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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. Departing from that, different conceptualizations of transference and countertransference as specific forms of creating relationship are described and the fundamental differences between successful psychotherapeutic relationships and empathetic every day relationships are worked out. 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 characterize 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.

1. Introduction

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

First of all, there is a disagreement about the generality or specificity of the transference inclination. One can, as *Weiss* and *Sampson* (2)*,* hold the opinion that the patients scrutinize 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 pass 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 artificially induced ”transference neurosis”. *Thomae* and *Kächele* (3) criticized *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” organized 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, it is controversial how one should actually surmise the transference process. One can view it as a form of illusory misapprehension, and with that, stay relatively close to the process of perception and thinking, or one sees it as a form of enactement, and with that focuses, more or less, on the action position, with the patients as the unconscious director of their own suffering. It is easy to recognize that the speculation about the ubiquity of transference processes, is closely connected with the notion of affective scripts and enactment . In terms of treatment techniques, the preference for interpretations and insight results from the preference of the illusory perception theory, where as the preference for the affective script and enactment , results in a preference for ”corrective emotional experiences” (6).

Thirdly, in the end, 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 the behavior as well in the inner experience, all patients are only partially infantile; therefore, the transference must be modified before it comes to the scenic, behavioral surface.

Many of these questions can be investigated, however, the greater portion only outside of the analytical sphere. One can test, for example, the ubiquity of the transference tendency, in that one provides patients, who have different unconscious conflicts, with 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 patients childhood, principally from their own account and affective scripts, the ”assessment” remains somewhat unclear. For the answer to this question, one needs epidemiological prospective longitudinal studies, which means we must exclude them from this report. Nevertheless, we want to think about which part of the patients flow of consciousness and overt behavior could be regressive.

Finally, one must urgently ask oneself, where is the curative portion of the psychotherapeutic relationship- and interaction events to be found. One can also approach this in parts, in an inductive and inquiring manner, in that one’s attention is directed toward what actually occurs in successful treatments differently, than in everyday relationships, and how this difference manifests itself in the inner world of the therapists and patients. It can not depend on the respective treatment technique 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 stable result, taken from psychotherapy research as a whole, is that the quality of the relationship is the best indicator for the result (7). However, it remains unclear what a qualitative good relationship should be in the field of psychotherapy, and especially in psychoanalysis. *Stone* (8) wrote that the psychoanalyst should be humane, which, during that time, was to be understood as a warning not to become too rigid in submitting to the rule of abstinence. The Client-centered therapists speak for an all-embracing empathy (9).

Above and beyond analysis, it must obviously be taken into consideration, that poor results must be reckoned with if a therapeutic technique rule becomes an exclusive relationship rule. A system that doesn’t know exception, is always inadequate. In the reverse situation, in which the relationship dominates the technique, one can postulate that poor results must also be expected.

One could formulate the problem in this way: How much of which type of relationship does the respective patient need in order to bear the treatment technique. It may be however that for some patients a good relationship consist of establishing and 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. The techniques of all the treatment forms are generally not natural, it is, for example, extremely unnatural to expect, someone to reveal themselves half publicly and share their most private fantasies. The client-centered psychotherapeutic expectation for 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 problem, that they repeatedly establish exceptional relationships which end exceptionally badly. Therefore, every treatment technique must also make a statement about which kind of relationship type, 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.

Then what is curative about 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 our interpretations, as long as they are not at least starting to be sure that we will react differently than the objects of their past scripts. Where is this difference in the reaction? A simple answer is that we

frequently maintain relationships to people who often do everything possible to end it. The most common ”empathic” reaction, from lay people, when confronted with the mentally ill, is to leave them alone and end the relationship. We do not do this, but what do we do differently if we maintain the relationship?

2. *Hypothesis and Operationalization*

The questions which we have put forth in our field of research on transference events and treatment techniques, sound somewhat more clearly formulated in the following:

1) Are there specific unconsciously created relationship patterns that are established with anyone, which are characteristic for patients with specific psychological disorders?
2) If this is so, which characteristics of the patient determines the relationship pattern? It could be, for example, the seriousness of an illness, completely independent from the content of the diagnosis. It could be structural characteristics, such as the differentiation between narcissistic vs. neurotic personality organization, or it could be the symptomatology or possibly a combination of different aspects, or perhaps something that we just do not know about yet.
3) Do healthy interaction partners react in a specific manner in terms of their behavior, their perception and their fantasies, when they interact with the patients without knowing that they are dealing with people who are mentally ill?
4) If this is the case, how do the patients manage to influence the behavior and fantasies of the healthy partners?
5) What differentiates the psychotherapeutic relationship from ordinary relationships, and what is curative about this difference?

For the investigation of the first four questions, we have 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 either healthy or suffered from paranoid schizophrenia, and was either being treated on an inpatient or outpatient basis. These groups, including their healthy partner made a total of 40 people. Ten suffered, in the broadest sense, from a psychosomatic illness, in one case, ulcerated colitis (N=10), others suffered from functional spinal column complaints (N=10) with a clearly neurotic etiology. These dyads together with their healthy partners were comprised of 40 people. The actual control group consisted of healthy test people, who interacted with each other (N=20). The healthy partners did not realize that they were speaking with a patient because the patients, including the schizophrenics, did not appear obviously ill.

To investigate what differentiates therapeutic interaction from an ordinary encounter, and what is there about this difference that could be curative, we were able to engage the help of a group of very experienced psychotherapists from the areas of cognitive behavioral therapy, psychoanalysis and client-

centered psychotherapy, all of who were able to treat the patients of their choice willing to allow the registration of the entire affective behavior and other events in front of the video. The treatment was designed as short term therapies of 15 hours duration.

The patients, who were chosen by our therapists, were very ill. In actuality, all of them had already undergone some sort of pretreatment. The treatments we recorded differentiate themselves sufficiently in terms of their success, independent from 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 treatment, as well as standardized complaint lists as pre-post measurements.

As one of the measures for the relationship- and interaction pattern we have chosen the 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 systems of measurement, i.e. eye contact, listener-speaker conditions etc., but for this 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, 18, 19).

3. Results

The first question, of specificity, can be answered in the following manner: The men, who suffered from schizophrenia and ulcerated 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 consequence of the absence of genuine joy, the social smile as well as forehead and eyebrow movements (Innervating of frontalis muscles) which accompany speech and which can be generally seen as a sign of intensive cathexis. In each case, the negative affective forms of facial expression, were also reduced, with one exception,. For the schizophrenic patients, this was only partially a result of the neuroleptic medication. Within the various groups of severely disturbed patients, one negative affect remains prominently available. We have named this the ”lead affect.” We will come back to this ”lead affect” in the discussion about psychotherapy. The ”lead affect”, for the schizophrenics, is clearly contempt, for the colitis patients, at least for males, this seems to be disgust.

The second question, regarding the possible organizing aspects of this specificity, we were able to answer in the following way: The general reduction is not typical for the neurotic patients, who displayed significantly more facial expression 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).

In terms of the third question, of the specificity of the reaction of the interaction partner to this ”offer”, one realized that the uninformed healthy partners managed to adapt almost perfectly to the quantity of facial affectivity of the patient, so that only in the case of the schizophrenic patients, who was treated on an inpatient basis, could a significant difference be found between were patients and their healthy interaction partners (19).

The fourth question was, how should one visualize, 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 hold for 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 was three minutes long, and allowed for, in a condensed way, access into the prototype of the entire interaction. Similar patterns of interaction repeated themselves during the conversation.

The table 1 on p. 6 should be read in the following way: The expression of affect, through facial expression, is depicted where portions of the transcript are underlined. An + indicates that both parties are speaking simultaneously.

If one observes the affectivity, separately, one finds, in this interaction sequence, a very clear phase distribution, with a high degree of anger-disgust-blends , a short interlude of exhaustion and a radical change in the direction of extremely charming behavior that is very unusual in the existing form 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. After the partner agreed with his verbal definition of the situation, the patient was willing to cooperate, for a certain amount of time, and change over to an extremely seductive behavior, which the partner subconsciously assimilated, in that he used the metaphoric to hammer in a stake to indicate the beginning of the political discussion. This metaphoric is not suitable to the context of a political discussion can be used metaphorically at all so it is tight to the real thing and in this context has a very sexual connotation. However, this readiness to cooperate only lasted for a short time, and then a similar sequence had to be repeated so that the partner never actually got to the point of the discussion. The rotation of these interaction sequences, which we have understood as ”paranoid” and ”homoerotic”, persisted throughout the entire discussion. The most important political topic that the patient produced, which was also 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. In summary, 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.

A table was not necessary or an account of the language-affect connection for the dyads with psychosomatic patients because their was no condensed sequences and almost no affective mimic(facial expression). In the example used here, we only found signs of disgust or sadness. The verbal context of the disgust reactions made a statement about the patient and her ignorance, which was exemplified it the following: ”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.

Table 1: Transcribed excerpt and mimic(facial) expression of affective of a dyad with a neurotic patient

	Patient	Partner
	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 <u>not</u> fighter for anything, + you know.	
		yes +
pause/event(?) exhaustion anger/disgust	that goes for everything, <u>um</u> everything is only <u>half serious</u> for me, it mustn’t get strenuous for me, + you know	
		that’s + right, + I think so too
anger/disgust ” ”	you know and + then I just quit, everybody can have their own opinion, <u>but I don’t have to tolerate it! With me</u>, you know, if someone <u>yells and screams</u> then + it’s, all over,. for me anyway,	
		hm +
		I always say that too, + if someone yells, then they’ve run out of arguments
	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 genuine joy	....	
		See + I don't see any
charming behavior		problem - it just depends
P1 clears his throat		okay then can I might hammer in the first stake. um
		as ah hm first of all I'll
genuine joy		hammer in the stake
	Hm In with it.	environment
both are laughing		

The female patient, who, on the whole, spoke very little, continuously accentuated that she can neither do anything nor knows anything. Her affective expressions reflected uneasiness and disgust, so that a concordance between expression and language is obvious. I will refer to additional related issues in the discussion. In the dyads involving schizophrenic patients, the affect expression is, from a quantitative perspective, very similarly. However there are 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 refer to the work done 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 affectivity of therapists and patients in the first hour of treatment in order to predict the success after the end of the treatment. One measurement, that we have referred to as the dyadic ”lead-effect”, correlated with r=.69 highly significant with the estimation of success which was obtained through patient and therapist as well as external systems of measurement after 15 hours of brief-therapy.

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

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

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

3) One of the protagonists has a ”lead-effect” with negative valence, the other with positive valence, whereby, positive can include genuine joy as well as surprise. It is unimportant, for our purposes, which ”lead-effect”, which protagonist expresses. We call this form of interaction, *complementary*.

This form is the most favorable for the prognosis, while the first, positive reciprocal, is the least favorable The fact that this sort of classification does not represent an artifact, can be seen from the following fact: The prominence of a ”lead-affect” by the therapist in the first hour correlated with 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 tight to the extent they themselves have preferred a single facial affect during this initial hour. In addition the change of facial affectivity of the patient, during the course of therapy from the anhedonic into the hedonic area, correlated with .75 with the success estimated by the patients, which again is an indicator for the validity of the measurement systems. Such data, of this size, over the various forms of therapy, makes it evident that we have obviously found extremely powerful factors of influence.

In order to better understand, not only the operative aspects of failure, but also that of success, we have selected the best and the worst treatment of psychoanalytic orientation and have examined 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 treatments from the area of cognitive behavioral therapy. Client-centered therapy was somewhere in the middle.

The best course of treatment was observed in the treatment of 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 hospitalized for depression, which he had developed on the occasion of a job promotion. His present condition was diagnosed as hysterical neurosis. The least successful course of treatment was the treatment of a 24 year old woman student (case A), who suffered from panic attacks and a personality disorder. A previously implemented behavioral therapy had already led to the worsening of the symptomatic. After completing the video recording, after 15 sessions, the therapy continued and then ended with a 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 a little bit of sadness, fear, anger and contempt. There was an absence of surprise and disgust. Her therapist was even more sparse within the negative spectrum. His facial affect was completely dominated by happiness expressions. We should keep in mind that massive anxiety attacks were being discussed. The complementary dyad H it 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 were all above anhedonic facial expression.

Throughout all other hours and beyond, 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 fear and sadness expressions.

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

If one looks at the temporal development of the dyadic interaction instead of the mean values, one discovers 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, for the entire treatment, we find an almost perfect synchronization of the expression of happiness from both protagonists. In the treatment of Mr. H, the situation was reversed. In the seventh hour of treatment, the therapist took the lead in terms of affectivity, whereas, in the first half of the treatment, we found an exact but slightly pronounced synchronization. Besides that, the variance of the affectivity of 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 sessions, introduced an affective interaction style, in that he listened intently and asked short questions, showing however, very little affect in order to intervene using a lot of facial affects in the second half.

Both protagonists have not only exchanged affects, but they have also spoken about something, preferably about the patients problems, of which we generally consider to be the essential aspect. Therefore, we have fully evaluated the texts and have set them in relation to the affects. In addition to that, we have used a method, from *Luborsky* (1977), which will make possible the extraction of typical relationship patterns from the texts, in that one analyzes the patient's description 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 reaction 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. But with a predominance of interaction themes with the therapist.

While, in the less successful case A, the null hypothesis, of an equal distribution of the number of narratives across 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.

Textually, the patient, in 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”. In this narrations the reactions, from the others, 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 dramatize things”, ”are not honest” and ”laugh at me”.

If one now places the narrations of the sessions in relation to the protagonists' affectivity, 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 from the therapist (contempt .59 and disgust .70). However, these two affective patterns of the therapists, also correlated

significantly positive with the patients narration about the reactions of his interaction partners (”Others degrade and ignore me and my work”) so one could possibly understand the facial emotional reaction of the therapist, as an affective empathic commentary to the described behavior of the action partners, because the narrative structure of both elements frequently occurred together. Since narration centered around the wish to be admired an to shine dropped 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 facial-affective signals of the therapist in the area of contempt and disgust, were actually more seldom in the second half of treatment (177 vs. 119), than in the first. The fact that the displayed genuine joy of the therapist negatively correlated (-63) with the frequency of the verbal account of the aggressive object reactions, also supports the idea of an empathic reaction to the reported cruel reactions of the partner. Seen from this perspective, the therapists’ negative facial affect could not represent the 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. Then, in that case, the therapist had taken over an important function as container (22) for the patient, in that he expressed the rejection, which the patient should have expressed, in view of such forms of interaction and interaction partners, which he himself was unable to do. This would correspond to the fact that we found only one significant correlation between the patients displayed affectivity and his own narrations which means that at least at the beginning of the treatment the narrations are not enacted effectively in the treatment. The therapist would react with affective complementary and subconsciously produce those affects, which the patient does not have available 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 the reality, especially in terms of the people who are really important to him. The object reactions, in the respective relationship episodes, are neither admiration nor recognition, but instead are assorted forms of degradation. From this perspective, the therapists’ ”disgust” mimic 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 behavior, 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 arose in the therapists’ facial expression, 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 bit of 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 interview, the therapist said that overcoming the countertransferential contempt for the patient's ridiculous behavior, presented a major problem, but also a great help for the understanding of the patient internal life.

The results in dyad A are very different. First of all, there is, neither in the affectivity nor in the frequency of the narrative, an indication for distinct phases within the treatment. Secondly, as it was already mentioned, the connections between the narratives and the expression of affect of both protagonists, do not exceed the limits of chance. If one still wants to acknowledge the data, one notices 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 facial affectivity of the therapist is related much more to the direct interaction regulation, mainly in the realm of positive affect. We have to keep in mind that the expressed smiles of both interaction partners was synchronized more and more perfectly over the course of the treatment This however was against the intention of the therapist who had described the smile of the patient as a mask and who had declared the absence of aggression as 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 enactement 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 favor in joining her in this defensive enactment pattern. As a consequence the treatment was remarkable dull not only for the outside observer but also for both interaction partners, which could be objectively ascertained from the absence of the facial reaction of surprise of 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 discriminated 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.

4. Discussion

The first part of our research brought us closer to the assumption, that the tendency for transference is an ubiquitous and measurable phenomenon, and probably part of the disorder. In the meantime, we know that the best predictor of relapse, for many illnesses, are specific emotional interaction styles, such as , i.e. high expressed emotion 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 enactment to turn out differently.

Ultimately, we believe we have clarified that the patients do not "transfer" on to other people, but instead that they choreograph the scenes or pieces. This scene contains at least three determining elements, namely, the author of the scene, an action partner and a sequence of interactions between both. This

sequence of interactions depicts itself most obviously in the exchange of affective signals, and then with the meaning structures which are connected to them (24). Emotions are the predominant exchange currency of interaction a fact which was greatly elaborated by *Stern* (25) for the psychological part as well as *Hochschild* for the sociological one (26, 27). The existence of these scenes and the nature of their realization, is mostly unconscious for the authors; one can subsequently call it Sandler and Sandler (28) ”present (momentary) unconsciousness”.

The actual enacted forms , are no exact replicas of 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 defense mechanisms, as they were described by *Suppes* and *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 externalization of inner structures, in which the action partner does not represent a person, but instead depicts 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, as real people, have naturally never existed. The externalization has the largest advantage, that one can actually seduce the real person, something that is not possible using the norm-led, 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 a affective dialogue structure which is disassociated from the act of narration. The happiness expression of the patient is redundancy without any relation to the narrative acts. It looks rather as a cry for help which manifests itself in the form of the solicitous behavior of an infant who fears that when it does not continuously smile, it will be abandoned. Borderline patients we investigated created degrading scripts. Only 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 depicts the internal splitting of the person in situ. The same goes for the anxiety patient who’s most important wish is for autonomy, but the opposite occurs on the behavioral level.

The difference between the structurally disturbed patients and healthy subjects can be described in the following way. With the healthy subject the negative shown facial affect is related to the cognitive content the two interaction-partners talk about. Whereas, the happiness expression is related to the relationship regulation. Within the structural disturbances the affect of the

face is related directly to the self or the partner. The algorithm how to connect facial affect is based on the context of eye-contact, as well as language production in the dyad. The are very different between structural disturbances and neuroses. Within 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 of the partners.

We wanted to tentatively answer the question as to what makes the successful therapeutic situation so essentially different from the everyday situation. We have done so in the following: 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, how one can fail within the sphere of this unconscious emotional answer.

1. On the lowest end, we find people, who are absolutely unable to perceive the affective unconscious relationship offer. This is not due to defenses, but instead a more or less habitual affective blindness. This is more frequently the case than one would think. We train an increasing amount of people, in the evaluation of affects, and often find people who are unable to produce valid judgments regarding the affects of others because they themselves function unreliably on the perceptive level. This essential part of empathy seems genetically based (30). This corresponds with the position of a lay person, who is void of empathy, or that of many people described as sociopaths. We had one such case in our study. This should rarely be found amongst the well trained therapists.

2. 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 behavioral level as well as internally. He or she found his behavior therapeutically appropriate. In general, this is more the guru type who completely and openly follows unconscious relationship offers and declares his or her actions as curative (31). This type differentiates itself from the first type in that he or she at least recognizes the relationship offer.

3. 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 behavioral level but finds this to be inappropriate, however, he or she is unable to defend himself against it. This is the most frequent form of failure under 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 affectively. 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 of her awareness without being noticed and without being reported during the supervision. Sometimes, this behavior is accompanied by the knowledge of eminent failure; but then, the therapists enlist diagnostic considerations, which subsequently justify this behavior. The affective signals, especially the face, less importantly the voice, generally evade the internal monitoring through those who produce them. I also see here the essential advantage of the couch setting, in that it allows for the immobilization 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.

4. 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 behavioral level, and on the other hand, on the verbal intervention, whereby the first has priority. It seems as if the therapist displays those affects which are missing in the episodes described by the patient, and which are also lost through his or her narrative. In this way, the discover and understanding of their meaning structure would be bound to the therapist's ability to recapture and revive the missing feelings first.

In fact in the successful treatments, one can actually find a clear separation 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, at which the situation must be completely newly organized for the patient. He has to include the enacted externalized feelings into his own internal sphere and in his narrations about himself. Then a wish can completely vanish or the enactment is changed in a way that more effective and beneficial subject-and object reactions can be expected.

In the unsuccessful treatment, one does not find any faces, which is probably because that the narrations do not provoke affects in the therapist and therefore they can not 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 defense structure of the patient.

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