2 Transference and Relationship

2.1 Transference as Repetition

Transferences arise in all human relationships, and this fact gives Freud's discovery wide significance. Initially, however, he based his definition of transference on observations made in the course of therapy:

> They are new editions or facsimiles of the impulses and fantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment. Some of these transferences have a content which differs from that of their model in no respect whatever except for the substitution. These then — to keep to the same metaphor are merely new impressions or reprints. Others are more ingeniously constructed; ... by cleverly taking advantage of some real peculiarity in the physician's person or circumstances and attaching themselves to that. These, then, will no longer be new impressions, but revised editions. (Freud 1905 e, p. 116)

Later, however, he generalized:

> Transference arises *spontaneously* in all human relationships just as it does between the patient and the physician. It is everywhere the true vehicle of therapeutic influence; and the less its presence is suspected, the more powerfully it operates. So psychoanalysis does not create it, but merely reveals it to consciousness and gains control of it in order to guide psychical processes towards the desired goal. (Freud 1910a, p. 51)

Transference is thus a generic term in both senses of the word: First, since a person's past experiences have a fundamental and persistent influence on his present life, transference is universal in *Homo sapiens.* Second, the concept embraces numerous typical phenomena which are expressed individually and uniquely in each one of us. Special forms of transference are found in psychoanalysis, and we will discuss these later. In this chapter we want to demonstrate the dependence of transference phenomena, including resistance, on the analytic situation and its shaping by the analyst — starting with the appearance of his office and continuing with his behavior, his sex, his countertransference his personal equation, his theory, his image of man, his weltanschauung, etc. Thus, we will be testing the principal thesis of this book on the central core of psychoanalysis — transference and resistance — and investigating the extent of the analyst's influence on the phenomena which are traditionally ascribed

solely to the patient. *As* we are writing or readers whose degree of knowledge varies, we first want to ensure a sound basis for understanding.

Experience has taught that it is not easy to grasp how the view of transference shifted from its being the major obstacle to treatment to the most powerful aid. Of course, the bewildering multiplicity of transference and resistance phenomena had not yet been recognized at the time of the original discovery. Therefore we will start at the beginning of the story. The first discovery was of resistance (association resistance) — to recollection and to the approaching of unconscious conflicts — which owed its strength to the revival of unconscious wishes and their transference to the analyst. Thus the transference actualizes conflicts in the relationship, any obstacle to this being termed transference resistance, though more accurately one should speak of resistance against transference. The psychoanalyst has the greatest difficulty in mastering these transference phenomena, but we must not forget "that it is precisely they that do us the inestimable service of making the patient's hidden and forgotten erotic impulses immediate and manifest. For when all is said and done, it is impossible to destroy anyone in absentia or in effigie." With these famous words, Freud (1912b, p. 108) characterized the here-and-now actuality of transference, which is convincing because of its immediacy and authenticity: nothing can be dealt with successfully "in absentia," i.e., by talking about the past, or "in effigie," by symbolic indirect representation. The development of transference, whether it be positive or negative in nature, is not only opposed step by step by the most varied forms of resistance; the transference can itself become resistance if there is an imbalance between the repetition in present experience and the patient's ability or willingness to replace the transferences with memories, or at least to relativize them. Since the patient "is obliged to repeat the repressed material as a contemporary experience," Freud emphasized in one phase of his thought the necessity "to force as much as possible into the channel of memory and to allow as little as possible to emerge as repetition" (1920g, pp. 18,19). The analyst should at least not give any occasion for unavoidable repetition, in order to allow the memories to retain their original faithfulness and to avoid their merging with any real impressions: the authenticity of transference in the here-and-now lies ideally in the uninfluenced reproduction of vivid memories actualized as contemporary experience.

The common denominator of all transference phenomena is repetition, which, both in ordinary life and in therapy, apparently arises spontaneously. Freud emphasized the spontaneity of transference to counter the objection that it was *created* by psychoanalysis. In fact, we are all familiar with transference in ourselves and in others. Ms. X or Mr. Y ends up time and again in the same conflict-filled relationships; for example, wishes and expectations are disappointed in the same stereotyped way. New editions and facsimiles seem to be repeated automatically, although at the conscious level the subject makes great efforts to change his behavior.

Freud's purpose was to give psychoanalytic practice a scientific foundation, and therefore he emphasized that transferences are natural phenomena, part of human life, and not artificial products of psychoanalysis. For the same reason, all

the relevant rules of treatment are designed to ensure the *spontaneous* occurrence of transference. But what does "spontaneous" mean? From a scientific perspective, we cannot content ourselves with waiting for transferences to occur naturally in analysis as they do in life itself. Looked at more closely, the spontaneity of transferences reveals itself to be conditional on unconscious *inner* expectations and their *external* precipitants. Thus, for *scientific* reasons we must create the most favorable conditions for transferences to happen, and *practical* considerations force us to adjust these conditions according to their therapeutic potential.

Freud's conception of the spontaneity of transference reveals itself as a variable readiness to respond which is released in the interrelationship with objects and the stimuli emanating from them. We can now imagine a kind of autorelease of unconscious responses with no positive external stimulus, as in deprivation of food and drink followed by "hallucinatory gratification of desires" (Freud 1900a). The similarity to the vacuum activities *(Leerlaufaktivitäten)* described by Konrad Lorenz in animals can be mentioned in passing. Creation of the circumstances for such endopsychic autoreleases (apparently independent of external factors) seems scientifically desirable, and not only in order to rebut the accusation of exerting influence. In a deeper sense, it is a matter of the patient's spontaneity in the analysis; he must find himself in the interchange with a "significant other" (Mead 1934). Thus on the one hand, true to the scientific spirit of the time, we have had passed down to us Freud's appeal to get transference phenomena into their purest form, and not to influence them, so that they apparently occur naturally. On the other hand, it is vital for the success of the therapy to create favorable conditions for spontaneity on the part of the patient.

The contradiction between these two aspects was often passed over in such a way that many psychoanalysts believed that by not exerting influence they could promote autorelease just as much as spontaneity in the more profound sense. It was even widely believed that this is a way of combining the demands of theory with therapeutic objectives, although in reality neither is well served. We hope that we can substantiate these claims adequately below.

Theoretical postulates have contributed to the conceptualization of the transference neurosis in the ideal psychoanalytic process as something apparently independent of the participating observer: it develops in the reflection of images by the analyst, who is, ideally, free of all blind spots of countertransference. In the here-and-now the repetition of the genesis of the neurosis is allegedly purer and more complete the less the analyst disturbs these new editions. If some initially unidentified factor X, e.g., the analyst's age, appearance, or behavior, disturbs the ideal course of the therapy, it is a matter not of new editions but rather of revised editions; the patient's memories enable factor X to be traced back to its original meaning in the patient's life history. It seems to have no autonomy. Freud's pioneering observations in the case of Dora (1905 e), whose breaking off of treatment was explained by the failure to recognize the factor X in the transference, have led to the neglect of real perceptions in the therapeutic relationship. The ideal model of the psychoanalytic process was elaborated by treatment rules aimed at enabling a pure repetition of the pathogenesis.

Observation of repetition in the most complete transference neurosis possible leads on the one hand — in the search for causes — to reconstruction of the genesis of the illness, and on the other — in the therapy — to emphasis on memory as a curative factor. The transference neurosis is said to be resolved by the patient's realization that his perceptions in the analytic situation are, to a greater or lesser degree, gross distortions. At fault here are projections through which earlier wishes and fears and their repercussions are transported into the present. The model of this analytic process is summarized in Freud's "Remembering, Repeating, and Working-Through" (1914g). This triad came to be regarded as an ideal through its association with Freud's recommendations on treatment technique, although he himself followed them in an assured and flexible fashion rather than dogmatically. In therapy, Freud always attached great importance to the potential influence of suggestion in the context of transferences — though admittedly this cannot be inferred from his technical writings (Thomä 1977; Cremerius 1981b). He considered this influence possible only in the degree to which the patient's experience of dependence on his parents had been good and he was thus capable of so-called *unobjectionable transference.* According to Freud, this is the root of suggestibility, which is used as much by the analyst as by the parents. It can hardly be doubted that suggestibility, in the sense of receptiveness for new experiences, presupposes a certain readiness to trust others that is rooted in the life history. However, trust and suggestibility also have an "actual genesis" (i.e., a basis in the reality of the here-and-now transactions of therapy) which for Freud went without saying. Actual genesis was largely neglected in the theory of treatment technique; for a long time, the genesis of transference relegated the present, including the analyst's situational and actual influence, to the background.

The willingness to neglect the here-and-now — in the sense of new experience as opposed to repetition — becomes more understandable when we consider how the recognition of transference appears to resolve a number of issues:

1. It became possible to reconstruct the origin of psychic and psychosomatic disorders in the interpersonal field of transference.
2. It became possible to diagnose typical neurotic response readinesses and to make so-called dispositional explanations, because internalized conflicts which manifest themselves as thought and behavior patterns in repetitions could be observed in the relationship to the doctor, in transference.
3. Internalized conflict patterns, i.e., conflict patterns which have been absorbed into the structure, can be transformed by transference into object relationships and observed *in statu nascendi*

The scientific goal was to explore the circumstances of the original development of the neurosis as thoroughly as possible and to create standardized conditions for this process. The view that explanation of the etiology would ideally also resolve the neurosis was in accordance with Freud's causal understanding of therapy, by which past and even obsolete determinants of wishes and anxieties which, however, still live on in the symptoms — should be repeated in a pure form, i.e., uninfluenced by the analyst. Even this incomplete

outline of the solutions reached through the discovery of transference gives an idea of why the actual genesis of the patient's experience and behavior was neglected, and why no commensurate place in the official genealogy of psychoanalytic technique has been accorded to the autonomous here-and-now, the decisive core of therapy. The theoretical and practical solutions provided by the revolutionary paradigm have to be relativized in regard to the influence which the analyst exerts through his individual technique (as determined by his theory), through his personal equation and countertransference, and through his latent image of man.

2.2 Suggestion, Suggestibility, and Transference

The relationship between transference and suggestion is two sided. On the one hand, suggestion derives from transference: people are suggestible because they "transfer." Freud traces the suggestibility contingent on transference back to its developmental prototypes and explains it by the child's dependence on its parents. Accordingly, the patient perceives the doctor's suggestion as a derivative of the parental suggestion. On the other hand, suggestion is viewed as an independent tool for steering transference. Trust in the efficacy of this tool is based on experience with hypnotic suggestion. In this respect the double meaning of suggestion originates in the difference between hypnotic and analytic therapy. Freud comments:

> Analytic treatment makes its impact further back towards the roots, where the conflicts are which gave rise to the symptoms, and uses suggestion in order to alter the outcome of those conflicts. Hypnotic treatment leaves the patient inert and unchanged, and for that reason, too, equally unable to resist any fresh occasion for falling ill .... In psychoanalysis we act upon the transference itself, resolve what opposes it, adjust the *instrument* with which we wish to make our impact. Thus it becomes possible for us to derive an entirely fresh advantage from the power of suggestion; we get it into our hands. The patient does not suggest to himself whatever he pleases: we guide his suggestion so far as he is in any way accessible to its influence. (1916/17, pp. 451-452, emphasis added)

The part of this passage which we have emphasized can be interpreted in several ways. One obvious interpretation is to see, in the "instrument" which we "adjust," the transference which would be shaped and instrumentalized accordingly by the psychoanalyst. However, a position outside of transference is needed for the analyst to be able to make transference an instrument. Freud saw in suggestion not only the patient's insight, but also the force which works on transference. Thus suggestion becomes the instrument which "makes an impact" on transference and shapes it.

The two faces of suggestion and the intermixture of suggestion and transference, which have always been obstacles to the understanding of psychoanalytic therapy, have two main causes. First, psychoanalytic suggestion developed from hypnotic suggestion. It was therefore only natural for Freud to stress the new and different form of therapeutic influence by contrasting it with the kind of suggestion practiced previously. Suggestibility was explained in terms of life history and conceived as regression into passive dependence, which naturally

means that one is strongly or totally dependent on something from the outside and assimilates what is instilled or suggested. By attributing the effect of suggestion to transference, Freud also threw light on the capriciousness of the successes of hypnosis, since only positive transference produces total trust in the hypnotist and his actions, as if the subject were safe in his mother's bosom. The limits of hypnotizibility and the failure of suggestive therapies have thus become explicable with the help of the psychoanalytic theory of transference (see Thomä 1977).

The second reason, which led to the derivation of the psychoanalyst's influence on the patient from the latter's capacity for transference, has already been hinted at. The genesis of trust/mistrust, affection/aversion, and security/ insecurity in the relationships to parents and other close relatives during the preoedipal and oedipal phases and in adolescence establishes the personal response readiness, which can be classified according to typical unconscious dispositions. The effect of these unconscious dispositions is that contemporary experiences are measured against unconscious expectations, i.e., the new material is experienced according to an old, more or less fixed "cliché."

As response readiness, transferences are bound to the past in which they originated. The doctor's suggestion, i.e., the influence exerted by the psychoanalyst, will not be determined by its autonomous, change-oriented function, but will be derived from the patient's life history.

In contrast to suggestive therapies, psychoanalysis calls for the exposition and resolution of transference.[1] The necessary suggestion and suggestibility are derived from transference, which thus seems, as Münchhausen claimed to have done, to be able to pull itself up by its own hair. However, appearances deceive. Münchhausen divided himself by ego splitting, making his hand the center of his self and the rest of his body an object. The fact is, of course, that transference does *not* pull itself up by its own hair. Freud divided transference into two classes. Unobjectionable transference is comparable to Munchhausen's hand; it is credited with possessing the powers which overcome the instinctive *positive* or *negative* transference. Unobjectionable transference is a characteristic and abstract hybrid from the preoedipal, preambivalent period of infantile development in which the basis for trust was formed. In this respect the concept of unobjectionable positive transference is also tied to the past; however, it survives only as response readiness and forms a certain component of that which we term "therapeutic alliance" or "working alliance" (Zetzel 1956; Greenson 1965). These are not fixed quantities, any more than Sterba's (1934) ego splitting, but rather dispositions which can manifest themselves in various ways under situational influences (see Sect. 2.5).

Thus the transference theories simply describe how clichés or, more generally,

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[1] In "An Autobiographical Study" (1925d, p.27) Freud described his experience of using hypnosis to induce catharsis. He explained his discontinuation of the technique by saying "that even the most brilliant results were liable to be suddenly wiped away if my personal relation with the patient became disturbed. It was true that they would be reestablished if a reconciliation could be effected; but such an occurrence proved that the *personal emotional re/ation* between doctor and patient was after all stronger than the whole catharsis process, and it was precisely that factor which escaped every effort at control" (emphasis added).

unconscious response readinesses, are formed. They leave open, however, what the analyst contributes to the particular manifestation of these entities, and above all, Freud's descriptions fail to clarify adequately how to overcome them. With suggestion, derived from transference, one remains rooted in a cycle of events facing backward. To clarify this problem, we point to one of Freud's theses on psychoanalytic therapy which has received little attention: "But, by the help of the doctor's suggestion, the new struggle around this object [i.e., the doctor] is lifted to the highest psychical level: it takes place as a normal mental conflict" (1916/17, p.454).

Recourse to *doctor's suggestion* does not do justice to the far-reaching, instantaneous, and novel influence exerted by the analyst. The outcome of this struggle differs from that of earlier conflicts in that it is waged by both sides with new weapons which facilitate elevation to "the highest psychical level." We will concern ourselves with this exacting goal in Chap. 8. Strachey's (1934) mutative interpretation is a particularly typical psychoanalytic tool for change in that it is the furthest removed from the conventional form of suggestion.

2.3 Dependence of Transference Phenomena on Technique

In contrast to the idealized theory of technique, which attempted to formulate standardized experimental conditions, psychoanalytic practice has from the outset been characterized by a flexibility oriented toward the therapeutic objective, rules being adapted according to the desired change. A questionnaire which Glover (1937, p.49) first reported at the Marienbad symposium showed that 24 English analysts did indeed differ greatly in their application of important rules of technique. The critical discussion of the effects on transference of applying rules flexibly was interrupted by political events. Not until the years after the war was significantly more light thrown on the decisive part played by the psychoanalyst in the therapeutic paradigm of psychoanalysis. Three pieces of work which all appeared in 1950 (Balint and Tarachow; Heimann; Macalpine) marked a turning point, and from one point of view, Eissler's work published in the same year could also be included (see Chap. 3). In her article "The Development of the Transference," Macalpine reports after a thorough study of the literature that despite fundamental differences of opinion on the nature of transference, there is surprising agreement on its origin: it is assumed that it arises spontaneously in the analysand. Macalpine supports her dissenting view — that transference is induced in a susceptible patient by the particular structure of the therapeutic situation — by listing 15 factors, and describes how typical technical procedures all contribute to the patient's regression, so that his behavior can be viewed as a response to the rigid, infantile setting to which he is exposed. She describes the typical situation as follows:

The patient comes to analysis in the hope and expectation of being helped. He thus expects gratification of some kind, but none of his expectations are fulfilled. He bestows his confidence

and gets none in return; he works hard but waits in vain for praise. He confesses his sins, but receives neither absolution nor punishment. He expects analysis to become a partnership, but is left alone (Macalpine 1950, p. 527).

The 15 factors (to which others could be added) yield numerous possible combinations, which lead to a variable picture of how a patient experiences the therapeutic relationship, or how the analyst induces transference through his application of the rules. Macalpine wants to show that transference arises *reactively*. It is thus logical to expect that every variation of the situational precipitants stimulus will lead to different transferences. The field dependence of transference becomes clear when one considers the multitude of possible combinations yielded by selective neglect of one or other of only 15 factors, quite apart from the differences between the various schools in their emphasis on certain aspects of interpretation. Thus it becomes understandable why the patient Mr. Z. had different transferences in his two analyses with Kohut (1979 cf. Cremerius 1982). Macalpine's convincing argumentation gained only little acceptance. Cremerius (1982, p.22) recently voiced the criticism that many analysts still see transference as an "endopsychic, inevitable process." Apparently, the recognition of the analyst's influence on transference is so unsettling that convincing theoretical argumentation has as little effect as the unequivocal observations which Reich summarized (1933, p.57) by saying: "Transference is always a faithful mirror of the therapist's behavior and analytic technique."

Eissler is considered one of the most influential exponents of the *basic model technique* (see Thomä 1983 a). His work on modifications of the standard technique and the introduction of the "parameter" (1958) contributed greatly to the formation of the neoclassical style and to psychoanalytic purism. His dispute with Alexander and the Chicago School (1950) delimited the classical technique from its variants, and almost totally overshadowed the fact that this piece of work contains an aspect which concedes the psychoanalyst's influence on transference a greater scope than the basic model technique really permits. What was then at issue? After Freud's death and the consolidation of psychoanalysis after World War II, the question of which variations in technique still lie within a correct understanding of psychoanalysis became prominent in theoretical controversies, although even among orthodox psychoanalysts there is a wide spectrum of practice. On the other hand, by defining rules precisely it is possible to exercise discipline and draw sharp lines. In the 1950s, the unexpected growth of psychoanalysis brought an abundance of problems. The natural reaction to the emergence of numerous forms of psychodynamic *psychotherapy* derived from psychoanalysis was to define the psychoanalytic method strictly and to keep it pure (Blanck and Blanck 1974, p. 1). The simplest way of defining a method is through rules of procedure, as if following them not only protects the psychoanalyst's identity, but also guarantees an optimal, particularly profound analysis.

Thus Eissler's (1950) practically and theoretically productive proposal was almost completely ignored. He defined psychoanalytic method in terms of its goal; vis-a-vis the technical modalities, including the handling of transference, he favored a great degree of openness and goal-oriented flexibility. He stated that

any technique can be termed psychoanalytic therapy as long as it strives for or achieves structural personality changes using psychotherapeutic means, regardless of whether sessions are daily or irregular and whether the couch is used or not.

The method can hardly be defined sufficiently in terms of its objective, except under the tacit assumption that only strict psychoanalysis strives for or achieves structural change — which is probably also Eissler's position. Nevertheless, Eissler provided here an early indication — one running counter to his basic model technique — that a more meaningful way of developing an appropriate theory of psychoanalytic technique, and of improving psychoanalytic practice, than censoring the method is to investigate the changes that the treatment strives for and achieves. It is dubious whether the regression produced by the standard technique, with its special transference contents, is the optimal way of changing the structure and therefore the symptoms (see Chap. 8). We cannot shut our eyes to the fact that some therapies do not have a favorable course (Drigalski 1979; Strupp 1982; Strupp et al. 1977; Luborsky and Spence 1978), but to blame this on an inaccurate determination of indications (i.e., to conclude that the patient is not analyzable) is to deceive ourselves. The standard technique has narrowed the definition of analyzability and placed ever-higher demands on the strength of the ego functions of the suitable patient, but there has been insufficient discussion of the problem that complications, right up to so-called transference psychoses, could be due not to the inaccurate determination of indications, but rather to the production of specific regressions displaying excessive sensory deprivation (see Thomä 1983a). Such omissions weigh even more heavily when there is simultaneous failure to prove that certain ways of handling transference do indeed lead to changes in structure and symptoms.

Bachrach's thorough and comprehensive discussion of the concept of "analyzability" (1983, p.201) is one of the contributions exemplifying the promising developments in the whole field of psychoanalytic theory and practice. Instead of the usual one-sided, and in many respects problematic, question of the patient's suitability, we should now be asking which changes take place in which analysand with which difficulties when the psychoanalytic process is applied in which way by which analyst. The boundaries of transference are being constantly pushed back by self-critical questions, as defined by Bachrach, in spite of simultaneous rigidity. Thus, as shown by Orr's survey as early as 1954, psychoanalysis has long been on the way to a new understanding of transference. Variations of treatment techniques create specific transferences which must be understood operationally.

2.4 Transference Neurosis as an Operational Concept

In his introduction to the discussion of the problems of transference at the 1955 IPA Congress, Waelder (1956, p.367) emphasized the analyst's influence: "As the full development of transference is the consequence of analytic situation and analytic technique, changes of this situation or technique can considerably alter the transference phenomena."

Glover (1955, p. 130) also stressed that *"the transference neurosis in the first instance feeds on transference interpretation;* in other words the transference, starting in a fragmentary form, tends to build itself on the foundations of transference interpretation."

Balint (1957, p.290) stated even more clearly: "Heaven knows how big a part of what he [the analyst] observes — the transference phenomena happening under his eyes — may have been produced by himself, viz. they may be responses to the analytic situation in general or to its particular variety created by his correct, or not so correct, technique."

The essential findings of the American Psychoanalytic Association symposium "On the Current Concept of Transference Neurosis," with papers by Blum (1971) and Calef (1971), confirm the view emphasized by Waelder and Macalpine. Basically, the introduction of the term transference neurosis expresses Freud's recognition that general human transference is transformed into a systematized relationship under the influence of the analytic situation and in the presence of particular neurotic types of transference readiness (although Freud underestimated this influence or believed he could limit it with standardized conditions). Loewald (1971) underlined the field dependence of transference neurosis by stating that it is not so much a quantity that can be found in patients, but more an operational concept. We agree with Blum (1971, p.61) that it is still meaningful to talk of transference neurosis if you understand the term to include all transference phenomena against the background of a modern theory of neurosis. In this sense, transient transference phenomena are just as much operational concepts as is symptomatic transference neurosis. We therefore do not differentiate between particular phenomena, e.g., situational transference fantasies, and the transference-neurotic transformation of symptoms of some nosologic class (disease group), including narcissistic neuroses, which Freud equated with psychoses. Transference neurosis is therefore a kind of artificial neurosis. In his *Introductory Lectures* (1916/17, p.444), Freud writes:

> We must not forget that the patient's illness, which we have undertaken to analyze, is not something which has been rounded off and become rigid but that it is still growing and developing like a living organism .... All the patient's symptoms have abandoned their original meaning and have taken on a *new* sense which lies in a relation to the transference. (Emphasis added)

The context of this quote places strict limitations on the "new sense." Other points in the text, where transference neurosis is spoken of as a "new condition" replacing the "ordinary neurosis" and "giving all the symptoms of the disease a new transference meaning," also restrict the innovative side of real experience to the favorable conditions for the awakening of memories which follows from the repetitive reactions (Freud 1914g, pp. 154-155). Since Freud did not consistently view the growth or development of the transference neurosis, which grows like a living creature, as an interpersonal process within a therapeutic relationship between two individuals, the psychoanalyst's major contribution to this "new, artificial neurosis" (Freud 1916/17, p.444) remained concealed. The depth of these problems is shown in Freud's rigorous choice of terminology when discussing the overcoming of the transference neurosis (1916/17, p.443). His words do not

reflect the ideal of freedom, but rather betray helplessness: "We overcome the transference by pointing out to the patient that his feelings do not arise from the present situation and do not apply to the person of the doctor, but that they are repeating something that happened to him earlier."
Even more forcibly, he then used a word which did not belong to his usual vocabulary: "In this way we *coerce* him to transform his repetition into a memory" (1916/17, p. 444, emphasis added; Strachey translated *nötigen* as *oblige).*

One further, obsolete meaning of transference neurosis should briefly be mentioned, namely its nosologic use in Freud's sense of the term. This use cannot be supported, as even people undergoing treatment for so-called ego defects or other deficiencies, perversions, borderline states, or psychoses develop transferences. Freud's theoretical assumptions concerning narcissism initially prevented recognition of the peculiar transferences displayed by borderline cases and psychotics, leading to the confusing nosologic differentiation between transference neuroses and narcissistic neuroses. All patients are capable of transference, and it is therefore invalid to define hysterical, phobic, and compulsive neurotic syndromes tautologically as transference neuroses and to contrast them with narcissistic neuroses. The various categories of illness differ in the form and content of transference, but it is never absent.

2.5 A Controversial Family of Concepts: Real Relationship, Therapeutic Alliance, Working Alliance, and Transference

We have already met the father of this family of concepts, although he did not identify himself as such. In Freud's work we find him in the person of the doctor to whom the patient attaches himself, as well as in the "real relationship," whose stability is a counterweight to transference. But what would a family be without a mother? We find her in the "unobjectionable transference" which early in the life history begins to build the quiet but solid background of trust. Unobjectionable transference is thus mother of the family of concepts we are now going to discuss. We attribute to real maternal reference persons the greatest influence on the establishment of attitudes of trust toward the environment. If a patient's trust outweighs his mistrust, stable unobjectionable transference (in Freud's terminology) can be expected. Why, then, when the father and mother of the family of concepts already existed, were new terms introduced which differ from one another and, like actual children, sometimes take more after the mother and sometimes more after the father? Sandler et al. (1973) pointed out that until the introduction of the concept of treatment alliance, Freud's inclusion of both unobjectionable and libidinal transference under positive transference was a source of confusion. Their work shows that the treatment alliance is made up of widely differing elements. Indeed, Zetzel's (1956) understanding of the therapeutic alliance is based on the model of the mother-child relationship. In her opinion the early phases of an analysis resemble the child's early phases of development in several ways. The conclusion Zetzel drew for the therapeutic

alliance was that especially at the beginning of the treatment, the analyst should model his behavior on that of the good mother. In contrast, Greenson's (1965) working alliance includes above all the real or realistic elements of the relationship which Fenichel (1941) had still called rational transference.

A controversial family: What are the points at issue, and who is involved? At issue are the relationships and hierarchies within the family: the significance of transference compared with the real relationship, and in general the many conscious or unconscious elements in the analytic situation which affect the interaction between patient and analyst and cannot have their origin exclusively in the past.

We hope the reader will indulge us when we talk of the concepts as if they were quarrelsome people in order to shorten and simplify our description. Later we will name a few authors who breathe the fighting spirit into the concepts. Insufficient consideration has been given to the fact that the concepts get along so badly because they belong to different schools of practice. The monadic concepts quarrel with their dyadic brothers and sisters. Transference, like Sterba's ego splitting and Freud's fictive normal ego, is monadic, whereas all relationship concepts are dyadic in design and purpose. Already the quarrel begins: But surely we speak of the transference relationship as an object relationship? Yes, we do, but without thus forsaking one-person psychology, as Klein's theory shows. So, this means we cannot disregard Balint's two- and three-person psychology. Transference resists this, for fear that it, the family's favorite child and the one to whom we owe our professional existence, could suffer just as much as the patient and we ourselves.

We do not need to repeat why Freud conceived transference monadically or why the interactional-dyadic members of the family were long nameless, having an even greater efficacy for being unrecognized and underground. The family of concepts therefore had to be enlarged by the addition of members who had always been there, but had been described in detail only colloquially. We recommend Freud's chapter "Psychotherapy of Hysteria" (1895d, p.282), where there is a wonderful description of how the patient can be won over as a "coworker" for the therapy. All the evidence indicated that Freud continued primarily to attempt to "ally" himself with the patient, to form one party with him. We emphasize that "not every good relation between an analyst and his subject during and after analysis [is] to be regarded as a transference" (Freud 1937 c, p. 222). But in the meantime, positive transference has become the strongest motive for the analysand to participate in the work (1937c, p.233). The relationship is formalized in a "contract" or "pact"; how "loyalty to the alliance" is cultivated remained unspoken (the words in quotation marks come from Freud's late work, 1937c, 1940a). Particularly instructive is the fact that Freud orients himself in his late work more toward monadically conceived diagnoses, to ego changes, which do not permit adherence to the contract. He continues, though, to emphasize that the analyst "acts as a model...as a teacher" and that "the analytic relationship is based on a love of truth — that is, on a recognition of reality" (1937c, p.248). From the context it is clear that at least the reality of the analyst as a person is also at issue, but how this affects transference is left open.

If treatment strategies had been developed to solve the problem of the recognition of truth, we could spare ourselves the discussion in Sects. 2.7 and 2.8. Instead, there are confrontations, typical of a family feud, between monadic concepts like unobjectionable transference, ego splitting (Sterba 1934), and fictive normal ego (Freud 1937c) and the dyadic concepts which have their colloquial prototypes in Freud's work: induction of the we-bond (Sterba 1940), the therapeutic alliance (Zetzel 1956), and the working alliance (Greenson 1965). Within the family, issues in the dispute include who has a particularly close relationship with whom, and whether all the members are not really descendants of unobjectionable transference, i.e., of the early mother-child relationship. If the controversies are to be understood, it is absolutely essential to appreciate that transference is proud of its subjective, psychic truth, which nonetheless contains distortions. It is said that if negative transferences gain the upper hand, they can completely paralyze the analytic situation. The basic prerequisite for cure, namely the realistic relationship, is then undermined. Here Freud introduced an apparently objective or external truth — patient and analyst are based in the real external world (1940a, p. 173) — which, examined more closely, is in fact no less subjective than the truth which comes from transference. The introduction of the real person, the subject, into the working alliance does not prevent verification of the truth; on the contrary, it makes the subjectivity of our theories manifest. The individual analyst's responsibility is thus all the greater, and he must be expected to subject his practice to scientific examination, beginning with critical reflection on his own thinking and methods, i.e., with *controlled* practice.

We will now look more closely at the genealogical tree of the members of the family. We will start with ego splitting as prototype of the monadic concepts and progress to the we-bond and its derivatives. Freud described "the ideal situation for analysis," the only one in which the effectiveness of analysis can be fully tested, as

> when someone who is otherwise his own master is suffering from an *inner conflict* which he is unable to resolve alone, so that he brings his trouble to the analyst and begs for his help. The physician then works *hand in hand* with one portion of the *pathologically divided* personality, against the other party in the conflict. Any situation which differs from this is to a greater or lesser degree unfavorable for psychoanalysis. (Freud 1920a, p. 150, emphasis added)

Sterba reduced Freud's description to its real, influential essence: Out of the division emerged splitting, and the patient's ability to recognize inner conflicts as determinants of his illness became a particularly important criterion of indication for the technique. Ultimately, it seemed that the only people suitable for psychoanalysis were those whose endopsychic conflicts were on the oedipal level. The fact that Kohut explicitly viewed self psychology and the technique for treating narcissistic personality disturbances as complementing the classic therapy of oedipal conflicts should suffice to illustrate the consequences of ego splitting as a misunderstood catchword. It is certainly simpler if the patient is already conscious of his conflicts, but the analyst must always be willing to help establish a sound therapeutic relationship. In the later reception of ego splitting it was widely forgotten how induction of the we-bond can be promoted by including the

elements of the relationship which are not transference determined, although Sterba (1934, 1940) and Bibring (1937) emphasized identification with the analyst, the we-bond, as a basis of therapy.

Because of the one-sided, rather negative conceptualization of psychoanalytic treatment, the genuine and extremely pleasurable experiences of discovering new areas of life through insights and we-bonds are underestimated, being viewed merely as sublimations. If, like Fürstenau (1977), one declares the relationship between analyst and patient to be a "relationship of a nonrelationship," one remains within an understanding of therapy in which the psychoanalyst is assigned a rather negative and paradoxical significance. On the other hand, it is misleading to talk of relationship, partnership, or encounter when it is unclear how these dimensions are shaped therapeutically. Freud taught us the analysis of transference, but relationship was for him self-evident, so that transference and relationship ran through his therapies side by side but unconnected. Today, however, it is important to recognize and interpret the influence of the two phenomena on one another; we therefore regard it as a mistake to employ a negative definition of the analytic situation and the particular interpersonal relationship which constitutes it, whether as relationship of a nonrelationship or as something asymmetrical, as if natural human relationships (e.g., groups that eat, live, and work together) were symmetrical like geometric shapes. The community of interests between analyst and analysand also has its asymmetries, but the starting point is decisive: the dissimilar positions, or the problem itself, which can only be solved by concerted, albeit varying efforts. It is in our view a mistake to make a partnership out of the community of interests, just as it must be antitherapeutic to stress the asymmetry so strongly that identifications are rendered more difficult or even prevented altogether.

However ambiguous the present family of concepts may seem, it became essential for both practical and theoretical reasons to find a concept to complement the equally manifold forms of transference, as the theory of transference attempts to explain the patient's contemporary behavior and his so-called analyzability in terms of the past. Ultimately, the patient's ability to overcome his negative and positive transferences, or resistance to transference, would go back to the mild positive and unobjectionable transference in the early mother-child relationship. One can see that the analyst's influence here would be essentially secondary in nature, i.e., merely derived.

This theory of transference not only failed to match therapeutic experience; on closer inspection, it also becomes clear that psychoanalytic ego psychology, with Sterba's therapeutic splitting of the ego as an early member of the family of concepts, had to lead to the working alliance, in the form of a treatment technique counterpart to the theory of autonomous ego functions. When the patient reflects on his utterances or observes himself, whether independently or assisted by the analyst's interpretations, he does not do this from an empty position. The analyst's ego may, because of its normality, be considered a fiction, but what he thinks and feels about the patient, and how he perceives the patient's transference, is by no means fictive. Just as the patient does not stumble into a no-man's-land when he emerges from his transferences, neither does the analyst

fall into a void when he speculates on the patient's unconscious fantasies or attempts to explore his own countertransference. How he approaches the patient is influenced just as much by his views about transference as by his opinions about the patient's realistic perceptions. Knowledge of genesis alone is not sufficient; a position outside this knowledge is necessary to allow us to recognize transference phenomena and call them by their name. The patient is also partially outside the transference; otherwise, he would have no possibility of having the new experiences that the analyst encourages through his innovative approaches. Transference is thus determined by nontransference — and vice versa.

The fact there is something beyond transference, namely identification with the analyst and his functions, is shown by the establishment of a therapeutic relationship which does not end with the discontinuation of treatment. The ideal of the resolution of transference was part of a monadically conceived treatment process, and thus it is no surprise that we do not actually encounter it in reality (see Chap. 8). It is true, of course, that there have always been differences in evaluation: unobjectionable transference was in any case not an object of analysis for Freud and was therefore outside the realm of what was to be resolved.

To facilitate understanding, we repeat that Zetzel explained the patient's ability to form a relationship in terms of the unobjectionable mother transference. Zetzel's therapeutic alliance is therefore derived from, and fits well into, the traditional theory of transference. Over the years, Greenson's working alliance has freed itself the most from the theory of transference. There are practical and theoretical reasons why Greenson's (1967) declarations of independence extended over many years and the links to the father- or motherland — i.e., transference — remained unclear. Thus he spoke of the working alliance as a transference phenomenon (1967, pp. 207, 216) but at the same time stressed that the two were parallel antithetic forces. How can this contradiction be resolved? Insofar as one equates transferences with object relationships (in the analytic sense) in the therapeutic situation, then the working alliance is also an object relationship with unconscious components, and thus requires interpretation.

Over the past decades, the expansion of the family of concepts we have been discussing was accompanied by extension of the concept of transference. The reader will not find it easy to reconcile these two trends, one stressing the non-transference-determined elements (the therapeutic relationship), the other emphasizing transference. The recognition of non-transference-determined elements and the perception of transference as a comprehensive object relationship (transference relationship) arises from separate traditions of psychoanalytic practice which have common roots. Fifty years ago, Sterba (1936, p.467) stated that transference was essentially an object relationship like any other, although he simultaneously stressed the necessity of differentiation. The essential contribution to the extension of the concept of transference was made by Klein and the "British object relationship theorists," to use a phrase coined by Sutherland (1980) to describe Balint, Fairbairn, Guntrip, and Winnicott and to stress their independence and originality within the English school. The ahistoric, almost unchangeable quality ascribed by Klein to unconscious object-oriented fantasies means that they are always present and extremely effective. Thus, in the

here-and-now, deep interpretations of unconscious fantasies can also be made immediately (Heimann 1956; Segal 1982).

Transference was ascribed a unique significance by Klein's school in the context of her special object relationship theory. The rejection of primary narcissism initially had fruitful therapeutic consequences. According to this theory, unconscious transference fantasies focus immediately on the object, the analyst; even more important, they seem to be unconcealed by resistance and thus immediately open to interpretation. In ego psychology, one wrestles with strategies of interpretation typified by catchwords such as surface, depth, positive and negative transference, and interpretation of resistance, but Klein's theory recommends immediately interpreting suspected unconscious fantasies as transferences. Anna Freud related transference interpretations almost exclusively to the past (1937, p.27), conceding a situational genesis only to resistance. In strict resistance analysis, as propounded by Reich and then by Kaiser (1934) and criticized by Fenichel (1953 [1935a]), the analyst broke his silence only with occasional interpretations of resistance. Klein thus relaxed the rigidity of resistance analysis and replaced silence with a new stereotype: immediate transference interpretation of unconscious, object-oriented fantasies and their typical Kleinian content of the "good" and above all the "bad" breast.

In Klein's theory, the here-and-now is understood exclusively as transference in the sense of ahistorical repetitions (Segal 1982). It is questionable, though, whether one can credit the unconscious parts of experience with a timeless, ahistorical, special existence, however impressive the storage of latent dream thoughts in long-term memory may be. The unconscious has no existence of its own; it is bound to the historicity of human existence. In Klein's view of transference, repetition assumes such great importance that temporality — past, present, and future — seems to be suspended. For this reason the question of change through new experiences was long neglected by the proponents of this theory (Segal 1964). Yet the patient must come to terms with the analyst and the latter's view of the psychic reality of present and past in order to free himself of transference and open himself up for the future. The her-and-now can at the very most only partially also be a then-and-there, otherwise there would be no future — which, revealingly, cannot be localized with such handy adverbs.

Thus the traditional definition of transference limits this concept to that which is not new in the analytic situation, i.e., to the repetitive new editions of intrapsychic conflicts which have their origin in past object relationships and are automatically triggered off in the treatment situation. But since new material emerges in the therapy, it became imperative to accentuate this side of the analysand-analyst relationship by means of the special terms that we have introduced as the dyadic members of the family of concepts associated with the working alliance. At the same time, however, the interpretation technique of ego psychology remained bound up with the past and with the intrapsychic conflict model. Since transference was viewed as a circumscribed distortion of perception, the analyst practicing ego psychology asks himself: What is now being repeated, which unconscious wishes and fears are being enacted, how are they blocked, and — above all — to whom do they relate? What mother or father transference is

now being duplicated on me? Obviously these questions refer primarily to the past, which, unnoticed by the patient, is being repeated. Certain rules of treatment behavior allow the repetition to attain full impact and permit it to be convincingly traced back to unconsciously preserved, dynamically active memories. The analyst behaves passively and waits until the mild, positive transference grows into resistance. Finally, he interprets the resistance.

"The here-and-now is primarily important because it leads back to the past where it originates." In our opinion, this statement by Rangell (1984, p. 128) characterizes succinctly an interpretation technique which concerns itself primarily with memories, relegating the contemporary relationship, i.e., the interactional approach, to second place. Exaggerating, one could say that only the transference portions of the dyadic therapeutic process are noted and attention is rapidly turned to the past and to memories. Although Rangell acknowledges the significance of the working relationship when he states that interpretations can be made only after such a relationship has been built up, he emphasizes that the analyst need make no special effort in this direction (1984, p. 126). Sterba's view was entirely different; he encouraged induction of the we-bond:

> From the outset the patient is called upon to 'co-operate' with the analyst against something in himself. Each separate session gives the analyst various opportunities of employing the term 'we', in referring to himself and to the part of the patient's ego which is consonant with reality. (Sterba 1934, p. 121)

The issue is thus one of treatment technique priorities. That transferences are object oriented is undisputed, since the wishes which rise from the unconscious into the preconscious are primarily associated with objects, even though the latter are not mentally represented in the very early stages of life. According to Freud's *topographic* theory of transference as laid out in *The Interpretation of Dreams*, these intrapsychic events form the basis of the clinical transference phenomena. The theoretical assumptions correspond to the experience that transferences — like dream formation "from above" — are triggered by a real day residue. Realistic perceptions, which vary in their course, thus concern the analyst. Neglect of this day residue, and thus of interaction, in interpretation of transference is a serious omission which can have grave consequences. The general neglect of the day residue in transference interpretation is inherent in this theory, and is linked with the avoidance of realistic ties with the person of the analyst, because these run counter to the paradigm of treatment technique based on mirror reflection. Thus, the obvious discrepancy between the consideration of the day residue in the customary interpretation of dreams "from above" and the neglect of it in the interpretation of transference is explained by reference to the past (and prevailing) clinical theory and practice of transference.

It was not only in Klein's school that the extension of the theory of transference led to considerable alterations in treatment technique. We would like to illustrate this by reference to a controversy between Sandler and Rangell. The following passage contains the essential points of Sandler's arguments:

> It seems clear that the introduction and description of these object-related processes, particularly the object-related defences, reflected a major new dimension in the analytic work and in the concept of transference. The analysis of

> the here-and-now of the analytic interaction began to take precedence, in terms of the timing of interpretations, over reconstruction of the infantile past. If the patient used defences within the analytic situation which involved both him' and the analyst, this was seen as transference, and increasingly became a primary focus of attention for the analyst. The question "What is going on now?" came to be asked before the question "What does the patient's material reveal about his past?"
>
> In other words, the analytic work became more and more focused, in Britain certainly, on the patient's use of the analyst in his unconscious wishful fantasies and thoughts as they appeared in the present i.e. in the transference as it is explicitly or implicitly understood by most analysts, in spite of the limited official definition of the term. (Sandler 1983, p.41)

Rangell's criticism is fundamental. He raises the question: "Is it still resistance and defences first, as it has been with Freud, Anna Freud, Fenichel and others? Or have we moved to what is promulgated by many as transference first, or even transference only?" He says it all boils down to a new polarization: many psychoanalysts everywhere now give the here-and-now precedence over reconstruction and insight. "Ultimately we may have to decide between two different concepts of transference, intrapsychic versus interactional or transactional. The same choice may need to be made between the intrapsychic and interactional models of the therapeutic process" (Rangell 1984, p. 133).

We believe that the decisions have been made and that the controversies are dogmatic in origin. It is in the very nature of the concept of transference that it needs to be supplemented if it is to meet the demands of therapeutic practice and a comprehensive theory of cure. The same goes for the choice between the intrapsychic and interactional models of therapy. After all, it is not a question of either-or, but rather one of not-only-but-also. Should some shabby compromise be made? Not at all. Psychoanalysis as a whole lives from integration, whereas each school attempts to retain its own individuality. This is the root of the continuing controversies which we will now illustrate with some typical examples. In our opinion, recognition of the fact that these controversies are dogmatic in origin must benefit psychoanalytic practice — clarification leads to change, and not only in therapy. Our examples make some problems plain. Rosenfeld's (1972) criticism of Klauber's (1972a) emphasis on the analyst's personal influence reached the level of personal polemic. Eissler (1958), in contrast to Loewenstein (1958), strictly separated interpretation from the person. Brenner (1979a) believed he could show, using some of Zetzel's cases as examples, that the introduction of the therapeutic alliance and other devices would be totally superfluous if only transference were analyzed well — such crutches being necessary only if the analysis of transference is neglected. And indeed, he has no difficulty in demonstrating omissions in Zetzel's analyses. Curtis, in a balanced statement of opinion (1979, p. 190), stresses where the danger lies, namely in seeing the therapeutic alliance and the whole family of concepts as a goal in itself, i.e., in creating a new, corrective object relationship instead of a tool for analysis of resistance and transference. In the light of this argumentation, it becomes clear why Stein (1981) even found fault with Freud's unobjectionable transference — for every type of behavior has unconscious aspects, which sometimes can or even must be interpreted in the here-and-now, even when they are unobjectionable, whatever their origin. In the analytic situation, one factor or another always gets neglected. If, like Gill and Hoffman (1982), one concentrates on the analyst's

contribution to the genesis of "resistance to the transference," one can lose sight of the unconscious genesis, as Stone (1981 a) rightly pointed out.

The youngest branch in this family of concepts is Kohut's comprehensive understanding of transference in the framework of his theory of selfobjects. It is comprehensive in the sense that Kohut (1984) considers human relations and the life cycle as the history of unconscious processes of seeking and finding selfobjects. These are archaic object relationships in which self and object, or I and you, are fused. The objects are described as a part of one's self, and the self as a part of the objects. Correspondingly, the special forms of transference described by Kohut, e.g., twinship or fusion transference, are variations within an interactional unit. Kohut's theory can be distinguished from other object relationship theories by the exceptional emphasis on the grandiose exhibitionistic expectations attributed to the infant. According to Kohut, the development of stable self-confidence is dependent on the recognition of and response to these expectations. Kohut's theory of selfobjects thus put disturbances of object relationships in a genetic relationship with disturbances of self-confidence — the eidetic component, the showing of one's self and the reflection in the eye of the maternal reference person, playing a very outstanding role.

Since human dependence on the environment lasts for one's entire life, Kohut's theory of selfobjects has both a general and a specific consequence for treatment technique. All patients depend on recognition, because of their insecurity, and they transfer the corresponding expectations to the analyst. In addition, Kohut described specific selfobject transferences and provided a genetic grounding for their interpretation, i.e., one referring to the origin. According to the summary given by Brandchaft and Stolorow (1984, pp. 108-109):

> These selfobject relationships are necessary in order to maintain the stability and cohesion of the self while the child gradually acquires, bit by bit, the psychological structure it needs to maintain its own self-regulatory capability. The course of selfobject relations reflects the continuity and harmony of the developmental process through its various hierarchically organized stages. In the "omnipotence" which has been described as characteristic of the pathology of archaic object relations (M. Klein, Rosenfeld, Kernberg) we can recognize the persistence of the confident expectation that these selfobject needs will be met. Where archaic selfobject needs persist, the differentiation, integration, and consolidation of self structures and the developmental line of selfobject relationships have been interrupted. Thus archaic, poorly differentiated and integrated selfobjects continue to be needed, expected, and used as substitutes for missing psychological structure.

The relationship to the analyst is thus molded by comprehensive unconscious expectations, which seem to require a completely different kind of reflection than that which Freud introduced with his mirror analogy. Although Kohut (1984, p.208) emphasizes that he applies the psychoanalytic method in an even stricter sense than that prescribed by Eissler's basic model technique, the interpretations of selfobject transference appear to convey a great deal of recognition. We will discuss this issue in more detail in Chap. 4.

The misgivings expressed in this representative compilation of controversies can all be justified, as it is always easy to show that an analyst has missed opportunities to interpret transference. We believe that these controversies can be raised to a productive level of discussion if their different theoretical assumptions are recognized and if the orthodoxies of the various schools can be overcome.

The followers of Klein, of Eissler's basic model technique, and of Kohut differ in their views of the typical contents of transference. At the same time, followers of these schools cling to their respective purist understandings of transference.

The very fact that each school describes typical transferences speaks for the analyst's influence on the transference contents, but no consequences have been drawn from this fact in the schools themselves. It can hardly be doubted that relativization — toward the analyst's own standpoint — would be inevitable if consequences were actually drawn. The field of transference is pegged out, tilled, and cultivated in different ways by the various theories and their corresponding treatment techniques. Transferences are defined by nontransference and vice versa. It is thus indispensable in theory and in practice that theories of transference oriented toward the past be supplemented. It is as understandable as it is illuminating that the strict schools, in contrast, neglected the transference-independent working alliance, as taking account of it would have meant replacing an intrapsychic model of transference and therapy with an interpersonal conceptualization. In school-independent psychoanalytic practice, decisions along these lines have long since been made. And the controversy between Sandler and Rangell about the here-and-now of transference interpretation concerns far more than priorities of interpretation technique. The analyst's apparently harmless change of approach, now first asking "What's happening now?," has enormous therapeutic and theoretical consequences, which affect, for example, the relative importance placed on construction and reconstruction. If one considers the complete current transference relationship in its broadest sense, one recognizes the interactional, bipersonal approach and thus the analyst's influence on transference. It is therefore misleading to speak only of an extension of the concept of transference. What we have here is a changed perspective, which long ago began to develop unobtrusively in psychoanalytic practice. The relationship between here-and-now and then-and-there has always been seen as important, although only more recently have we fully realized how strongly "what's happening now" is influenced by us.

Neurotic, psychotic, and psychosomatic symptoms have their roots in the patient's life history, and the observation of repetitions and conflicting reinforcements yields vital insights into psychogenetic and psychodynamic connections. Therapeutically, it is decisive how long and with what degree of attentiveness the analyst wears his retrospective glasses, when he puts on his reading glasses to improve his close vision, and where his glance rests longer. The relationship between the different perspectives largely determines what is viewed as transference. Finally, what about the comprehensive understanding of transference, in which the relationship to the analyst is central?

Interpretations of transference can be made on various preconscious or unconscious levels of this object relationship. The patient's perspective is deepened and extended by his confrontation with the analyst's opinions. Although the ideal is mutual communication, the analyst's influence can become particularly great if he takes the extended, comprehensive view of transference (transference relationship). Thus Balint criticized the stereotypic interpretations of transference, which make the psychoanalyst all-powerful and the patient extremely dependent.

The target of his criticism was Klein's technique, in which the transference relationship is viewed exclusively as repetition. The more interpretations of transference are made, the more important it is to heed the real precipitating stimulus in the here-and-now and not to lose sight of the patient's external reality.

We hope we have shown that it is necessary to recognize the working alliance (Freud's real relationship) as a therapeutically essential component of the analytic situation, and always to take it into account. Otherwise we get stuck in Münchhausen's paradox, and transference must pull itself out of the swamp by its own hair. Schimek (1983, p.439) spoke of a clinical paradox whereby transference is resolved by the force of the transference. Ferenczi and Rank had already drawn attention to this in their book *Development Goals of Psychoanalysis* (1924, p. 20): it would be a *contradictio in adjecto,* an impossibility, to use the patient's love of the doctor to help him do without this love.

Finally, we would like to emphasize that we are not dealing with constant personality traits when it comes to the patient's ability to establish a working alliance. The analyst's contribution to the therapeutic dyad can positively reinforce or negatively weaken the alliance. E. and G. Ticho (1969), in particular, pointed out the interrelationship between the working alliance and the transference neurosis. Luborsky (1984) has since provided empirical evidence that the working alliance has a decisive influence on the course and outcome of treatment. The proof of the change, which Freud (1909b) called for on practical and theoretical grounds, justifies and limits both the scope of the psychoanalytic method and the influence exerted by the psychoanalyst through his handling of transference, a vital part of the analytic process.

2.6 The New Object as Subject: From Object Relationship Theory to Two-Person Psychology

Freud spoke of the "new object" and of the 'new struggle" which he said leads out of transference: the first phase of therapeutic work is the genesis of transference through the liberation of the libido from the symptoms, the second phase is the struggle for the new object, the analyst (1916/17, p.455). It is clear that the innovative side of the struggle consists in the new object, whose qualities were especially elaborated by Loewald (1960). It speaks for the productive psychoanalytic zeitgeist that Stone's (1961) influential book on the psychoanalytic situation appeared almost at the same time. We believe that the path from the new object must inevitably lead to recognition that the subject is the participant observer and interpreter guided by his subjective feelings and theory. The weight of the therapeutic work is borne not by the new object, but by the person, the psychoanalyst. Through his interpretations, the analyst shows the patient step by step how he sees him, enabling him to see himself differently, gain new insights, and change his behavior. The new subject has an innovative effect on the patient. How could suggestion, as part of the transference to be eliminated, possibly bring about change? Repetitions are not suspended by the patient being talked out of

them in sublime, interpretative suggestion. But this is how the therapeutic changes would have to be explained if the psychoanalyst's influence were included in the analogy of transference and suggestion.

Freud drew such analogies, thus contributing to distortions which delayed deeper understanding of the therapeutic function of the new subject.[2] The subject is of course also used as object, as Winnicott (1971) noted. The transferences take place on the object. The therapeutic problem is to end the repetition, to interrupt the neurotic, self-reinforcing vicious circle. Now there are two people who can act self-critically. If the vicious circle of compulsive repetition is to be broken, it is essential that the patient can discover new material in the object, as Loewald (1960) put it. The analyst as person fails largely or completely to meet the patient's expectations in certain areas — particularly the area of his symptoms or special difficulties in his life — which have previously always been fulfilled by virtue of unconscious steering mechanisms.[3]

Because the psychoanalytic theory of instincts speaks of the object, and this usage has also been adopted in object relationship psychology, the fact is easily overlooked that we are dealing with living beings, with people who are affected by one another. The psychoanalyst offers at least implicit solutions to problems, even unspoken, when he believes he is discussing nothing more than transference. Today, thanks to the many painstaking studies of Freud's technique, which Cremerius (1981 b) critically examined and interpreted, we know that the founder of psychoanalysis had a comprehensive, pluralistic concept of treatment and used a wide range of therapeutic devices. The revolutionary significance of the introduction of the subject in observation and therapy remained concealed, however, because the associated severe problems were a heavy burden on psychoanalytic theory and practice. Only in recent decades has it become possible to solve these problems (see, e.g., Polanyi 1958)[4] Freud tried to reeliminate the subject immediately and shift it outside the realm of "psychoanalytic technology" (Wisdom 1956; see Chap. 9). The subject surfaces again in the discussion of treatment technique, this time reduced to countertransference, which should be kept to a minimum for the sake of objectivity. Freud left the subject in the extratechnical area, where the analyst as real "person" remained until very recently, if only in the theory of technique. Now transformations are taking place, however, which change Freud's therapeutic and theoretical paradigm. Gill broke new ground with his "The Point of View of Psychoanalysis: Energy Discharge or Person?" (1983), in which he pleaded convincingly for the integration of

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[2] The "person of the doctor," with which the patient has a "proper rapport" in an "effective transference," is in Freud's theory of technique only "one of the imagoes of the people by whom he was accustomed to be treated with affection" (1913c, pp. 139 140).

[3] Freud regularly explains the "new" in terms of biographical patterns—the child-s "faith." The following is one example: "This personal influence is our most powerful dynamic weapon. It is the new element which we introduce into the situation and by means of which we make it fluid .... The neurotic sets to work because he has faith in the analyst .... Children, too, only believe people they are attachedto." (Freud 1926e, pp.224-225, emphasis added)

[4] Weizsäcker's explicit "Introduction of the Subject into Medicine" lacked the methodology which could have cracked the therapeutic and theoretical problems of the special interpersonal encounter in psychotherapy.

interpersonal and intrapsychic interaction and for the synthesis of instinct theory and the object relationship theories. Simply the fact that an author who three decades ago, together with Rapaport (1959), extended the metapsychologic points of view now sees the person as more central than energy discharge, and everything else as subordinate, should provide food for thought. More important, of course, is that and how psychoanalytic observations change under the primacy of the person, or more correctly, from the point of view of Gill's conception of interaction between persons.

The cornerstones of psychoanalysis — transference and resistance — were laid on the foundation of an idealized scientific detachment (Polanyi 1958, p.VII), and elimination of the resulting construction faults can only increase their load-carrying capacity.

As we know from Lampl-de Groot (1976), Freud worked on two therapeutic levels — sometimes relationship, sometimes transference. Lampl-de Groot says it was clear when Freud was speaking to her as a real person and when as a transference object. The differentiation between these two aspects must have been very marked, as relationship and transference are not only complex systems in themselves, but are also closely entwined. This raised many theoretical and practical problems, for which Freud found a monadic solution in the ideal therapy model and a dyadic solution in practice.

Anchoring the pluralistic view in the theoretical paradigm, and not just practicing it, meant investigating the implications of all the psychoanalyst's influences on the patient (and vice versa). No model for this was created. In recent years it has become public knowledge how Freud practiced psychoanalysis. The model handed down was the monadic one, which Freud's successors refined with the aim of achieving the purest form of transference. In fact, in the whole of Freud's work there is no detailed discussion of the actual "real relationship." The analyst's influence is traced back to his predecessors in the patient's life history, i.e., the parents, and termed unobjectionable transference. This was bound to lead to confusion (Sandler et al. 1973). The real relationship seems to be in opposition to transference and threatened by it: intensive transference can allegedly wrench the patient out of the real relationship with the doctor (Freud 1912b, p.105; 19t6/17, p.443). And there — with such global descriptions or negative characterizations (distortion of the real relationship by transference) — the matter remains. Thus Freud later adds that every good (therapeutic) relationship is to be viewed as transference; it could also be founded in reality (Freud 1937c, p.221). We have no words to describe anything new, including the innovative components of problem-solving strategies.

A. Freud (1937) points out that we describe everything in the analytic situation which is not new as transference. Therefore the spontaneity of the transference neurosis, which according to her is not created by the doctor, is emphasized time and again. "Abolition" or "destruction" (Freud 1905e, p. 117) of the transference neurosis will, indeed must, lead to elimination of the symptoms, since, as Freud said later (1916/17, p.453), when transference has been "dissected" or "cleared away," those internal changes which make success inevitable have, according to theory, then been achieved. Only rarely in Freud's

work is there any intimation of how much the psychoanalyst contributes to the patient's problem solving and thus to his new potentials, his freedom of decision.

2.7 The Recognition of Actual Truths

The fundamental uneasiness which gripped Freud the human being, Freud the doctor, and Freud the scientist on the discovery of transference did not fade away. After making the discovery (]895), Freud emphasized the vital therapeutic significance of transference in the postscript to "Dora," whose treatment ended in December 1900 and was written up as a case history in January 1901. The idea that we "destroy" transference by bringing it into the realm of the conscious originated in this "Fragment of an Analysis of a Case of Hysteria" (Freud 1905e). Later, in the Introductory Lectures(1916/17), Freud wrote that we must "compel" the patient to make the shift from repetition to recollection.

That is one of the signs showing that Freud's uneasiness persisted. The problem had resisted solution by the treatment rules which had in the meantime been formalized, although one of their principal goals had been to facilitate the handling of transference. The aggressiveness of Freud's metaphors (dissection, destruction) may show that he too was painfully touched by the actual, situational truth, i.e., by the realistic component of every transference. There are many ways of rejecting the patient's realistic observations, and paradoxical though it sounds, one widespread interpretation of transference is one of them. The interpretation we mean is offered when the patient has made relevant observations which are realistic, and thus in principle potentially accurate. Instead of accepting a perception as plausible, or contemplating the effects of a realistic observation on the unconscious and on its enactment in transference, the analyst often offers interpretations which take into account only the distortion of perception: "You think I would withdraw from you like your mother — I could get angry like your father." It is true that shifting an impulse to the past can have a relieving effect, because the patient is thus freed from an ego-dystonic impulse in the present, as A. Freud described (1937). However, the form taken by the interpretation of transference is vital. If it is constructed as though the patient is just imagining everything in the here-and-now, the situational truth in the patient's perception is ignored, often leading to grave rejections and irritations which result in aggression. If these are then interpreted as reprints or new editions of old clichés (Freud 1912b, p.99), then we have the situation that A. Freud discussed. She pointed out the fact that "analyst and patient are also two real people, of equal adult status, in real personal relationship to each other," and wondered "whether our — at times complete — neglect of this side of the matter is not responsible for some of the hostile reactions which we get from our patients and which we are apt to ascribe to 'true transference' only" (1954a, pp. 618-619). Balint's (1968) descriptions of artifacts, in the sense of reactively reinforced repetitions, also prevent us from contenting ourselves today with the careful raising of questions. Not only the consequences of the real personal relationship on the treatment process are important, but also the recognition of the analyst's

enormous influence on transference. We can no longer ignore the fact that the "hypocrisy of professional practice" — drawn to our attention by Ferenczi (1955 [1933]) — can even produce transference-neurotic deformations. Freud (1937d) assumed that "historical [life-historical] truths" even lay behind psychotic misperceptions of reality.

The life-historical relevance of these historical truths can at best be reconstructed. The actual truths, however, can be demonstrated *ad oculos,* and with their recognition the component of transference affected or triggered by the analyst becomes all the clearer. The fear that acceptance of the patient's realistic perceptions could pollute the transference beyond recognition is unfounded. On the contrary, through the patient's contributions, deeper truths can be broached. If the realistic, situational truths are accepted as such, i.e., integrated into the interpretation technique as initially autonomous elements, the procedure is no different than when one starts from the day residues and takes them seriously. The analyst reveals no details of his private life, makes no confessions (cf. Heimann 1970, 1978; Thomä 1981, p.68). The atmosphere changes radically with the admission, as a matter of course, that the patient's observations in the here-and-now and in the analyst's office could be absolutely accurate. According to Gill it is essential, in cases of doubt, to assume at least the plausibility of the patient's observations, for the following reasons. No one is in a position to sound himself out with full self-knowledge, or to control the impact of his unconscious. One should, therefore, be open to the possibility of patients noticing things which have escaped one's own attention. Any argument over who is right will probably end up with the patient withdrawing, due to his dependence, and noting the experience that his remarks *ad personam* are not welcome. In this situation the analyst will have given no good example of composure and shown no willingness to take someone else's critical opinion as a starting point for self-critical reflections. Gill and Hoffman (1982) showed that systematic investigation of the analyst's influence on the form taken by transference is possible.

The ideal of pure mirror reflection must be abandoned not only because it is unattainable and can, from the epistemological viewpoint, lead only to confusion; from the psychoanalytic viewpoint, it must even be therapeutically harmful to strive after this fata morgana, because the patient can experience pure mirror reflection of his questions as rejection. Sometimes it is not just the patient's imagination that his observations or questions are at least irksome (see Sect. 7.4). The mirror reflection of questions is experienced as evasion;actual truths are bypassed. Patients who are so disposed undergo malignant regressions, in the course *of* which the historical truths also become deformed, because the contemporary realistic perceptions are obstructed. Although it seems that the patient is saying everything that occurs to him, he has preconsciously registered the analyst's sensitive points and unconsciously avoids them. It is often no illusion or transferred feeling; the patient does not only feel that this or that question or observation might be unwelcome — his critical and realistic observations often are unwelcome. One cannot deal properly with these problems if one's own narcissism prevents recognition of the plausibility of realistic observations. If, on the other hand, one strives to base one's interpretation technique on the

situational realities and their consequences for transference, essential changes occur. These changes not only affect the climate, they also facilitate the establishment of a therapeutically effective relationship, as new experiences are made in the here-and-now which contrast with the transference expectations. It now seems a natural step to place a particular construction on Freud's statement, quoted above, that conflicts are raised to the highest psychic level and thus abolished: the analyst's recognition of his realistic perceptions enables the patient to complete psychic acts and reach the agreement with the subject/object which is one of the most important preconditions for the formation of object constancy and self-finding. The ability to complete psychic acts in this way characterizes the genuine, therapeutically effective experiences in the psychoanalytic situation.

However, there are unfavorable consequences for the new "artificial neurosis," as Freud also called the transference neurosis, if the psychoanalyst's interpretations bypass contemporary realistic perceptions or attribute them to distortions. What we are confronted with here is nothing less than a violation of the love of truth which Freud (1937c, p.248) wanted to practice through the recognition of reality. However, the very problem of how the analyst recognizes realistic perceptions has still not been cracked by any development in treatment technique. Just as denied historical truths lie at the root of psychotic processes, chaotic transference neuroses or even transference psychoses can be created by failure to recognize actual truths. According to psychoanalytic theory, the summation of an infinite number of unconsciously registered rejections of realistic perceptions can result in a partial loss of reality. It can thus hardly be doubted that the analyst's shaping of the transference neurosis also has a bearing on the outcome of the treatment and the more or less problematic resolution of transference. The fundamental difficulties in resolving transference, which go beyond the individual case, are probably linked with the great underestimation of the effects of the therapeutic one-to-one relationship on the course of treatment.

2.8 The Here-and-Now in a New Perspective

We have tried to show that the analytic situation involves complex processes influencing both parties. Systematic investigations are thus methodologically difficult and demanding. How a real analyst's personal equation, countertransference, theories, and latent anthropology act on the patient cannot be grasped in its entirety, either clinically or theoretically. The typical dilemma therefore arises time and again: the complex real person cannot be used as a tool in treatment technique, but on the other hand, investigation of one section of the here-and-now does no justice to the complexity of the situation. Difficult situations are the true test of the master! Gill and Hoffman's qualitative and quantitative studies (1982) are centered on the theme of resistance to transference, including the analyst's contribution to its genesis and to its alteration in the here-and-now. Both aspects of this resistance must be emphasized. The her-and-now is self-evident, as the therapeutic change can only take place at the current moment — in the present. Of course, Gill and Hoffman's theory also

assumes that resistance (and transference) originates partially in the past, but they stress the situational, actual aspects of the genesis of resistance. Their reasons for placing less importance on the reconstructive explanation are as follows: In psychoanalytic technique the analyst's contribution to transference and resistance was neglected. The reconstruction of the genesis of transference must also start in the here-and-now. In our opinion, one can arrive at the earlier determinants of neurotic, psychosomatic, and psychotic states in a therapeutically effective and theoretically convincing manner only if one always, even when making causal connections, starts with the factors that maintain the state in the here-and-now. Exactly this is the central point of Gill and Hoffman's theory. It is a remarkable fact that the here-and-now, the essential pivot of therapy, has only recently laid full claim to its deservedly prominent position. The simultaneous extension of the concept of transference, which is now understood by many analysts as the entirety of the patient's object relationship to the analyst, has already been described in Sect. 2.5 above as a sign of a radical transformation. Retrospection and the reanimation of memories has always served to resolve them in order to widen the perspective for the future. Although repetition has dominated the traditional understanding of transference, we would like to quote two striking passages from Freud; their therapeutic and theoretical potential is, in our opinion, only now being fully realized. In "Remembering, Repeating and Working-Through" (1914g, p. 154), he states:

> The transference thus creates an intermediate region between illness and real life through which the transition from the one to the other is made. The new condition has taken over all the features of the illness; but it represents an artificial illness which is at every point accessible to our intervention.

And in the *Introductory Lectures* (1916/17, p.444) we read:

> The beginning of the treatment does not put an end to this development; when, however, the treatment has obtained mastery over the patient, what happens is that the whole of his illness's new production is concentrated upon a single point his relation to the doctor. Thus the transference may be compared to the cambium layer in a tree between the wood and the bark, from which the new formation of tissue and the increase in the girth of the trunk derive. When the transference has risen to this significance, work upon the patient's memories retreats far into the background. Thereafter it is not incorrect to say that we are no longer concerned with the patient-s earlier illness but with a newly created and transformed neurosis which has taken the former's place.

It is no wonder that the enormous implications of these comparisons have remained disconcerting for the psychoanalyst. If one translates these metaphors into practice, and sees transference as the cambium, a plant tissue capable of lifelong division, then the growth and proliferation of transference in all its forms and contents becomes a quantity which is also dependent on the analyst's influences. Indeed, in therapeutic practice all analysts start from the present, the here-and-now. They construct or reconstruct, interpret the past in light of insights gained in the present. We reconstruct the portion of transference whose genesis we suspect is in the past by starting from the here-and-now.

Since human beings are environment-oriented from infancy onwards, and since psychoanalytically we find objects even in narcissistic fantasies — even if they are Kohut's selfobjects on a totally unconscious level — transference can

also be nothing other than an object relationship. There never used to be a fuss made about such truisms (see Sterba 1936, and Sect. 2.5). Even Nunberg, who viewed the analytic setting as closely analogous to the hypnotic attachment of the patient to the doctor, credited transference with an autonomous object reference:

> Insofar ... as in transference the wishes and drives are directed towards the objects of the external world, ... transference is independent of the repetition compulsion. Repetition compulsion points to the past, transference to actuality (reality) and thus, in a sense, to the future. (Nunberg 1951, p. 5)

The analyst's contribution to transference gives it a process-like quality. Both in the genesis and in the passing of transference, the precipitating and innovative circumstances of the analytic situation are to be taken even more seriously than the past and its partial repetition, because the opportunity for change, and thus for the future development of the patient and his illness, exists only in the present. Central in the expansion of the model of the therapeutic process over the past decades has been the solution of a problem which was described by Gill (1982, p. 106) as follows:

> Important though the recognition of the distinction between the technical and personal roles of the analyst is, I believe the current tendency to dissolve this distinction completely is a sign of a more basic problem — the failure to recognize the importance of the analyst's real behavior and the patient's realistic attitudes and how they must be taken into account in technique.

The reconstruction now becomes what it in practice always was: a means to an end. The adaptation of the handling of transference to the goal of the psychoanalytic process — structural change and the logically dependent change in symptoms — is a sine qua non of this argumentation. The influencing of the patient casts doubt on the objectivity of our findings [following Freud (1916/ 17, p. 452)], but this doubt can be lifted. Freud interpreted the evidence of therapeutic efficacy as proof of the validity of his theoretical assumptions. When resistances are successfully overcome, change (in symptoms) is the necessary and empirically verifiable result, going beyond the evidential feelings of the purely subjective truth — finding of the two participants in the psychoanalytic process. The psychoanalytic influence is vindicated by the evidence of change which can be explained theoretically, especially when the influence itself is made an object of reflection and interpretation. In the intersubjective process of interpretation, which relates to those conscious and unconscious "expectations" (Freud 1916/17, p.452) on the part of the patient which the analyst suspects on the basis of indications, this influence cannot, as a matter of principle, be ignored. As a goal-oriented intention, it forms part of every therapeutic intervention. If from the very outset the analyst makes his contribution to transference in the full knowledge of his function as new subject-object, there emerges a significant intensification and extension of the therapeutic paradigm of psychoanalysis which is currently in full swing. The discussion between Grünbaum (1982) and M. Edelson (1983) shows that there are considerable theoretical problems to be solved.

To do full justice to the role of intersubjectivity or two-person psychology in the *psychoanalytic technique* it is necessary to go beyond both the traditional object relationship theories and the model of drive discharge. All the objects

essential to man are constituted from the very beginning in an intersubjective space which is vitiated by vital pleasures (G. Klein 1969), yet it is not possible to link them closely to the drive discharge model. In their excellent study Greenberg and Mitchell (1983) showed that the drive/structure model and the relational/structure model are not compatible; it therefore seems logical to seek ways toward an integration at a new level.

In Chap. 4 we will employ the fundamental approaches discussed here in the presentation of typical forms of transference and resistance, including features specific to the various schools, and we will use them to help us to understand the psychoanalytic process (Chap. 9) and the interpretation of transference (Sect. 8.4). It can be deduced from purely theoretical considerations that at least the so-called unobjectionable transference cannot be resolved, but only recently has research also shown empirically how decisively the outcome is affected from the very beginning by the handling of transference.