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MODERN REVISIONS OF FREUD'S CONCEPT OF TRANSFERENCE

The Psychoanalytic Century

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It is my reading of Freud that up to a certain point in his career we might see his development as prototypic of many elements in psychoanalytic theory and practice (Ellman 1991). In addition his clinical concepts are a good reflection of the struggles he endured while creating both a theory of mind and a theory of treatment. Given these assumptions, it may be that the understanding of the development of his clinical concepts may shed some light on current controversies in contemporary psychoanalysis. Today I will look at the fate of two of Freud's ideas on transference and try to show their relevance to contemporary analysts. The two concepts are transference as memory or action, and the "unobjectionable positive transference." It is my view that the recent literature on enactments is in part a growing realization that it is a difficult task for the analyst to maintain what I have called narcissistic equilibrium in the face of intense transference-countertransference sequences. I believe that each current theoretical perspective has characteristic ways of deflecting transference reactions while allowing enactments to continue outside of the analytic process. Freud's struggles with transference manifestations were not unique to him, but were

rather prototypic struggles of an analyst attempting to survive situations beyond his comprehension.

FREUD'S VISION[1]

Freud was at the height of his career as an analyst during the period of 1905 through 1914. Before that time (1890-1905) his efforts were devoted almost solely to the uncovering of pathogenic memories. Transference (up to the postscript to the Dora case (1905)) was considered to be an obstacle in his hypnotic or psychotherapeutic procedure (1895). Later, in the 1920s and 30s, he no longer practiced as an analyst. It is a sign of the religious devotion of psychoanalysts that Kanzer (1980) could say that at the end of his career Freud was evolving into a contemporary psychoanalyst. At the end of his career Freud's practice consisted largely of intellectual discussions and quasi training analyses. In these analyses he was frequently blatantly disregarding some of the strictures that he thought were necessary for an analytic process to unfold (Ellman 1991).

My use of the term "unfold" is anachronistic, since Freud had only a glimpse of analysis as an unfolding process. This was in *Repetition, Recollection and Working Through* (1914a). There he sounds almost Winnicottian, he is inviting, even facilitating in his tone, he seems at home with the clinical manifestations of transference. But I am getting ahead of

myself, for I wish to go back in Freud's career and try to look at some of the difficulties in Freud's conceiving of the importance of transference. We know there was a point in his career when he distinguished between psychogenic and actual neuroses. From 1894 to 1896 he was in the midst of conceiving both forms of neurosis in terms of accumulated libido (Stewart 1969). In the psychogenic neurosis the accumulation could be conceived of as a vulnerability caused by the patient being sexually overstimulated or traumatized as a child. This stimulation (usually by a parent) excited the child, but owing to sexual immaturity there was excitement without the possibility of discharge. This made children vulnerable as adults to stimulation and the accumulation of excess (undischarged) libido. The actual neurosis, on the other hand, was caused by sexual practices of adult patients. "Coitus reservatus," for example, could lead to anxiety neurosis, excessive masturbation led to neurasthenia, and so forth. How did Freud arrive at conclusions that today seem so foreign to our ears. I want to offer a partial explanation of how a theorist with such literary sensibilities could be so blatantly mechanistic.[2]

We must remember this is before Freud had fully developed his concepts of the importance of unconscious motivation and universal childhood sexuality. But at this point in time Freud relies heavily on the idea of undischarged excitation (Stewart 1969). Freud will leave these concepts, but it will take him a surprisingly long time to leave the idea of the actual

neuroses.[3] In fact, when he develops the concept of narcissism (1914b), he purposes another category of actual disorders, an actual narcissistic state, that is hypochondria. Freud maintains that:

> I am inclined to class hypochondria with neurasthenia and anxiety-neurosis as a third "actual" neurosis. It would probably not be going too far to suppose that in the case of the other neuroses a small amount of hypochondria was regularly formed at the same time as well. [p. 83]

That Freud has even posited the category of actual neurosis is an issue that still is not completely explained, but it may be that we get important clues to Freud's difficulties[4] if we consider the concept of an actual hypochondriacal state. I posit that he sees the hypochondriacal patient as an actual disorder (there is an increase of libido in a particular part of the body) because he is unable to understand his experience of the transference while interacting with hypochondriacal patients. They come to him and talk about their pains or somatic concerns, and he feels left out of their object world. Freud virtually tells us that without the beginnings of a positive transference relationship, he is not able to experience a connection with a patient (1912b). Without this experience, he casts them out of the analytic world; by labeling them an actual disorder, he maintains that they are untreatable in terms of psychological methods. He attempts to perform a similar excision with psychogenic narcissists or patients who have intense negative transference states; he maintains that they are not analyzable. He postulates that narcissistic patients have little object libido, cannot form transference

relationships, and are thus unanalyzable (1916). They are analytic exiles bound to wander the byways and offices of the psychotherapist. My hypothesis is that patients diagnosed as actual neurotics (in the 1890s) were primarily types of narcissistic or borderline disorder. These patients did not provide Freud with a transference love relationship, and were thus relegated to the position of receiving advice about their sexual life.[5] We see that Freud is not unlike a number of present-day analysts; it is difficult in general to tolerate the patient who does not include us in their object world, particularly if the patient is noncompliant. He had particular difficulty if the patients were skeptical about psychoanalysis.

Earlier, I maintained that Freud for a period of time began to understand the centrality of transference. I cited *Repetition, Recollection and Working Through,* but in his paper "On Transference Love" he also shows his insights into the emergence of transference. Here he provides warnings to analysts about some of the dangers of acting out (enacting) transference-countertransference sequences. This warning demonstrates he has experienced and recognized the intensity of transference (and countertransference) reactions. He has seen that transference can have a compelling impact on the analyst and at times stimulate the analyst to act in a manner that is out of control—and perhaps irreversible—in an analytic treatment.

One main way of understanding the competing schools of analysis is to see how they have transformed, extended, or at times truncated the idea of transference. Before I go to that I will summarize what I believe to be Freud's most complete vision of how to utilize the transference in the analytic situation.

Freud (1914) tells us that:

> The main instrument . . . for curbing the patient's compulsion to repeat . . . is the transference. We render the compulsion harmless, and indeed useful, by giving it the right to assert itself in a definite field. We admit it into the transference as a playground in which it is allowed to expand in almost complete freedom and in which it is expected to display to us everything . . . that is hidden in the patient's mind. [Cited in Ellman 1991, pp. 60-61]

How do we facilitate a definite field in which this can occur? Here Freud says that "We must allow the patient to become attached to the analyst (physician) before we can interpret the transference." Then when "We have made it clear to ourselves that the patient's state of being ill cannot cease with the beginning of his analysis," than we must wait until the transference develops and treat the person's conflicts, "not as an event of the past, but as a present-day conflict." Transference thus "creates an intermediate region between illness and real life through which the transition from one to the other is made." Let me add some additional quotes of Freud: "The negative transference deserves a detailed examination, which it cannot be given within

the limits of the present paper." As we know, this detailed examination never took place. If we summarize these quotes (1912-1915), we can say that Freud did not believe that transference could be interpreted before an attachment was made to the person of the analyst (physician). He did not believe that the patient could accept an interpretation before a transference love relationship was initiated. He came to accept (for a short time) the transference as not simply a resistance, but rather as the thing itself, in fact the only thing where "a patient arrives at a sense of conviction of the validity of the connections which have been constructed during the analysis." He does tell us, prophetically, that dealing with the transference "happens, however, to be by far the hardest part of the whole analytic task." Here I would agree with Freud. A good part of the analytic world has been struggling with the practice and concept of transference since he wrote these words in his postscript to the Dora case. However, I would disagree with Freud when he says, "Practical experience, at all events shows conclusively that there is no means of avoiding it (transference)" (1905, p. 116). He, as well as contemporary analysts, have shown that there are a variety of means of avoiding, suppressing, and overlooking the transference. Let me give some examples.

CONTEMPORARY ANALYSTS[6]

Gill

Gill, in his conceptualization of the here-and-now transference, starts with the idea that analysts have underestimated the extent to which there are transference manifestations in the treatment situation. Gill conceives of transference as ubiquitously present from the beginning to the end of a treatment. In his view transference should be interpreted from the beginning, and throughout the course of the treatment. To my mind, here is an example of an analyst who correctly criticizes an aspect of practice, and then truncates Freud's vision. For once he recognizes the ubiquitous nature of transference he does not allow the patient to develop consistent repeated reactions to the analyst without immediately intervening and offering interpretations.

I will cite a brief clinical illustration taken from Gill's taped sessions:

A woman patient is dressed in a T-shirt. Gill begins the session by asking the patient "What is the writing on your T-shirt?" [Coney Island or Bust.] This is done before the patient has sat down or said anything. The rest of the session is spent detailing and interpreting the patient's seductive, provocative transference state. Let us assume that Gill is correct in his understanding of the patient's behavior. Can the patient gain a sense of conviction in the treatment if the analyst is so consistently providing interpretations?[7] Does the patient feel invited-into the playground of transference given Gill's stance? In this example and in others, Gill does not tolerate the unfolding of the transference; instead he stimulates and at times provokes the patient to

respond to him. He correctly states that transference is a ubiquitous experience, but he can't allow it to develop. He creates a relationship in analysis where he proves that all of analysis is an interaction between analyst and patient. He correctly criticizes Freud for not persisting in his insights about transference but he rejects Freud's depiction of the playful (in Winnicott's sense) and illusory quality of transference experience of psychoanalysis.

Brenner

There are interesting parallels between Gill and Brenner. They are in agreement in some ways in their handling of the transference. Both interpret transference early in the treatment. Neither analyst distinguishes between the transference and the transference neurosis. Brenner advocates interpreting whenever an unconscious derivative appears, regardless of how often this element may emerge. Brenner seems to imply that the repeating of an interpretation will have a cumulative effect.

Although Brenner and Gill address transference in a systematic manner, they do so in a way that in my view is highly dependent on the patient accepting the analyst as the authority (the interpreter). It is difficult to see how the analysand will gain conviction through the transference if the analyst is interjecting and penetrating with interpretative efforts. It may be that

neither analyst sees phenomena like the transference neurosis because of iatrogenic factors in their treatment approach. Early and frequent interpretations may not allow for the type of intense, cohesive transference reactions that are described in continuous states that have been labeled "transference neurosis."

Kohut

Kohut is perhaps the only analyst I will mention (I have not included B. Bird) [1972], who allows the transference to unfold and be experienced over a period of time without interpretation. Kohut (1968, 1977), on the other hand, allows either mirroring or idealizing (or bipolar self) transference states to continue until there is a perceived (on the patient's part) break in empathy. One might say it is as if all transference is unobjectionable (I am referring to Freud's concept), according to Kohut. The implications of handling transference in this manner are two-fold: defensive tendencies are reinforced, and the patient is not helped to explore active fantasies, particularly active fantasies that have aggressive content. Kohut has provided an invitation to the playground but he is only willing to watch, not interact in, the illusory play. At crucial points in the manifestation of transference Kohut turns a two-person back into a one-person field. In his terminology it is as if the only developmental processes have to do with mirroring and lending oneself to idealization.

RELATIONAL ANALYSIS

Up to this point in the paper I have tried to show how aspects of Freudian thought have been clarified, transformed, and truncated by contemporary analysts. Nowhere do these tendencies seem to be more pronounced than with authors who derive their inspiration from a relational orientation. To demonstrate this I will look at a distinction that Greenberg (1993) has recently introduced and relate this distinction to the other parts of the present paper.

In highlighting these distinctions Greenberg relates: "In his highly technical language Freud is telling us that we can become conscious of something when we can name it." Greenberg emphasizes that for Freud "the cure awaits the word."

Greenberg continues:

> It will help us to look at this view of therapeutic action from a contemporary perspective if we realize that, for Freud, actions are things. The work of analysis is to move the patient beyond the act or repetition (in the transference), which is a thing, to the memory, which is a word. . . . The development of mind itself depends upon restraining drive discharge. The reality principle gets established when thinking (which depends upon the ability to use the word) replaces impulsive discharge (the action, which is a thing that cannot be delayed because it has not been symbolized), [pp. 5-6]

Greenberg takes the distinction he has derived from Freud and then

characterizes Freud's ideas on technique as requiring restraint on the part of the analyst and patient. "The patient is pledged to try to follow the fundamental rule, which requires saying rather than doing." The patient pledges restraint by promising not to make decisions during the analysis and Freud is in favor of "avoiding action in favor of the word." However, "Our broader experience with the psychoanalytic process allows us to see clearly what Freud initially overlooked: words do not restrain or substitute for action; they *are* actions." This applies equally to patient and analyst. Free association is an action and is not necessarily "a phylogenetically fixed higher way of being." Freud therefore fails to see that there are continuous interactions between analyst and analysand.

Greenberg concludes that "Freud's early model of the mind has stifled discussion about what actually goes on in analysis. . . . Neutrality or the blank screen or reflecting mirror" are all myths that attempt to camouflage the fact that all that the analyst does involves action.

Let me start with a relatively small point and yet to me it seems glaring. Dr. Greenberg writes as if affect didn't exist in Freud's ideas on technique. He takes , one dichotomy—the thing and the word representation—and from this derives that for Freud the cure awaits the appropriate words. But Freud's treatment method always involved not just in the word, but in the affect and the representation being brought together. From *Studies on Hysteria* (1895)

onward, Freud continuously intoned against memories, fantasies, and experiences that were only intellectual. This was true when he used the cathartic, and later, the psychotherapeutic or the analytic method. What Freud discovered in the transference was that the feeling or the desire is conveyed most directly via the transference. It is no wonder that his interest in the topic fluctuated throughout his career. But while he was interested in the topic between 1905 and 1915, he assumed that transference is the vehicle that fuels the analysis. It is the vehicle through which the language of desire and emotion is communicated. Thus the transference is not simply a recapturing of words, but the vehicle through which affect is expressed and united with representations.

By leaving out affect, Greenberg can more easily dichotomize Freud's ideas. He can see Freud's technique as a translation into words while attempting to restrict or limit actions. Although Freud at times undoubtedly attempted to restrict the activity of his patients, it is only the classical tradition in the United States that made this a matter of technique. Greenberg can make his statements about Freud since for many relational analysts there is so much interaction via disclosure and other means that manifestations of the transference are frequently lost. It is the interaction that becomes the focus rather than the transference. This position is more extreme if one actualizes an "intersubjective" position, which I will not detail here.

ANALYTIC TRUST

If we go back to Freud's original requirements for interpretation, he says that the patient must first become attached to the person of the analyst before he/she is in a position to interpret. Freud's conceptualization of this attachment had two components; what he called the unobjectionable transference from the patient, and the natural generally kindly behavior of the analyst towards his patients. I will not discuss his behavior at this point. But the "unobjectionable transference" was a component of Freud's method of attempting to influence patients based on the authority of the analyst. The concept of the unobjectionable transference was attacked from all sides. Classical analysts maintained that it affected neutrality and that all transference should be analyzed. Critics included the unobjectionable transference as part of the Freudian authoritarian stance towards patients. I maintain that both groups were correct in their criticisms. They however did not address the question that Freud raised: Why should a patient trust the analyst and continue in treatment particularly when difficult material arises? Freud's answer was that the unobjectionable transference allows patients to continue because of their respect for, fear of, or general compliance with the implicit voice of authority. Later analysts (Greenson 1965, Zetzel 1966, Stone 1967) answered this question with the concept of the therapeutic or working alliance. Greenson says:

> The reliable core of the working alliance is formed by the patient's

> motivation to overcome his illness, his conscious and rational willingness to cooperate, and his ability to follow the instructions and insights of his analyst. The actual alliance is formed essentially between the patient's reasonable ego and the analyst's analyzing ego. The patient is willing to cooperate with the analyst's instructions and maintain an effective working relationship with the analyst, [p. 162]

Brenner has criticized the therapeutic, or working alliance, on the same basis as the unobjectionable transference. That is the working alliance is the use of transference to attempt to influence the patient's behavior rather than analyzing the patient's transference reactions. Even as benign a concept as the alliance can be seen as using the analyst's authority to influence the patient (Hoffman 1996). Nevertheless, Greenson, Stone, and Zetzel were striving to answer the question that Freud posed. I have tried to answer this question and my answer is based on writings over the last thirty years that in my mind—not necessarily in agreement with the authors I cite—has led to specifying the conditions under which transference becomes interpretable. To be more specific, it is a way of looking at the conditions under which a patient can come to trust an analyst, based not on the analyst's instructions or identifying with the analyst, but rather on the patient's experience of the analytic situation which obviously includes the analyst's behavior.

I am positing that what I have labeled as "analytic trust" is the necessary condition during which transference becomes interpretable in the analytic situation. I define analytic trust as the continuing sense between analyst and

patient that the analyst is able to feel and process the patient's experiences in a meaningful manner. At the beginning of treatment this may mean reflecting back and providing new syntheses of the patient's conscious but often suppressed experiences. It also entails being able to contain and not necessarily interpret frustrating and destructive fantasies that the patients provide and perhaps fill the room with. That fills both analyst and analysand. As the analysis continues and the patient is able to develop more continuous transference experiences, analytic trust is renewed by the patients being able to see their internal worlds in a deepened and new light. The analyst's interpretive efforts are only one way to achieve insight. In an optimal therapeutic relationship, interpretations by both analysand and analyst are joined. A crucial aspect of this trust is the analyst as container. The analyst is able to receive the patient's actions without malevolently returning the patient's conscious and unconscious messages. Although I doubt that any analyst would deny that enactments by both patient and analyst are continuous and necessary occurrences, I would maintain that if the patient does not trust in the analyst's ability to contain, control, and eventually observe their enactments, then the analytic process can be irreversibly damaged. An important aspect of both the issue of containment and enactment are the limits and boundaries of these experiences.

To come back to shifts in transference states: I have seen, for example, analyst's reacting in a surprised manner when a patient who has come to

meet the analyst, once again views them with suspicion or distrust. From my perspective this is not always—or perhaps even usually—the other side of a split. Rather it is frequently a sign of different transference material arising in a new phase of the treatment. If it is recognized as such (or at least if the possibility is recognized) then some aspects of the beginning phase of treatment may have to be repeated briefly. To be sure this happens more dramatically with patients who utilize splitting and projective identification as significant defensive structures, but to some extent I believe that this occurs in all treatments. In some treatments it may happen to such a minor extent that it will go largely unnoticed or be seen as a bad day for one or another reason. This it seems to me is the relatively rare case in today's analytic world. Most times, if the transition is missed, either the patient is disrupted or has to present an aspect of his false self in other parts of the analysis.

Let me conclude by stating that analytic trust is an answer to Freud's question, "Why should a patient trust the analyst?" It is an attempt to take in the criticisms of contemporary analysts while not truncating Freud's concepts. Trust develops when there is a shared experience of understanding, first in the conscious but often suppressed aspects of the mind, and later through understanding how the unconscious world has influenced patients' lives more thoroughly than one could have imagined before Freud offered us his revolutionary vision.

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Notes

1 In the historical review I provide documentation for my contentions in *Freud's Technique Papers: A Contemporary Perspective* (1991). London: Allen &. Unwin.

2 See Stewart's *The First Ten Years: 1888-1898 (1969)* for what I consider to be the most definitive account of this era of Freud's career.

3 Not until *Inhibitions, Symptoms and Anxiety* (1962) does Freud renounce the idea of actual disorders in writing.

4 I am anachronistically considering the concept of actual disorders a difficulty. It can be considered a difficulty in the sense that Freud eventually disavowed the concept (1926) and that most modern analysts no longer find the concept useful in their clinical conceptualizations.

5 This clearly is only one aspect of Freud's response to these patients. We know that Freud treated severely disturbed patients such as the Wolf Man, and that if a patient could engage intellectually (the Rat Man)k, then he underdiagnosed such a patient. It is also my view that Kohut is correct in some of his corrections of Freud's views on narcissism. Freud, in some instances, is not consistent in his ideas on technique with his own view of narcissism (Ellman 1991).

6 These sections on Gill, Brenner, and Kohut are taken from Ellman 1991.

7 Perhaps the patient was attempting to be seductive but felt deeply ashamed of the fact that this was her only mode of relating and was focusing more on her sense of shame and emptiness than on the seductive behavior. Perhaps the last session had induced some change, and so forth.