CHAPTER 10
BEYOND INTERPRETATION: THE
ELABORATION OF TRANSFERENCE
IN PERSONAL CONSTRUCT THERAPY

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A patient runs into me on the elevator and when she comes into my office she taunts me with my "nervousness" on the elevator. At other times she wants to hold my hand. Another patient lies on my couch, in a terror, feeling that I'm going to crush his head with a hammer. A year later, he wants to crush my head in. A third patient feels that my life is wonderful: I do just what I want, and seldom, if ever, worry about anything. Whatever I say to her is for her own good, whether she experiences any benefit from it or not. These feelings persist over years; no matter what unpleasant feelings she suffers from, she knows that I am there for her, accepting as always.

These feelings and wishes in my patients are among the many that I become aware of as I do psychotherapy. They are typical of those that arise as I see a patient over a period of time. Gradually I become aware of feelings such as these and help the patient to express them. They are among the varied manifestations of transference exhibited in my office. A central issue for therapists concerns how they deal with such transference manifestations. Do they ignore them? Do they view them as intrusions into the real work of therapy that should be made to go away, if possible, or reduced in impact? Are they regarded as opportunities for the therapist to interpret how these feelings and wishes are manifestations of the patient's basic conflicts, perhaps having arisen from experiences with parents and others early in childhood? Or are these expressions of transference viewed as an opportunity for the patient to experiment by thinking about the therapist in various ways, seeing which of the possible construals seems useful and which are best discarded? It is these issues that I want to address in this chapter. I will describe how transference is viewed by me as i
engage in that complex and fascinating form of personal relationship known as psychotherapy.

CONCEPTUALIZATIONS OF TRANSFERENCE

Transference has been one of the central constructs used by psychotherapists since the early days of modern psychotherapy, at the end of the last century. It is generally considered to be one of Freud's seminal ideas. Freud claimed that his ignorance of the transference implications of his interventions with patients interfered with his ability to cure them. Communications from the therapist, he realized, have multiple meanings, including meanings about the nature of the relationship of the patient and therapist. Since that time the transference concept has remained controversial. It has been hailed as a great discovery and denounced as an excuse used by therapists to shift blame and responsibility for therapeutic difficulties onto the patient.

In developing a personal construct psychology (PCP), Kelly was impressed by the transference construct and made it a cornerstone of his approach to psychotherapy. The essential nature of people's psychological functioning for Kelly, was the development of organized constructs for understanding and anticipating the world with which one is faced. Transference, for Kelly, was an aspect of all construal. Constructs developed for understanding past situations and relationships are transferred onto present ones. This process occurs in the therapy situation, as in all relationships. As the therapist becomes the focus of the patient's problematic construal processes, the therapist is endowed with the ability to use influence to modify these processes in less problematic directions. The modification takes the form of not correcting mistaken construals, but of facilitating the patient's elaboration of and experimentation with his individual construal processes. I believe that PCP was ahead of its time in calling attention to the interactive nature of psychotherapy and to the constructive nature of transference.

Some of the thoughts put forward here are consistent with ideas put forward by those from other theoretical perspectives, most notably, contemporary schools of psychoanalysis (Soldz, 1988), but I believe that certain baggage from the analytic tradition has hampered the understanding of transference and its use in treatment. Some analytic schools, such as the modern psychoanalytic school, in which I was trained and by which I was greatly influenced (Spottitz, 1976, 1985; Spottitz & Meadow, 1976), have many constructivist elements in practice, while clinging to outmoded metapsychological drive theories and simplistic notions about the influence of childhood on development. Other psychoanalytic perspectives are more constructivist in theory, while in practice maintaining an overemphasis on therapeutic interpretation, or the giving of meaning to the patient by the therapist. Thinking about transference using personal construct concepts, I believe we can integrate the best of the ideas from other perspectives while remaining free of some of the baggage that hinders further theoretical and practical development. I believe, furthermore, that PCP is by nature more open to some of the technical implications of a constructivist view of transference than are many psychoanalytic theoreticians and practitioners.

Transference, traditionally, has referred to characteristic ways of construing and relating to others that are relatively stable over time, that are characteristic of the individual, that contribute to a person's personal difficulties, and that become manifest in the relationship with the therapist. Recent research by Luborsky and Cris-Cristoph (1980; cf. Soldz, 1989, in press) has supported this notion. These researchers have developed a method for measuring what they call Core Conflictual Relationship Themes (CCRT) in patients' narratives about their relationships to others. Each CCRT consists of a wish, a response from the other, and a response of the self to the response of the other. They demonstrated in a number of studies that patients tend to have a characteristic CCRT that is consistent whether they are describing relationships with others or with the therapist. These relationship patterns remain relatively stable throughout a therapy, but become less salient over the course of therapy. That is, change occurs, not in the predominant pattern so much as in the ability to sometimes view relationships through other lenses.

From a personal construct perspective, the relative stability of a patient's CCRT can be seen as indicating limits to the degree of change that usually occurs in core constructs. As the CCRT represents a central aspect of how one construes one's interactions with others, abandoning it would require abandoning the most central pillars of how one makes sense of relationships. What the research suggests is that people are unlikely to go this far in modifying their construct systems. They are more likely to elaborate this core pattern so that it is more familiar to them, while developing alternative relationship patterns that can be used in many situations. But the pattern described by the CCRT is unlikely to totally disappear. It is likely to return when
alternatives cease to function well in predicting relationships. If the
new fails, return to the old seems to be a common tactic of people
under stress.

The CCRT finding that conflictual patterns in relationships with
the therapist parallel those with other people in the patient’s life lends
support to the therapeutic idea that in dealing with the relationship
between patient and therapist one is also likely to modify those
construal patterns that are most problematic in dealing with others. In
this light, the therapeutic relationship is viewed by both psychoana-
lysts and Kelly as a paradigm of relationships in general. The therapy
situation thus can be viewed as a laboratory for modifying trouble-
some construals.

One of the other central themes in the psychoanalytic literature on
transference has been that transference arises from the earliest rela-
tionships with the parents and other significant childhood figures.
This assumption has always seemed reasonable because the influences
early in life, when one has the least pre-existing psychic structure, are
likely to be the most powerful. This idea has remained virtually
untestable and of debatable status as the constructive nature of mem-
ory has become clearer. That there are frequently analogies between
how a person construed a parent early in life and how he construes
people in the present appears clear whenever one listens to patients
talk of their childhoods in the midst of having intense feelings toward
the therapist. Luborsky and Criss-Cristoph (1990) found that the
CCRT’s of patients when describing their reactions to their therapists
were similar to the conflictual relationship themes expressed toward
their parents. However, it needs to be remembered that the childhood
account is always a story of how childhood appears to the adult patient
in the present. Kelly may have been among the first to point out that
childhood can be recreated in the light of present concerns. In fact,
for some patients, such recreation may be an important part of the
therapy. Yet, it remains very questionable to assume that the way
childhood is remembered bears any one-to-one relationship with the
way it was experienced at the time. (A similar point can be made for
adult experiences that seem like actual returns to childhood experi-
ences, not just memories.) In the absence of any prospective research,
it seems best to consider childhood analogies for adult ways of constru-
ing as (possibly) useful metaphors rather than a representation of
childhood “reality.”

In the psychoanalytic literature, it frequently has been implied that
there is something wrong with transferring early childhood con-
structs onto present relationships, but the reason for this is seldom clear. The

apparent reason this type of transferring is not a good practice is that
it is “unrealistic” to construe adult others as one construed one’s par-
ents, but the force of this concern is only clear to those who view being
“realistic” as an asset. As psychoanalysis has tended to move toward a
more constructive view of reality, it has been plagued by difficulty
explaining why certain forms of construal are worse than others.
Gradually, ideas regarding the relative degree of differentiation and
integration of psychic structures have been developed that bear strik-
ing similarity to some of the themes elaborated by Kelly (1955) as he
developed PCP.

Kelly assigned transference a central place in the clinical theory that
he derived from PCP, but he construed it somewhat more broadly
than do most psychoanalysts. The essence of transference, for Kelly,
was that it involved the transferring of constructs developed for pre-
vious relationships onto the relationship with which one is presently
dealing. While these constructs may have been developed in dealing
with one’s parents, they may also have been generated in relation to
other people in one’s life or at later periods of life than those usually
considered crucial in psychoanalytic thinking. While many of one’s
core constructs are probably developed in childhood, this is not a
necessary feature of Kelly’s approach. The origins of transference are
of little importance. It is, rather, the role that they play in one’s con-
temporaneous life and in the life problems that plague one in the
present that are of significance. To some degree, this position is consis-
tent with that of recent analytic authors who have emphasized the
importance of examining the patient’s “here and now” experience of
the transference (Gill & Hoffman, 1982).

Because Kelly was not a realist and did not believe that reality can be
“accurately” represented by one’s construct system, he is not con-
cerned with the correctness of a patient’s constructs, but with whether
they are useful in making sense of and anticipating the world, most
notably the world of relationships. Constructs become problematic
when they are not specified to a degree that they can be tested, or
when they are not modified after a test has shown that they are not
very useful. In the latter case, the person often tries to force the
evidence to conform to the prediction, rather than considering modi-
fying the construct or its usage; Kelly referred to this extortion of
evidence as hostility (Kelly, 1966, 1969b; Soldz, 1983).

As indicated, Kelly (1955), like many other psychological theorists,
felt that the role of interpersonal relationships was especially impor-
tant for most patients. True to his emphasis on the primacy of
construal processes, Kelly believed that it was the ability to construe
the other's way of construing the world, or point of view, that was especially important. For Kelly, the essence of what he called role relationships was the construal of others as construers: "To the extent that one person construes the construction processes of another, he may play a role in a social process involving the other person" (Kelly, 1955, p. 95). This position regarding the importance of interpersonal relationships is compatible with that of many other schools of therapy, as well as with many of our patients. Horowitz (1979), for example, studied the presenting complaints of patients in outpatient therapy and found that they are primarily interpersonal in nature. Yet, the emphasis of PCP on construal of others' point of view as the most central aspect of interpersonal relationships distinguishes PCP from other theories which are more concerned with the capacity of others to fulfill one's needs than with forming a relationship with them based on understanding.

In thinking about transference, it is important to realize that the concept of transference is itself a construction. Therapists may choose to construe certain patient activities in terms of the transference construct. This choice is not dictated directly by what the patient says or does, and is to be judged largely by its utility. Peterfreund (1985), writing about different models of psychoanalytic therapy, described therapy as a process of applying heuristic strategies in determining what patients and therapists should do. In this light, the concept of transference is a model that can be applied to patient material. The value of thinking and intervening based on one's understanding of transference is determined by its utility to a particular therapist and therapy. It is best not to think of a phenomenon as a manifestation of transference, but as an occurrence that usefully can be thought of in terms of the concept of transference. The former way of thinking puts the responsibility on the patient, whereas the latter, consistent with Kelly's (1969a) approach, puts the responsibility on the therapist who chooses to think in these terms.

THE ROLE OF TRANSFERENCE IN THERAPY

While there is no one-to-one relationship between a clinical theory and how one thinks about treatment, different conceptualizations of the nature of transference are likely to imply different therapeutic approaches. Classical psychoanalytic theory, especially in its early variants, tended to view transference as an unrealistic distortion that was relieved by the patient becoming more realistic. Ultimately, treatment took the form of the therapist confronting the patient with his unrealistic transferences and attempting to modify them through relating them back to their origins in childhood. One concomitant of this approach is the belief that self-understanding or insight is the curative factor and that this insight is derived largely through absorbing the therapist's interpretations regarding the patient's psychic reality. Gradually, many psychoanalytically-oriented therapists have abandoned or diluted the exclusive emphasis on self-understanding as the vehicle of change, but belief in the centrality of interpretations among therapeutic interventions has continued with only occasional dissent. Much of what has gone for criticism of the centrality of interpretation is, in fact, an assertion that the range of allowable interpretations should be enlarged. Kohut (1977, 1984), for instance, argued that interpretations should focus less on the patient's "unconscious drives" and more on the patient's experience of the reaction to occasions where the patient experienced the therapist as unempathic. While certain more orthodox analysts viewed these ideas as an attack of the centrality of interpretation, I would argue that such interventions still retain the core feature of interpretation, namely the therapist explaining the nature of the patient's psychic experience to the patient. That such interpretations are more "experience near" than other types of interpretations does not make them interpretations any the less.

From Kelly's constructivist perspective, the essence of therapy consists of the therapist helping the patient to define, elaborate and test his constructs so as to be better able to deal with the world. Of course, the world of greatest concern to most therapists is the intrapsychic and interpersonal one of self and other construal. The patient will construe the therapist using the constructs that are available for construing people.

To the extent that all construing is deductive, we find that a person, in making a prediction on the future, must lift a construct from his repertory and use it to determine the nature of his bet. This is essentially a transferring process. The construct may not fit and he may lose his bet, but the point is that the construct has drawn an available construct from his store and used it as a basis of action (Kelly, 1955, p. 603).

If the therapy goes well, the patient will feel safe enough to bring his most problematic construal processes to bear on the therapist, the better to experiment with and ultimately modify them.

In the process of experimentation, the patient receives both validat-
could understand why she has such difficulty with a certain patient; it was because this patient was (as she always) different from the therapist on every construct that was important to the therapist. She had remained unaware of this issue despite several years of discussing this patient with her supervisor. It is likely that the therapist's awareness that she construed this patient as being unlike her may have opened up new avenues for her elaboration of her patient.

Kelly described his theory in terms of a fundamental postulate and a set of corollaries. His choice corollary is especially relevant to the argument of this chapter. It states that "a person chooses for himself that alternative in a dichotomized construct through which he anticipates the greater possibility for extension and definition of his construct system" (p. 561). One implication of this corollary is that it does not have the potentials for extension and definition of the various alternatives posed by his construct system. As the person moves, the more options available for change. In therapy, the elaboration of these options will allow a person greater flexibility in his construing processes, thus reducing the power of the repetitive patterns of interpersonal construal that form the core of transference.

INTERPRETATION AND ITS LIMITS

I believe that the common ways of dealing with transference material through interpretation are frequently counterproductive in that they short circuit the patient's elaboration processes, rather than fostering them. By imposing the therapist's meaning on the patient's experience, interpretations often lead the patient to accept one version of her experience as the truth, rather than promulgating an awareness of the multiplicity of construals possible.

Another difficulty with the overuse of interpretation is that it promotes the view that self-understanding and "insight" are the prime routes to personal change. This emphasis on the curative role of self-understanding has been one of the cornerstones of psychoanalytic therapy until very recently. One of the mysteries repeatedly explored in the analytic literature is how it is that many patients gain "insight" without changing in other ways. While other therapeutic schools have also implicitly or explicitly adopted this idea of the central importance of self-understanding, from a personal construct perspective, it is very limited. If change consists in a person becoming more flexible in her construing processes, then self-understanding is not necessarily a helpful or an important factor in bringing about change. In some cases,
patients can use self-understanding to free them from repetitive patterns that bind them. In other instances, insight follows significant change, as if the change of perspective involved in construing differently allows one to construe one's self differently. Self-understanding is then a result rather than a cause of change. In still other cases, significant change may occur without the patient understanding much more about her construal processes. Kelly pointed out, for example, that patients may sometimes resolve problems derived from childhood experiences through construing to childhood experiences the use of constructs derived from interactions with the parents in childhood, while developing alternative constructs for construing adult relationships. In other words, the patient decides that a given way of construing the world made sense when she was a child; however, there are other ways to understand her experiences as an adult. In order for this process to occur, the patient does not necessarily have to understand much about what kinds of constructs were developed in childhood, or what was experienced then.

Interpretation and the concomitant emphasis on self-understanding are especially dangerous when applied to transference because the patient is extraordinarily vulnerable when revealing how she feels and thinks about the therapist. Interpretation is frequently perceived as a criticism, as an indication that the patient has a distorted view of the therapist, and that the therapist wants this distortion corrected. "No, I am not withholding, but it is you who have unreasonable and unrealistic wishes of me," the therapist can be perceived as saying, regardless of the therapist's intentions.

The dangers of interpretation were vividly brought home to me when a patient whom I had seen for six years left therapy precipitously after I offered an interpretation of how her hostile way of approaching people served to push away those who might offer the support she claimed to desire. Previously, I had been wary of offering her any interpretations, because I was aware that she frequently experienced them as attacks and reacted by becoming very hostile and wanting to terminate treatment. The relationship between us had improved considerably since the earlier stages described in Solórz (1987). I mistakenly believed that she was ready to acknowledge that she played a role in bringing about the repeated rejections to which she was subject. Her reaction made it clear that I was wrong.

These negative results of interpretation are not always the case, however. Depending on the therapist, the patient, and the state of their relationship, the patient may take an interpretation as an invitation for exploration rather than a pronouncement of truth. Interpretations may also be perceived as indications that the therapist does, indeed, understand the patient as the patient desires to be understood. In other cases, interpretive comments help put words to some non-verbal construal that the patient is trying to express, a process that Kelly calls word binding. Yet, even in these cases, interpretations are often not the most efficacious way of facilitating elaboration and experimentation. They may tend to prematurely specify what terms should be used in exploring the patient's construal processes. I am by no means arguing that therapists should never use interpretative comments. Therapy is too complicated a phenomenon to lend itself to unequivocal do's and don'ts. What I am arguing is that interpretation is vastly overrated in importance as an intervention, and that therapists would do well to widen their repertoire of types of interventions. When I read case reports written by therapists from widely different theoretical orientations, I am often struck by the ubiquity of interpretation, even from therapists whose theories emphasize the constructive nature of construing and the relativity of interpretation. It is as if therapists don't know what else to do, so they continue focusing on interpreting the meaning of the patient's experience.

ALTERNATIVES TO INTERPRETATION

The issue of alternatives to interpretation is especially salient when dealing with transference material. Therapists often feel threatened by some of the ways their patients view them. Interpreting these views as distortions arising from the patient's pathology is a convenient way to short-circuit these construals, resolving the therapist's discomfort. An alternative is to consider these construals as possibilities in need of elaboration and definition.

One central issue regarding the elaboration of transference (or other problematic construals) is the question of testing the construals. PCP emphasizes the experimental nature of construals, that they should be used to anticipate events and then modified, depending on how useful they were in the anticipatory process. While this perspective is a crucial one, I believe that it can lead therapists to encourage patients to prematurely test their construals, to examine how useful they are before they are sufficiently elaborated and defined to stand up to inspection. Patients usually are limited in the construals they have available to them. Premature testing can lead to invalidation of the construals that are available, contributing to the development of anxiety, threat or hostility. As I have argued elsewhere (Solórz,
1983, 1986, 1987), more severely disturbed patients tend to have undifferentiated construct systems. Premature invalidation can lead to a drastic loss of the ability to make sense of the world, that is, to anxiety, in Kelly's sense. Premature invalidation may also lead to threat, defined by Kelly (1955) as "the awareness of an imminent comprehensive change in one's core structures" (p. 565). Leitner (1988) has discussed aspects of these processes, using the term terror. One way of avoiding this calamity is to try and make the world conform to the constructions, a process that Kelly (1955, 1969b) termed hostility: "the continued effort to extort validation evidence in favor of a type of social prediction which has already been recognized as a failure" (1955, p. 565).

In helping patients elaborate their transference construals, therapists help patients develop differentiated construct systems so that they can become more flexible. Through elaboration, more alternatives become available to the patient. These alternatives can gradually be used in dealing with other people, including the patient herself and significant other people in the patient's life.

Working with the transference has several advantages over working with other types of material. The relationship with the therapist has an actuality to it that other material does not. After all, both the therapist and patient are present in the room. The patient can try on alternative construals of the analyst in order to assess the fit. The patient's construal processes are much more available for examination when the moment-to-moment construals of the therapist and the therapeutic situation are the focus. Furthermore, the patient can experiment with various construals of the therapist without risking as much as would be risked if construals of important others, or even of the self, are modified. That is, the therapy relationship can be considered a (relatively) safe laboratory for experiments in construal.

TECHNIQUES FOR WORKING WITH TRANSFERENCE

Several types of interventions are especially useful in facilitating transference elaboration. One of these is the object-oriented question (Spotnitz, 1976, 1985; Spotnitz & Meadow, 1976; Soldz, 1986, 1987, 1988). Object-oriented questions are about matters external to the patient's thoughts and feelings. They can be about mundane matters or other people (Soldz, 1986). But the object-oriented questions which
If one of the fundamental aspects of the therapy relationship is that the patient experiments with a variety of construal processes in relation to the therapist, it is helpful if the therapist can manifest a variety of roles, as opposed to maintaining a single role. Kelly frequently adopted role-playing techniques in order to help the patient experience a variety of different types of interpersonal situations. His widely discussed (though seldom adopted by others) fixed role therapy (Kelly, 1955) is a rather extreme aspect of both the experimental conception of therapy and of the use of role-playing. In fixed role therapy, the patient is presented with a written description of a character and asked to play this role for a short period of time, usually two weeks. During these two weeks the therapist relates to the patient only in role and adopts the roles of the various persons in the patient's life: boss, friend, lover. The purpose is not to suggest that the fixed role is a better one for the patient, but to encourage the patient to adopt a more experimental approach to life, rather than being stuck with one set of constructions. Furthermore, by encouraging the patient to construe others from a radically different vantage point, this technique facilitates the development of role relationships.

While I seldom use explicit role-playing techniques, I am not adverse to assuming various roles during the course of therapy. One day I may be very quiet, calmly allowing the patient to go wherever her thoughts lead. At other times, I may be very confrontative, challenging the patient's constructions. Sometimes I am understanding, other times obverse. I often join in the patient's constructions, by agreeing and supporting them. If a patient is feeling very suspicious, I may join by asserting that suspicion is a good thing, that you never know what someone is up to and that it's a good idea to keep an eye on others. I may mirror the patient by assuming a similar attitude to what she is manifesting. A patient who says she feels like giving up off the couch and killing me may be told that I'll get her first if she takes one step toward me.

This position is in stark contrast to that of many therapists who seem to want to adopt only one role, that of the understanding, wise, warm caretaker. I am not adverse to this role, it fits in well with my personality. I love to be helpful to people. But, following Kelly's position (and that of the modern psychoanalytic school in which I was trained) that the purpose of therapy is not to help the therapist feel good, but to facilitate the development of a multifaceted personality in the patient, I draw on the multiple facets of my own personality in adopting a wide variety of roles over the course of therapy.

Patients, like all of us, have to deal with many different types of people. Some people are warm and understanding, others cold and selfish. They will function better if they are able to enter into role relationships with people who have a wide range of personality types. It can be constricting if the therapist maintains one posture throughout the therapy. If the therapist is always trying to be warm and understanding, the patient may be deprived of needed experiences in forming relationships with people who are less warm and sensitive. In other cases, despite the therapist's intentions and best efforts, the patient may still construe the therapist as cold and insensitive. Many therapists have difficulty when this type of construal occurs, especially if it persists for an extended period of time. Such thoughts on the part of the patient can be a threat to the therapist's self image. When therapists feel threatened, they often engage in various maneuvers in order to encourage the patient to see the therapist as the therapist views himself. That is, the therapist is engaging in hostility, in Kelly's terms. The types of interventions criticized above are not uncommonly used for such hostile purposes. In unfortunate cases, the therapist succeeds in getting the patient to adopt the "correct" construals of the therapist at the cost of the patient feeling that there is something wrong with her because she is a defective person who cannot even correctly accept that such a wonderful person as the therapist could be so kind and helpful.

In other situations, patients persist in negative construals of their therapists despite therapist attempts to change their minds. In these cases the patient is likely to start receiving negative labels from the therapist; borderline and passive-aggressive are among the current favorites. One indication that such a process is occurring is that the therapist finds himself changing the patient's diagnostic assessment in a negative direction. The therapist may also despair of helping the patient or experience a desire to get rid of her. Hospitalizations and transfers to other clinicians are not uncommon at this point.

The therapist, by accepting the patient's negative construals, can help the patient to feel comfortable with negative ways of construing that are often disowned and that can be sources of great shame. For many patients, the effort to avoid negative construal, which they feel is bad, leads to constriction that causes them to remain isolated and avoid active growth and construct elaboration. As the therapist accepts these construals, the patient becomes more familiar and comfortable with them. Gradually, the patient feels more in control of her construals and aware that she has choices as to how to construe and interact with others.

Another type of transference that therapists often find problematic
is the idealizing transference. When these types of construals are occurring, the therapist is considered to be near perfection. He leads a wonderful life and may be all knowing, and all powerful. Therapists often find it extremely uncomfortable to be construed in this manner. They feel like frauds and phonies and are afraid that their patients will figure out that the therapist is little better off than they are. It is quite common for therapists to quickly disabuse their patients of these “illusions” by a healthy dose of “reality.” It was one of the major contributions of the psychoanalyst Kohut (1971, 1977) to point out that idealizing transferences can be very beneficial to patients and that therapists are often acting destructively when they discourage these transferences too early in the therapy. From my perspective, these transferences are another opportunity for the therapist to encourage patient elaboration, simply by allowing the patient to maintain her construal, until ready to try another one, and by asking questions: “Why am I so wonderful?” “What makes me so happy?” “Am I happy all the time, or just sometimes?” “Should I take out my magic wand and instantly cure you?” If the therapist senses that the idealization is a way of avoiding negative transference, the patient can be asked “If I’m so powerful and wonderful, how come I haven’t cured you?” The therapist may then discover that he isn’t so powerful after all.

**SYMBOLIC COMMUNICATION**

The interventions that have been proposed so far have, for the most part, been questions that lead to the patient elaborating explicit transference constructions. It is important to remember that important transference communications are often made symbolically, rather than directly. A patient who says that she finally feels at home in her new house may be expressing a feeling of comfort with the therapist, while another who complains about an unfeeling spouse may be communicating a dissatisfaction with the therapist. Traditional therapeutic approaches to these types of communications often consist of interpreting the connection to the therapist. If the impulse to enlighten the patient with these brilliant interpretations can be resisted while the patient’s mode of communication is accepted, the patient will often arrive at such connections by herself.

For example, a patient complained for several sessions about an overpowering friend with whom she wished she could break off relations, but felt too weak to do so. I had learned from long previous experience that any attempt on my part to try to bring her attention to possible transference meanings of this topic would be fruitless. She was an expert at resisting any direct expression of dissatisfaction with me. I therefore explored her complaints in detail. Eventually, she found a statement of mine she didn’t like. She took advantage of my “mistake” to become furious with me and draw out the parallels between the ways she was treated by her friend and myself. The experience of being able to express these negative feelings toward me without having to destroy our relationship led to a deepening of her sense of closeness to me.

If I wish to direct a patient’s attention to a possible transference meaning of a topic being discussed, I rarely do so by means of a traditional interpretation. I either ask a question as to whether there might be such a connection, or I make a simple declarative statement. An example of the latter might be when a patient of mine is complaining that no one ever helps her, I might simply state, in an emphatic tone “I certainly don’t!” By making such a declarative statement I am likely to avoid the intellectualization and possible implied criticism that might follow a more traditional intervention such as “I wonder if you might be feeling that way toward me?”

**JOINING AND MIRRORING**

In the foregoing I have provided a number of illustrative questions that can be used to help elaborate patient construals of their therapists. I have argued that the therapist should be willing to assume various roles during the course of therapy. One set of therapist roles that can facilitate transference elaboration consists of the use of joining and mirroring interventions (Spotnitz, 1985; Marshall, 1982). The essence of these interventions is that they accept the patient’s construal processes in such a way that the patient is encouraged to either elaborate current constructions or try out new ones. The difference between these interventions is often somewhat confusing: the essence of joining is the therapist agreeing or going along with, sometimes in an exaggerated form, a construal of the therapist; mirroring consists of the therapist acting out a part of the patient’s self. It is important that, in using these interventions, the therapist does not always respond to the patient’s overly expressed thought or wish. A patient may ask for help, while subtly communicating that she doesn’t expect the therapist to help. The therapist may join the patient by asking “Why should I help you?”, which encourages the patient to express the subtle communication more overtly, as she responds, “I knew it
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was useless to ask you." If the therapist wished to mirror this patient, he might respond "Why don't you help me?"

These types of interventions can serve several uses. They can give the patient the feeling that her construals are acceptable to the therapist, thereby undercutting the patient's struggle to avoid these ways of being. As this struggle declines, the patient can begin experimenting with alternatives. Furthermore, as the patient sees that the therapist can be comfortable being like the patient, the patient feels less alone. "There are others who are like me. I'm not the only one," the patient tends to feel. If these construal processes are disowned by the patient, the patient can experience and explore them at a distance from the patient's self. If the therapist can exhibit these disowned modes of being without great suffering, then perhaps the patient can as well.

The patient described above, who idealized me for years and avoided expressing any negative feelings about me while complaining of being overpowered by others, was silent for a long time at the beginning of a session. She finally said she felt terrified of me, I was very intimidating. I judged from previous experience that, if I was quietly accepting or gently exploring of this feeling, she would soon feel guilty about it and disown the negative feelings. I therefore felt that it would be more productive if I joined her construal of me and assume the role she assigned me. I asked "How do I intimidate you?" in a way that assumed it was true. She then talked of how it made her feel lonely. I felt that she was in danger of simply feeling sorry for herself, which is something that she does quite often, resulting in little change on her part. I therefore provocatively said, "Here's something that may make you more lonely. I won't be here on (day a month away)." After a pause, she became angry at me for making her more lonely. I continued the joining by asking, "Why shouldn't I do that?" She then indicated angrily that she didn't feel like talking to me. She was thus demonstrating in a live form how she uses sullen withdrawal to deal with feeling intimidated by others, while at the same time overtly expressing the anger at me that she is usually too intimidated to express when she feels overpowered. My joining her construal of me as intimidating by means of a role enactment enabled her to experiment with more actively confronting the intimidating person, rather than passively assuming the victim role.

In the following session, this patient started by discussing how inconsiderate (medical) doctors are, thus expressing her feelings about me in symbolic form. She then revealed that she has been keeping a number of secrets from me and that she derived pleasure in the last session from withholding information from me. My intervention in

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the previous session thus appears to have helped this patient to experience herself as actively taking a part in her feeling "victimized" by others without my ever interpreting this dynamic to her. I, rather, created an emotionally charged interaction which allowed her to come to the realization herself. One can speculate that this change in her construal will gradually lead to her feeling less powerless and more able to influence her interactions with others.

CONCLUSION

What I have tried to communicate in this chapter is that the concept of transference is a useful one to apply when listening to our patients. Furthermore, while transference may relate to the patient's construal of experience with parents early in life, it is the immediacy of the experience with the therapist that is of greatest importance. Through the construal of the therapist, the patient has an opportunity for in vivo experimentation with alternative ways of construing other people in her life. In addition, such experimentation can be facilitated if the therapist combines elaborative questioning with a willingness to enact various roles, including roles with which the patient may have trouble dealing.

My hope is to widen the range of interventions that personal construct therapists have available to them when engaging in therapy. As Kelly pointed out a long time ago, it may be easy for us to be gentle and understanding while delivering interpretations of the patient's experience, but insistence on only this one mode of interacting with patients may be less than optimal in facilitating patient change.

REFERENCES