

**Managing the Idealising
Transference:**

Preventing escalation and avoiding
harm

CfBS Advocacy service

- 592 relevant enquiries
- 462 psychological therapists
- 130 other healthcare professionals

Categories of harm

MISMANAGING THE THERAPEUTIC PROCESS

Unsatisfactory contracting; Mismatching transference; Damaging disclosures; Encouraging dependency; Destroying defenses; Termination difficulties; Multiple roles; Breaching confidentiality; Unorthodox practices; Inappropriate care; inadequate conflict resolution

PERVERTING THE THERAPY

Sexual contact; Sexualized actions; Criminal actions; Psychological sadism; Repeating developmental trauma.

DEPRIVING THE CLIENT OF THE THERAPEUTIC SPACE

Incompetence; Inadequate practice maintenance; No therapeutic content; Determining agenda; Role reversal; Inattention; Reducing session time; Impaired mental state

DISEMPOWERING COMMUNICATION

pathologising; non-sense; certainty; intrusion; aggression; withholding.

CORE CATEGORY

Relinquishing professional role

Incidence of AIT at CfBS

63% of people who enquire about advocacy services have experienced an adverse idealising transference.

Transference

- The predisposition we all have to transfer experiences, related emotions and unmet longings, associated with people from the past, onto people in the present.
- This leads us to experience new relationships in a distorted way.

Idealising transference

In an idealising transference the client will typically project onto the therapist the qualities they longed for in early care givers, and so experience the therapist in a particularly positive way.

Beneficial effects on therapy

- Can assist in establishing the therapy and motivating the client.
- Can help in understanding the client's developmental experiences.
- Can help in understanding current relationship difficulties.
- Can help in understanding the dynamics in the therapy.

Adverse Idealising Transference (AIT)

A transference reaction that impacts on a person, so that over a sustained period their ability to function in their usual way is adversely impaired.

What is different about AIT

- Clients identify with the therapist in such a way that they feel merged and part of the idealised object.
- This can be a very primitive and profound experience and can create the illusion of power and belonging.

Transcendence

- Creates a feeling of elation.
- Creates the illusion that the client has transcended the problems of ordinary life. Clients frequently describe the experience as 'magical'. They also frequently compare it to a psychotropic drug or a profound religious experience.
- Because the person feels they have transcended ordinary life it typically masquerades as a cure.

Jenny's accounts

.....I felt as if I had been injected with a drug that not only took away all my problems but made me feel powerful and whole. I felt elated and profoundly energized, as if I could accomplish anything. I have always felt alone - on the outside - never part of anything, and now suddenly I was not only connected, I was part of something amazing and profound. Nothing else mattered, I wanted this feeling to last for ever.....

Dependency

- Since the client feels that they have been 'cured' the reasons they came into therapy are no longer of interest.
- The client typically becomes consumed with the therapist's interests and loses the motivation for anything else.
- They know that the newly acquired feeling is dependent on maintaining the relationship with the therapist, and so the therapist becomes indispensable and all powerful.

Rosie Alexander's account

.....My feelings for Marion intensified. During the 166-and-a half hours a week when I was not with her I thought about her constantly. The rest of my life was dwarfed into insignificance. Whether I was working, interacting with other people or engaged in any kind of activity whatsoever, a part of my mind was always reserved for her. In fact I resented all the other activities of my life as they occupied mental space which I needed in order to let this relationship flourish to the full. 'Relationship' was no longer an adequate word to describe what bound us together. In my mind, I was transported into another world where I existed in a state of rhapsodic communication with Marion. We did nothing, we said nothing, we just were.....

Alexander, 1995

Michelle Matheson's Account

.....I cannot over-emphasize the devastating effect all this had on my husband and children. I think they could not recognise the person they had known – a family orientated wife and mother. It was as if an alien had invaded my being and I was speaking and behaving in ways that were just not me. It is difficult after these years to understand the intensity of my feelings for him and the total subjugation of my will to his.....

Matheson, 2008

Deterioration

- The client begins to feel that they need to increase their contact with the therapist as the sessions are not enough.
- Even the increased contact begins to feel inadequate, and the feelings of elation give way to feelings of anxiety and depression.

Effects on everyday life

- Loses interest in previously important people in their life, such as friends, children or partner.
- Finds it impossible to make a decision without consulting the therapist.
- Becomes isolated.
- May begin to compare their partner with the therapist in an unfavourable way.

Outcome 1

- The client's need for more care and connection is so strong that they will seek a 'real' relationship with the therapist. Often the only way they can articulate this is to suggest a sexual relationship.
- If the therapist responds by offering a sexual relationship, they miss the fact that this is an infantile desire for love and nurture not an adult desire for sex.
- The client can't cope with an adult sexual relationship and feels exploited and abused.

Outcome 2

- The client becomes frustrated by the constraints of a professional relationship, especially as other relationships are likely to be deteriorating. They begin to feel resentful and envious of the therapist and will frequently feel they have been used.
- The therapist does not understand the transference dynamic and believes the client is unreasonable and will often blame the client and terminate the therapy.

Freud

- Freud used the analogy of a chemist handling highly explosive materials, to allude to the potentially catastrophic consequences when an erotic transference becomes adverse.
- But, crucially, Freud's focus was on the **therapist's** experience of the phenomenon, rather than on the harmful effects on the patient.
- He did however warn that the patients feelings should be interpreted and NOT reciprocated

Kleinians

- Proposed that destructive and aggressive feelings are also present, so emphasizing that this was not a positive transference situation.
- Believed that the client was envious of the therapist and that this should be interpreted, particularly the client's difficulty in tolerating the independent existence of the analyst.

Kohut

- Kohut introduced the term 'idealizing transference' and saw it in much more positive terms.
- He focused on the facilitative aspects of the transference and insisted that it should NOT be interpreted but rather left to take its course until firmly established.
- Again the potentially catastrophic effect on the client is not considered.

Focus on idealisation

- Not all clients experience erotic feelings, and even when they do, the feelings are almost always infantile and sensual rather than adult and sexual.

More recent attitudes

- In the 1980's and 1990's the focus returned to the erotic aspects of the transference and the idea of participation through countertransference disclosures of erotic feelings for the client. This gained ground with the notion of 'erotic playback' and 'erotic bond'.

Erotic countertransference

- Erotic countertransference is no different to other types of counter-transference such as a negative CT.
- It should be taken to supervision.
- Therapist needs to understand what belongs to the client and what belongs to them. Sometimes we can be too ready to see our own feelings as the clients projections.

Erotic Countertransference

- Should be used as information but not communicated to the client any more than hate in the countertransference would be communicated.
- If the the therapist’s erotic feelings continue then they are likely to have an adverse effect on the client, as the client will pick up on them.

**HOW DO WE
REDUCE THE
INCIDENCE OF AIT?**

More awareness amongst therapists

- We need to speak about this kind of transference as a potentially harmful side effect of psychotherapy.
- We need to educate therapist so that they don’t unwittingly encourage the transference to develop.
- We need to stop speaking about transferences of this kind as if they only affect people with BPD.

Assessment for AIT

- Whether the client has a history of idealising or becoming dependent on previous therapists or other professionals.
- Determining whether the client is primarily looking for care rather than insight.
- Assessing the clients expectations of therapy.

Informed consent

Outcomes research on 14,000 cases of psychological therapy, reported that outcomes were improved when clinicians:

“obtain informed consent to treatment by ensuring that people considering psychological treatment for their condition are aware that there is the potential for both positive and negative effects”.

(British Journal of Psychiatry, 2016)

Client attitudes to informed consent

- Clients frequently compare the adverse effects to the side-effects of surgery or a drug and believe they should have been informed about them before the therapy began.
- They also believe that the experience would have been less harmful and confusing if they had been aware of it.

Reluctance to discuss adverse effects

- They believe people will be put off therapy or made anxious by this kind of discussion.
- There is a very clichéd, exaggerated view of how transference issues would be discussed.

Low risk

- Talk about how some people develop quite confusing feelings about their therapist but that it's an ordinary part of the therapy process.
- That it's important to discuss these feelings if they come up as the therapy progresses.

High risk

- Discuss risk versus benefit and how to reduce the risk – if client is reluctant to engage in such a discussion it is a further risk factor.
- Try to determine whether the gender of previous professional was a factor.
- Try to determine whether the therapist's actions contributed to the transference becoming adverse.

Regular reviews

- Important in ensuring the therapy is on track.
- They give the client the space and opportunity to bring up transference issues that they might not otherwise talk about.
- If a client has had a previous AIT I would always ask specifically about any similar feeling.

Consistent Boundaries

- Avoid any boundary breach that makes a client feel that they are being treated in a special way.
- If you need to extend a boundary always make sure that the client knows that it is your normal practice to do this.

Disclosures that encourage AIT

- Disclosures that elicit sympathy from client.
- Self-enhancing disclosures.
- Soul-mate type disclosures.
- Disclosure of erotic feelings
- Discourse that hints at a future 'real' relationship.
- Disclosures of how the therapist would treat the client if he/she was client's partner.

If AIT emerges

- Talk about it in a collaborative way.
- Treat it as information which can be useful to the therapy.
- If the client is able – think about its defensive function – but not if it could sound blaming.
- If the client talks about actions that encouraged idealisation, don't react in a defensive way and be open to learning.

If AIT emerges

- Take it to supervision
- Seek external consultation if it persists.
- Don't act with rejection and sudden rigid boundaries.
- Be very wary about terminating the therapy without the agreed notice period.

Client factors associated with AIT

- The literature suggests that the absence of an early nurturing experience can create a predisposition to AIT, because it creates an insatiable desire for the mother they never had.
- Since not all people who have had inadequate parenting are predisposed to AIT, it seems likely that genetic makeup and the neurobiology of the brain also play a part.

The therapeutic setting

- Low lights, a comfortable room, prolonged eye contact and intense focus and interest may be a unique experience for the client and so may become unconsciously associated with a promise of love and nurture.
- Because the 'love' is asymmetrical, it tends to mimic a maternal relationship rather than a mutual romantic relationship, which makes the experience all the more unique.

Gender and AIT

- Most common in female client/male therapist combinations
- Is also common in all female dyads.
- Males are affected most often in all male dyads.
- In male client/female therapist combinations, the therapist has always been older than the client.

Psychopath

At the most extreme end is the psychopath who becomes a therapist. This is the "unscrupulous therapist" described in the Foster Report (1971) who sets out to use transference to create dependency and then intentionally exploits the client for emotional, financial or sexual advantage, for years or even decades.

Opportunist

May not set out to exploit the transference but find themselves doing so when it emerges. They reap the emotional, financial and/or sexual rewards, and often convince themselves that it is in the client's best interest. They typically have poor professional boundaries, operate from a narcissistic position and often have relationship problems, so the client becomes a source of comfort and validation.

Carer

Offers love and care in the belief that they can compensate for parental failures. Clients often respond with appreciation and idealisation, which encourages the therapist to continue practicing in this way. If the client is predisposed to developing AIT they are likely to find it difficult to tolerate the constraints of a love relationship that is time limited.

Client's account

.....When I met Karen I was struck by her warmth and confidence. She said she was an expert on my condition that my life would change. I felt elated, as if I'd been blessed and chosen. We had a special bond, she looked out for me like nobody had done before. When my boss changed my hours causing childcare problems, Karen phoned him and sorted it..... I began to find it hard to cope between sessions and began to worry about the therapy ending because she was more important than anyone else. She said she would always be there for me and when I questioned "how", she hugged me, fixed her eyes on mine and said "trust me". This didn't help. I needed to know how and this irritated her. I began to be silent during sessions and Karen said I was trying to sabotage the therapy and didn't want to get better. She told me that her other clients improved because they trusted her. At the next session, when I saw her previous client leave I experienced a sudden, visceral feeling of rage. I was drenched in fizzing emotion and couldn't think. I went into the room, picked up a glass and smashed it. I held it to my throat.... That was the last time I saw Karen.....

Refusers

Refuse to engage with the transference. They may do little or nothing to encourage the idealisation but its emergence precipitates anxiety and they ignore it or are disapproving. The therapist may feel incompetent, irritated or ashamed that this situation has arisen and this produces shame and confusion in the client. The client then conceals the idealising feelings and they flourish in silence, until the adverse aspect can no longer be hidden.

Appropriate

The client is predisposed to developing a regressive transference. This is the situation in which people without a history of psychosis develop intense, delusional ideas about the therapist's actions, even when the therapist has acted entirely appropriately. This is likely to become apparent just as the therapist feels the therapy is going well, and it frequently involves delusional ideas about both the therapist's actions and intentions. It may be impossible for the therapist to resolve the situation because the client's beliefs are so tenacious.

Regressive transferences

- Referred to in the literature as malignant, malign and psychotic transference.
- Whilst most cases of AIT can be avoided by the therapist acting appropriately, this is not always the case with this kind of transference.
- Careful assessment is needed to exclude people who are likely to develop a regressive transference.

Lawrence Hedges

“At present these treacherous transferences are so scantily understood, even in the community of practicing therapists, that one therapist after another is succumbing to disastrous charges of misconduct. We have no effective protection even from our own professional ethics committees because the people sitting on them are sometimes making judgments on deep psychological processes that their own training have not prepared them to be knowledgeable about.”

Hedges 1994
