THE TECHNIQUE OF PSYCHOTHERAPY

IDENTIFYING IMPORTANT TRENDS AND PATTERNS

THE EXAMINATION OF ATTITUDES TOWARD THE THERAPIST INCLUDING TRANSFERENCE

LEWIS R. WOLBERG M.D.

Identifying Important Trends and Patterns:

The Examination of Attitudes toward the Therapist, Including Transference

Lewis R. Wolberg, M.D.

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All people progress from childhood to adult life with attitudes, values, and behavior tendencies that are parcels of past experience. These persist in the form of fixed patterns that repeat themselves compulsively in certain interpersonal situations. Thus, a grown man, intimidated as a child by a punitive father, may respond to all authoritarian men with a cowering, ingratiating set of reactions, as if he virtually still were a little boy awaiting punishment for a misdeed. A grown woman who, as a child, was violently competitive with a younger sister for the attentions of her parents may carry on a campaign for absolute supremacy in important endeavors or situations, as if she repeatedly had to prove that she was "best" and hence worthy of praise and affection. Such patterns, given the proper stimulus, go on repetitively, forming the very fabric of the individual's way of life. They are stoutly defended, irrespective of how irrational they may be or how inherently contradictory they are in operation. The motivants for these drives, and the early experiences that engendered them, seem to exist in the unconscious of every individual. One is aware merely of an impelling urge that forces the adoption, in certain situations, of stereotyped ways of thinking, feeling, and behaving.

Obviously such tendencies, sooner or later, are potentially disruptive to the individual and, when they cannot be controlled, may create difficulties that disorganize adjustment. Normal people are capable of exercising some measure of control by virtue of wanting to avoid the unpleasantness that usually follows unrestrained responses. The defenses employed to curb such impulses may help one to adjust, but in no sense do they minimize the urgency of drives that periodically may express themselves in direct or highly symbolized form.

Fortunately, in addition to immature stereotyped patterns, all persons exhibit reactions that are reality-determined. These make up many, perhaps most behavioral tendencies.

Thus, the man described above who behaves like a little boy may respond to certain males in an assertive manner once he has assured himself of their good will or has ascertained their incapacity to

hurt him. Indeed, with selected men, under special conditions, he may even act the part of authority. Or the woman who competes blindly may be content with a secondary role whenever her security and self-esteem are assured.

Each individual will, therefore, play varying roles with different people, and, contingent on how secure one feels and the measure of one's self-esteem, one will react with either infantile past patterns or more mature patterns.

In Chapter 39 we have considered the examination, through focused interviewing, of the patient's current interpersonal involvements in order to identify disturbing patterns responsible for the emotional disorder. In the present chapter, we shall cover the process of investigating both stereotyped infantile and mature rational responses as they are expressed toward the therapist within the framework of the therapeutic situation.

Before taking up this process, it is necessary to emphasize that in supportive therapy, and in directive forms of reeducative therapy, it is often unwise to delve into the nature of the relationship with the therapist. Such a move tends to challenge the position of the therapist as a benevolent authority and the foundations of faith on which success in treatment may depend. Indeed, the attempt is made to perpetuate in the patient the illusion of the therapist's protective powers, no effort being extended coward examining the irrational sources of the patient's dependency need. The hope is to adjust the individual to less disturbing unconscious impulses, to increase repression of the more destructive ones, to expand existing assets, and to encourage compensations and sublimations so that patient can live as happy a life as is possible with his or her liabilities. Nevertheless should the patient's attitude toward the therapist become disturbing and interfere with the conduct of therapy, they are dealt with as manifestations of resistance to problem-solving and symptom relief.

In some forms of reeducative therapy, however, the more conscious manifestations of stereotyped patterns projected into the therapeutic relationship are explored and discussed in an attempt to modify or to control them. In reconstructive therapy, where an effort is always made to bring infantile patterns and their manifestations to full awareness and to determine their genetic origins, a thorough study of what goes on in the patient's relationship with the therapist is mandatory.

Insight into many of the patient's problems may be gained expediently through exposure of feelings and attitudes toward the therapist. The patient always projects into the relationship strivings that are both reality-determined and conditioned by habitual, unrealistic impulses toward people. The differentiation by the therapist of these two kinds of strivings helps the patient to understand the automatic, compulsive nature of some responses.

There is nothing so dramatic to a patient as to realize that he or she reacts to the therapist, not as a real personage, but as a virtual reincarnation of a parental or sibling figure (transference). The demonstration of how attitudinal and behavioral reactions are rooted in past relationships and how they distort the present reality situation is a living demonstration to the patient of the irrational way that he or she feels and behaves in everyday contacts with people. This realization may start a process of re-evaluation of the self.

One of the important effects of understanding the nature of impulses and attitudes toward the therapist is that it enables the patient to differentiate rational from irrational authority. Expectations of being treated by the therapist in a manner similar to the way that the patient was handled by previous authorities are not fulfilled. Avoiding a punitive, judgmental attitude, the therapist regards the patient's difficulties with sympathy and understanding. Expressions of hostility by the patient are accepted without indignation or retaliation. This allows the patient to display resentment more and more openly. It permits the patient to investigate its source as well as to understand reasons for its present existence.

Although every patient responds to the therapist with some patterns that are unrealistically determined, these may not be openly expressed. Subjected to reality testing, certain impulses are recognized by the patient as irrational. They may be considered threatening to an idealized relationship with the therapist. Accordingly, they are disassociated, suppressed, or repressed. Sometimes they impinge merely on the periphery of awareness, appearing in a symbolized form in dreams and fantasies or revealing themselves in slips of speech and random behavior, such as acting-out. Transference may manifest itself in relationships outside of therapy, the patient discharging toward a mate, relative, friend, or other personal feelings and attitudes that he or she dares not express toward the therapist.

Certain activities on the part of the therapist discourage or encourage the revivification in the

therapeutic relationship of archaic patterns. Where the therapist considers that desired goals in therapy can be achieved without the stirring up of excess transference, the therapist may decide to deal with emerging irrational attitudes in as immediate and forthright a manner as possible. Thus, hostility, sexual impulses, and intense dependency are handled by discussion and clarification as soon as they become apparent, an effort being made to keep reality in the fore. The relationship is maintained constantly on a positive level. This is the stance utilized in many, perhaps most, forms of therapy.

Among the techniques utilized to reduce transference are these:

1. Focusing discussions on present relationships and the current life situation
2. Minimizing or avoiding the consideration of the past, including relationships with parents
3. Avoiding dreams, fantasies, and free associations.
4. Avoiding the couch position and employing face-to-face interviewing
5. Spacing interviews no more frequently than once or twice weekly
6. Dealing with any unrealistic attitudes or feelings toward the therapist as soon as these are perceived
7. Playing a role opposite to that which the patient anticipated on the basis of past relationships with traumatizing authority
8. Exercising activity rather than passivity in the relationship

Through the use of these techniques it may be possible to withhold infantile urges from awareness, or to direct them away from the therapeutic relationship toward outside relationships, or to relegate them to a position where they may be held in check by rational controls.

In spite of these activities and precautions, transference may burst forth in full fury, interfering with the treatment plan. When this happens, it will have to be handled like any other kind of resistance, by such techniques as active interpretation.

Transference, may, however, be encouraged in certain patients whose problems are very deeply

repressed and who are constantly being upset by unconscious conflicts. No movement may be possible except through the direct experiencing of their problems in the relationship with the therapist. Among syndromes in which obstinate repression may occur are anxiety reactions, phobic reactions, conversion reactions, dissociative reactions, stress reactions, and certain obsessive-compulsive reactions. Here mobilization of transference as a learning vehicle may be helpful.

Transference may become so intense that the patient will actually live through with the therapist some early developmental blocks and traumatic experiences that produced the original repressions and other mechanisms of defense. The development of exaggerated transference reactions (transference neurosis) enables the patient to reexperience early deprivations and intimidations and to master them in another, more favorable setting with a new, more accepting, more permissive, better disciplined authority.

During classical psychoanalysis the therapeutic situation is deliberately manipulated so as to induce regression. This is considered inevitable and important for the revivification and working through of the most unconscious conflicts. The patient "will become a child again and be reborn, so to speak. Then he will grow up again, grow up better than he did before, guided by his now more mature intelligence and the warnings and lessons of his unhappy experiences now better understood" (Menninger, KA, 1961).

There is disagreement regarding the necessity for such regression, the neo-Freudians considering the here-and-now problems more important than those of the past, and believing that personality change can be achieved without the patient regressing to the infantile neurosis. Indeed, there are some analysts who, while analyzing positive and negative transference, consider the outbreak of a transference neurosis a sign of bad therapy.

Transference may operate both as stimulant toward and resistance against uncovering the unconscious; it may function, as Waelder (1936) has remarked "as the condition under which it is eminently possible to bring direct influence to bear on the patient." As a means toward understanding the most dynamic drives in the individual, transference has no parallel. The concerted analyses of both positive and negative transference are ways of bringing the patient to an understanding of the self in

depth.

> I recall the first patient I had as a "control" when I was in analytic training, who taught me how persistent and irrational a transference reaction could be and how in its proper handling a profound understanding may evolve. The patient was an attractive young lady in her early 20s who had a slight stammer and whose complaint was that she was unable to "fall in love" or even to develop a warm relationship with a man. Yet she had intensely romantic and erotic fantasies about men, which made her actual detached experiences with them so much more disappointing. The technique that I was employing was patterned after the classical model. I judiciously maintained a passive, non-interfering manner under the weekly tutelage of my supervising "control analyst." Several months of free associations rolled by during which I judiciously took notes from behind the couch and waited hopefully for something interesting and dramatic to emerge from the depths of her unconscious. And one day to my consternation it did, with a violence that left me dismayed and somewhat frightened.
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> The start of this episode was, to my surprise (since I could see no reason for it), sudden and complete silence on the part of the patient. Whereas she was customarily a spirited and garrulous analysand, a complete change had occurred in her since the session on the day before when she had rambled along enthusiastically, associating vigorously to events in her past. This day she walked into the room, cast a furtive glance at me, and retreated to the couch, where she stared fixedly at the ceiling with face flushed, fists and jaw clenched. Sensing that something was happening. I waited expectantly in vain for her to reveal her thoughts. After 20 minutes had passed, my curiosity overwhelmed my studied noninterference, and I proceeded to interrogate her. But nothing seemed capable of penetrating her muteness.
>
> Ten minutes prior to the end of the session she precipitously propelled herself from the couch and was about to bolt out of the room. I stopped her before she reached the door, and losing my therapeutic composure, I urgently insisted that she tell me what her reaction was all about. Her response was violent consisting of a torrent of abuse and invective. "You bastard," "You son of a bitch" were among the milder expletives. Shrieks mounted into an accusatory crescendo. "You know, you know what you did!" she repeated with no trace of a stammer.
>
> It required almost a half hour of reassurance to induce her to tell me what had upset her. The pith of her agony, it turned out, was that after she had left my office following the last session, she noticed me dashing across the street against traffic. This was no illusion or hallucination. Opposite my office building there was an optical shop that filled prescriptions for eyeglasses. I had left a prescription there some days previously and, having a few minutes before my next patient arrived, I decided to rush out, get my eyeglasses, and return to my office as expeditiously as I could. I did not notice that my patient was waiting at the corner and that she observed me dodging a few cars in my haste. This, she protested, was exactly what her father would do. He took risky chances to the horror of her mother and the entire family, and he was involved in several serious accidents, finally being killed in a car crash. "You are like him," she remonstrated. "You did it to defy me." My explanation of what prompted my hasty journey fell on deaf ears. I was, she insisted, making up a story to appease her, following the style of her father. It was only after I showed her the receipt of payment for my prescription that she stopped her attack. But for months she was emotionally convinced that I had perpetrated a ruse.

The experience opened up a deep pocket of distrust that she had harbored for men since her childhood. With the help of my supervisor who guided my analytic work, I was finally able to win her trust. This was the start of a new era in her relationships with men. Had I not provided her with a precipitating incident, I am sure that she would perhaps later on have found another reason to justify

her transference reaction.

As resistance, transference manifests itself in attempts to gratify childish impulses. Stubbornly refusing to acknowledge their unreality, the patient insists on living them through with the therapist. The analysis of the resistance aspects of the transference is an important aim in all psychotherapies.

Employing positive aspects of the transference relationship to promote supportive and reeducative measures is common in non-analytic psychotherapy. Positive transference, accordingly, in many forms of therapy is left unanalyzed; it is even encouraged to expedite the therapeutic process. On the other hand, negative transference is always considered an impediment in treatment; it is analyzed and worked through exhaustively as soon as it is perceived.

When one wishes to effect a transference interpretation, rather than dissipating it by some active gesture, one should permit it to build up to a peak without defending oneself. Once the top of the reaction has been reached, one should wait until it has receded somewhat before interpreting it. In the height of emotion the patient will tend to deny the validity of the therapist's remarks or look upon them as evasions of blame. This is in contrast to what is done in classical analysis when interpretations are often made at the peak of the emotion purposefully to foster frustration and in order to put the patient into contact with repudiated parts of the self.

On the other hand, the therapist may seek to prevent the full transference reaction by interpreting it at its start, when it is at the fringe of awareness, from evidences of transference in silences, peculiarities in behavior, dreams, or acting-out. Here the need for stirring up a past emotional reaction in its *full* intensity may either be contraindicated or deemed unnecessary.

The way of making a transference interpretation may be important because the patient needs to be prepared for it. The patient's most natural reaction would be to deny its validity since its roots are unconscious. The therapist first points to the manifestations of the reaction and asks if this may not be more extreme or more unusual than the reality situation demands. Should the patient deny this, the decision may be to wait until the reaction reappears, when again it is brought to the patient's attention. Once the patient acknowledges that perhaps his or her reaction is unusual, the therapist may then suggest its origin in past relationships and perhaps, if there is sufficient evidence, speculate on the

person or persons with whom the therapist is being identified. Finally, the therapist should study the patient's response to these interpretations.

The techniques that may be used to accentuate transference are:

1. Employing passivity and anonymity in the relationship.
2. Focusing discussions away from the present life situation.
3. Encouraging consideration of the past, including relationships with parents.
4. Using free association and the couch position. Removing of oneself from the direct gaze of the patient.
5. Concentrating on dreams and fantasies.
6. Increasing the frequency of sessions to 4 or 5 times weekly in order to break down repression.
7. Avoiding answering questions and restricting interpretations.
8. Avoiding dealing with unrealistic attitudes or feelings toward the therapist until these have built up to overwhelming proportions.
9. Acting in a role that coordinates with that assumed by the patient's traumatizing parent.

Patients will respond variably to these techniques, from failure to mobilize transference in certain rigid and detached persons, to explosive reactions that prove traumatic to the individual in borderline conditions. Indeed, in some patients intense transference may promote too great a shattering of repression which, not being reestablished, may eventuate in a psychosis. Syndromes such as borderline conditions, psychotic states, and certain personality disorders, psycho-physiologic reactions, and some obsessive-compulsive reactions do not respond favorably to the deliberate mobilization of transference. Even in cases where it is indicated, the fostering of transference is not to be encouraged by any therapist who has not had extensive analytic training and experience. (See also Chapter 49)

QUESTIONS ABOUT TRANSFERENCE

The following questions are frequently asked about transference to which are given to accent what

has been said above.

1. Aren't transference, relationship, and corrective emotional experience interchangeable terms?

Transference has become a watered-down expression that is sometimes confused with other forms of the patient-therapist relationship. At different times in this relationship the patient will play different roles, depending on the special needs that exist at the time. One of the roles is transference, whose meaning should be restricted to the feelings and reactions that the patient harbors toward significant persons in the past that are now being projected into the present. To a large extent such feelings are repressed and relegated to the oblivion of the unconscious. When they do surface during therapy they give us insight into infantile conflicts. They also tend to distort the immediate reality situation and divert the patient from engaging in goal-directed therapeutic tasks. Because transference can in this way act as a resistance to therapy, an attempt is often made to work it through or resolve it by interpretation whenever traces of archaic stereotyped negative or eroticized reactions manifest themselves. There are circumstances, however, when the allocation and deliberate buildup of transference is encouraged in order to examine its dimensions, origins, and effects, and especially how it engenders the present neurosis or character disturbance.

Analysis of transference is the major task in classical analysis and to elicit transference, techniques are utilized to encourage regression and the acting-out in the therapeutic relationship of repressed feelings and memories. When the buildup becomes so intense that the patient actually confuses the therapist with past important persons, the phenomenon is sometimes termed a *transference neurosis.* In certain patients, like borderline cases, the behavior may be explosive and psychotic-like (transference psychosis). Utilizing the leverage of the therapeutic alliance that has been built up, and appealing to the patient's "reasonable ego," the therapist actively interprets the patient's transferential responses, with the goals of bringing reality into the picture and of inculcating insight.

"Positive transference" is rooted in the patient's ever-present longing for an idealized parental figure who will love, protect, and lead the patient on to happy security and creative self-fulfillment. Positive transference thus is deliberately employed as a catalyzing force to promote supportive and

reeducative therapy. It is only when it becomes unreasonable, the patient reaching out for magic in the hope of fulfilling infantile dreams and archaic sexual needs, that the transference must be neutralized by interpretation since its indulgence will interfere with or destroy therapeutic progress.

Positive transference should be distinguished from the working alliance in which the patient cooperatively relates to the therapist with expected trust. Experiencing understanding and empathy, the patient is encouraged to distinguish between punitive and non-punitive authority, and to dissociate the therapist from the judgmental, punitive agencies in his or her past as well as from their precipitates in the superego. It is this unique kind of relationship that facilitates restoration of morale, alleviation of tension, the ability to divulge and face repudiated impulses and hurtful past experiences, tolerance of confrontations, absorption of constructive suggestions, identification with the value system of the therapist, utilization of reinforcements toward more adaptive modes of coping, and acceptance of clarification and interpretations that will lead to better understanding and a working through of one's basic problems. The relationship itself then acts as a "corrective emotional experience."

These varying dimensions of the relationship do not operate exclusive of each other, but may shift from one to the other at different phases of the therapeutic process. It is important for the therapist to recognize what is happening to the relationship to avoid a bad impasse, which, should it happen, will eliminate perhaps the most potent corrective force in treatment.

2. We know that the patient's reactions to the therapist are important. How do you present this to gain the patient's cooperation in reporting his or her feelings about the therapist, which in my experience is too often concealed out of embarrassment, anxiety, and so on?

One can say to the patient: "I am constantly going to look for the manner in which you react to me and how you feel about me. The reason for this is that in these reactions we can learn about how you have reacted to your parents and other people better than in wringing it out of your memories, many of which have been forgotten. So no matter how embarrassing it may seem, or how anxious you get, tell me about your feelings and ideas about me so we can both learn about you."

3. It is paradoxical to me that transference, which is the central issue in psychoanalysis, is not considered to be of importance in many other forms of therapy like behavior modification.

How would you account for this?

I believe that this dilemma can be explained. In classical analysis there is a deliberate creation of transference through frequent visits (four to five sessions weekly), studied anonymity, free association, and other devices for the purpose of activating unconscious and repudiated aspects of early experience. The surfacing of this material is often in the form of projection onto the therapist of the incorporated parental introjects. The working through of unresolved past needs and conflicts in the more congenial atmosphere of the therapeutic alliance is for the purpose of resolving unconscious conflict, which is what analysts believe to be the pathogenic core of the neurosis.

In other less intensive forms of therapy no attempt is made to liberate unconscious ideation, the focus of therapy being on the more conscious and here-and-now aspects of experience. Repressive defenses are either unaltered or are approached obliquely, with the consequence that transferential projections do not occur with the intensity that they manifest in classical analysis, where they may take the form of a stormy transference neurosis or frenzied transference psychosis.

This does not mean that transference is absent in symptom-oriented or problem-solving types of therapy like behavior modification. Transference may appear in attenuated forms as in dreams, in restrained acting-out, or in other highly disguised kinds of behavior. Under such circumstances therapy may still not be interfered with and may proceed satisfactorily with achievement of sought-for goals of problem-solving and symptom alleviation. Sometimes, however, especially where defenses are not too strong, transference may break through in force and act as resistance, under which circumstance its resolution may be required to expedite therapeutic progress.

4. Cannot reconstructions of the past from the history of the patient, dreams, and recollections serve as well as activating the past through transference?

Not at all. Such reconstructions may have some effect, but only an attenuated one compared to the insight gained through living the past through in some dramatic situation in the present such as a transference neurosis.

5. What is the true value of transference in psychotherapy?

Transference reactions enable us to penetrate into the past of the patient and to see how early experiences with important persons, usually parents and siblings, have produced a paradigm around which the individual fashions many present reactions. This knowledge is especially important in patients whose symptoms and behavioral difficulties and problems in their relationships with others are repetitively sustained through the insidious operations of transference. More importantly, the therapist often becomes the target of transference projections and, when this happens, the therapeutic process may get derailed because of resistance to the therapist and to the treatment techniques. Resolution of this resistance (generally through interpretation of what is happening) puts the treatment process back on the rails, so to speak. At the same time, the patient's new insight is an opportunity to appraise one's behavior from a causative perspective, and, if motivated to do so, to correct unrealistic patterns and attitudes so that they are not contaminated by past experiences, traumas, and fantasies. In this way, the therapeutic relationship can act as a corrective emotional experience.

6. Are all positive reactions to the therapist manifestations of neurotic transference?

There are genuine positive feelings in human relationships that do not have to be considered neurotic or transferential. These must be differentiated from distorted overvaluations and ideas of the therapist's magical powers, undaunted givingness and benevolence that are manifestations of neurotic transference. The former feelings are productive aids in the psychotherapeutic process; the latter are sooner or later destructive to the process.

7. When does transference especially act as resistance?

Transference acts as resistance when the patient tries to live through with the therapist early ungratified needs and impulses at the expense of getting involved with therapeutic work. For example, needs to gratify oedipal wishes through sexualizing the relationship with the therapist (by fantasies, overt behavior during the session, or acting-out away from the treatment) may become an obsession with the patient. Also, needs and impulses, or mere awareness of these, may create anxiety and mobilize resistance to the therapist and to his or her interventions. Another and not uncommon form of transference resistance involves fighting off the influence of the therapist the way the individual fought

off an authoritarian and interfering parental figure during the developmental separation-individuation struggle.

8. Can transference occur toward persons other than the analyst?

Of course this can happen, but we must always alert ourselves to the possibility that such a reaction is a displacement from transference on the analyst, which is being repudiated and expressed through a surrogate. Thus, infantile sexual wishes which ordinarily would be projected onto the analyst may be denied and then expressed through the body of another person outside of therapy.

9. Should you try to regard a patient's unusual emotional reactions as manifestations in some way of the transference?

If possible, yes. Often what may be helpful is questioning whether in responding to certain happenings the patient had or now has thoughts, feelings, or fantasies about the therapist. If the patient denies this, one may casually accept this but should search in the nonverbal behavior, slips of speech, etc., for evidences of transference and confront the patient with such evidences.

10. Can one take transference reactions at their face value?

It is always essential to search for latent content behind manifest behavior.

For example, one of my patients experienced anxiety in one session and hesitatingly revealed a rape dream in which she was the victim and I the rapist. Thoughts of my having sexual designs on her had occupied her for several days. I interpreted her reaction as concealing a desire to be seduced by me. This interpretation started a series of memories related to lascivious fantasies about her father that accompanied her early masturbatory activities. Our focus on her oedipal fears and feelings had a most constructive effect on her relationship with me and resulted in a good deal of progress in her treatment.

11. Are there different kinds of transference interpretations, and if so, which are most effective? Also, is it better to relate transference to the here-and-now or to the past?

Transference traditionally has connoted a concentration on the therapist of the patient's

involvements with early objects. Accordingly, the therapist is conceived of as a resource for archaic needs and impulses, as well as a vehicle for defenses against them. This common concept of transference, namely that it acts like a bridge between the past and the present, has been expanded to include reactions related to here-and-now relationships between patients and therapists, as well as between patients and other authority figures. Defenses against such reactions have been also considered aspects of the transferential spectrum. The transference interpretation, while not neglecting exposure of origins in the past, may productively include how the past is influencing present reactions. Some analysts also search for manifestations of the self that are being expressed through transference.

Consequently, when we talk about transference interpretations, we are alluding to a range of activities, such as:

1. relating the patient's reactions to those he or she originally had toward parents or siblings;
2. differentiating the patient's distorted attitudes and feelings toward the therapist from the actual reality of what the analyst is like;
3. pointing out how the manifest behavior toward the therapist shrouds latent intentions;
4. indicating how the patient's feelings and behavior toward the therapist reflect important incidents that have happened in the past; and
5. depicting how drives embodied in character structure operate to create pathology.

Transference interpretations may also embrace displacements from the self onto the therapist.

12. Does interpretation of the transference always lead to insight?

No, the patient may not be ready for or may resist the interpretation. The best results in transference interpretation will be obtained where the patient is immersed in strong emotions and the interpretation links these emotions to the transference situation. Similarly, a current conflict that can be connected with transference may make the impact of the interpretation greater.

13. Some authorities contend that only transference interpretations are important. Do you agree?

There are many analysts who affirm C. Brenner's (1969) contention that "every interpretation must be a transference interpretation if it is to be effective." This implies that true insight can be achieved only through interpretation of the transference. Any analyst who has utilized and witnessed the effectiveness of interpreting the transference once it has developed to full intensity cannot argue with the sentiment behind these statements, but the implication that other kinds of interpretations are ineffective may certainly be challenged.

When we observe the resistance encountered in analyzing neurotic symptoms and character traits directly, we must credit transference interpretation with making the greatest impact on the patient. But to restrict ourselves to this single activity limits the therapist's flexibility. Indeed, attempting to wedge all events and reactions into a transference formulation may do no more for the patient than to mobilize resistance. Nontransference interpretations can be extremely important in their own right, apart from reinforcing the impact of transference interpretations.

14. How does free association relate to transference?

Free association loosens past memories, which liberate emotions, which in turn tend to activate transference.

15. How truly essential is a transference neurosis for successful analysis?

Most analysts believe it to be indispensable. Some do not. Thus, Gill and Muslin (1976) have pointed to Glover's assertion that "there may be successful analysis ... where no transference neurosis develops." Of course we are dealing here with the definition of a "successful analysis." If it means the surfacing and interpretation of the unconscious repressed aspects of childhood, a transference neurosis provides the patient with the best opportunity for the working through of these residues. If it means the achievement of reconstruction of the personality, there is no guarantee that a transference neurosis will

accomplish this objective in every case. Nor is there validity in the idea that it is only through a transference neurosis that one can achieve personality reconstruction. Admitting these exceptions, the majority opinion still is heavily on the side of a working through of a transference neurosis as a most helpful vehicle for a successful analysis.

16. Is acting-out always a manifestation of transference?

Where a patient is in therapy, it should be regarded as such unless proven otherwise. But, factually, acting-out can occur exclusive of transference.

17. Why, if transference acts as a resistance to dynamic therapy, do dynamic therapists try deliberately to produce it in their patients?

Transference embodies some of the core infantile conflicts that operate unconsciously to produce neurotic illness. Its elicitation allows the therapist to confront, interpret, and clarify the meaning and purpose of the patient's illness. It may, however, create resistance as it develops; a chief therapeutic task is the resolution of this resistance, the working through of which becomes an important part of the cure. The purposeful encouragement of transference is an aspect of psychoanalytic treatment, particularly in its classical form. In other forms of dynamic therapy no effort is made to mobilize transference, but it still is dealt with by interpretation and clarification where it operates as resistance to therapy.

18. When would you consider it unwise to encourage transference as a therapeutic technique?

Transference should not be encouraged:

1. When the patient already has a problem in reality-testing (as in psychoses, unstable borderline cases, and paranoidal personalities);

2. when there is not enough time to work through transferential dependencies (as in short-term therapy);

3. when the therapeutic alliance has not been firmly established to sustain the rigors of transference;

4. when the defenses of the patient are so fragile that he or she cannot handle anxiety or tolerate frustration (which is inevitable in the transference experience);

5. when the objective in therapy is not deep conflict resolution but, rather, a more harmonious adjustment to the current reality situation.

From a practical standpoint this limits the number of candidates for transference mobilization to a highly selected group. It must be remembered, however, that, as sincere as our attempts may be to limit transference, it may still appear spontaneously, and it will then require careful resolution should it interfere with the therapeutic process.

19. Should positive transference be analyzed?

Positive transference should not be analyzed in short-term therapies, where it is utilized as a catalyzing force. It requires analysis in longer-term therapy where, because of the inherent magical expectations it invokes, the dependency it inspires, and the erotic interest stimulated, it can be a deterrent to progress. Incidentally, when a positive transference is resolved, a hidden negative transference may surface that will, of course, have to be worked through.

20. How soon will transference reactions begin?

They can occur in the first session and even before the first session with fantasies about the therapist and anticipation of what will happen in treatment. Manifestations of transference may be more easily controlled early in therapy than later on when intensity increases. Transference may exhibit itself only in dreams, slips of speech, and nonverbal behavior.

21. There is a form of transference during therapy that we call "falling in love" with one's therapist. Isn't this really a help in treatment?

On the contrary, I would consider it as a resistance. It often comes when the patient is working on especially difficult phases of a problem. This transference is usually not a mere verbalization to appease the therapist, but stems from archaic eroticized needs that have been deeply repressed and have little to do with the real person of the therapist. The patient will urgently and persistently demand gratification, if not in an actual sexual experience, then in intimacies that have symbolic sexual values. The therapist's

refusal to abide by the patient's wishes is extremely frustrating to the patient and the patient may seek external outlets for gratification in the form of acting-out with potentially disturbing and even dangerous consequences. So long as this transference need exists, the patient will resist the real aims of treatment. It is urgent, therefore, to resolve the transference. The best way to do this is to continue refusing to abide by the erotic transference need (gratification of which can be extremely destructive to the patient and the therapist) and to handle it through interpretation both as a form of resistance and as a means of understanding some of the deepest needs, conflicts, and defenses of the patient, certain manifestations of which are reflected in the symptoms for which therapy is now being sought. Interpretation of transference is an art and will call for astuteness and objectivity, as well as awareness and management of the therapist's own countertransference. Analysis of transference provides a way of metamorphosing archaic sexual fantasies and impulses into mature, fulfilling sexuality and constructive sublimations.

22. In dynamic psychotherapy how do you keep a balance of an empathic working relationship and the transferences that you want to come through to give you an idea of the patient's innermost conflicts?

While you are interested in finding out the nature of the patient's infantile conflicts, you try to keep the lid on transference material that will act as too great resistance to you and your techniques. You do not have to use special tricks to bring out these transference manifestations. They will come through, if not in direct behavior toward you then in acting-out away from therapy. You will generally get clues about transference from nonverbal behavior and especially from dreams. If there are evidences of hostility, fear, sexual interest, detachment, or paralyzing dependency, deal with these through open discussion before they germinate into full-blown patterns that may be more difficult to handle.

Even though these manifestations will give you inklings about some of the most urgent conflicts, your first task is to see to it that transference does not interfere with the working relationship, at the same time that you utilize it to give the patient some insight into the origin and nature of some of his or her conflicts. In psychoanalytically oriented therapy one may want to encourage some transference, but, as I mentioned before, transferences will probably not need encouragement, emerging spontaneously in some form as defenses are challenged. Where controls are rigid, some therapists utilize techniques to encourage transference (more passivity on the part of the therapist, increasing the frequency of sessions,

focusing on the past and on early relationships, encouraging dreams, etc.), although too great regression should be avoided. Where one wants to deal with present-day adaptations, transference is discouraged (by its early exposure and interpretation, by decreasing session frequency, by activity in the relationship, and by focusing on real events rather than the past and dreams).

23. How can you tell when a patient is in transference or is going into transference?

Generally, the therapist will be able to discern in the patient a manner that is different from the usual behavior. At the start of therapy the patient is generally highly defended and plays the conventional role of a patient with helping authority. After a while, and particularly where the patient's defenses are challenged, a change in demeanor becomes manifest. The patient may engage in periods of silence, or complain of having nothing in mind or having little to talk about, or cancel or break appointments, or come late, or keep looking at his or her watch if time is passing too slowly, or forget to pay the therapist's bills. On the other hand, the patient may verbally or nonverbally show an extraordinary interest in the therapist's private life, or become competitive with the therapist or with the therapist's other patients, or display dependency on the therapist, hanging onto every word, or openly or covertly make sexual advances toward the therapist. More difficult to detect are acting-out tendencies that the patient conceals from the therapist, in which feelings that are related to the therapist are projected to outside persons or situations. One way the patient has of concealing acting-out is by talking almost exclusively about the past, or speculating on dynamics, or bringing in involved dreams that are extremely difficult to decode.

Often the first intimations of transference are in dreams in which certain behaviors are exhibited toward symbolized versions of the therapist. The way such intimations are handled will depend upon whether the therapist wants to let transference build up until it reaches a crescendo, as in psychoanalysis, or to dissipate it by exploration and interpretation before it acts as resistance, as in non-analytic treatment.

ILLUSTRATIVE CASES

Example 1

A beginning breakthrough of transference is indicated in the following excerpt.

Th. You know sometimes I get the impression that you act with me as if you are walking on eggs. I wonder if you have any feelings toward me you are not talking about.

Pt. I don't, I don't know. This is one of the disturbing things ... when I'm all tangled up inside and don't know *(weeps*)... I don't want to cry ... I'll wipe my nose ... I don't know why I'm so upset today, really I don't. I felt so much better yesterday.

Th. Perhaps it's because I bring up the subject of your feelings toward me.

Pt. (cries) I feel irritated, just a momentary anger. I haven't been particularly conscious of it. I don't dislike you, just irritated, *(pause*)

Th. Do you want to tell me more about your feelings toward me?

Pt. I don't want to have feelings for you.

Th. You don't want to have feelings for me?

Pt. No. I don't know why.

Th. Perhaps you are afraid of showing emotion?

Pt. I certainly would be afraid of feeling affectionate.

Th. You would?

Pt. I certainly would.

Th. I wonder why?

Pt. I was thinking of it, as a matter of fact, yesterday. I felt...well... if I behaved well ... perhaps you would be good to me ... fatherly like, I mean.

Th. If you behaved affectionately to me you mean?

Pt. Yes, but I'm afraid.

Th. Afraid? Of what?

Pt. That it would not be taken seriously. Would it?

Th. If you felt affectionate toward me, of course I would take your feelings seriously. Perhaps what you're saying is that I might reject you or hurt you in some way?

Pt. What I mean is that I'd be ashamed of my feelings, that this would be a one-sided relationship. I think I feel you'd ridicule me.

Th. Actually, you don't know how I'd act, and yet you behave as if I do ridicule you for your feelings.

Pt. If I had feelings would they be responded to … would they?

Th. You mean would I reciprocate with the same kind of feeling?

Pt. That's it.

Th. If I did, this would not be a therapeutic situation for you.

Pt. I suppose not.

Th. But if you allowed yourself to talk about your feelings, I might be of considerable help to you in your problem.

Pt. (*giggles*) Now I feel very silly.

Th. Silly?

Pt. I do like you very much.

Th. (*smiling*) Mm hmm.

Pt. And I did feel about you … that you were able to help me. I did feel you were protective, something like I wanted father to be.

Example 2

The following excerpt is from a session with a patient suffering with a severe anxiety reaction with psycho-physiologic components. During the session the patient brings up a transference reaction that she traces to its source and then recognizes the operation of similar reactions in her relationships with people.

Th. I notice that you don't want to look at me today.

Pt. I don't want to like you. I'd rather not like you.

Th. I wonder why?

Pt. I feel I'll be hurt. Liking you will expose me to being hurt.

Th. But how *do* you feel about me?

Pt. I don't know. I have conflicting emotions about you. Sometimes I like you too much, and sometimes I get mad at you for no reason. I often can't think of you, even picture you.

Th. Do you feel that you stop yourself in your feelings toward me?

Pt. Yes, I don't want to like you. If I do, I won't be able to stop myself. I'll get hurt. But why do I feel or insist that I'm in love with you.

Th. Are you?

Pt. Yes. And I feel so guilty and upset about it. At night I think of you and get sexual feelings and it frightens me.

Th. Do I remind you of anyone?

Pt. Yes. *{pause*) There are things about you that remind me of my brother. (*laughs*) I realize this is silly.

Th. Mm hmm.

Pt. My brother Harry, the one I had these sex experiences with when I was little. He made me do things I didn't want to. I let him fool with me because he made me feel sorry for him.

Th. Do you have any of the same feelings toward me?

Pt. It's not that I expect that anything will really happen, but I just don't want to have feelings for you. I never liked doctors or dentists, especially dentists. The other day I had to go to a dentist. My mind was filled with crazy thoughts.

Th. Mm hmm.

Pt. These crazy things come into my mind that make no sense. I made this dental appointment, and I thought of the drill going into my tooth. Then I thought of the drill being an egg beater. Later I went to the movies, and in a cartoon I saw eggs. I then realized my attitude toward eggs has always been wrong. As a child my mother scolded me for frying eggs and burning them. Then the day before I went to the dentist, I got nervous. I then pictured eggs being cooked, and then I had a picture of a raw egg and realized the white of the egg looked like seminal fluid and I got sick. It's like this fluid can kill me. I remember my brother wanted to have sex with me when I was a child. He said he had this fluid in him and it would poison him if he didn't get it out. I let him fool with me. Then he told me about people putting it in their mouth. It disgusted me, made me sick. I have dreams of my mouth being smashed and my teeth falling out. The whole thing seems to be connected with sex.

Th. But what about your feelings for me?

Pt. I know it's the same thing. I'm afraid of you taking advantage of me. If I tell you I like you that means you'll make me do what *you* want.

Th. Just like Harry made you do what he wanted.

Pt. Yes. I didn't want to let him do what he did, but I couldn't stop myself. I hated myself. That's why. I know it now because there is no reason why I should feel you are the same way. That's why I act that way with other people too. It's like what happened not long ago with my art lessons. I went to this art place where I study, and I got very nervous and I had to go home. *(pause)*

Th. Try to connect up what happened.

Pt. It irritates me that I can't paint as well as I should. This woman who runs the art place seems to like me. I don't like that. It's like I'd get too friendly with them. I don't like to have people get too close to me. I think wrong about that. When I was little my sister used to take advantage of me too. But the most of it was my brother. The whole thing is the same as happens with you. It's all so silly and wrong. You aren't my brother and the other people aren't my brother. I never saw the connection until now.

Example 3

A patient on the verge of experimenting with the expression of aggression brings out transference feelings that help her understand some reasons why she repressed aggression.

Pt. I want to talk about my feelings about you.

Th. Mm hmm.

Pt. You sit here, a permissive person who lets me go on. I want to do something now, but I'm afraid you will be disappointed in me if I upset the apple cart, if I explode. I think we are too nice to each other. I'm ready not to be nice. My greatest fear of you is that you are potentially going to be severe with me if I get loose. Also, I fear I will let you down by not performing well, by not being nice. I feel I will gain your disapproval. And yet I see you don't condemn and don't criticize. It is still important to me to gain a nod from you or a smile *(pause)*

Th. It sounds as if you would like to let loose with me, but you are afraid of what my response would be. *[summarizing and restating]*

Pt. I get so excited by what is happening here. I feel I'm being held back by needing to be nice. I'd like to blast loose sometimes, but I don't dare.

Th. Because you fear my reaction?

Pt. The worst thing would be that you wouldn't like me. You wouldn't speak to me friendly; you wouldn't smile; you'd feel you can't treat me and discharge me from treatment. But I know this isn't so, I know it.

Th. Where do you think these attitudes come from?

Pt. When I was 9 years old, I read a lot about great men in history. I'd q them and be dramatic. I'd want a sword at my side; I'd dress like an Indian. Mother would scold me. Don't frown, don't talk so much. Sit on your hands, over and over again. I did all kinds of things. I was a naughty child. She told me I'd be hurt. Then at 14 I fell off a horse

and broke my back. I had to be in bed. Mother then told me on the day I went riding not to, that I'd get hurt because the ground was frozen. I was a stubborn, self-willed child. Then I went against her will and suffered an accident that changed my life, a fractured back. Her attitude was, "I told you so." I was put in a cast and kept in bed for months.

Th. You were punished, so to speak, by this accident.

Pt. But I gained attention and love from mother for the first time. I felt so good. I'm ashamed to tell you this. Before I healed, I opened the cast and tried to walk to make myself sick again so I could stay in bed longer.

Th. How does that connect up with your impulse to be sick now and stay in bed so much? *[The patient has these tendencies, of which she is ashamed.]*

Pt. Oh ... *(pause)*

Th. What do you think?

Pt. Oh, my God, how infantile, how ungrown up. *(pause)* It must be so. I want people to love me and be sorry for me. Oh, my God. How completely childish. It is, *is* that. My mother must have ignored me when I was little, and I wanted so to be loved. *[This sounds like insight.]*

Th. So that it may have been threatening to go back to being self-willed and unloved after you got out of the cast, *[interpretation]*

Pt. It did. My life changed. I became meek and controlled. I couldn't get angry or stubborn afterward.

Th. Perhaps if you go back to being stubborn with *me,* you would be returning to how you were before, that is, active, stubborn but unloved?

Pt. (excitedly) And, therefore, losing your love. I need you, but after all you aren't going to reject me. The pattern is so established now that the threat of the loss of love is too overwhelming with everybody, and I've got to keep myself from acting selfish or angry.

Example 4

A patient with a homosexual problem is brought to an awareness through transference of sexual feelings toward her father that incite anxiety and detachment from men.

Pt. Inwardly I feel like a wreck right now. And yet I just sit here very quietly and calmly as if nothing is wrong.

Th. In other words, you can put on a beautiful front.

Pt. Yeah, I'm doing it right now. You don't know what I look like from the other end. You don't know what I look like. I mean. I wondered what would happen if I came in here and said exactly what I feel. I'm sick of this faking, which I still do in here. But in what respect. I don't know. I'm so scared to tell you a lie; I live in a fear of it. And the other day when you asked me—this is an example of it. You were pointing out an example and asked me.

did I see. what was it, "Born Yesterday?" I said, “Yes.” But I saw the play, not the movie. Now what the heck difference it makes, I don't know, but it bothered me later. Don’t you remember it. But a few sentences later I, I corrected myself and said "I saw the play.” because it bothered me. The thought of telling you even that much of a lie is intolerable.

Th. Do you feel you've been lying to me in any other way?

Pt. I haven't lied to you about anything that I know of.

Th. Mm hmm.

Pt. But it’s just that I feel I’m still not myself. I want to find somebody to give my whole self to.

Th. Mm hmm.

Pt. That’s exactly what I want to do, and still I don’t do it. *(pause)*

Th. Still you're holding back.

Pt. But, in what way I don't know.

Th. And you feel somehow that maybe I don’t know the real you.

Pt. Yes. Like everything that happened to me all day long. I carry on long discussions with you in buses and trains *(laughs)* and, I say, “I must remember to tell him that tomorrow.” And then I never bother to tell any of these things.

Th. Are they any specific kinds of things?

Pt. Yes, now I, I could just pick out one.

Th. Mm hmm.

Pt. Yesterday I went to buy some glasses, dark glasses, with the idea of getting some eccentric looking things—things must be eccentric looking with me.

Th. Mm hmm.

Pt. So I asked the saleslady what she would suggest. So she suggested black. So I said, ‘‘That’s idiotic, but I’ll get black glasses.” And they are a bit eccentric looking, but silly, and, I wanted to go and read you something out of a book that I thought about today. But why? Because I wanted you to see those glasses. You see? And I would have gone right through with it, but I doubled back on myself in the train today and said it’s silly to do that. And when I put them on on the train, I noticed somebody looking over at me. I'm aware of myself all the time, and of being a fake. I sit down with a book in front of me, one leg over the other. I’m doing it now, and I don't feel this way at all. I don’t feel like a blah-blah woman of the world person at all.

Th. What *do* you feel?

Pt. I don't know. I don't know what it is that I feel. All I know is that what I look like— what I believe I look like anyway—I'm not. And I do a billion things during the day which, which are just crazy, which I carry on about.

Th. Do you feel that way right now?

Pt. All the time. And then before I came up here I got weak. By god, I didn't feel I had the strength to walk one block over to the Madison Avenue bus. I took a taxi. Absurd. And then I stopped to have this drink. It's ridiculous.

Th. Maybe you're afraid and tense about coming here.

Pt. No. It, it, it's the idea, it's always been, "If I could only have one person to tell the whole truth to, one person who could see me just nude, period. With nothing on." *(pause)*

Th. Mm hmm. And?

Pt. And that's exactly what I'm not doing. And I try so desperately.

Th. In other words, what you're saying to me is, "Look, I'm putting something over on you. I'm not letting myself be completely exposed to you."

Pt. But why I do it, I don't know, *(pause*) I'm putting up a front with you, or maybe I'm pulling the wool over your eyes, the way I'm pulling the wool over my father's eyes, and my mother's, and over at the school, and with everybody. And I feel maybe you're going to be sucker enough to fall for that.

Th. Perhaps I know you better than you think I know you.

Pt. I have the feeling as though you don't know a darn thing about me.

Th. Mm hmm.

Pt. I mean I've never talked about these things that have meant so much to me, like this morning.

Th. Mm hmm.

Pt. Uh, I go along wearing filthy clothes, underclothes. (*laughs)* I mean what people can't see, I don't care. Nobody sees it, it's so small it couldn't possibly smell, so I don't worry about it. (*laughs)*

Th. Mm hmm.

Pt. And so I didn't bother with it, and I thought about it, "Now here you sit down in the doctor's office, and he sees you look very decent in that. Does he know that you've got filthy underclothes on? There's no button here; there's no button there. Does he know that?"

Th. You feel very guilty about how you are inside, and the kind of person you are. *[interpreting]*

Pt. I want somebody to see it; that's the point of it.

Th. Do you think I'm not observant enough to see it?

Pt. No, but I feel as though I'm putting on an act for you. Oh, I know *(laughs)* it's your business after all, I mean ...

Th. Maybe you feel I'm not smart enough to know you, all of you?

Pt. That's not it. I feel that I haven't given you a chance to see everything *(laughs)*

Th. (laughs) I see.

Pt. But I don't know why I'm so upset. It has something to do with you.

Th. What do you feel about me?

Pt. (pause) Number one. *(sigh)* the thing I felt very much about you. I mean, uh, uh, as a person I like you very much.

Th. Mm hmm.

Pt. But I have a tremendous curiosity about you.

Th. Have you?

Pt. Yeah.

Th. For instance?

Pt. Marriage, children, everything about you. I'm interested in knowing.

Th. What about your theories about that? What do you think?

Pt. Well, I, it's always my purpose. I'm concerned with that all the time. When I talk to your secretary, I walk out with a smile and joke about something, and I always think, "Oh, I bet she thinks I'm a really happy little kid running around. I bet she likes me. Or maybe she doesn't like me." Always concerned with what people think.

Th. Mm hmm.

Pt. And, and with you. For instance, there were two men I was putting on the young lady act with, always an act. I dressed up to kill every time I saw them, and all that kind of thing. And then, when I found out they had grown daughters, I felt like a fool. I said, "What are you trying to impress them with? They've got one of their own." And that's why I'm interested in you, too. I, I must impress you still.

Th. Mm hmm.

Pt. I want to know what you think of me. How do I strike you, and how I would strike you if you met me on the street.

Th. Do you have any theories about how I might feel about you?

Pt. Well, the only think you've ever said which stuck in my mind so hard was that you thought it was all right to say what I wanted. But I want to know more. I want to know what strikes you? Every analyst also is, is a casual observer, and I want to know what you think of me.

Th. It's more important for me to get an idea of what *you* think I think of you, than for you to find out what *I* actually think of you at this time. You're not quite sure of what I think of you.

Pt. No, not at all.

Th. You're not sure that I like you?

Pt. Yeah, I believe you like me. I believe you consider me rather intelligent.

Th. Well, how do you know?

Pt. Well, first of all you told my father so.

Th. Mm hmm. Did he tell you that?

Pt. Yeah. I had him repeat it thousands of times *(laughs)* just to make sure. It made me feel like a million dollars that day. In fact, I even celebrated. I went downtown.

Th. Is that so?

Pt. This is absurd, but that's, that's just the way I felt. So concerned over what you must think of me.

Th. Now if I told you I liked you and that sort of thing, it would not help you. In fact, it would prevent you from feeling spontaneously about me. It's important that you become aware of all of the feelings you have, some of which are justified and some of which have nothing to do with reality. We can get important clues about things that are happening to you from your feelings.

Pt. Yes.

Th. It may be a little hard on you if I don't come out and tell you exactly how I feel all the time.

Pt. Mm. Yeah.

Th. If I keep saying, "What do you think I feel about you?" …

Pt. Yeah.

Th. Or, "What are your theories about this or that?" it might be a little hard on you, but in the long run it will be most helpful to you.

Pt. Yes.

Th. But if you resent this kind of role that I'm playing with you, then tell me about it.

Pt. No, it, it's just pleasantly annoying, you know, that's all; it's tantalizing, so to speak. *(pause)* If you asked me to be truthful and tell you what I would most like to do right now, I'd have to say, "I want to sleep with a man, but I want him to have his pants on."

Th. Mm hmm.

Pt. "But no top. Big shoulders. And I would be nude. And I want to inspect his penis, and I want to play with it. And I want him, just, just to sort of annoy me, but I don't want to have to lie back and just take it. I want to be able to just squirm around and let myself go, just be a whole physical thing and no mind at all.

Th. Yes.

Pt. And then I come to think about what would this man have to look like. From his shoulders, right around about here —and that's you. It just came to me. The man is you. I have been thinking these thoughts since I started coming here, sex thoughts.

Th. The man is I?

Pt. Yeah.

Th. Mm hmm.

Pt. I got, I got those feelings of sex now that are driving me crazy. By god, I didn't know I could ever say that.

Th. You couldn't say that to me?

Pt. No, no. Well, but I did. But I thought. "Well, maybe it's not so. Maybe it's just nonsense." But the more I thought about it, the more it was you. I tried to push it out of my mind, but it's true.

Th. Maybe that's why you were upset.

Pt. It's possibly that. But it's a horrible thought that I can think that. I remember seeing daddy without his clothes. His penis seemed enormous. I get a funny feeling. It's repulsive and exciting too. Just like I feel about you. I try not to think about it. *[It is apparent that her feelings toward me are projections of her feelings toward her father.*]

Th. What about your sex feelings about men?

Pt. I just have no feeling about it. Maybe it's safer that way.

Th. Maybe it's safer to feel sexy toward women, because it's not safe to feel sexy with men? [*interpreting her homosexuality]*

Pt. Definitely.

Example 5

The following case illustrates the operation of a transference neurosis in facilitating insight. Sporadic backaches (lumbago) were among the patient's most disturbing symptoms. From time to time backaches became exaggerated during a treatment session. Observing the content of his conversations

when this happened, it was determined that backaches developed whenever the patient bragged or boasted about himself, whenever he voiced comments that might be construed as criticisms of me, whenever he expressed demands that I might possible reject, or whenever he mentioned circumstances in which he had behaved in a selfish or intolerant manner. On one occasion, when these facts were brought to his attention, the patient stiffened with severe back pain, which became so intense that he winced. This was coupled with pain in his scrotum and drawing sensations in the perineum. Asked to tell me what was on his mind, he expostulated that he could never express himself frankly with his father. A stern puritanical man, his father had subjected him to severe discipline whenever the patient deviated in the least from the righteous path of moral, unpretentious living. Even childish pranks were forbidden. When questioned about the form of punishment his father employed, the patient said, "He would beat me across the back with a stick." The area of attack coincided precisely with the zone of his present backaches.

At this point I mentioned that it was rather significant that in talking to me about certain topics, he had symptoms of backache. This sounded as if he were being punished for his thoughts. Seemingly, no impression was made on the patient by the interpretation. However, when he appeared for the next session, he was manifestly disturbed. Hitherto gentle and courteous, he stormed into my office and launched into a verbal attack on me. A fragment of this session follows:

Pt. I haven't wanted to say this, but it's bothered me for some time. Your attitude, I mean. *[The patient is quite anxious as he talks.]*

Th. My attitude?

Pt. You remember when I first came to see you and told you about my flight instruction and taking my instructor's test?

Th. Yes. *[This incident was a minor one that I almost had forgotten.]*

Pt. Well, you acted very flippant and disinterested.

Th. In what way?

Pt. The way you talked and looked.

Th. I wonder. Why didn't you mention this at the time?

Pt. (pause) Well, I thought that I was wrong to boast about it. And I felt you resented my boasting, blowing my horn. I

know I feel this, and you'll say it's my imagination, but I feel I'm right that you cut me off from talking. I felt you were contemptuous of me.

Th. If this were true, I certainly wouldn't blame you for feeling the way you do. But searching into myself, and trying to recapitulate what happened, I don't remember wanting to cut you off, or feeling flippant, or deriding you in any way or acting contemptuous toward you. Is it possible that you see in what I did or said, something that wasn't there?

Pt. (angrily) I don't believe you. I think you're saying that to be therapeutic. I feel that.

Th. As if I'm saying this to reassure you?

Pt. Yes, because I feel this is what you did.

Th. Cut you off and acted contemptuous on the basis that you were boasting?

Pt. Yes. It's confusing to me.

Th. Say, how come you bring that up now? This happened 5 months ago.

Pt. Something you said last time I was here made me mad. I don't know what it is now. *[Apparently my pointing out the possibilities of a transference reaction removed his repression and released hostility.]* I still feel you don't want to admit what you did.

Th. Well, I'll try to examine my feelings about you and see if I really did cut you off and deride you. As far as I know right now, this isn't how I felt. As far as I can see right now, I don't feel at all contemptuous toward you.

Pt. It's hard for me to believe that. I mean it's hard to see why you shouldn't be annoyed.

Th. Why should I be annoyed at you?

Pt. Look at the crazy things I did, I told you about. That episode with that woman and everything else that followed.

Th. Maybe you feel I ought to look down on you for what you've done?

At the next session the patient was again accusatory. He said that I acted detached and unfriendly. I did not give him an opportunity to attend my lectures or to socialize with me. He recalled that he had recently met me at a restaurant and that I had nodded but did not offer to share my table with him. Again I assured him that if it were true that I had willfully rejected him, he had a right to be angry. However, the nature of the therapeutic situation was such that any social contact might interfere with an opportunity to work out his problems.

For several sessions we talked back and forth in this manner. I was aware of the fact that the patient

was trying to goad me into acting in an angry, recriminatory way, paralleling his father's reactions. Were I to have responded in this way, he probably would have left therapy, convinced that I was an arbitrary , hostile person. Or he would have submitted himself and then developed a dependent, compliant attitude with a continuance of his symptoms. The upshot of our talks was a recognition of his projection into our relationship of attitudes that he had about his father that had conditioned his general feeling toward authority. His ability to challenge my reaction, to vent his hostility, to understand that his reactions were carryovers of earlier patterns, without encountering counterhostility enabled him successfully to work through his problem in therapy.

Were the patient in formal psychoanalysis, he would have been allowed to experience his feelings intensely without my interpreting and attempting to resolve them as soon as they developed. This would have dredged up from the deepest recesses of his unconscious early memories and feelings, and he would have lived through his infantile neurosis in the transference neurosis. Whether the outcome would have been more successful than that which I had been able to achieve through once-a-week dynamic psychotherapy is a matter of speculation.