Psychotherapy Guidebook

Transference-Focused Therapy

Joseph Rechetnick

Transference-Focused Therapy

Joseph Rechetnick

e-Book 2016 International Psychotherapy Institute

From *The Psychotherapy Guidebook* edited by Richie Herink and Paul R. Herink

Table of Contents

Transference-Focused Therapy

Joseph Rechetnick

DEFINITION

Transference-Focused Therapy is used in this article to refer to the treatment of acutely disturbed patients in an in-patient service. The methodological issue confronting the clinician in the acute treatment service is how to appropriately utilize transference phenomena so that effective, brief, analytically oriented treatment can be accomplished.

Transference here is defined as the displacement of patterns of feelings and behavior, originally experienced with significant figures of one's childhood, to individuals in one's current relationships. This is an unconscious process that brings about a repetition, not consciously perceived, of attitudes, fantasies, and emotions (of love, hate, anger, etc.) under many different circumstances. The parents are usually the original figures from whom such patterns are displaced, but in many instances siblings, grandparents, childhood teachers, and doctors may be contributing figures. In the treatment of exacerbated psychotic symptoms, it is important to distinguish, with Glover (1958), between the transference manifestation which, in spillover fashion, confronts the clinician during the first few

sessions, from transference neuroses or psychoses (Searles, 1965), which develop as a consequence of long-term analytic treatment. The judicious use of early transference manifestation constitutes the important technical problem I (Joseph Rechetnick) will discuss here.

HISTORY

A number of people have made significant contributions to the treatment of psychotic patients by means of psychotherapeutic interventions. Among them, Brody (1952) makes the point that in establishing contact with schizophrenic patients, the therapeutic activity should be directed at clarifying the central issues through interpretation, giving the patient ego support, and making "therapeutic utilization of the transference situation." Freda Fromm-Reichmann (1952) stresses the fact that an intensively charged relationship can be established between the schizophrenic patient and the therapist. This general notion of the healing properties of a positively charged transference experience has been stressed by Sechehaye, Jacob-son, and Winnicott. Arlow and Brenner (1964) stress an additional element, which has contributed in great measure to the therapeutic approach to schizophrenia. They state that by interpreting defenses, we approach more directly what is upsetting the patient, namely, anxiety.

TECHNIQUE

The approach to the patient is to utilize the transference and attempt limited insight-oriented psychotherapy in treating short-term patients. In so doing, an attempt is made to focus on one or two critical themes and not to try a more comprehensive psychotherapy. Using this technique it is necessary to identify critical themes rapidly with each patient. These themes include repressed and suppressed hostility, excessive dependency, symbiotic relationships, etc. The treatment strategy is to select aspects of transference manifestations that maximize the insight into the acute exacerbation of symptoms, with which the patient comes to the hospital, and to utilize the selection theme to effect a more integrated consolidation of the patient's resources. Many disturbed patients are ready to relate to a person they consider a special figure as soon as they are admitted to the hospital. This attitude is used by the therapist to help patients in a constructive direction. In addition to fostering the development of the transference, the therapist should interpret the nature of the transference to the patient in the course of treatment. It should also be mentioned that the greater the empathic ability of the therapist, the more likely he will be able to establish a strong transference. The transference with such patients is utilized to enable them to look at internal conflicts, to become aware of their problems, and to encourage the patients to make changes in behavior, attitudes, and so on.

APPLICATIONS

This article is based on the treatment of patients in an open ward of a general hospital. In each case, an early development of transference was fostered and the transference manifestation was utilized to interpret anxiety and defenses against anxiety by the patient. The following is a brief description of a patient who was so treated.

The patient was a thirty-year-old married student with two children. He had a psychotic episode in a foreign country where he was attending school. Immediately after this episode, he returned to the United States and was hospitalized at this hospital. He had delusions of persecution involving one of his professors with whom he was disappointed because this professor had demanded payment from the patient in order to help him pass his courses. He became enraged at his professor, whom he initially saw as a giving and affectionate father. In this rage, he developed a belief that the professor was pumping gases into his apartment. Evidently this belief reflected his guilt over his anger and hostility toward his previous idol. Throughout his life, he had sought a fatherly, positive relationship with various men in his life. Yet he would become furious if these protective relationships were withdrawn and he was dealt with in a man-to-man way. While he was a student in the United States, the patient had a personal relationship with a college teacher whom he would ask for advice on personal problems. In his own family, he had a passive, “nonexistent” father and a dominating, controlling mother.

In the brief three-week treatment program covering seven sessions, three distinct phases of intervention, while overlapping, could be delineated. (Although these phases are essential constituents of Transference-Focused Therapy, they do not necessarily occur in the following sequence.) The first dealt with the interpretation of the panic underlying a disappointing "parental" experience. His need for a father figure who would be affectionate and giving was explained to the patient, as well as his disappointment and rage when this need was frustrated (as he experienced with the professor's demand for payment). This theme was selected for interpretation not only for its central postion in the patient's pathology but also in view of its potential use for transference interpretation.

A second phase was the evocation of a positive transference. The therapist seemed to take the place of the patient's former college teacher and elicited the same feelings of protection that the patient wanted to get from his foreign professor. The issue of timing is critical here. Without waiting for the patient to make an explicit connection between his expectations of his professor and of the therapist, this connection is made for him. He developed confidence in the therapist whom he saw as a nonthreatening, nonpunitive person who did not deny his paranoid delusions as his family did.

The third step involved the utilization of this transference experience in the decision-making process revolving around disposition. The patient

requested the therapist to see him privately and was disappointed when this could not be done. The therapist showed him that this disappointment could lead to anger and hostility toward him; this would result in a negative attitude toward the therapist and to the same type of situation as when the patient attributed to his professor harmful intentions toward him. He regularly saw men as either treating him like a giving father or wanting to harm him. This ambivalence manifested itself when the therapist referred him to someone else for private treatment. After this conflict was explained to him, the patient was able to accept this referral without feeling that the therapist was rejecting him or meant him harm. In this phase of treatment, the transference experience was utilized to help the patient accept a referral to another therapist. This decision could be made in the context of a weakening in the delusional system that made it clinically possible and desirable for the patient to embark on an out-patient treatment program.