courtship; or a life crisis, for example illness, forces a shift in the equilibrium so that the previous "transference" need is no longer gratified.

In couples therapy, because individuals are involved in *reliving* the history of their object relations conflicts and

desires, instead of just reporting it, there is a unique opportunity to understand and make interpretations about the transference components of the relationship as well as the transference to the therapist.

> Whereas the individual therapist deliberately conducts himself in such a way as to reduce to a minimum the limitations of what can be brought into the transference, the partners in a marriage are continually defining between them the limits of what can be expressed within the relationship, such that the "material" that is brought to the therapy is, in a sense, pre-defined.
>
> (Colman, 1993, p. 73)

Unresolved oedipal issues, in both the individuals in the couple are a rich source of conscious and unconscious transference triggers in this type of therapy. Guttman (1982) states that when the particular triadic situation of couples therapy, involving the transference between the partners and the therapist, is added to the partner transferences, marital conflicts may be heightened. This allows the therapist to see them more clearly, make helpful interpretations, and speed up the process of working through, especially because the other person is present. The occurrence of the transference-like process raises the question of identifying the curative factor in couples therapy, since the traditional resolution of the transference that indicates a "cure" in individual psychoanalysis and leads to a more realistic view of the analyst, is, in a way, already present from the start with couples.

Being aware of the transferences in working with couples means thinking about the following permutations and combinations: the transference of each individual to the therapist, in other words, how the therapist is represented for each person; how the therapist is represented for the couple together; and the transferences of the partners to each other.

Transferences to the therapist

The *idealizing transference* that is usually present at the start of treatment, as described earlier, is often a nurturing one, as partners need to believe they have found a safe haven at last, and the therapist needs to feel that they think he or she can help them. The idea of expressing negative feelings toward the therapist is too threatening at first, even though a couple may perceive the therapist as withholding, intimidating, or just plain wrong; there are enough negative feelings already in the room. It seems so important to keep the therapist idealized, at least in the beginning and sometimes throughout the treatment, that partners may displace anger and negative feelings onto each other in order to "protect" the therapist. Often this is difficult for a couple to acknowledge, and discussions of why they need to do this may be only minimally productive.

The joint fantasy is that the therapist is in a happy marriage with a wonderfully attuned spouse (whom he or she may have "trained"), and has healthy, normal children who are all successful in their endeavours. Since this is rarely – actually, never – the case, the couples therapist seems even more charged with walking the fine line between real life and the transference expectations of the two partners than is the individual therapist.

To the extent that one sees the real characteristics of the therapist as seeping into the transference, the *gender of the therapist* can be salient (Kalb, 2002). Kulosh and Mayman (1993), who conducted a study on gender-linked determinants in transference and countertransference in individual therapy, found that the therapist's gender is a significant, powerful and organizing influence on the way transferences emerge. Turkel (1992) discusses the *choice* of the therapist by gender. When couples choose a therapist, both partners' fantasies about therapist gender have to coincide, to some extent, and so discussion about this has probably already taken place within the couple in some form (e.g. "Are you OK with seeing a male/female? Will you feel ganged up on/sympathized with?").

"Excuse me for a moment. It's my idiot husband."

The patient's gendered response may trigger a reaction in the therapist. If we think of this as a two-subject co-created influence, then we cannot distinguish absolutely between fantasy and reality. "Instead, transference represents a fluid, perpetually intermingling blend of fantasy and reality, similarity and uniqueness, which focuses on the experiences of both the internal and external relationship. It is inevitably laden with both the . . . [therapist and patient(s)'] reciprocally intertwined gender constructions and actualized by . . . [all] parties" (Kalb, 2002, p. 121). The cartoon at the opening of the next chapter speaks to this issue from the perspective of gender-related countertransference.

At the beginning of treatment, the therapist usually elicits a *parental* transference, and, as therapy progresses, remains in some version of this – expert, teacher, "doctor." As the

maternal transference settles onto me, and usually hangs around, in some form, as mentioned above, until the end of treatment, I have found that couples need "parenting" as much or more than individuals. Perhaps it is not particularly surprising that the triadic situation of two patients with one therapist evokes this children–parent dynamic.

Most studies show that in couples therapy, the transferences seem more likely to be congruent with the therapist's gender and other realistic characteristics. I have never had the experience of being the object of a father transference here, as I have occasionally in individual therapy, and more frequently in psychoanalysis. This relates to the limited opportunity for regression in this milieu, as the reminder of reality is ever present in the person of the other partner. Another factor in the dilution of the regressive transference to the therapist in couples therapy may relate to the transfer – or, at least, sharing – of the libidinal action between the therapist and the partner; it also could be a result of the therapist's more active, and hence more "real," involvement with the couple. In fact, the transference seems to lighten as the work goes on.

Couples who come to therapy presenting with their own parenting problems as one of the difficulties in their relationship may see the therapist as the parent they never had, who they hope can provide them with the inner resources to parent their own children. Sometimes a couple in this situation will collusively contrive to bring their young child to the session (e.g. "We couldn't find a babysitter . . ."), so that the therapist can directly observe, help, and indirectly parent them parenting their child. One or two sessions like this, later discussed with the couple, are often very productive for normalizing their anxieties about their child and supporting their parenting skills; as well, and the therapist can see how the couple interact when their child is present. This rich discussion takes place, of course, *after* the babysitter has been re-found.

Complementary to the parental transference is the evoking of the inevitable *sibling* transference in the partners, which

yields material rarely seen in individual treatment. The setting is perfect for sibling rivalries. Depending on how the couple relate when they are not in the consulting room – e.g. some couples are already rivalrous in terms of work achievements or household tasks – the couple will respond to the therapist in a more or less competitive manner. The most obvious competition is for the role of the good, wounded person versus the bad, aggressive person. Some couples will go out of their way to fight out these roles for the therapist's "benefit," to vie for the therapist's attention. It is surprising how all ages of partners will resort to tattling on each other, or to scolding each other.

There may also be competition for the limelight, such as it is, or for avoidance of it. In the case of one couple I saw, who had come into therapy to separate, they were often playing "whose session is it anyway." In one session, the female partner referred to the therapy as *his* therapy; he retorted that she felt that way because for once she wasn't taking up the total time.

The wish to have the therapist judge who is "right" is almost always expressed to some extent at the beginning, and with some couples can be prolonged and exaggerated through the treatment (an example of this was mentioned in the report-card behaviour described in the last chapter). These couples may not notice their competition for the therapist, as it is an integral part of how they usually relate, i.e. like siblings.

The therapist's skill in balancing airtime and giving each person attention in turn, as discussed earlier, can limit the sibling rivalry that is aroused from the anxiety of being in this triadic situation. If that is not enough, then tracing the individuals' family experiences, particularly with siblings, will be helpful. When this kind of situation threatens to become destructive to the therapy, it is often found that one or both partners are involved in eternal feuds with a sibling, or do not have any contact with him or her. Analogies may then be helpfully drawn to the relationship of the couple themselves, especially as it manifests itself in the therapy.

Of course, there can be different, or *asymmetrical*, transferences to the therapist in the two partners. In the case of Mirella and Nick, described in the preceding chapter, Mirella developed a dependency on me for some time, which Nick did not *seem* to have. She insisted on saving important discussions for our time together, even though Nick protested that they could surely talk about controversial issues without me. Mirella had found a mother and father in one, and had the natural expectation projected from her past that I would understand and help her. Nick felt that coming for therapy was like taking medicine. It was "OK," but his preference was not to be here. He was impatient with how slowly it moved, whereas Mirella enjoyed the slow, detailed pace. Nick was glad of a recent one-month break, taken because of their holiday, saying that now they would have a chance to try out what they had learned; Mirella appeared sad to have the break.

The therapist must also be aware that the different overt transferences may reflect the couple's internal dynamics. In the case of Mirella and Nick, Mirella knew of Nick's need to be seen as the strong, independent one, and she may have taken the other role to help out. This ensures for Nick that he can keep coming to therapy without having to face his own dependency needs – that is, until this dynamic is explored.

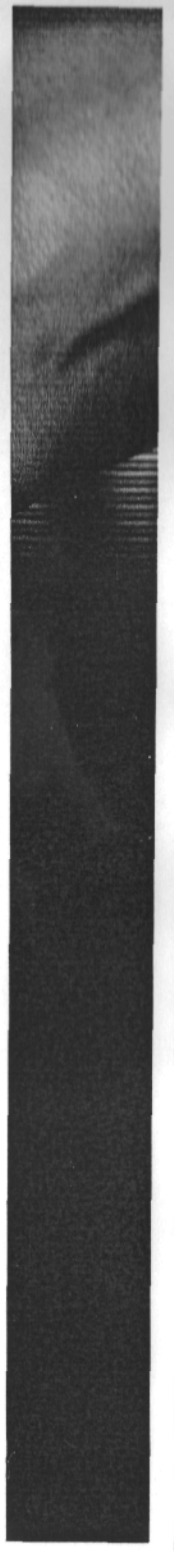
Another window into dissimilar transference reactions is provided when one partner keeps cancelling appointments or one is consistently late. In this situation, the "delinquent" partner evokes a reaction in both the other partner and the therapist, and it is difficult to tell whether one, or both, are the object of the transference fantasy being manifested as a resistance, until it is analysed.

A difference in transference reactions can also come about in the situation where a couple are engaged in the dichotomy of caretaker–cared-for, mentioned in the last chapter. The cared-for partner may make a switch to the therapist as caretaker, while the caretaker partner feels threatened and competes with the therapist. In the case of Gail and John, the couple who met when Gail was a graduate student in John's

department, introduced briefly in Chapter 3, Gail, fifteen years younger than John, was often in the position of being looked after. At first, John did not seem to mind that I was taking over in this role with her; in fact, it sometimes seemed that he appreciated it. There came a time, however, when he needed to be part of the interaction, especially when Gail was complaining about issues other than their marriage. At these times, John (who was very close to my age) and I became parents together. I particularly remember that at the time of 9/11, Gail was extremely anxious, afraid to travel in the city, certain that Toronto would soon be under attack. John and I were both involved in trying to help her feel calmer, which she actually seemed to like very much. In fact, *both* were smiling as I communicated that observation, confirming my dawning sense that I was participating in an enactment, as McLaughlin (1991) defined it. John's gratification at our mutual participation may have been: *You can see what I have to deal with; or, I'm as good or better at helping her than you; or you and I are one.*

The fantasy of being identified with the parent (in my case, mother) in playing co-therapist is a special type of transference in couples therapy, as there is a "child" in opposition to whom one stands. This idea is also evident in the report-card behaviour, and was seen in the example of Lisa and Eric who were working on issues of separation from Lisa's parents. A scientific enquiry into the different transferences of each (opposite- or same-sex) partner to the one therapist, and their effects on outcome, would be interesting, but is beyond the scope of this book.

There are some couples who strongly want to be admired *as a couple* (Sharpe, in Solomon and Siegel, 1997), overshadowing in the beginning their individual competition for the therapist's approval. This is known as the *whole couple transference*. This type of couple often present as playful in exhibiting their wit and charm, and may even be entertaining. I once saw a couple who started each session with comedy routines, as if they were on stage. They were very amusing, at first, with jokes that were sometimes spontaneous, and that



sometimes seemed already practised in social situations. These types of couples strive to be the therapist's favourite couple, and often succeed – at least for a while. Their joint idealizing transference to the therapist often evokes a corresponding idealization of the couple.

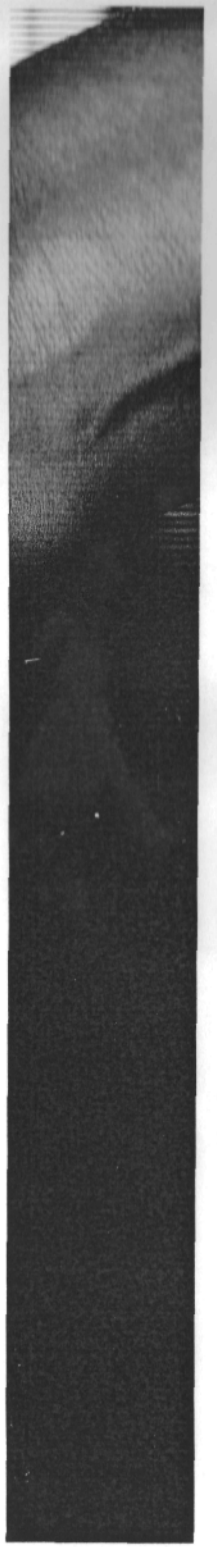
The good news about borderline couples who are locked in chronic dysharmony and who have an angry and negative whole couple transference to the therapist (as happened in the case of Rita and Stan, described briefly in Chapter 2) is that at least they can unite about something. Both Rita and Stan had a historical tendency to use denial and splitting as defences. Making me into the inadequate and incompetent one served the function of a mutual denial and splitting off of undesirable traits in themselves and in each other, to some extent. They then were able to react negatively or punitively to me, which seemed, miraculously, to make their marriage better – at least in the first month or two. In fact, when they left our sessions after fighting loudly with each other, and telling me that I didn't understand them at all, they always remarked that they felt much better, and their week together went well. (*Glad to be of service*, I would say to myself.)

There may, of course, be a private "whole couple" transference that is difficult to discern – i.e. how the couple talk about the therapist when they are not with him or her. Sometimes how they refer to me when they are alone together slips out – for example, one couple, in describing a conversation they had, unwittingly referred to me as "the Ush." I was unsure what to make of this; somewhat embarrassed, they quickly assured me it was a term of affection.

Individual *erotic transferences* seem much more diluted, if they occur at all. It is hard to flirt with someone with your partner present. The way I have sometimes noticed them is in the discomfort that (mostly) male partners may feel when they are left alone with me. In the way I work, this does not happen when they arrive early, as I ask them to wait in the waiting room until their partner arrives; it only occurs if their partner leaves the session momentarily to use the washroom or take a cellphone call. However, the resultant discomfort may partly be accounted for by the therapy set-up, which is that we are always a threesome, so that a twosome feels unusual. If I think erotic feelings are present unconsciously, I hesitate to interpret them unless they are getting in the way.

A whole couple unconscious erotic transference, however, may be a different story. When the therapist is seen in a couple's life as someone to whom they can talk openly about sex for the first time, the therapist's being incorporated, or included somehow, in their sexual life is a distinct possibility. I have seen this manifested in varying degrees: from a couple arguing in bed together saying "What do you think Dr Usher would say about this?" to a couple (Anne and Michael) who haven't had sex for a long time telling me (jokingly?) that they'll leave me a voicemail message when they do. One sexually troubled couple who were trying to stimulate their intimate life developed the idea – one weekend during their therapy – of having a threesome in bed, and actually crafted an ad for the local newspaper. Since they brought it to the session first for discussion, I was able to interpret the fantasy of having me in bed with them – which both agreed they would like! Now, an overly zealous reader might comment on the countertransference contribution to this fantasy: was I turned on by one, or both, of them? Had I had (unconscious, of course) fantasies of threesomes? Or did I just need to be included so badly in this oedipal couple that I'd go for anything? Chapter 6, on countertransference, answers these and other perplexing questions a couples therapist must ask him- or herself.

(A note here on the above couple referring to me as "Dr Usher." I do not indicate a preference as to how any of the people I see should refer to me, but leave that as a bit of grist for the transference mill. Interestingly, there always appears to be consistency *within* the couple. Professionals of about my age may refer to me on a first-name basis, although this occurs overall less frequently with couples than in individual therapy, as the parental transference is a sticky one. Older or younger



couples usually prefer "Dr," as do couples who are working towards separation.)

I have never been the object of a *sibling transference*, i.e. older brother or sister, in couples therapy, as I have in individual therapy. This could be because the sibling is already present in the room, or because, as noted above, people seem to need an "authority" type of person when their intimate relationship is threatened.

Partner-to-partner transferences

In Chapter 3 there was a discussion of object choice, which gave some idea of the transferences and projections manifested within a relationship. Has the individual paired off with mother, father, sibling, or a combination? Have the transferences changed since the relationship began, and if so how and why?

> What each marital partner brings to a marriage is an internal psychic model that comprises childhood events and fantasies about his or her own parents and their relationship. These internal parents are never wholly realistic because they are always filtered through a multitude of complex unconscious feelings such as idealization, envy, sexual longings and rivalries . . . hostility and dependent yearnings.
>
> (Frank, 1997, p. 87)

Thus there are many opportunities for within-couple transferences, as has been noted, depending on the perceptions of the parents' marriages and their derived expectations about how they themselves will be treated by a committed partner. It will also depend on the developmental milestones achieved – particularly the resolution of oedipal conflicts and separation-individuation issues.

The possible sibling transferences within the partnership, both in relation to the therapist and in relation to each other, have been described earlier.

"This is my wife—the founder and executive director of our marriage."

Some writers have found it helpful to organize couples into types to predict possible partner-to-partner transferences. Sharpe (1997), for example, describes the differences in reactions in what she refers to as the "oppositional" couple – whose interaction is dominated by dependence–independence conflicts, as distinguished from the "symbiotic" couple. Partners in the oppositional couple are always opposing what the other partner wants or values, either in open combat or covert resistance. This, of course, interferes successfully with emotional intimacy. Sharpe's description of the symbiotic couple, on the other hand, is of two people with a merged, blurred boundary between them, which often successfully interferes with sexual intimacy. Both these types of couples have had difficulty in the separation-individuation phase. Oppositional couples may share the internal objects of a critical and controlling parent; symbiotic couples may have had parents who did not support individuation but rewarded compliance. Both couples may be locked in a struggle for validation from the other, and for permission to be independent without fear

of abandonment or destruction of the relationship. In these situations, the spouse represents the disapproving or needful parent, and the partner acts accordingly.

The idea of partner-to-partner transferences fits the conceptualizations of the intersubjectivists who state that whatever takes place between the two partners is determined by mutual influence, and that psychopathology should not be considered apart from the context in which it is expressed. Speaking to the unconscious level on which the partners relate, this perspective raises the possibility that what on the surface may look like unequal levels of disturbance in a relationship, may, on a deeper level, turn out to be dyadically co-constructed (Berkowitz, 1999).

Within-couple transferences are often appropriate to the environment; therefore, to understand the transference, we must understand the individual's experience of the current here-and-now climate that has contributed to it. When one member of a couple acts in accordance with the other's transference expectations because it taps into a defensive way of acting that was adaptive for them in earlier days, the partner-to-partner transference becomes credible, or plausible. This interaction in the couple is reciprocally influential, like the interplay of transference and countertransference in therapy with individuals. In the earlier example, when Gail began to depend on me instead of John for caretaking, John felt he didn't matter and was no longer needed, and so found a way of joining me in helping Gail. Being needed and helpful had been the only way he had been able to gain self-esteem in an emotionally impoverished childhood household. When Mirella demanded more affection from Nick, he bristled, because his earlier experience with a needy mother had made him feel controlled and intruded upon. Although bristling and moving away might have been adaptive in the situation with his mother, we saw how it was not adaptive with Mirella.

Kohut's (1977) concept of selfobject transferences is relevant here. The mirroring, idealizing, and, particularly, twinship selfobject functions speak not only to the experience of

falling in love, but also to the feeling of being alike, that many partners maintain. (Just as people begin to look like their pets after some years, they may also start to resemble their partners.) One partner's narcissistic need to make the other fit their perception of a perfect match – as in, *When we look in the mirror, we are a great couple*! – is a special kind of partner-to-partner selfobject transference.

Interpreting the between-partners transferences has always seemed to me more urgent, more useful – and more interesting – than interpreting each individual's, or even the whole couple's, transference to me. The relationship with the therapist here seems less important than in individual therapy; I actually spend considerable time in the background as the therapy goes on. This does not mean that there are not times when there are virulent transferences to me, as we have seen earlier, but this occurs much less frequently with couples. And I do not attempt to stir them up. I try to maintain the position of a benign, positive, caring helper, whose focus is on the relationship between the two partners.

As therapy progresses, and these partner-to-partner transferences are explored and (co-)interpreted, individuals begin to understand how these deep connections may be affecting the relationship in a negative (or positive) way. Then it is easier to cooperate in working towards change. When this happens, the internal shifts in each are noticed and remarked on by both partners, as they manifest themselves in overt behaviours. The shifts in the interactions of the couple are similarly noticed and are very clearly self-reinforcing.