Commentary on “Transference as a Therapeutic Instrument”

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Foreseeing the Real Relationship

Having completed residency and psychoanalytic training in the Midwest, I missed the fascinating history of political intrigue surrounding psychoanalysis in New York City and Washington, D.C. Clara Thompson was a central figure in such events, particularly in New York. Her career was certainly colorful, and I will assume that perhaps other readers, like me, know little of the intrigue or of her writing. Indeed, in neither my residency nor at the psychoanalytic institute had I ever been assigned to read anything by her or about her. I can recall no teacher ever mentioning her. Her conspicuous absence in my education may reflect the provincialism of my teachers, the orthodoxy of American psychoanalysis during the past 60 years (Heinz Hartmann, 1956, demeaned the interpersonal school by referring to its members as “culturists”), my lack of initiative in reading beyond the assigned papers, or a combination of all three. Providing a commentary on one of Thompson’s papers can be understood as either a lack of humility (chutzpah) or, hopefully, curiosity that has yet to disappear. With these caveats, I will share what I have learned about Clara Thompson’s life and then comment on her article, “Transference as a Therapeutic Instrument.”

THE LIFE OF CLARA THOMPSON

Like her influential and close colleague, Harry Stack Sullivan, Thompson was said to have struggled with her sexuality and loneliness as a child, college student, and throughout her professional career. As a young adult, she decided to leave the church and became estranged from her highly religious mother for more than 20 years. During the last year of college, she became engaged to a man who demanded that she choose marriage and abandon her hope of studying medicine. Thompson chose to attend Johns Hopkins and broke off the relationship and never married.

Numerous authors have noted that Thompson possessed a rebellious streak as exemplified in her college yearbook entry, where she stated that her future plans were to “Murder people in the most refined way” (Moulton, 1986, p. 89). During her residency at the Phipps Clinic in Baltimore under Adolph Meyer, Sullivan attended one of her talks on schizophrenia. Thus began a very close and enduring relationship, and he undoubtedly became the most significant influence on her thinking throughout her career.
He pressed her to move to Budapest and undergo an analysis with Sandor Ferenczi, whose ideas on childhood trauma Sullivan found attractive and believed should be introduced in the United States. (It was rumored that as a child, Thompson suffered significant sexual abuse at the hands of her father.) Sullivan also hoped that once analyzed in Hungary, Thompson would return and become his analyst.

After Ferenczi’s unexpected death in 1933, Thompson moved to New York City and joined the New York Psychoanalytic Institute, where she taught and worked closely with Karen Horney and Eric Fromm, whose writings provoked the Institute, leading to the ouster of Horney in 1941. Thompson sided with Horney and others, leading to the creation of the Association for the Advancement of Psychoanalysis, a short-lived group that was marked by an intense rivalry between Horney and Fromm. With assistance from the Washington School of Psychiatry (Janet and David Rioch, Frieda Fromm-Reichmann, and Sullivan), a New York branch (later becoming the William Alanson White Institute) was created and Thompson became its executive director, a position she held until her death in 1958.

There is much more to be said of her time in Budapest and her own questionable clinical practice, affairs, and analysis with Ferenczi (which appears to have involved physical contact), about which the reader is referred to Shapiro (1993) for more evocative stories. However, her time with Ferenczi, albeit stormy, was important to Thompson’s development of her positions on feminine psychology and the therapist-patient relationship, the latter complemented by Sullivan’s ideas as well. Ferenczi accurately perceived the importance of the preverbal in working through early childhood trauma and avoiding the retraumatization of patients; however, his reputation for questionable practices with his patients destroyed his professional standing after his dramatic break with Freud (Masson, 1984). In the early 1950s, significant acrimony developed between the American Psychoanalytic Association and the White Institute when the latter was not permitted to train analysts. By 1956 the more open and liberal American Academy of Psychoanalysis was formed, although Thompson was disappointed in this organization’s barring PhD psychologists from full membership.

**The Writing of Clara Thompson**

For the sake of brevity, Thompson’s contributions to psychoanalysis can be placed into four categories:

2. Elucidation of interpersonal psychiatry (*Interpersonal Psychoanalysis: The Selected Papers*, 1964, edited by M. R. Green)
4. Refinement of the concepts of transference and countertransference and greater appreciation of the contribution of the therapist’s personality to the treatment relationship (“Transference as a Therapeutic Instrument,” 1945/2014)

With respect to the first category, she was open-minded and inclusive about the contributions of many schools of thought and delineated what she believed were the limitations of classical analytic theory. Second, she embraced the interpersonal model of psychiatry as espoused by Sullivan that, among other things, elevated the role of cultural contributions to personality development and psychopathology (Sullivan, 1953). Both Thompson and Sullivan therefore at-
tempted to bring balance to the classical psychoanalytic reliance on drive theory and intrapsychic phenomena by emphasizing the importance of the interpersonal/interactional approach. They recognized the enduring imbalance accorded to social contributions within what today is called the biopsychosocial model. It is likely that Thompson is remembered most for being a psychoanalytic pioneer in the study of female psychology and aspects of women in treatment (Thompson, 1950/1964b, 1964a). She placed great emphasis on the role of culture in defining the characteristics of men and women. For her, gender was a product of the cultural meanings assigned to observable biological differences, and she recognized, for example, the limitations placed on adolescent girls through differential social treatment (Thompson, 1942/1990). She was also attuned to the impact of economic inequality on modern women and considered some alleged female differences such as seductiveness and the propensity for narcissism, noted by Freud, as mechanisms to address the limited opportunities for women. In addition, Thompson (1947) wrote an important paper on homosexuality and psychoanalysis.

**SOME COMMENTS ON “TRANSFERENCE AS A THERAPEUTIC INSTRUMENT”**

Thompson’s first point in her paper is to specify a narrower view of transference by restricting its use to the irrational aspects of the doctor-patient relationship. Building on Ferenczi’s ideas, she criticizes the attribution of all feelings toward the analyst to transference and notes that a patient’s nondistorted feelings regarding, for example, the helpfulness of the therapist is a component of what Greenson (1967) would term the real relationship some 20 years later. Greenson used the term “real to refer to the realistic and genuine relationship between analyst and patients opposed, that is, to unrealistic and inappropriate, albeit genuine, transference reactions” (p. 217). Zetzel (1956) and Greenson (1967) would later introduce their concepts of the therapeutic alliance and the working alliance, respectively, to refer also to a nontransference component in analysis that is necessary for successful treatment. Today psychotherapy research has confirmed that the most potent predictor of positive treatment outcome is the therapeutic alliance.

Thompson’s second point addresses the contribution of the therapist to the therapeutic process by acknowledging that a patient’s hostility toward the therapist may be an accurate reflection of what will later be termed in the literature an empathic failure or unanalyzed countertransference. To explicate this point more concretely in my teaching to residents, I might refer to the myth of the analyst as blank screen that categorizes all feelings by the patient as distortions placed onto the analyst. In other words, this would constitute a one-person model of treatment. This notion, of course, is a caricature of what transpires in analysis but is illustrative of a position that the analyst’s contributions to the dyad, be it his or here demeanor, personality, or speech, are somehow less significant than those of the patient. Thompson, then, is foreshadowing what will evolve from self psychology and relational/intersubjective psychoanalysis. The latter argues that there can be no effective treatment without the appreciation that the contributions of the analyst/therapist are as important as those of the patient and that the treatment experience is a cocreation by the patient and the analyst. Simply, Thompson urges moving beyond blaming the patient and appreciating the role of the analyst’s personality and capacity to evoke certain feelings in the patient that determine his or her unconscious response based on earlier developmental experiences (see also Thompson, 1956/1964c). Greenson would later advocate for the genuineness of the real relationship through admission of errors on the part of therapist.

It is clear that Thompson, as later did Kohut, subtly questions the primacy of the
Oedipus complex and alludes briefly to a central concept of attachment theory in her description of how the child develops in his or her relationship to the primary caretaker. This emotional reciprocity will later be incorporated into the idea that a patient, like an infant, must achieve a secure base in treatment. Thompson acknowledges that after the oedipal conflict, new significant personalities influence development and contribute to irrational ways of responding to others that become manifested in the transference during treatment. In other words, personality development does not end with the resolution of the oedipal stage. The reader will note that Thompson does not mention drive theory anywhere in “Transference as a Therapeutic Instrument.”

Thompson subscribes to the classical analytic position that favors insight as more effective than that utilizing the transference as a basis for suggestion or manipulation. She does acknowledge that the latter can be helpful in many situations outside of psychoanalysis. Effective psychoanalysis consists of assisting the patient to become curious about how his or her mind works. With each discovery of how and why, the patient is compelled to act in a specific way. Thompson believes there is a “modification of the personality in the direction of mental health” (1945/2014, p. 4).

Self psychologists would undoubtedly criticize Thompson’s ideas of demonstrating to the patient that the analyst is not a paragon of virtue and omniscience. This debunking of the patient’s idealization of the analyst would become a central issue in a self psychology–informed treatment through examination of an idealizing transference.

Thompson first read her paper during the April 1945 American Psychopathological Association meeting. Unsurprisingly, she notes the impact of World War II on the question of brief psychotherapy utilizing recognition and interpretation of transference leading to insight versus those approaches that favor medication (narcoanalysis) and hypnosis that utilize transference as a means for influencing patients by authoritative suggestion. She correctly notes the limited but no less important goals of brief psychoanalytic psychotherapy compared to psychoanalysis. This is an idea that will be found in the works of Franz Alexander, David Malan, John Mann, Peter Sifneos, Hans Strupp, Lester Luborsky, Mardi Horowitz, and many others (Kay, 1997). All modern brief psychoanalytic psychotherapies have adopted Thompson’s idea that acute traumatic experiences can be treated effectively by selecting a focus without emphasizing long-standing characterological issues. Although the degree to which transference is interpreted varies in the psychoanalytically informed brief psychotherapies, all advocate, as did Thompson, for the importance of recognizing it.

In contrasting narcoanalysis and hypnoanalysis to a more interpretive approach, Thompson notes the powerful role likely played in the therapeutic relationship by the first two treatments. She is prescient in her view that positive outcome with medication is strongly dependent on the ability of the physician to establish a sense of security and safety for the patient. She also rightly acknowledges that drugs could abbreviate the common initial period of treatment resistance and permit the patient to recover more quickly. That the effectiveness of medication relies on the strength of the doctor-patient relationship has come to be a firmly established practice in psychiatry, although in the early ascendency of psychopharmacology, psychoanalysis was remarkably disdainful of the use of medications.

In conclusion, it appears that my training experiences were indeed deficient and I have discovered why. The interpersonal model of Sullivan and Thompson, with its insistence on the importance of culture, was rejected by orthodox psychoanalysis beginning the 1950s, and this devaluation clearly persisted, more than 20 years later, throughout all of my postgraduate experiences. Many of Clara Thompson’s ideas have become integrated into our treatment of all patients regardless of their disorder and
symptomatology. She has much to offer today’s medical students and residents in establishing effective doctor-patient relationships through her advocacy of nontransference elements. Over the past half century, this concept has evolved into the most central issue today in psychoanalytic technique; namely, how to appreciate the contributions of the analyst to the treatment experience. This question has led to a reconceptualization of countertransference. Many now argue that there can be no patient transference without a corresponding countertransference. Even the analyst/therapist use of self-disclosure is considered to have a role in the treatment relationship. Thompson, along with Sullivan, attempted to correct the imbalance of classical psychoanalytic metapsychology focused on drive theory by introducing the importance of social contributions to understanding human behavior in health and in illness.

REFERENCES


