Managing Complex Transference With Preparatory Psychoeducation

TO THE EDITOR: I appreciate the Clinical Case Conference by Gabrielle Hobday, M.D., Lisa Mellman, M.D., and Glen O. Gabbard, M.D. (1), published in the December 2008 issue of the *Journal*. Dr. Hobday is clearly a gifted therapist, and Dr. Gabbard's supervision was wise. Unfortunately, the treatment used in the case presentation was not successful. Given the problems the patient posed, failure may have been inevitable. However, I would like to share some thoughts about managing difficult transference.

Before starting dynamic psychotherapy, especially with an individual for whom there may be "warning signs" that transference might be confusing (as with Dr. Hobday's patient), I educate the patient about the process, goals, and possible pitfalls to be expected (2). Usually, the patient and I have decided to undertake psychotherapy because we believe there is a psychological component to his or her suffering, which manifests itself as troublesome patterns in the patient's life. I explain that dynamic therapy works by looking deeply at how the patient experiences his or her life, especially in the realm of feelings, in order to understand how these patterns began, how they made sense at one time, and how to change them.

I usually explain that therapy focuses on the following three realms: current relationships, important past relationships, and, sometimes, the relationship with the therapist. When the relationship with the therapist is a focus of interest, we need to attend to two important aspects of our relationship. The first is the real, actual relationship. For example, if the therapist is chronically late, that would be a real factor in the relationship to address. The other aspect is the transference relationship. This—I explain to the patient—occurs when important feelings from the patient's past come into the relationship with the therapist. Transference presents an opportunity to scrutinize and understand these feelings in the therapy. However, these feelings that arise in the relationship with the therapist can promote the occurrence of the same self-destructive patterns in therapy that occur in the rest of the patient's life. Therefore, I tell the patient in advance that it is critical that when the transference arises (if it does) that both the therapist and the patient recognize it and deal with it effectively.

Thus, when transference arises (as it did for Dr. Hobday in her patient's diary), we can say, "Mr. A, do you remember our discussion about transference? Well, this is it!"

This preparation sometimes creates a cognitive framework to "hold" the therapy while the patient and therapist collaboratively develop a way to use the transference rather than have the transference explode the therapy. Whether this approach would have been helpful in Dr. Hobday's particular case is, of course, not clear.

I congratulate Dr. Hobday on her courageous willingness to share her work and am thankful that our field is graced with new practitioners of such intelligence and openness who are capable of such candid self-reflection.

References

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Sexuality and Narcissist Injury in Male Patients With Female Therapists

TO THE EDITOR: Dr. Hobday (1) is to be commended for her candid description of her struggle to understand her narcissistic patient and to deal with the discomfort of his sexually provocative and demeaning communications. However, I would like to suggest a somewhat different interpretation of the patient's departure from treatment than what was emphasized in the case report.

Although the discussants view "Mr. A" as a patient who did not comprehend the rules of the therapeutic situation, the facts as presented do not support this. The patient did not, after all, try to insist that his therapist see him outside the sessions or engage in sexual activity. His provocative and hostile writings were his attempt to express his thoughts and feelings, as his therapist had instructed, albeit within the limitations of his narcissistic defensive structure, and they demonstrate his acute awareness of the rules of therapy and his concern about the possible consequences of violating them.

The therapist's own understandable anxiety interfered with her ability to respond from a secure empathic position, which would have entailed acknowledging the patient's rage (and with time, shame) at finding himself sexually aroused by someone who had no intention of reciprocating. His perception of being manipulated by a stimulating but aloof object, rather than his sexual arousal itself, was the transference to be dealt with in therapy. The patient made several attempts to engage around his expectation of rejection, but the therapist let these attempts pass in favor of setting limits. What followed was an enactment in which Mr. A's growing narcissistic rage and paranoia further alarmed the therapist, who then treated him as a dangerously out-of-control child, undermining his sense of self-worth and adult efficacy still more. After a few vain attempts to salve his self-esteem through blame, devaluation, and reaction formation, he terminated the therapy.

This case is a good example of how sexuality can obscure underlying deficits in self-efficacy and self-esteem and make it difficult for therapists to maintain an empathic holding environment in which to understand and repair these deficits.

Reference

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