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Basic Psychoanalytic Concepts: III. Transference

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In a previous paper in this series (Sandler, Holder and Dare, 1970a) aspects of the doctor-patient relationship were discussed under the general heading of *treatment alliance*. It was pointed out that the concept included features which have been at times referred to as 'transference', and the purpose of the present paper is to consider some of the further meanings of the latter term.

It will be seen that the concept can only be appreciated in terms of its historical development, and that different schools within psychoanalysis tend to emphasize different aspects of the definition of transference. The understanding and analysis of transference phenomena are regarded by psychoanalysts as being at the very centre of their therapeutic technique, and the concept is widely applied outside psychoanalysis in the attempt to understand human relationships in general. A dissection of the various meanings attributed to the word seems necessary in order to consider its current and potential applications.

Freud first made use of the term *transference* when he was reporting on his attempts to elicit verbal associations from his patients (Freud, 1895). The aim of the method of treatment was for the patient to discover, through his associations, the link between his *present* symptoms and feelings on the one hand and his *past* experiences on the other. Freud assumed that the 'dissociation' of the past experiences (and the feelings connected with them) from consciousness was a major factor in the genesis of the neurosis. He noted that changes developed during the course of treatment in the patient's attitude to the physician, and that these changes, which involved strong emotional components, could cause an interruption to the process of verbal association, often resulting in substantial obstacles to treatment. He commented (1895) that '. . . the patient is frightened at finding that she is transferring on to the figure of the physician the distressing ideas which arise from the content of the analysis. This is a frequent, and indeed in some analyses a regular, occurrence.' These feelings were regarded as 'transference', coming about as a consequence of what Freud called a 'false connection' between a person who was the object of earlier (usually sexual) wishes and the doctor. Feelings connected with past wishes (which have been excluded from consciousness) emerge and become experienced in the present as a consequence of the 'false connection'. In this connection, Freud remarked on the propensity of patients for developing erotic attachments towards their doctors.

In a paper published some years later (Freud, 1905), the term 'transference' was once again used in the context of the psychoanalytic treatment situation. Freud put the question: 'What are transferences? They are new editions or facsimiles of the impulses and phantasies which are aroused during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment. Some of these transferences have a content which differs from that of their model in no respect whatever except for the substitution. These then—to keep to the same metaphor—are merely new impressions or reprints. Others are more ingeniously constructed; their content has been subjected to a moderating influence . . . by cleverly taking advantage of some real peculiarity in the physician's person or circumstances and attaching themselves to that. These, then, will no longer be new impressions, but revised editions.'

Thus far transference had been seen as a clinical phenomenon which could act as an obstacle or 'resistance' to the analytic work; but a few years later (1909) Freud remarked that transference was not only an obstacle to analysis but might play 'a decisive part in bringing conviction not only to the patient but also to the physician'. This is the first mention of transference as a therapeutic agent. It should be noted that Freud consistently distinguished the analysis of transference as a technical measure from the so-called 'transference-cure' in which the patient appears to lose all his symptoms as a consequence of feelings of love for and a wish to please the analyst (1915).*

Somewhat later, Freud pointed out that 'a transference is present in the patient from the beginning of the treatment and for a while is the most powerful motive in its advance' (1916/17). By now it would appear that Freud was using the term to include a number of rather different phenomena, although they all had the quality of being a repetition of past feelings and attitudes in the present. In 1912 Freud had spoken of 'positive' transferences as opposed to 'negative' ones, and had further subdivided positive transferences into those which helped the therapeutic work and those which hindered it. Negative transferences were seen as the transfer of hostile feelings towards the therapist, the extreme form being seen in paranoia, though in a milder form it could be seen to co-exist with positive transference in all patients. This co-existence enabled the patient to use one to protect himself against the emergence of the other. Thus a patient might use the hostility which he has transferred to the analyst as a means of keeping positive transference feelings at bay. Here the patient employs his hostile transference feelings to protect himself against emerging and threatening positive (usually erotic) transferences. Moreover, that aspect of the positive transference which 'is present . . . from the beginning of treatment' is different in quality from the erotic transferences which arise during the course of treatment. The former can be regarded as a component of the treatment alliance (Sandler, Holder and Dare, 1970a).

Freud suggested that the particular characteristics of a patient's transference stem from the specific features of that patient's neurosis, and are not simply an outcome of the analytic process and common to all patients (1912). The specific qualities of a patient's transference were given a further meaning when the concept of 'transference neurosis' was introduced (Freud, 1914). This emphasized the way in which the earlier relationships which were components of the neurosis itself also mould the dominating pattern of the patient's feelings towards the psychoanalyst. The 'transference neurosis' concept was amplified by Freud (1920) when he commented that the patient in analysis is 'obliged to *repeat* the repressed material as a contemporary experience instead of, as the physician would prefer to see, *remembering* it as something belonging to the past. These reproductions, which emerge with such unwished-for exactitude, always have as their subject some portion of infantile sexual life . . . and they are invariably acted out in the sphere of the transference, of the patient's relation to the physician. When things have reached this stage, it may be said that the earlier neurosis has now been replaced by a fresh, 'transference neurosis'.* The repetition of the past in the form of contemporary transferences was seen by Freud as a consequence of the (inappro-

* The relation of transference to *resistance* will be dealt with in a later paper (Sandler, Holder and Dare, 1970b). The 'transference cure' can be distinguished from a 'flight into health' which is regarded as a form of resistance.

* It is unfortunate that the term 'transference neurosis' as used by Freud is so close to the label which he applied to a whole class of psychiatric *disorders*—the so-called 'transference neuroses', i.e. those disorders in which transference phenomena could be observed. In his earlier writings he showed his belief that these could be distinguished from other types of disorder, the 'narcissistic neuroses', in which transference phenomena were not thought to develop readily. The latter group corresponds to what we would now refer to as the functional psychoses. Most psychoanalysts now believe that transference phenomena occur in patients belonging to both groups. However, it should be said that Freud thought that the transference neurosis could occur characteristically in the psychoanalytic treatment of patients suffering from the 'transference neuroses', i.e. conversion hysteria, anxiety hysteria and obsessional neurosis (1916/17). A great deal of confusion attaches to the term transference neurosis (Kepecs, 1966).

priately named) 'compulsion to repeat' (1920).

The increasing emphasis on the analysis of transference has led other psychoanalytic writers to attempt to refine and expand the concept in order to achieve a clearer understanding of clinical phenomena. In order to put later developments into perspective it is necessary to point out that Freud conceived of sexual wishes towards an important figure of the past as an investment ('cathexis') of sexual drive energy ('libido') in the image of the person (the 'libidinal object') concerned. Transference was thought of as the displacement of libido from the memory of the original object to the person of the analyst, who became the new object of the patient's sexual wishes, the patient being unaware of this process of displacement from the past.

Anna Freud (1936) proposed a differentiation of transference phenomena, in which transference as described by Freud represented one main category; a second type of transference was described as 'transference of defence'. She included in the latter group the repetition of the former measures which the patient had taken to protect himself against the painful consequences of childhood sexual and aggressive wishes. An example of this would be the patient who develops, during the course of his analysis, an attitude of belligerent rejection of the analyst, transferring here an attitude which he had taken up in childhood in order to protect himself against feelings of love and affection. Such a formulation extends the earlier and simpler view of Freud in which the 'defensive' hostility would be seen, not as a repetition of a defensive measure of childhood, but rather as the employment of existing hostile feelings to protect the individual against the consequences of his emerging positive transference. Anna Freud further differentiated 'acting in the transference', in which the transference intensified and spilled over into the patient's daily life. Thus, feelings and wishes towards the psychoanalyst, aroused during the course of treatment, might be enacted towards other people in the patient's current environment. This is close to the concept of *acting out*, to be discussed in another paper in this series (Sandler, Holder and Dare, 1970c).

At the same time, Anna Freud added a further category which she regarded as a *sub-species* of transference and which she believed should be kept separate from transference proper. She referred here to *externalizations*, exemplified by the patient who feels guilty and instead of experiencing the pangs of conscience expects the analyst's reproaches. This externalization of a formed part of the personality was thought to be different from the repetition, in the transference, of the patient's childhood relationships towards, for example, a punitive father. A further example of externalization would be that of the patient who develops the belief (or fear) that the analyst wishes to seduce him, such a belief being based upon the externalization (or 'projection') on to the analyst of the patient's own sexual feelings towards him. What is 'externalized' are the patient's unconscious sexual desires, and this need not necessarily be regarded as the repetition of an infantile defensive manoeuvre. The distinction between externalization and transference 'proper' has not been systematically pursued by later writers, although it is of interest that both Alexander (1925) and Freud (1940) referred to the psychoanalyst 'taking over' the role of the patient's conscience (or 'superego'), and saw this as being an important part of the therapeutic process.

There has been a strong tendency, within psychoanalysis, towards a widening of the transference concept. This can be traced in part to two trends in psychoanalysis which found their expression in the so-called 'English school' of psychoanalysis. James Strachey (1934) had suggested that the only effective interpretations in psychoanalytic treatment were transference interpretations; as a consequence, analysts who were influenced by his views chose to formulate as many of their interpretations as possible in transference terms, in order to increase the effectiveness of their interventions. The second trend was represented by the theoretical formulations of Melanie Klein, who as a consequence of her analytic work with children came to view all later behaviour as being very largely a repetition of relationships which she considered to obtain in the first year of life (1932). The combination

of these trends resulted in a tendency for some analysts to regard all communications brought by the patient as indicating the transference of early infantile relationships, and to refrain from comments which did not refer to the transference features of the relationship between the patient and the analyst. This has been fully discussed by Zetzel (1956). Many analysts have contributed to the extension of the transference concept. For example, Edward Glover (1937) emphasized that 'an adequate conception of transference must reflect the *totality* of the individual's development . . . he displaces on to the analyst not merely affects and ideas but *all* he has ever learnt or forgotten throughout his mental development'.

While some authorities have extended the concept within the psychoanalytic situation, others (while not accepting that all aspects of the patient's relationship to this analyst should be regarded as transference) have taken the view, in line with a comment of Freud's on the ubiquity of transference (1909), that transference should be regarded as a general psychological phenomenon. Thus, Greenson (1965) writes: 'Transference is the experiencing of feelings, drives, attitudes, fantasies and defences towards a person in the present which are inappropriate to that person and are a repetition, a displacement of reactions originating in regard to significant persons of early childhood. I emphasize [says Greenson] that for a reaction to be considered transference it must have two characteristics: it must be a repetition of the past and it must be inappropriate to the present.' Such a definition appears to include more than Freud had originally intended; for example, it would include habitual types of reacting to other persons which have become part of the patient's character (e.g. a tendency to be afraid of authority), and which might be regarded as inappropriate to the present. This is quite different from the conception of transference as the development, during the process of the psychoanalytic work, of feelings which were not apparent at the beginning of treatment, but which emerged as a consequence of the condition of treatment.

Because of the belief that the extensions of the concept made by many psychoanalytic writers must lead to lesser rather than greater clarity, a return to a more limited view of transference has been advocated by a number of authors. Waelder (1956) has suggested that the concept of transference should be restricted to occurrences within the classical psychoanalytic situation. He says: 'Transference may be said to be an attempt of the patient to revive and re-enact, in the analytic situation and in relation to the analyst, situations and fantasies of his childhood. Hence transference is a regressive process . . . Transference develops in consequence of the conditions of the analytic experiment, viz., of the analytic situation and the analytic technique.' More recently, in a very full discussion of the divergent trends in regard to the transference concept, Loewenstein (1969) concluded that 'transference outside of analysis obviously cannot be described in identical terms with the transferences which appear during and due to the analytic process'.

It seems clear that different psychoanalytic authors have advocated rather different definitions of transference. The meaning of the term varies according to the context in which it is used, and it is apparent that if the term is to be used in a broad sense, subcategories need to be distinguished. At present the term 'transference' is used by different psychoanalysts in some or all of the following senses:

(1) To describe the treatment alliance (Sandler, Holder and Dare, 1970a).

(2) To denote the emergence of infantile feelings and attitudes in a new form, directed towards the person of the analyst, essentially as described by Freud (1895, 1905, 1909, 1912, 1914, 1916/17, 1920).

(3) To include 'transference of defence' and 'externalizations' (A. Freud, 1936).

(4) To encompass all 'inappropriate' thoughts, attitudes, fantasies and emotions which are revivals of the past and which the patient may display (whether he is conscious of them or not) in relation to the analyst. This would include such things as the patient's initial 'irrational' anxieties about coming to treatment, particular attitudes towards people which form part of his personality structure and which

also show themselves towards the analyst (Greenson, 1965).*

(5) To include *all* aspects of the patient's relationship to his analyst. This view of transference sees every aspect of the patient's involvement with the analyst as being a repetition of past (usually very early) relationships. Indeed, *every* verbal and non-verbal communication or expression by the patient during the course of his analysis is regarded as transference. Analysts who take this view of transference regard all the patient's associations as essentially referring to some thought or feeling about the analyst (e.g. Rosenfeld, 1965).

It would seem that the argument (Waelder, 1956; Loewenstein, 1969) that the concept of transference should be limited to the psychoanalytic situation alone is unnecessary. Obviously the same phenomena which occur in psychoanalytic treatment can occur outside it. Freud put it thus: 'It is not a fact that transference emerges with greater intensity during psychoanalysis than outside it. In institutions in which nerve patients are treated non-analytically, we can observe transference occurring with the greatest intensity' (1912). It has been emphasized, however, that the classical analytical situation does appear to provide conditions which foster the development of transferences, and which enables the phenomena to be examined in relatively uncontaminated forms (Stone, 1961).

At the other extreme, the widest use of the concept, in which all communications and behaviour within the psychoanalytic setting are regarded as transference, seems to remove all value from the concept if it is to be extended outside psychoanalytic treatment; for it would then follow that all behaviour could be described as transference, i.e. determined by the tendency to repeat past patterns of behaviour and experience. While it is true that aspects of past reactions and even infantile experiences will tend to be repeated in the present, and that present reality will tend to be perceived in terms of the past, there are also factors which oppose this distortion (so-called 'reality-testing'). It seems likely that the relative lack of opportunity to 'test' reality in the psychoanalytic treatment situation allows transference distortions to develop readily and to be seen most clearly.

It seems important to distinguish between the general tendency to repeat past relationships in the present (e.g. as can be observed in persisting character traits such as 'demandingness', 'provocativeness', 'intolerance of authority' and the like) and a *process* characterized by the development of feelings and attitudes towards another person (or an institution) which represents a concentration of a past attitude or feeling, inappropriate to the present, and directed *quite specifically* towards the other person or institution. From this point of view, the anxieties which a patient might have on entering treatment need not be regarded as transference, even though they may be a repetition of some earlier and important experience. On the other hand, a patient who has been in treatment for some time may develop fears about coming to treatment, fears which are now believed and felt by the patient to be a function of the specific qualities of the therapist, even though there may be little foundation in reality for such transference beliefs and feelings. In this sense transference can be regarded as a specific illusion which develops in regard to the other person, one which, unbeknown to the subject, represents in some of its features a repetition of a relationship towards an important figure in the person's past. It should be emphasized that this is felt by the subject, not as a repetition of the past, but as strictly appropriate to the present and to the particular person involved.

It may be added that transference need not be restricted to the illusory apperception of another person in the sense in which it is described here, but can be taken to include the unconscious (and often subtle) attempts to manipulate or to provoke situations with others which are a concealed repetition of earlier experiences and relationships. Transference elements enter to a varying degree into all

*Greenson nevertheless distinguishes transference from the 'working alliance' (1965) and from the 'real' relationship of the patient to his analyst (Greenson and Wexler, 1969). Szasz has discussed many of the logical difficulties which arise in the distinction between transference and 'reality' (1963).

relationships, and these (e.g. choice of spouse or employer) are often determined by some characteristic of the other person which (consciously or unconsciously) represents some attribute of an important figure of the past.

It would seem to be useful to differentiate transference from non-transference elements in any patient-doctor relationship, rather than to label all elements in the relationship (arising from the side of the patient) as transference. This may lead to greater precision in defining the clinically important elements and elucidating the relative roles of the variety of factors which enter into the interaction between patient and doctor in any form of treatment.

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