

REPRINTED FROM GROUP PSYCHOTHERAPY,
PSYCHODRAMA AND SOCIOMETRY, VOL. XXXII,
ZERKA T. MORENO, EDITOR, COPYRIGHT 1979
BEACON HOUSE INC., BEACON, N.Y.,
PUBLISHER

TRANSFERENCE, COUNTERTRANSFERENCE AND TELE

PETER FELIX KELLERMANN

Comments regarding this paper:

"The time has come to evaluate the advances made by psychotherapy and to spell out, if possible, the common denominators of all its forms". Thus Moreno commenced his paper "Transference, Counter-transference and Tele: their relation to group research and group psychotherapy" which was published in the book Psychodrama, Vol. 2. And he asked in the introduction: "How can the various methods be brought into agreement, into a single, comprehensive system?"

The introduction and the paper have led to my interest in comparing different psychological theories. My answer to Moreno's question is that, to begin with, we must have a common language for communication. All schools have their own terminology and that increases the difficulty of discussing problems which are common in all psychotherapy.

This discussion will stress the common denominators but can of course not completely exclude the differences. Moreno's psychodrama is mostly compared with classical psychoanalytic theory. In part because it is most widely spread and partly because it always has been regarded as dissimilar to psychodramatic theory. The effort is to show that certain aspects of the interpersonal theory in both schools are in agreement, although they may have different presuppositions. Of course, analytic psychotherapy is individual therapy, whereas psychodrama usually is group therapy. This does not however make the comparison impossible.

Introduction

The new development within psychotherapy, which emphasizes emotional insight, abreaction and catharsis, would seem to attach less importance to the relationship between therapist and patient. In primal therapy, for example, the relation between therapist and patient is wholly put aside. Many other schools of psychotherapy, however, have a different approach. They view the therapeutic relationship as the true curative force in psychotherapy. "The warm, subjective human meeting between two people", says Carl Rogers (1969), "is more effective in easing change than anything else". It is thus in relation to the therapist that the patient creates that situation in which his problems can be solved. Among psychoanalysts, the school of Object relation has been foremost in em-

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phasizing this attitude. Freud (1920) observed this relation when he decided to no longer use hypnosis or the abreactive catharsis method:

“It is true that the symptoms disappeared after catharsis, but in order that the treatment should be completely successful, the patient’s relation to the doctor showed itself to be especially important. If this relation were disturbed, all the symptoms returned, precisely as if they had never disappeared.”

This paper attempts, from the standpoint of the therapeutic relation, to compare psychoanalysis¹ and psychodrama in seeking common characteristics and to distinguish those differences which are dependent upon clearly defined concepts. When in psychotherapeutic history, attention has been devoted to this therapeutic relation, psychoanalytic concepts have most often been used. One of these concepts, which has been taken out of its original context and applied elsewhere, is that of *transference*, which is used loosely in several different connotations. It is even to be found used as a synonym for “relationship” in general. The concept *countertransference* is used in a general connotation in the same way, both within and outside of psychoanalysis.

It is best to deal with the personal relationship between patient and therapist from the standpoint of Freud’s original transference phenomena, for, even though transference does not cover the whole problem, it is an important part of it. This problem has been thoroughly researched. Here it is presented so that it can be integrated with the therapeutic relationship in psychodrama therapy. In this connection, J. L. Moreno’s concept *Tele* will be defined and discussed.

Transference

What are transferences? That question was posed by Freud as early as 1905, and countless theoreticians have since then attempted to answer it. It is not here the intention to recount all aspects of the meaning and development of the concept. An excellent summation is presented in Sandler et al. (1973).

With each analyst’s special views on treatment, the concept has been obscured rather than clarified. Changes in its significance have occurred as psychoanalysis has developed and its theories have been altered. Not even Freud’s followers have been able to unite around a common definition. Nonetheless, understanding and analysis of transference phenomena

1. With the term psychoanalysis, I refer not to psychoanalysis proper, but rather to psychoanalytically oriented psychotherapy.

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are regarded as being central to psychoanalytic technique. Freud regarded transference as one of the pillars of psychoanalysis, and he wrote that "finally every conflict has to be fought out in the sphere of transference" (1912).

Transference, as a psychoanalytic term, is a rendition of the German word "Übertragung", meaning literally the act of transforming something from one place to another. But it has become an everyday word, which is widely used even outside the circle of psychotherapists. The idea behind transference is to get the patient to discover the connection between *present* symptoms and feelings on the one hand and *earlier* experiences on the other.

Simply, transference can be described as follows: The patient comprehends the therapist in a manner which is unrealistic and colored by the significant persons in the patient's life. Attitudes and feelings which are "advanced" to the present but which correspond to the patient's own past, are brought forth through what the patient says.

A more exact definition is given by Greenson (1965). "Transference is the experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which do not befit that person but are a repetition of reactions originating in regard to significant persons of early childhood, unconsciously displaced onto figures in the present. I emphasize that a reaction in order to be regarded as transference must have two distinctive features: it must be a repetition of the past and it must be inappropriate in the present."

Counter-transference

Transference thus describes processes taking place within the patient. Counter-transference on the other hand, has to do with the therapist's attitudes, feelings and professional posture. Increased attention has been devoted to this aspect of the therapeutic relation in recent years. Nonetheless there still exists a lack of unanimity as to the exact meaning of the term. Most writers emphasize the potential danger of counter-transference and the need for thorough analysis by the therapist, but many advocate positive functions of counter-transference. Much of what has been written about transference could also apply to counter-transference, which demonstrates the inseparability of the terms. If all transference varies in expression, then all counter-transference will also vary from day to day in line with the daily changes in both patient and therapist.

Two aspects of counter-transference can, according to Rycroft (1968), be distinguished:

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On the one hand, counter-transference can constitute the therapist's own transference upon his patient. In this sense, counter-transference is a disturbing, distorting element in treatment. Dewald (1969) writes that counter-transference in this case has its origin in the therapist's *unconscious* tendencies. These cause him to react toward the patient in a way which to a certain extent is inappropriate for the way the therapeutic relation should actually be formed and which constitutes a displacement from earlier relations and experiences in his own life. The therapist's counter-transference is, in this sense, abnormal and represents relations and identifications which have been repressed.

On the other hand, counter-transference can also become an important tool in treatment. In such cases, the therapist's personal experiences and development become the bases for therapy and make his work different in character from that of others. Counter-transference is in this case the therapist's emotional attitude toward his patient, his *conscious* reaction to the patient's behavior. According to Heimann (1950), Little (1951), Gitelson (1952), Racker (1968) and others, the therapist can use this latter kind of counter-transference as a type of clinical evidence. He may assume that his own emotional response is based on a correct interpretation of the patient's true intentions.

Fliess (1935) views counter-transference as an unconscious, disturbing factor in treatment, and he suggests the term "counter identification" in order to describe the conscious, desirable process.

Tele

Transference and counter-transference, as concepts, are not sufficient to describe what takes place between patient and therapist in psychotherapy. Moreno (1959) suggested instead, or as a supplement, the concept *tele*, from the Greek "at a distance".¹ This peculiar choice is no exception from the obscure psychodramatic terminology, which has been largely influenced by classical Greek drama.

The terminology of psychodrama, as well as the terminology of psychoanalysis, has often tended to lead to confusion rather than to understanding. This applies to Moreno's definition of *tele* which is unorganized and sometimes inconsistent.

Moreno defines *tele* as "insight into," "appreciation of," and "feeling for" the "actual makeup" of the other person. Tele should not be con-

1. Tele has no connection with the concept "telos" which means "finish" and/or "purpose/goal".

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fused with the related concept "empathy". Empathy is a necessary component of tele and was considered by Moreno as a "one-way feeling into the private world of another person". It was for him a one-way feeling which distinguishes itself from the mutual two-way feeling in the tele relation. "Einfühlung" (empathy) becomes, as tele, "Zweifühlung" (two-way empathy). Tele is thus a "mutual exchange of empathy and appreciation", according to Moreno. He also subjectively described tele as "therapeutic love".

In order to restrict the meaning of the concept tele, it will be regarded as a process, not as a condition. Tele is considered as a sort of relationship and the application is restricted to the level of inter-personal relations. Tele may be simply described as the flow of feeling between two or more persons. It embraces not only the attractive, but also the *repulsive* aspects of relations between people. It is in Moreno's words: "the total sum of the emotional aspects of a relationship".

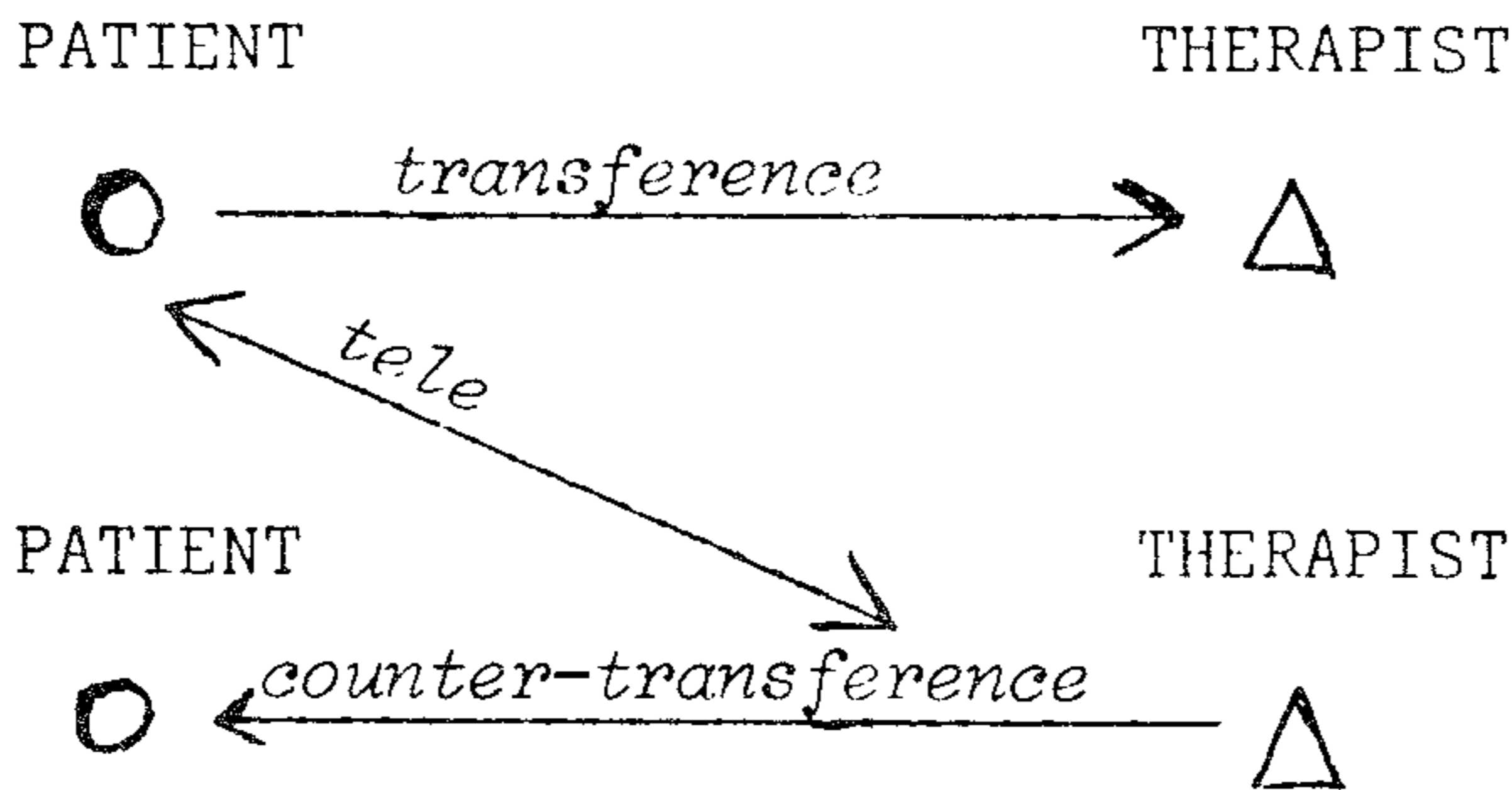
In a tele relationship, people can communicate with each other "at a distance", be in contact "from far" and send messages "on the feeling level". Like a telephone (tele-far, phone-sound) it has two ends and facilitates two-way communication.

This tele relationship *hopefully* carries with it an open, real communication where persons take each other for what and whom they are. The past which so often influences persons in the present has thus no distorting influence on the relationship. Tele, as opposed to transference, is not a repetition from the past but a spontaneous process which is appropriate in the present here and now.

The concept is strongly associated with the existential *encounter* concept. Encounter, which Binswanger (1975) designates with the German "Begegnung", we can describe as a direct "meeting" between two persons. Rollo May (1967), writes that transference should be seen as a distortion of encounter. Encounter is a human meeting in which tele processes are active. Martin Buber, who around 1920 was a contributing editor to a journal which Moreno edited, maintained that the smallest human unit is not one, but two: I-Thou. I cannot be I except in relation to a Thou. This I-Thou relationship is unlike that which Buber (1970) calls an I-It relationship, in which the I treats the other person as an object rather than as a subject. Tele assumes in this connection the significance of an I-Thou relationship, while transference most nearly can be characterized as an I-It relation.

In the figure below is shown, simply and schematically, how the therapeutic relation is formed in transference, counter-transference and tele.

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Moreno's criticism of transference: *Real reaction versus transference reaction*

Moreno observed, that when a patient is attracted by a therapist, another type of behavior arises within the patient as well as transference behavior. At the same time as the patient unconsciously projects and displaces fantasies on the therapist, another process is also active. A part of his ego is not drawn into regression, but rather feels into the therapist, here and now. This part of his ego judges the therapist and appreciates intuitively what type of person the therapist is. These feelings into the therapist's real self are an expression of the tele relationship. Even though it does not seem so strong at the beginning of therapy, one strives to reduce the transference upon the therapist and replace it with this "attraction". The attraction which the patient feels for the therapist is a type of admiration for the therapist as a human being. In reality, it was there all along, but it was eclipsed by the transference (Moreno, 1959).

Even many psychoanalytic writers admit that there exist other interactions than transferences in psychoanalysis. But these are usually seen as irrelevant and trivial according to Greenson and Wexler (1969). However, in recent years, increasing numbers of these writers have become interested in what can broadly be termed the "nontransferring" or "real" aspects of the relationship between patient and therapist.

Analogous to Freud's distinction between real and neurotic anxiety, a distinction between real reaction and transference reaction is desired. The real relation between patient and therapist has different names: Greenson calls it the "working alliance", Zetzel "therapeutic alliance", Fenichel "rational transference", Stone "mature transference" etc. Sandler et al (1973) who traced the concept through the psychoanalytic literature, believes it to be advantageous to put the various terms for the reality oriented elements together under the general heading "working alliance".

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The working alliance constitutes an important part of the tele relation, but it can (as with the empathy concept), only describe a one-way process.

Is it really possible to distinguish between a real reaction and a transference reaction? Is it possible to decide what is real or unreal in a relationship, what is appropriate or inappropriate, what is reality or fantasy, what originates from the present or the past? And is there a real reaction which lacks the characteristics of transference?

I believe that all reality, that is to say, all relations contain elements of transference, just as all transferences contain a measure of reality. Relationships contain most often a mixture of both components. One is more or less dominant. If we were to place both processes on two sides of a continuum it would perhaps be easier to envision the problem:

WORKING ALLIANCE

here and now
reality
appropriate
rational
new response

TRANSFERENCE

then and there
fantasy
inappropriate
non rational
old response

It should be established that our transference ability, even though it exists and is universal, is nonetheless undesirable in personal relationships. Intensive transference is to be regarded as an abnormal expression, and the goal should be to reduce its intensity. Even if, as in psychoanalysis, transference neurosis is used as a therapeutic instrument, this neurosis must finally be dissolved. In order to ease this dissolution, it is important toward the end of therapy, to distinguish, accept and even encourage the real reaction which exists between patient and therapist. Certain psychoanalysts, however, regard such interventions as non interpretive or nonanalytic, but they are according to Greenson and Wexler (1969) not anti-analytic. Harry Guntrip (1971) writes:

“. . . psychotherapy involves that the patient must grow out of unrealistic positive and negative transference relations, in which he is seeing his internal fantasized good and bad objects projected into his therapist, by means of discovering what kind of actual relationship is given to him by his therapist as a real person. This involves much more than experienced psychoanalytic interpretation” (p. 66).

The theoretical dilemma of psychoanalytic technique has to do with the difficulty of managing the working alliance and the transference. The

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analyst has to maintain communication with both poles at the same time. The analyst's double role arises because on the one hand he is the therapist (reality) and on the other hand he is experienced as someone out of the patient's past fantasy. The patient alternates between a condition where transference is dominant, and one where the working alliance is dominant. A breakdown in the working alliance would lead to an interruption in treatment and a suspension in transference to a failure of the psychoanalysis. The question of how this problem is to be dealt with, is the core of psychoanalysis.

Kanzer (1953) pointed out how the analyst always must be aware of the two images which are projected upon him—the one from the past and the one in the present. He should not concentrate on either image so much, but rather on the relationship between them. In the same manner, Sterba (1940) emphasized the necessity for the psychoanalyst to bring to pass in the patient the ability to distinguish those elements which are oriented toward reality and those which are not.

Dewald (1969) writes that there should be an attempt to give rise to a split in the ego function between emotional reaction and intellectual reflection:

“As the emotional experience has been allowed to assume increasingly regressive expression, the patient is encouraged to seek emotional distance from himself and to observe and reflect over what he has just experienced and expressed”.

These nuances in emphasis between an *experiencing* ego on the one hand and an *observing* ego on the other, recur as a central element in most schools of psychotherapy. One is reminded of the division between intellect and emotion, objectivity and subjectivity, secondary and primary processes. All of these dichotomies are well integrated in healthy individuals. The aim in psychotherapy is to unify, to progress from disunity to integration of these dichotomies.

Moreno's criticism of counter-transference: *The attitudes of the therapist*

“If the transference phenomenon exists from the patient toward the physician it exists also from the physician towards the patient”, writes Moreno (1905, p. 5). “It would be then both ways equally true. That educational psychoanalysis produces a basic change in the personality of the therapist cannot be taken seriously. . . . It provides him at best with a method of therapeutic skill. According to this we could just as well call the physician's response transference and the patient's response counter-

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transference. It is obvious that both the therapist and the patient may enter the treatment situation with some initial irrational fantasies.”

In the sense described above, counter-transference is found by Moreno to be a disturbing unconscious factor in the treatment. The similarity between Moreno's formulation and that of psychoanalytic writers such as Balint (1965), A. Reich (1973), Hoffer (1956) and Tower (1956) is worth stressing. Greenson (1965) explains counter-transference thus:

“When the analyst reacts to his patient as though the patient were a significant person in the analyst's early history, counter-transference occurs. Counter-transference is a transference reaction of an analyst to a patient, a parallel to transference, a counterpart of transference” (p. 348).

“A personal analysis”, say Menninger & Holzman (1973) in their classic volume on the Theory of Psychoanalytic Technique, “no matter how long or thorough, is never sufficient to eradicate all of one's blind spots or all of one's tendencies to find surreptitious satisfactions for infantile needs in other than realistic ways” (p. 92). These quotes show that Moreno's critique of counter-transference is also found in psychoanalytic theory itself.

The idea of classical psychoanalysis is that the patient follows the laws of free association, while the analyst follows or attempts to follow the laws of interpretation. The analyst assumes the form of receptive passivity known as “free floating attention”.

The analyst remains neutral and does not manipulate the patient through suggestion, maintained Freud. He compared this behavior to a blank screen which is nontransparent. The behavior and attitude of the analyst should reflect back to the patient nothing but what the patient had manifested. The analyst's “shadowiness” was instituted, among other reasons, in order that he should not “transfer back” feelings which the patient had transferred upon him. This makes it possible for the patient's distorted and unrealistic reactions to be demonstrable as such. Freud recommended observation and interpretation instead of participation and activity.

“The motivation for this requirement of emotional coldness is that it creates the most favorable preconditions for both partners” (Freud, 1958).

Greenacre (1971) has also elucidated the reason for this attitude. She writes that the analyst should analyze, not act as a guide, model or teacher, in order to protect the patient's autonomy. Because of the

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analyst's non-contagious, non-directive attitude, the patient's self-reliance is not compromised, thus his associations are freer.

"Human beings do not thrive well in isolation, being sustained then mostly by memories and hopes, even to the point of hallucination", Greenacre (1971) wrote. If a patient is emotionally isolated in some way or other, and at the same time finds himself in the same room as an analyst, he will most likely develop a transference upon the analyst. Isolation and the analyst's neutrality, are thus indirect methods of bringing about a transference.

"One must conclude that the analyst as a mere screen does not exist in life. He cannot deny his personality nor its operation in the analytic situation as a significant factor. He will appear as he is actually: in manner, speech and general spontaneity" (Gitelson, 1952).

Beside Gitelson, a number of prominent psychoanalysts have criticized the so-called neutral attitude of the analyst. The disciples Adler, Jung, Reich, Fromm etc. assumed a standpoint other than that of Freud on this question, and within the International Association of Psycho-Analysis the question has been hotly debated for many years.

The analyst's passive attitude can be compared to the psychodrama-therapist's active attitude. The difference between them is not only due to their different temperament, but also to different theoretical foundations. The theory of psychodrama holds that even increased stimulus can give rise to memories and hopes through the use of directive techniques. As opposed to the analyst's non-transparent "free floating attention", the psychodrama therapist assumes a transparent, subjective attitude toward the patient.

On the one hand, the application of manipulative techniques have a damaging effect on the patient's independence, autonomy and self-confidence. On the other hand, can techniques which emphasize spontaneity, self-actualization and the finding of one's own solutions be insufficient for patients who by themselves do not have the ability to change?

Empathy, transference and tele in psychodrama

The way in which the theory of psychodrama attempts to solve problems of transference and counter-transference has been studied by Leutz (1971), who compared the role of the psychodramatist to the role of the psychoanalyst. Leutz writes that the processes transference, empathy and tele varies in expression in the three different phases of psychodrama. She writes (p, 114-115):

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“In the *first phase*, the so called warming-up process, the psychodramatist mobilizes his *empathy* to size up the psychic structure of the protagonist in order to understand his problem and to warm him up to action. During this phase the protagonist may transfer images of persons of former importance on the psychodramatist But this transference is of short duration. . . . the psychodramatist does not let the protagonist “act out his feelings” with the therapist, instead he cuts the narration short and moves into the *second phase* of psychodrama, that of enactment. The psychodramatist does not let the protagonist act out his conflict with him in person but encourages the patient to take it up in a psychodrama. He asks him to choose members of the group to spontaneously play his father, mother, wife, friend, etc. While the protagonist chooses these auxiliary egos he already *transfers* his memories, feelings and ideas of these people to the chosen group members. . . . During this process the psychodramatist is hardly even noticed by the protagonist. Certainly he is not the target of the patient’s transferences. He follows the course of the psychodrama with empathy and sovereignty, to which Freud attributed great importance.”

The *third phase* is called “sharing” to describe the group discussion which follows every psychodrama. The transferences on the auxiliary egos are interrupted and discontinued consciously through, for example, de-roling and role-feedback. Protagonist, psychodramatist and group members see and take each other for what and who they are. The *tele process* is in effect.

In summation, the processes in the psychodrama consist of the following phases:

1. Empathy—from therapist to patient
2. Transference—from patient to auxiliary ego
3. Tele—between all the participants in the group

We may now compare empathy, transference and tele, each concept by itself, with their respective meanings in the theory of psychoanalysis and psychodrama.¹

Empathy

The term *empathy* from the Greek “*empathia*” (affection), is constructed as an equivalent to the German word “*Einfühlung*”, lit. “infeeling” and connotes a mental entrance into or appreciation of the feelings

1. For papers on transference, empathy and tele in German, see also Leutz, 1972 and 1974.

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of a person or thing. In psychotherapy, the concept was widely applied by Theodor Lipps (1907) and taken over by Husserl as a name for acts which give address into the consciousness of others.

Gitelson (1962) views empathy as a two-way relationship, whereas Moreno, as mentioned above, sees empathy as a one-way process. It appears that Gitelson's concept of empathy is in some way congruent with Moreno's tele-concept, which is also a two-way relation, in which empathy has decisive significance.

Dewald (1969) explains the therapist's empathy as a state of regression in the service of the ego. By this controlled regression, the therapist attempts to understand the unconscious meaning behind the patient's words. Thus the therapist attempts partially to identify himself with the patient such as he has shown himself during therapy. The therapist tries to experience the patient, as if he himself were the patient. This formulation is very similar to the way we describe the "double" technique in psychodrama: "an auxiliary ego is asked to represent the patient, to establish identity with the patient, to move, act, behave like the patient".

According to one definition by Jane Kessler (1966), empathy was described as the ability to put on the other person's shoes and then step out of them. Here again the potential danger with counter-transference becomes evident. To step out of the shoes means to be able to see the patient "objectively". At the same time we stress the importance of the emotional sensitivity into the patient's inner subjective life. This problem was discussed above with reference to the critique of the old psychoanalytic concept of counter-transference. The psychodramatic solution of this problem—how can the psychotherapist be subjective and objective at the same time:—now claim our attention.

Transference

Psychoanalytic and psychodramatic theory both regard transference phenomena as something undesirable, but nevertheless something which can be used as an important instrument in therapy. Through the dissolution of transference, the patient gains the necessary insight (psychodrama terminology: action-insight) for a cure. The psychoanalyst has to struggle with transference in the "real" patient-therapist situation. He has to safeguard the development of both the transference neurosis and the working alliance. The psychodramatist, by letting the patient play his conflict toward the "unreal" auxiliary ego, is free to engage with the patient in a direct person-to-person relationship.

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While transference in psychodrama occurs in the protagonist when he acts towards an auxiliary ego, in psychoanalysis it arises in the analysand in relation to the analyst.

Psychodrama: protagonist → auxiliary ego
Psychoanalysis: analysand → analyst

In this context we may examine possible similarities and differences between the functions of the analyst and the auxiliary ego.

As a consequence of the emergence of psychoanalytic ego-psychology and the treatment of the so-called borderline cases, the function of the analyst has changed radically. It has in fact become more like the function of the psychodramatic auxiliary ego. The therapeutic situation is now regarded as containing certain elements of the mother-child relationship and the therapist can use himself more or less as an instrument. In recent years, the entire human milieu has begun to be described with the term "holding environment".

Gitelson (1962) emphasized that it is necessary for the analyst to present himself as an appropriate object for the patient and as an "auxiliary ego".¹

"... the analytic attitude, as manifested in the good analytic situation, provides 'presence' to the libido and operates as an *auxiliary to the patient's own ego with its own intrinsic potentialities* for reality testing, synthesis, and adaptation". (my italics)

With almost the same choice of words, Strachey (1934) writes that the patient sometimes uses the analyst as an "auxiliary super ego". The therapist in Dewald's (1969) supportive psychotherapy, has the function of a "substitute ego" or a "surrogate ego". Blanck & Blanck (1974) write that "it is inherent in the therapeutic situation that the therapist is a potential identification model". The therapist can also function as a "transitional object" according to a concept created by Winnicott (1953).

Anna Freud (1965) writes that the child uses the analyst as a new object, as an object for externalization and as an auxiliary ego. Finally, Gadpaille (1967) writes about the analyst as auxiliary ego in the treatment of action-inhibited patients. These examples have been selected because they represent the so-called "orthodoxy" in psychoanalysis. The neo-freudian schools have long been in agreement with Moreno.

Transference, in psychoanalytic treatment, can also be exploited as a possibility for direct influence of the patient. Franz Alexander is perhaps the foremost advocate of this concept. He maintains (1946) that when infantile conflicts are repeated in transference, the therapist must assume

1. Moreno (1972) writes: "... the infant binds its spontaneous energy to the new milieu, via ... auxiliary egos—mothers, midwives, and nurses—If they would not come to his rescue by caring and feeding him, its spontaneous energy would subside" (p. 54).

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an attitude which contrasts with that of the parents and thereby gradually give the patient a "corrective emotional experience". This attitude has been much criticized in the psychoanalytic literature. This sort of influence, with the therapist playing a role, opposes the psychoanalytic canon of the therapist's objectivity.

Expanding Alexander, Greenson (1967) writes

"In a strange way the analyst becomes a silent actor in a play the patient is creating. The analyst does not act in this drama; he tries to remain the shadowy figure the patient needs for his fantasies. Yet the analyst helps in the creation of the character, working out the details by his insight, empathy, and intuition. In a sense he becomes a kind of stage director in the situation—a vital part of the play, but not an actor" (p. 402).

In this case, the analyst becomes a sort of psychodramatic figure and the psychoanalytic situation can be compared to a *psychodrama a deux*. The role of "the other" is played by the director himself.

The psychodrama therapist, however, need not participate as an actor or opposite to the patient, but can completely concentrate on directing, according to Moreno. An auxiliary ego, sometimes especially trained for this assignment, is chosen as the counterpart. The auxiliary ego is not to analyze and observe, but is expected to assume intimate roles and mannerisms consistent with the patient's mental image of "the other".

Instead of "talking" to the patient about his inner experiences, the auxiliary egos portray them and make it possible for the patient to encounter his own internal figures in both dialog and action. An auxiliary ego becomes the instrument which is used to help the patient solve his problems. Schützenberger (1966) is not in agreement with Moreno in his opinion of the absence of transferences in psychodrama. She writes that transferences upon the directors *do* exist in a psychodramatic group, though not so often as in psychoanalytic psychotherapy.

A key question thus is whether there is counter-transference experienced by the psychodrama therapist. It would appear that the therapist can retain a certain degree of objectivity and neutrality, but naturally, he is not completely free from some of his own transferences upon the patient. The suggestions he gives the patient, the questions he asks, the distance he prefers to hold and the entire way he directs the work on stage, can influence the process. If the director is not sufficiently perceptive this influence can disturb the psychotherapeutic process. This distorting element in treatment is considerably minimized because of the instrument of auxiliary egos and the constant possibility of the group to "guard" the patient and guide and supervise the therapist.

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The counter-transference of the auxiliary egos can also influence the process. Moreno (1972) writes:

“A minimum of tele structure and resulting cohesiveness of interaction among the therapists and the patients is an indispensable prerequisite for the ongoing therapeutic psychodrama to succeed. If the auxiliary egos are troubled among themselves because of (1) unresolved problems of their own, (2) protest against the psychodramatic director, (3) poor portrayal of the roles assigned to them, (4) lack of faith and negative attitude toward the method used, or (5) interpersonal conflicts among themselves, they create an atmosphere which reflects upon the therapeutic situation. It is obvious, therefore, that if transference and counter-transference phenomena dominate the relationship among the auxiliary therapists and toward the patients, the therapeutic progress will be greatly handicapped” (p. XVIII).

Moreno is here referring to the professional auxiliary egos. Usually, however, a group member or “another patient” is chosen to play the role of the other. In this case, it is of course not required that the auxiliary egos be free from “counter-transference”. On the contrary, it can be very productive if the director knows how to make use of it. The psychodramatist R. Korn has developed a special technique to select particularly “warmed up” auxiliary egos.

The dilemma of the patient who needs love to become healthy and the therapist who does not want to act as a love partner, can be solved through the engagement of a third party. An auxiliary ego should be someone other than the therapist himself, and provides the best solution to the problems of transference and counter-transference.

Tele

In psychoanalytic terms, tele may be defined as the mystical affective contact between analyst and analysand without which analysis could not function. The hypnotist calls this patient-therapist relationship “rapport” or “psychological rapport” (Jung).

The school of “object relations” which arose from the work of Klein and Fairbairn expresses much which is in agreement with Moreno. Guntrip (1961) describes mature relationships as two-way relation between equals. These relationships are characterized by mutuality, spontaneity, co-operation, appreciation and preservation of individuality within the friendship. The theory of “object relations” could by this definition just as well be called the theory of “*tele relations*”.

As noted in the introduction, psychotherapy is now viewed by some

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people as a type of human relationship in which the therapist's personality is of greater significance for the treatment than the techniques he uses. It is thus of the greatest importance that each patient be assigned to a therapist who fits his special needs. All therapists are not appropriate for all patients—there exist definite limits, writes Moreno. The choice and formation of pairs is dependent upon an advantageous tele process. Persons who enter into the relationship must be drawn to each other because of real aspects of their personalities. Both the patient and the therapist can be attracted, repulsed or indifferent to the other's real individual qualities. It is precisely because of this tele factor that a therapist can succeed with some patients and fail with others. Moreno recommended that each patient be carefully assigned a therapist through sociometric choice, based on a functioning tele relation.

Conclusions & Summary

The concepts transference, counter-transference and tele are defined and discussed within the framework of interpersonal theory. Their application in psychoanalytic and psychodramatic therapy are compared and certain similarities are stressed. Both schools have the dilemma of how to handle the real reaction contra the transference reaction of the patient in common. In the attitudes of the therapist, the analyst has to struggle with counter-transference, while the psychodramatist assigns an auxiliary ego as the "counter-part" which gives the psychodramatist the opportunity to develop a real and congruent tele relationship.

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Address: Peter Felix Kellerman
Ostermalmsgatan 62,
S-114 50 Stockholm
Sweden