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**IDEALIZATION:  
CLINICIANS AND THE IDEALIZING TRANSFERENCE**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2015

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Christine Spera  
Idealization: Clinicians  
and the Idealizing  
Transference

### **ABSTRACT**

This qualitative study explores the ways that therapists describe and address the idealizing transference in therapeutic encounters. It also explores how clients utilize the idealizing transference and how clinicians view their participation in the idealizing transference. The study was based on interviews conducted with 12 licensed therapists, all of whom have been practicing for a minimum of two years. Other topics explored were: Are certain clients more susceptible to idealization? Is there always a “fall from grace”? Do therapists experience idealizing countertransference?

The findings of this research study revealed that 10 out of 12 clinicians felt that tolerating the idealizing transference, therefore providing unmet needs for their client, was more important than interpreting the idealizing transference as a defense. Eleven out of 12 of the participants were able to describe how they addressed the idealizing transference in therapy. Common themes included: holding the transference, tolerating discomfort, openly discussing the transference with the client, acting as a place to “store” qualities that the client is unable to acknowledge in herself, and allowing it to “run its course.”

## **CHAPTER I**

### **Introduction**

For a clinical social work student with an interest in psychodynamically oriented therapy, the theories of Heinz Kohut hold a special appeal. Kohut's introduction of the transformative power of empathy brought a new, more relational perspective to the field of psychotherapy. How different this was from the Freudian view of psychoanalysis, where the clinician acted more like an archeologist, unearthing repressed desires and revealing them to his client with the hopes of a breakthrough. Kohut's view of transference also marked a departure from the traditional views of psychotherapy. Of course, the writings of Kohut were informed by great thinkers before him, especially highly regarded object relations clinicians such as Winnicott, Klein, Fairbairn and Bion; however, Kohut's language used to describe psychological development and the therapeutic process was unique. Surely, these theoretical concepts could be discussed and applied in a less conceptual and more grounded way. Kohut was talking about empathy, after all, and the power of relationship. These are tenets of social work.

Perhaps the reason that the researcher was drawn to the theories of Kohut was because they were reminiscent of the interventions already being applied by social workers. After reading an article entitled "The Theories of Heinz Kohut and Clinical Social Work Practice" by Elizabeth Eisenhuth, these suspicions were confirmed. In her article, Eisenhuth (1981) described how Kohut's ideas were more in accord with social work values and precepts than those of other theoreticians in the field (p. 80). Eisenhuth (1981) remarked on Kohut's non-pejorative view of

narcissism and his beliefs in the intrinsic worth of the individual. These ideas are resonant with clinical social work practice, where social workers are encouraged to take a non-judgmental stance with their clients and seek to understand a client's symptoms, no matter how contemptuous, as opposed to pathologizing them.

Further education and reflection on Kohut's theory of Self Psychology led the researcher to wonder about what Kohut called the idealizing transference. Kohut (1971) was the first theorist to explicitly regard the idealizing transference as a positive transference. Kohut used the idealizing transference to describe the need of an individual to idealize in order for healthy psychological development to take place (Kohut, 1971). Oftentimes, due to insufficient access to a parent, sibling, or caretaker to idealize, a client held this transference towards her therapist, and in the parlance of Kohut, the therapist acted as a selfobject. In the selfobject transference, the client could temporarily utilize aspects of the therapist that she needed, or perhaps was not yet able to acknowledge in herself, until she could metabolize these qualities in a process that Kohut (1971, 1977, 1984) named transmuting internalization. While other theorists would wholeheartedly agree that ideals and the process of idealization were critical to social and emotional development, they viewed the idealizing transference towards the therapist as a defense, not a growth-promoting phenomenon.

Freud (1914) defined the ego ideal as the perfect, or ideal, self that is housed in the superego, consisting of "the individual's conscious and unconscious images of what he would like to be, patterned after certain people... whom he regards as ideal"(p. 17). Freud (1914) felt that humans sought to regain the narcissistic "perfection of [his] childhood" via the ego ideal. By the 1923 publication of "The Ego and the Id," Freud had completely replaced the term ego ideal with the term superego, although what he was describing remained the same. Freud was

describing the ideal version of our self that we spend our lives striving to attain. Also, ideals provide our lives with meaning. When we feel that we have crafted an existence that is satisfying and enriching, we have reached, or perhaps even approximated, the attainment of an ideal (Morrison, 2009).

Social work could be one of the most idealistic professions. Social workers seek to help individuals, families, and communities create a meaningful existence with access to resources and opportunities for growth. Social workers want social justice for all individuals and see people as inherently good and capable of having agency over their own lives. In my own search for a meaningful career, social work had long been at the top of the list, but it wasn't until I was able to do my own work in therapy, my own self-analysis, that I could see this as a path in a tangible way.

I believe that my therapist's ability to tolerate my idealizing transference towards her, as well as the slow process of devaluation, is largely responsible for my personal psychological growth, particularly recovery from childhood trauma. This realization did not come without its baggage. After many years of therapy, I decided to go to graduate school to become a clinical social worker, as my therapist did, and was even accepted to the same school that my therapist attended. At school, I experienced shame as I constantly compared myself to her, the ideal graduate student, the ideal therapist, the wisest woman I knew. I imagined her as the beacon of intellect and felt silly for thinking that I could follow in her footsteps and match the facile with which she accomplished her goals. I brushed up against what Chasseguet-Smirgel (1985) described as the "malady of the ideal," experiencing an ongoing internal competition with this woman whom I admired. She was responsible for so much goodness in my life, and yet, my envy towards her drudged up an unexpected aggression during my time at graduate school. How



could she let me hold her in such an omniscient light? Why didn't she correct me when I told her about my obsessive musings of how she was the ideal therapist? It seems to me now that what she was doing during that phase of treatment was what Kohut advised therapists do with the idealizing transference: nothing. Kohut recommended that the clinician withstand the transference, allow it to run its course, and observe its natural unfolding.

In the seemingly magical process of transmuting internalization, I learned to honor my own strengths and intellect. As I slowly internalized the aspects of myself that I idealized in her, I became more grounded, confident, free from harmful thought patterns and maladaptive coping strategies. I began to feel more like myself and less like a version of her that I aspired to be. I became whole. My therapist allowed my idealization of her to take place. She also graciously welcomed my gradual devaluation process, whereby I questioned her, confronted her, and slowly lowered her from the pedestal where I had placed her. I began to self-regulate with less and less of her assistance. I began to trust that I knew how to tolerate discomfort without her there to soothe me.

Research on the idealizing transference should not be limited to psychoanalytic literature. There is a place for this conversation in the annals of social work. How can we take the phenomenon of idealizing transference and translate it into concrete clinical interventions? In an effort to better understand how therapists address the idealizing transference in the therapeutic process, the following literature review and research study were conducted. The researcher's hope is that the participants' responses will shed light on how clinicians address this powerful medium for psychological growth.

## CHAPTER II

### Literature Review

#### Introduction

In a review of the empirical and theoretical literature on idealizing transference, the researcher found that authors questioned what was the most effective use of its presence in the therapy room. Should the clinician interpret the client's idealizing transference, or should the clinician allow the idealization to take place? Exploration of how clinicians address the idealizing transference could provide direction for clinical intervention. In addition, how clinicians address the idealizing transference could elucidate where the current view of this debate stands.

The first section of this literature review provides brief definitions of transference and countertransference. The second section describes idealizing transference and countertransference. The third section compares and contrasts the viewpoints of two predominant psychodynamic theorists who wrote extensively on the idealizing transference, Heinz Kohut and Melanie Klein. The final section presents different points of view on how clinicians should address idealizing transference.

#### Transference

Before discussing the idealizing transference, it is necessary to first understand the broader concept of *transference*. The earliest writings on transference are in the letters written between Freud and Breuer regarding the first psychoanalytic patient, Anna O, in the early 1880s (Berzoff, Flanagan, & Hertz, 2011). Although they do not name the phenomenon transference, Breuer and Freud described the experience of the client bringing feelings, wishes, and

assumptions from past formative relationships, namely with parents or siblings, into the therapeutic relationship (Berzoff, Flanagan, & Hertz, 2011, p. 25). The process of re-enacting and re-experiencing past relationships can happen in all relationships, especially in those where some sort of dependency is marked. However, this phenomenon is most useful in the therapeutic relationship because it provides access to the client's unconscious and internal processes (Berzoff, Flanagan, & Hertz, 2011; Thompson, 1945).

By 1900, transference stood as it does today, at the core of psychoanalytic theory (Levy & Scala, 2012). Freud is credited with making transference, what was initially thought of as an obstacle to treatment, the chief therapeutic instrument of psychoanalysis and psychotherapy (Thompson, 1945). *Transference interpretation* is the phrase used to describe the process by which the clinician uses feelings and behaviors that are occurring in the therapy room in the "here and now" to draw a link to the client's preconceived representational models of significant others that are a result of the "there and then" (Levy & Scala, 2012). When a client demonstrates insight into her unconscious transference patterns, she makes the unconscious conscious. Therefore, transference can be viewed as a therapeutic tool for making unconscious patterns or trends consciously available to the client (Thompson, 1945). When a client is able to bring awareness to a pattern being enacted in the transference, a significant and lasting change in her personality is thought to result (Thompson, 1945). In more current psychotherapy discussions on the topic of transference, terms such as *internal working model* and *control/mastery theory* are more prevalent than the term transference; however, the ultimate goal of therapy remains the same even though the terminology has evolved (Marmarosh, 2012).

The concept of transference and transference interpretation is a controversial one (Marmarosh, 2012). Firstly, not all psychotherapists believe that transference exists (Clarkson &

Nuttall, 2000; Levy & Scala, 2012). Secondly, transference interpretation has decreased in popularity. Where it was once seen as the gold standard of psychoanalytic practice, developments in the field that emphasize the importance of the therapeutic relationship have overshadowed the importance of transference interpretation (Levy & Scala, 2012). Many psychodynamic theorists view transference interpretations as aggressive acts that are unhelpful, especially among clients with personality pathology (Bateman & Fonagey, 2004). Others criticize the popularity of transference interpretation, saying that there is insufficient clinical evidence of its effectiveness (Spence, 1992). Understanding the debate on whether or not to interpret transference will become more relevant when discussing the debate on how clinicians choose to address the idealizing transference.

### **Countertransference**

Freud (1910) first used the term *countertransference* in a paper that he wrote in 1910 entitled, “The Future Prospects of Psychoanalysis.” Freud viewed countertransference as interference, a reflection of the pathology of the therapist that needed to be overcome. Essentially, Freud viewed countertransference as the therapist’s transference towards their client (Clarkson & Nuttall, 2000). Because of his views on countertransference, Freud stressed the importance of self-analysis so that the therapist’s unconscious issues did not interfere with the client’s process.

By the late 1940s and 1950s, countertransference was viewed as equally as important to the therapeutic process as transference (Clarkson & Nuttall, 2000). Paula Heimann (1950) expanded on the ideas of Freud, differentiating between the type of countertransference that Freud described, what is called proactive countertransference, and reactive countertransference, which concerns the therapist’s responses and reactions to the client and what the client presents

in sessions. Today, when we use the term countertransference, it is viewed as a combination of proactive and reactive countertransference. Countertransference refers to what the therapist brings to the room in addition to her reactions and responses to the client. As opposed to seeing countertransference as purely a hindrance as Freud did, Heimann (1950) felt that countertransference could provide the therapist with useful information to direct the therapeutic process. Heimann did not, however, feel that the therapist should disclose or communicate her feelings to the client (Gabbard, 2001). This intervention is known as use of self and is regularly applied in contemporary psychotherapeutic practice.

Around the time that Heimann was writing about countertransference, Melanie Klein (1946) was writing about the process of projective identification. Klein's views on projective identification were essential to the realization that countertransference could facilitate therapeutic process (Clarkson & Nuttall, 2000). Klein (1946) described projective identification as the negative affects of the client that are unwanted, for example, anger and fear, that were subsequently displaced, or projected onto the therapist. An example of projective identification might be a clinician who works with clients with bulimia who finds herself occasionally engaging in atypical eating behaviors. Projective identifications are unconscious communications between therapist and client (Berzoff, Flanagan, & Hertz, 2011). The therapist's acknowledgment of these displaced affects that are in her, but do not belong to her, provides excellent clinical information. Projective identification provides a way for the therapist to discover feelings that the client is not yet able to confront.

Another contemporary of Klein, Winnicott, was also writing about countertransference. Winnicott agreed that countertransference was a useful tool in the therapeutic process (Gabbard, 2001). In his famous essay, "Hate in the Countertransference," Winnicott (1947) described an

objective form of countertransference where the therapist reacted to the client the same way that everyone reacted to that client. For example, Winnicott found that certain clients were so contemptuous and provocative that they elicited hate from everyone that they encountered, including their therapist. According to Winnicott, this reaction had much less to do with the therapist's own personal past and much more to do with the patient's behavior and need to evoke specific reactions in others. Winnicott (1947) felt that there was immense utility in the therapist's willingness to engage with her own countertransference towards a contemptuous client. If the therapist was able to understand and tolerate her own countertransference, she was, in effect, letting the client know that her own hate or aggression can be tolerated. This facilitated the possibility of therapeutic alliance and, therefore, therapeutic process.

The view of countertransference today reflects a combination of the therapist's pre-existing internal object world, what Freud described, as well as the presence of feelings that are induced by the client, closer to what Klein, Winnicott, and Heimann described. The current view of countertransference is that it is present in all of us and can never be fully eradicated (Clarkson & Nuttall, 2000; Gabbard, 2001). The best we can do is to understand it, tolerate it, and recognize its potential to help or hinder the therapeutic process (Clarkson & Nuttall, 2000; Gabbard, 2001; Heimann, 1950). Countertransference is only problematic when the therapist is not conscious of it (Sharp, 1947). For example, suppose the primary motivation of a therapist is unconsciously to save her depressed mother. This unresolved issue will make her an ineffective therapist until she reconciles this desire. In contemporary psychotherapy, countertransference is regarded as a jointly created phenomenon that involves contributions from both client and clinician (Gabbard, 2001). This idea becomes especially relevant when we discuss how clinicians respond to and utilize the idealizing transference.

## **Idealizing Transference**

In order to better understand idealizing transference, one must take a look at the theory of Self Psychology originated by Heinz Kohut (1913-1981), where the idealizing transference was defined. Self Psychology was the first significant psychoanalytic movement to originate in the United States (Berzoff, Flanagan, & Hertz 2011). Kohut's theory of Self Psychology differed from the other three schools of psychology (Drive Theory, Ego Psychology, Object Relations) because 1) Kohut de-emphasized the importance of drives and internal conflict and 2) He proposed a different definition of transference (Berzoff, Flanagan, & Hertz, 2011). Kohut (1971) understood transferences as based on needs instead of conflict, and viewed the interpretation of transferences as destructive and unhelpful. Theorists such as Winnicott, Balint, and Fairbairn were reportedly offended by Kohut because many of his theories bore a striking resemblance to theirs, but he did not give them any credit (Lessem, 2005). Nonetheless, Kohut's contributions to contemporary psychotherapy are significant.

Three major themes can be identified to describe how Kohut (1971, 1977, 1984) understood psychological development: 1) the importance of empathy; 2) the structure of the tripolar self; and 3) the role of selfobjects. Themes two and three are especially important to this research study. Kohut (1971, 1977, 1984) identified *poles* to refer to aspects of the self that each have their own specific needs in order to fully develop. Kohut (1971, 1977, 1984) described three poles of the self: the pole of the grandiose self, the idealized parent imago, and the pole of twinship. At each pole of psychological development, an individual requires selfobjects (formerly known as "self-objects") to meet the needs required by that pole (Kohut, 1971, 1977, 1984). In the *Dictionary for Psychotherapists*, Chessick (1993) defined selfobjects as follows:

An object may be defined as a selfobject when it is experienced intrapsychically as providing affect attunement, consensual validation, tension regulation and soothing, recognition of one's autonomous potential, and restoration of a temporarily threatened fragmentation of the self through a variety of activities and comments (p. 357).

In Kohut's (1984) latest publication, he defined selfobjects as "that dimension of our experience of another person that relates to this person's functions in shoring up the self" (p. 49).

The creation of selfobjects offered a completely different take on transference in the therapeutic process. Kohut (1971) described each selfobject need in terms of transferences. Where transference interpretation was once viewed as the predominant vehicle for growth in psychotherapy, Kohut (1971, 1974) suggested an exchange between clinician and client where the clinician meets the client's selfobject needs. Self Psychology views the selfobject dimension of transference as a catalyst and vehicle for growth (Kohut, 1971). It is through this transference that the client can reinstate the psychological growth that was interrupted in her development (Kohut, 1971). In other words, the client can utilize strengths of the therapist until she is able to metabolize them and make these qualities her own. Kohut (1971) referred to this process as transmuting internalization.

Each pole of the self, the pole of the grandiose self, the idealized parent imago, and the pole of twinship, require specific empathic responses from selfobjects in order for optimum psychological development to occur (Berzoff, Flanagan, & Hertz, 2011; Lessem, 2005). The first pole, the pole of the grandiose self, requires mirroring selfobjects (Kohut, 1971, 1977, 1984). As expected from their name, mirroring selfobjects reflect unique capacities, talents, and characteristics of an individual (Berzoff, Flanagan, & Hertz, 2011; Lessem, 2005; Mitchell &



Black, 1995). The pole of the idealized parent imago requires someone strong, calm, and wonderful to idealize and merge with in order to feel safe and complete within the self (Berzoff, Flanagan, & Hertz, 2011). Lastly, the pole of twinship requires others that are similar to oneself, but it can also refer to a philosophy, religion or political movement that can provide sufficient sustenance in the lack of a selfobject (Berzoff, Flanagan, & Hertz, 2011).

Therapeutic activation of the selfobject need at the pole of the idealized parent imago is known as the idealizing transference (Kohut, 1971, p. 28). The idealizing selfobject serves two predominant functions for the development of a healthy self. As mentioned above, the idealizing selfobject helps an individual develop a sense of safety and calmness by allowing the individual to merge with someone in whom they feel confident (Kohut, 1971). This is especially important in times of upset and fear (Lessem, 2005). Individuals who lack the ability to self-regulate or self-soothe may have not had access to adequate idealizing selfobjects in the course of their development. The idealizing selfobject also helps an individual develop a sense of values, aspirations, and life goals (Field, 1987; Kohut, 1971; Lessem, 2005; Marmarosh & Mann, 2014; Morrison, 2009). Consequently, individuals who lack direction and initiative may not have had access to adequate idealizing selfobjects in the course of their development. This will become especially important when examining which types of clients are more prone to the idealizing transference.

### **Idealizing Countertransference**

The only known literature in the field of psychotherapy on idealizing countertransference is by Joyce Slochower (2011, 2014). While much has been written on the topic of idealization and the idealizing transference, very little has been written about the therapist's participation in the clients' idealization (Slochower, 2011). In her article, "Analytic Idealizations and the Disavowed: Winnicott, His Patients, and Us," Slochower (2011) argued for the ubiquity of the jointly created idealization process in which the therapist plays a role in the client's idealization of them, what Slochower refers to as a co-created idealization. Also, Slochower (2011) sought to open the discussion regarding therapists' idealization of their clients. Because the idea that a therapist would idealize their client goes against our professional vision, therapists tend to evade discussion of the topic (Slochower, 2011).

Slochower (2011) proposed that co-created idealizations could support the treatment or result in therapeutic collapse. She utilized the beloved analytic figure, D.W. Winnicott, and showed through personal unpublished correspondences how Winnicott likely idealized two of his clients, Masud Khan and Harry Guntrip. By choosing a highly regarded and beloved psychoanalytic figure like Winnicott, Slochower intentionally challenged the reader to inspect her own idealization of Winnicott. Slochower believes that all therapists have idealized clients at some point in their career and presented the positive and negative results of this phenomenon. The work of Slochower is important because she demanded that therapists take credit for their participation in the idealizing transference, which had not been done before. Also, she brought a relational lens to the phenomenon of idealization. This will become important when looking at the qualitative data regarding how therapists view the process of idealization.

## **Idealization as a Defensive Process or a Growth-Promoting Process**

Controversy over how clinicians address idealizing transference began in the 1970s, mainly because that was the time that Kohut's most influential works were published (Gedo, 1975; Hopkins, 2011). Kohut's new take on transference and his creation of selfobjects stirred the psychoanalytic community, and rightfully so. Clinicians asked, does the idealizing transference, like other transferences, demand analytic interpretation? Should therapists adopt Kohut's approach and withstand the uncomfortable feelings of being idealized by a client in order for this strange process of transmuting internalization to occur? Critic of Kohut, Joseph Newirth (1987) felt that if a therapist allowed herself to be idealized by her clients, she was acting "passively and irresponsibly" (p. 240). It is not surprising that Kohut's vision of a completely new way to interact with transference brought about conflicting points of view in the field of psychotherapy.

The concept of idealization is classically viewed as a primitive defense that negates envy, ambivalence, or rage (Freud, 1915). Freud (1915) felt that idealization protected the individual from shameful feelings, wishes, or impulses, ultimately keeping the individual shielded from the harshness of the real world. In the process of escaping into the fantasy of idealization, however, the individual suffered because she missed the opportunity for the development of the ego (Freud, 1915).

Klein (1946) endorsed the views of Freud. Expanding on idealization as a fantasy, Klein called it a hallucination. Klein (1946) felt that idealization came from the infant's primitive need to split, when she created *good breast* and *bad breast*. The infant exaggerated and emphasized the greatness of the good breast in an effort to protect herself from persecutory fear (Klein, 1946). Klein (1946) viewed idealization as one of the mechanisms that maintained the paranoid-

schizoid position during the first 3-4 months of life. The other mechanisms included splitting, denial, and projection. Klein (1975) expanded her views on idealization when she published *Envy and Gratitude*. Klein elaborated that idealization is an early and primitive defense aimed at unlimited gratification because of its function to defend against envy. Envy is the wish to destroy something that someone else has; therefore, envy stems from an aggressive instinct (Klein, 1975).

Freud and Klein, as well as other theorists such as Kernberg (1974) and Chasseguet-Smirgel (1985), agreed that the existence of envy in the transference precluded psychological growth from taking place (Allphin, 1982). The client may envy the therapist because the envy towards her parents as a child went unacknowledged or because her therapist has finally been able to meet the client's necessary developmental needs that have been unmet since childhood. While the client is overcome with gratitude that these needs have finally been met, this gratitude exists alongside envy, which is aggressive and destructive. Although this flavor of idealization appears to be directed outward, it actually reflects the self-deprecating feelings of the client (Slochower, 2011). In the client's idealization of her therapist, she becomes inadequate, naive, or childlike. The client renders herself inferior, unknowing, and undesirable in order to sustain a liaison with the omniscient analyst (Davies, 2003). The self-deprecating nature of idealization in this context is also aggressive, but the aggression is directed towards the self.

If we only look at the negative associations with idealization, we overlook the many positive dimensions (Slochower, 2011). Kohut did not view idealization as a defense or a primitive organization of the world (Newirth, 1987). Kohut (1971, 1977) viewed idealization as a natural and necessary part of psychological development. He felt that idealization served a crucial developmental function in childhood and was central to work with narcissistically

vulnerable clients. For some, to be connected to an all-powerful and perfect therapist can be vitally sustaining (Slochower, 2011). Close association to an idealize-able therapist can protect the treatment space, encourage forward movement, and strengthen the sense of self (Gedo, 1975).

Kohut viewed the process of idealization as fulfilling a number of developmental needs, especially the need to experience oneself as being part of and protected by an admired and respected other (Lessem, 2005). This other is worthy of our idealization because she possesses qualities that we envy but do not possess. Kohut (1971, 1977) claimed that the need to idealize, what he called the idealizing selfobject need, was the need to feel linked to another person because it helped create a sense of soothing, calming, and safety. The mere presence of this person, Kohut (1971, 1977) explained, helps organize a “fragmented self.” Eventually, as the natural process of transmuting internalization unfolds, the person is able to internalize the idealize-able qualities that were previously borrowed from the selfobject. When the person takes the qualities into herself and digests them, she has become less fragmented, more whole. Kohut overlooked the aggression and destruction associated with envy, and found positive possibilities there.

There are a number of negative consequences for the child whose parents did not meet her idealizing selfobject needs (Lessem, 2005). The child may struggle to modulate or regulate feelings of anxiety, fear, and aggression. Also, the child is left without a model to identify with or organize around (Lessem, 2005). This child will often lack ambition and have a nagging yearning for a relationship with an idealized other. For this person, the chance to have idealizing selfobject needs met in the therapeutic relationship is a precious opportunity.

### **How Do Therapists Respond to the Idealizing Transference?**

For more relationally oriented therapists, such as Winnicott and Kohut, the illusion of the idealizing transference was regarded as an opportunity for growth. For the more traditional, drive-oriented therapists, like Freud and Kernberg, the illusion of the idealizing transference was considered a defense that must be interpreted (Mitchell, 1986). In the first instance, the word “illusion” carried a positive connotation, and in the latter instance, the word “illusion” carried a negative connotation.

In her paper, “Analytic Idealizations and the Disavowed: Winnicott, His Patients, and Us,” Slochower (2011) adopted a positive connotation of idealizing transference as an illusion. She called for “porous” idealizations where the clinician embraces the illusion of idealization as a place for “play” and “creativity” (p. 7). Slochower (2011) felt that idealization invited a fuller articulation of the client’s fantasy life that could provide useful clinical information. However, Slochower (2011) warned, in order “for this space to be sustained, we must maintain contact with, yet bracket our own conflicted response to being valorized” (p. 7). Slochower was talking about withstanding the discomfort of being on the receiving end of idealizing transference in order for the process of transmuting internalization to take place. The benefit of tolerating the idealizing transference for the client is manifold. Not only does the client get to gradually become more self-regulated, more confident, and more goal-oriented, she is able to learn the benefit of seeing her therapist and, therefore herself, as flawed and imperfect (Field, 1987).

Prior to Kohut, routine management of the idealizing transference was to promptly interpret it and point to its defensive aim (Gedo, 1975; Mitchell, 1986; Newirth, 1987). Although there were differing views on when to interpret and how aggressively to interpret, clinicians of Drive Theory and Ego Psychology viewed interpretation of the idealizing transference as the most useful clinical intervention (Gedo, 1975). What Kohut suggested and

Slochower elucidated was the possibility for the clinician to hold onto the idealizing transference and utilize it as a means of clinical assessment and intervention. Perhaps the clinician's ability to tolerate the discomfort of transference can yield positive results. Kohut encouraged clinicians to question what the client's idealization of them was saying, essentially, what did the client need? What selfobject needs have not been adequately met? If we prematurely interpret, we foreclose therapeutic process (Slochower, 2011). We must accept instead of reject, and view the therapeutic process as more of an ongoing dance of recognition of needs and the fulfillment of those needs and less like a transaction, e.g. if you are my client, I must unmask your defenses in the form of interpretation.

Kohut's ideas marked a shift in the field of psychotherapy from a one-person model of treatment to a two-person model of treatment (Mitchell, 1986; Lessem, 2005). Winnicott (1945) also played a large part in this shift and embraced the notion of illusion as growth-promoting instead of defensive. According to Kohut, the client's creation of narcissistic illusions, such as idealization and grandiosity, in the therapeutic situation represented the client's attempt to establish opportunity for psychological development (Mitchell, 1986, p. 115). This creation of opportunity via illusion is reminiscent of Winnicott's infant who imagines the breast or blanket, only to have it magically appear. The mother is meant to intuit the child's needs and provide accordingly, just as the therapist provides for the client when she provides a selfobject need. The appearance of narcissistic illusions within the therapeutic relationship constitutes a fragile opportunity for the revitalization of the self (Mitchell, 1986, p. 115).

Similar to what Winnicott called an impingement, Kohut (1971) warned against any "slight over-objectivity of the analyst's attitude or a coolness in the analyst's voice; or a tendency to be jocular with the admiring patient or to disparage the narcissistic idealization in a

humorous, kindly way” (p. 263). The idealization must not be interfered with, but allowed to breathe in order for the development of the healthy self. Kohut (1971) viewed methodical interpretation of transference as an “assault” which generated intense narcissistic rage.

## **Summary**

In summary, this literature review defined the concepts of transference and countertransference broadly, and then more narrowly, the idealizing transference and countertransference. Differing views on the significance of the idealizing transference and how it should be addressed in therapy were explored. Special attention was paid to significant historical figures in psychodynamic theory, particularly the contributions of Heinz Kohut.

Transference can be defined as the process of re-enacting and re-experiencing past relationships in current relationships (Berzoff, Flanagan, & Hertz, 2011). Transference is most often discussed in reference to the therapeutic relationship. Whether or not it is beneficial to interpret transference is a controversial debate among the psychotherapy community. Countertransference is as equally an important phenomenon as transference (Levy & Scala, 2012). The definition of countertransference today reflects a combination of the therapist’s pre-existing internal object world as well as the presence of feelings that are induced (i.e. projective identification) or elicited by the client (i.e. therapist’s subjectivity).

Therapeutic activation of the selfobject need at the pole of the idealized parent imago is known as the idealizing transference (Kohut, 1971). Kohut was the first theoretician to explicitly state the necessity and benefits of the idealizing transference. Kohut claimed that an individual requires a selfobject to idealize in order for normal psychological growth to occur. An idealizing selfobject creates a sense of groundedness, calm and safety, and also helps provide a sense of values, aspirations, and goals (Kohut, 1971, 1977). In the absence of adequate idealizing



selfobjects, one's therapist often serves this selfobject function. Slochower was the first clinician to write about the idealizing countertransference. Slochower highlighted the therapist's participation in the idealizing transference and the need for clinicians to view idealization as a co-created process.

There are differing views of how clinicians should address the idealizing transference in therapy. Until the writings of Heinz Kohut in the 1970s and 80s, the idealizing transference was viewed as a defense that should be interpreted. Kohut's views on transference via his introduction of the concept of selfobjects, shifted the conversation of whether transference interpretation was always the best way to practice. This questioning shaped the beginning of contemporary psychodynamic theory, where relationship and the subjectivity of the therapist is paramount to therapeutic process.

## **CHAPTER III**

### **Methodology**

Further exploration of how therapists view and address the idealizing transference is warranted. Do therapists acknowledge the presence of idealizing transference and if so, how? Do they interpret it? Do they let it be, as Kohut would suggest, and allow for the natural unfolding of transmuting internalization? Is the idealizing transference viewed as a defense, a necessary step in psychological development, both, or neither?

The purpose of this exploratory qualitative study was to work toward filling the gap in social work literature on the idealizing transference and to answer some of the questions raised above, essentially, how do clinicians use the idealizing transference as clinical information for assessment and intervention? A detailed exploration of the idealizing transference can provide a snapshot of where this concept stands today in contemporary psychodynamic practice. Also, this study has the potential to yield insight that could inform clinical interventions that can benefit the field of clinical social work.

#### **Research Method and Design**

The following research study was designed to be qualitative in nature in order to elicit the most nuanced responses. Face-to-face and phone interviews were conducted with licensed therapists of any theoretical orientation who have been practicing for at least two years. Interviews were approximately 35-60 minutes in length and were audio-recorded with the written consent of the interviewees.

## **Operational Definitions of Concepts**

**Transference.** The process of re-enacting and re-experiencing past relationships in current relationships, particularly the therapeutic relationship (Berzoff, Flanagan, & Hertz, 2011).

**Countertransference.** A combination of the therapist's pre-existing internal object world as well as the presence of feelings that are induced or elicited by the client; also referred to as the therapist's subjectivity (Knoblauch, 2008).

**Idealizing transference.** Therapeutic activation of the selfobject need at the pole of the idealized parent imago (Kohut, 1971); the client's idealization of their therapist.

**Interpretation.** The phrase used to describe the process by which the clinician uses feelings and behaviors that are occurring in the therapy room in the "here and now" to draw a link to the client's preconceived representational models of significant others that are a result of "there and then" (Levy & Scala, 2012).

**Defense.** Mechanisms that operate below the level of conscious awareness to protect the self from what it perceives as internal or external danger (Berzoff, Flanagan, & Hertz, 2011, p. 56).

## **Sample**

Participants were collected via availability, or convenience, sampling. Inclusion criteria to participate in this study were the following: 1) Licensed clinician with the following acceptable credentials: LCSW, PhD, PsyD, LMFT, or MD, for a minimum of two years. 2) Agreeable to audio- recording. 3) Willing to offer at least 30 minutes of time for face-to-face or phone interview. A letter to recruit participants was disseminated to the members of the

International Association of Relational Psychoanalysis and Psychotherapy, or IARPP. The letter that was disseminated to recruit participants can be found in Appendix C. The letter to IARPP yielded the most results. Within 24 hours of posting the letter on the IARPP listserv, six responses were received. Recruitment letters were also dispersed via colleagues and friends in the social work and psychoanalytic communities of Los Angeles. Through these friends and colleagues, a recruitment letter was posted on the listservs of two different psychoanalytic institutions in the Los Angeles area, the New Center for Psychoanalysis and the Institute of Contemporary Psychoanalysis, also known as ICP. One clinician from The New Center for Psychoanalysis contacted the researcher within 24 hours. The letter to ICP did not yield any results. The dean of the Sanville Institute, Mario Starc, made an announcement to recruit participants at the annual colloquia held in Los Angeles on February 28, 2015. His announcement yielded three participants who spoke personally to the researcher at the event. Lastly, New York analyst Joyce Slochower sent an email to members of the post-doctorate community in New York City. This yielded seven potential participants who emailed within 24 hours of receiving the letter from Dr. Slochower. In the end, not all of those clinicians who expressed interest in participating were ultimately able to schedule an interview or were not willing to be audio recorded. Consequently, the final resulting sample was 12.

As the researcher received emails, she responded to them within 24 hours time, following up by ensuring that the participant was okay with being audio recorded, and then sending a consent to participate. In five instances, participants were not comfortable with being audio recorded and were subsequently eliminated from participation. The researcher politely thanked these individuals for their willingness, but explained that audio recording was necessary for accurate data collection. Scheduling interviews was the most time consuming aspect of

correspondence. With some participants, it took several weeks before the interview could be conducted. In most cases, the interview was scheduled within one to three weeks of the participants' initial email expressing interest in participating. Participants were aware that they would not be compensated for their time and participation, and that their cooperation would be in their own personal interest in helping out a graduate student. However, the researcher explained that participants might learn something new or even enjoy the process of talking about their practice with a graduate student. All of the participants were extremely kind and generous with their time, some even offered to help with follow-up if needed.

### **Ethical Considerations**

An effort was made to recruit a diversity of participants based on race, gender, academic credentials, and theoretical preference. In-person interviews were conducted in private or semi-private spaces, usually at the participant's private office or in a conference room in their office building. Phone interviews were conducted only in the event that the participant lived more than two hours away.

Prior to being interviewed, each interviewee signed a consent to participate and be audio recorded. Please refer to Appendix A to view the letter of consent. If the interview was conducted on the telephone, the participant was e-mailed a consent form and asked to hand mail the consent to the researcher. Upon receipt of the signed consent, a telephone interview was subsequently scheduled. Prior to the interview, both in-person and over the telephone, the researcher explained the research study design, the purpose of the study, reviewed the possible benefits of participation, and reminded the participant that the interview was purely voluntary and that they had the right to end the interview at any time. The limits of confidentiality were also reviewed. The interviews conducted were anonymous. The researcher matched participant

names to numbers, e.g. “Participant 1, Participant 2,” for each interview file in order to disguise the identities of the research participants.

### **Data Collection Methods**

The Smith College School for Social Work Human Subjects Review Board approved this research study (see Appendix E). Participants were provided with the informed consent at the time of the interview for face-to-face interviews and in advance for telephone interviews.

Data collection was obtained through semi-structured interviews that lasted from 35-60 minutes depending on the length of participants’ responses. Please see Appendix D to view interview questions. The participants were asked a total of six open-ended questions that pertained to the subject of the idealizing transference, namely, how clinicians view and address the idealizing transference in the therapeutic process. Additional questions included: clinical experiences with idealizing transference and countertransference, personal experiences with idealization, and whether or not there is a “fall from grace” when an idealization is terminated.

The following is a concise list of interview questions:

How do you view the idealizing transference?

Are certain clients more susceptible to idealization?

Can you talk about a specific client that idealized you?

What do you think about the “fall from grace” that happens when a client’s idealizing transference is challenged?

Can you talk about a time when you, the therapist, idealized a client?

What has your experience been with idealizing supervisors, mentors or therapists while you were in training?

Narrative data was collected via audio recording with a digital audio recorder. The files were uploaded to the researcher's computer to a folder that required a password to access. The only person that heard the interviews aside from the researcher was the hired transcriber. Transcriptions were completed by an outside source who signed a confidentiality agreement and was paid for their labor. Please see the transcriber's confidentiality letter in Appendix B.

### **Data Analysis**

Transcribed data was manually coded thematically, with attention to both similarities and differences in responses. The researcher utilized Microsoft Word documents, where each document contained a theme. The researcher then cut sections of the transcriptions and pasted them in the document with the other data that was most relevant to that theme. The themes were generally derived from the interview questions; however, a separate document was created for outliers or interesting responses that did not fit in with any of the identified themes.

After organizing all of the data according to six themes based on the questions listed above, the researcher further organized each theme by subcategories, if applicable. This was done by printing out the documents for each theme and highlighting sub-themes by color. The researcher linked the data obtained in interviews and compared and contrasted it to the research obtained in the literature review. The researcher noted patterns or trends among the participant responses that were consistent or inconsistent with the literature review.

All research materials including recordings, transcriptions, analyses and consent documents will continue to be stored in a secure locked file for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured in a locked file until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

## **Discussion**

One limitation to this research study was that the researcher was only able to obtain 12 interview participants. The researcher suspects that she would have been able to obtain more interviews if she asked for 30 minutes as opposed to 45-60 minutes of time to conduct the interviews. As the researcher conducted interviews, she became increasingly more efficient in the process, and in the end, was able to complete a successful interview in a 30-minute time frame. This was not the case for interviews conducted earlier in the research process. Also, the researcher found it hard to keep participants' responses on topic when they responded to questions. This also improved as the researcher became a more efficient interviewer.



## CHAPTER IV

### Findings

The purpose of this study was to explore how clinicians in the field of psychotherapy defined and addressed the idealizing transference. This section contains findings that are based on interviews conducted with 12 licensed therapists of various theoretical backgrounds, all of who have been practicing psychotherapy for at least two years. Although the requirement to participate in the study was a minimum of two years of licensed practice, all of the participants had been practicing for at least ten years. Interview questions were designed to explore how clinicians define the idealizing transference, how they view its role in treatment, and what their personal experiences have been with the idealizing transference. The researcher hopes that the perspectives and responses of the interviewees will provide relevant information to guide clinical practice, offer an updated and contemporary perspective of how the idealizing transference is viewed, and possibly contribute to social work literature.

The first section of the interview was briefly dedicated to demographic data including race, gender, clinical degree, and number of years practicing therapy. In the next section of the interview, participants were asked to describe how they understand and address the idealizing transference. In the last section of the interview, participants were encouraged to share their own personal experiences with idealization of clients, as well as mentors, supervisors, or their own therapists. Other questions that were covered included: Are certain clients more susceptible to the idealizing transference? and Is there always a “fall from grace”?

The data were organized as follows:

1. Demographics of participants
2. How do clinicians define and/or describe the idealizing transference?
3. Specific clinical encounters with idealizing transference
  - a. What does it feel like?
  - b. Tolerating the transference
4. Is there an inevitable fall from grace?
5. Who is prone to the idealizing transference?
  - a. How do clients use the idealizing transference?
6. Idealizing countertransference
7. Idealization of supervisors, mentors, analysts, and therapists.

### **Demographic Data**

Of the 12 participants, three identified as men and nine identified as women. Eleven of the clinicians were Caucasian and one was Hispanic. Five participants were licensed clinical social workers, five participants were licensed clinical psychologists with PhDs, one participant was a licensed clinical psychologist with a PsyD, and one participant was a licensed marriage and family counselor. In terms of years of practice, six participants had been practicing for 10-15 years, three participants had been practicing for 15-25 years, two participants had been practicing for 25-35 years, and one participant had been practicing for over 35 years, 60 years to be exact.

### **How Do Clinicians Define and/or Describe the Idealizing Transference?**

All but one of the clinicians interviewed identified positive and negative aspects of the idealizing transference. The clinician who viewed the idealizing transference as a purely negative phenomenon had a fairly concrete view of the topic. This clinician, Participant 5, was

90 years old at the time of the interview. He compared therapists of today with therapists of his generation who he felt were more likely to encourage the idealizing transference. Participant 5 stated, “Therapists used to encourage idealization by not answering questions, by being mysterious, by pretending they didn’t have feelings. I’ll make it clear that I think that’s harmful. I think our patients should know about us.”

Were the therapists to whom Participant 5 was referring intentionally encouraging idealization by “being mysterious” and “not answering questions,” or were they simply practicing in a more traditional, one-person model of therapy? Although Participant 5’s opinion was that this approach to treatment resulted in increased idealizing transference, was it necessarily the aim of these therapists? The researcher suspected that Participant 5 regarded idealization in a more straightforward way as opposed to thinking about it in terms of a transference in which the client’s regard for the clinician might be representative of unconscious wishes.

Participant 5’s concrete approach to the question was reiterated when he explained that if he were to catch a client idealizing him, he would “tell him to stop.” He expanded, “I will usually make a joke about it or point out how I am just a normal human being.” This overly simplified view of prematurely cutting off the development of an idealizing transference was in direct opposition to the advice of Kohut. Kohut (1971) warned against any “tendency to be jocular with the admiring patient or to disparage the narcissistic idealization in a humorous, kindly way” (p. 263).

Among the other interviewees, the researcher noted opinions that were varied, but most were clearly influenced by the theories of Self Psychology (n=10/12). If Participant 5 had the

most concrete description of the idealizing transference, Participant 3 had the most conceptual, calling it:

A form of dreaming, a fantasy that allows. It serves us and our patients to dream about things that we want, ways we want our therapist to be with us, ways we imagine they are in the world. They're kind of embellished wishes.

This language reflected Mitchell's (1986) positive association with narcissistic illusions. Traditionally, illusions have been regarded as negative, defensive structures. However, Mitchell (1986) believed that a more contemporary approach to psychotherapy utilized illusions, such as idealization, as opportunities for exploration of the clinical relationship. Kohut (1971) felt that idealization represented the patient's attempt to establish critical developmental opportunities for herself, a selfobject relationship that was not available during childhood. Kohut (1971) regarded this act as one of creativity, "drawing on illusion for inspiration" (Mitchell, 1986, p. 113). Kohut saw the presence of the idealizing transference as a sign of the client's ingenuity and a chance for the client and clinician to be creative in their process. This resonated in the language of Participant 3 who artfully called the idealizing transference "a dreaming platform." Also, Participant 11 described the idealizing transference as "a place to imagine together."

The majority of participants described the idealizing transference as a reflection of an underlying developmental need, a view directly influenced by Kohut's theories. Some also acknowledged that it can serve defensive functions. Participant 2 described the presence of the idealizing transference as evidence of a "developmental derailment" or "self deficit." She explained, "It is often about attachment or regulation needs." This view was derived from Self Psychology and the pole of the idealized parent imago. It is at this pole of development where the child needs access to a secure parent who provides the ability to soothe and comfort. This

goes along with Participant 4's view of the idealizing transference as "containing." However, Participant 2 also emphasized that the idealizing transference is contextual and cannot be assessed and treated the same way across all clients.

The majority of participants felt that the idealizing transference was contextual, and that it meant different things to different clients. When asked to define the idealizing transference, Participant 2 stated,

Idealizing transference isn't any one thing. It can be a lot of different things in the context of how therapy evolves and what the person's developmental status is... and also current stressors. So I don't think every idealizing transference is the same.

Participants 10 echoed this opinion, stating:

I don't view it one way or the other. It just depends on the patient. I would have a problem generalizing it. It depends on what the patient brings to therapy. They will use it differently. It is a response to a history. It varies widely from patient to patient. I mean, if you go back to what Kohut says about it being a developmental step, I would tend to think that it is a reflection of what happened to that patient at that particular stage of his development. It is something that happens in the course of therapy. I believe it is co-constructed by patient and therapist.

Participant 9 also voiced a concern for overgeneralization when defining the idealizing transference. She stated, "I don't think there's any hard and fast rule that says that it serves or disserves the client. I think that it's entirely a function of the way the matter is handled between therapist and client."

## **Clinical Encounters with the Idealizing Transference**

**What does it feel like?** The researcher not only wanted to know how clinicians defined the idealizing transference, she wanted to know what it felt like in the room. Participants used specific encounters with clients to describe their clinical experiences with the idealizing transference. Participant 6 admitted, “When I was an intern, you know, when I was younger, I have to say I kind of enjoyed it.” However, the rest of the participants overwhelmingly reported that the idealizing transference made them uncomfortable. Participants explained that this discomfort was a result of not being seen for who they really were. Participant 7 said, “It’s very uncomfortable. It’s hard to negotiate that feeling. It’s hard not to start to pretend that you are that!” Participant 8 said:

It made me exquisitely uncomfortable. Hearing someone imbue me with healing capacity that I didn’t think I had yet was really unnerving. There was definitely a pull to correct the person. You know, there was this one client who had imagined I had a really good life just because I was wearing slacks and a button-up shirt. He thought I was wealthy and brilliant and so amazing. If he only knew that I was making \$16,666 that year! He would have been disabused of that idea!

In addition to discomfort, many participants described anxiety. Participant 2 recalled a time when she overheard a new client talking about her to the woman who worked at the front desk of the mental health clinic where she was employed:

She was saying how amazing I was, how I went to Smith College and how I am just the best. It made me want to throw up. It was such a hyperbole, but at the

same time, she was making it evident to me how desperate her needs were. Her needs were so profound. She couldn't tolerate anything less than perfection.

Participant 4 reported, "It made me so anxious. I wanted to correct her right away. That's not who I am!" Participant 4 went on to provide crucial information to the complicated nature of the clinician's response to the idealizing transference:

But it's okay for them not to see me realistically. It's okay for them to think of me the way they think of me, even if it's larger than life. It's for their benefit, not mine. In one's gut it doesn't feel authentic, but this is exactly why we need theory to guide us. So that we can tolerate the transference. Staying empathic with someone is allowing them to feel the way that they feel towards you, regardless. When you stay empathic with them, they will open up more and more, go further into the work.

Participant 4's response contrasted significantly with the responses of Participant 5, who demonstrated his inability to withstand the discomfort of the idealizing transference through his pull to immediately correct the client.

**Tolerating the transference.** When Participant 4 was asked to expand on what it was that she *did* with the idealizing transference, she explained that she "held the idealization," and emphasized once again that although the idealizing transference felt unpleasant to her, she had to hold the transference for the client's sake. Although none of the participants used the term transmuting internalization, they beautifully described the natural unfolding of the idealization that Kohut (1971) called transmuting internalization. They described what happened when the therapist was able to tolerate the discomfort. It may sound simple to "do nothing" with a client's idealizing transference, but simple does not mean easy. Participant 2 said of the idealizing

transference, “I don’t endorse it or challenge it. She [the client] needed someone confident and bigger than her to merge with. So I let it be.” Participant 8 expressed a similar sentiment, “I just kind of let it go. And I don’t think there’s harm in that.” Participant 10 also provided a response that reflected the delicate nature of the idealizing transference when she said, “I notice it.” It is important to note that most clinicians did not respond immediately to the idealizing transference, but allows its presence in the room.

After the idealization is present for as long as it needs to be, often over the course of many years, participants spoke about how they discussed the idealizing transference in session. Out of 12 participants, only one, Participant 5, indicated that he did not explicitly discuss the idealizing transference with his clients. He stated, “I would never use the word idealization with patients because that’s become jargon. I like to talk in plain English. So I say things like, ‘you know yourself or your spouse better than I do.’” Other participants openly investigated what the client idealized about them and explored why she might hold these beliefs. These discussions provided access to many of the client’s repressed emotions, especially envy which was the case for the client of Participant 8 who envied his supposed wealth. Participant 3 reported that “talking openly about the idealization makes the relationship more real. It also serves to tame our narcissism. It forces us to be real.” Participant 9 talked about how it is possible to explore the idealizing transference, but the client must feel sufficiently safe and the relationship must be firmly established before doing so. Participant 9 said:

It took a few years to establish that it was safe, that there was a real confidence and trust that we could talk about it without judgment. It was really okay for us to look at it. This person was extremely traumatized as a child and never had any access to a maternal and loving figure. There was a lot of gentle consistency to



elicit the safety to discuss it. Now it's okay because we've been working together long enough that we can talk about it and this person can reflect on it. They are very articulate and they are very in touch with their idealization of me. The idealization itself has become almost a presence and personality of its own in the room which is quite interesting.

Participant 9's description of the idealizing transference as a "presence in the room" showed that she utilized the idealizing transference as a clinical tool. Participant 8 also talked about how he utilized the idealizing transference to assess clients, and to a lesser extent, make clinical interventions. Participant 8 said that the idealizing transference was important "diagnostically" and that he used it to assist with "personality assessment," but cautioned that therapists cannot always view it as curative. While participant 8 endorsed overt clinical discussion of the idealizing transference, he felt that defensive idealizations deserved a traditional interpretation. The following quotation is from Participant 8 in regards to a client with Borderline Personality Disorder:

At first, I thought it was serving the treatment pretty well, but underneath there was a lot of envy, and in that regard, it served the treatment in that I was able to assess what was happening, but I saw that as a defense for sure and that needed to be analyzed. There were several years where we spent the bulk of the treatment vetting its [the idealizing transference] voracity, talking about why it would be there, all kinds of things, how she understood it, we had to explore how she thought I felt about it. It was fascinating. But in the end, it was part of an overall pattern for her, and that is why it needed to be interpreted. She tended to look for

mentors to put up on a pedestal. She had to come to terms with her own authority and learn that she was as good as these people. That was the work.

Participant 1 regarded some idealizing transferences as defensive, but did not feel that interpretation was always the best course of action. She said,

Even though it could be a defensive position, I feel like people idealize because that is what they need to do at that point in time and they will continue to do it until they don't need to do it anymore. So I see it as a necessary evolution, it's where someone is and where they need to go. It's developmental.

When the researcher questioned further on the topic of interpretation, Participant 1 said,

I'm not too big on the interpretive thing. I work dialogically, so I sort of approach it based on our mutually understanding and knowledge. So I may suggest some connections. There are times when we make connections that seem to crack open a way of knowing, and sometimes connecting the dots could be viewed as a sort of interpretation. Sometimes sharing knowledge about what's going on could be viewed as an interpretation, I guess.

Aside from Participants 5 and 8, most participants held similar views of interpreting the idealizing transference. They felt that the idealizing transference should be left alone, which is consistent with the recommendations of Kohut. Participant 6 explained,

The worst thing you can do at that point [if someone is idealizing the therapist in order to meet a selfobject need] is to interpret it. You don't want it to change. It just will... if you see them long enough. It has to run its course.

These descriptions of letting the idealizing transference exist in the treatment by withstanding the discomfort of the transference and letting it “run its course” are consistent with Kohut’s theory of Self Psychology.

### **Is There an Inevitable “Fall From Grace”?**

Participant 2 described planning for the potential devaluation of the idealizing transference with clients who are prone to idealizing. This was less aggressive than making a direct interpretation, but still a somewhat confrontational approach. Participant 2 discussed how to “soften the blow” for a client whose idealizing transference was likely to shift abruptly. This open discussion reduced the chance of a rupture in the therapeutic relationship. Participant 2 said:

It’s like setting the stage. I can present it early on if I see it coming down the pike. I might say something like, ‘I want to say that, you know, if the therapy works the way it's supposed to work, then at some point there may come a time when I am disappointing to you. And even if I try my hardest, I’m still only human, and I'll probably, at some point, be disappointing for you. What's really important is that when that happens, you will be able to comment and let me know. Because I can take it, and I won't be upset and we can work it through.’ I see that as more of an object relations thing than a developmental thing.

Participant 2 brought an important point to the table when she discussed how working with the idealizing transference is a way to work on the client’s object relations. Other participants voiced similar opinions about the importance of the idealizing transference and rupture and repair in the therapeutic alliance. Participant 6 said,

I think it's good to be let down, but hopefully it doesn't all come at once. Sometimes it happens that way, especially with people that are extremely vulnerable. Hopefully it happens gradually and then you talk about it. It's important to talk about in a non-defensive way. I might say something like, 'It's okay to get really pissed off at me. I'm not going to walk away.' That has been a major breakthrough for many people when they have gotten really angry at me, and I was still there. I want to understand, hear more about it. Not being reactive can be extremely therapeutic.

Participant 11 made a link between therapeutic process and the client's other relationships:

The nature of idealizing transferences is that they disappear! I mean, that's what a successful treatment is... to be able to see the other person, or you know, the therapist for who they are and be okay with it. There's this idea that being able to get to the point where people aren't perfect, they are going to disappoint you and you have to be able to live with that. That's what a successful treatment is. So I figure if a patient is stuck in idealizing transference for too long, then there would be a problem with the treatment.

Participant 11 showed that the client's ability to move through the idealizing transference represented the way the client could successfully navigate other relationships in her life. Part of moving through the idealizing transference for a client was being able to tolerate disappointment, learning to see someone as a whole person with all of their positive and negative qualities.

When asked about whether or not there is always a "fall from grace" in the idealizing transference, Participant 10 responded,

I would hope so. It's healthy. You ought to get there. You want to move through it. That's the rupture and repair model. Researchers actually attribute this to one of the most important structures for creativity. You need to be able to rupture and repair. And with that, inevitably after time, you will fall from grace. But it shouldn't be a crash and burn. It should be a very progressive series of small events in which you can co-construct and reflect with the patient what is going on... talk about how the patient is experiencing it, how you experience it. And over time, the patient should get to have a more realistic view of who you are and be okay with it. It's going to be disappointing, it always is, but that's part of life. In every relationship you go through that. The idea is that the therapeutic relationship mirrors all of your other relationships and if you are able to negotiate that one in a positive way then you will be able to take that knowledge or that feeling or that realization into your other relationships.

Participant 10 echoed the sentiment of participant 11 when she described how the therapeutic relationship serves as a template for other relationships in the client's life. Participant 10 saw the idealizing transference as a learning and growing opportunity for the client to navigate relationships.

Participant 8 held a unique view of the devaluation process, saying the following:

The fate of the idealizing transference is not just devaluation... because it can also resolve in admiration. Admiration is different than idealization. Admiration is born of real qualities and accomplishments that the person has that you can see and like. I also feel I've had many successful treatments now, so why can't some of the things they are describing in me be true and not delusional or defensive?

Participant 8 felt that an idealization could end in admiration, oftentimes, what he described as mutual admiration. Participant 9 also endorsed a relationship between idealization and admiration, as well as love. She reported, “Sometimes people start at idealization and sort of arrive at a more healthy, grounded feeling of love.” The contributions of participants 8 and 9 highlighted the connotations of the word “idealization” itself. Although most participants viewed the idealizing transference as a positive opportunity for the client’s psychological growth, they were all willing to admit that idealization could be reflective of a pathological personality.

### **Who is Prone to the Idealizing Transference?**

Clients who had the capacity to love or admire were described as clients who presented with the idealizing transference. Participant 8 described individuals who are more prone to the idealizing transference in the following way:

If you look at Kernberg’s book on love, the capacity to fall in love, to idealize, is a developmental achievement. In some ways, the capacity to idealize is a strength, a form of development. There are many people who have never been in love with anybody, especially schizoid patients, even their family of origin... child patients are... which connects to the healthy form or capacity to look for mentors, someone to admire, so that they can use that in terms of their learning and identity development.

Participant 3 expressed that “we are all prone to it.” Participant 4 clarified that we are all prone to the idealizing transference because “many of us have experienced a lack of attuned parenting. At least, many of the individuals who find themselves in therapy.” In addition to lack of attuned parenting, clients who have experienced trauma were also listed as more likely to idealize their

therapists. Clients who were survivors of trauma were more likely to have difficulty with self regulating and impulse control which is a direct consequence of missing selfobject needs at the pole of the idealized parent imago (Kohut, 1971).

When the researcher discussed the nature of the therapist's fall from grace, it was clear that clients on the borderline spectrum were most susceptible to an ever-shifting pattern of idealization and devaluation of their therapist. This tendency towards idealization directly correlates to these clients' tendency to split. Participant 9 described the connection between patients with borderline personality traits and splitting:

The Borderline Personality Disorder patients are the ones that will be problematic because that's the nature of BPD so with them it becomes very difficult. So the realization for them is so much more difficult because that's the nature of the underlying issue is that they see things in all black or white terms. You can definitely see the idealization happen more readily.

### **How Do Clients Use the Idealizing Transference?**

We have seen the variety of ways that clinicians described and addressed the idealizing transference, but how did they perceive clients made use of the idealizing transference? As we saw in the first section, clients reportedly used the idealizing transference to meet the selfobject needs that were not met during the course of their development. The needs provided by the therapist via the idealizing transference are directly in line with Kohut's (1971) selfobject needs at the pole of the idealized parent imago: the need for comfort and security, the need to merge with someone greater than oneself in order to feel safe, and the need to have goals and aspirations.

Many clinicians described how the client utilized them for comfort and security. Some clinicians described themselves as “the good enough mother” or even “the ideal mother” that the client never had. Participant 4 highlighted that the need for safety and security found in the idealizing transference is what allows some clients to come to therapy. She said:

I don't always see it the same way. But for people who its developmental, I see it as an important way for them to feel safe doing the therapy at all. And eventually, it becomes internalized and allows them to have a stronger sense of self.

Participant 12 reported, “75% of what I'm doing in therapy in subtle and not so subtle ways, is to repair what their [my clients] parents were not able to give them.” Participant 6 said, “You need to idealize someone when you are developing. You need to have that type of security.”

Participants 2 and 9 described use of the idealizing transference from a Kleinian perspective, where the client used projective identification in order to borrow qualities from the therapist. Participant 2 said:

We often forget about Klein's idea of projective identification. Sometimes people need to put their self-esteem in you because it's too fragile for them to tolerate, and you become like a lock box. This is something good! We tend to have a negative association with projective identification, but it's not necessarily something bad. Clients put in us qualities in them that are... nascent, underdeveloped, fragile. We locate it somewhere else for safekeeping because the client cannot tolerate it. Eventually they gradually can tolerate more and more of it until it can become their own.

Participant 9 discussed a similar phenomenon with a specific client, but warned that this type of borrowing could resemble the client taking on a false self (Winnicott, 1965).



I suppose if there is any degree of troubling, the most troubling it ever gets is when it becomes a situation where I feel that there is a temptation on the other person to subsume my personality or my mind. When I imagine this person out in the world, I know that there are times when she kind of borrows me to navigate a particular situation. That can be very helpful to this person. She has social anxiety, and I know that she channels me in social situations where she can barely be present so it's useful to her. It can be very useful but it can slide into a grey area into a sense of false self. Where the only time it ever becomes troubling is where I wonder if there is a little too much of the client gliding on the boat of a false self in a social situation.

Lastly, as discussed earlier, clients reportedly used the idealizing transference to practice the process of rupture and repair that occurs in healthy intimate relationships. Participant 12 elucidated,

There's this piece of communicating the durability of your relationship. If you [the client] gets pissed at me, I can take it. I am so durable and sturdy and I'll stick around. And then, we can work through it together. It's a place to practice this level of trust and working through.

### **Idealizing Countertransference**

More than half of the participants struggled to come up with a client that they had idealized. Admittedly, a lot of the struggle could have been related to the confusing nature of the question. Clinicians were not sure if their love and admiration of a client could be labeled an idealization. In the end, the researcher and the interviewees had to agree on a definition of what it meant to idealize a client before they could fully answer the question. Most participants felt

that if a client unnerved them or intimidated them to the point where they had to seek help in supervision, it was considered an idealization.

Many therapists admitted to idealizing clients whom they felt were intelligent. The presence of intellect was overwhelmingly more intimidating than clients with tremendous financial success or even celebrity status. One participant had to terminate therapy with a client whom she admired so much that they were unable to move deeper into the work. Participant 3 reported a similar experience, although she was able to negotiate her countertransference enough to maintain the therapeutic relationship. She said the following of the therapist's idealizing countertransference:

It keeps the process from going deeper, it keeps the client and clinician from taking risks when you idealize them. We want it to stay lovely and romanticized.

Therapist and patient can collude with the patient to keep it there, too.

Participant 7 offered an excellent example of how her idealization of Ivy League schools interfered with a client's process. She reported:

When I found out that she went to Yale, I said 'congratulations,' but this foreclosed exploration of what that meant to her. I found out soon enough that my client felt that Yale was bullshit and that getting in was the hard part and the rest was really easy. I idealized the Ivy League so it was always in my mind that she was a lot smarter than I was. It didn't overtly interfere with our work, but I think what made it okay is that she clearly needed my help and after a while it didn't matter that she was so smart. We would get into long debates about whether she was worthless, or worth anything. It was impossible to win an argument with her. In short, I admired her status as an Ivy League graduate but I

was able to feel that she admired me back so it ended up being kind of a growth experience for me. Because I was able to in my own way, proceed through a level of development, perhaps.

Participant 8 also described a client who he idealized for her intellect. He described his experiences with this client below:

With one patient, we had a mutual admiration club. We had this motto, ‘We can do anything! We’re brilliant and hard-working!’ She was in the field, too. But I came to see that her believing that she could accomplish anything was a problem because she was a graduate student! There were real limitations there that we had to look at together.

Participant 2 did not feel that she idealized the intellect of any of her clients, but she idealized a client whom she felt was “strongly rooted in her sexual identity.” Participant 2 said that at the time she was treating this client, she was feeling particularly insecure around her sexuality. This client had a specific impact on her in this state of vulnerability. Participant 6 was unable to identify a client whom he idealized, but he reported that there were many times when he experienced a strong longing to be a client’s friend as opposed to their therapist.

Many participants expressed difficulty identifying a client whom they idealized, and Participant 5 denied ever having idealized a client. Although they were unable to identify a client whom they idealized, these participants offered interesting reflections on the idealizing countertransference. Participants 9 and 12 pointed out how the therapeutic set-up lends itself to the process of idealization because clients put their best foot forward when they come to therapy. Furthermore, they are more likely to put their best foot forward if they idealize the therapist. Participant 10 endorsed a similar sentiment, saying,

It's very unlikely that I will dislike someone that walks into the room. You know, people walk in to the room with a need to be loved, so like any romance, people present themselves using the parts of themselves that are the most loveable.

Lastly, Participant 11 made an interesting observation, saying,

The achievement that my poorest client makes in an effort to be happy is the same to me as the achievement of my super wealthy and successful client. It's all about their ability to do what makes them happier. I'm kind of a little different from other clinicians in this regard, just based on feedback I've gotten.

### **Idealization of Supervisors, Mentors, Therapists, and/or Analysts**

The usefulness of the idealization process does not stop at the relationship between mother and child or client and clinician, it also extends to clinicians and their mentors, supervisors, therapists and/or analysts. Participants unanimously agreed that it is vital for clinicians to have access to supervisors, mentors, and therapists that they can idealize. All participants expressed idealization of their own therapists, but only about half of participants were able to report that they had a supervisor whom they idealized. Participant 10 shared a story about her supervisor regarding idealization in therapy:

One of my supervisors said, you are always going to fall in love with your analyst and then look at your spouse and say, 'what's wrong with you?' Because who else in your everyday life sits down and focuses on you intensely for 45 minutes and processes everything you're saying as important? (Laughs) And doesn't get distracted. Of course you idealize this person!

Participant 3 shared on the importance of idealization of supervisors, saying,

We need to idealize supervisors and mentors. We hope it's a gradual devaluation, but never complete because you still admire them! We have to have them! Over time, they become more dimensional. It's good. They get into your cells. You have a felt experience of them personally.

Participant 7 also shared about her idealization and devaluation process with her therapist:

For the first however many years I would compare myself to her in a negative way, thinking, 'Oh she would know what to do with this client. Boy, was I stupid to think this work was easy!' But I know that I have learned so much from her, and I have absorbed so much from her and of the way she works. So I think I would respond in ways that she would have responded and I catch myself using some of her explanations for things... I used to think that she was indestructible and intellectually perfect and that everything she said was absolutely true and right, but it's gotten refined into a really deep respect for her.

In this instance, the term idealization was questioned as clinicians reported a deep admiration and respect for their therapists, supervisors, and mentors. Participant 8 voiced here, similarly as he did in an earlier question on the idealizing transference, that the devaluation process is not necessary for an idealization to lose its intensity. It can simply morph into admiration and respect. Participant 8 reported,

I had a long course of idealizing my therapist of 11 years and it sort of resolved gradually. You know, I saw his quirks and the chinks in the armor, but many of the qualities that I admired in him were simply true.

## **CHAPTER V**

### **Discussion**

The purpose of this study was to explore how clinicians in the field of psychotherapy defined and addressed the idealizing transference. Interview questions were designed to explore how clinicians described the idealizing transference, how they viewed its role in treatment, and what their personal experiences have been with the idealizing transference. The results generated from this study supported the argument that clients can benefit from the clinician's ability to tolerate the idealizing transference. Ten out of 12 of the clinicians interviewed for this study felt that holding the idealizing transference was more important than interpretation.

The choice of participants to hold the idealizing transference instead of interpreting it was consistent with the views of Kohut (1971, 1977, 1984). Kohut (1971) felt that transference interpretations were destructive and unhelpful, and the client should be able to utilize the therapist as a selfobject to meet specific developmental needs. Kohut's new take on transference, whereby the therapist meets specific developmental needs of the client, was reflected in the responses of 11 out of 12 of the participants in this study.

### **Demographics**

There was no apparent correlation between responses of the participants and their academic credentials. Also, there was not a consistent trend between participant responses and number of years in practice. However, the responses of Participant 5, who had been practicing for the most number of years, reflected more traditional psychoanalytic tradition. The researcher did not note a relationship between participant gender and responses.

## **Defining the Idealizing Transference**

**A contemporary perspective.** Ten of the clinicians that were interviewed related the idealizing transference to the theories posited by Kohut (1971, 1977, 1984). One clinician was more cautious. He felt that therapists have been so influenced by Self Psychology that they often forget that idealization can be a defense. Another participant held a fairly superficial view of idealization and failed to see its clinical implications.

Ten out of 12 participants who viewed the idealizing transference as an opportunity for growth were directly influenced by the theories of Kohut and the role of selfobjects. These clinicians utilized the presence of the client's idealizing transference in order to determine where these clients were in their psychological development. Another way of saying this would be that they utilized the presence of the idealizing transference as an indication that the client was lacking the selfobject needs at the pole of the idealized parent imago (Kohut, 1971). These needs are to have someone wonderful and greater than oneself to merge with in order to feel safe and secure within oneself. The pole of the idealized parent imago needs to see strength and wonder outside of the self, in others, in order to merge with their own growth-enhancing qualities (Berzoff, Flanagan, & Hertz, 2011, p. 172).

The researcher heard interviewees describe different clients who did not have access to the selfobject needs of the idealized parent imago in the course of their psychological development. These clients were described as "survivors of trauma," individuals with "insecure attachment relationships," "lack of attuned parenting," "regulation needs," "self deficits," "part object relating," and "object hungry." The participants agreed that for these clients, whom the need for the idealizing transference was developmental, it should especially not be interpreted.

The interviewees also acknowledged that the idealizing transference was contextual and each client must be assessed according to their personal history. The participants' responses suggested that there cannot be a manualized treatment approach to working with the idealizing transference. One of the interviewees, who identified as a Self Psychologist, admitted that perhaps for a particular client, interpretation of the idealizing transference would be beneficial. This willingness to regard every client and every treatment as unique is indicative of a more relational approach to treatment. Not surprisingly, half of the participants in this study identified themselves as relational therapists.

For the majority of the participants who regarded the idealizing transference as a positive transference, their responses were consistent with the writings of relational psychoanalyst Slochower (2011, 2014) in multiple ways. Firstly, a few participants emphasized that the idealizing transference was a co-created phenomenon between client and clinician. This was especially true for participants who overtly identified as relational therapists. This view of the transference was consistent with the writing of Slochower (2011) who defined the idealizing transference as a co-created process where both client and clinician share in the illusion (p. 4-5). In the words of Participant 10, "We create it together. It doesn't happen on its own,"

Secondly, like Slochower, the majority of the participants saw the facilitative benefits of the idealizing transference. Instead of viewing it as a defense that needed to be interpreted, they viewed the illusion of idealization in a positive light (Mitchell, 1986). Slochower (2014) stated of the idealizing transference, "Idealizations create a partially illusory protective buffer that facilitates inner exploration" (p. 130). This view was directly expressed by Participant 4 who shared that the idealizing transference creates enough safety for many clients to be able to participate in therapy at all. For just this reason, Slochower (2014) called idealization a



“therapeutic support.” Other participants like participants 3 and 11 also described idealization as a positive illusion, a place where the client and clinician can dream their ideal therapeutic relationship, and also a place where the client can dream how she wants to be in the world.

Lastly, in her most recent book, *Psychoanalytic Collisions*, Slochower (2014) utilized relational theorist Jessica Benjamin to explore the relationship between love and idealization. Two participants that were interviewed also expressed this relationship, especially Participant 9. Benjamin (1994) described idealization as “identificatory love.” Participant 9 stated, “there is a fine line between idealization and love.” Another participant shared similar views when they expressed that the work of therapy would not be possible without love for the client and the client’s love towards their therapist.

### **Clinical Encounters with the Idealizing Transference**

**Transference.** The process of transference is especially useful in the clinical relationship because it provides access to the client’s unconscious and internal processes (Berzoff, Flanagan, & Hertz, 2011; Thompson, 1945). Contemporary psychotherapy continues to view transference as a transformative vehicle for psychological growth, however, the ability to hold a transference has become more important than transference interpretations (Marmarosh, 2012). In reference to how to handle a client’s idealizing transference, Slochower (2014) stated, “A genuine tolerance for personal complexity and contradiction makes it easier to accept a patient’s idealization without fully embracing or rejecting it” (p. 135). “Holding” can be viewed as not fully embracing or rejecting. This view was reflected in 10 out of 12 participant responses.

The participants’ willingness to tolerate the discomfort elicited from the idealizing transference reflected their ability to do sophisticated clinical work. In her article, “Empirically Supported Perspectives on Transference,” Marmarosh (2012) described more contemporary

approaches to working with transference. All but one participants reported contemporary approaches to working with transference as described by Marmarosh. For example, although they did not necessarily use the terminology, participants described holding the idealizing transference as a corrective emotional experience, a phrase coined by Franz Alexander (1891-1964). In the idealizing transference, the client was able to obtain needs that were not met in her development, therefore having a corrective emotional experience. These needs could have gone unmet due to childhood trauma and/or misattuned parenting. The opportunity to have these needs met in therapy can be tremendously healing.

Again, although most participants did not use the terminology transmuting internalization, they described the process of the clients' slow and gradual ability to incorporate aspects of the therapist into themselves over time. Kohut (1971) described the process of transmuting internalization as performed by a selfobject through the use of optimal mirroring, interaction, and frustration. As the self takes in the functions of selfobjects, they are gradually changed and made one's own so that the healthy self is not a mere replica of the selfobject (Berzoff, Flanagan, & Hertz, 2011, p. 176). The participants' ability to hold the idealizing transference allowed for this natural unfolding to take place.

**Countertransference.** All of the clinicians interviewed agreed that the presence of the idealizing transference made them uncomfortable. This seemed to be a reasonable countertransferential reaction to being idealized. Participant 2 made reference to Klein's contribution to countertransference, projective identification, and related this to how she conceptualized working with the idealizing transference. As opposed to the client viewing the therapist as a selfobject to merge with, Participant 2 described the process where the therapist holds qualities, "like a lock box," for the client who is unable to tolerate those qualities in

herself. These qualities are often qualities worthy of idealization, such as intelligence, confidence, or groundedness. The client is unable to honor these qualities in herself, but she is able to idealize these qualities in her therapist. Over time, the therapist helps the client incorporate these qualities and make them part of herself.

One usually thinks of projective identification in terms of the introjection of negative traits into the therapist, however, the client can introject positive qualities into the clinician as well. Ogden (1979) outlined four functions of projective identification. The function described by Participant 2 was concordant with Ogden's (1979) description of projective identification as an important pathway for psychological growth and change where the projector identifies with the qualities she has projected onto the other person. The client gradually identifies with these qualities she has introjected into the therapist, slowly internalizing them to be her own.

Only one participant that was interviewed responded to the pull to correct that comes with being on the receiving end of the idealizing transference. This participant did not necessarily use the presence of the idealizing transference to make interpretations, he simply cut it off from the get-go by telling the client to stop. The researcher suspected that this participant's choice of intervention was not grounded in any theoretical approach. He was simply too uncomfortable to withstand the transference, or he did not recognize the clinical relevancy of the idealizing transference. Perhaps he was regarding transference in more traditional terms where it "included all attitudes that a patient has towards his therapist" (Thompson, 1945) instead of considering the therapeutic relationship as a template where the client's other relationships will play out.

**The devaluation process.** Participants who regarded the therapeutic relationship as a template where the client's other relationships will play out were able to see the benefits to

tolerating the idealizing transference, holding the transference for as long as the client needs it to be held, and then discussing the idealization when the client is ready to discuss it.

Participants reported that these discussions were useful in helping their clients learn about rupture and repair and also to decrease their tendency towards splitting. Participants described conversations with clients about their idealizing transference where there was a gradual devaluation as well as an abrupt, ever-shifting idealization and devaluation process. The latter tended to happen with clients who were more prone to splitting.

The gradual devaluation process was described by many participants as a fascinating experience where they could slowly watch their therapeutic relationship evolve. The devaluation process was generally described as starting after a few to several years of treatment. In that process, the client was described as slowly becoming more able to see their therapist in a realistic light, as Participant 3 said, “more three-dimensionally.” Most of the clinicians reported using the illusion of idealization as a way to explore what the client wanted from life, how they viewed themselves in the world, and how they perceived their therapist. Participants discussed using self disclosure to de-bunk aspects of the client’s idealizing transference, but only after many years of treatment and the foundation of a strong therapeutic alliance.

### **Personal Encounters with the Idealizing Transference**

**Idealizing countertransference.** Many participants struggled to come up with a specific client whom they had idealized, but others were immediately forthcoming. The challenging nature of this question was not surprising to the researcher since this is a relatively new topic in psychodynamic literature. As the researcher highlighted in the literature review, the only existing literature on idealizing countertransference was published by New York psychoanalyst Joyce Slochower in the journal *Psychoanalytic Dialogues* and in her newest book. Most

participants discussed clients whom they felt that they admired for their intellect. In one instance, Participant 4 had to terminate therapy with a client because the idealization was too strong. In the case of Participant 8, he sought help from his supervisor in an effort to tame his idealization of a client who he described as a highly intelligent graduate student.

In the idealizing countertransference reported by Slochower (2011, 2014), Winnicott also reportedly admired his client, Masud Khan, for his intelligence. Similar to Participants 7, 8, and 12, Winnicott admired Khan not only because he was very intelligent, but because he was in the psychotherapy field. As participant 10 humorously reported, “We are a field of narcissists, so it does not surprise me that we would idealize our clients who are successful therapists.”

Winnicott and Khan maintained a professional relationship after Khan’s analysis ended.

Winnicott would refer patients to Khan and Khan helped Winnicott edit professional papers (Slochower, 2011, p. 10). Further exploration of the professional implications of the relationship between therapist and client when the client is a therapist in training could be quite fascinating.

**Supervisors, mentors, and therapists.** All participants unanimously agreed that the idealization of supervisors, mentors, and especially, therapists was crucial to their personal and professional development. The researcher initially undertook this project to further explore the impact of her own idealizing transference. Participants spoke fondly, often with nostalgia, of their first encounters with the idealizing transference in their own therapy. They also spoke about analytic figures whom they admire who continue to help guide their clinical practice. They also described shame associated with not being able to live up to these ideals. All participants described a gradual devaluation process where they continued to admire and respect their therapists and supervisors but let go of their idealization. In his article on psychoanalytic figures as transference objects, Spurling (2003) stated of this process,

In order to be able to theorize for oneself it is necessary to start to free oneself from the authority of received theory, and to separate from the former figures of identification, one's teachers and those royal psychoanalytic figures they represent (p. 32).

Just as the idealizing transference is crucial for personal psychological development, it is important for professional development. All participants agreed that clinicians require role models and touchstones from which to develop their own form of practice.

### **Implications for Social Work Practice**

This study described how therapists define, describe, and address the idealizing transference. This study also provided insight into how clients make use of the idealizing transference through specific clinical interventions, and how clinicians view their own role in the idealizing transference. The results of the study suggest that the therapists' ability to hold the idealizing transference for a client can be critical to their psychological development. Ten out of 12 participants regarded the idealizing transference as an opportunity for growth as opposed to a defense. It would be interesting to do another qualitative study to explore how contemporary psychotherapists view defense mechanisms and when, specifically, the idealizing transference is considered a defense? It would also be interesting to explore how contemporary psychotherapists view interpretation, seeing how the definition of a transference interpretation has evolved over time.

This study may be relevant to the field of clinical social work for many reasons: 1) It encourages clinicians to take a closer look at how they utilize the idealizing transference, 2) It affirms the importance of the theories posited by Kohut and their influence on contemporary psychotherapy practice, and 3) It affirms the importance of tolerating an uncomfortable transference for the client's sake. Further research on the idealizing transference should be

conducted so that the field of social work continues its alignment with psychodynamic theory and practices. Further investigation on the idealizing transference may help dispel the common myth that privately practicing therapists rely on the idealizing transference in an effort to keep their clients in therapy.

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**APPENDIX A**

**INFORMED CONSENT FORM**

**Consent to Participate in a Research Study  
Smith College School for Social Work • Northampton, MA**

.....

**Title of Study:** Idealized Transference and Counter-transference in the Therapeutic Dyad: An Exploratory Study

**Investigator(s):** Christine Spera, Smith College School for Social Work 2<sup>nd</sup> year MSW candidate,  
(555) 555-5555.

.....

**Introduction**

- You are being asked to take part in a research study on idealization in the therapeutic encounter.
- You were selected as a possible participant because you are a licensed clinician who applies psychodynamic theory in practice.
- I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

**Purpose of Study**

- The purpose of the study is to explore similarities and differences among clinicians in how they address idealized transference and counter-transference in the therapeutic dyad.
- This study is being conducted as a research requirement for my master’s in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

**Description of the Study Procedures**

- If you agree to be in this study, you will be asked to do the following things: meet with the researcher for one 45-60 minute semi-structured interview that will be audio recorded. The interview will include questions about your experiences with idealized transference and counter-transference in clinical practice.

### **Risks/Discomforts of Being in this Study**

- There are no reasonable foreseeable (or expected) risks to participating in this study.

### **Benefits of Being in the Study**

- The benefits to participation in this study are having the opportunity to talk about your clinical experiences and potentially gaining insight into your clinical practice.
- The potential benefits to social work/society are: contributing to an empirical study that may further the field of psychodynamic psychotherapy.

### **Confidentiality**

- This study is anonymous. I will not be collecting or retaining any information about your identity.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. I will not include any information in any report I may publish that would make it possible to identify you.

### **Payments/gift**

- You will not receive any financial payment for your participation.

### **Right to Refuse or Withdraw**

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researcher of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by April 1<sup>st</sup>, 2015. After that date, your information will be part of the thesis.

### **Right to Ask Questions and Report Concerns**

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Christine Spera at [cspera@smith.edu](mailto:cspera@smith.edu) or by telephone at 610-247-0466. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

**Consent**

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....

Name of Participant (print): \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_

.....

**[if using audio or video recording, use next section for signatures:]**

**1. I agree to be audio taped for this interview:**

Name of Participant (print): \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_

**2. I agree to be interviewed, but I do not want the interview to be taped:**

Name of Participant (print): \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_



## APPENDIX B

### TRANSCRIBER'S CONSENT FORM

#### **Volunteer or Professional Transcriber's Assurance of Research Confidentiality**

This thesis project is firmly committed to the principle that research confidentiality must be protected and to all of the ethics, values, and practical requirements for participant protection laid down by federal guidelines and by the Smith College School for Social Work Human Subjects Review Committee. In the service of this commitment:

- All volunteer and professional transcribers for this project shall sign this assurance of confidentiality.
- A volunteer or professional transcriber should be aware that the identity of participants in research studies is confidential information, as are identifying information about participants and individual responses to questions. The organizations participating in the study, the geographical location of the study, the method of participant recruitment, the subject matter of the study, and the hypotheses being tested are also be confidential information. Specific research findings and conclusions are also usually confidential until they have been published or presented in public.
- The researcher for this project, Christine Spera, shall be responsible for ensuring that all volunteer or professional transcribers handling data are instructed on procedures for keeping the data secure and maintaining all of the information in and about the study in confidence, and that that they have signed this pledge. At the end of the project, all materials shall be returned to the investigator for secure storage in accordance with federal guidelines.

#### **PLEDGE**

I hereby certify that I will maintain the confidentiality of all of the information from all studies with which I have involvement. I will not discuss, disclose, disseminate, or provide access to such information, except directly to the researcher, Christine Spera, for this project. I understand that violation of this pledge is sufficient grounds for disciplinary action, including termination of professional or volunteer services with the project, and may make me subject to criminal or civil penalties. I give my personal pledge that I shall abide by this assurance of confidentiality.

**APPENDIX C**  
**RECRUITMENT LETTER**

Licensed therapists,

Are you interested in IDEALIZATION? Do you have an interesting story to share on idealized transference? Have you ever struggled as a clinician with the idealization of a particular client? Do you have something to say about how clinicians use idealization as analytic information? If so, or if you're not sure but intrigued, I want to talk with you!

I am a Masters of Clinical Social Work student from Smith College, one of the oldest and most respected graduate schools of clinical social work in the country. I am currently living and interning in West Los Angeles and writing a thesis on idealization, namely idealizing transference, and the lesser-researched topic of "reverse idealization," or idealizing countertransference.

I am looking for practicing clinicians who would be willing to participate in a 45-60 minute interview on the topics discussed above. Your responses may contribute to filling the gap in social work literature on an area of inquiry that can inform clinical interventions and improve social work practice.

I can be reached at xxxxxx@smith.edu.

THANK YOU FOR YOUR INTEREST IN MY STUDY!

## APPENDIX D

### INTERVIEW GUIDE

1. How do you define idealization? Can you tell me about your earliest experience with idealization? Was it a parent? A friend? A superhero? A teacher?
2. How do you define idealization in therapy?
3. Do you view idealization of the therapist as a defense (traditional view) or as a part of necessary development (more contemporary view)? What does your client's idealization of you tell you about them?
4. Can you talk about a specific client (disguising their identity) that idealized you and elicited particularly interesting or troubling counter-transferential reactions? How did you choose to handle this transference? Did you interpret it? Did you just "let it be"? How did the idealization impact the therapeutic alliance? How did you handle the inevitable devaluation process?
5. Can you talk about a time when you, the therapist, idealized a client? What was their diagnosis? Did the client's diagnosis impact your idealization of them? How did this affect the therapeutic alliance?
6. What has your experience been with idealizing supervisors or mentors while you were in training? How about currently?
7. How do you utilize your experiences with idealization in your own therapy when you are working with clients?
8. Do you think that certain themes or areas are more likely to elicit feelings of idealized transference? How about counter-transference? Do you feel that clients who have experienced trauma are more likely to be idealized?

9. When does a client's idealized transference serve them? When does it inhibit their progress in treatment?

## APPENDIX E

### HUMAN SUBJECTS REVIEW BOARD APPROVAL



#### School for Social Work

Smith College

Northampton, Massachusetts 01063

T (413) 585-7950 F (413) 585-7994

December 18, 2014

Christine Spera

Dear Chrissy,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read "Elaine Kersten". The signature is written in a cursive style with a large initial "E".

Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: John Erlich, Research Advisor