

# Intrapsychic Conflict, Transference, and a Healing Relationship.

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## **Abstract:**

In this rejoinder to “Responses to Relational Healing of Early Affect-Confusion: Part 3 of a Case Study Trilogy”, the author defines an Integrative Psychotherapy perspective of transference and addresses the significance of working within a transference-countertransference milieu. Descriptions of how to understand and therapeutically use client’s “idealization” are provided. The concept of avoidant and disorganized attachment is related to a clinical case.

**Key Words:** Avoidant attachment, disorganized attachment, affect-confusion, interpersonal-contact, borderline personality disorder, integrative psychotherapy, case study, healing relationship, transference, intrapsychic conflict.

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## **Response to Maša Žvelc**

Maša Žvelc begins her commentary on *Relational Healing of Early Affect-Confusion: Part 3 of a Case Study Trilogy* by identifying several significant therapeutic points in the psychotherapy of early affect-confusion. Each of the points Masa outlined reflects an important aspect of an in-depth relational psychotherapy: differentiating the past from the present; inquiring about physiological sensations and helping the client make sense of them; helping the client get in contact with unconscious and vulnerable experiences; redirecting the client’s complaints about current events by inquiring about the physiological and affective reactions; the recognition of introjection and the therapist’s use of interpositions. There are certainly many other aspects to a relational and in-depth psychotherapy that neither time nor space allows us to describe in these short discourses.

Masa, you said in this response, as you also did in your second response, that the presentation of the transference-countertransference matrix was not discussed in my case study. It seems to me that this case is about using both the transferential enactments of every-day-life and the various forms of transference in relationship to the psychotherapist. It is also about the use of phenomenological and relational inquiry (corresponding to the transference and

informed by countertransference) to uncover neglect, ridicule, and physical abuse. The relational inquiry facilitates the creation of an interpersonal-contact wherein the client can finally put words to her physiological sensations and implicit memories. The whole therapy with Theresa was about making conscious what was previously unconscious.

Your concern may be based on my failure to write a more detailed explanation about how I make therapeutic use of Theresa's *transferences of every-day-life* as well as her various forms of transference with me to uncover and resolve her early childhood neglect and trauma. I think that the largest percentage of our client's unconscious transferences is enacted in their day-to-day life with the partners, children, siblings or parents, with people at work, with friends, and even with strangers on the street or in a store. A smaller percentage of unconscious transference is actually enacted with the psychotherapist.

In my practice of psychotherapy I am listening for the muted versions of unconscious transference dramas that may be encoded in the client's stories and reports about what happened at home or at a party. I am frequently asking myself, "What relational experiences are being revealed through the content and style of the client's narrative?" Both the content and affect of the client's stories about their day-by-day life experience provide the fabric for forming my phenomenological inquiries and the many inquiries about how the client perceives our interpersonal relationship.

I would like to take this opportunity to explain what I think about the concept of transference. I presume that it is similar to your concept. My understanding of transference is multifaceted and incorporates concepts from child development, psychoanalysis, transactional analysis, Gestalt Therapy, existential philosophy, as well as a relational perspective.

I think of transference as the means whereby a client can demonstrate the sub-symbolic and procedural memories of his or her past, the relational-needs that have been thwarted, and his or her archaic ways of self-reparation and self-stabilization that were established to compensate for repeated relational disruptions. Transference may also be an expression of a person's inability to form explicit memory while, paradoxically, being an emotionally-laden expression of childhood pre-symbolic and implicit memories. Transference includes the expression of intrapsychic conflicts (what Ray Little, in his 2006 article, calls "relational units") and the desire to achieve intimacy in relationships. Therefore, transference is the expression of a universal psychological striving to organize experience and create meaning (Erskine, 1991/1997).

We are all well aware that in any psychotherapeutic relationship the unsatisfied childhood needs may be projected onto the therapist who will be experienced by

the client as the source of possible needs satisfaction (what Steven Stern calls the “needed relationship” and Michelle Novellino calls the “positive pole of transference”) as well as the source of frustration and rejection (what Stern calls the “repeated relationship” and Novellino calls the “negative pole of transference”). It seems wise to assume that in every case the transference will be characterized by the simultaneous presence of both poles: *the needed and the repeated relationship* (Novellino, 1985; Stern, 1994).

Psychotherapy is effective when the intrapsychic conflict or dialogue (what Little has referred to as internal “relational units”) is externalized and transferred to the psychotherapist, allowing for the identification, exploration, and resolution of relational conflicts and traumas. The more the client’s memories are composed of pre-symbolic, sub-symbolic, and implicit affect-laden experiences, the more actively the psychotherapist needs to take on the transference relationship, to be stimulated and impacted by it, and to convert it into a healing relationship. The psychotherapy of unconscious transference is facilitated when the therapist does not simply take the client’s words or behavior at face value but also looks for the unaware meaning of what patients are saying or not saying, doing or not doing, their affective communication, and body gestures.

Masa, my other comments about working with Theresa (and other clients) within a transference-countertransference milieu are articulated in my rejoinders to parts 1 and part 2. Reiteration here does not seem necessary.

### **Response to James Allen**

Jim, you said, “I think I would have put more emphasis on Theresa’s taking more responsibility for providing herself with the internal dialogues and external relationships that would better support her relational needs.” Although I may not have emphasized this point as much as you may have, Theresa’s taking responsibility for her own welfare was an important aspect to our work together each spring as I prepared her for our twelve-week summer recess. My going away was always a time to highlight my message to her that she was capable and competent and could change her old ways of being in relationship. It was essential in providing such a message that I made clear distinctions between her archaic organizing functions and current mature organizing functions.

For years Theresa had relied on archaic forms of self-reparation, self-stabilization, and self-regulation as reflected in her “crying spells”, making demands on her boyfriend, and getting into conflicts at work. Throughout these last two years of therapy she increasingly transferred her archaic forms of self-organization to her relationship with Robert and to me. She was then learning to depend on her two intimate relationships to provide mature relational reparation,

stabilization, and regulation. She put energy into developing a “loving relationship” with her boyfriend, she actively changed her relationships at work, and she called me for support. Although there was not space to say it in my case study, Theresa also developed a close friendship with a woman she met at work. During this period of time she was increasingly engaging in mature forms of responsibility

I appreciate your comment, Jim, about, “validating health, growth, and development.” Your statement reflects Eric Berne’s use of the Greek word *physis* to describe a person’s inherent “capacity to challenge the forces of acquiescence” and aspire to new personal horizons (cited in Cornell, 2010, p. 244).

It was not until our fifth year that I sought opportunities to inquire about Theresa’s aspirations. By then she had healed from much of her affect-confusion and it was time to stimulate her vitality, support her innate desire to grow, and celebrate her desire to expand her potential. As I planned ahead I kept her words “I am just like my mother” in mind; there was still a need for more psychotherapy to resolve Theresa’s internal criticism.

### **Response to Ray Little**

Ray, you wondered about the psychological organization of Theresa’s mother. Along with the “developmental images” I had of Theresa as an infant, toddler, pre-school and school age child, I had several impressionistic images of her mother’s personality that were formed from Theresa’s stories. I kept in mind that such impressions were created from her stories and my resulting associations about someone I have never met. If I had the opportunity to do psychotherapy with Theresa’s introjected mother, I would have used my impressions and associations to form many inquiries and shape my attunement to the introjected mother. I imagined Theresa’s introjected mother to be cold, critical, controlling, and self-centered. I assume that her marriage was loveless and that her husband had learned to shut-up and adapt in order to keep peace. In an in-depth psychotherapy with Theresa’s mother I would have explored her possible envy, underlying loneliness, and early childhood attachment patterns.

I like, and often use, your idea of “relational units”. Theresa was bonded to her mother through the intrapsychic influence of her mother’s neglect, control, ridicule, lack of empathy, and physical mistreatment. Simultaneously, Theresa was also bonded to this repetitive “relational unit” by her own *inexorable loyalty* to her mother. This intrapsychic energy exchange of inexorable loyalty and unconscious parental influence is what maintains psychological attachment, even in the presence of painful awareness. In Theresa’s situation this pain-inducing

“relational unit” resulted in her enduring affect-confusion and disorganized attachment. An important therapeutic task, essential in resolving such dysfunctional relational units, is to earn the client’s loyalty through a consistency, dependability, and protectiveness that provides the client with a sense that this psychotherapist is invested in my welfare.

Ray, although you say that the therapist’s interposition between the client and the introjected parent “may serve a protective function and is a needed part of the therapy” you also say that it is important to be “aware of the risk of idealization”. I agree because idealization is the client’s unconscious communication that he or she needs to be in the presence of someone who is attuned, capable, protective, and reparative. Bowlby said that security is developed in the young child through the caretaker’s ongoing availability of emotional responsiveness, consistency, and dependability, where such caretakers are experienced as “stronger and/or wiser” (1988, p.12).

The similar sense of security occurs in psychotherapy when the client comes to rely on the therapist’s competency and wisdom for protection from the intrapsychic influence of introjections. Such protection can only occur if the psychotherapist also honors the client’s inexorable loyalty to the introjected parent. The “risk of idealization” occurs when the psychotherapist fails to provide a stable, protective, and reparative relationship to the troubled inner child or fails to honor the client’s intense loyalty. With such failure in therapeutic protection the client may feel abandoned by the psychotherapist and cling even more tightly to the archaic “relational unit”. The potential of Theresa feeling abandoned is one of the reasons I postponed my intended psychotherapy with Theresa’s introjected mother.

Ray, you also wondered about the significance of Theresa’s urgently wanting to see me in August rather than waiting for our scheduled appointment in September. Robert had received a job offer and they were moving to another city together prior to our agreed upon appointment time. I saw Theresa’s plan to move and get married as a sign of success in our work together. She was fulfilling two of her aspirations: to return to school to become an attorney and to be in a loving, committed relationship. There was no time to explore what you call “a multiplicity of motivations”. Perhaps a new therapist in her new city may someday investigate her motivations for getting married, moving, going to school, and terminating with me.

It was time for me to celebrate her success!

## **Response to Grover Criswell**

Grover, you raised the question whether I considered medication for Theresa. Like you, I too am generally conservative in recommending medication; I am a profound believer in the healing power of an interpersonally-contactful psychotherapy. However, I briefly considered medication for Theresa when she was in the midst of a great deal of emotional turmoil. Metaphorically, medication may plug a psychic leak and allow the therapeutic relationship to fill an empty tank.

Theresa refused to even discuss the option of medication. Such conversation resurrected her rage at a psychiatrist who had previously diagnosed her with having a bi-polar disorder and wanted to put her on medication. I realized that her rage at being diagnosed, “controlled”, and “not understood” were transference reactions to her mother’s behavior. It seemed better to unfurl her transference story rather than continue to suggest medication. I supported her, “No, I won’t do what you want me to do”, as an important statement of healthy protest – a protest that her mother never allowed. Theresa’s saying “no” to me about the medication provided many opportunities for phenomenological and relational inquiries and to discuss her relational-need to make an impact.

Grover, I liked your statement,

“Resistance is more than an impediment to the therapy that must be breached. When the resistance can be identified, owned and given voice, then it’s positive and negative functions allow new options and choices. The resistance can be embraced as a part of the self.”

This reminds me of what Laura Pearls would frequently repeat in her training group, “Resistance is not against something. It is an attempt at self-support. It is the client’s expression of integrity. The therapist’s job is to support that emerging integrity”. When we validate what appears to be “resistance” and normalize the client’s integrity in saying “no”, we offer new opportunities for the client to make an impact on us and to further his or her self-definition. Thank you for mentioning this important point.

Grover, you wondered if physically holding Theresa would have facilitated her experience of parental nurturing and the working through of the childhood trauma? Perhaps. And perhaps it would have been too intense and would have created further juxtaposition reactions. This was often my concern. Although I frequently inquired about Theresa’s physiological sensations, gestures, and body postures, my purpose in such inquiries was to facilitate her awareness, ownership, and integration of her bodily experience. We only engaged in physical touch when she initiated hugging me good-by and that was not until the end of the third year. I often encouraged Theresa to ask Robert to hold her in his arms when she was feeling sad, scared, and confused.

Grover, your first long paragraph contains a succinct description of how Theresa's attachment disruptions became established: "aloof distancing of her father and the intolerant criticalness of her mother". You go on to describe the "inadequate parenting" and how it created "early childhood affect confusion that gave her an unstable base for her personality development". Damasio (1999) reminds us how cumulative neglect of the child's needs, repetitive criticism, disregard for the child's level of development, and physical punishment are all recorded in the brainstem as sub-symbolic, procedural memories of self-in-representation. In Theresa's circumstances these procedural memories were infused with contradictory and confusing physiological and affect sensations

Bowlby described how these unconscious procedural memories form an individual's internal working models that provide "a sense of how acceptable or unacceptable he himself is in the eyes of attachment figures" (1973, p. 203). If you remember the work in Parts 1 and 2, Theresa thought of herself as "unlovable", "a piece of shit", and that something was profoundly wrong with her.

As I worked with Theresa it was evident at times that she had an avoidant attachment pattern with men. In the beginning she often expressed her internal working model and archaic self-stabilization by undervaluing and dismissing the importance of her relationship with her current boyfriend, her father, other men in her life, and me. She picked fights when Robert wanted to be intimate or blamed him when she imagined a lack of attention. She frequently complained to me about him. She embraced resentment at her father and scoffed at my expressions of tenderness toward her.

For most of the first three years, Theresa belittled my expressions of empathy and pushed away my attempts to attune to her affect or vulnerability. In the first couple of years she was periodically angry and dismissive of me. Inquiring about how she perceived me in relationship to her was a continual focal point in our work together. On occasions I had earned her anger by either miss-attuning to her affect or miss-understanding her experiences. Then it was necessary that I acknowledge and take active responsibility for my errors (something her parents never did). Frequently, such inquiry led to either sorrowful or angry memories about her father's lack of intimacy and initiative or his failure to take responsibility in the family.

It seems that Theresa avoided emotional closeness with men because she had an implicit fear of vulnerability and intimacy. Theresa's many stories about her father revealed that she repeatedly experienced him failing to give her recognition and attention and that he was predictably unresponsive to her needs for affection and protection. In child-like attempts at self-stabilization, she denied the significance of her needs for affection, intimacy, and protection and scoffed at any suggestion that she may have such needs.

Early in the psychotherapy it became clear that Theresa had a disorganized attachment disorder in relating with women. She was disdainful of previous female therapists, in a rage with the women at work, deeply hurt by Joan's rejection, had no female friends, and hated her mother. She was disturbed and confused by all these unresolved relational conflicts with women. Disorganized attachment disorders, such as Theresa's, reveal a profound psychological disorientation caused by unresolved trauma and significant loss of caring, reparative, and stabilizing interpersonal-contact.

Theresa experienced her mother as the only person who would act in response to her day-to-day physical needs but who, simultaneously, was the source of neglect, ridicule, rejection, and physical abuse. Theresa had a profound fear of emotional and physical violation and she continually anticipated rejection. Her childhood was marked by the lack of a reparative, stabilizing, or regulating relationship with her mother. As a child she prematurely attempted to self-repair the wounds of criticism and physical abuse, to stabilize herself when she was confused and disturbed, and even regulate herself at bedtime and before school because she could not depend on either parent to provide these necessary relational functions.

Throughout our five years of therapy I had these two destabilizing types of attachment in mind. Many of my transactions with Theresa were aimed at identifying and redressing her early childhood internal working models of self-in-representation. It is in the psychotherapist's full involvement, a commitment to being with and for the client, that healing of early affect-confusion is possible.

## **Conclusion**

It is both a pleasure and an arduous task to write this series of rejoinders to the commentaries on the Case Study Trilogy. I have felt honored by the four respondents sharing their thoughts about theory and clinical practice, their dedication to developing a body of literature on relational-integrative psychotherapy, as well as providing us with a glimpse of how they would have approached the psychotherapy differently.

I am highly appreciative of James Allen, Ray Little, Grover Criswell, and Maša Žvelc and hope that each of them will realize that they have made an impact on me. No matter how much I think I am writing about a case, there is so much more that is not clearly articulated or that is left unwritten. I apologize for the significant information that may have been left out of the case study, yet the missing information has led us to a useful discourse. I am elated with the many compliments, challenged to rethink some concepts and methods, confronted with

other points of view, and stimulated to learn the intricacies of psychotherapy once again as though I were a young student. This professional dialogue has encouraged me to re-evaluate various theories and methods of psychotherapy and your commentaries have stretched me both personally and professionally. Thank you!

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*Richard G. Erskine, PhD. is co-author with Janet P. Moursund on the book Integrative Psychotherapy: The Art and Science of Relationship (2004, Pacific Grove, CA: Thomson: Brooks/Cole) that describes in detail many of the concepts used in this article.*

*Other articles are available on the website: [www.IntegrativePsychotherapy.com](http://www.IntegrativePsychotherapy.com)*

**References**

- Bowlby, J. (1973). *Separation: Anxiety and Anger. Volume II of Attachment and Loss*. NY: Basic Books.
- Bowlby, J. (1988). *A Secure Base*. NY: Basic Books.
- Damasio, A. (1999). *The Feeling of What Happens: Body and Emotion in the Making of Consciousness*. NY: Harcourt Brace.
- Erskine, R.G. (1991). Transference and transactions: Critique from an Intrapsychic and integrative Perspective. *Transactional Analysis Journal* 21:63-76. Reprinted in R.G. Erskine, (1997). *Theories and Methods of an Integrative Transactional Analysis: A Volume of Selected Articles*. San Francisco: TA Press.
- Little, R. (2006). Ego state relational units and resistance to change. *Transactional Analysis Journal*, 36, 7-19.
- Novellino, M. (1985). Redecision analysis of transference: A TA approach to transference neurosis. *Transactional Analysis Journal*.15: 202-206.
- Stern, S. (1994). Needed relationships and repeated relationships: An integrated relational perspective. *Psychoanalytic Dialogues*, 4(3), 317-345.

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