Presence and Involvement: Personal Perspectives on Countertransference

Richard G. Erskine

Abstract

Reactive countertransference is nontherapeutic, whereas responsive countertransference is an integral aspect of psychotherapy when the psychotherapist is attuned to the client's affect and needs. Personal examples are used to illustrate the concepts of responsive and reactive countertransference. Awareness and use of each form of countertransference is essential. The psychotherapist's stance of presence and involvement delineates the necessary elements of an effective relationally focused psychotherapy.

Keywords

Countertransference, reactive countertransference, responsive countertransference, resonance, transference, developmental image, presence, involvement, relational psychotherapy, integrative psychotherapy

"Countertransference"! In my early years as a psychotherapist, I suffered whenever someone alluded to my having any countertransference with my clients. I believed that countertransference was irrefutable evidence that something was wrong with me as a psychotherapist. I reacted with intense shame—shame for being keenly interested in my client's private life, in worrying about them when they were in crisis, for feeling irritated by them, for wanting to protect them, for being bored by them, or for loving them. If my emotions were influenced by my clients, that was proof that something was wrong with me. I thought that I should be emotionally neutral—free of any countertransference.

I did not talk about my emotions and fantasies, either in supervision or with colleagues, because I was ashamed. In those early years, I had only a superficial understanding of countertransference. I believed that if I had an emotional reaction in response to my clients, it meant that I was unconsciously reliving some unfinished aspect of my own life and enacting it within the psychotherapy. It was convenient to disavow my feelings and focus on being "neutral." Without realizing it, my superficial understanding of the theory of countertransference, and the resulting sense of shame for having my emotions, was interfering with how I practiced psychotherapy.

Neither my supervision in client-centered therapy nor my training in gestalt therapy addressed countertransference. My transactional analysis supervision only focused on the clients' personality dynamics and how I could identify their games and life scripts. However, I was influenced by a cursory understanding of psychoanalytic concepts. I was aware that Sigmund Freud and other psychoanalysts postulated that countertransference is the analyst's transference of old emotional reactions onto the client, which is a hindrance in the psychoanalysis. Freud (1910/1957) said that countertransference was the "result of a patient's influence on his [the psychotherapist's] unconscious feelings" (p. 144).

Eric Berne (1972) echoed this idea when he warned that psychotherapists often play out their life script in response to the client's script. As I understood it, countertransference meant that

I was possibly reliving my own unsettled story through unconscious interactions with clients. I was troubled by this idea and repeatedly questioned myself:

- If I enjoy my interactions with one client more than another, does that mean I am reliving some unfinished business from my childhood?
- If I feel angry when I hear about the physical abuse that my client received as a child, does that mean I have a neurotic parental transference to my client?
- If I feel irritated with the client's frequent bragging about their successes, does that mean I am envious?
- If I repeatedly look at my female client's revealing cleavage, does that indicate that I have an erotic countertransference, or is her behavior unconsciously revealing something about her life?
- If I dislike a client, is that an indication that I have an unresolved relational problem, or am I responding to something within the client?

I was relieved of my worry when, early in my psychoanalytic training, I read Donald Winnicott's article entitled "Hate in the Counter-Transference" (1949), in which he depicted countertransference as having two dimensions. Winnicott referred to one as *personal countertransference:* the therapist's reactions that are based on their own unresolved issues. The other he termed *objective countertransference:* the tender, understanding response by the therapist that may be needed by a client who was consistently criticized as a child. Winnicott saw objective countertransference as normal, understandable responses "to the actual personality and behaviour of the patient" (p. 60).

I spent hours in my own psychoanalysis talking about my emotional and behavioral reactions to my clients, feeling ashamed of how I had failed to be empathic, and wondering what I could have done differently. I searched the psychoanalytic literature for more understanding and discovered that Paula Heimann (1950) elaborated on Winnicott's idea. She said that the psychoanalyst's total emotional reactions to the client were often an indicator of what was happening within the client's unconscious. This idea, along with my psychoanalytic supervision group's discussions of our personal reactions to our clients, shifted my understanding of countertransference. I no longer viewed it as solely my personal failure. Countertransference was also a way to understand the client's unconscious experience.

Heinrich Racker (1957) furthered Heimann's ideas and delineated two distinct types of countertransference identifications: *concordant* and *complementary*. In a concordant identification, the psychotherapist is stimulated by the client and responds to them with empathy. In a complementary countertransference, the analyst identifies with the client's internal "other" and responds with indifference, boredom, distain, superiority, or merely a lack of empathy. Otto Kernberg (1976) reiterated Racker's ideas when he described countertransference as being present in any therapy situation because of two factors: the therapist's history of relationships and the feelings induced by the client. Heinz Kohut (1971) defined the concept of *self-object transference* as an unconscious portrayal of significant others onto the psychotherapist and how such a portrayal mobilized countertransference in the psychotherapist. Kohut proposed that in order to understand the client's intrapsychic process, it is essential that the psychotherapist be introspective about their own feelings and fantasies—and to then use their phenomenological experience to empathically respond to the client's subjective experience.

Earlier, Kurt Lewin (1935), writing from the perspective of gestalt psychology, saw countertransference as a dynamic field, the interplay of both the client and therapist as though they were cocreating a story together. Although the psychotherapist's countertransference is part of the client's unresolved emotional conflicts, it may also reflect what is unresolved in the

psychotherapist and therefore warrants psychotherapy for the psychotherapist. In their discussion of contemporary psychoanalytic theory, Greenberg and Mitchell (1983) defined the interpersonal field this way: “Countertransference is an inevitable product of the interaction between the patient and the analyst rather than a simple interference stemming from the analyst’s own infantile drive-related conflicts” (p. 389). This is what Stolorow et al. (1987) described as *intersubjective*—the melding together of two unique perspectives.

Sandor Ferenczi (1932, 1949) was the first psychoanalyst to propose that countertransference was the psychotherapist’s identification with the client’s unconscious communication, and therefore, countertransference constituted an essential component in understanding the client’s relational history and inner life. Ferenczi declared that the psychotherapist’s feelings of tenderness, patience, and concern were the core of the relationship between therapist and client. However, classical psychoanalysis continued to characterize countertransference as the analyst’s transference onto the client (Greenson, 1967).

Ronald Fairbairn (1952) elaborated on Ferenczi’s ideas when he called for “genuine emotional contact” (p. 16) in the practice of psychotherapy—a form of intimacy from the psychotherapist to the client that provides the client with a new, transformative relationship. Harry Guntrip underscored Fairbairn’s relational perspective when he wrote, “It is the psychotherapist’s responsibility to discover what kind of parental relationship the patient needs in order to get better. . . . If the psychiatrist cannot love his clients in that way, he had better give up psychotherapy” (Guntrip as cited in Hazel, 1994, pp. 401–402).

Transference or Countertransference?

The 16th-century Spanish author Miguel de Cervantes (1605/1992) wrote a novel entitled *The Ingenious Gentleman Don Quixote of La Mancha*. His entire book is about transference. His main characters, Don Quixote, Sancho Panza, and Dulcinea, are all in transference with each other. The intriguing plot of the book lies in the various characters’ reenactment of their life story via their illusions about each other. There are many examples in classical literature and modern novels that depict the transferential illusions of everyday life. In the psychotherapy profession, Sigmund Freud was the first to describe such illusions; he called these aroused psychological experiences “transference,” wherein a person is inappropriately reacted to as though they were a person in the other’s past (Freud, 1905/1955, p. 116).

As a starting point in understanding transference and countertransference, it may be helpful if we use the same definition of transference. Therefore, let us keep the following definition in mind while we think about the concept of transference from a couple of coinciding perspectives. Transference is:

> the expression of the universal psychological striving to organize experience and create meaning; as well as the means whereby the patient can demonstrate his or her past, the developmental needs which have been thwarted, and the defenses which were erected to compensate. (Erskine, 1991, p. 73)

Therefore, transference is an unaware enactment of an old story that may include three additional impulses:

1. A reluctance to feel the discomfort of fully remembering
2. An unaware enactment of earlier relationally disruptive experiences
3. The desire to achieve resolutions in relationships

If we emphasize the first part of this definition, then we are all in transference all the time. We cannot escape our own way of organizing a lifetime of experiences. Transference is our distinct way of creating meaning; it is simply the idiosyncratic way we express ourselves. We transfer our unique predisposition into every situation.

When we emphasize the second part of this definition, we focus on the relational disruptions, unrequited relational needs, and how the person has managed to stabilize and regulate themselves. These stories are revealed, often without awareness, through physical gestures, unaware enactments, snippets of memory, or metaphors (Erskine, 2009). Consequently, the transferences that occur in the process of psychotherapy may be the client's unaware attempt to reveal and heal. This definition asserts that transference is a normal and universal experience.

Clarifying Countertransference

Is countertransference transference? Yes, according to the definitions of transference that I am suggesting, we cannot escape our own internal organization of life experiences: physically, affectively, cognitively, and behaviorally. Heimann (1950) defined countertransference as "all the feelings which the analyst experiences towards his patient" (p. 81), whereas Winnicott distinguished between a personal reaction to the client and an objective response—what Racker called complementary and concordant countertransference. I prefer to use the terms "reactive" and "responsive" to describe the psychotherapist's various interactions with their client. The term "reactive countertransference" describes the psychotherapist's emotional expressions and behaviors that are an expression of their own internal conflicts in reaction to their client. This is what has been traditionally thought of as countertransference.

Here are some examples of the type of questions I ask myself to help distinguish between a reactive countertransference and a responsive countertransference:

- Am I in a responsive countertransference when I am fully present, in contact with my own affect and motivation, while at the same time being committed to the client's welfare? Or does this describe an intimate person-to-person involvement?
- Am I in a reactive countertransference or am I genuinely engaged with my client when I worry about them at night, when I feel irritated by their mannerisms, or when I feel love for them like I do for my children?
- Are my feelings—such as affection, boredom, or disregard—a reactive expression of my own experiences, or am I responding with something intrinsic in the client's history?

Perhaps it is beneficial if we think of countertransference as the psychotherapist bringing into the therapeutic situation their internal organization of experience and their unique way of creating meaning. Our professional training, the theories on which we rely, the style of how we transact with our clients, our childhood and school experiences, the joys and sorrows of our love life, the quality of our current family relationships, what we read and the music we enjoy, the things we dislike or avoid—all of these individual proclivities form the unique substance of what we bring to each therapeutic encounter. When we consider this perspective, every moment of the psychotherapy involves the interplay between two people, a coconstructive process.

We provide a responsive countertransference when we are in attunement with our client's affect, rhythm, and developmental level of making meaning; when we are compassionate with their sadness; when we are angry at the person who abused them; when we are patient and sensitive to their needs; and when we communicate with respect and choice. In each of these

circumstances, we may be engaging in a responsive countertransference, that is, attunement to what the client requires in a healing relationship (Erskine, 2021b).

We are in a reactive countertransference when our transactions with our clients are unconsciously tinged with unresolved anger at someone in our own life, if we are inhibited by our own grief and fears, when we disavow our own emotional history, when we are constrained by remnants of loss or trauma, or when we are confined to a specific theory. When there is a reactive countertransference in play, the client-therapist dialogue becomes a manifestation of the psychotherapist's truncated needs, and their communication is no longer in the service of the client. Reactive countertransference is countertherapeutic, whereas responsive countertransference can promote the client's healing and growth.

However, not all that transpires from the psychotherapist to the client should be called countertransference. Each psychotherapist has their own natural inclinations and demeanor; some tend to be quiet while others are more exuberant, some are sensitive to the client's affect while other's attend to how the client is reasoning. It is essential that we psychotherapists remain aware of our own relational needs and cognizant of how our needs influence our therapeutic dialogue (Stewart, 2010).

Each psychotherapist, even if using the same theories and concepts as others, will conduct their interactions with their clients in a different manner. The central challenge for each psychotherapist is how to make use of our natural proclivities in providing for our client's welfare. This requires acceptance and appreciation of our own natural inclinations and vigilance about how our affect and behavior may influence our clients.

Theory-Induced Countertransference

Often overlooked in training programs, supervision, and professional publications is a distinctive countertransference that is induced by psychotherapy theory. Psychotherapists often form allegiances to specific psychotherapy schools, each of which emphasizes certain theories of personality and preferred therapeutic methods. When we as psychotherapists repeatedly rely on a particular concept or therapeutic technique, we increase the possibility that we will not understand what is occurring within the client or in the therapeutic interchange.

I remember the days when I was actively involved in attending gestalt therapy and transactional analysis training workshops. I watched well-known psychotherapists who valued short, 20–30 minute therapy sessions. These therapist-client encounters often gave prominence to the psychotherapist stimulating immediate and dramatic change. For a while I tried to follow this model of a short, intense piece of therapy. I was captivated by the concept; it was evident that for some clients the fervent work was effective. I was following the theory, but my reliance on the concept interfered with the therapeutic involvement that some of my clients needed.

It took me a few years to realize that this rapid, dramatic therapy approach did not work for those clients whose distress and agony were masked by their compliance with my expectations and fast-track pace. My clients might have achieved a very different outcome if I had understood that some individuals find greater benefit when the therapist is patient and gracious, focused on their inchoate affect, and engaged in a person-to-person dialogue.

Throughout the 1970s, it was the trend in both transactional analysis and gestalt therapy to make frequent use of confrontation. Although my original background underscored the importance of respect and empathy, I joined this trend and used confrontation often with my clients. It was only after I observed the distress and shame my confrontations caused that I realized that confrontation was a powerful intervention and should only be used with full awareness of its impact on the relationship between therapist and client. I still use confrontation but now much like I use hot pepper in cooking: sparingly, in order to not overpower the food.

When I relied on the concept of confrontation, I created a situation in which my transactions were countertherapeutic.

I have a concern about the future of our developmentally based, relationally focused integrative psychotherapy. We have a unique set of theories and methods. I do not want our theoretical ideas—attunement, phenomenological and historical inquiry, relational needs, involvement, or any other concepts—to become static, where the psychotherapist using these ideas slides into a theory-induced countertransference. We all need to evaluate in an ongoing manner our reliance on a specific concept or method. Our task is to have a substantial repertoire of concepts and the flexibility to relate to each client according to who they are and what they need in a therapeutic relationship.

My Inner Conflict: Reactive or Responsive?

When Loraine came for her first psychotherapy session, I was repulsed by her. Over the phone she was pleasant, but when she arrived, I discovered that she was slovenly dressed, with unwashed hair that smelled like mold. Her teeth were obviously in need of dental repair. I wished that she had not come to my office. Yet, in our initial session, I sensed that she was serious about improving her life. That stimulated me to commit myself to being fully present with her.

During the next several weeks, I became fascinated by Lorraine's intellectual brilliance, her articulate language, and her frequent quotations of literature, but, at the same time, I could not escape my sense of repulsion. Listening to her was interesting if I did not look at her. I did not want her to sit close to me. I wished that I could hold my breath for an hour. I certainly did not want her to ask me for a good-bye hug. Disgust may be too strong a word to describe my feelings, but I certainly had a strong urge to turn away from her. Staying in contact with Loraine was a constant struggle. I was committed to doing effective psychotherapy with her, but I was perturbed. Repulsion and tender concern were my conflicting sentiments.

We were many months into the psychotherapy before Loraine allowed me to inquire about her childhood relationship with her mother. When she talked about her childhood, she reported stories of perpetual neglect, such as wearing the same clothes for a few weeks at a time and eating the same rice soup every day because her mother "didn't like to cook." She described how notes were sent home from both kindergarten and elementary school asking that she be bathed and her hair washed before returning to school. I wondered if my sense of repulsion was only my own proclivity, a reactive countertransference (what Winnicott called "personal countertransference"), or was I sensing and identifying with her mother's emotional reactions to her (what Racker called a "complementary countertransference")?

In subsequent sessions, Lorraine talked about the absence of any conversation with her mother: "She always watched TV. She never attended any of my school activities. There was never any affection." Loraine said that her mother never wanted to touch her and certainly did not want to give her a bath. The few times she had a bath, her mother screamed and told her she was making a mess. When Lorraine was an adolescent, her mother admitted, "I wish you had never been born." I was impacted by how Loraine recounted the relationship with her mother, and I had two primary responses: I felt an intense tenderness for the neglected child and anger at her mother's disregard for her daughter's welfare.

As Lorraine continued to tell me stories of how she was uncared for, I thoughtfully examined my sense of "repulsion." Although at first I assumed that my feeling of repulsion was my own, I began to wonder if I was picking up on some unconscious communication encoded within her stories. One day I inquired, "I wonder if your mother was disgusted by you." She immediately responded with, "That's it. That's the word … DISGUSTED, that describes my mother … she was always repulsed by me."

My sense of repulsion and my subsequent inquiry revealed an integral part of Loraine's childhood experience. My reaction had provided me with a window into the disdain Loraine's mother felt about her and allowed me to come up with the word "disgust." For almost a year I was nonconsciously identifying with Loraine's mother's attitude of "disgust" and assumed that it was mine. Yes, Lorraine's musty smell remained, but what was now most important was my anger at her mother's neglect of her and my desire to be protective and gracious to the child she once was. Our therapy eventually addressed how Loraine replicated her mother's behavior by neglecting her own appearance, cleanliness, and health.

Identifying With the Client

Over the years I have explored my own countertransference as well as the countertransferential experiences of many supervisees. It is apparent that countertransference begins with our identifying with our client. In facilitating an in-depth psychotherapy, it is essential that the psychotherapist attune to the unintegrated and unaware aspects of the client, such as their physical sensations, affects, stabilizing fantasies, or unrequited needs. We may also identify with some features of an internalized significant other, such as a father's criticism, a mother's lack of tenderness, or a grandmother's harsh expectations. At first, we may mistakenly identify these aspects of the client as our own. The story of Loraine's psychotherapy provides an example of how I was influenced by her unconscious communication of her mother's "disgust." I used this unaware identification—what I experienced as my "repulsion"—to eventually shape my inquiry about her mother's attitude toward Loraine. This changed both the direction and depth of our psychotherapy.

Henry also influenced me, but in different way than Loraine had. Henry was a successful actor who in our first session described himself with "something is missing within me." As I listened to Henry's constant sadness, I resonated with his lament. He touched my heart. I had the sense that his sad expressions were those of a 5-year-old boy who longed for the playful companionship of his father. Perhaps I was particularly sensitive to Henry's developmental needs because I too had lived without a father's caring involvement. I envisioned Henry being alone with no emotional support and guidance. I used my internal image to form several inquiries about his life and the quality of his relationship with his parents when he was in his early school years.

Henry held back his tears as he told me about never being sure if his father would visit him or not on weekends. "Sometimes he would take me to meet his friends in a bar, but I hated that; I just wanted him to teach me how to play ball." Later on, he talked about his "absent-minded mother": "She was always too busy or too tired to play with me or even help me with school work." He cried, "I was in a lot of school plays but neither of them ever seemed interested." Throughout our psychotherapy, I expressed interest not only in his history but in many of the activities of his life. I inquired about the TV scripts he was reading and how he made the characters he played come alive. I focused on his relational need for a shared experience, the companionship that had been missing during his young life. With my consistent involvement, Henry's persistent sadness dissipated.

Developmental Image

A significant feature of a responsive countertransference is the psychotherapist's capacity to have a developmental perspective and to use that knowledge to cultivate a developmental image. As I

attune to my client's affect, rhythm, and manner of thinking, I imagine them as a child, usually at a specific age. I form an impression about the interpersonal crisis in their life, the relational needs that may have been unrequited, and what a child of that specific age needed in a stabilizing and regulating relationship. I keep in mind that my developmental images are only mere impressions, but they are impressions that guide my phenomenological and historical inquiry.

In accordance with my image of the child's age, I inquire about the emotionally vulnerable moments in the child's day: breakfast time, bathing activities, going to and coming home from school, play time, and bedtime rituals. I ask my clients to describe their parents and any other significant adult with whom they interacted during their childhood. I also inquire about who was at the dinner table and particularly about the nature and quality of the communication between the child and other family members.

The details of my inquiry shift as I focus on different ages. The kinds of questions I ask if I am inquiring about the interpersonal relationships of a 9-year old are very different from those I might ask if I imagine my client at age 2. Most clients will initially answer with "I don't remember." I remind them that they know their parents' personalities and to just imagine how they would have responded to the child's needs at that particular age. Although their responses may not represent an accurate representation, like a photograph might, their answering provides an important outlook on what may have occurred, much like an impressionistic painting. It is through consistent inquiry about the client's developmental experiences that their various affects, nascent understandings, and physiological sensations are shaped into a narrative.

Resonating With the Vibes

As Melissa walked into my office for the first time, I was shocked by how skinny she was. She walked with her head slumped forward and her chest curved inward. I wondered if she was hiding her breasts. She sat on the sofa and pulled her knees up to her belly as she told me how she needed psychotherapy because of her constant body tension. I was concerned that she was anorexic. Although I did not address her appearance directly, in the first several sessions I made many inquiries about her nutrition, level of exercising, and general health care. As we had those conversations, I began feeling sexually excited. I was both surprised and disconcerted that my body was feeling aroused. I did not find her attractive. She looked more like an emaciated 12-year old girl than a 28-year-old school teacher.

Over the next several sessions I continued to be aroused and considered terminating the therapy on the basis of my having an erotic countertransference. I was worried. Ethically I was committed to my client's welfare, but my body was reacting to something that I did not understand. I talked about my sexual arousal with a colleague who previously had served as the chairperson of her association's ethics committee. She suggested the possibility that I was picking up some "vibrations" and misidentifying them as emanating from within me.

Based on Melissa's waifish appearance and apparent body tension, I formed a developmental image of a preadolescent under stress. I decided to ask about her life when she was 12 years old. Over the next several sessions she painstakingly told me about her father's sexual abuse of her, which began when she was 11 years old and continued until she had her first menstruation at age 14. As soon as she told me about her father's sexual abuse, my sexual arousal stopped. I was then able to attune to and concentrate on her frightening and painful experiences. In hindsight, it became clear that my sexual arousal was in resonance with Melissa's yet untold experience of sexual abuse.

Responsive Countertransference

Ronald was encouraged to come to therapy by his sponsor in Alcoholics Anonymous. He had lost two jobs because of his alcoholism before he seriously joined the 12-step program. From the beginning of the work with Ronald I felt protective of him. I could sense a fragile boy-in-the-man. My protectiveness seemed right even though I did not know why. My phenomenological inquiry appeared to be too intrusive for Ronald, so I let our work together flow its natural course rather than setting a direction by inquiring. Instead, I quietly listened to him and responded with tenderness and compassion. Eventually, Ronald revealed stories of the physical abuse his father had inflicted on him. On one occasion he was shaking with fear as he vividly remembered being 9 years old; his father was demanding that he fetch a leather belt that his father then used to whip him.

As Ronald relived this memory, I imagined myself standing between him and his father, blocking his father from hitting him. I said nothing to Ronald about my protective imagery; I just focused on it. Suddenly Ronald looked up at me and said, “I feel so safe with you.” Then he angrily shouted at his image of his father and fantasized running out of the house. Although I never said anything to Ronald about my sensitivity to the boy-in-the-man and my desire to protect him, he could feel my involvement. One day he said, “I’ve never told anybody about the beatings, not even my wife.” When I inquired about why he was telling me, he said, “I feel safe in your presence. Until I went to AA, whenever I would have any memory of my father, I would get drunk. But when I’m here with you, I feel protected. I can let myself feel the terror I felt when he beat me. And I can now feel my anger at his cruelty.”

A therapeutic relationship based on the psychotherapist’s responsive countertransference creates a relational environment in which the client can depend on the psychotherapist’s consistent and reliable presence, their capacity to provide affective attunement and stabilization, and their sensitivity to the client’s developmental needs.

Reactive Countertransference

For many years I have been ashamed of my strong reactive countertransference and how I acted when I told a group member that I wanted him to leave the Tuesday evening men’s group because I was no longer willing to work with him. Matthew was a mental health counselor and the business manager of a large private clinic. He was in group therapy to fulfill the therapy requirements for his training as a professional counselor. In the early months of the group, Matthew was an active participant, appreciated by most of the men for his lively contributions.

After the group had met for several months, Matthew began to boast about the lies he perpetuated at work and how no one was wise enough to realize what he was doing. He bragged about the famous people he knew as well as his academic and sports accomplishments. Soon it became evident that he did not have the university degrees that he pretended to have. I wondered if his telling us these stories was an exhibition of narcissistic grandiosity. The confrontations that various group members made seem to have no impact on Matthew. He remained jovial and impervious to the group’s feedback. All this while I curiously listened to his exploits. I was apprehensive. I was waiting to see what more might be revealed.

As I observed the group’s dynamics, it was evident that each week the men in the group were steadily more silent after Matthew told us some story. It seemed that the group members no longer knew what to say to him. And I did not know what was true and what was not; he certainly was embellishing his accomplishments. My discomfort with Matthew had been building for several weeks. I had been unsuccessful in addressing his dishonesty because he always seemed to deflect from taking any responsibility. One evening he was excited as he told us how he had embezzled money from his employer. Suddenly I was furiously angry at him for his constant lying and now for his stealing. I jumped up from my seat, opened the door, and told him to never come

back. As the group resumed, it was evident that some members were relieved and a couple were shocked by my impetuous behavior.

I certainly had experienced a reactive countertransference. I was frustrated in my attempts to get Matthew to be aware of how his behavior affected other people. The emotional tension that I felt inside had been building for several weeks. In response to Matthew's dishonesty, I had lost my capacity to be sensitive and empathetic. In hindsight, I realize that I could have invited Matthew into individual psychotherapy where I would have had the time and opportunity to explore with him the various psychological functions underlying his lying and stealing. I regret how I reacted to Matthew; my behavior was not therapeutic. The shame about how I treated Matthew was significant enough that I sought more training in how to provide an effective psychotherapy with narcissistic clients.

Bernard was another client with whom I had a reactive, and therefore nontherapeutic, countertransference. Even though we had a weekly session for several months, I doubt if I was ever therapeutically helpful to him. From the beginning of our work together, Bernard bragged about his affluent lifestyle. I was impressed by his detailed descriptions of lavish vacations, the championship sporting events he attended, and the important people he had met at various parties.

When we were not in session, I thought about his narcissistically inclined self-aggrandizement and how I could therapeutically address him. However, when we were in session I was often dazzled by his stories. Several times in our first months together I attempted to develop a therapeutic contract with him, but Bernard always seemed to move the subject of our conversation to some dramatic event. I tried unsuccessfully to inquire about his phenomenological experiences, something at which I am usually quite good. My attempts at inquiry about Bernard's subjective sensations only brought about more stories of impressive social events. His answers to my questions about his childhood were superficial. I was able to learn that his father was a "full-time gambler" who had taught him how to gamble and that Bernard had lived most of his childhood in casino hotels.

In my own psychoanalysis, I explored the possibility that both my lack of empathy and my floundering therapeutic skill with Bernard were the result of my being envious of his affluence or resentful that I had no influence on him. It was clear that Bernard's impressive stories continued to distract me from making any therapeutic impact. During this time, when I was evaluating my possible contribution to our therapeutic impasse, Bernard began to challenge me with, "You are not really interested in me" and "You are only tolerating me because of the money you make." I was dumfounded. Internally, I wanted to both defend myself and confront him about his self-centeredness. Instead, I tried, unsuccessfully, to inquire about the relationship between us. I was frustrated that I could not find a way to have an authentic person-to-person dialogue with him.

I had been listening carefully for a possible metaphor encoded in the story that Bernard was telling me when he surprised me with, "I am wasting my time with you. You never clicked with me." He walked out of my office. Often with other clients who have abruptly terminated, I had reached out to them with a note or phone call to invite them to discuss their ending of the psychotherapy. With Bernard I did not reach out and contact him. I was relieved that he had terminated. He was correct; we just did not "click."

I indeed had reactive countertransferences with both Bernard and Matthew. When we have a reactive countertransference, we are self-absorbed in our own internal story. With both Bernard and Matthew, I lost my sense of presence—a personal and ethical commitment to be with and for the client. I was not able to respond to what either man needed within a restorative therapeutic relationship. As a result of my reactive countertransference, the psychotherapy for both Bernard and Matthew was damaged.

Presence: Fostering a Healing Relationship

Earlier I described how Donald Winnicott used the term "objective countertransference" to describe the psychotherapist's tender, understanding responses that may be needed by a client. Most likely he was delineating the concept of *presence*: a form of countertransference that is in resonance with the client. Presence is fundamental to the process of relationship-focused integrative psychotherapy. It is provided through our sustained attunement to the client's verbal and nonverbal communication and through our constant respect for and enhancement of our client's integrity.

Presence is an expression of our full internal and external contactfulness, and it communicates our dependability and willingness to take responsibility for our part in whatever happens in the therapeutic relationship. It includes receptivity to our client's affect, that is, our willingness to be impacted by our client's emotions, to be deeply moved while not becoming anxious, depressed, or angry. At times my eyes have filled with tears or I have felt a protective anger when I hear about the neglect or abuse my clients suffered in their young lives. Presence occurs when our behavior and communication, at all times, respects and enhances the client's integrity.

There is a duality to presence that entails our simultaneous attention to our client and to ourself. Presence flourishes when we temporarily decenter from our own needs, feelings, fantasies, or desires and make the client's process our primary focus. But, paradoxically, we must not lose awareness of our own internal process, resonance, and reactions. Our personal history, relational needs, sensitivities, theories, professional experience, own psychotherapy, and reading interests all shape our unique reactions to every one of our clients. These are the essential parts of therapeutic presence.

Each psychotherapist has a unique set of past experiences, current interests, needs, and wants. We have our preferred theories, concepts, and methods, and we use our experience as a kind of reference library that helps us attune to our clients and to understand how they function. Importantly, presence includes our willingness to be transparent in our uniqueness, to let our clients see who we are and what we are experiencing, to be impacted by that which is significant to our client, and for that impact to be seen.

Presence provides a container for our therapeutic involvement, an interpersonal safety net that supports without constraining and protects without demeaning the client (Schneider, 1998). More than just verbal communication, presence describes a communion between us and our clients. It is the basis of a healing relationship. The respectful interplay between our self-awareness and decentering opens the way for what Buber (1958) called an "I-Thou" relationship, a relationship between two connected, contactful, self-and-other-aware individuals. The I-Thou relationship, in turn, is the primary source of the transformative potential of relationship-focused integrative psychotherapy.

Involvement: With and for the Client

Does the term "involvement" imply countertransference? From a classical psychoanalytic perspective, involvement violates the principal of therapeutic neutrality. For several decades, the task of the psychoanalyst was to remain a blank screen, with evenly hovering attention (Freud, 1912/1958; Greenberg, 1986). For the psychoanalyst to provide the client with more than a reflecting mirror was considered to be a therapeutically disruptive countertransference (Poland, 1984).

In integrative psychotherapy, we consider involvement to be one of the essential dimensions of an authentic, person-to-person relationship. A central premise of a relationally

focused integrative psychotherapy is that "effective healing of psychological distress and relational neglect occurs through a contactful therapeutic relationship—a relationship in which the psychotherapist values and supports vulnerability, authenticity, and inter-subjective contact" (Erskine, 2021a, p. 212).

Therapeutic involvement begins with the psychotherapist's commitment to the client's well-being, an unwavering awareness that the client, and what they need in a therapeutic relationship, is most important. This commitment is the bedrock that makes an authentic involvement possible. The involved psychotherapist is with-and-for the client, fully contactful, honest and willing to put energy and effort into helping clients achieve their goals. When we are fully committed to the client's welfare, our involvement enriches the client's vitality and helps them form a secure sense of self. Involvement is what makes relationship vibrant: two people exchanging ideas and feelings, each challenging and enhancing the authenticity of the other.

Involvement emerges from the psychotherapist having a genuine interest in the client's intrapsychic and interpersonal worlds and then communicating that interest through attentiveness, patience, and respectful inquiry. When I am fully involved, I am vulnerable; I allow myself to me emotionally touched. I strive to let my caring for the client show by being curious, tender, and respectful. My involvement has to do with my commitment to being an active, caring, vulnerable, and authentic participant in the therapeutic process. Our involvement is reflected in our acknowledgment, validation, and normalization of what the client presents as well our willingness to be known. Involvement has more to do with being than doing.

Involvement is about the therapist-client interchange. It is about us as psychotherapists: how we feel, think, and respond to the client. And involvement is about the client: how they perceive our investment in them and how we are impacted by what happens in the relationship. Involvement is about the intersubjective interplay between us, the dance of interpersonal contact. Involvement is best understood in terms the client's perception: their sense that the therapist is attending to their relational needs and truly committed to their welfare.

When we psychotherapists identify and resonate with our clients—when we are fully aware of our reactive countertransference and make therapeutic use our responsive countertransference—we create an intersubjective process of two people sharing an intimate experience together. The important aspects of psychotherapy are embedded in the distinctiveness of each interpersonal relationship, not in what we consciously do as a psychotherapist but in the quality of how we are in relationship with the other person. Our attitudes and demeanor, the qualities of our interpersonal relationship, and the authenticity of our intersubjective connections are central in creating an effective psychotherapy. Presence and involvement are the essential ingredients of a healing relationship.

Richard G. Erskine*, PhD, is the training director of the Institute for Integrative Psychotherapy in Vancouver, Canada, and Professor of Psychology in the Faculty of Health Sciences, Deusto University, Bilbao, Spain. He has written extensively on the theories and methods of psychotherapy. His web site is: www.IntegrativePsychotherapy.com*

References

Berne, E. (1972). *What do you say after you say hello? The psychology of human destiny*. Grove Press.

Buber, M. (1958). *I and thou* (R. G. Smith, Trans.). Scribner.

de Cervantes, M. (1992). *Don Quixote* (P. A. Motteaux, Trans.). Wordsworth. (Original work published 1605).

Erskine, R. G. (1991). Transference and transactions: Critique from an intrapsychic and integrative perspective. *Transactional Analysis Journal, 21*(2), 63–76. doi: 10.1177/036215379102100202

Erskine, R. G. (2009). Life scripts and attachment patterns: Theoretical integration and therapeutic involvement. *Transactional Analysis Journal, 39*(3), 207–218. https://doi.org/10.1177/036215370903900304

Erskine, R. G. (2021a). *Early affect confusion: Relational psychotherapy for the borderline client*. nScience Publishing.

Erskine, R. G. (2021b). *A healing relationship: Commentary on therapeutic dialogues*. Phoenix Publishing.

Fairbairn, W. R. D. (1952). *An object relations theory of the personality*. Basic Books.

Ferenczi, S. (1932). *The clinical diary of Sándor Ferenczi* (M. Balint, Trans.). Harvard University Press.

Ferenczi, S. (1949). Confusion of the tongues between the adults and the child—(The language of tenderness and of passion). *International Journal of Psycho-Analysis, 30*(4), 225–230. https://doi.org/10.1080/00107530.1988.10746234

Freud, S. (1955). Fragments of an analysis of a case of hysteria. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 7, pp. 1–122). Hogarth Press. (Original work published 1905).

Freud, S. (1957). The future prospects of psycho-analytic therapy. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 139–152). Hogarth Press. (Original work published 1910).

Freud, S. (1958). Recommendation to physicians practicing psychoanalysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 109–120). Hogarth Press. (Original work published 1912).

Greenberg, J. R. (1986). Theoretical models and the analyst's neutrality. *Contemporary Psychoanalysis, 22*(1), 87–106. https://doi.org/10.1080/00107530.1986.10746117

Greenberg, J. R., & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory*. Harvard University Press.

Greenson, R. R. (1967). *The techniques and practice of psychoanalysis*. International Universities Press.

Hazell, J. (Ed). (1994). *Personal relations therapy: The collected papers of H. J. S. Guntrip*. Jason Aronson.

Heimann, P. (1950). On counter-transference. *International Journal of Psychoanalysis, 31,* 81–84. sycnet.apa.org/record/1951-02486-001

Kernberg, O. F. (1976). *Object relations theory and clinical psychoanalysis*. Jason Aronson.

Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorder*. International Universities Press.

Lewin, K. (1935). *A dynamic theory of personality*. McGraw-Hill.

Poland, W. (1984). On the analyst's neutrality. *Journal of the American Psychoanalytic Association, 32*(2), 283–299. https://doi.org/10.1177/000306518403200203

Racker, H. (1957). The meanings and uses of countertransference. *Psychoanalytic Quarterly, 76*(3)*,* 725–222. https://doi.org/10.1002/j.2167-4086.2007.tb00277.x

Schneider, K. J. (1998). Existential processes. In L. S. Greenberg, J. C. Watson, & G. Lietaer (Eds.), *Handbook of experiential psychotherapy* (pp. 103–120). Guilford.

Stewart, L. (2010). Relational needs of the therapist: Countertransference, clinical work and supervision. Benefits and disruptions in psychotherapy. *International Journal of Integrative Psychotherapy, 1*(1), 41–50.

Stolorow, R., Brandschaft, B., & Atwood, G. (1987). *Psychoanalytic treatment: An intersubjective approach*. Analytic Press.

Winnicott, D. W. (1959). Hate in the counter-transference. *International Journal of Psychoanalysis, 30*, 69–74. https://pep-web.org/browse/document/ijp.030.0069a