Affects, Regulation of Relationship, Transference and Countertransference

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Abstract

The following report tries to compile the results of several research projects of the main author and his co-workers dealing with the exchange of affect within different types of relationships. Different conceptualizations of transference and countertransference as specific forms of creating relationships are described and the fundamental differences between successful psychotherapeutic relationships and empathetic every day relationships are outlined. Our investigations make it highly probable that transference is a very ubiquitous phenomena to be found in nearly every relationship as specific forms of affective scripts. The specificity of these scripts follows the disturbance with quantity and quality of the shown affect being the main differential marker. Within the severe disturbances we find reductions of affect with one remaining negative “lead-affect”, with neurotic patients an excess of conflicts affects. Within the group of severe disturbances affect is attached to the self or to the relationship within neuroses and healthy subject to the objects the dyad talks about. The main difference between successful psychotherapeutic and every day relationships can be characterized by the fact that the therapist does not interactively react to the unconscious affective relationship offers, the patient makes, but develops instead those affects the patient is unable to generate, despite they would be urgently necessary from the meaning structure of the situation.

In the psychoanalytic literature, one finds several concepts of transference which are, in part, incompatible (1). Due to the close connection of the concepts of countertransference and treatment technique with that of transference one must assume that we have, in theory and practice, various forms of “psychoanalysis”, which differ fundamentally in their interpretations of a what constitutes a relationship, what is meant by a curative therapeutic relationship and what transference and countertransference are. If one attempts to find some sort of deep structure of the various concepts, one can list the following:

First of all, there is a disagreement about the generality or specificity of the transference inclination. In accordance with Weiss and Sampson (2), one can hold the opinion that the patients tend to scrutinise every object, to see whether it follows the pattern which is known or feared by them. These tests are designed in such a way, that no one can avoid them even under the most natural circumstances. However, one also finds the opinion that transference, in the regressive setting of the analysis, is initially produced in order to make the historical relationship experience accessible again through an artificially induced “transference neurosis”. Thomä and Kächele (3) criticised Freud's (4) notion of the natural development and spontaneity of the transference process. Argelander (5) argued that transference, governed by the purpose of providing information, directly expresses itself in a relationship, by way of an “offer” organised by Gestalt principles. This offer is used, from the beginning, in the analyst's understanding of the scene. In the German technical language this mode of understanding is called “szenisches Verstehen”

(understanding of the scenes). As always, there are compromise formulas, which do not do justice to the volatility of this central question of treatment technique.

Secondly, there is some controversy about how one should actually understand the transference process. One can view it as a form of illusory misapprehension, and thereby stay relatively close to the process of perception and thinking, or one can see it as a form of enactment, and focus, more

or less, on the action position, with the patient as the unconscious director of his own suffering. It is easy to recognise that the speculation about the ubiquity of transference processes is closely connected with the notion of affective scripts and enactments. In terms of treatment techniques, the preference for interpretations and insight results from a preference for the illusory perception theory, where as a preference for the affective script and enactment results in a preference for “corrective emotional experiences” (6).

Third, the question remains open as to what is actually transferred. The idea that only infantile feelings and attitudes, towards past objects, determine what happens, can not be correct, because both in their behaviour as well in their inner experience, all patients are only partially infantile; therefore, the transference must be modified before it comes to the scenic, behavioural surface.

Many of these questions can be investigated, the greater portion, however, only outside of the analytical sphere. One can for example test the ubiquity of the transference tendency, by providing patients with different unconscious conflicts the opportunity to interact in different situations, with different people, who are not aware of their conflicts. In such a setting one can also, at least inductively, investigate the question of “how”. The question of “what” is actually transferred cannot be approached in such a way. However, the analytical setting does not manage this either. Due to the fact that we, as therapists, are only informed about the patient's childhood principally through their own account and affective scripts, the “assessment” remains somewhat unclear. For an answer to the question, one needs epidemiological prospective longitudinal studies, which means we must exclude them from this report. Nevertheless, we wish to reflect upon which part of the patients flow of consciousness and overt behaviour might be regressive.

Finally, we must urgently ask ourselves: where is the curative part of the psychotherapeutic relationship and interaction events to be found? One can also approach this question in an inductive and inquiring manner, by directing ones attention toward what actually occurs in successful treatments which differs from occurrences in everyday relationships, and how these differences manifest themselves in the inner world of the therapists and patients. It can not depend on the respective treatment techniques alone because so many methods are successful. There must be some curative aspect of the relationship, which goes beyond the official treatment technique. The most reliable result, taken from psychotherapy research as a whole, is that the quality of the relationship is the best indicator for a successful outcome (7). However, it remains unclear what constitutes a qualitatively good relationship in the field of psychotherapy, and especially in psychoanalysis. Stone (8) wrote that the psychoanalyst should be humane, which, at that time, was to

be understood as a warning not to become too rigid in submitting to the rule of abstinence. The client-centred therapists speak for an all-embracing empathy (9).

Above all we must take into consideration, that poor results must be reckoned with if a rule of therapeutic technique becomes the exclusive relationship rule. A system that does not know of exceptions is always inadequate. In the reverse situation, in which the relationship dominates over technique, poor results must also be expected.

One could formulate the problem in this way: How much of which kind of relationship does the respective patient need in order to bear the treatment technique? It may be that for some patients a good relationship means establishing an intensity level of the interaction which is so low that they can endure it. This seems to be true for the more severely disturbed patients. No forms of treatment technique are quite natural. It is, for example, extremely unnatural to expect someone to reveal himself and share his most private fantasies, with a person he does not know. The client-centred psychotherapeutic expectation of authenticity is just as “unnatural” as riding up and down in an elevator with a phobic patient. The confrontation of relationship and technique is obviously an oversimplification because it seems to be a part of our patients' problems, that they repeatedly establish exceptional relationships, which end exceptionally badly. Therefore, every treatment technique must also make a statement about which kind of relationship a particular patient with particular symptoms establishes, and how one can deal with this type of relationship. Psychoanalysis has truly created a large treasury of such rules.

What then is curative in the therapeutic relationship? Interpretation and the insight that comes with it, is certainly of great importance, but we now

know that patients can not believe in our interpretations, as long as they are not at least beginning to believe that we will react differently than the objects of their past scripts. Where is the difference in the way of reacting? A simple answer is that we frequently maintain relationships to people, who do everything possible to end it. The most common “empathetic” reaction, in lay persons, when confronted with the mentally ill, is to leave them alone and end the relationship. We do not do this, but what is it we do differently when we maintain the relationship?

Hypothesis and Operationalisation

The questions which we have raised in our research on transference events and treatment techniques, are more clearly formulated in the following:

o Are there specific unconsciously created relationship patterns, which are characteristic for patients with specific psychological disorders and which are established with anyone?

o If this is the case, which characteristics of the patient determine the relationship pattern? It could be, for example, the seriousness of an illness, completely independent of the diagnosis. It could be structural characteristics, such as the differentiation between narcissistic vs. neurotic personality organisation, or it could be the symptomatology or possibly a combination of different aspects, or perhaps

something that we just do not know anything about yet.

o Do healthy partners in an interaction react in a specific manner in terms of their behaviour, their perception and their fantasies, when they interact with the patients, without knowing that they are dealing with people who are mentally ill?

o If this is the case, how do the patients manage to influence the behaviour and fantasies of the healthy partners?

o What differentiates the psychotherapeutic relationship from ordinary relationships, and what is curative about this difference?

To study the first four questions, we created the following conditions: Two people of the same age, sex and with approximately the same level of education, who did not know each other, carried on a discussion for twenty minutes in which they were asked to solve the four most important political problems in Germany in the coming year. One of the partners was healthy, the other was either healthy or suffered from paranoid schizophrenia, and was either being treated on an inpatient or outpatient basis. A total of 40 people, including the healthy partners, made up the groups. Ten persons suffered, in the broadest sense, from a psychosomatic illness, in one case, ulcerative colitis, another ten suffered from functional spinal column complaints with a clearly neurotic etiology. The control group consisted of twenty healthy persons, who interacted with each other. The healthy partners did not realise that they were speaking with a patient because the patients, including the schizophrenics, did not appear overtly ill.

To investigate what differentiates therapeutic interaction from an ordinary encounter, and what there is about this difference that might be curative, we were able to engage the help of a group of very experienced psychotherapists from the areas of cognitive behavioural therapy, psychoanalysis and client-centred psychotherapy. All were able to treat the patients of their choice, willing to allow the registration of the entire affective behaviour and other events in front of the video. The treatments were designed as short-term therapies of 15 hours.

The patients, chosen by our therapists, were very ill. In fact, all of them had already undergone some sort of pre-treatment. The treatments recorded differ sufficiently in terms of their success, independent of their therapeutic orientation (10). In order to measure the success of the therapy, the therapist and patient were systematically interviewed. Additionally, a goal-attainment-scale was used over the entire course of the treatment, as well as standardised complaint lists, for pre- and post measurements.

As one factor of measurement of the relationship- and interaction pattern we chose affects, as they are expressed in the facial expressions of the interaction partner. The process of registration and evaluation were developed by Ekman and Friesen (11), Friesen and Ekman (12) as well as Merten (13), and termed Facial Action Coding System (FACS) or Emotion Facial Action Coding System (EMFACS). These expression data were correlated with affective experience using the DAS (Differential

Affective Scale) described by Merten and Krause (14). The verbal discourse of both protagonists was transcribed in accordance with the Ulmer Textbank rules, allowing automatic Data processing (15). Naturally, we utilized many more factors of measurement, i.e. eye contact, listener-speaker conditions etc, but for the general work we had to limit ourselves to the expression, the inner experience and the language. The more exact method can be found in (16, 13, 17-19).

Results

The first question, of specificity, can be answered in the following manner: The persons who suffered from schizophrenia and ulcerative colitis, demonstrated a significant reduction of expressed facial affect, in comparison to neurotic patients and healthy test subjects, who were both observed when speaking with healthy test subjects. This reduction was primarily the absence of genuine joy, social smiles as well as forehead and eyebrow movements (Innervating of frontalis muscles) which accompany speech and which can be generally seen as signs of intense cathexis. In each case, the negative affective forms of facial expression were also reduced, with one exception. In the schizophrenic patients, this was only partially a result of the neuroleptic medication. Within the various groups of severely disturbed patients, one negative affect remained prominently apparent. We have named this the “lead affect.” We will come back to this “lead affect” in the discussion about psychotherapy. The “lead affect”, in the schizophrenics was clearly contempt, in the colitis patients, at least in the males, it seemed to be disgust.

The second question, regarding the possible organising aspects of this specificity, we were able to answer in the following way: The general reduction of expressed affect was not typical for the neurotic patients, who displayed significantly more facial expressions than the schizophrenic and the colitis patients. The affect was not generally reduced, it was more as if there was an excess of different negative and positive affects that could be conflicting in nature, i.e. contempt/joy, contempt/anger, and which occurred simultaneously. More specific results can be found in (18).

Regarding the third question, the specificity of the reaction of the interaction partner to this “offer”, we could see that the uninformed healthy partners managed to adapt almost perfectly to the quantity of facial affect of the patient. Only in the case of the schizophrenic patients, who were treated on an inpatient basis, could a significant difference be found between patients and their healthy interaction partners (19).

The fourth question was, how should one visualise the influence patients have on their partner? This question was surely the most difficult to answer because, as expected, the type of influence, in the various illness groups all have their specific differences. These differences, in the expression-experience connection, we have described more methodically and precisely elsewhere (20). In order to clarify the process of this connection, for those readers who are clinically interested, we have singled out two interaction types, that we regard as characteristic of the neurotic and the psychosomatic relationship type. The first example was a male patient suffering from a functional spinal column complaint and a conversion neurosis, who spoke with a healthy partner he had not previously met. The segment is three minutes long, and, in a condensed way, is a prototype of the entire interaction. Similar patterns of interaction repeated themselves during the conversation. (Table 1).

If one observes the affects separately, one finds, in this interaction sequence, a very clear distribution of phases, with a high degree of a mixture of anger and disgust, followed by a short interlude of exhaustion and then a radical change towards extremely charming behaviour, that is very unusual between men. The semantic portion of the first part contradicted the affect expression. The patient said that he is not a fighter, he would normally leave rather than fight, he does not take things very seriously and does not work hard. When the partner agreed with his verbal definition of the situation, the patient was willing to co-operate, for a certain amount of time, and changed over to an extremely seductive behaviour, which the partner subconsciously assimilated, by using the metaphor “to hammer in a stake” (einen Pflock einschlagen) to indicate the beginning of the political discussion. This metaphor is not suitable to the context of a political discussion. If it can be used metaphorically at all so it is tight to the real thing and in this

Table 1. Facial expression of affect and excerpt of dialogue between a healthy person and a neurotic patient*

Facial affect	Patient (P1)	Partner (P2)
	I already have my opinion about certain things + and	Yes +
Anger (annoyance) Anger/Disgust	If it doesn't suit me, I normally just leave because I'm not fighter for anything, + you know.	yes +
anger/disgust	that goes for everything, um everything is only half serious for me, it mustn't get strenuous for me, + you know	that's + right, + I think so too
exhaustion (P1)		
anger/disgust	you know and + then I just quit, everybody can have their own opinion, but I don't have to tolerate it!	
anger/disgust	With me, you know, if someone yells and screams then + it's, all over, for me anyway,	hm +
genuine joy (P2)		I always say that too, + if someone yells, then they've run out of arguments
genuine joy (P1)	You know, hm, ya, ya, if it's like that for you too, then we'll get this twenty minutes over with without …	
gagging gesture +		

(P1) genuine joy (P1, P2)		
charming behaviour P1 clears his throat		See + I don't see any problem - it just depends okay then can I might hammer in the first stake. um
genuine joy (P1, P2)		as ah, hm first of all I'll hammer in the stake environment
both are laughing	Hm In with it.	

context had a very sexual connotation. However, the patient's readiness to co-operate only lasted for a short time, and then a similar sequence had to be repeated so that the partners never actually got to the point of the discussion. The rotation of these interaction sequences, which we have understood as “paranoid” and “homo-erotic”, persisted throughout the entire discussion. The most important political topic that the patient brought to the fore, in accordance with the partner, was the fall of the chancellor. The partner laughed disproportionately and heavily, repeatedly confirmed the definition of the situation and offered, shortly thereafter, a very odd topic, which was actually only understandable from the perspective of the unconscious dynamic. To summarise, we were able to ascertain that the unconscious conflict was dramatically choreographed in a condensed form, and that the partner was very quickly involved in the enactment conflict.

In the dyads where the patients were psychosomatic, it was not necessary to record the language-affect connection because there were no condensed sequences and almost no affective facial expressions. In the example below, we only found signs of disgust or sadness. The verbal context of the disgust reactions gave a picture of the patient and her ignorance, which is exemplified it the following

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* The expression of affect, through facial expression, is shown where parts of the transcript are underlined. + indicates that both parties are speaking simultaneously.

statements which were accompanied by disgust expressions: “I don't know anything about that, I've never taken part in such demonstrations” or, at another point in the conversation, “I don't catch a lot of what happens because I live in a small village, you know, and there, you just don't hear about things like that”. It seems that, on the thematic level, the persisting transference constellation of the discussion was repeated.

The female patient, who, on the whole, spoke very little, continuously accentuated that she could neither do anything nor did she know anything. Her affective expressions reflected uneasiness and disgust, so that a concordance between expression and language was obvious. I will refer to additional related issues in the discussion.

In the dyads involving schizophrenic patients, the affect expression was very similar, from a quantitative perspective. However, there were major differences in the choreography of speech, eye contact and affect expression, which I will also return to in the discussion. Those who are interested in questions regarding the methods, should consult the work by Merten (13) and Steimer-Krause (19).

In connection with the fifth question, regarding the uniqueness of the therapeutic emotional script, we have used, among other things, the facial affects expressed by therapists and patients in the first hour of treatment in order to predict the success after ending the treatment. One measurement, that we have referred to as the dyadic "lead-effect", was highly significantly correlated to the estimation of success obtained through the patient and the therapist as well as trough external systems of measurement after 15 hours of brief-therapy ($r = .69$).

We distinguished between three different constellations of dyadic "lead-affects" which produced the mentioned prognostic data:

o In the first hour, both protagonists showed a "lead-affect" with positive valence. In a concrete case, this would be, for example, that genuine joy is the most frequently displayed affect, both in patient and therapist. We call this constellation reciprocal hedonic.

o The "lead-affect" of therapist and patient has a negative valence. As far as content is concerned, the affects do not have to be similar. The therapist can, for example, predominantly show disgust and contempt, and the patient rage. We call this constellation reciprocal anhedonic.

o One of the protagonists has a "lead-effect" with negative valence, the other with positive valence, whereby the positive one may include genuine joy as well as surprise. It is unimportant for our purposes which "lead-effect" is expressed by which protagonist. We call this form of interaction, complementary.

The last form is the most favourable for the prognosis, while the first, positive reciprocal, is the least favourable. That this kind of classification does not represent an artefact, can be seen from the following: The prominence of the therapist's "lead-affect" in the first hour correlated by $r = .67$ with the therapist estimation of success after the end of the treatment. That means that our therapists, independent of their theoretical orientation, had already, in the first hour, a preconscious knowledge about the failure. This knowledge is preconsciously tied to the extent to which they themselves preferred a single facial expression during the initial hour. In addition the patient's change of facial affect during the course of the therapy, from the anhedonic to the hedonic area, correlated by $r = .75$ with the success estimated by the patients, which again indicates the validity of the measurement systems. Such data on the various forms of therapy, give evidence of extremely powerful factors of influence.

In order to better understand, not only the operative aspects of failure, but also those of success, we selected the treatments of psychoanalytic orientation with the best and the worst outcomes, examining the entire time of treatment. Within the entire sample, the best psychoanalytical treatment was in second place and the worst in the second to last place. The first and last places were held by cognitive behavioural therapy treatments. Longterm catamnesis of the last cognitive behavioural treatment

was sad. The patient had a very severe relapse after 1½ years. Client-centred therapy came somewhere in the middle.

The best course of treatment was observed with a 55 year old personnel manager (case H), who was seeking therapy because of relationship conflicts with his wife and alcohol abuse. He had already been hospitalised for depression, which he had developed on the occasion of a job promotion. His

condition was diagnosed as hysterical neurosis. The least successful course of treatment was that of a 24 year-old female student (case A), who suffered from panic attacks and a personality disorder. A previously implemented behavioural therapy had already led to the worsening of the symptoms. On completing the video recording, after 15 sessions, the therapy continued and was subsequently ended by mutual understanding. The therapist and the patient were both unsatisfied with the outcome.

Ms. A and her therapist were, from the first hour on, a typical reciprocal hedonic joy dyad. The patient also showed some sadness, fear, anger and contempt. There was an absence of surprise and disgust. Her therapist expressed the negative spectrum even less. His facial affect was completely dominated by expressions of happiness. We should keep in mind that massive anxiety attacks were being discussed. The complementary dyad H looked rather unpleasant in the first hour. Mr. H displayed happiness, however, this was immediately followed by anger and disgust. Disgust was the most recurrent affect displayed by his therapist. However, the frequency of joy and surprise together dominated over all anhedonic facial expressions.

Throughout the other sessions, the patients were also distinguished by their specific affective pattern.

One can characterize Ms. A as happiness-, anxiety-, sad-type with an absence of surprise, while patient H represents a happiness-, anger-, disgust-type, without any actual deficits in using the total spectrum of facial affects.

Both therapists can be distinguished from their patients by their low frequency of fear and sadness expressions.

Mr. H's therapist was seven times more often surprised than Ms. A's therapist. Other than that, one does not find any significant differences in facial affect between the therapists, summing up the values from the entire treatment.

If one looks at the temporal development of the dyadic interaction instead of the mean values, one can make two remarkable findings. In the therapy with Ms. A, the micromomentary expression of happiness of the therapist and his patient became increasingly similar, which means, that in taking a sample, every minute, during the entire treatment, we can find an almost perfect synchronisation of the expression of happiness in both parties. In the treatment of Mr. H, the situation was reversed. In the seventh hour of treatment, the therapist took the lead in terms of expression of affect, whereas, in the first half of the treatment, we found an exact but slightly pronounced synchronisation. Besides, the variance in the expression of affect in Mr. H's therapist

was, from the seventh hour on, significantly lower than what had been observed up to that point of time. This means, that the therapist, in the first half of the therapy, introduced an affective interaction style, in that he listened intently and asked short questions, showing, however, very little affect when intervening, but using a lot of facial affects in the second half.

Both parties not only exchanged affects, but they also spoke about a theme, mostly the patients problems, generally considered to be the essential aspect of the therapy. Therefore, we have fully evaluated the texts and have related them to the affects. In addition to that, we have used a method, from Luborsky (21), which enables the extraction of typical relationship patterns from the texts, by analysing the patient's descriptions about relationships to other people. This method facilitates the extraction of the patient's wishes, the reactions of the interaction partner to these wishes and the reactions of the narrator.

Beyond the therapy sessions, in both treatments, there seemed to be, at times, a relatively large fluctuation in the frequency of the narratives. There were sessions that were nearly devoid of narratives, with a predominance of interaction with the therapist.

While, in the less successful case A, the null hypothesis of an equal distribution of the number of narratives throughout the sessions, could not be refuted, the narratives, in case H, were significantly unequally distributed, with a conspicuous maximum in the seventh and a minimum in the eighth, ninth, and eleventh sessions.

Case H, very often expressed the wish: “I want to defend myself against exploitation and domination”, followed by, “I want to shine and be admired” and “I want closeness and solidarity with others”. The reactions from others (outside therapy?) were negative and spanned from exploitation, over destruction, to degradation and disregard.

Patient A's main wish was for “support and

help”, next was “to make a good impression on others”, after that, “others should not interfere with my affairs” and “should be open and honest”. The object reactions were “others dramatise things”, “are not honest” and “laugh at me”.

If we now compare the narratives from the sessions with the expressions of affect of the respective parties, the following conclusions can be made: Only in the treatment of Mr. H, the expected limit of 5 significant coefficients between narratives and frequency of facial affect exceeded the chance level. We found, between the facial expression of Mr. H's therapist and the narratives of his patient, 11 significant coefficients, which led us to assume that, in this case, there are unequivocal connections between the verbal account of the patient and the shown affects of the therapists. The frequency of the wish to “shine” and to be admired, positively correlates, in an impressive way, with the expression of negative affect of the therapist (contempt .59 and disgust .70). However, these two affective patterns of the therapist, were also positively correlated to a significant degree, with the patient's narration about the reactions of his interaction partners (“Others degrade and ignore

me and my work”). One could therefore maybe understand the facial emotional reaction of the therapist, as an affective empathic commentary to the described behaviour of the patient's interaction partners, because the both elements frequently occurred together in the narrative. Since the patient's wishes to be admired and to shine decreased dramatically in the second part of the treatment between the 7 and 8 hour, it is conceivable that the correlation arose mainly through the two phases of treatment. The therapist facial-affect signals of contempt and disgust were actually less frequent in the second half of the treatment (177 vs. 119), than in the first. The fact that the therapist's display of genuine joy correlated negatively (.63) with the frequency of the verbal account of aggressive object reactions, also supports the idea of an empathic reaction to the reported cruel reactions of the partners. Seen from this perspective, the therapists' negative facial affect would not represent disapproval of the patient as a person, but instead is merely his “commentary” on the content of the reported relationship episode, especially on what this patient allowed to happen to himself. In that case, the therapist had taken over an important function as container (22) for the patient, by expressing the rejection towards such forms of interaction and interaction partners, which the patient himself should have expressed but was unable to do. This would correspond to the fact that we found only one significant correlation between the affects displayed by the patient and his own narrations which means that at least at the beginning of the treatment the narrations are not enacted effectively. The therapist would react with complementary affects and subconsciously produce what the patient could not express during interaction, but which he certainly introspectively addressed in his verbal account. Such an interpretation is in no way conclusive and exclusive. Just as likely is the following:

According to his verbal account, the patient failed to implant the wish for admiration in his real life, especially in the people who were really important to him. The object reactions, in the respective relationship episodes, were neither admiration nor recognition, but instead various forms of degradation. From this perspective, the therapists' expression of “disgust” could reflect the usual rejection and degradation of his partners. This means that the patient would enact the same unconscious script of rejection he reported in his verbal account. In comments made by the therapist the patient's behaviour, and especially his gestures, were described as “clowning around” as it is typical for hysteria.

The correlative analysis, on an hourly basis, allows no definite decision as to which hypothesis is correct. In an initial analysis attempt, all of the treatment passages were targeted, in which disgust and contempt were expressed by the therapist, and the corresponding parts of the text were identified. In fact, most of the therapist's expressions of disgust are found, not during the patient's narrative, but instead at the point at which the therapist refers to the above mentioned pattern of the objects in a confrontational manner. This interpretation is further supported by the fact that this represents the therapist's form of intervention, which ends, in the seventh hour with the comment “Do you really need this sort of self degradation?”. The patient answers this question with a slight movement “obviously”, with the knowledge that he himself had repeated this pattern.

The two interpretations do not exclude each other because it is probable that the patient had, to

a certain extent, successfully seduced the therapist into joining the historical pattern. In the post therapy interview, the therapist said that overcoming the countertransferential contempt for the patient's ridiculous behaviour, presented a major problem, but also a great help for understanding the patient's internal life.

The results in dyad A are very different. First of all, there is, neither in the expression of affect nor in the frequency of the narrative, an indication of distinct phases in the treatment. Secondly, as was already mentioned, the connections between the narratives and the expression of affect of both parties do not exceed the limits of chance. If one still wants to acknowledge the data, one may notice that, in contrast to dyad H, there are no significant connections what so ever, between the wishes of the patient and the affective facial reactions of the therapist. It may well be that the patient has experienced this style as a lack of emotional solidarity and containing. The therapist's facial expressions of affect are related much more to the regulation of direct interaction, mainly in the realm of positive affect. We have to keep in mind that the expressed smiles of both interaction partners were more and more perfectly synchronised during the course of the treatment. This, however, was against the intention of the therapist who described the smile of the patient as a mask and who declared the absence of aggression to be the patient's central problem. We had the impression that the patient was quite happy that the central wish for honesty was not fulfilled. The defensive enactment despite her fear allowed her to make a “good impression”, which was another central wish. Unconsciously she was convinced she would loose her important objects in not doing so. Therefore the therapist did her a favour by joining her in this defensive enactment pattern. As a consequence the treatment was remarkably dull, not only for the outside observer but also for both interaction partners, which could be objectively ascertained through the absence of facial reactions of surprise in both partners, and the patient's internal feeling of interest as measured with the DAS. Without such surprise reactions we have few reasons to expect new reconstructive insights and experiences, neither on the side of the therapist nor on that of the patient. This treatment can not be distinguished from an empathetic every day relationship. The therapist unconsciously follows the interaction offers of the patient instead of containing them internally and using specific therapeutic reactions.

Discussion

The first part of our research brought us closer to the assumption, that the tendency for transference is a ubiquitous and measurable phenomenon, and probably part of the disorder. In the meantime, we know that the best predictor of relapse, in many illnesses, are specific emotional interaction styles, such as, i.e. strongly expressed emotions for psychotic, manic and depressive episodes (23). Obviously psychoanalysis does not bring about these phenomena, they arise on their own. If all goes well, psychoanalysis allows these enactments to turn out differently.

Ultimately, we think we have clarified that the patients do not “transfer” on to other people, but instead that they choreograph scenes or pieces of scenes. This scene contains at least three determining elements, namely, the author of the scene, an action partner and a sequence of interactions between them. This sequence of interactions depicts itself most clearly in the exchange of affective signals, and in the structures of meaning connected to them (24). Emotions are the predominant exchange currency of interaction a fact which has been greatly elaborated by Stern

(25) from the psychological point of view as well as by Hochschild for from a sociological viewpoint (26, 27). The existence of these scenes and the nature of their realisation, is mostly unconscious for the authors; in accordance with Sandler & Sandler (28) one can subsequently call them “present unconsciousness”.

The actual enacted scenes, are no exact replicas of the historical relationship because, with that, they would be, in their childishness, immediately and completely obvious, and would then lose their entire manipulative and seductive power. The enactment as a recent scene can include all of the defence mechanisms, as they were described by Suppes & Warren (29), i.e. the exchange of subject and object, the distortion of affects into the opposite, the displacement onto other objects etc. It particularly includes the externalisation of inner structures, in which the action partner does not represent a person, but instead represents an instance, i.e. the punishing conscience, the shameful

superego or the inexhaustible narcissistic horn of plenty which incessantly has to generate admiration. These structures have of course never existed as real people. The largest advantage of the externalisation is that one can actually seduce the real person, which is not possible using the normled, primitive, pre-autonomous super-ego structures, which are inexorable in the sequence of their scenes.

Transference is not the illusionary transmission of false perception onto an innocent victim. If that were the case, it would never have this immense power, but instead transference deals with the creation of scenes, in which others “must” take over a part in a real object relationship. Emotions are exceptionally suitable for that because they have a double function: They change the internal perception of the world and they exert an incredible power to create scenes and scripts for the outside world. The individual clinical pictures distinguish themselves through the types of scenes and the lead affects laced into the scenes as well as different forms of interweaving of verbal accounts and affective enactment.

Structural disorders like schizophrenia and psychosomatic disorders show an affective dialogue structure, which is disassociated from the act of narration. The patient's expression of happiness is in its redundancy without any relation to the narrative acts. It appears rather as a cry for help, which manifests itself in the form of the solicitous behaviour of an infant, who fears that it will be abandoned if it does not smile continuously. Borderline patients we investigated created degrading scripts. One of them showed disgust 187 times in the first hour, and, at the same time, repeatedly expressed the wish to be loved and accepted. The therapist promptly answered with 38% contempt as a “lead affect” in his face. The main ingredient of the borderline degradation script is the disassociation of the wish and enactment, which shows the internal splitting of the person in situ. The same goes for the anxiety patient who's most important wish is for autonomy, but where the opposite is shown on the behavioural level.

The difference between the structurally disturbed patients and healthy subjects can be described in the following way. In the healthy subject the negative facial affect shown is related to the cognitive content in the discussion between two interaction-partners. Whereas the expression of happiness is related to the relationship as such.

In the structural disturbances the facial affect is related directly to the self or to the partner. How to connect facial affect is related to eye-contact and speech in the dyad. There are great differences between structural disturbances and neuroses. In the neurotic enactment the affect is tied to a cognitive structure but it is not shared in the dyad, and it is unconscious to both partners.

We wanted to tentatively answer the question as to what makes the successful therapeutic situation so essentially different from the everyday situation. We feel that it is obviously the unconscious emotional answer of the therapist to the relationship offer from the patient. Based on our work, we believe one could develop a hierarchical scale of how one can fail within the sphere of this unconscious emotional answer.

o On the lowest end, we find people, who are absolutely unable to perceive the unconscious affective relationship offer. It is not due to defences, but instead a more or less habitual affective blindness. This is more frequent than one would think. We train an increasing amount of people in the evaluation of affects, and often find persons who are unable to give valid judgements regarding the affects of others, because they themselves function unreliably on the perceptive level. This essential part of empathy seems genetically based (30). It corresponds with the position of a lay person, who is lacking empathy, or those described as sociopaths. We had one such case in our study. Among well-trained therapists this should not be acceptable.

o The therapist internally perceives the affective relationship offer and reacts to this as an empathetic lay person, which means he or she behaves reciprocally to the patient's offer on the behavioural level as well as internally. He or she finds his behaviour therapeutically appropriate. In general, this is more of a guru type who completely and openly follows unconscious relationship offers, and declares his or her actions to be curative (31). This type differentiates itself from the first type in that he or she at least recognises the relationship offer.

o The therapist internally perceives the relationship offer and reacts to it like an empathetic lay person, which means he or she behaves reciprocally to the patient's offer on the appropriate behavioural level but finds this to be inappropriate. However, he or she is unable to avoid responding in this way. This is the most frequent form of failure among well-trained therapists. We generally find here a disassociation between the internal experience and the enactment. One can also facilitate the revisions, not based on the emotional experience, as it internally presents itself to the therapist, but instead on what he or she actually produces in terms of affect. It can very well be that an analyst is vigorously acting out his or her countertransference because this also, to a great extent, escapes his or her awareness and is not reported in the supervision. Sometimes, this behaviour is accompanied by the knowledge of eminent failure; but then, the therapists enlist diagnostic considerations, which justify their behaviour. The affective signals, especially the facial ones, less importantly the voice, generally evade the internal monitoring of those who produce them. The essential advantage of the couch setting is that it allows for the immobilisation of the unconscious enactment and the unavoidable emotional script, in the area of affect, over the direct interaction, and with that, the unwanted pathogenic participation is easier to avoid.

o The therapist internally perceives the relationship offer as externally induced feelings, but keeps these feelings to him or her self, and gives a completely different answer than the one which is being forced upon him. The difference relates to, on the one hand, the affective dialogue on the behavioural level, and on the other hand, on the verbal intervention, whereby the first has priority. It seems as if the therapist is displaying the affects which are missing in the episodes described by the patient, and which are also lost through his or her narrative. In this case, the discovery and understanding of their meaning is bound to the therapist's ability to recapture and revive the missing feelings.

In the successful treatments, one can actually find a clear differentiation into two parts. In the first part, the patient gives his or her verbal account with great intensity, but due to the absence of a central affect, which the therapist now has, the patient is unable to completely understand his or her own narrative. The feelings, which have been evoked in the therapist, are handed over to the patient again and there comes a point, in which the situation must be completely reorganised for the patient. He has to include the enacted externalised feelings into his own internal sphere and in his narratives about himself. Then wishes may vanish completely or the enactments may change in a way which allows for more effective and beneficial subject- and object reactions.

In the unsuccessful treatment, one does not find any phases which is probably because the narratives do not provoke affects in the therapist and therefore cannot be given back. We are unable to judge what causes this. Because we have only worked with highly experienced people, we assume that in such cases, the therapist shares the defence structure of the patient.

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