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## ACTIVE CONTROL OF TRANSFERENCE AND COUNTER-TRANSFERENCE IN PSYCHODYNAMICALLY ORIENTED SHORT-TERM THERAPY<sup>1</sup>

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### *Abstract*

The characteristic features of psychodynamically oriented short-term therapies are described in order to present an unconventional or even paradoxical method that diverges from standard psychoanalytic procedure. The importance of the therapist's active control over transference and counter-transference issues is highlighted in this context, since it allows the therapist to focus on the patient's core conflict, as illustrated in immediate therapist-patient interactions. Furthermore, the question of integrating as well as differentiating non-analytical forms of short-term psychotherapy is addressed.

### *Keywords*

*PSYCHODYNAMIC SHORT-TERM THERAPY, CORRECTIVE EMOTIONAL EXPERIENCE, TRANSFERENCE MANIPULATION, PROJECTIVE IDENTIFICATION*

### *Riassunto*

L'articolo descrive le caratteristiche delle psicoterapie brevi che si fondano sulla psicologia del profondo al fine di presentare un metodo non convenzionale o perfino paradossale che diverge dalla procedura psicoanalitica standard. Viene evidenziata in questo contesto l'importanza del controllo attivo da parte del terapeuta sia del transfert sia del controtransfert, in quanto permette al terapeuta di concentrarsi sul nucleo conflittuale del paziente, come è illustrato nelle interazioni immediate che si sviluppano all'interno della coppia terapeuta-paziente. Inoltre, si affronta anche la questione dell'integrazione e della differenziazione fra le forme non analitiche di psicoterapia breve.

### *Parole chiavi*

*PSICOTERAPIA PSICODINAMICA BREVE, ESPERIENZA EMOTIVA CORRETTIVA, MANIPOLAZIONE DEL TRANSFERT, IDENTIFICAZIONE PROIETTIVA*

## **I Introduction**

Short-term psychotherapy is a rather unloved child of psychoanalysis and, not infrequently, the subject of fierce controversy (Leuzinger-Bohleber, 1985). Other branches of psychotherapy, however, have aligned their procedure with time-limited techniques. This applies particularly to the strategic and client-centered methodology (de Shazer, 1985, 1988; Fisch et al., 1982; Hoffmann, 1979; Rogers, 1951). In this context, important representatives of humanistic psychology do not hesitate to refer to analytical concepts of short-term therapy in a detailed and explicit way (Petzold, 1993).

At the outset, the following must be stated: Socio-economic reality in many countries seems to favor the "competitiveness" of short therapeutic procedures merely out of monetary reasons. In many cases, insurance companies pay only a part of the costs for psychotherapy. Hence, the patient's pecuniary contribution is essential. This can motivate the patient to decide, merely out of economic reasons, against long-term therapy.

Of course, it should not be expected that the days of the standard procedure of psychoanalysis are numbered. After all, this methodology has proved its efficiency over past decades sufficiently. In

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addition, it is undisputed that psychodynamic short-term therapies have various limitations, mainly in regard to their indication. Besides, analytical long-term treatment can be understood as “a continuing focal therapy with a changing focus” that is not limited in the chronological respect (Thomä & Kächele, 1988). In fact, interest in the well-proven practice of psychodynamically oriented short-term therapy has increased steadily over time (Goleman, 1981). An important reason is that this form of psychodynamically oriented therapy represents a true alternative to newly developed cognitive or strategic approaches (Yapko, 1989).

Furthermore, psychodynamically oriented short-term therapies are by no means in conflict with the tradition of psychoanalysis. Thus, Beck (1974), Leuzinger-Bohleber (1985), and Malan (1963) draw attention to the fact that Freud, Ferenczi, Rank, and Stekel have conducted low-frequency psychotherapies, which comprised only a few months of analytical treatment. During this time, it seemed relatively unproblematic that an analyst:

- faced his patient in a downright active way (Ferenczi, 1927);
- s/he thematically controlled the analytical discourse;
- s/he intentionally imposed certain frustrations on the patient (Malan, 1963).

In the following, I would like to outline some core concepts of psychodynamically oriented short-term therapy. This will provide the conditions to discuss the possibility of an unconventional, partially even “paradoxical” approach, which has been utilized so far only for non-analytical short-term therapies. In this sense, my contribution can be seen as a suggestion for an integrative practice of short-term therapy in general.

## **II. The “corrective approach”: Manipulation of transference and the “corrective emotional experience”**

Since 1938, one of the earliest short-term therapy approaches has been modeled, systematized, and catamnistically examined by Chicago-based analyst Franz Alexander (Alexander, 1965; Alexander & French, 1946). The critical objection, in this context, was that short-term therapies would only serve a didactic cognitive mediation of insight and disregard the dynamics of transference. This objection had been countered by the so-called Chicago Group with the concept of “transference manipulation”. This means that the therapist is looking to specifically produce a realistic empathic relationship with the patient that differs significantly from the quality of the original relationship with «failing, punitive, indifferent or overprotective parents» (Alexander & French, 1946, p. 53). There is an identifiable correspondence with Sandor Ferenczi’s (1927) “elastic psychoanalytic technique”. The *focus* of the therapeutic work here is based on an active control of transference that refers to the patient’s current living conditions as well as to his/her specific experiences within the frame of the therapeutic relationship (Klüwer, 1977). It is intended from the outset that those “corrective emotional experiences” might arise on the part of the patient, which facilitate termination of the determining repetition compulsion being related to the patient’s neurotic “core conflict.” These transference experiences provide “preparations and a training for the real battle of life” (Alexander & French, 1946, p. 38).

### **III. The “interpretative approach”: Focusing and thematization**

Following Ferenczi, Michael Balint<sup>2</sup> developed a unique form of short-term therapy in the 1960s (Balint et al., 1972). In this context, it is intended to create a positive therapeutic relationship as the *sine qua non* for the application of the so-called “focal psychotherapy” technology. Overall, the emphasis of therapeutic activity is placed on an interpretation of neurotic conflicts, which are related to a specific “focus” (Malan, 1963). This corresponds to an unconscious conflict that has to be stochastically detected by the therapist, thereby taking into account anamnestic data, the triggering event, and the counter-transference. This conflict, then, has to be related, in a structured way, to the patient’s current problems: «The focused conflict corresponds to the compression of a significant aspect of the patient’s pathology. Therefore, it is to be formulated preferably as an interpretation, giving henceforth direction for the ongoing therapy» (Klüwer, 1977, p. 1137).

A *focus* can also serve as a «unifying theme» (Malan, 1976, p. 7) that is embodied in an «inner formula» (Beck, 1974, p. 24). Based on that formula, the further work of interpretation can unfold (Malan, 1976; Thomä & Kächele, 1988; Titze & Salameh, 1995). Malan and Sifneos (1973; 1979) favor the focusing of an Oedipal conflict, which should “crystallize” within the first sessions (Malan, 1963). All material that is not relevant with regard to the selected focus should be omitted. The therapist has to establish actively linkages between the neurotic manifestations of the focused conflict in:

- the past of the patient’s biography;
- the current life situation;
- the immediate dynamics of transference.

As regards defensive attitudes, little consideration is taken. Rather, the patient is to be confronted with all the feelings associated with the focused conflict (e.g. anger, fear, sadness) (Sifneos, 1973).

Overall, it must be emphasized that direct confrontation with the unconscious core of personality is a great challenge to the therapist, because the phenomena of transference and counter-transference inevitably get involved.

### **IV. Strengthening of self-esteem, encouragement, and pragmatic help with narcissistic injuries**

Leopold Bellak’s short-term therapy is characterized by an unconventional premise: to convey to the patient, specifically and without further ado, the very thing he needs in his acute psychological emergency situation the most – a strengthening of his self-esteem (Bellak, 1979; Bellak & Small, 1965). Thus, Bellak’s concern, in many respects, corresponds to the teleoanalytical approach of Rudolf Dreikurs who makes use of a “mirror technique” that confronts the patient with his/her unconscious goals and objectives, while, at the same time, s/he is encouraged and reinforced in his/her self-confidence systematically (Dreikurs, 1980). This requires that the therapist really is convinced «of the patient’s strength and his/her (positive) decisiveness» (*Ibid.*, p. 106). In correspondence to this principle, Bellak (1979) assumes that the therapist’s unrestricted empathic interest in the patient’s life history may effectuate a “narcissistic satisfaction” that enables the rapid establishment of a stable

<sup>2</sup> In the 1950s, Michael Balint developed a supervision group for physicians, in which the therapeutic relationship was a central theme.

therapeutic alliance. The therapist, therefore, is expected to strive consistently to apply a sympathetic understanding of the patient's problems and concerns, thereby creating a «sense of hope» (Bellak, 1979, p. 566).

In doing so, the therapist should proceed actively, particularly with regard to a “modification of *ideal Self* and *introject*”. Hence, the therapist him-/herself operates as a “modifier” because s/he, in the context of real interaction, immediately introduces concrete material by relating, for instance, anecdotes about him-/herself or by offering viewpoints and “unusual examples” «that are in contrast to most of the usual procedures of psychoanalysis or long-term therapy» (Beck, 1974, p. 40). Here, an affinity to Milton Erickson's strategic brief therapy approach (Rosen, 1990) and Waleed Salameh's (1987) humor-related *Integrative short-term Psychotherapy* is easily identifiable.

Likewise, Goldberg (1973) and Mann (1973) assess the rapid establishment of an empathic relationship with the patient to be an essential prerequisite for coping with early separation conflicts. This is intended, in the sense of a new “emotional experience,” to help the patient (re)gain autonomy and self-respect. Goldberg, following Heinz Kohut, claims that the real reason for consulting a therapist can be seen in “narcissistic vulnerability.” The therapist's primary task, therefore, is to serve the patient as a self-object that fulfills a reflective and sheltering function. Thereby, the patient is supported in:

- recovering from his suffered injuries and
- restoring his organizing fantasies (Burke et al., 1979).

In this context, the therapist should not hesitate to even tolerate primitive idealizations that, in the course of transference, are projected by the patient towards him/her. This might be a pragmatic precondition for regaining the «narcissistic equilibrium» (*Ibid.*, p. 180).

## **V. Specific particulars of psychodynamically oriented short-term therapies**

With regard to psychodynamic short therapies, certain characteristics of the therapist's practice can be listed:

- seeking actively and empathically to establish a positive therapeutic relationship (“transmission manipulation”);
- selecting and focusing, in a quite “unconventional” way, affectively significant material that serves as the determining factor in regard to the thematized “core conflict”;
- being fundamentally oriented to the patient's specific resources. Thus, a (at least partial) restoration or (re)strengthening of self-esteem and self-confidence can be provided in the course of continuous encouragement; and
- intending to modify inhibiting effects from the rigid “Ideal Self” by relativizing the corresponding normative imperatives (ideals) in an ironic or humorous way.

## **VI. Projective identification and introjective communality**

The «intuitive empathic identification with the patient» (Larbig, 1983, p. 108) is of central importance for the psychodynamically oriented short-term therapy approach. In this context, the con-

ventional concept of *identification* does not necessarily accord with the multifaceted meaning that is attributed to that term in psychoanalytic literature (Laplanche & Pontalis, 1967). This notion refers more to the process of *empathy* that has been defined by Alfred Adler in the following way (cf. likewise Titze & Kühn, 2012):

«How can this be explained? This is short to say. You have to produce it within yourself. You have to get in touch with the other. You have to look with the eyes of the other, you have to listen with the ears of the other and you have to feel with the heart of the other – in short: you have to identify with him» (Adler, 1930, p. 176).

This definition implies an active access into the patient's private sphere of affective experiences. The Adlerian Bernard Shulman (1968) noted that an essential prerequisite for successful identification is the therapist's capability to relate to the patient's private logic. Shulman explains: «Discovering the private logic (the way the patient perceives and apperceives) requires certain sensitivity. The therapist must be able to see “the wheels turning inside the patient's head”» (p. 135).

In this context, Heinrich Racker (1948) establishes a connection with counter-transference by using the term “concordant identification”. The patient him/herself may unconsciously initiate that interactive process on his/her own. This is expressed in the concept of “projective identification” as well.

Originally, Melanie Klein (1946) had conceptualized the interactive phenomenon of projective identification as an unconscious separation of affective parts of the self. These parts are, according to Klein's view, “inserted” or “dumped” into another person – for example, the analyst. In this way, the affects in question could be better controlled by the patient. Because of its interactional significance, this specific defense mechanism (that was originally conceived as being relevant only in a psychopathological sense) can be used therapeutically as well. Hence, Zwiebel (1988), following Wilfred Bion (1977), points out that the phenomenon of projective identification features the potential of »processes such as empathy, intuition or infatuation« (Zwiebel, 1988, p. 260). If the therapist takes a sympathetic and basically accepting attitude toward the patient, he behaves, so to speak, as a generous host who provides his guests with the facilities of his large house. He thus acts as a “container” for those affective shares of the *Self* that the patient has split off by means of «omnipotent phantasies» (Bion, 1977, vol. I, p. 31; vol. III, p. 8) because they partially took a toxic effect (Ogden, 1982). By allowing this projection, or by internalizing those toxic parts of the patient's self, the therapist is “detoxifying” that self (Hinz, 1989, p. 612). Thus, the therapist acts as a model of comprehensive self-acceptance: «By taking the detour of the (therapeutic) interaction, the patient can identify, with the help of the analyst's interpretations, the disarranged parts of his own self... As long as the patient is alienated from these parts, these cannot be accepted and (re)internalized» (Thomä & Kächele, 1988, tomo 2, p. 155).

Ogden (1982) goes one step further. He calls upon the therapist to actually make the patient's affective problems his own: «If the patient feels hopeless, being unlovable and untreatable, then the therapist has to endure the feeling that *he as a therapist* is without any value for this desperate patient» (p. 30).

If the therapist is willing to take on such basal feelings, that indicate a “core conflict” or to temporarily “make them his own problem,” s/he certainly is “acting out”, but this is an integrated part of the analytic relationship's vitality and may be utilized as current material for the ongoing analytic process (Zwiebel, 1988).

The concept of projective identification matches the concerns of psychodynamic short-term therapy because it enables, last but not least, an «analysis of the real process of interaction» (Thomä & Kächele, 1988, vol. 2, p. 159), with the direct inclusion of affective dynamics.

A phenomenological substantiation of this specific attitude has been given by Michel Henry (1992, p. 210, p. 218), who coined the term “intropathic communality” to denominate a special kind of basal inter-subjective experience. The term “intropathy” goes beyond that of “empathy.” Henry argues that we are dealing, in this context, with an affective yielding into the “existence of another” (Kühn, 1994). Therefore, the constitution of intropathic communality is creatable only if the therapist senses the patient’s affective state as a genuine common affective being. Henry (1992) explains: «That mutual pathos (*pathos-avec*) is always and initially displayed as a real and concrete common being: the being of mother and child, of hypnotist and hypnotized person, of lover and beloved person, of analyst and patient, etc.» (p. 243).

## **VII. “Irrational” paradoxical therapeutic alliances**

Lawrence Friedman (1969) differentiates between a “rational” and an “irrational” therapeutic alliance. The latter comes about when the therapist covertly becomes the patient’s object of magical fantasies. Such fantasies may be excited in the course of a psychodynamic short-term therapy merely by the time limits. Thus, the short-term therapist is in a paradoxical situation: S/he is intending to cure, within a few therapy sessions, a person who has fought for a longer period of time in vain against his/her symptoms. Hence, omnipotence-bound fantasies are similarly promoted as tendencies of regression and/or resistance are stimulated. The reason is that, already in the initial interview, the patient may experience disappointment when confronted with the temporal limitation of the treatment offered; hence, the issue of separation is implicitly decisive (Mann, 1973).

Giuseppe Ferrigno (2014b) focuses precisely on this issue. He points to the fact that the therapist’s “childishness” becomes, in a reciprocal way, linked with the patient’s apparent “sloppiness”. This therapeutic maneuver can create «a bond of resonance [...] between the operator and the patient» (p. 49). Thereby it can be ensured that “the patient is no longer a clinical case”, but a person, a human being. Instead, a personal liaison within the *hic et nunc* of the therapeutic relationship may be fostered. Thus, an empathic and encouraging dialogue can come to effect that is in full accordance with the Adlerian conception.

It is undeniable that (re)experiencing regressive desires, in accordance with the inherent psychodynamics, cannot be gradually deployed in short-term therapy. The time frame for this process of evolvment is simply too short. But this fact should be kept in focus so that it can be considered in the course of the therapeutic discourse. Thereby, the therapist has to benevolently meet and even foster all indications of paralogic primary processes. This allows for an immediate and rapid awareness of “hidden” psychodynamic linkages as well as latent tendencies of resistance (Davanloo, 1986). Thereby, the establishment of a viable therapeutic alliance is ensured. Shulman (1968) considers this as a communicative precondition: «When the therapist understands the patient’s private world well enough to formulate a meaningful statement in return, a useful interchange may take place» (p. 96).

Under these conditions, a therapeutic alliance can arise that may seem to be quite irrational from a third party's viewpoint.

A perspicuous instruction for establishing such an "irrational alliance" can be found in a short article written by Jackson already in 1963. This essay deals with the treatment of a paranoid patient. Jackson places great emphasis on the establishment of a therapeutic relationship that is characterized by sincerity and warmth. It follows the premise that the therapist should unconditionally offer his partnership to the patient. Further, s/he should

- serve as a model for gaining new insights; and
- help the patient to maintain distance from defensive thoughts of self-doubt (Jackson, 1963).

Jackson describes how he reacted to the fear of a patient who had expressed suspicion that hidden microphones were installed within the treatment room. Jackson immediately became part of that fantasy by unmistakably expressing the same concern and insisting, together with the patient, on turning the treatment room upside down in order to find the "bugs".

While this procedure dragged on, the patient acted increasingly insecure and embarrassed. But that did not impress Jackson at all. After the search had to be discontinued without success, the patient began to speak spontaneously and explicitly about the relationship with his wife, which gave rise to suspicion.

From a psychodynamic viewpoint, this procedure is not to be assessed merely as a "paradoxical intervention", but as an impressive example of transference manipulation. The reason is that the patient's biographically founded mistrust, which had been reinforced in the course of his marriage, had been carried by him into the therapeutic situation, in order to be projected onto the therapist. By not only tolerating this projection, but by intropathically identifying with the patient within the immediacy of the therapeutic situation, Jackson established a connection to the patient's affective world of imagination. He created exactly that "twin relationship" (Grotstein, 1981; Rosenfeld, 1987), which enables a truly authentic reflection of affect-bound notions.

Thomas Ogden describes a therapy that has been impaired by various manifestations of resistance (extensive silence, demonstrative disinterest of the patient, etc.). After the therapist had realized that he had fallen into the patient's trap, he decided to offer him something that was his own trademark. So he asked the patient, after a long period of silence: «Shall we play again the game "we are stubborn today"?» (Ogden, 1982, p. 64). When the patient looked at him in an astonished way, the therapist declared that the answer to this question was a mystery. But he would not reveal secrets because, otherwise, he would lose more and more of himself, "until there would be finally nothing left of me". The further interaction then posed a playful staging of all those explosive elements which the therapist had absorbed by means of projective identification (fear of merger/desire for connectedness; fear of utter separateness/desire for separation).

### **VIII. The "conspirative alliance"**

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The "conspirative method" serves specific purposes of short-term therapy and it is also well compatible with the basic purpose of Adlerian psychotherapy: to encourage a process of reciprocal understanding that results from a "dialogic change of perspectives" (cf. Titze, 1978, 1979, p. 316 ff.,



1985, 1987, 1989). This requires, on the therapist's part, a constant control of counter-transference in order to promote that process of identificatory understanding. In this context, the therapist should, according to the phenomenological "reduction" (Husserl, 1907, 1923), exclude all secondary notions being derived from the real world of normative conventions (Titze, 1992). The point is that the therapist is expected to orientate him-/herself at the patient's (unconscious) "primary reference system" (which includes his/her "private logic"). This is the precondition for comprehending intropathically the patient's specific *lifestyle*, or his/her implicit plan of life. Based on that process of reciprocal identification, the therapist can disclose the unconscious but, nevertheless, meaningful finality of the plan of life that is inherent in all of the patient's manifestations of life, even the pathological ones.

By adopting the patient's unconscious views of life, the therapist can, with a twinkle in his/her eye, mirror the inherent finality. Thus, s/he may encourage the patient, out of the therapeutic situation's immediacy, to gradually develop a more self-reliant attitude toward him-/herself. But this presupposes that the positive qualities of the patient's primary lifestyle had been experienced intropathically by the therapist. Thereupon, s/he can go on reflecting exactly these qualities back to the patient. This proceeding is in full accordance with the concept of transference manipulation, but we could even speak about a *control of projective identification*. As an example, a dialogue sequence with a depressive patient is cited.

*Patient (P.), at the beginning of the session: «I hardly slept last night!». (After a long silence) «I do not know what I should say now!».*

*Therapist (T.): «If I were in your place, I would be pretty angry».*

*P. (interested): «Why?».*

*T.: «Why? If it were on my side, that I was doing so badly for such a long time and if I had endured, after so many years of matrimony, so much unkindness and ungratefulness, I would be mad at the whole world, even at my therapist!»*

*P.: «But for that I have no reason at all. After all, you take so much trouble with me».*

*T.: «Troubles. That's exactly what your mother always said to you: "I have taken so much troubles with you"».*

*P.: «Yes, yes, but I'm really not angry at you!».*

*T.: «In confidence: in your place, I would be angry! Look, today we have had our tenth hour, and you're still not feeling good! If you had set it up in such a short time to show me that you're fine, that you are free of symptoms, then you would have done the same thing to me, you always did to your mother, your husband and the other people, that we already have spoken about. That is, you show everyone that he's fine, that he's doing everything right, so that all can really feel at home. If I were you I would not give my therapist this satisfaction. By feeling bad, I would show him that I'm angry with good reason: so angry, how I could be with other attachment figures having let me down ...».*

Proceeding "conspiratively" means, as a matter of principle, to challenge exactly those exaggerated normative constructs within the patient's conscience or Ideal Self that had been internalized in the course of his/her socialization and that had affected the patient in a destructive way since then. This may well happen with a wink, because humor is particularly effective in relativizing all kinds of rigid claims to the alleged absolute truth of conscience's idealistic constructs (Titze, 1985; 1995; Titze, Eschenröder & Salameh, 1994; Titze & Eschenröder, 1998). Thus, the humorous therapist can

have rapid and direct access to the sphere of unconscious and irrational events within the psyche, which are designated as “primary processes.” Inevitably, such a therapist will gradually begin to think and speak differently from the normal, everyday person. He or she will also use a corresponding parabolic (figurative, concrete) language, which differs from the normal colloquial speech. As a result, an access is established to the affective sphere of the “young child within the patient”, to whom the therapist is becoming an ally. Summing up, the following conditions will facilitate that process:

- create an atmosphere of empathy;
- focus on experiences related to the “here and now”;
- identify unconditionally with the patient’s needs and expectations;
- become a model for assertive acceptance of exactly those needs and expectations;
- reflect to the patient how s/he could be less (self-)destructive by performing more realistic self-assessment.

## **IX. Conclusions**

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There is no doubt that especially the psychodynamically oriented psychotherapy can be understood as an intensive interactive process. This statement applies equally to the standard method of analytical long-term treatment as well as to the various forms of psychodynamically oriented short-term therapy. The latter treatment model remained controversial until today, even though this form of psychotherapy has a long tradition and – particularly in the United States – has become widespread. Moreover, various non-analytical brief therapy techniques have been developed in recent years. These attach central importance to the communicative challenges of paradoxical interventions, but without considering the interactional dynamics of transference and counter-transference significantly.

This article discusses the possibility of an integrative therapeutic proceeding in psychodynamically short-term therapy. As a precondition for this work, an active control of transference and counter-transference is considered indispensable. Thereby, a quick dissolution of resistance tendencies can be ensured. This, in turn, can facilitate the creation of a “conspirative alliance”: Under this condition, the focal treatment of specific core conflicts, by utilizing the reciprocal mode of projective identification, is rendered possible. This – in comparison to standard methods of psychoanalysis – “unconventional” approach superficially resembles the paradoxical interventions and symptom prescriptions of strategic psychotherapy. But in terms of methodology, it consistently follows the premises of the interactional model of psychodynamically oriented psychotherapy.

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