Reading Therapies Group 24th Feb 2018

When psychotherapy is harmful

Phil Mollon PhD

Psychoanalyst and Energy Psychotherapist

President of the Association for Comprehensive Energy Psychology [ACEP]

[See end for resources to reduce harm, slide 84, and additional references]

Themes and structure of the talk

- Research indicates that psychotherapy is often not very effective in alleviating people's problems – and can sometimes leave people in a worse state
- The legitimate goals of psychotherapy (in my view) are to do with reducing a person's internal obstacles to work and love
- Some goals of psychotherapy seem less legitimate – and may implicitly promise illusions
- The excessive pursuit of transference, or excessive privileging of the 'relationship' can be unhelpful
- The original sensible and simple mode of therapy developed by Freud has become perverted in a variety of ways
- EMDR offers an illustrative model of therapy that contrasts with many more traditional forms and styles of psychotherapy
- ADHD provides an illustration of impaired ego functions – impaired relationship to reality
- The ethics of listening

Bad experiences I have heard about

- A patient sees an analyst for 30 years – but the problems are unresolved
- A patient is in a long analysis – does not feel he/she is improving – but the analyst discourages him/her from leaving, pointing out how many problems are unresolved and arguing that ending would be a defensive escape
- A patient experiences the analyst as constantly belittling them – his/her self-esteem is eroded – but they feel unable to leave
- A patient is told that the only approach that will help them is a long analysis 5 times a week

Bad experiences ctd

- In an assessment/intake meeting, a woman patient from South America is described. She is distressed about her brother who is one of the 'disappeared' – the military rulers engage in aggressive repression of protesters. The senior analyst remarks that this woman's problems are to do with her own projected aggression
- The analytic work dwells exclusively on the supposed unconscious relationship of patient to analyst – any reference to external events, or to the historical past, are taken as metaphorical speech relating to the present interaction
- The analytic work continues for years, but crucial early traumatic experiences are never addressed
- Early trauma is addressed continually – with the result that the patient becomes increasing depressed and retraumatised

Bad experiences ctd 2

- An NHS patient with severe regional pain syndrome (a terrible degenerative condition triggered by injury) will soon be better if she has CBT
- A patient is told that CBT will cure her anxiety – when it does not, she experiences even more panic
- A traumatised patient is taught 'anxiety management' techniques by her CBT therapist, but the trauma itself is not addressed
- An NHS Trust pays a large amount of money for a patient with chronic OCD to attend a prestigious in-patient unit specialising in these problems, using CBT methods. Whilst there the patient makes some improvement. After discharge, she gradually returns to her previous level of functioning
- A patient is referred for psychotherapy because of 'unexplained medical symptoms' – but he/she has Lyme disease or Ehlers-Danlos Syndrome
- A patient undergoes years of psychotherapy without the therapist being aware the client has ADHD or Autistic Spectrum conditions

The Elephant on the couch – side effects of psychotherapy

[Berk & Parker, 2009]

- “The longer any patient attends a psychotherapist, irrespective of how therapeutic the therapy, the patient risks contracting their independent capacity to make decisions (self-mastery), whether by deferring in sessions to their therapist or by filtering decisions outside therapy through the therapist’s decision-making model. The risk is for the patient to remain in a therapeutically shaped ‘comfort zone’, distanced from the capacity and risks inherent in making their own mistakes in the real world and, more importantly, learning from them, and so shifting their interpersonal investments to limit primary and extended relationships.”
- **Australian and New Zealand Journal of Psychiatry 2009; 43:787-794**

The case of Osheroff

- "Osheroff, a 42-year-old physician, was admitted to Chestnut Lodge with symptoms of psychotic depression, received near daily intensive psychotherapy and, over his 7 month admission, was denied medication despite his own requests. Subsequently transferred to another hospital, he recovered after receiving psychotropic medication, although his wife had left him, he had lost his hospital accreditation and his medical partner 'ousted him from their joint practice' during his extended hospitalization. Osheroff sued for malpractice on grounds that he should have received medications of demonstrated efficacy rather than intensive psychotherapy." [Berk & Parker, p 787]
- **Reported by: Shorter E. *A history of psychiatry: from the era of the asylum to the age of Prozac*. New York, NY: John Wiley and Sons, 1997.**

[Elephant etc.] Dangers of emotional arousal

- It has been suggested that therapists who induce high emotional arousal may inadvertently cause an increase in alcohol consumption, especially in those with comorbid mood disorders. **Dishion TJ, McCord J, Poulin F. When interventions harm. Peer groups and problem behavior. Am Psychol 1999; 54: 755764.**
- Interventions that risk increasing a person's feeling of being stigmatized or in which they are blamed for not meeting intervention targets, have been held to increase helplessness and self-blame, and so undermine self-efficacy. **Marlatt GA, Gordon JR. Relapse prevention: maintenance strategies in the treatment of addictive behaviors. New York, NY: Guilford Press, 1985**

[Elephant etc] Hazards of CBT

- CBT assumes that the individual has an ongoing cognitive schema that causes them to view themselves, the world and their future with negative ascriptions. Therapy is designed to challenge their cognitive assumptions and encourage behavioural repertoires generating more positive outcomes. The focus on rational thinking assumes a certain level of reasoning capacity, which may be lacking due to low intelligence or current symptoms. Some patients confronted with such expectations and unable to meet them (particularly as a consequence of severe depression) may have their sense of self-worth further undermined. Further, CBT shifts responsibility onto the individual for active engagement and conduct of the techniques. A recipient may feel guilty if treatment does not result in the expected improvements, without realizing that there are many other factors that may affect response.

Dangers of mindfulness

- Adverse effects of meditation: a preliminary investigation of long-term meditators. *David Shapiro. Int J Psychosom. 1992;39(1-4):62-7*
- Of the twenty-seven subjects, seventeen (62.9%) reported at least one adverse effect, and two (7.4%) suffered profound adverse effects – including anxiety, panic, and depression.
- *The Buddha Pill,* by Miguel Farias and Catherine Wikholm (Watkins, 2015) – explores the dark side of mindfulness

The varieties of contemplative experience: A mixed-methods study of meditation-related challenges in Western Buddhists:

Jared R. Lindahl, Nathan E. Fisher, David J. Cooper, Rochelle K. Rosen, & Willoughby B. Britton: PLOS: 24th May 2017. Open Access

- investigated meditation-related experiences that are typically underreported, particularly experiences that are described as challenging, difficult, distressing, functionally impairing, and/or requiring additional support.
- a taxonomy of 59 meditation-related experiences:
- “The associated valence ranged from very positive to very negative, and the associated level of distress and functional impairment ranged from minimal and transient to severe and enduring.”

[Elephant etc] Dangers of psychodynamic therapy

- High session frequency and length of treatment make danger of dependency particularly salient
- May meet multiple needs so that life outside therapy is neglected
- Decreased capacity for independent judgement
- Therapist's reflective style "risks being viewed by the patient as lacking empathy, being at variance with the style of communication that underlies usual reciprocal and rewarding human interaction"
- "A potential consequence of externalizing attributions of current difficulties to the behaviour of others (particularly parents) is estrangement, disengagement and passive adoption of the victim role."
- "Over time, long-term bonds of attachment to the therapist may make termination of therapy a traumatic life event, particularly if transference has been an important therapeutic component."

Adverse therapeutic styles: Experiences of Therapy Questionnaire

- 4 adverse therapeutic styles [based on 700 respondents]:
- 1. lack of empathy or respect; not having the patient's interests at heart
- 2. preoccupied therapist who made the patient feel alienated and powerless
- 3. controlling therapist who encouraged dependency
- 4. passive therapist who was inexperienced, inactive, or lacked credibility
- **Development of a measure quantifying adverse psychotherapeutic ingredients: the Experiences of Therapy Questionnaire (ETQ). Parker G, Fletcher K, Berk M, Paterson A. Psychiatry Res. 2013 Apr 30;206(2-3):293-301**

The clinical dilemma with traumatised people

- Traumatised people may be retraumatised by the process of talking of their trauma.
- This is particularly the case with those who have experienced multiple abuse traumas in childhood – people with severe personality disorders.
- Such people may be traumatised by an ordinary empathic psychotherapeutic consultation.

Traumatic memory functions as an internal phobia

- Traumatic memories act like internal phobic stimuli – generating avoidance.
- Over time they consume more and more psychic resources.
- Mental (and behavioural) life becomes impoverished and restricted.
- The traumatic memories need to be processed/desensitised.

Exposure to traumatic memory

All effective treatments for trauma, in effect, follow the principles proposed by Foa and colleagues:

1. Traumatic memories, and trauma-related affect and cognitions, must be activated

2. Trauma-discrepant information is provided

“Flooding and exposure are by no means risk-free treatment techniques” [van der Kolk, Mcfarlane, van der Hart 1996]

Danger of sensitizing (rather than desensitizing)

Excessive arousal evokes reliving of trauma and blocks the taking in of new information

Intense fear and discomfort provoke avoidance

Arousal blocks mentalizing

"…mentalizing goes offline in the context of intense emotional arousal as the fight-flight response comes online" [p 134]

"…thresholds for switching out of mentalizing can be lowered by early trauma" [p 146]

Mentalizing in Clinical Practice, by J.G. Allen, P. Fonagy, & A. Bateman [American Psychiatric Publishing 2008. Washington DC]

“can get worse rapidly”

- “Given the combination of sensitization and impaired mentalizing, we should not be surprised that persons with a history of attachment trauma can get worse rapidly in excessively expressive treatments that focus exclusively on talking emotionally about traumatic experiences.” [p 223]

EGO FUNCTIONS IN SCHIZOPHRENICS, NEUROTICS, AND NORMALS

A Systematic Study of Conceptual, Diagnostic, and Therapeutic Aspects

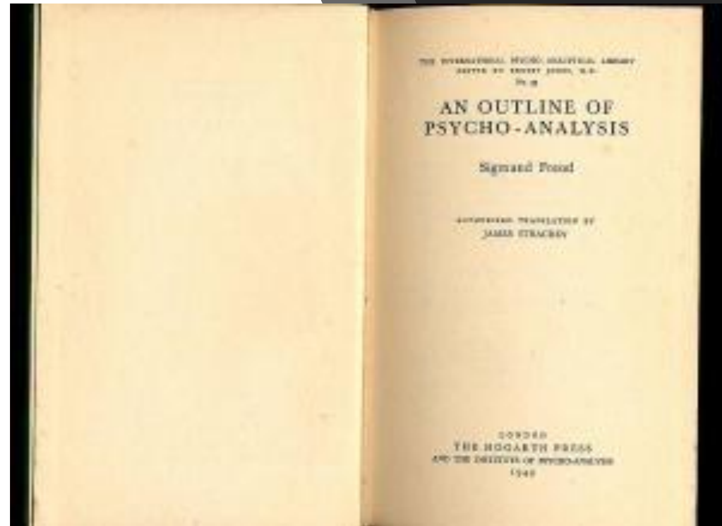
Leopold Bellak, Marvin Hurvich, and Helen K. Gediman

A volume in the Wiley Series on Personality Processes, edited by Irving B. Weiner

The functions of the ego – dealing with [1] inner needs and desires, [2] internal moral values, [3] external reality Freud: An Outline of Psychoanalysis. 1940

- "An action by the ego is as it should be if it satisfies simultaneously the demands of the id, of the super-ego and of reality – that is to say, if it is able to reconcile their demands with one another.
- The details of the relation between the ego and the super-ego become completely intelligible when they are traced back to the child's attitude to its parents. This parental influence … includes … not only the personalities of the actual parents but also the family, racial and national traditions handed on through them, as well as the demands of the immediate social milieu which they represent. … [T]he super-ego … receives contributions from later successors and substitutes of his parents, such as teachers and models in public life of admired social ideals." [Freud, 1940. p 146]

The psychoanalytic task
Freud: An Outline of Psychoanalysis. 1940

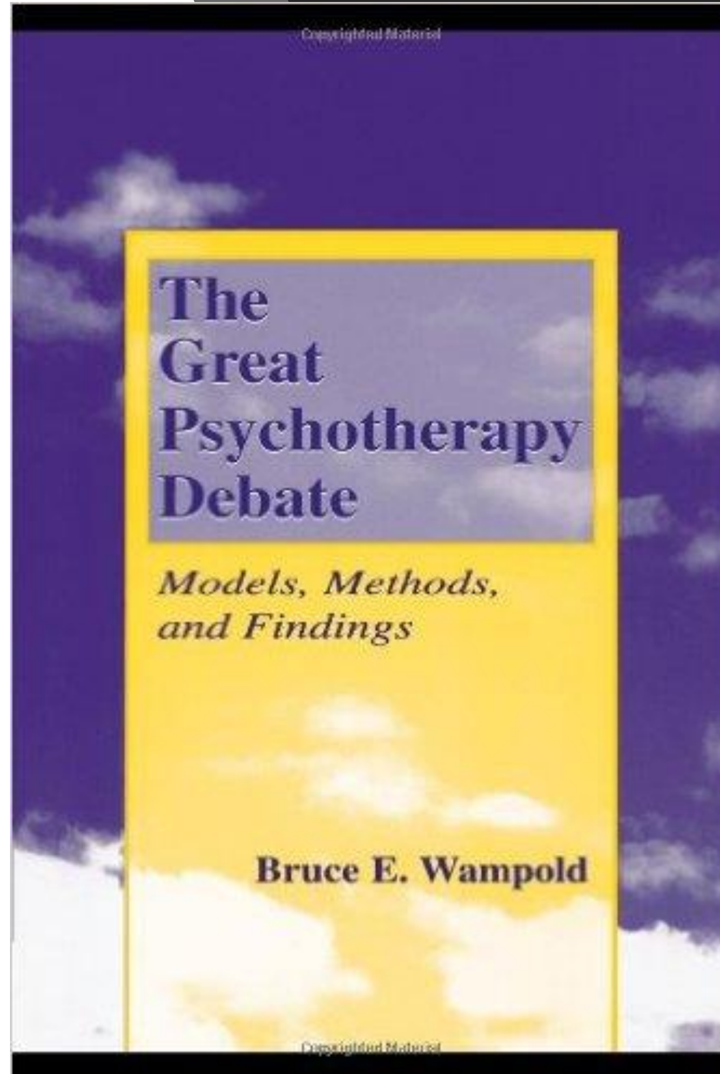

AN OUTLINE OF
PSYCHO-ANALYSIS

Sigmund Freud

JAMES STRACHEY

THE HOGARTH PRESS

- “The ego is weakened by the internal conflict and we must go to its help. The position is like that in a civil war which has to be decided by the assistance of an ally from outside. The analytic physician and the patient’s weakened ego, basing themselves on the real external world, have to band themselves together into a party against the enemies, the instinctual demands of the id and conscientious demands of the super-ego. We form a pact with each other. The sick ego promises us the most complete candour – promises to put at our disposal all the material which its self-perception yields it; we assure the patient of the strictest discretion and place at his service our experience in interpreting material that has been influenced by the unconscious. Our knowledge is to make up for his ignorance and to give his ego back its mastery over the lost provinces of his mental life. This pact constitutes the analytic situation.” [p 173]



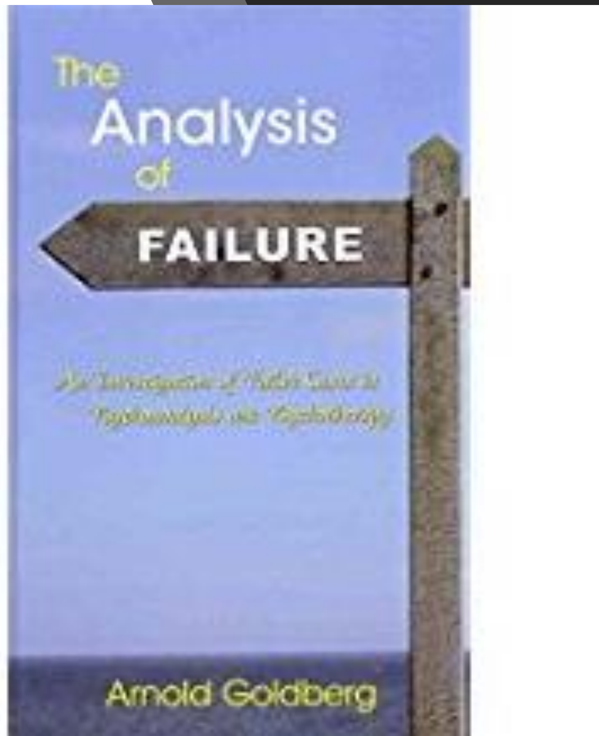
The truth about psychotherapy: it sometimes is not very effective!

- Best results from research suggest around 60% of clients benefit
- About 8% of adults deteriorate during psychotherapy [Lambert]
- 15-24% of adolescents leave therapy in a worse state than when they started [Lambert]
- Only 6% of people referred to the IAPT programme recovered (43% of those who completed treatment recovered) [Parry et al.]
- The most consistent finding in psychotherapy research is that when genuine therapies are compared there is very little difference in outcome [Wampold]
- There is much more difference in effectiveness between therapists than between therapies [Wampold]

Psychotherapists' 'Blind Spot'

- 90% of psychotherapists think their treatment outcomes are better than those of their peers! [Michael Lambert]
- Lambert et al. asked 40 therapists (20 qualified and 20 trainees) to identify patients who were deteriorating and might leave therapy worse off. The researchers identified 40 out of a sample of 350 patients (using objective measures) – but only one therapist (a trainee) identified one deteriorating patient. The qualified therapists did not identify a single case!
- "Psychodynamic therapists are usually over-confident in their clinical judgement" [Lambert]
- https://www.psychotherapy.net/interview/preventing-treatment-failures-lambert#section-the-blind-spot

Doing what we do



- “We do what we do and explain both success and failure on the basis of the theoretical approach that is most congenial to us. Perhaps that is a mistake …” [p 106]
- “We do what we do, and we regularly and sometimes persistently keep on doing it. Sometimes it works, and sometimes we lose patients” [p 116]

Addiction to psychoanalytic beliefs

- “ .. in the largest number of instances, a future analyst’s training commits him … to a particular set of theoretical beliefs. With very rare exceptions … the analyst does not stray from these beliefs, which he comes to make his own. Rather, he defends them loyally, displaying hostility and contempt toward those who do not share them. … I do not believe that groups whose members display such deep and unswerving loyalty to specific sets of theories are encountered with equal frequency in other sciences.” [Heinz Kohut: How does analysis cure? 163]

Lilienfeld's 'Potentially Harmful Therapies' [PHTs]

- Survey of 12 leading outcome researchers found agreement that about 10% of clients deteriorate during therapy
- Symptom worsening
- Appearance of new symptoms
- Excessive dependence on therapist
- Harm to family members
- Reluctance to seek other treatment
- Opportunity costs – not seeking more effective treatment

Lilienfeld, S. O. 2007. Psychological Treatments That Cause Harm. *Perspectives on Psychological Science*, 2(1) 53-70

Dr. Scott O. Lilienfeld

PHTs identified by Lilienfeld

- Critical incident stress debriefing
- ‘Scared Straight’ programmes for young offenders
- Grief counselling for normal bereavement reactions
- Boot camp interventions for conduct disorder
- Drug abuse programmes
- Therapies focused on identifying early trauma
- **All these may involve exposure to intense emotion**

We all may cause harm

- “However painful it may be, it is important for those of us who are psychotherapists to recognize that we have all likely harmed one or more of our clients. … we would venture to guess that all experienced psychotherapists have, at one point or another in their careers, failed to meet the most basic and ethically important principle guiding the profession: First, do no harm”
- **Castonguay et al. 2010. Training Implications of Harmful Effects of Psychological Treatments. American Psychologist, 65(1), 34-49**

Legitimate goals of psychotherapy

- To help the client resolve internal obstacles to achieving goals and satisfying desires in relationships and in work
- Supporting Freud's view of mental health as the capacity to love and work
- Help to counter unrealistic illusions about life (including illusions regarding psychotherapy)
- Facilitate the shift from neurotic misery to ordinary unhappiness (Freud)

Three interrelated forms of internal obstacles

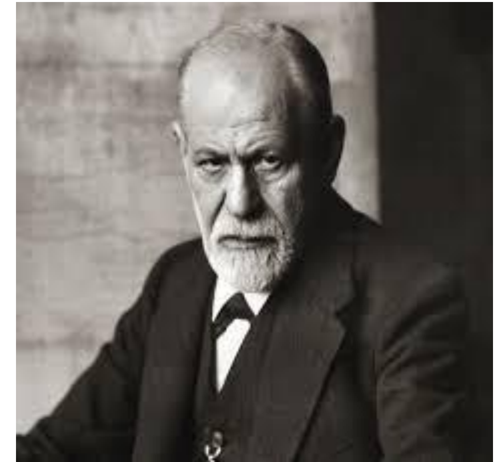
- Psychodynamic conflict
- Trauma
- Impaired ego functions – insufficient dominance of the reality principle

Goals that are not legitimate

- Offering formulas for illusory happiness
- Persuading the client to adopt the therapist’s world view, values, and life strategies
- ‘Reparenting’, creation of ‘secure attachment’, or other attempts to provide reparative experiences that would compensate for traumas and deficiencies in childhood
- The therapist as “one who knows” – the analyst is not in possession of special insights or knowledge concerning the secrets of life

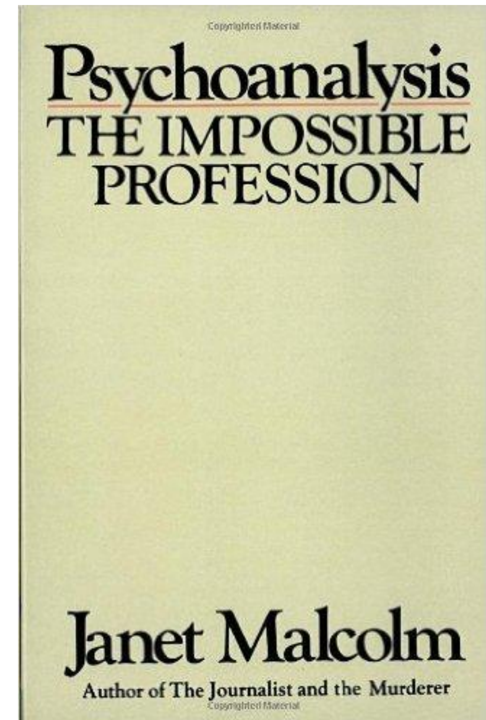
When psychotherapy loses its legitimate purpose …

- A waste of years of life (and money)
- The endless pursuit of ‘transference’ becomes a wild goose chase
- A collusion whereby the analyst gets a regular income and the client gets to postpone reality
- Importance of accepting when [a] therapy is not working, or [b] when therapist and client have done as much as they can do.



Dangers of long term psychotherapy

- Becomes a substitute for 'real life'
- A massive drain of financial and psychological resources
- The 'transference neurosis' is never resolved – the client keeps hoping the conflictual relationship with the therapist will be put right, but it never is
- A focus on transference – particularly negative transference – entrenches the client in a narcissistically wounding relationship that is pervaded with hostility – the aggressive drive is constantly provoked
- The absence of childhood (historical-developmental) context, traps the client in a conflictual dyad that is experienced as real. It is the historical-developmental context that reveals the transference as illusion



The Big Illusion

- An implicit idea has become prevalent in our culture that the psychotherapeutic relationship can somehow make up for, or repair, what went wrong or was missing in childhood
- This is fostered by a prevalent emphasis upon the crucial role of the therapeutic relationship – in the 'here and now' fashion of transference interpretation – in 'relational psychoanalysis' – in attachment based psychotherapy - and in Rogerian based counselling
- It is a dangerous illusion – likely to lead to malignant regression and a toxic transference relationship pervaded by intense need, rage, and ultimate disillusionment over wasted years

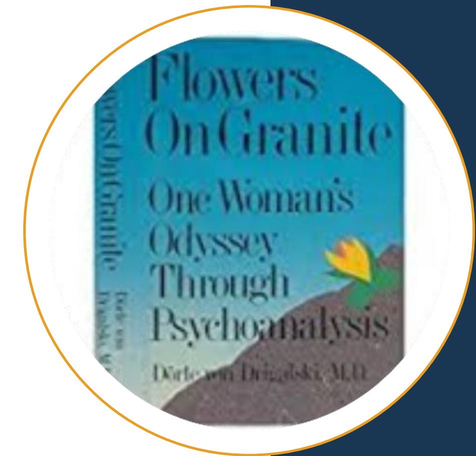
A study of clients who terminated early

- Content analysis of the final session
- Preponderance of transference interpretations
- Client expressions of frustration with therapy were interpreted as transference reactions
- A power struggle, marked by therapists “being sharp, blunt, sarcastic, insistent, impatient, or condescending”

- **Piper, W. E., Ogrodniczuk, J. S., Joyce, A. S., McCallum, M., Rosie, J. S., O’Kelly, J. G., & Steinberg, P. I. (1999). Prediction of dropping out in time-limited, interpretive individual psychotherapy. Psychotherapy: Theory, Research, Practice, Training, 36, 114–122.**

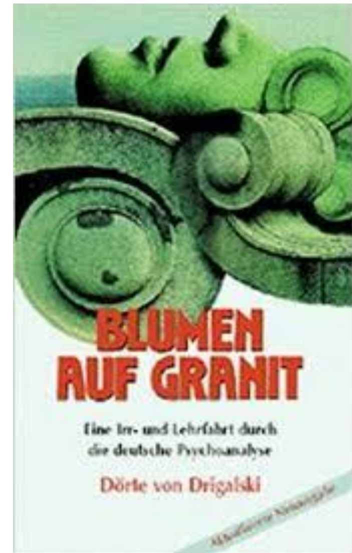
Dorte von Drigalski: Flowers on Granite

- An analysis not going well – analyst appears cold and aloof – patient is furious and desperate, presses him why he appears indifferent. He says “if I were to tell you just how much I’ve suffered from this analysis, how it’s worn me down, well, I just can’t tell you; you’d never recover from your guilt feelings” [p 174]
- “I was all at sea: what kind of powerful, destructive, omnipotent person was I if I could do such a thing? Make a training analyst suffer to the point where it wasn’t even possible for him to tell me the extent of his suffering and of my own destructive rage” [p 175]



“I was destructive, unwholesome, unendurable”

- “I pressed him to say more. He seemed to be very uncomfortable. Yes I had caused changes in the structure of his family life; his wife had been angry about the strain I put on him. In what way? Well she would have liked to see the analysis come to a speedy end. I was doing him in. … When I questioned him further, he finally and definitely said: doubt had arisen in regard to his general ability to live.
- So it was all connected with my castrating tendencies, my destructive basic structure which damaged his ability to love and made him doubt himself. My hating, loveless, unloving inner being, bringing turmoil to everything … As a person, a human being, a woman, an analysand and an intellectual partner I was destructive, unwholesome, unendurable, exacting.” [p 175]



Drigalski's reaction to the analyst's threat of abandonment

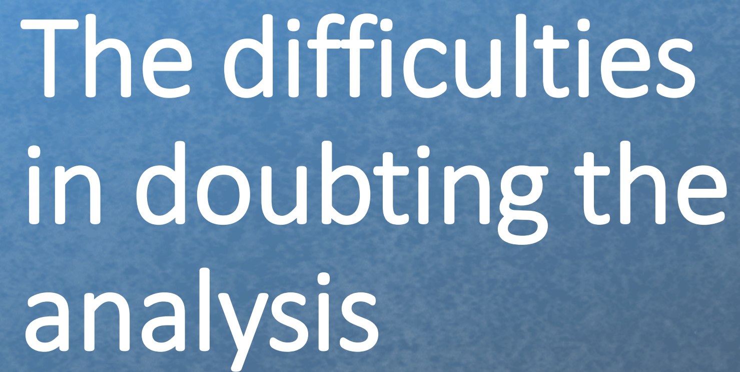
- "I often felt I was at the end of my tether. It was a blow when, during one of our arguments, he remarked wearily, and with obvious irritation, "Then you will just have to end the analysis." The worst thing about this remark was his tone of voice. I couldn't help seeing that he had had it with me, was utterly, totally fed up with me, and just now he could wish for nothing better than to be free of me at last. I disgusted him …. I wept my heart out at home
- What was so fundamentally unlikeable about me? What was it, deep down inside me? Something that no one could ever possibly love? Something of which I knew nothing at all myself?" [p 85-87]

Reinforcing the original trauma

- “If there was one trauma, one neurotic failure to work things through which really weighed on me, it surely had to do with my father. The probable interpretations were: (1) Sexuality is deadly; conception is destructive. He had died after my conception. (2) I am deadly, annihilating, destructive: According to my mother’s account of it, life had been delightful before my birth, and after it everything was over: My father gone, wartime, my uncle shot and bleeding to death, economic difficulties. Paradise was lost at my birth. (3) The evil within me had driven my father away, put him to flight: He didn’t want to come back for someone like me. It wasn’t worth staying or coming back for such a malevolent, competitive creature …” [p 88]

Von Drigalski “diagnosis”

- “I wanted a diagnosis and asked for one. It came slowly, with difficulty: ‘Sensitive paranoid personality, narcissistic disturbance.’ This was partly fashionable and partly outmoded. The idea of paranoia had been a bone of contention between us; I thought that he simply had no empathy for my sensitive perceptions, and that was why he described them as crazy” [p 188]



The difficulties in doubting the analysis

- “It really was extremely hard to admit (to myself, too) that six years of life, of intense identification, emotional activity and introspection had done me no good, had injured me, possibly changed me irreversibly, and that in any case it would take me some years to build myself up again, even if I could do it at all.” [p 242]
- “Doubting … [the analyst] … would mean questioning the whole analysis, one’s entire personal commitment, the point of the expense of time, emotional and money, and not least one’s professional identity … To doubt the analyst and all institutions his authority is based on , requires self-confidence, something that I for one very soon lost.” [p 243]

It was my fault

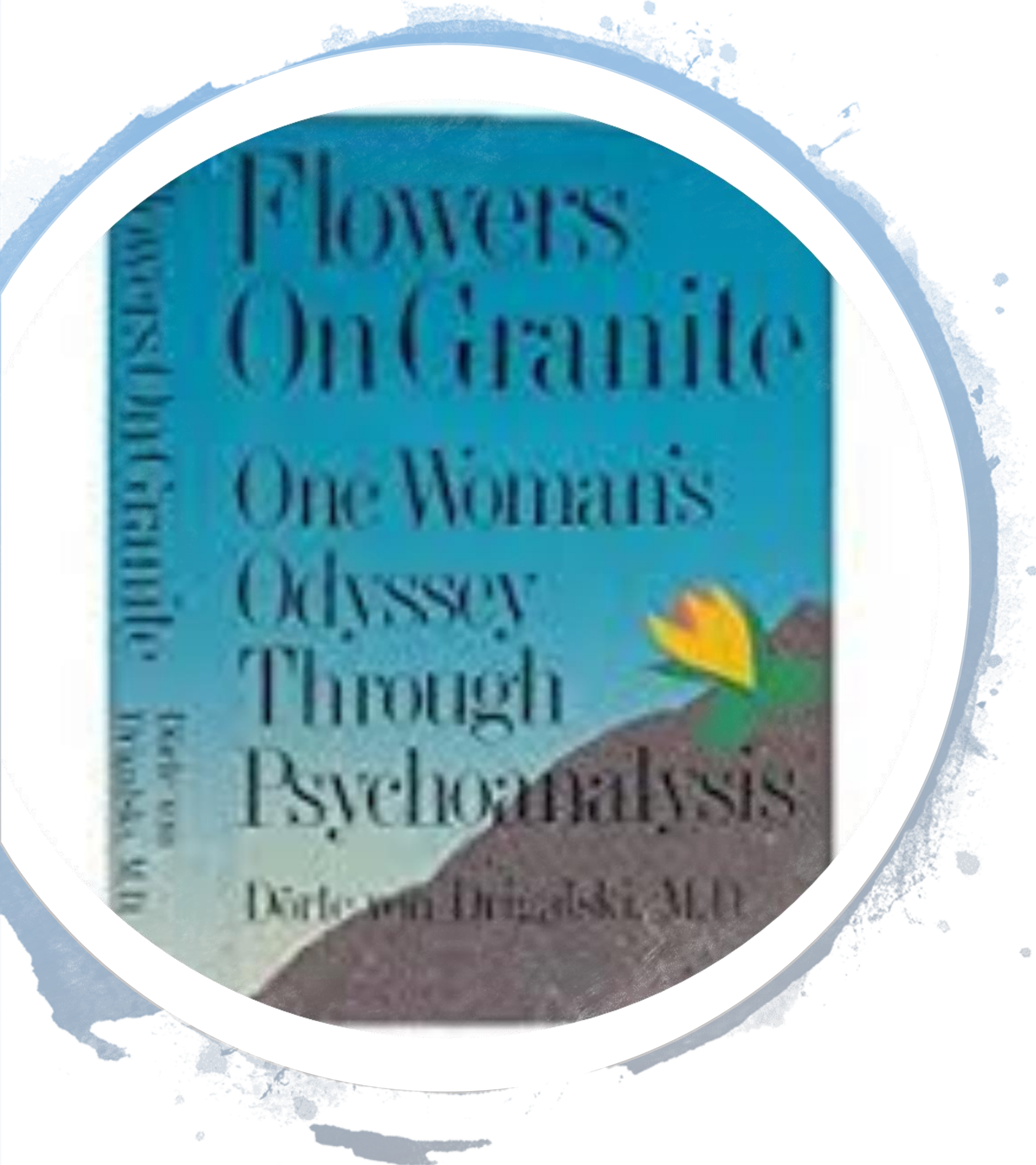
- “The fact that he had been so annoyed with me was my fault: A countertransference reaction. I had forced him to reject me … I had forced the role upon him … Maybe he ought to have seen through the countertransference mechanism quickly so that he could put the brakes on his negative feelings and modify them, but I was a difficult, complicated, sly person, leading him up the garden path, robbing him, as analyst, of power and potency. He was the recognized analyst; I was the hard case.” [p 89]

Adverse characteristics of Drigalski's analyst

- Facilitated dependence but then threatened abandonment
- Argued with the patient about her perceptions – suggesting she was 'paranoid': "I felt as if the session were a wrestling match. Arguments, wrangling, attempts to prove our points as if we were in a law court" [p 56]
- His pleasant demeanour shifted to cold and hostile
- He was dogmatic: "He insisted on his own interpretation" [p 50]
- He lacked empathy
- He blamed the patient

Drigalski 'Afterword'

- "During the course of my writing I heard of many cases of analysands becoming seriously ill, suffering fatal accidents, even committing suicide. It would be irresponsible to dismiss these events as accidental. It does not make sense to me to declare them to be the unavoidable consequence of the original neurosis." [p 286]
- "Readers who wrote to me from all over convinced me that the experience of deterioration in psychoanalysis is the rule, not the exception: some people in analysis became 'psychotic', some were sent to psychiatric institutions; some became deeply depressed or remained in such a depression; some became addicted to alcohol or drugs; some killed themselves; as did some of my fellow trainees. I was actually luckier than most." [p 287]



Drigalski's final sentence

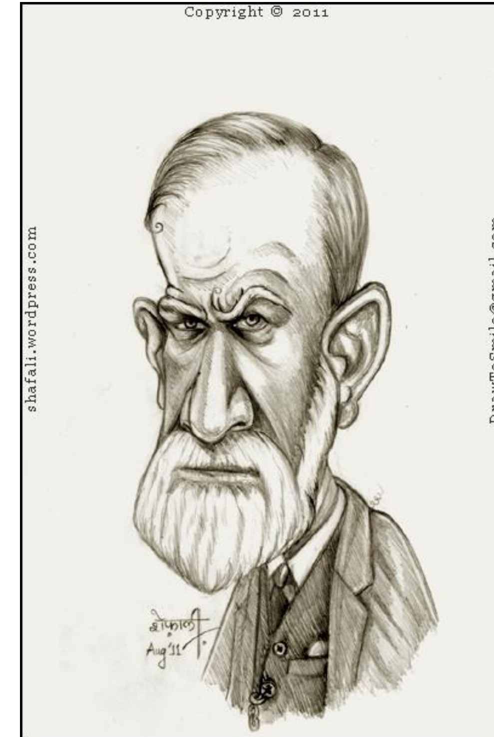
- "All things considered, having both been in therapy and dispensed it for many years, I would now take the position that the climate created by psychoanalysis destroys human relations, and that by and large psychoanalytic treatment does more harm than good." [p 288 August 1986]

Some of the more obvious ways that analysis can become perverted in the service of destructiveness toward the patient

- Making hurtful interpretations
- Aggressively imposing a theory on the patient
- Being disparaging of other analytic theories that the analyst does not favour
- Charging very high fees, or raising them unduly
- Allowing a patient to spend a very high proportion of his or her income on psychoanalysis
- Coercing, by means of 'interpretation', the patient to have more sessions per week

Perversion of analysis 2

- Discouraging independent and autonomous action or decision by the patient without the issues being first explored extensively within the analysis
- Maintaining the patient in a position of infantile dependence on the analyst
- Placing emphasis upon the patient's psychopathology – including pathologising aspects that are actually common within the population
- Discouraging the patient from ending analysis, on the grounds that the analysis is not 'finished'
- Allowing the patient to idealise analysis and persist with it, despite a lack of evidence that he or she is benefiting



Perversion of analysis 3

- Allowing the patient to continue in analysis despite indications that his or her libido is so bound up with the analysis and the analyst that life is passing by – so that the analysis has become a substitute for life rather than a stepping stone into a more rich and free life
- Sticking to a strict analytic stance (e.g. avoidance of friendly gestures, only interpreting here-and-now transference, or other modern fashions of technique) that is in the service of sadistic control and withholding
- Subtly denigrating or dismissing the patient's own insights and perspectives

Transmission down the psychoanalytic generations – a hypothetical process

- **The analyst adheres to a 'strong' theory – rigidly held, all-encompassing, perceived as 'deep'**
- **The analysand's own perceptions, beliefs, and emotions are consistently invalidated**
- **Perspectives based on the analyst's 'strong theory' are substituted for the analysand's original view**
- **The analysand may leave**
- **If the analysand does not leave, he or she will identify with the aggressor, learn the theory, and impose it on self and others**
- **May result in a perverse and cultish variant**
- **Contrast with the alternative view of the analysand as 'an unknown Other'**

Alienating effects of diagnostic labels

- The commercially organised nature of the NHS requires all patients be given a diagnosis, and then be provided with treatment specified by the NICE guidelines for that particular diagnosis
- The diagnosis has commercial implications
- It appears on all letters
- The client is then inclined to identify with the diagnosis – alienating them from their own lived experience
- This becomes another false self
- A hall of mirrors effect

Misuse of the diagnosis of ‘personality disorder’ (particularly BPD)

An alienating imposed identity

With a plethora of negative connotations

The diagnosis is unstable and shows low inter-rater reliability, test-retest reliability, and internal consistency

Information about the course, family history, laboratory and physiological correlates of PD is largely absent.

‘Treatments’ are imposed (by the NHS and by courts) on the basis of these flawed diagnoses

The ‘logic’ of the diagnosis of personality disorder

- Why does Sally get depressed, feel anxious, and sometimes self-harm?
- Because she has a borderline personality disorder
- How do you know she has a borderline personality disorder?
- Because she gets depressed, feels anxious, and sometimes self-harms

It matters!

- Mothers and children are torn apart.
- Family courts are bound to rely on the opinions expressed by ‘experts’
- The experts seem unaccountable
- They express personal opinions as if objective scientific or medical fact.
- A PD is alleged to exist when there is no current evidence
- Forms of therapy are prescribed by courts

Basic thesis regarding transference in psychoanalysis

- A profound slippage from the clarity of Freud’s concept is apparent in contemporary usage of ‘transference’
- Many practitioners have implicitly forgotten that transference is ‘a menacing illusion’ [Freud 1940 p 176-7]
- Transference is treated as if it were real.

5 ways in which ‘transference’ is misused

- Everything is related to the therapist
- Everything in the relationship is called ‘transference’
- The ‘transference’ is continually addressed without interpreting it clearly as [a] repetition, [b] projection, [c] selfobject structure seeking, [d] character structure
- Transference not linked to reconstruction of the developmental past
- Excessive preoccupation with the ‘negative transference’, of malignant hostility & envy.

Arthur Couch – his analysis with Anna Freud

- “Anna Freud was a listening companion of my current life and a knower of my past life. She never commented on the here-and-now interaction between us. Such interpretations about the ongoing communications would have seemed very foreign to the analysis that was focused on our task of working together.” [Couch 2002]

Topographic transferences

- Freud's broader concept of transference (Freud 1900), as a penetration of unconscious contents into the preconscious and conscious mind
- These might be viewed as 'topographic' transferences, whereby content leaks from one area of the psyche to another

Historical transferences

- The more specific transference of infantile images of the past onto the present figure of the analyst might be considered the ‘historical’ transference (although the ‘past’ images are alive in the present unconscious).

Kohut's selfobject transferences

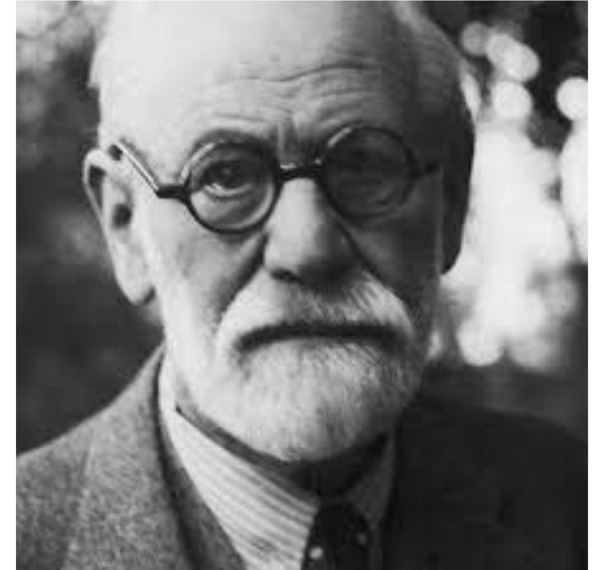
- Kohut identified the selfobject transferences whereby the patient is attempting unconsciously to establish a systemic functional connection with the analyst, whereby narcissistic equilibrium, affect regulation, and soothing are sustained sufficiently to allow the aborted developmental processes of the self-structure to be re-engaged.

The Freud-Kohut view

- The combination of the original Freudian (topographic and historical) concepts of transference, with the addition of Kohut's concept of the selfobject transference, forms a powerful lens and technical instrument to facilitate an optimum psychoanalytic process. I call this the Freud-Kohut view of transference.

Freud: Memory v transference

- "He [the patient] is obliged to *repeat* the repressed material as a contemporary experience instead of, as the physician would prefer to see, *remembering* it as something belonging to the past
- It has been the physician's endeavour to keep this transference neurosis within the narrowest limits: to force as much as possible into the channel of memory and to allow as little as possible to emerge as repetition." [Beyond the Pleasure Principle 1920]



Modern technique reverses Freud's position

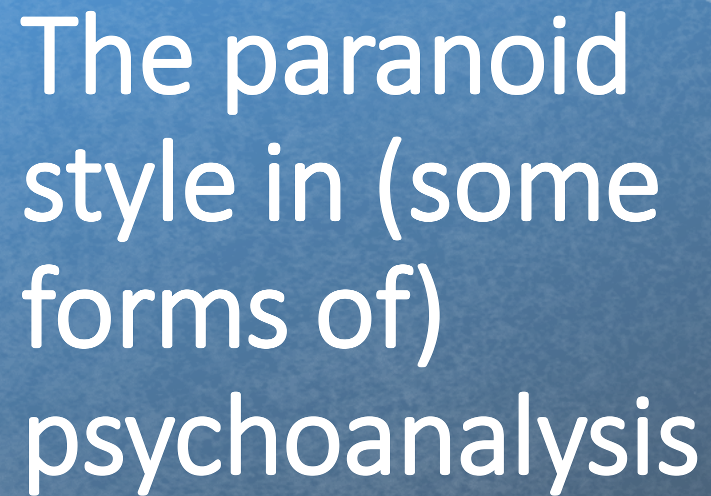
- Modern British technique reverses this stance. Ruth Malcolm's comment:
- "interpretations that refer to the patient's past history, are not the aim of analytic work ..." and that "what should be the centre of the interpretation ... [is] the immediate relationship between analyst and patient, with its verbal and non-verbal expressions" [p 73-74].

Modern ‘here-and-now’ technique

- Malcolm [1986] states:
- “The transference is an emotional relationship of the patient with the analyst which is experienced in the present, in what is generally called 'the here-and-now' of the analytic situation.”

Another modern view Bateman & Fonagy 2004

- “In contrast, the 'modern' view sees transference not so much as the inexorable manifestation of unconscious mental forces, but rather as the emergence of latent meanings and beliefs, organised around and evoked by the intensity of the therapeutic relationship. In clinical application there is a de-emphasis upon reconstruction.” [p 207]



The paranoid style in (some forms of) psychoanalysis

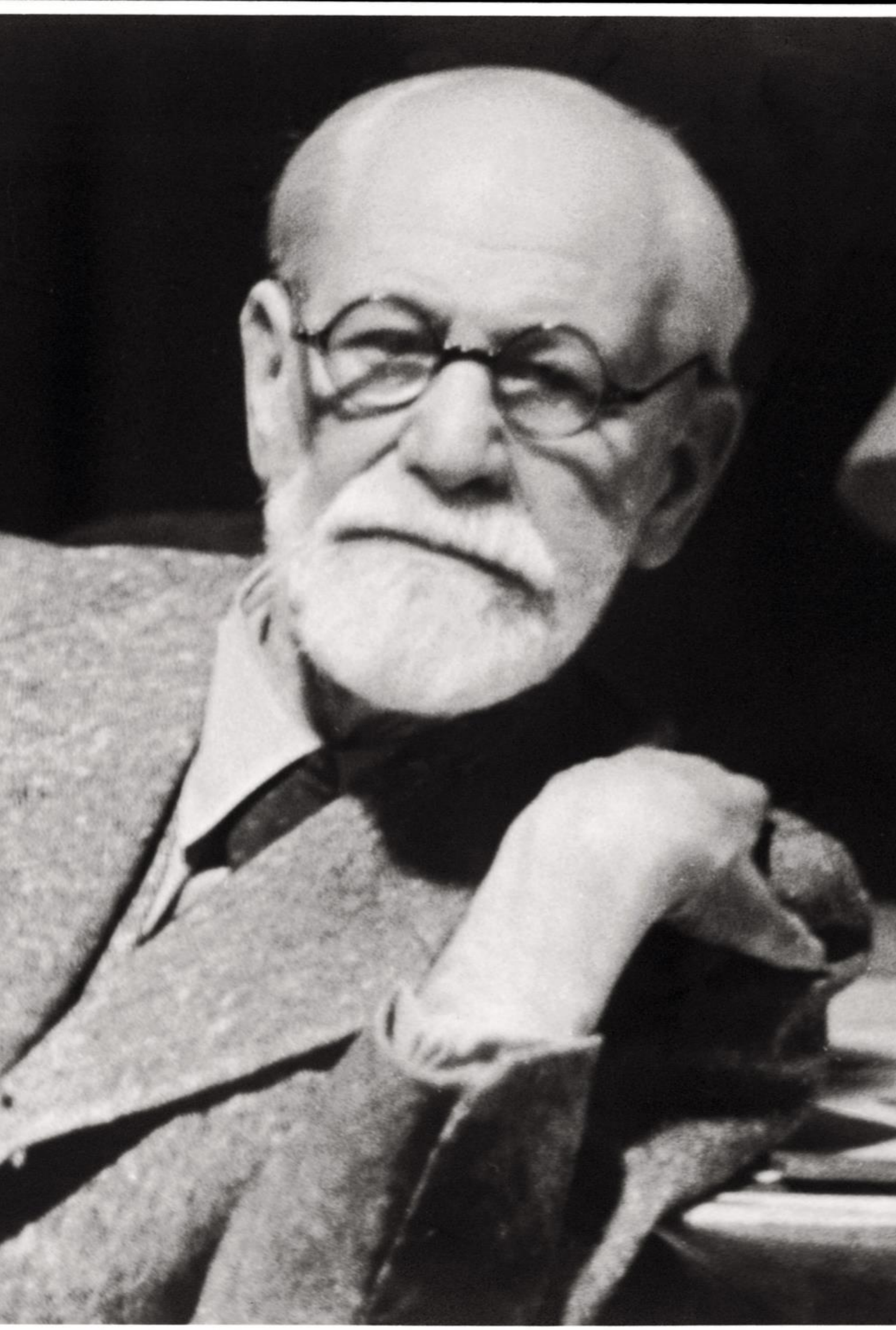
- The patient is viewed with suspicion – as seeking to evade reality, pervert or twist the truth, seduce, or engage in unconscious destructive envious activity
- Attention is paid more or less exclusively to the ongoing ‘here-and-now’ unconscious relationship – seen as pervaded by destructive or perverse motives
- Aggression is given prominence over love and sexuality – Thanatos privileged over Eros
- Discourse about the childhood past may be viewed as a defensive retreat from the present ‘transference’
- All the patient’s remarks are seen as unconsciously referring to the analyst
- Patients are referred to in disparaging terms
- How did this paranoid culture and style arise?

“What is going on in the transference?”

- This insidious question corrupts the necessary state of trust in the client
- It implies something is going on in another order, that is entirely at odds with the client’s conscious communication
- Sometimes this is the case – but at other times what is going on is that the client is trying to communicate his or her distress in the best way they can

Negative consequences of the modern approach

- [1] The privileging of the 'here and now', both in theory and technique, may obscure the significance of childhood traumas and impede their exploration through their disguised unconscious expression in the transference
- [2] Since the modern view emphasises the playing out of the patient's inner object relational world in the relationship with the analyst, there is no need to wait for unknown and unconscious meanings to emerge through free-association – the meanings are all potentially available (to the astute analyst) in the manifest content of the session. This could, however, mean that more hidden unconscious meanings are not discovered, since free-association is replaced by a continual examination of the relationship
- [3] The diminished focus on reconstruction and absence of a continual movement between past and present, could mean that the patient feels trapped in a fused past-present claustrum, from which the 'third party' of history has been excluded from the analytic dyad.
- [4] With the lessened scope for a concept of 'real relationship', the patient may have little space from which to speak outside the transference.



Freud’s last comments – transference as ‘menacing illusion’

- “The danger of these states of transference evidently lies in the patient's misunderstanding their nature and taking them for fresh real experiences instead of reflections of the past … It is the analyst's task constantly to tear the patient out of his *menacing illusion* and to show him again and again that what he takes to be new real life is a reflection of the past” [1940 p 176-7 italics added]

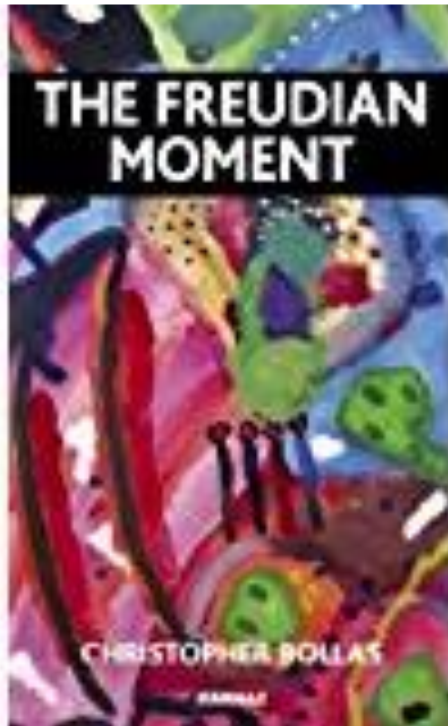
True transference is revelatory

- Something is expressed or enacted in the present that suddenly vividly illuminates the inner life of the childhood past
- Its expression comes from the client – it is not forced by the therapist
- Past and present are suddenly connected in a manner that is completely persuasive
- True transference only arises in a psychoanalytic process. It is not the same as simply an expression of an ‘internal working model’

Lacan: The ‘imaginary’ transference

- Initially the analysand may idealise the analyst as ‘the subject who is supposed to know’. If the analyst colludes with this fantasy that he or she knows, then the two may continue for years in a relationship based on illusion – the register of the ‘imaginary’- endlessly avoiding the primal loss
- Dwelling in the imaginary is one way in which the patient may avoid introspection and free-association
- A healthy stance towards transference is where there is a continual exploration of the information contained in the client’s feelings and fantasies towards the analyst, throwing light on early development – such work takes place within the Lacanian register of the ‘symbolic’
- If the analyst interferes in the client’s life, through action or advice, then he or she has stepped out of the correct realm of the symbolic and has entered the register of the ‘real’

Christopher Bollas, on the 'here and now' fashion of interpretation



- "Here and now interpreters are … highly prejudiced. … Before a session begins the psychoanalyst knows that he or she will listen to the people, places, and events described as portrayals of the analysand's experience of the psychoanalyst in the here and now. …. It is disturbing that this paranoid listening system has led the analyst to view the analysand as always trying to get something over on him. … In the British School, 'what about the transference?' became a speech act: 'Stop thinking about anything else!' " [p 95-99]

- From: On transference interpretation as a resistance to free association. In ***The Freudian Moment***. Karnac. London. 2007

Some experiences are not safe to be represented within the transference

- Early trauma and severe abuse may not be safe to work with in the transference
- Severe emotional deprivation similarly is not manageable in the transference
- Dangers of ‘transference psychosis’
- If the transference is left to unfold without limit, the therapist will inevitably at some point be perceived as the worst abuser in the client’s experience or fantasy
- With severely traumatised clients, the transference is potentially destabilising

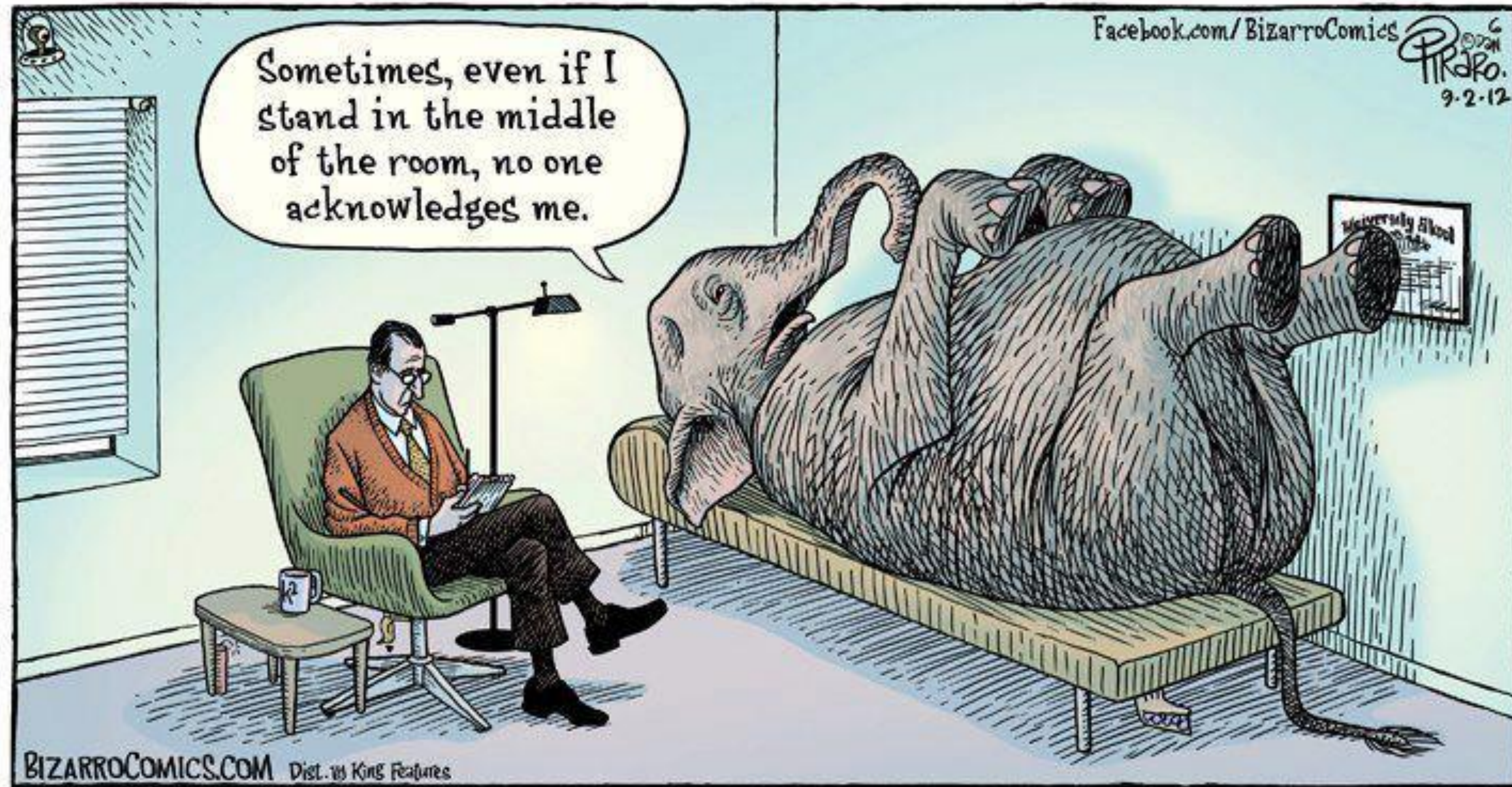
The case of Dr K

- “Clearly the sexual act was not the culmination of a love relationship, nor was it a simple matter of an irresponsible therapist grabbing some gratification where he could find it. It was the desperate act of a therapist who was out of control, primarily with frustration and rage. His patient had continuously accosted him and rendered him impotent as a therapist. He, in turn, blamed her for his inability to take control of the situation, and no doubt fantasized having sexual power where legitimate power as a therapist no longer existed” [p 51]

Ways of discouraging transference

- Be alert to it, but do not seek it out, and do not dwell on it – show no more interest in it than any other material
- Address transference only when it emerges fairly consciously
- Be extremely cautious about transposing the client's narrative about a situation in his or her life as if it were unconsciously a reference to the therapeutic situation.
- Convey the idea (sometimes explicitly) that transference (the client's thoughts, feelings, and perceptions of the therapist) is not in itself important. The significance of transference is as a pointer to something important in the past
- Point out that the client has not sought therapy because he or she has a problem with the therapist, but because there are problems in his or her mind and these are what we need to address
- The 'car mechanic' analogy

But sometimes it is important to acknowledge transference!



Schwartz & Flowers: 50 ways to lose or damage your patients

- Presuming to know too much
- Failing to seek feedback
- Ignoring science
- Failing to convey empathy
- Failing to develop a collaborative relationship with the client
- Failing to attend to the client's beliefs and expectations
- Failing to provide an appropriate therapy for the client's condition
- Failing to maintain appropriate boundaries – either too loose or too rigid

EMDR as a model of psychotherapy

- Processing emotion – becoming free of the traumas of the past
- Internal focus
- Transference is rarely relevant
- The therapist’s task is to facilitate the process, but keep out of the way
- Rarely make ‘interpretations’ – just occasional comments to facilitate a shift of perspective
- Most of the therapist’s comments would be along the lines of “just notice that”, or “just go with that”

Nina Coltart: Buddhism and psychoanalysis

- “Unless there is a growing openness on the part of both patient and therapist, each to the other, and a willingness by both to make efforts in an atmosphere of trust, no treatment occurs.” [p 61]

- “The more one just attends and the less one actually thinks during an analytic session the more open one is to learning to trust the intuition which arises from the less rational and cognitive parts of the self, and the more open one is also to a full and direct apprehension of the patient and of what is actually going on.” [p 62]

- **Coltart, N. 2015. The practice of psychoanalysis and Buddhism. In A. Hoffer [Ed] Freud and the Buddha. Karnac. London p 53-64**

John Keats: Negative Capability

- “several things dovetailed in my mind, & at once it struck me, what quality went to form a Man of Achievement especially in Literature & which Shakespeare possessed so enormously – I mean Negative Capability, that is when a man is capable of being in uncertainties, Mysteries, doubts, without any irritable reaching after fact & reason”
- **The Letters of John Keats, ed. by H E Rollins, 2 vols (Cambridge: Cambridge University Press, 1958), i, pp.193-4**
- Often it is what the analyst does not do that is most important – does not presume to know, does not try to fit the patient into a theory or dogma, does not assume the position of authority
- But this ‘negative capability’ must be balanced with active enquiry and appropriate concern

‘Disintegration anxiety’ the bedrock resistance to change

- Any change can be destabilising.
- There may be a natural ‘speed limit’ to psychological change, just as with biological change
- Shifts in the basic structures of belief, expectation, and emotional patterning can threaten the basic structure of the psyche.
- At some point the client may develop extreme anxiety or panic – dreams of structures collapsing – or endless narratives of being pursued by fear
- Identity panic!

The client’s temperament

ADHD as a model of avoiding reality

- The ADHD temperament reject the (Freudian) ‘reality principle’
- Pursues pleasure – seeks instant gratification
- Unrestrained narcissism
- Therapist’s task is to support ego functions
- Some people require long term ego support

Ways to minimise risk of harm

- Seek feedback – is this helping?
- Regular review – annual review in long term work
- Clarify goals – therapy is not an end in itself
- Frame problems in terms of positive goals – explore obstacles to achieving goal
- Balance exploration of traumatic past with an intention for a positive future – explore obstacles to positive future
- Any form of impasse or lack of progress is a signal to step back and consider what is going wrong

Ways to minimise risk of harm [2]

- Avoid illusions of knowing – step out of the archetype of "the wise one who knows"
- Recognise that all interpretations/understandings are in error – they may have a partial truth from one perspective. If you repeat a previous 'interpretation', you are using it defensively
- Stay within 'scope of practice' – do not make pronouncements about the client's life. The therapist's task is to receive and expand what the client is communicating

Ways of minimising risk of harm [3]

- Use the ‘linguistic code’ to unlock higher dimensional guidance: [1] I am in error; [2] I am sorry and ask forgiveness; [3] I seek guidance and truth
- “If something were stopping you from getting better, what would you guess it might be? What comes to mind?”
- Convey that it is the client’s deeper mind that ‘knows’ what needs to be addressed – the therapist’s skill is in being guided by the client

The ethics of listening

- The client is a sacred Other
- At their core, the Other is essentially unknown and unknowable
- If we listen, without judgement, and without a clamour to impose our ‘understanding’, this sacred Other may reveal something of him/herself
- The precise words used by the Other are important – we should not distort them by substituting our own words
- We should take care that our own words, in response, have coherence and clarity – and not to add confusion to the client’s discourse
- New understanding will emerge in the client’s free-associative discourse – not through the analyst’s ‘showing’ him or her what is ‘unconsciously’ going on
- To disregard what the client consciously means, and to transpose this as an unconscious narrative about the ‘here and now’ relationship, is a potentially harmful invalidation of the client’s subjectivity.
- To seek to understand the client without consideration of the historical childhood past is similarly invalidating of their formative experience which provides context for his or her current mental state, beliefs, and behaviour

Resources to reduce harm

- Scott Miller: www.scottdmiller.com/
- CORE questionnaire – free download:

www.coreims.co.uk/download-pdfs

- Therapy Exploitation Link Line [TELL]: http://therapyabuse.org/index.htm
- EMDR: http://emdrassociation.org.uk/
- Energy Psychology (safe and effective treatments for trauma):
- www.energypsych.org   www.philmollon.co.uk

Phil Mollon's books

- 1993.The Fragile Self: The Structure of Narcissistic Disturbance. [Whurr]
- 1996. Multiple Selves, Multiple Voices: Working with Trauma, Violation, and Dissociation. [Wiley]
- 1998. Remembering Trauma. [Wiley]
- 2000. Freud and False Memory. [Icon books]
- 2000. The Unconscious. [Icon books]
- 2001. Releasing the Self: The Healing Legacy of Heinz Kohut
- 2002. Remembering Trauma (2nd Edition). [Whurr].
- 2002. Shame and Jealousy. [Karnac]
- 2005. EMDR and the Energy Therapies: Psychoanalytic Perspectives. [Karnac]
- 2008. Psychoanalytic Energy Psychotherapy. [Karnac]
- 2015. The Disintegrating Self: Psychotherapy of Adult ADHD, Autistic Spectrum, and Somato-psychic disorders. [Karnac]

And some additional relevant papers by Phil Mollon

- 2002. Dark dimensions of multiple personality. In V. Sinason [Ed.] Attachment, Trauma, and Multiplicity. London. Routledge.
- 2007. When the imaginary becomes real. Reflections of a bemused psychoanalyst. In G. Galton & A. Sachs. Forensic Aspects of DID. London. Routledge.
- 2009. The NICE guidelines are misleading, unscientific, and potentially impede good psychological care and help. Psychodynamic Practice. 15 [1] February 9-24
- 2009. [with Richard Reeves] The state regulation of psychotherapy. From self-regulation to self-mutilation? Attachment 3 [1] March 1-19
- 2010. Our rich heritage – are we building upon it or destroying it? Some malign influences of clinical psychology upon psychotherapy in the UK. Psychodynamic Practice. 16 [1] February 7-24
- 2013. A Kohutian perspective on the foreclosure of the Freudian transference in British technique. Psychoanalytic Inquiry.
- 2014. ‘Analysis terminable and interminable’ revisited: Expressions of ‘death instinct by patients and analysts. Psychoanalytic Inquiry