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COUNTERTRANSFERENCE AND THE GESTALT APPROACH[1]

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Abstract: The term *countertransference* is an important theoretical concept with useful practical value to the Gestalt approach. Although commonly accepted by most therapeutic theories, it has multiple meanings that have shifted over the years. In this article, this concept is first looked at from a historical perspective, as it developed from psychoanalytic theory. This phenomenon is then discussed from a Gestalt framework. Common forms of countertransferential patterns that emerge in working with individuals, couples, families, and organisations are then articulated. Finally, suggestions for noticing common indications of countertransferential experiences are described.

Key words: Gestalt, countertransference, transference, projection.

I sometimes do executive assessments as an organisational consultant. Recently, while looking over the results of a standardised test (California Psychological Inventory, 1966), I became concerned. An important client, the head of a large company, tested as rigid, uncreative, and authoritarian. I did not know how to give him this negative feedback.

I was amazed that he smiled when I hesitantly told him of his test results. To my surprise, he said that he agreed with them and felt 'seen and understood'. Furthermore, he appeared proud of these traits that I viewed so negatively.

In that instant I realised that I had misperceived important aspects of this man. I had somehow overlooked much about him, including his history, his three years in the Marines, and his support of conservative political candidates.

In hindsight, I realise that, together, we had jointly created an incomplete image of him. I had wanted to see his less developed, friendly, flexible and creative side. He needed to show it. In our many discussions we both ignored his lifelong commitment to hierarchy. I believe that his need for my approval led him to leave out important parts of himself, and my values helped me to collude in this joint creation. Of equal importance, how I related to his organisation was also coloured by my view of him.

The result was that we, he and I, had co-created a myth of who he was in the world, what he was capable of, and what he wanted for his organisation. It resulted in a series of interventions designed to flatten hierarchy and emphasise relationships among engineers, who, if you pardon the stereotype, are by temperament and training highly analytic and linear, and who value high structure and predictability, just like their boss. The results of my organisational interventions could, at best, be described as ineffective.[2]

Introduction

As illustrated by the above anecdote, we do not exist in a vacuum, waking each morning to a brand new world. We are always surrounded by, and are part of, a relational field, continuously co-existing with the three dimensions of time, the present, the future and the past.

The terms transference and countertransference, *as traditionally defined*, refer specifically to the past. They refer to the exact same phenomenon, *the unaware projection of past experiences onto the present.* However, transference refers to the patient's experience and countertransference to the therapist's experience.[3, 4] For the purpose of this paper, I will be focusing on countertransference.

Countertransference, as originally conceived, includes the shoulds, should nots, rules and beliefs that we learned from our parents. At the same time, the term also refers to the more intangible, *i.e.* those unaware values, assumptions and patterns that exist deep within us, that evolve from religion, social class, sex, culture, etc., and that affect our relationships with others.

At first, it may appear surprising that Gestalt literature on countertransference (at least in English) is so sparse, given that our approach emphasises resolving *unfinished business* in the here and now.[5] Furthermore, we also place a high value on the therapist's self-awareness and ability to notice and bracket off his/her acontextual reactions, *i.e.* the phenomenon of countertransference.

Why, then, have we historically avoided discussion of the concept? Perhaps, because as an organising idea it reifies a process and implies a dualistic frame, which pulls us away from our holistic perspective. Placing our approach within this paradigm risks losing or distorting some of that essential core. And finally, countertransference as a way of organising the field and of dealing with complexity is simplistic. We have other, more elegant ways of describing experience.

If this concept is, in many ways, so foreign to Gestalt thinking, then why even attempt to describe and apply it? I have three important answers. The first is that countertransference was essential to our initial professional study and training. And furthermore, it does have relevance for how we experience the world and view the therapeutic encounter. Second, in order to communicate with the dominant therapeutic theories, we must not only be able to speak their language, but also translate our concepts for mutual understanding. Last, Gestalt therapy has some of its strongest roots within the analytic tradition that generated these ideas and applied them to important problems. By starting at the beginning, we can see how the term evolved from the individualistic tradition of Freud, a psychoanalyst, to its current usage within Gestalt circles. As a result, we can reclaim this concept and expand its meaning.

Attempting to connect these two paradigms will not be an easy task. Even if successful, the reader may ask, 'So what?'. This question will be answered later in this article, where I look at management of countertransferential patterns. More specifically, I address how our awareness of these patterns informs the therapeutic work, and end by describing some of the common forms of countertransference.

Countertransference Traditionally Defined

Countertransference involves the projection of the past onto the present ongoing relationship (Blechner, 1992). Historically, analysts have defined the term in many ways. For example, it has been used to mean:

Residues in the therapist's personality of early experience that cause blocks in his or her work with a patient. A therapist's parents divorced and his mother habitually denigrated his father, eventually resulting in the father's withdrawal. Now when he works with men who remind him of his father, he is filled with longing and resentment. He de-emphasises male/male relationships as a topic of discussion and avoids focusing on the (male) patient to (male) therapist relationship in the here and now.

The aspects of the therapist's experience that are responsive and complementary to the patient's psychopathology. A therapist has an 'anti-authoritarian streak'. She is also incensed at how managed care companies have wreaked havoc upon the psychotherapy profession. Recently, when a patient talked about filing a phony disability claim that would cheat a managed care insurance company, she found herself silently cheering him on and ignoring the moral, legal, ethical and possibly sociopathic aspects of his actions.

The entirety of the therapist's experience and personality. Who one is determines what one sees and focuses on. In essence, one is always helping to co-create the therapeutic hour, implicitly or explicitly determining the content and process. There is an old saying that if a thief were in the presence of Jesus, he would notice only his pockets.

In sum, even within the psychoanalytic movement, the precise definition of countertransference is not consensually agreed upon. Yet, the phenomenon is almost universally accepted. We know it when we experience it, or when it is revealed to us, usually by a patient or a supervisor.

Historical Perspective and Development

A young girl... aroused a feeling of pleasure in me... I suddenly found myself standing directly behind her and throwing my arms around her from behind; for a moment my hands met in front of her waist (in front of her lap, in front of her genitals) (Freud, 1901, p 176; cited in Haynal and Falzeder, 1993).

In traditional psychoanalytic treatment,[6] the primary emphasis has been on the analysis of the patient's transference. The focus was usually on the patient's projection of sexual fantasies and aggressive impulses onto the analyst. In fact, Blum (1971) considers the creation and resolution of a transference neurosis as primary in distinguishing psychoanalysis from all other

types of psychotherapy.

Countertransference, by contrast, has been underemphasised historically. It was to be explored and understood *outside* of the therapeutic relationship in which it was experienced. This is because, traditionally, countertransference was viewed as a *failure of abstinence* (Reed and Levine, 1993), and reflected the analyst's inability to act as an accurate mirror. It was both the result of flawed technique and, more importantly, an inability on the part of the analyst to monitor his/her internal process. The analyst was well advised to get help, usually via therapy or supervision.

Its discovery by Freud and his reaction foreshadowed how it would be approached for many years after. At the beginning of psychoanalysis, Breuer, Jung, Ferenczi, and Freud himself, committed boundary violations with patients that were terrifying to Freud. How disturbing this was can be guessed from Freud's remarks to Jung in which he suggested that a paper on countertransference seemed to be 'sorely needed', adding, 'Of course we could not publish it, we should have to circulate copies among ourselves' (McGuire, 1974, p 476).

Freud's attempts to hide the existence of countertransference from the public record may appear puzzling at first glance.[7] Why did he view this concept so negatively? Was it because its existence strongly challenged the value of analytic objectivity that was a cornerstone of his approach and necessary for cloaking his young theory in scientific respectability? Possibly it was his belief, arising from his medical orientation and training, that the clinician is (or should be) mature and healing, in contrast to the patient whom he viewed as sick and immature (Aaron, 1992). Or, maybe he believed that illusion was and should be the property of the patient alone. Whatever the reasons, he viewed counter-transference with much concern, and believed that it needed to be resolved outside the therapeutic relationship. It is unfortunate that Freud was unable to see the potential hidden wisdom in countertransference and the rich possibilities for therapeutic treatment.

The analytic approach to understanding and working with countertransference has shifted over time. Of prime importance was Ferenczi's focus on the interactive dimensions of the therapy and the importance of the analyst's feelings as a tool for understanding the analytic procedure and relationship (1988). In fact, he experimented with 'mutual analysis' in which analyst and patient took turns analysing each other. In time, he began looking at countertransference in new and expansive ways.

Today, countertransference is no longer considered solely as a problem of the analyst, but also as a valuable source of information about the psychodynamics of the patient and, more importantly, about the interpersonal dynamics *between* the analyst and patient. Both transference and countertransference are considered a joint creation arising out of the interaction. Yet for many analysts, the study, and meaning making, of counter-transference is still left largely up to them. As in the past, the relationship aspect is not actively addressed during the therapeutic hour.

Countertransference -- a Gestalt Perspective; Gestalt Versus Psychoanalsis

As discussed previously, Gestalt theorists have not been very interested in countertransference – at least as psychoanalysts have historically described it. This is, to some extent, because we do not believe that you can distinguish between reality and illusion, believing instead that reality is never clear cut and consensual. Instead, it is viewed as always co-created, and always containing large elements of subjectivity. We always exist in contexts that are, to various degrees, opaque and hidden from each other and ourselves.

Another difference between the Gestaltist and the traditional analyst involves the therapeutic contract. The Gestalt therapist is committed to using his/her subjective experience of self and relationship, not just as a source of data, but as selective enrichment of the therapeutic hour. Unlike the traditional psychoanalyst, the Gestalt therapist does not attempt to create a 'blank screen' to evoke or heighten transference. In fact, we have not been very interested in the *origins* of either our, or our patient's, distortions. We are less concerned with explanation and in identifying specific content that generated the projections than in how they impact, influence and colour the current encounter. Rather than being analytic, interpretive and judgmental, we are more engaged and subjective, operating from the inside rather than the outside.

One last difference involves how we use feedback and self-disclosure. Projections of both the therapist and patient are continuously brought into awareness and worked through in the moment. Phenomenologically-based feedback is ongoing, and selective self disclosure is an important therapeutic tool. Thus our goal is to heighten awareness of patterns and pattern making, not to create a transferential/countertransferential experience.

Gestalt Definition of Countertransference

We define countertransference as an organised series of projections that are relatively fixed, not phenomenologically based in the present, and originating in the past. They may include perceptual distortions (of what I see, hear, smell, etc.), and attributions – how I make meaning of experience. When these *series of projections* exist outside of awareness, they influence the

themes and *foci* of the therapeutic hour in ways related to the therapist's unaware history and needs. As a result, the therapist will have diminished presence and capacity to respond to the patient's wants and wishes. When unaddressed, countertransference will have reductionistic impact, reducing vitality, robustness, and excitement.

If I am unconsciously frightened by interpersonal anger, then the possibilities for a patient to express his/her anger towards me, and for me to express towards him/her, are diminished. As a result, our ability to move towards an increased awareness of the meaning of our anger and how it impacts and helps shape our relationship is distorted. As I become aware of how pleasant we are to each other, how agreeable we are, I also begin to notice my collusion.

In order fully to understand the concept of countertransference from a Gestalt perspective, it is important also to discuss *field theory*, *the past*, and *the paradoxical theory of change*.

Field Theory: Gestalt therapy relies on a field theory perspective to view countertransference. The therapeutic landscape is always a co-construction of the patient and the therapist. Furthermore, we understand that whatever we emphasise will always affect (and be affected by) the dynamic field. To the best of our ability, we attempt to be aware of our *countertransferential reactions* as well as our preconceived assumptions about the patient. We also realise that our countertransferential responses are not only affected by the immediate field (the patient-therapist system), but by larger field conditions. We believe that with heightened awareness, these acontextual patterns become minimised, although they never totally disappear. As a result of this heightened awareness, fluency and a greater capacity to respond are returned to the system and the potential for creative adjustment increases.

Practically speaking, this means that I create you, you create me, and we create the relationship from moment to moment. Or, more accurately, there is a *simultaneous* creation at the boundary. How I am with you and you are with me in this moment is different from how we are with others and how we will be with each other in the next moment. It is when we are experiencing each other and our encounter as fresh, vivid and unique that change and growth occur.

The Past: Every present and future moment must incorporate the past, for, as I said previously, we do not awake each morning to a brand new world. Maintaining a dynamic interplay between the old and the new, what we term creative adjustment, is viewed as the essence of good health and psychological growth. Thus, for a perception to take place, past experience must be *transferred* onto the new situation. Every new experience, as such, consists in large part of what is carried over from before. What *is* is shaped by what was and by what one expects.

If we have minimal past experience, or a poor or distorted memory, then the ground upon which our perceptions rest may be poorly formed, chaotic or, in some cases, constantly novel. Yet, on the other hand, if the past is overly compelling and weighs too heavily on the present, we may be left with experiences that are indiscriminately repetitive and redundant, with little novelty.

Paradoxical Theory of Change: The Gestalt approach to working with this phenomenon is based on the paradoxical theory of change (Beisser, 1970). This involves a belief that by heightening one's awareness of what is, change and growth naturally follow. The therapist does this by being fluid, by moving from awareness of self, to the other, to the dyad, and back again. There is also something paradoxical in this movement. For in order to do this, to be aware, one must artificially stop ongoing experience and temporarily step outside of it. This is not easy to do. It takes a finely tuned ability to notice where the quality of the contact at the boundary seems frozen, sparse or redundant. Yet sometimes noticing is not enough. The therapist must also be able to use this information to create a dialogue, involving the selective use of self disclosure and feedback. S/he must have the skills to focus on the intrapsychic experience of the patient, and him/herself in the dyadic interaction.

Common Theoretical Patterns

Although countertransference patterns can have unlimited form, some are more common and seem to appear repeatedly. Five of the more obvious ones that have received much attention in Gestalt writings are: *introjects*, *sensory experience*, *energy*, *interpersonal patterns*, and *explanatory style* (*meaning making*).

Introjects are the unassimilated shoulds and should nots, delivered from the past (*c.f.* Perls, Hefferline and Goodman, 1953; Polster and Polster, 1971). Sometimes, they can be understood quickly and clearly.

> A male patient reminds me of my father. This man is the same age and shares many of his beliefs. I grew up learning that one should always respect one's elders. Treating him with unwavering respect, in turn, causes him to respond to me as a father would. He treats me in a loving, paternalistic manner. This pattern of *mutual respect at all costs* diminishes the possibilities for authentic contact. (Of course, as previously discussed, it is not so simple. One might just as easily say that he treats me like a son, causing *me* to respond to him like a father. What is, in fact, occurring is a simultaneity of experience. It is the therapist's responsibility,

> however, to notice his/her *distortions* at the boundary.)

There are many introjects that are more elusive and may be evoked not by specific individuals, but instead, by certain situations. For example, 'I was brought up to avoid helplessness or disillusionment. When I begin to experience these emotions with patients, I find myself leading them to action.'

Sensory experiences consist of smells, sounds, sights, touch and tastes. The Gestalt approach has always placed a strong emphasis on sensory experience (*c.f.* Stevens, 1975). In fact, Perls' oft-quoted statement, 'Lose your mind and come to your senses', may be seen as an attempt to correct the Freudian emphasis on intellect and underemphasis on sensations.

The colour of my patient's hair reminds me of my first love. When working with her, I often find myself gazing lovingly at her – filled with tenderness. She, in turn, finds herself deeply touched by my unconditional, unearned empathy and concern. Yet, she also feels terribly confused as to why she touches me so deeply, and why she is so special for no apparent reason.

One can argue that the therapeutic encounter primarily involves the heightening of awareness and management of *energy*, whether on the intrapsychic, interpersonal, or larger systems level. It is important that the therapist attend to his/her response to the form (*e.g.* anxiety, excitement and blockage), and intensity (or lack) of the patient's energy. The level of interest experienced by the therapist may relate more to the therapist than to the patient's ability to be interesting. In these situations, one is likely to witness countertransferential patterns.

> A patient talks endlessly in a monotonous voice. His intellect seems devoid of emotion. Soon I find my mind wandering. I find myself bored, blaming him for being so dull. Soon I become aware that I am angry with him and want to confront him with his 'out of touch' style. In talking to a colleague about him, I become aware of how, in my family of origin, we always wore our emotions on our sleeves. Furthermore, in order to get attention, we had to create melodrama.

As I said earlier, Gestaltists, among others, expanded the therapeutic contract from a focus on the patient's patterning behaviour (*i.e.* transference), to an inclusion of how the therapist's still active preconceptions, preoccupations and unresolved issues (countertransference) contribute to shaping the therapeutic moment. Together, both the patient and the therapist create *interpersonal* patterns – some unique, others reminiscent. In time, certain patterns begin to repeat in the therapeutic meeting.

> Mary's life began to go downhill quickly, beginning with the immune deficiency disease that ultimately made her housebound. In time she became depressed. As she became less capable, she began relying more on me. At first, stepping into this supportive role was easy. However, as her acute condition became more chronic, I found myself becoming resentful of her dependency. She, on the other hand, became extremely aware of my increasing unspoken criticism and resentment. She became more overtly fragile, and I more protective at first, and then more self-protective.

Through consultation, I became aware that I was recreating the lifelong dynamic I had with my mother and she with her father. I was responding in an overtly supportive way while hiding my resentment. She experienced me like her father who had, in fact, been very critical and angry with her whenever she attempted to lean on him. It is important to note that the shape of this relationship was neither good nor bad. It was the unaware redundancy that we created that limited the possibilities for contact and growth.

As we grow up, we are influenced, often with little awareness, by our parents' response to life's events. If I am not aware of my preconceptions, I may inadvertently create or *make meaning* for my patients, rather than letting the meaning emerge from our dialogue.

> A few months ago a long-term patient came down with terminal cancer and was given five years to live. After his diagnosis, he surprised me by how quickly he accepted his fate. I found myself getting angry, believing that he was giving up too soon. I was reacting to this sad situation in much the way I had learned to do as a child. I had been taught that there is no good way to leave, and it is always the fault of the one who is leaving.

As you can imagine, the reasons I was reacting in this manner are complex. However, one result is that my reaction was more about me than about him. I was at risk of creating a meaning about his decision (*i.e.* giving in), that was more about my countertransferential interpretation, and less about his *meaning* (*i.e.* acceptance), that emerged from his experience and his approach to adversity.

Countertransference When Working with Couples, Families and Organisations

When working with systems greater than one (couples, families and organisations), countertransference takes on a new complexity and becomes more abstract. We cannot touch an intimate system, smell a family, or see an organisation in other than an abstract, metaphorical way. Furthermore, there are simply more countertransferential possibilities. For example, when working with couples I am not only affected by each person as an individual, but how they are as an interactive dyad. Past experiences observing couples (such as parents), or participating in dyads (such as my best friend and I), reside in my ground, at times leading to countertransference.

When consulting with a new organisation, memories of early experiences with larger systems such as schools, church groups, camps, and doctor's offices can be quickly evoked. I have found that if I do not pay attention to these past experiences, they can inadvertently colour my work with the organisation.

In addition to past experience, one needs to be aware of preferences for working at a specific level of system (individual, dyadic or large system). I have found that most therapists/consultants prefer engaging at one particular level. Much of this is, of course, dependent on character and training. Thus, individual therapists will often prefer a one-on-one focus, even when working with families. Couple and family therapists often prefer working at the intimate system level. Often, group process and organisational development professionals tend to favour a more big-picture, complex and abstract focus, and are less interested and effective in working at other levels of system. However, if I am unaware of my preferences, I may choose to focus on a level of system that is less in tune with the emerging needs of the client system.

As indicated previously, in working with systems greater than one, the therapist must not only be aware of individual countertransferential patterns (introjects, sensory experiences, energy, interpersonal patterns, and meaning making), but patterns at a larger system level. Three that seem to occur commonly in my work are *identification*, *values* and *interactional processes*.

Identification

In consulting with multi-person systems, countertransference usually takes the form of identifying more with one individual or subsystem than with another. As a result, interventions may lose their balance and fluidity. However, not only must I be aware of identifying with one subsystem over another, I need to be aware of my response to the system as a whole. This awareness encompasses not only the obvious, such as my parents' relationship, but others that are less apparent, such as parent/child, brother/sister, good friends, tennis partners, etc. Furthermore, not only am I influenced by their overt interactions, such as the expression of anger and love, but also by their values, prejudices, blind spots, and cultural and religious undertones.

I recently worked with a couple struggling to decide whether to stay together or separate. They seemed like opposites. He liked to work; she liked to play. He was moralistic; she was having an open affair. Her career was moving forward; his was in a rut. He was a talker; she was quiet. She was in therapy; he was not. Most importantly, she wanted a divorce. He did not. In order to create balance in the system, I referred him to a colleague, and began to work with the couple.

> Although I worked hard to maintain a balanced perspective, I found myself agreeing internally with the woman. To his credit, the husband complained that I, at times, did not support him enough. They left after seven sessions, stating that they 'needed a break'. They never returned.

I am certain that, although I was aware of my biases and identification, and although I worked extremely hard to stay balanced, my strong identification with one part of the system was experienced by this couple and led to their termination of therapy.

Values

When working with larger systems we carry internal pictures of the way life should be. These values are often hard to articulate because they are not about individuals, but more about how our social fabric should be composed. Many are so deeply embedded in us that even as aware adults these patterns can still influence us in powerful and hard to define ways.

I value organisations that are flat, collaborative, and have minimal hierarchy. This value was nurtured during my childhood. When invited to coach a CEO of a large medical facility that is highly stratified and rigid, I found myself espousing the importance of collaboration. The CEO – a pharmacist by training – who leads by staying in his office counting and manipulating data, appeared confused by my suggested intervention strategy. I was not invited back.

Interactional Processes

As previously discussed, when working with systems, we are most concerned with countertransference with regards to interactional processes – what goes on *between* the individuals in the system. In addition to paying attention to such variables as balance and values, there are

three areas of focus that are extremely important. They are: *support and nurturance*, *power and influence*, and *vulnerability*.

Support and Nurturance: It is important to look at how support was expressed in one's family, in one's parents' relationship, educational settings, teams, etc. Did individuals touch, encourage, and nurture each other? Was the support fluid or rigid, variable or assigned? How did family, friends and others deal with the polarity of non-support and neglect? And, now, how does the client system handle these tasks, as they play out against the backdrop of the therapist's support/nurturance biases, and determine what is possible?

I grew up in a family that valued autonomy and self-support. One did not ask for help. When working with a therapy group where support was regularly requested and overwhelmingly granted, I felt critical and judgmental of the seemingly sentimental nature of the interactions.

***Power and Influence*:** Surprisingly, little has been written about power in Gestalt literature.[8] By power we mean influence, *i.e.* the ability to create a figure, to move towards a decision, to impact the process or to create the agenda. How power is utilised in a system involves not only who influences the decisions, and how decisions are made, but also more importantly it incorporates how influence is actualised. Influence is affected by a host of variables such as gender, age, competence, knowledge, intelligence, looks, and physical strength.

> I grew up in a family where gender played a role in how influence was defined. My father played the 'top dog' role of making every decision – small or large – without consulting my mother. She played a traditional underdog role in that she had the capacity to make him pay a price regarding decisions with which she disagreed. More importantly, she had a style of impacting decision making that was subtle and covert. My mother always knew what my father's strategy was going to be and worked to influence his direction. She would get angry when she was not able to lead him to the 'right' decision.

I have worked with a group of medical specialists for a number of years. One of the partners is a woman who constantly operates the way my mother did with my father. The six other partners, men, rather than fight the way my father did, instead tell her how much they value her and how selfless and important she is. I have watched this process at least 100 times. Each time I witness this, a part of me expects and wants them to fight with her. I have to work to make sure that this tendency does not sink into countertransference and subvert the wonderful solution they have designed.

***Vulnerability*:** Freud once said that 'Neurosis is the avoidance of legitimate suffering'. The catch, however, has always been to figure out what, in fact, is legitimate. How open to suffering (as well as joy, anxiety, sorrow, and desire), is legitimate? How vulnerable and open must a system be to operate optimally is an important question. The answers are, of course, complex.

Our dilemma is that as we struggle to help our patient determine how open and vulnerable to be (when is too little and when is too much?), our own beliefs and experiences come into play.

I grew up primarily in a stereotypical, male-controlled culture. Although we could hug and express love in my family, males seldom expressed the 'dependent emotions'. Rarely, if ever, did we discuss feeling needy, cry, or express pain. As a result, it was up to my mother to discuss her hurt and angst – which she did constantly.

> I worked with a family in which the wife experienced anger, need for space and autonomy, while her partner tended to reside at the more feminine pole, valuing connectedness, vulnerability and softness. I kept stroking my head wanting to tell them they had it backwards. On one occasion, I brought the countertransference into awareness and actually did. It created the best session we had had for a long while.

Common Indicators of Countertransference

The analytic literature provides many signs that indicate countertransference is occurring. For example, a therapist always starts late with a particular individual, group, or family, or runs overtime with another. One may notice one's self responding to standard transactions such as cancellations, phone calls and extension of credit in ways that deviate slightly from one's standard procedures. Below are areas to attend to when noticing a loss of therapeutic balance.

Content

Besides level of interest toward an individual or one part of a system, I also notice my reactions to the content. For example, do I find myself asking for details of events that no longer interest my patient? On the other hand, as indicated previously, boredom (the unaware withdrawal of energy), is also often a sign of countertransference.

Self-disclosure

When driven by countertransference, self-disclosure is experienced as a personal need to share one's self, not as a facilitation of the therapeutic process.

> A patient comes to you in distress questioning whether she can continue to carry on an affair while struggling to live in a committed relationship. You, yourself, have managed to do this. So you find yourself wanting to tell her how to manage this difficult balancing act, rather than joining her in exploring topics more directly relevant to her phenomenological reality.

Story Telling

At their best, personal stories of the therapist are presented at the end of the cycle when the patient and therapist are making meaning of experience and looking for similarities in the wider field. However, when told prematurely, they can draw energy away from the patient system and instead focus on the therapist or therapist/patient system. I find that when I feel a compulsion to tell a story, it is almost invariably an attempt to complete a situation from my past or to move the patient more quickly to learning.

Giving of Advice

Advice giving can be positive as we are the experts and, in some circumstances, know more than the client system. However, I find that giving advice might instead be masking my difficulty in living with uncertainty, or a sense of inadequacy in the moment. This often involves influencing a patient to finish a situation that is unfinished for me. My advice giving may also sometimes be a cover for a moralistic or judgmental attitude. This is especially so if my advice is related to similar life situations that I imagine I manage well.

Wanting More for the Other

For therapy to succeed, a relationship needs to be developed and maintained. Aesthetically, there is just the right amount of caring that the relationship can sustain.

> I have a patient who always wanted to be a physician. My mother wanted the same for me. When he did not get accepted to medical school, I was disappointed. When I next saw this patient, I found myself angry with him because he had accepted the rejection and moved on. I thought he should study and try again.

If I find myself caring more – not just about the patient, but about his/her hopes and dreams – problems can ensue.

Conclusion

The purpose of this paper has been to look at countertransference, a subject that has received scant attention in Gestalt writing. Gestalt therapy is, at its core, a theory of awareness and contact. It shares with the analytic orientation a heightened interest in the distorting effects of interjects, shoulds and should nots. More recently, as a field perspective has been emphasised, we have focused less on the distortions that can be traced back to individuals and experiences in our past, and more on the subtle patterns that are created within the therapeutic context. We attend not only to the patient and the therapist but, more importantly, to what happens between them. When these patterns become redundant, *i.e.* fixed gestalts that are out of awareness, they lessen possibilities for contact and hinder the emergence of new and creative ways of relating. The therapist's lack of awareness (countertransference) of projections from the past is the enemy of lively new figures.

In Gestalt therapy, the therapist must continually strive for awareness. In this way, s/he maximises the potential of recognising those moments when countertransference is manifesting. At these times, the personal, unfinished, and still lively material that can emerge, irrespective of the patient's needs, can be intercepted, and either bracketed or used to enhance the therapeutic encounter.

Notes

1. This article was developed from a series of lectures at the Couples and Family Training Program of the Gestalt International Study Center at Cape Cod, MA. I would like to thank my colleagues, Stephanie Backman, Sonia March Nevis, and Joseph Zinker, for their assistance, and especially my wife, Gloria Melnick, for her editorial help and input on content.
2. The first person is used for many of the vignettes and anecdotes in this article. Many, but not all, reflect my own experience with certain information having been altered to protect confidentiality. The others are taken from stories told to me by colleagues, supervisees, and friends. Each vignette is, in its essence, true.
3. Throughout this article I will usually use the terms *therapist* and *patient* for simplicity's sake. However, this analysis is intended equally for practitioners who work outside the therapy realm, especially within the fields of education and organisational development. If one substitutes the words *consultant* for *therapist* and *client* for *patient,* these principles should still be relevant.
4. Although I will be focusing on distortions, or the fixed gestalts of therapists, it is impossible to describe countertransference without reference to the actual context in which it occurs, including the patients' contributions.
5. I am not aware of any articles that are devoted solely to countertransference. Articles that address transference

and countertransference directly or indirectly are by O'Shea (1999), Philippson (2002), Sapriel and Palumbo (2001), Van de Riet (2001), and Wollants (1966).

6. As indicated previously, psychoanalysis is emphasised because Gestalt therapy grew out of this approach and because of the importance that psychoanalysis has placed on transference/countertransference. There are, of course, other sophisticated approaches to this concept, such as that of Jung.
7. The need consistently to present psychoanalysis in a positive light, despite often contradictory data was, unfortunately, part of Freud's character.
8. It is beyond the scope of this paper to address this issue in depth. To my knowledge, little Gestalt writing has addressed this topic. I would refer the interested reader to Melnick and Nevis (1987, 1994).

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