Using Transference To Improve Connection

David Puder, M.D.

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In today's episode of the podcast, I would like to give you my take on transference. I want to share with you what I actually believe. Often lectures focus on the history of transference or what certain papers say, but I'd like to share my accumulated, internalized experiences and understanding of transference.

My hope is to make this easy to read and understand. I want to give a talk on this that can be understood both by experienced clinicians who are familiar with these concepts, who will imagine where I am pulling different pieces of wisdom and maybe where I am being creative and uniquely contributing to the field, but also by people who don't have much of a background on transference and want to further explore it.

What is transference in therapy?

By categorizing past close relationships, we can be prepared for meeting new people. Our early attachment relationships are always alive in the present. We have transference with every person, in therapy or out of therapy.

Working in the transference in therapy is a focus on the degree the present and past are interacting with each other, but is also a focus on what is going on between us. As a patient places transferences from the past on you, how they believe you may be thinking or feeling about them, they hope for working through some of the dynamics that are unworked through from the past. They hope for (often unconsciously) a way to overcome obstacles, moments of emotional dysregulation, traumas, and to have a corrective emotional relationship.

Often transferences will wait to come out until they have increased trust in you. Raw, unmet needs are thus transferred onto the safest person in the room, so to speak. This happens to a lot of leaders in various positions—teachers, pastors, bosses, anyone in authority, and anyone that they are in an attachment relationship with. I might add, people may also transfer onto their conception of some divine person (consider Greek mythology, as humans transfer their, at times, taboo desires on the gods or characters).

Why work through transference:

To show you how important working through transference is, consider this thought experiment. Imagine you, as a patient, spending 100 hours with a therapist, pouring out your life, talking over the most traumatic memories of your past, and at the same time secretly considering:

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This person hates me.
This person has disgust towards me.
This person just wants my money.
This person laughs at me, secretly persecuting me behind closed doors and does not care about me.
This person is a quiet bystander who does nothing.
This person will only love me if I perform, am perfect, or show up in a certain way.

Or the thoughts can be positive:

I am overwhelmed by positive feelings towards this person.
I idealize this person; they embody all that is good, all that I aspire to be.
I envy this person and their authority, their position, how they wield their power.
I feel safe and desire this person to make my decisions.
I desire approval from this person.
I desire closeness, but also desire distance and pushing them away feels safer.

Responding to Patient Transference

Having compassion on what comes up is all important. By compassion I mean knowing that a lot of this contains suffering or conflict. They may have never had a safe place to express such things before in an interpersonal relationship. Their memories might not even be narrative memories (preverbal, early memories, repetitive experiences that are very unconscious usually) where they actually have words to put to their yearnings or desires and now, when expressed, they may be very strong, raw words, all or nothing words, and black and white words.

People are not choosing to have this transference—it's not a conscious choice. They are not choosing to have these strong feelings (sometimes they are only consciously experienced fleetingly, come out as an image that does not make sense, come out as a quick jab in session or get pushed out from the mind as dreams, which may hide the identity of the therapist).

The narratives that people have about you, as the therapist, and your narratives that you have about the patient, are worth your focus and curiosity. How do we put the stories in their minds into words? How do we empathize with the distress when these narratives come up?

As we talk about these things, my goal is to:

1. Decrease the shame, fear, and the inner critic.
2. Celebrate their courage to share and put words to these thoughts.
3. Empathize with any distress.

4. Make sense of what might be going on between us.

Why help them decrease the negative internal voice?

1. Increased creativity occurs.
2. Increased connection outside of therapy.
3. Having a good transference helps them process through life's traumas effectively.
4. Over time the patient's transference becomes less fixed, more chosen, and more context dependent.

Listening for this inner interpersonal conversation and what to do with it is something I will wrestle with. As safety is established, they will be able to access memories and events that were previously compartmentalized and dissociated in their mind (lonely memories, memories of trauma).

Supporting Data

1. Most therapies have very similar outcomes.
    - ACT vs. CBT (episode 103) have similar outcomes.
    - BPD episode with Dr. Feinstein (episode 140): MBT, CBT, DBT, TFT, SFT, good psychiatric management, are considered the "Big 6" specialized therapies for treating BPD.
        - Two studies have found TFT to help with attachment security and mentalizing (Levy, 2019). One study by Levy (2006) of Transference Focused Psychotherapy (TFP) vs. DBT vs. Supportive Psychodynamic Psychotherapy for BPD found that TFP had increased secure attachments (whereas the other 2 did not change) with increased narrative coherence and also improved reflective function (ability to mentalize the thoughts, feelings, goals of another person).
        - Transference Focused Therapy showed the following brain changes, with successful treatment in patients with BPD (Levy, 2019):
            - This is twice weekly therapy for 12-18 months.
            - Found "relative increase in dorsal prefrontal (dorsal anterior cingulate, dorsolateral prefrontal, and frontopolar cortices) activation and decreased ventrolateral prefrontal activation and hippocampal activation following treatment."

2. The impact of aspects of the therapist are more important than the particular therapy. So we know that treatment differences have more to do with the following:
    - Empathy

- Alliance
- Positive regard
- Congruence

The below table is taken from Better Results, summarizing the "Great Psychotherapy debate":

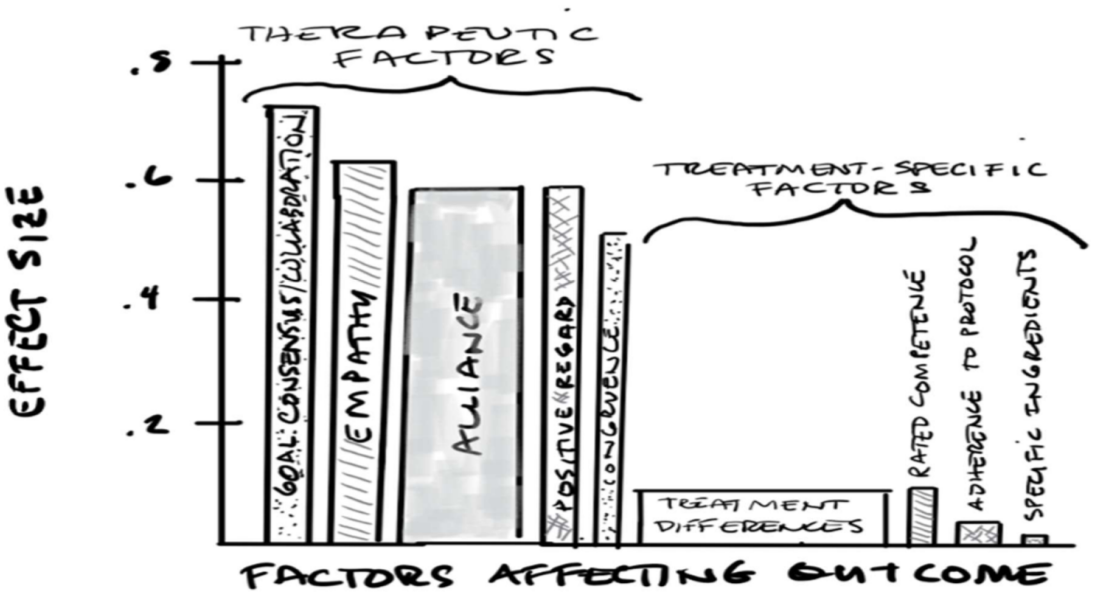

Figure 6.4. **The Effect Size of Factors Affecting the Outcome of Psychotherapy**

(*Note:* Width of bars reflects the number of studies reflecting effect sizes for each therapeutic factor. Adapted with permission from "The Great Psychotherapy Debate," by B. Wampold and Z. Imel, 2015, p. 258)

3. In my own research creating "The Connection Index", I found that burnout decreased if a resident had a supervisor they were highly connected with. I created the connection index to measure connection. Connection was defined by empathy, therapeutic alliance (or education alliance in this case), psychological safety, and feedback. When high in one of these, the supervisor was high in all of them. Which points to why transference is so important—it is the essence of connection. It is putting to words the type of connection going on. When connection is present, the therapy is going to work. Transference is just a way of navigating the relationship to lead to change.

4. Therefore, therapeutic knowledge, the knowledge about transference and countertransference, has to have the goal of allowing you to remain empathic, with strong

alliance and positive regard for the patient, *and* the patient needs to experience you as having these things. If this teaching allows you increased empathy, alliance, and positive regard, then it is a success.

A Practical Understanding of Transference Work

1) How do we see when transference is happening?
    a) Identify small slips that speak about the relationship.
        i) How you respond to these will dictate the safety of further exploration.
        ii) Are you enthusiastic for their aggression towards you? Positive feelings?
        iii) Microexpressions of anger, disgust, pain, when talking about something sometimes raises my curiosity about what is going on between us.
    b) Here are some insights that are "gold" coming from the patient:
        i) Last time, I said something and realized you did not understand me…
        ii) Dreams/fantasies
        iii) Poetry
        iv) Art
    c) More subtle signs:
        i) How things are said
        ii) What is not said
        iii) Your inner experience (different from previous experiences—your countertransference)
        iv) They are reacting to you differently
        v) Changes in behavior (being late, trying to open up things right at the end of the session to get more time with you, or pushing away in some way).

2) Things I believe that impact what I say:
    a) I believe it takes courage to share vulnerability, so I am grateful when patients share these vulnerabilities, especially interpersonal ones. Therefore, I often share how courageous they are being for sharing vulnerable interpersonal content. I know this is positive feedback for sharing in the future.
        i) We must expect their hesitations to trust us, to avoid us, to have feelings of reluctance, shame, guilt, and embarrassment. It is uncomfortable to share what one feels ashamed of, what might alienate, cause rejection, loss of face, cause one not to like/love and fear being unliked and unloved.
    b) I believe that what we bring to session also impacts the transference. It is important to know that their transference is a valid experience and your actual behavior influences it. Understanding this can help move you from the expert role into more of a student role in the session.

c) Sharing more easily in the future will help the work move forward.
   i) Therefore, I want to open the door of these discussions in different ways.
   ii) Normalize discussion of the interpersonal things going through their head. I will say things like:
      (1) I think the more we can put to words even fleeting thoughts about what happened in session or what is going on between us will be helpful. Any thoughts, positive and negative, will be helpful.
   iii) Was there any moment where you felt connected (explore good feelings)? Was there a moment you were afraid I would not grasp all that you were saying? Normalizing that I will not be perfect habituates them to a kind of unique state of permissiveness—it's ok to talk about this. Anything that goes on in words is ok. Anything that is put into words will not necessarily become translated into behavior. There is no action, it is just words.
   iv) When that happens, there may be doubt, shame and diminished esteem. To prepare the patient for exploring those negative feelings together, we may say: "When that happens, let's learn together what is happening and how to repair our connectedness."
   v) Here are some various thoughts my mentor, Dr. John Tarr has expressed that he might say at the end of a session: "We can now say it is now time to put into words some of the feelings we don't express anywhere else in life. We want to be able to share with each other some of the happiness and gratification that goes on between you and me, and I would like to say I am delighted if you have any feelings of sadness or lack of gratification with me, it will be helpful for me to know that. You can't do this anywhere else in life as safely as you can here. Do you feel this is bewildering, odd? Does it help you relax or make you more tense? When I just said this to you about your mother, do you think I did not grasp what you were feeling or did you hope I could be angry about what you were telling me? What were you hoping I would feel? You are now overcoming the social restraints you feel anywhere else. Here it is a unique and special place—it resembles more early maternal nurturance."

d) I want to have them feel heard, understood, and empathized with in whatever they bring up.
   i) When we listen from the patient's world, acknowledge their subjective perspective, resonate with their affect, and look for their meanings. Then an alliance is formed with the patient's expressed experience.
   ii) We attempt to listen from an others-centered perspective (from what is going on in a different person).

iii) By opening an interpersonal feedback possibility from the beginning, we introduce the patient to the likelihood that he or she will develop feelings of being misunderstood.

e) I don't want to over-intellectualize in the present moment.
   i) Instead, I want an integration of emotion and cognition. DBT calls this "wise mind." Spinosa talked about how the mind and body are one. I want to see beyond the defenses and stay present and instead empathize with the distress they may be feeling.

f) I see the false self (the idealized image they wish to portray to the world) and being governed by the "shoulds" as an adaptive response to belonging to a "clan." I call this the "clan leader transference" (to date Google has never seen this word before).
   i) Someone very invested in their false self may have transference idealizing me or imagining me being judgemental (embodying their shoulds).
      (1) For example, they idealize me as embodying all their shoulds—the clan leader.
      (2) Or they imagine that I am critical of them, embodying their shoulds—the critical clan leader.
         (a) I should be perfect→ He knows I am not perfect and is therefore critical of me.
         (b) Here is a long quote from a patient who I have worked with for a number of years, which expresses a warm positive transference "I had a pattern of not being enough in my life, constantly needing to prove myself for attachment relationships. There is freedom on the other side." The patient shared this gratitude with me: "You did not leave. I used to have a lot of repeat tapes when I left, repeating what I said, thinking I should have said something else instead. And I think it is just that, ya, the freedom to be myself [microexpression of sadness flashes on her face]. Of course I wish to be around you all the time, but the end result is that life can be free and there can be reciprocation of acceptance, and care, and authenticity, and I think that [microexpression of anger seen on her face], the "false self" was kind of how I was raised. I had to wear the mask all the time because that is how I earned approval. It is the earning, the "shoulds", achieving and accomplishing to get love, which is not real love, which is false love, which leads to emptiness, because it is an insatiable addiction. The difference is, the peace and love that I feel here, I can access any time. I love spending time with you, and I know you have exemplified trust, which I

can struggle with." The feeling of hearing this was fresh and alive. "I can run hard enough and fast enough and be a workhorse. It is letting go of that and trusting God is going to provide. There are times I am sad of the brokenness of the world and I can't believe I am in certain situations, but I have to trust that God brought me to you and I have to trust that I am thankful for where I am now. I am thankful for my story [microexpression of pain on her face at this point] and even when it has been painful and difficult I am able to forgive. In a way, I can understand it could not be any different. I am grateful for how I am supported and have managed to transcend that difficulty. There are certain things—a new home, new creation, a journey home—that bring me joy." There was a creative explosion in her life after this shift. The acceptance goes with her.

(3) Episode 148 has more on the false self.

g) There is also transference in the shadow. I see the shadow (ID, competitive, dark archetypes (Gangas Khan), inner warrior) as part of the true self, and dark archetypal aspects of the personality need to get worked through in order to create boundaries.
   i) I uniquely see the shadow having multiple heads. Each of these are traumatic, developmental figures who might have had some more raw and un-worked through aspects of the relationship. Object relations theory informs this for me. Because the attachment figures are so internalized, it doesn't feel like a façade of false self, it feels like a part of the person. There is a need for integration and processing, and out of that comes transference.

h) When thinking about the hero's journey, I believe the hero is the patient. But imagine the desire of a patient to make you the hero and give you the power so they do not have to face the dragon themself. When you are properly in the hero's journey, you are one of many guides, not the main character. Maybe they come with an unmet need that they need to work through. The temptation is to move into the hero role, but the frame is to stay grounded as the guide. Now, their hero's journey is an internal one, not necessarily an external one. The internal is the walk into the parts of their life that are chaotic, potential "identity diffusion."
   i) Often the patient-hero has untapped creative genius (especially in those with high openness on the big 5). So much of it is blocked for various reasons. The identity is diffuse, often not fully in touch with emotions, desire, playfulness, or huge unconscious resistances that lead to a lack of their creative life being explored.

ii) Their self-hatred may cause you to become the villain in terms of transference. You may become the object of the hate or the idealized person. They will test you to see if you are as they fear you to be (uncaring, unloving, laughing, critical) and they will, at some point (if you are doing this properly), idealize you and feel comforted by the representation of you in their mind, a solid object that has unmoving compassion. This is where you need to, as Dostoevsky pointed out, give them their internal locus of control, their freedom, and step out as a guide, but keep them as the hero of their story. This will require you not being the mother who won't let them go (the Oedipal mother), not being the narcissistic dictator who wants all the power, not being the obsessive compulsive who would leave them in theory and intellectualize where heart and mind need connection. This person is the guide who distracts from the person's creative core. You have to not be the villain who adds your own chaos back into their life, while you also have to not be the silent observer of the hero's story, which they might see you as, and allow the patient to know this is a real relationship and you are affected by them.

i) Viktor Frankl says this is achieved by stopping at the most true part of them. The way to do this is through love. "Love is the only way to grasp another human being in the innermost core of his personality. No one can become fully aware of the very essence of another human being unless he loves him. By his love, he is enabled to see the traits and features in the beloved person; and even more, he sees that which is potential in him, which is not yet actualized but yet ought to be actualized. Furthermore, by his love, the loving person enables the beloved person to actualize these potentialities. By making him aware of what he can be and of what he should become, he makes these potentialities come true." Rumi said, "Your task is not to seek love, but merely to seek and find all the barriers within yourself that you have built against it."

Acknowledgments:

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Further reading:

Levy, K. N., Draijer, N., Kivity, Y., Yeomans, F. E., & Rosenstein, L. K. (2019). Transference-focused psychotherapy (TFP). *Current treatment options in psychiatry*, *6*(4), 312-324.

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Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. Routledge.

Microexpression Training: here