Resistance and Defense

Acting Out and Resistance
Altman (1957), Bird (1957), Ekstein and Friedman (1957), Kanzer (1957), Spiegel (1954), Zeligs (1957).

Character Disorders and Resistance

Ego-alien and Ego-syntonic Resistances
Glover (1955), Menninger (1958), Sharpe (1930).

Greenson
The Technique and Practice of Psychoanalysis

3

Transference

The development of the technique of psychoanalysis has been determined essentially by the evolution of our knowledge about the nature of transference. The greatest advances in psychoanalytic technique were derived from Freud's (1905c) major discoveries about the twofold power of transference; it is an instrument of irreplaceable value, and it is the source of the greatest dangers. Transference reactions offer the analyst an invaluable opportunity to explore the inaccessible past and the unconscious (Freud, 1912a, p. 108). Transference also stirs up resistances that become the most serious obstacle to our work (p. 101). Every definition of psychoanalytic technique must include as a central element the analysis of the transference. Every deviant school of psychoanalysis can be described by some aberration in the way the transference situation is handled. Transference reactions occur in all patients undergoing psychotherapy. Psychoanalysis is distinguished from all other therapies by the way it promotes the development of the transference reactions and how it attempts systematically to analyze transference phenomena.

3.1 Working Definition

By transference we refer to a special kind of relationship toward a person; it is a distinctive type of object relationship. The main characteristic is the experience of feelings to a person which do not
For example, a young woman patient reacts to my keeping her waiting for two or three minutes by becoming tearful and angry, fantasizing that I must be giving extra time to my favorite woman patient. This is an inappropriate reaction in a thirty-five-year-old intelligent and cultured woman, but her associations lead to a past situation where this set of feelings and fantasies fit. She recalls her reactions as a child of five waiting for her father to come to her room to kiss her good night. She always had to wait a few minutes because he made it a rule to kiss her younger sister good night first. Then she reacted by tears, anger, and jealousy—precisely what she is now experiencing with me. Her reactions are appropriate for a five-year-old girl, but obviously not fitting for an thirty-five-year-old woman. The key to understanding this behavior is recognizing that it is a repetition of the past, i.e., a transference reaction.

Transference reactions are essentially repetitions of a past object relationship. The repetition has been understood in a variety of ways and apparently serves multiple functions. Instinctual frustration and inhibition cause the neurotic to seek belated opportunities for satisfaction (Freud, 1912a, p. 100; Ferenczi, 1909). But the repetition has also been understood as a means of avoiding memory, a defense against memory, as well as a manifestation of the compulsion to repeat (Freud, 1912a, 1914c; A. Freud, 1936; Fenichel, 1945b).

It is this fact, that a piece of behavior repeats something in the past, that makes it likely to be inappropriate to the present. The repetition may be an exact duplication of the past, a replica, a reliving, or it may be a new edition, a modified version, a distorted representation of the past. If a modification of the past transpires in the transference behavior, then it is usually in the direction of wish fulfillment. Very often fantasies of childhood are experienced as having actually taken place (Freud, 1914b, pp. 17-18; Jones, 1953, pp. 265-267). Patients will experience feelings toward the analyst that can be construed as a sexual seduction by the father, which are later revealed to be a repetition of a wish that occurred originally as a childhood fantasy. Transference feelings that are acted out usually turn out to be such attempts at wish fulfillment (Freud, 1914c; Fenichel, 1945b; Greenacre, 1950; Bird, 1957). An extension of this idea is to be seen in patients who attempt to complete unfilled tasks in their acting out (Lagache, 1953).

The objects who were the original sources of the transference reactions are always inappropriate. They may be in the quality, quantity, or duration of the reaction. One may overreact or underreact, or one may have a bizarre reaction to the transference object. The transference reaction is unsuitable in its current context, but it was once an appropriate reaction to a past situation. Just as ill-fitting as transference reactions are to a person in the present, they fit snugly to someone in the past.
reaction are the important people of a child's early years. They usually are the parents and other upbringers, the dispensers of love, comfort, and punishment, the siblings and other rivals. However, transference reactions may be derived from later figures and even current figures, but analysis will reveal that these later objects are secondary and were themselves evolved from the primary, early childhood figures. Finally, it should be added that parts of the self may be displaced onto others, that is, projection may take place. These will also appear like transference reactions, but I question whether this type of response correctly belongs in the realm of transference reactions. This will be discussed in greater detail in Section 3.41.

Transference reactions are more apt to occur in later life toward people who perform a special function which originally was carried out by the parents. Thus, lovers, leaders, authorities, physicians, teachers, performers, and celebrities are particularly prone to activate transference responses. Furthermore, transference reactions can also occur to animals, to inanimate objects, and to institutions, but here, too, analysis will demonstrate that they are derived from the important people of early childhood (Reider, 1953a).

Any and all elements of an object relationship may be contained in a transference reaction; any emotion, drive, wish, attitude, fantasy, and the defenses against them. For example, a patient's inability to feel anger toward his analyst may stem from his childhood defense against expressing anger. As a boy he learned that the best way to prevent terrible quarrels with his explosive father was to remain unaware of anger in himself. In the analysis he was unaware of the anger that lay behind his persistent blandness.

Identification may arise during analysis, which may be transference reactions. One of my patients would take on one or another of my character traits from time to time during the analysis. This was apt to occur when he felt left behind by a more successful competitor. It was as though he had to become like me when he could not possess me as a love object. His history indicated that he employed this mechanism when he competed with his older brothers for the love of his father.

Transference reactions are essentially unconscious, although some aspect of the reaction may be conscious. The person experiencing a transference reaction may be aware that he is reacting excessively or strangely, but he is unknowing of its true meaning. He may even be intellectually aware of the source of the reaction, but he remains unconscious of some important emotional or instinctual component or purpose.

All people have transference reactions; the analytic situation only facilitates their development and utilizes them for interpretation and reconstruction (Freud, 1905c, 1912a). Neurotics are particularly prone to transference reactions, as are frustrated and unhappy people in general. The analyst is a prime target for transference reactions, but so are all the important people in the life of an individual.

To summarize: Transference is the experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which do not befit that person but are a repetition of reactions originating in regard to significant persons of early childhood, unconsciously displaced onto figures in the present. The two outstanding characteristics of a transference reaction are: it is a repetition and it is inappropriate. (For an amplification of this definition see Section 3.41.)

### 3.2 Clinical Picture: General Characteristics

In this section I would like to familiarize the student with some of the most typical manifestations of transference phenomena as they are apt to occur during the course of analysis. I believe this can best be done by focusing on those characteristics of the patient's reactions to the analyst which indicate the likelihood of a transference reaction. It should be borne in mind that the presence of the qualities I am highlighting is not absolute evidence of transference. The quality under scrutiny must also be a repetition and inappropriate.

#### 3.21 Inappropriateness

A basic question immediately arises as we attempt to illustrate the clinical picture of transference reactions. Could we not classify all reactions to the analyst as transference? According to our definition, the answer is no. Let us take a simple example: A patient becomes angry with his analyst. One cannot determine from this
fact alone whether one is dealing with a transference reaction. One first has to ascertain whether the analyst's behavior justifies the anger. If the patient became annoyed because the analyst interrupted the patient's associations by answering the telephone, then I would not consider the patient's annoyance a transference reaction. His response seems realistic, in accordance with the circumstances, and appropriate to a mature level of functioning. This does not imply that the patient's reaction is to be ignored, but we handle such occurrences differently than we do transference phenomena. We might explore the patient's history and fantasies in regard to anger reactions, but, despite our findings, we would remind the patient and ourselves that his overt reaction to the frustration was realistic. If the patient had become furious and not just annoyed, or if he had remained completely indifferent, then the inappropriate intensity of the reaction would indicate that we are probably dealing with a repetition or a reaction from childhood. The same would hold true if his annoyance lasted for hours or if he reacted to the interruption with laughter.

Let me cite a typical example of an inappropriate reaction. My telephone rings repeatedly during an analytic hour and I answer, thinking it is an emergency. To my dismay it turns out to be a wrong number and I indicate my annoyance by inadvertently mumbling "Goddamn it" under my breath. Then I am silent. The patient resumes talking where he left off. After a few minutes I interrupt him and ask him how he felt about the phone call. He replies: "How am I supposed to feel? It was not your fault." Silence. He tries to return to the earlier conversation, but it seems strained and artificial. I then point out how he seems to be trying to cover up certain of his emotional reactions by acting as he imagines he "is supposed to." This leads the patient to recall a momentary flash of anger as he heard me answer the phone. This was followed by a picture of me shouting at him angrily. The patient then recalls a host of memories of how he was forced to submit to his father's ideas about how he was "supposed" to behave. I interpreted to him how he had reacted to me as though I were his father.

The inappropriateness of a reaction to a current situation is the prime sign that the person who triggers the reaction is not the decisive or true object. It indicates that the reaction probably belongs to and fits an object in the past.

3.22 Intensity

By and large, intense emotional reactions to the analyst are indicative of transference. This is true for the various forms of love as well as hate and fear. The usual restrained, nonintrusive, consistent behavior and attitudes of the analyst do not realistically call for intense reactions. Here again appropriateness has to be kept in mind. It is important to acknowledge that a patient may be justified in reacting with great intensity if the analyst's behavior and the analytic situation warrant this. For example: An analyst falls asleep while listening to his patient. The patient becomes aware of this and finally manages to awaken the analyst by calling to him. The patient becomes furious when the analyst does not concede his error but instead interprets that the patient unconsciously wanted to put him to sleep by being boring.

In such a situation, I would not consider the patient's fury a transference reaction, but essentially justifiable and appropriate. In fact, any other reaction would have been a more likely sign of a transfer from the past. This does not mean that the patient's reaction is not to be analyzed, but the ultimate analytic aim is different if we are dealing with a transference reaction rather than with a realistic one. Furthermore, there is always the possibility in all intense reactions, no matter how justifiable they seem, that in addition to the realistic superstructure, there is also a transference core. In the ordinary course of analysis, however, intense reactions to the analyst are a reliable indication of a transference reaction.

The converse of intense reactions to the analyst, the absence of reactions, is just as surely a sign of transference. The patient may be having reactions but is withholding them because he is embarrassed or afraid. This is an obvious manifestation of transference resistance. The situation is more complicated when the patient is not consciously aware of any but the blandest and most innocuous of feelings. It may be that there are strong feelings within the patient, but they are repressed, isolated or displaced. Sometimes it requires persistent analysis of the fear of reacting emotionally to the analyst before a patient will dare to allow himself some spontaneous reactions. Such resistances to the transference were described in Chapter 2. At this point I want to mention briefly the frequent clinical experience that my patients will react quite rea-
sonably to my idiosyncrasies but tend to become distraught by any sign of peculiarity in another analyst. This is a clear-cut example of a displacement of a transference reaction and has to be recognized as a defense against transference feelings toward the patient’s own analyst. A similar resistance is manifested by patients who react blantly in the hour and who have unexplained intense emotional reactions toward strangers after the hour.

It may happen that a patient will not be particularly concerned with his analyst for a short period of time, because important events are going on in his life apart from the analysis. However, prolonged absence of feelings, thoughts, or fantasies about the analyst is a transference phenomenon, a transference resistance. The analyst is too important a person in the life of the analysand to be absent from his thoughts and feelings for any considerable period of time. If the analyst is really not important, then the patient is not “in analysis.” The patient may be going through the motions of analysis to please someone else or coming for some purpose other than for treatment.

It may also occur that some other person in the patient’s life may absorb the patient’s intense emotions and that the absence of intense feelings for the analyst may not be due primarily to a transference resistance. For example: a patient during the first part of his analysis is freed from his fear of emotional involvement and in the later course of his analysis falls in love. The love affair will in all likelihood contain important elements from the patient’s past, but the contribution from the analytic situation may or may not be of decisive significance. One would have to explore such a situation very carefully and repeatedly before coming to any reliable conclusions. Is the patient falling in love to please you? Is he falling in love to spite you because you do not give him sufficient love? Is he falling in love out of identification with you? Has the patient fallen in love with someone who resembles you? Is the falling in love a sign of maturity? Does there seem to be some realistic hope for a sustained happy relationship?

These questions are not easy to answer; there are no clear-cut answers and only prolonged exploration and time can offer a reasonably reliable answer. This is the basis for the practical rule suggested by Freud that the analyst should ask the patient to promise not to make any major changes in his life situation during the analysis (1914c, p. 153). This piece of advice can also be misconstrued by the patient because of the transference distortions and has to be given at the proper time and in the proper context (Fenichel, 1941, p. 29). The fact that the duration of analytic treatment has increased in recent years has prompted a further modification of this rule. Today I believe we would tell the patient that it would be better not to make important changes in his life situation until the change in question has been sufficiently analyzed. This problem will be pursued further in Volume II.

3.23 Ambivalence

All transference reactions are characterized by ambivalence, the coexistence of opposite feelings. It is customary in psychoanalysis to assume that by ambivalence we mean that one aspect of the feelings is unconscious. There is no love for the analyst without hate hidden somewhere, no sexual longings without some covert repulsion, etc. The ambivalence may be easily detectable when the feelings involved are capricious and change unexpectedly. Or one aspect of the ambivalence may be tenaciously maintained in consciousness for long periods, while its opposite is stubbornly defended. It can also happen that the ambivalence is handled by the patient displacing one component onto some other person, often another analyst. This is frequently seen in the analysis of candidates in training. They will maintain a positive relationship to their personal analyst and displace their unconscious hostility onto a supervisor or seminar leader—or vice versa.

It should not be forgotten that preambivalent reactions also may take place in the transference. The figure of the analyst is split into a good and a bad object, each of which leads a separate existence in the patient’s mind. When patients reacting in this way—and they are always the more regressed patients—become able to feel ambivalence to the same whole object it denotes quite an achievement.

Let me cite a clinical example. For several years a borderline patient of mine would give bizarre responses to my interventions whenever he felt anxious. I was slowly able to piece together the following explanations. When he felt angry and hateful toward me, he became afraid and therefore never listened to my words because he felt those were like poisoned darts, and his defense was to become impervious to them. At
of my patients, who are “poor rich neurotics.” She defends herself and her group by attacking me as one of those evil-minded psychoanalysts who lives off the rich but who despises them. She finds the odor of my cigar repulsive, even nauseating.

The following hour she finds my attempts to analyze her hostile feelings clumsy but endearing. I am probably well intentioned and warm-hearted, only moody. I must have changed my brand of cigar and bought a more expensive one because of her criticism, and she was grateful for my consideration. She hopes I will some day become her guide and mentor because she has heard I am brilliant. When I keep silent she feels I am being “stuffy,” conventional, and a killjoy. I probably am a grind and a hack who only loves his work. She leaves the hour feeling that I may be a good analyst, but she pities anyone married to me.

This is a rather extreme example of capriciousness, but it highlights the erratic and whimsical character of transference reactions early in the analysis of some hysterical and neurotically depressed patients.

3.25 Tenacity

It is a striking characteristic of transference reactions that they possess a contradictory nature. I have just described how capricious and transitory transference can be, and now I must add that transference phenomena are often distinguished by their tenacity. Whereas sporadic reactions are most apt to occur early in analysis, prolonged and rigid reactions are more likely to appear in the later phases, although there is no absolute rule about this.

Patients will take on a chronic set of feelings and attitudes toward the analyst which will not readily yield to interpretation. These tenacious reactions require a long period of analysis, sometimes years. This long duration does not mean that the analytic work is stalemated, because during such periods other behavioral characteristics of the patient may change and new insights and memories may appear. The patient is compelled to hold on to this fixed position because the feelings involved are overdetermined and serve important instinctual and defensive needs. These tenacious reactions may be relatively intense or subtle.

A patient of mine, Mrs. K., maintained a positive sexual and erotic transference reaction to me for almost three years. These feelings sur-
vived and were not measurably influenced by my persistent interpretations of their resistive function, my prolonged silences, my occasional errors and lapses. Only after she had improved sufficiently to be able to achieve a partial vaginal orgasm which helped abate her fear of homosexuality, did this chronic positive transference change. Only then did she dare to let herself consciously feel her hatred and revulsion toward me and toward men in general.

Tenacity and lack of spontaneity are signs of transference reactions. Even in the best conducted analyses, the human frailties of the analyst would give rise to occasional hostility if a defensive positive transference were not at work. Analytic work is often painful, and that too would occasion some resentment. Above all, transference reactions stem from the patient’s warded-off past and that must include a great deal of unconscious aggression which is seeking discharge. Conversely, the compassionate neutrality of the analytic attitude does not call for the prolonged hostility of some patients. The tenacity and rigidity of transference reactions are due to a combination of unconscious defense and instinctual satisfaction.

The five qualities noted above are the most typical characteristics denoting a transference reaction. The outstanding trait, which overrides all others and is included in all the others, is inappropriateness. It is inappropriateness in terms of intensity, ambivalence, capriciousness, or tenacity which signals that transference is at work. This holds true not only when such responses occur in regard to the analyst, but also when they arise in regard to other people. Reactions which are out of character or out of place are transference phenomena.

### 3.3 Historical Survey

I would like briefly to sketch the major contributions Freud and others have made to our understanding of the theoretical and technical problems concerning transference. I shall take them up in chronological order covering the years 1895 to 1960. I shall stress only those points which I consider to be significant advances and shall omit many valuable papers which are essentially summaries or repetitions. The student is advised to read the original papers.

My version of the meaningful contents is not only extremely condensed but also a subjective selection. This subject has already been touched upon in Section 1.1.

Freud’s first description and discussion of the role of transference is to be found in Chapter IV on psychotherapy in the *Studies on Hysteria* (1893-95). At first he considered it a disadvantage that the patient unduly forced his personal relations to the physician into the foreground, although he recognized that the personal influence alone can remove certain resistances (p. 301). Some patients tended to feel neglected, others feared becoming dependent, even sexually dependent. Later he described some patients who tended to transfer onto the figure of the physician distressing ideas which arose from the content of their analysis. These patients, said Freud, had made a “false connection” onto the analyst (pp. 302-303). In some cases this seemed to be a regular occurrence. He then went on to describe the technique of handling this situation. (1) It should be made conscious. (2) One should demonstrate how it is an obstacle. (3) One should attempt to trace its origin in the hour. At first Freud was “greatly annoyed” at this increase in work, but he soon realized its value (p. 304).

The Dora case is a landmark in psychoanalytic technique (Freud, 1905a). Here, in all humility and with great clarity, Freud described how he learned about the decisive importance of transference by his failure to recognize and handle it in one of his patients. This led to a premature interruption of treatment and a therapeutic failure. In this paper, Freud described how his patient perceived feelings in regard to his person during the analysis that were new editions, facsimiles, reprints, and revised editions of feelings which originally belonged to persons of significance in the past (p. 116). Such feelings seem to be a new creation, but actually are a revival of old emotional reactions. Freud called this phenomenon transference, and declared it to be a necessary part of psychoanalytic therapy. It produces the greatest obstacles, but it is also a most important ally in the treatment. He realized too late that the patient’s transference feelings to him had changed and that she was acting out with him a fragment of her past. She broke off with Freud as she had not dared to do with her lover (pp. 118-119). Freud then recognized that the analysis of the hostile transference is necessary for a successful therapeutic result (p. 120).
transference and resistances are compromise formations (pp. 102-103). Every conflict of the patient has to be fought out in the transference situation (p. 104). It is of crucial importance in the analysis, since it makes it possible for the patient to struggle in the present with his unresolved conflicts concerning important object relations in his past. One cannot slay the enemy in absentia or in effigy (p. 108). It is necessary to work these problems out in the ongoing transference situation occurring during analysis.

In this paper Freud discussed some of the relationships between transference and resistance, particularly the differences between the positive (i.e., sexual and erotic) transference and the negative transference, and how they influence resistance formations (pp. 105-106). He distinguished between the sexual, erotic transference and the negative transference, on the one hand, and, on the other, “rapport,” which is the nonsexual, positive transference reaction. In Freud’s opinion all transference reactions are essentially ambivalent (p. 106). It is interesting to note, said Freud, that patients not only have transference reactions to the analyst and to physicians but also to institutions (p. 106).

The paper “Recommendations to Physicians Practising Psycho-Analytic” (1912b) is noteworthy because in it Freud for the first time described countertransference, and the analyst’s need for “psychoanalytic purification.” Here Freud states for the first time the famous “mirror” simile. In order to resolve the transference it is necessary for the analyst to maintain his anonymity. “The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him” (p. 118).

The essay “On Beginning the Treatment” (1913b) contains the recommendation by Freud that the theme of transference should be left untouched as long as there is no appreciable sign of resistance. He also suggested that one make no interpretations to the patient until a rapport has been developed between analyst and patient. Rapport will come about if we show a serious interest in the patient, work on his resistances, and indicate an attitude of sympathetic understanding (pp. 139-140). (I would be tempted to say this is the first description of the working alliance.)

In the paper “Remembering, Repeating and Working-Through” (1914c), Freud discussed in some detail the patient’s tendency to act out in the transference situation. He also introduced a new
hypothesis in explaining transference reactions, namely, the concept of a repetition compulsion, but that is not yet tied up with the death instinct. Furthermore, in this paper there is the first mention of the concept of the transference neurosis (p. 154). The transference neurosis is an artifact of the treatment and replaces the patient’s ordinary neurosis. It is curable by the analytic work.

“Observations on Transference-Love” (1915a) is noteworthy for two main reasons. In it for the first time Freud mentioned the “rule of abstinence.” It is a fundamental principle, said Freud, that the patient’s needs and longings be allowed to persist in order that they may impel him to do the analytic work (p. 165). It is also an outstanding paper because of Freud’s sensitive, personal, and literary presentation of the problem of properly dealing with a patient’s romantic love for the analyst.

The chapters on “Transference” and “Analytic Therapy” in the Introductory Lectures (1916-17) are essentially a rather systematic and thorough review of Freud’s basic ideas about transference up to that time. Furthermore, there is a discussion of the term transference neuroses as a category of neurosis to be contrasted to the narcissistic neuroses as well as a brief discussion of the transference problems in the psychoses (pp. 445, 423-430).

A major change in Freud’s theoretical ideas about the nature of transference phenomena was put forth in Beyond the Pleasure Principle (1920). Certain childhood reactions are repeated in the transference not because there is the hope of pleasure but because there is a compulsion to repeat which is even more primitive than the pleasure principle and overrides it (pp. 20-23). The repetition compulsion is a manifestation of the death instinct (p. 36). For the first time, transference reactions were regarded as manifestations of both the libidinal and death instincts.

After these papers there were no major new developments until Glover’s series of technical papers published in 1928. They were the first systematic clinical description of some of the typical problems in the development and resolution of the transference neurosis and transference resistances. Glover distinguished different phases of transference development, and the typical problems in handling the various transference reactions.

Ella Freeman Sharpe’s (1930) technical papers illuminated the importance of analyzing the fantasies of the patient in regard to the analyst. In her literate and sensitive presentation she emphasized how the representations of the superego, ego, and id are played out in fantasies regarding the analyst. Transference reactions are not only displacements but may be projections. In keeping with the Kleinian point of view, Ella Sharpe was of the opinion that analyzing the transference is not a separate task but is the task from the beginning to the end of the analysis, that the transference situation has to be constantly sought out. Of particular clinical value is her description of some of the complicated problems in the subtle transference resistances to be found in the compliant, submissive patient.

Freud’s “Analysis Terminable and Interminable” (1937a) is notable because in it Freud continued the discussion of controversial hypotheses about transference and transference resistances. He emphasized the problem of protracted negative transference and acting out, which he attributed to the compulsion to repeat, a manifestation of the death instinct. He drew attention to physiological and biological factors (pp. 224-226). Freud also discussed the poor prognosis and limitations of psychoanalytic therapy and the special problems inherent in patients with a so-called negative therapeutic reaction (pp. 241-243). In this paper he touched upon the question of whether or not it is right for the analyst to stir up latent problems in the patient. Freud was adamant that the analyst should not manipulate the transference; his task is to analyze and not to manipulate (pp. 232-234).

Richard Sterba’s two papers on transference (1929, 1934) make an important contribution to our understanding of the therapeutic process. He described the split in the patient’s ego which occurs when he is able to identify partially with the analyst’s observing function. In this way the patient is able to become an active participant in the analysis. He not only produces the material, but on the basis of the identification he can work with it analytically. This idea is a central element in what later became known as the “therapeutic” or “working alliance.”

Fenichel’s (1941) slim volume on technique is essentially a highly condensed, systematic, and thorough review of the theoretical basis of psychoanalytic technique. It also offers an outline of the technical steps to be considered in approaching the typical problems of technique.
The most outstanding contribution in Macalpine’s paper “The Development of the Transference” (1950) is her careful dissection of how the analytic situation itself converts the patient’s transference readiness into transference reactions. She isolated some fifteen different factors which play a role in inducing the necessary regression in the patient undergoing psychoanalysis.

Phyllis Greenacre’s “The Role of Transference” (1954) added some important insights into the origins of transference, the “matrix” of transference reactions. She also carefully explained the importance of safeguarding the transference, the avoidance of “contamination.” Her notion of the “tilted” relationship in the analytic situation, the unevenness between patient and analyst, is another helpful idea (p. 674). Greenacre realizes that the transference relationship is an inordinately complex one and suggests we ought to pay more attention to the splitting of the transference relationship (Greenacre, 1959).

The Discussion of Problems of Transference (held at the 19th International Psycho-Analytical Congress in 1955) is an excellent summary of the current psychoanalytic point of view (see Waelber, et al., 1956). Elizabeth Zetzel’s (1956) analysis of the importance of the “therapeutic alliance” is an outstanding contribution. In that paper, she stresses how differently it is regarded by the classical analysts and the followers of Melanie Klein. This distinction is, in my opinion, the basis for some important differences in theory and technique. Spitz’s (1956b) paper deepens our understanding of how the analytic setting revives some of the earliest aspects of the mother-child relationship. Winnicott’s (1956a) essay stresses the modifications in technique required by patients who did not experience adequate mothering in the early months of life. It is his opinion that only when a patient has been able to develop a transference neurosis can we depend essentially on interpretive work.

In a very sensitive and penetrating study on the “Therapeutic Action of Psycho-Analysis,” Loewald (1960) focuses on certain nonverbal elements in the transference relationship. He describes a type of mutuality that resembles the mother’s nonverbal and growth-promoting interactions with the child. This hinges partly on the mother’s selective, mediating, and organizing functions which aid the child in forming an ego structure. The mother’s picture of the child’s potentials becomes part of the child’s image of himself. A similar process occurs unnoticed in psychoanalytic therapy.

Leo Stone’s (1961) book on The Psychoanalytic Situation is, in my opinion, an important step forward in clarifying some of the problems of transference phenomena. The concept of necessary gratifications, the therapeutic intent of the analyst, and his emphasis on different, coexisting, relationships between analyst and patient, represent a significant advance in our theory and technique. I believe it was Zetzel’s paper on the therapeutic alliance and Stone’s book on the psychoanalytic situation which led me to formulate the working alliance (Greenon, 1965a). The separation of the relatively nonneurotic relationship to the analyst from the more neurotic transference reactions has important theoretical and technical implications. A patient must be able to develop both types of relationships in order to be analyzable.

One cannot conclude a historical survey of such a basic topic without including a brief description of some controversial developments. I have selected what seem to me to be the two most important current deviations among psychoanalysts, the schools of Melanie Klein and Franz Alexander.

The followers of the Kleinian school consider the interpretation of the unconscious meaning of transference phenomena to be the crux of the therapeutic process. However, they believe that the patient’s relationship to his analyst is almost entirely one of unconscious fantasy (Isaacs, 1948, p. 79). Transference phenomena are regarded essentially as projections and introjections of the most infantile good and bad objects. Although these early introjects arise in a preverbal phase, the Kleinians expect their patients to comprehend the meaning of these primitive goings-on from the beginning of the analysis (Klein, 1961; Segal, 1964). They do not analyze resistance as such, but instead make interpretations about the complex, hostile and idealized projections and introjections of the patient in regard to the analyst. It seems as though they expect to influence the internal good and bad objects in the patient’s ego by interpreting what they sense is going on. They do not communicate with a cohesive, integrated ego; they do not attempt to establish a working alliance, but seem instead to establish direct contact with the various introjects (Heimann, 1956).

Kleinians hold the view that only transference interpretations are
effective. No other interpretations are considered important. Their approach is equally valid, they claim, for working with children, psychotics, and neurotics (Rosenfeld, 1952, 1958). One cannot do justice to these views with so short a description; it is necessary to be familiar with the entire school of thought. The student should read the three most recent books published by Melanie Klein and her followers (1952, 1955; Segal, 1964). For a lucid and temperate discussion of this subject, the student is referred to the chapter on Melanie Klein's work by Brierley (1951).

Although one may find much to disagree with in the Kleinian approach, nevertheless the Kleinians use the psychoanalytic approach insofar as they interpret the transference. Alexander and his followers (1946) challenge this basic attitude of analyzing and interpreting the transference. On the contrary, they advocate that the transference should be regulated, controlled, and manipulated. It should not be allowed to flower in accordance with the patient's neurotic needs. One should not permit the patient to get into deep regressions since these regressions will lead to dependent transference reactions which are essentially resistances and not productive. It is best to avoid the patient's distrust and antipathy; a hostile and aggressive transference is a needless complication. Analysts may avoid all mention of the infantile conflicts and avoid thereby the dependent transference reactions. A transference neurosis of moderate intensity is permissible, but intense transference neuroses are to be avoided. One ought to focus much more on the present and less on the past.

This is but a small sample of the views expressed by Alexander and French in their book Psychoanalytic Therapy. This volume created quite a stir in psychoanalytic circles in America (it seems to have been ignored in Europe), since many of the contributors were psychoanalysts of prominence and the views expressed contradicted many accepted basic principles of psychoanalytic theory and technique. The reverberations of this attempt to alter psychoanalysis led, in my opinion, to the setting up of fixed training standards in the American Psychoanalytic Association. It was believed that candidates trained according to the methods advocated by Alexander and his followers would not have undergone a deep psychoanalytic experience.

As I stated in the beginning of this chapter, every aberration in psychoanalysis can be demonstrated in the deviant way that transference phenomena are regarded.

3.4 Theoretical Considerations

3.4.1 The Origin and Nature of Transference Reactions

Before we explore some of the theoretical issues concerning transference phenomena, it is imperative to be more precise about the meaning of the term. There are many different theories about what constitutes a transference reaction and I have the impression that some of the divergencies stem from a failure to define one's terms in sufficient detail. Let me repeat at this point the definition of transference I employed in Section 3.1. Transference is the experiencing of feeling, drives, attitudes, fantasies, and defenses toward a person in the present which do not beset that person but are a repetition of reactions originating in regard to significant persons of early childhood, unconsciously displaced onto figures in the present.

This definition rests on four basic propositions: (1) Transference is a variety of object relationship. (2) Transference phenomena repeat a past relationship to an object. (3) The mechanism of displacement is the essential process in transference reactions. (4) Transference is a regressive phenomenon. For a psychic phenomenon to be considered transference, all four of these elements must be present. Each of the four components has important theoretical and clinical connotations.

Psychoanalytic treatment does not create transference reactions; it merely brings them to light by facilitating their development. Transference phenomena in neurotics are a specialized class of relationship to another person. They represent a kind of intermediary realm between illness and real life (Freud, 1914c). Other modes of relating to the analyst occur during psychoanalytic treatment. A working alliance and a real relationship also take place and play an important role in the psychoanalytic therapy of neurotic patients. They differ from transference phenomena and will be considered separately.

More primitive ways of relating to the analyst may occur as well. Reactions of a delusional or psychotic character take place but
t is not certain whether they may be rightfully called transference reactions (Freud, 1915b). In order to avoid any ambiguity, if the term transference or transference reaction is employed without further specification in these writings, it shall refer to neurotic transference phenomena. In a variety of severely regressed patients, we may see transient psychotic reactions to the therapist. These manifestations are quite different from neurotic transference reactions. The main distinctions stem from the fact that the psychotic has lost his object representations and as a consequence can no longer differentiate between the self and object world (Freud, 1915b; M. Wexler, 1960; Jacobson, 1964). It should not be forgotten, however, that psychotic patients may have neurotic and healthy components and the converse is equally true (M. Katan, 1954). One does see patients who manifest both neurotic and psychotic transference reactions.

The multiform ways of relating to the analyst during psychoanalysis have to be distinguished from one another because they imply important clinical, theoretical, and technical differences. Simply lumping them all together as transference phenomena does not do justice to the complexities of human relationships and to the intricacies of the therapeutic processes involved in psychoanalytic treatment.

4.11 Transference and Object Relations

A transference reaction in neurotics is a relationship involving three whole people—a subject, a past object, and a present object (Searles, 1965). In the analytic situation it usually comprises the patient, some significant person from the past, and the analyst. A patient who becomes afraid of his analyst in the same way he once feared his father is misunderstanding the present in terms of his past as long as he is in the grip of the transference reaction (Fenichel, 1945a). However, the neurotic patient knows the analyst is not his father, and he also knows that he, the patient, not the analyst and also not his father. In other words, the neurotic may react temporarily and partially as if the analyst were identical to his father, but intellectually he can clearly distinguish the analyst from his father and himself. In clinical terms, the neurotic patient is able to split off his experiencing ego from his observing ego. He may do this spontaneously or he may need the help of the analyst’s interpretations.

Neurotic transference phenomena are based on two achievements: (1) the individual’s capacity to differentiate between the self and the object world; (2) the ability to displace reactions from a past object representation to an object in the present (Jacobson, 1964; Hartmann, 1950). This means that the neurotic has an organized, differentiated self, an entity separate and distinct from his environment, which has the capacity to remain the same in the midst of change (Jacobson, 1964; Lichtenstein, 1961; Mahler, 1957 [see Rubinfine, 1958]; and Gresnac, 1958).

Very young children have not yet achieved their separation, their individuation, from the mother. Older children have a hunger for new objects. In the treatment situation they do not merely repeat the past, they try new ways of relating (A. Freud, 1965). Psychotics have lost their internal object representations and strive to fill up the feeling of a terrible void by creating new objects (Freud, 1915b). They are prone to fuse and confuse remnants of their self and object representations. Furthermore, their world is full of part objects which they introject and project in their attempts to build or rebuild their lost object relationships (M. Wexler, 1960; Searles, 1963).

One of my schizophrenic patients was convinced for years that she was made of soap and blamed me for this. These ideas were based in part on her literal and concrete acceptance of the axioms, “Silence is golden” and “Cleanliness is next to Godliness.” She felt my attempts to get her to talk resulted in the loss of her “pure” silent state. I had used “dirty words” and this had turned her into soap. (Note the confusion of self and analyst.) The basic problem, however, was her sense of emptiness, her awareness of having lost her world of objects. The feeling of being made of soap was an acknowledgment of this as well as an attempt at restitution.

This kind of relatedness to the analyst is very different from neurotic transference reactions. The reader is referred to the works of Freud (1915b, 1911a), Searles (1963), Little (1958), and Rosenfeld (1952, 1954) for further clinical and theoretical material on transference phenomena in psychotics.

The foregoing deliberations merely hint at some of the problems that lie behind the differences in the therapeutic approach to the
child, the adult neurotic, and the psychotic (A. Freud, 1965). Freud’s (1916-17) separation of the transference neuroses from the narcissistic neuroses seems to be based on similar grounds. People who are essentially narcissistic will not be able to maintain a consistently analyzable transference relationship. Their relationship to the therapist will abound with fusions of self and object images, primitive forerunners of identification (Jacobson, 1964). There are transitions between narcissistic relations and object relations, as Winnicott (1953) has demonstrated with the concept of transitional objects. The serious student is advised to read Jacobson (1964), Fenichel (1945a), Spitz (1957, 1965), and Mahler (1965) for a more thorough view of the beginnings of self and object representations. I agree with Greenacre’s (1954) formulation that the matrix of the transference relationship is the early mother-infant union. Man is not able to endure aloneness very well for any considerable period of time. The analytic situation mobilizes two antithetical sets of reactions. The sensory isolation of the patient on the couch stirs up the feeling of aloneness, frustration, and a hunger for object relations. On the other hand, the high frequency of visits, the long duration of the treatment, and the devotion to the patient’s needs stir up memories of the early closeness between mother and child.

3.412 Transference and Ego Functions

Transference reactions demonstrate the neurotic patient’s strengths and weaknesses in terms of his ego functions. As previously stated, neurotic transference phenomena indicate that the patient has a stable self representation which is sharply differentiated from his object representations. This implies his early ego development has been essentially successful, he has had “good-enough” mothering, and he can relate to whole people (Winnicott, 1955, 1956b). When he “misunderstands the present in terms of his past,” the misunderstanding is only partial and temporary. The regression in ego functions is a circumscribed one and limited to certain aspects of his relationship to the transference figure. Furthermore, it is reversible.

For example, a patient of mine is in the throes of an intense, hostile transference reaction. He spends most of several hours complaining vociferously that I am incompetent, unscrupulous, and callous. Yet, he comes punctually to his appointments, listens attentively to my interventions, and functions adequately in his outside life. Even though he thinks of quitting the analysis, he does not seriously contemplate such a move.

A patient in such a state of mind is allowing himself to be carried away by his feelings and fantasies. He is letting himself regress in terms of his object relations and ego functions. He renounces certain of his reality-testing functions partially and temporarily. (This is to be differentiated from role playing or pretending.) In the case cited above, the transference reaction was mobilized when I did not answer one of his questions. This action of mine overrode momentarily all my qualities which were in contradiction to his charge that I was incompetent, unscrupulous, and callous. The patient’s ego function of discrimination was impaired during this phase of treatment. I became his harsh and punitive father when I remained silent. The patient was able to work with this reaction, began to understand it, when his observing ego and the working alliance were re-established.

Other mechanisms indicative of a regression in ego functions occur in transference reactions, but they are a supplement to the mechanism of displacement. Projection and introjection may take place, but they are not the basic process in neurotic transference. They may operate in addition to the displacement. I want to stress this point because it is in conflict with the views of the Kleinian school whose followers interpret all transference phenomena on the basis of projection and introjection (Klein, 1952; Racker, 1954; Segal, 1964). They neglect the displacement from a past object relationship and therefore relatively ignore the historical experiences of the patient. I believe this is due in part to their failure to differentiate projection and introjection from displacement as well as to an inexact usage of the terms projection and introjection.

At the risk of seeming pedantic I shall define these terms briefly, as they are used in the classical psychoanalytic literature. Displacement refers to the shift of feelings, fantasies, etc., from an object or object representation in the past to an object or object representation in the present. When a person projects, he is ejecting something from within his self representation into or onto another person. Introjection is the incorporation of something from an external object into the self representation. Projection and introjection
may occur during analysis, but they occur in addition to the disposal. They are *repetitions* of projective and introjective mechanisms which once took place in regard to past objects of historical importance (Jacobson, 1964).

Let me give an example of projection as a neurotic transference reaction. Professor X, who suffered from stage fright complained frequently during his analysis that he felt I was mocking him, laughing at him behind his back, or deriding him whenever I made an interpretation. There were many determinants for this reaction in the patient's history. His father had been known to be a tease who delighted in sadistically embarrassing the patient, especially before company. The patient had developed a very strict superego and flagellated himself severely for a variety of activities he considered shameful. In the course of the analysis his sense of shame was changed to a feeling that I would shame him if I knew what he had done. The patient had projected parts of his superego onto me. His fantasy of being humiliated by me not only was painful but also contained masochistic and exhibitionistic pleasure. This was a carry-over from his childhood relationship to his father which was replete with sexual and aggressive fantasies. However, one important aspect of his humiliation fantasies was based on projection.

In one hour he shamelessly reported that he got drunk over the weekend and had entertained a gathering of his friends by doing an imitation of "Gruesome Greenon, the great psychoanalyst." He was amazed at how long a period of time he was able to keep his audience laughing at his analyst. In the analytic hour he realized he did this occasionally at home by imitating certain expressions or gestures of mine whenever there were people present who knew me. The patient became quite apprehensive when he spoke of this; he felt certain "the roof would fall in." This phrase led him to recall a hitherto forgotten memory of being caught by his father doing a burlesque of his father's manner of speech. His father beat him unmercifully and then tormented him for crying. This episode ended the patient's attempt to imitate his father and led eventually to the stage fright.

It seemed clear to me that, in part, the patient had projected his impulses to be a humiliated one me. This was a defense against his hostility, a means of avoiding anxiety, as well as other things. But this projection was a supplement to the basic determinant of his feeling of humiliation—the history of a father who humiliated him and whom he longed to humiliate in retaliation.

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2 See also Sections 2.64 and 2.652.

The acting out or enactment of transference reactions is indicative of other regressive features in the ego functions in transference. The relationship of transference to memory will be discussed in some detail in the following sections on repetition and regression.

### 3.413 Transference and Repetition

One of the outstanding characteristics of transference reactions is their repetitiveness, their resistance to change, their tenacity. There are many factors which play a role in this phenomenon and there are diverse theoretical explanations. Here only some of the major issues will be briefly touched upon.

Transference is a reliving of the repressed past—to be more exact, of the warded-off past. The repetitiveness and rigidity of transference reactions, as contrasted to more realistic object relations, stem from the fact that the id impulses which seek discharge in the transference behavior are opposed by one or another unconscious ego counterforce. Transference satisfactions are never wholly satisfying because they are only substitutes for real satisfaction, regressive derivatives, and compromise formations (Fenichel, 1941). They are the product of a constant countertransference. Only if the countertransference, the defense, is resolved can adequate discharge take place.

Instinctual frustration and the search for gratification are the basic motives for transference phenomena. Satisfied people and people in a state of apathy have far fewer transference reactions. Satisfied people can modulate their behavior in accordance with the opportunities and demands of the external world. Apathetic people have withdrawn into a more narcissistic orientation. The neurotic who suffers from a variety of unresolved neurotic conflicts is in a constant state of instinctual dissatisfaction and, as a result, is in a state of transference readiness (Freud, 1912a). A person in such a condition will meet every new person with conscious and unconscious libidinal and aggressive anticipatory ideas. These are already present before the patient meets the analyst, and the neurotic's history is replete with transference behavior long before he comes for treatment (Frosh, 1959).

The warded-off impulses which are blocked from direct discharge seek regressive and distorted channels in their attempts to gain access to consciousness and motility. Transference behavior is an example of the return of the repressed. The person of the ana-
lyst becomes a prime target for the dammed-up impulses because the patient uses him as an opportunity to express the short-circuited impulses instead of facing the original objects (Fenichel, 1941). The transference is a resistance in this sense, but it is a necessary detour on the road to insight and memory. The analyst’s nonintrusive, nongratifying behavior makes the patient’s transference reactions demonstrable. Freud’s (1915a) so-called rules of the “mirror” and of abstinence are founded on this basis. If the psychoanalyst will not gratify the patient’s neurotic instinctual wishes, these impulses will become demonstrable as transference distortions and will become the vehicle for valuable insights. These issues will be discussed more thoroughly in Sections 3.92, 4.213, 4.223.

The repetition of a psychic event may also be a means of achieving belated mastery over it (Freud, 1920; Fenichel, 1945a). The active repetition of a traumatic experience is a case in point. The infantile ego learns to overcome the feeling of helplessness by actively repeating the situation that once induced the original sense of panic. Games, dreams, and thoughts concerning the painful event make it possible to discharge some of the excessive excitement which had flooded the ego. The ego which was passive in the original traumatic situation actively reproduces the event at a time it chooses, in circumstances favorable to it, and thus slowly learns to cope with it.

Repetition of a situation may lead from coping and mastery to pleasure. In part this may be due to the sense of triumph over a once-feared event. This is usually transitory unless there still is a counterphobic element at work (Fenichel, 1939). This means that the event is repeated because it is feared, the repetition is an attempt to deny that the anxiety still persists. For example, excessive sexual activity may mean that the person in question is trying to deny his anxiety. His actions indicate that he is attempting to persuade himself he is no longer afraid. His counterphobic sexuality is also an attempt to get witnesses who will confirm this. The excessive repetitiveness indicates that a neurotic conflict is involved. The unconscious ego prevents full instinctual discharge and the activity has to be performed again and again.

Transference reactions may well be approached from the points of view sketched above. A frightening relationship to a person in the past is repeated as an attempt to achieve belated mastery over the anxiety which was contained in the original experience. For example, a woman seeks out harsh, cruel men as love objects. In the transference she reacts repeatedly as though the analyst were cruel and punitive. In addition to its other meanings, this type of reaction can be profitably understood as a belated attempt to master the original anxiety. As a child she was helpless before her harsh father. As a patient she unconsciously selects the aggressive components of her psychoanalyst to react to, as a means of achieving control over her anxiety. She enacts the painful situation instead of remembering the original experience. The repetition in action is a prelude, a preparation for memory (Freud, 1914c; Ekstein and Friedman, 1957).

Lagache (1953) added a valuable point to our understanding of the repeated acting out of transference phenomena. He demonstrated that the acting out may be an attempt to complete unfulfilled tasks. This is related to Anna Freud’s (1965) ideas concerning the transference problems in children due to their hunger for new experiences. Some of these points will be elaborated upon in Section 3.84 on the acting out of transference reactions.

This discussion of the meaning of the repetition of transference phenomena leads us to Freud’s (1920, 1925b, 1937a) concept of the repetition compulsion. Freud speculated that the compulsion to repeat is ultimately derived from a primal death instinct. He believed there is a self-destructive drive in living creatures which impels them to return to the Nirvana of the original inanimate state. This theoretical issue has been hotly debated in psychoanalytic circles and is beyond the scope of this volume. The reader is urged to read Kubie (1939, 1941), E. Bibring (1943), Fenichel (1945a), the recent excellent panel on the subject reported by Gifford (1964), and Schur (1966). I can only state at this point that, in my experience, I have never found it necessary to understand or interpret the compulsion to repeat as a manifestation of a death instinct. Clinically it has always seemed possible to explain repetitiousness within the bounds of the pleasure-pain principle (Schur, 1960, 1966).

Another theoretical problem which is raised by the repetitiveness of transference reactions is the question of an instinct to master (Hendrick, 1942; Stern, 1957). There can be no doubt that the human being is impelled in this direction. However, it would seem that the urge to master is a general tendency, a general principle, and not
limited to a specific instinct (Fenichel, 1945a). The concepts of adaptation and fixation are also relevant issues but would lead us too far afield. The writings of Hartmann (1939, 1951), Waelder (1936, 1956), and E. Bibring (1937, 1943) are particularly illuminating.

3.4.14 Transference and Regression

The analytic situation offers the neurotic patient the opportunity to repeat, by means of regression, all his past stages of object relations. Transference phenomena are so valuable because they highlight, in addition to the object relations, the developmental phases of the different psychic structures. One can observe in the transference behavior and fantasies early forms of ego, id, and superego functioning. There are two general points which must be kept in mind concerning the regression in transference. In the neurotic patient in the treatment situation, we see temporary regressions as well as progressions. The analyzeable patient can regress and rebound from it. The regressive phenomena are usually circumscribed and not generalized. For example, we may see a regression in the id manifested by anal-sadistic impulses toward figures of authority. At the same time instinctual impulses for a love object may be operating on a higher level and certain ego functions may be quite advanced. This leads to the second generalization. Regressive phenomena are uneven and therefore each clinical fragment of transference behavior has to be studied with great care. Anna Freud’s (1965) discussion of regression illuminates and clarifies many of the problems (see also Menninger, 1958; and Altman’s panel report [1964]).

In terms of object relations, the transference situation gives the patient an opportunity to re-experience all varieties and mixtures of love and hate, oedipal and preoedipal. Ambivalent and pre-ambivalent feelings to objects come to the surface. We can see transitions between abject helplessness with the craving for symbiotic closeness and stubborn defiance. Dependency may alternate with spite and rebellion. What looks like self-sufficiency may turn out to be a resistance against revealing an underlying dependency. The wish to be loved may lead to superficial therapeutic benefits but can cover a deep-seated fear of object loss. In general, the regressive nature of transference relations is manifested by the inappropriateness, the ambivalence, and the relative preponderance of aggressive strivings.

The regression in ego functions which takes place in transference reactions can be demonstrated in various ways. The very definition of transference indicates this. The displacement from the past indicates that an object in the present is being confused, in part, with an object from the past. The ego’s reality-testing, discriminating function is temporarily lost. Primitive mental mechanisms like projection, introjection, splitting, and denials will occur. The loss of a sense of time in regard to object relations also resembles the regressive features we observe in dreaming (Lewin, 1955). The tendency to act out transference reactions indicates a loss in the impulse-control balance. The increased tendency to somatization reactions as a transference manifestation also speaks for a regression in ego functions (Schur, 1955). The externalization of parts of the self, i.e., ego, id, and superego, is another sign of regression.

The id also participates in the regression in many ways. The libidinal aims and zones of the past will become involved with the person of the psychoanalyst and will color the transference picture. The more regressive the transference becomes, the greater will be the preponderance of the hostile, aggressive strivings. Melanie Klein (1952) was among the first to stress this clinical point. Edith Jacobson (1964, p. 16) explains this on the basis of an energetic regression and speculates about an intermediary phase with an undifferentiated, primordial drive energy.

The regressive features of transference also influence the superego. The most common finding is the increased strictness in the patient’s superego reactions which are displaced onto the psychoanalyst. In the beginning there is usually a prevalence of shame reactions. We also see regressions to a time when superego functions were carried out externally. The patient no longer feels guilt, instead he is only afraid to be found out. The more the patient regresses the more likely will the analyst be felt to possess hostile, sadistic, critical attitudes toward the patient. This is due to displacements from past objects supplemented by the projection of the patient’s own hostility onto the psychoanalyst.

Before leaving this brief discussion of regression it should be pointed out once again that the analytic setting and procedures play an important role in maximizing the emergence of the regres-
sive features of transference phenomena. This will be discussed in some detail in Chapter 4.

3.415 Transference and Resistance

Transference and resistance are related to each other in many ways. The phrase "transference resistance" is commonly used in the psychoanalytic literature as a shorthand expression for the close and complex relationship between transference phenomena and resistance functions. However, transference resistance can mean different things, and I believe it would be wise to clarify this term before going on to the clinical material.

I have already discussed Freud's (1905c, 1912a, 1914c) basic formulation that transference phenomena are the source of the greatest resistances as well as the most powerful instrument for psychoanalytic therapy. Transference reactions are a repetition of the past, a reliving without memory. In this sense, all transference phenomena have a resistance value. On the other hand, the reactions to the analyst provide the most important bridges to the patient's inaccessible past. Transference is a detour on the road to memory and to insight, but it is a pathway where hardly any other exists. Not only does the transference offer clues to what is warded off, it also may supply the motive and incentive for work in the analysis. This is an unreliable ally because it is capricious and also produces superficial "transference improvements" which are deceptive (Fenichel, 1945a; Nunberg, 1951).

Certain varieties of transference reactions cause resistances because they contain painful and frightening libidinal and aggressive impulses. Sexual and hostile transference responses are particularly prone to be the source of important resistances. Very often the erotic and aggressive components appear together. For example, a patient develops sexual feelings for her analyst and then becomes furious at his lack of reciprocity, which she perceives as a rejection. Or the patient is unable to work in the analytic situation because of the fear of humiliation in exposing infantile or primitive fantasies.

It may occur that the transference reaction itself makes the patient unable to work. For example, a patient may regress to an extremely passive, dependent stage of object relationship. The patient may not be aware of this but will act it out in the analytic hours. It may appear as a pseudostupidity or a blissful inertia. The patient may be re-experiencing some early aspect of the mother-child relationship. In such a state the patient cannot perform the analytic work unless the analyst succeeds in re-establishing a reasonable ego and a working alliance.

The situation becomes more complicated when certain transference reactions are clung to tenaciously in order to hide other types of transference feelings. There are patients who stubbornly maintain a façade of realistic cooperation with the analyst for the purpose of concealing their irrational fantasies. Sometimes a patient will split off certain feelings and displace them onto others in order to remain unaware of his ambivalence toward the analyst. It often happens that my patients will express great hostility toward other psychoanalysts while they profess great admiration for me. Analysis will reveal that both sets of feelings actually pertain to me.

The most difficult resistances to overcome are the so-called "character transference" reactions. In such situations, general traits of character and attitudes which have a defensive function are manifested toward the analyst as well as toward people in everyday life. These are so deeply rooted in the patient's character structure and so well rationalized that they are difficult to make the subject of analysis. These problems will be described in greater detail in Sections 3.82 and 3.83.

To summarize: Transference and resistance are related to each other in many ways. The term transference resistance condenses this clinical fact. Transference phenomena in general are a resistance to memory despite the fact that they indirectly lead in this direction. Transference reactions may cause a patient to become unable to work analytically because of the nature of the reaction. Some transference reactions may be used as a resistance against revealing other transference reactions. The analysis of transference resistances is the "daily bread," the regular work of psychoanalytic therapy. More time is spent in analyzing the transference resistances than in any other aspect of therapeutic work.

3.42 The Transference Neurosis

Freud used the term transference neurosis in two different ways. On the one hand, he used the term to designate a group of neuroses characterized by the patient's ability to form and maintain a rela-
tively cohesive, multiform, and accessible set of transference reactions (Freud, 1916–17). The hysterics, phobics, and obsessive compulsives were thus differentiated from the narcissistic neuroses, the psychoses. In the latter group, the patients were able to develop only fragmentary and sporadic transference reactions and therefore were not treatable by classical psychoanalysis. Freud also used the term transference neurosis to describe a regular occurrence in the transference reactions of a patient undergoing psychoanalytic treatment (Freud, 1905c, 1914c, 1916–17, Chapt. XXVII).

During the course of an analysis, it can be observed that the patient’s interests become increasingly more focused on the person of the analyst. Freud (1914c, p. 154) pointed out how the neurotic patient’s compulsion to repeat is rendered not only harmless but useful by admitting it “into the transference as a playground in which it is allowed to expand in almost complete freedom and in which it is expected to display to us everything in the way of pathogenic instincts that is hidden in the patient’s mind.” If the transference situation is handled properly, “we regularly succeed in giving all the symptoms of the illness a new transference meaning and in replacing his ordinary neurosis by a ‘transference-neurosis’ of which he can be cured by the therapeutic work.” The transference neurosis takes over all the features of the patient’s illness, but it is an artificial illness and is accessible at every point to our interventions. It is a new edition of the old disease.

In the early phases of psychoanalytic treatment we usually see sporadic transient reactions, designated as “floating” transference reactions by Glover (1955, p. 37). If these early transference reactions are properly handled, the patient will develop more enduring transference reactions. Clinically, the development of the transference neurosis is indicated by an increase in the intensity and duration of the patient’s preoccupation with the person of the analyst and the analytic processes and procedures. The analyst and the analysis become the central concern in the patient’s life. Not only do the patient’s symptoms and instinctual demands revolve around the analyst, but all the old neurotic conflicts are remobilized and focus on the analytic situation. The patient will feel this interest as some variety and mixture of love and hate as well as defenses against these emotions. If the defenses predominate, some form of anxiety or guilt will be in the foreground. These reactions may be intense, explosive, subtle, or chronic. In any event, once the transference neurosis has set in, such constellations of feelings are omnipresent.

In the transference neurosis the patient repeats with his analyst his past neuroses. By proper handling and interpretation it is our hope to help the patient relive and eventually remember or reconstruct his infantile neurosis. The concept of transference neurosis includes more than the infantile neurosis because the patient will also relive the later editions and variations of his childhood neurosis as well. Let me try to illustrate this with a clinical example.

I shall use the case of Mrs. K. This young woman came for psychoanalytic treatment because she had recently become tormented by obsessive ideas and impulses to become sexually promiscuous with a Negro. This alternated with feelings of being a “zombie” or else she felt empty, bored, worthless, and depressed. She had recently married an outstanding man in the community some twenty years her senior whom she had loved prior to the marriage but toward whom she now felt resentment and fear. The outstanding feature in her past history was the fact of her having been brought up by a warmhearted, erratic, alcoholic mother, who alternately worshipped and adored her, indulged her, and at times abandoned her. The father deserted the family when the patient was one and a half years old and the mother’s later three marriages each lasted about one year. There were two brothers, three and two years younger, whom the mother ignored and who were looked after by the patient. They were her companions, her responsibility, and her rivals. There was great poverty, much changing of home locations, and little education. When the girl was fifteen her mother insisted she was able to shift for herself; and although shy, frightened, and untrained, the patient did make a successful career for herself as a fashion model. At twenty Mrs. K. met and fell in love with her future husband who taught her the niceties of life and who married her five years later. She had been married some two years when she came for analysis. I shall now try to sketch the main transference developments of a successful analysis lasting some four and a half years.

The early transference reactions consisted of her urgency to be accepted as a patient by me, whom she fantasied as the “top” analyst of the community and thus a guarantor of a successful analysis. At the same time she dreaded that I would find her boring, unworthy, unattractive,
or untreatable. She was torn, on the one hand, by her desire to be a good patient and reveal all her weaknesses, and, on the other hand, by her wish to be loved by me, to be found sexually and mentally attractive, and therefore to hide her defects. I was to make restitution for her lack of a father by making her my favorite patient and by doing for her what I would not do for any of my other patients. I would be the ideal, incorruptible father of whom she would be proud and also the delinquent father who would satisfy her incestuous wishes. Very early Mrs. K.'s symptom of promiscuity impulses shifted to me, as an oedipal figure. This alternated with an image of me as the stern, disapproving, and puritanical, idealized father.

While this was going on the analysis was concerned with attempting to understand the patient's great shame about masturbation, which she "discovered" only at age twenty-one, and which seemed to occur without fantasies and with little orgastic relief. The analysis of her shame led us to recognize that I was not only the puritanical father but also the fanatically clean mother of her toilet-training days. Mrs. K.'s boredom and her feeling of emptiness were revealed to be defenses against sexual fantasies, and became resistances in the analysis. She was afraid to fantasy, because to fantasy meant to become excited, and to become excited meant to lose control and to wet. This was manifested in the analysis by her reluctance to continue talking when she became emotional or excited. If I were to see her weep, or flushed, I would find her unattractive. She removed the Kleenex tissue from the pillow after each hour because she did not want me to see her "soiled" tissue. How could I love her if I knew she was dirty and performed toilet functions. I was either the idealized, desexualized, de-toiletized father who deserted her dirty mother, or I was the compulsively clean mother who loathed dirty children. She then recalled many memories of seeing her drunken mother naked and being repelled by her ugly genitals. Now she dreaded being like her mother, or having her dirty mother inside her, and was terrified that I would abandon her like father had deserted mother. She would rather be empty than full of dirty mother. But empty meant silence and resistance in the analysis and that was equivalent to being a bad patient. Here the working alliance and her longing to be loved by her father analyst won out and she was able to work on what was hidden behind the emptiness.

Behind the emptiness came a flood of sexual fantasies concerning a great variety of oral, sucking, scopophilic actions performed both actively and passively with a forbidden man. That man was the analyst or a Negro or Arab who was both sadistic and masochistic. She and her partner alternated roles. At this time I was not only her accomplice in her sexual adventures, but I also permitted her to hate her mother, which she did with gusto. In this period of analysis she longed for each analytic hour, dreaded weekends and even the end of each hour, for I had become the main content of her fantasies, and absence from me meant emptiness and boredom. She felt "hooked up" to me and charged with feelings in my presence and felt drab and flat away from the hour.

As Mrs. K. slowly realized that I was determined to analyze her and was neither afraid of her impulses nor revolted by them, she slowly dared to permit more regressive impulses to come up. With me as her father protector, she dared to recall occasional dreams and fantasies of oral sucking and sadistic impulses toward feminine men and finally to women. As she trusted me more she also dared to feel some primitive hatred and rage toward me. Earlier she could feel mild hostility to me as the critical father or the disapproving mother. Later she could hate me as the robber of her capital, her secret, and the valuable lump she felt she had inside her which gave her security. She could also love me as her good investment, her security for the future, her guarantee against emptiness, the man who gave her substance. At this time I was also her defense against penis envy by being the penis-man she possessed.

At this stage of analysis, Mrs. K. was able for the first time to experience an orgasm during intercourse. This gave her the courage to become aware of strong homosexual feelings toward her baby daughter, which she could recognize as being a repetition with reversal of roles of her childhood impulses toward her mother. The fact that these impulses could be experienced without interfering with her capacity to obtain heterosexual orgasms if she so desired, enabled her finally to go through a violent phase of penis envy. She could hate me furiously as a possessor of a penis, who "only wanted a hole to stick his filthy thing in," who didn't give a damn for women, who impregnated them and deserted them. When the patient was able to express these feelings and find that I was neither destroyed nor antagonized she began to feel that I loved her and accepted her unconditionally and permanently—even when I did not agree with her. I had become a fixture inside her, reliable and permanent—a loving, parental, internal object. Now she could allow herself to become a full-fledged mother and wife and could work out her hate and love for her mother without feeling that this would overwhelm her. The case of Mrs. K. will be described in greater detail in Volume II.

This brief sketch, as complex as it may seem to read, by no means does justice to all the transference reactions of the patient. It does indicate, I hope, how the patient's symptoms, conflicts, impulses, and defenses become focused on the analyst and on the
analytic procedure and to a great extent replaced her original neurosis. The transference neuroses enabled me to observe and work on the patient’s conflicts in the living present. Transference experiences are vivid, alive, and real and bring a sense of conviction unparalleled in psychoanalytic work.

In his description of the transference neurosis, Freud (1914e) indicated that the patient’s ordinary neurosis is “replaced” by the transference neurosis. Anna Freud (1928) concurs with this and insists that only a structure of this kind deserves the name of transference neurosis.

In the clinical material cited above, one can observe how during different intervals Mrs. K.’s involvement with me supplanted the original neurosis. For a period of time the patient’s promiscuity impulses focused on me and were absent elsewhere. Her conflicts about losing control were intense during the analytic hour and concerned her fear of letting out dirty material, and hiding the “soiled” Kleenex. During this period her anal anxieties outside the analysis did not disappear, but they receded into the background. In my experience, that particular aspect of the patient’s neurosis which becomes active and vivid in the transference situation will diminish in the patient’s outside life. However, often it merely pales and becomes relatively insignificant compared to the transference neurosis—only to reappear in the patient’s outside life when another constellation dominates the transference picture. For example, Mrs. K.’s promiscuity fantasies shifted to me exclusively for a period of time. However, when the analysis became focused on her toilet anxieties and shame, her obsessive-impulsive ideas about dark-skinned men returned.

Another question should be raised concerning the extent to which the transference neurosis totally replaces the patient’s neurosis. I have had the experience that some aspects of the patient’s neurosis become displaced onto a figure in the patient’s outside life who then appears to function as a supplementary transference figure. For example, many of my male patients fall in love romantically with a woman during the course of their analysis. This is a transference manifestation but occurs outside of the analysis. This will be discussed in Section 3.84.

This question of the transference neurosis replacing the patient’s ordinary neurosis touches upon the problem of what happens in the analysis of young children. Anna Freud (1928), Fraiberg (1951), and Kut (1953) used to maintain that young children manifest a variety of isolated transference reactions but do not develop a transference neurosis. Only after the resolution of the oedipus complex, in latency, does one see evidence of a transference neurosis developing in the analytic treatment of children. Anna Freud (1965) and Fraiberg (1966) have recently modified their points of view on this matter. Older children do develop intense, enduring, distorted reactions to the analyst which resemble the transference neurosis in adults. These reactions do not replace the old neurosis to the same degree that they do in adult analysis (see Nagar, 1966). The Kleinian child analysts do not differentiate between transference reactions and transference neurosis and claim that transference phenomena in young children are identical to those in adults (Isaacs, 1948).

Glover (1955), Nacht (1957), and Haak (1957) have described how certain forms of the transference neurosis can become an obstacle to uncovering the infantile neurosis and can lead to a stalemate situation. One of the most frequent causes of this is the analyst’s countertransference, which unwittingly prevents the full sweep of the patient’s transference reactions. For example, undue warmth on the part of the analyst can prevent the hostile transference from developing fully. Above all, the incomplete interpretation of some aspects of the transference reactions will produce a protracted stalemate situation. This subject will be discussed more fully in subsequent sections.

The question might be raised: what does one do to ensure that a transference neurosis will occur? The answer is as follows: if the analytic atmosphere is essentially that of compassion and acceptance and if the analyst consistently searches for insight and interprets the patient’s resistances, a transference neurosis will develop. This will be covered more fully and demonstrated in Sections 3.7 and 3.9.

The classical psychoanalytic attitude toward the transference neurosis is to facilitate its maximal development. It is recognized that the transference neurosis offers the patient the most important instrumentality for gaining access to the warded-off past pathogenic experiences. The reliving of the repressed past with the analyst and in the analytic situation is the most effective opportunity for overcoming the neurotic defenses and resistances. Thus, the psychoanalyst will take pains to safeguard the transference situation and
prevent any contamination which might curtail its full flowering (Greenacre, 1954). All intrusions of the analyst's personal characteristics and values will be recognized as factors which might limit the scope of the patient's transference neurosis. Interpretation is the only method of dealing with the transference that will permit it to run its entire course. In combination with an effective working alliance it will ultimately lead to its resolution (Gill, 1954; Greenson, 1965a).

The deviant schools of psychoanalysis have a different approach to the transference neurosis. Alexander, French, et al. (1946) overemphasize the dangers of the regressive elements and therefore advocate various manipulations of the transference situation in order to avoid or curtail the transference neurosis. The Kleinian school goes to the opposite extreme and relies almost entirely on transference interpretations to the exclusion of everything else (Klein, 1932; Klein, et al., 1952; Strachey, 1934; Isaacs, 1948). Furthermore, they see the most infantile and primitive impulses occurring in the transference from the very beginning of analysis and interpret these immediately (Klein, 1961). Finally, the patient's individual history seems to be of little importance since the transference developments seem to be alike in all patients.

Before leaving the theoretical discussion of transference, it should be mentioned that the analytic situation and the personality of the analyst contribute to the patient's transference reactions. This will be discussed in some detail in Chapter 4.

3.5 The Working Alliance

At this point in our discussion of transference phenomena, it is necessary to make a digression. We have stressed the outstanding importance of the transference reactions for the psychoanalytic treatment of the neurotic patient. I can epitomize the psychoanalytic point of view by stating that the psychoanalyst takes great pains to provide an analytic situation that will maximize the unfolding of the various transference reactions. This is our prime method for reaching the pathogenic material which is otherwise inaccessible. However, collecting the historical data is only part of the therapeutic process. Another major component is the giving of insight by means of interpretation.
coming in myself when I resumed analysis with patients I had previously treated.

It was in working with these seemingly unanalyzable or interminable patients that I became impressed with the importance of separating the patient’s reactions to the analyst into two distinct categories: the transference neurosis and the working alliance. Actually this classification is neither complete nor precise, points which I shall attempt to clarify later on. However, this differentiation helps make it possible to give equal scrutiny and attention to two essentially different types of reactions to the psychoanalyst.

3.51 Working Definition

The notion of a working alliance is an old one in both psychiatric and psychoanalytic literature. It has been described under a variety of different labels, but, with the exception of Zetzel and Stone, it has either been considered of secondary importance or it has not been clearly separated from other transference reactions.

The term working alliance will be used in preference to the diverse terms others have employed for designating the relatively nonneurotic, rational rapport which the patient has with his analyst. It is this reasonable and purposeful part of the feelings the patient has for the analyst which makes for the working alliance. The label working alliance was selected because the term emphasizes its outstanding function: it centers on the patient’s ability to work in the analytic situation. Terms like the “therapeutic alliance,” of Zetzel (1956), the “rational transference” of Fenichel (1941) and the “mature transference” of Stone (1961) refer to similar concepts. The designation working alliance, however, has the advantage of stressing the vital elements: the patient’s capacity to work purposefully in the treatment situation. It can be seen at its clearest when a patient is in the throes of an intense transference neurosis and yet can still maintain an effective working relationship with the analyst.

The reliable core of the working alliance is formed by the patient’s motivation to overcome his illness, his sense of helplessness, his conscious and rational willingness to cooperate, and his ability to follow the instructions and insights of the analyst. The actual alliance is formed essentially between the patient’s reasonable ego and the analyst’s analyzing ego (Sterba, 1934). The medium which makes this possible is the patient’s partial identification with the analyst’s analytic approach as he attempts to understand the patient’s behavior (Sterba, 1929).

The working alliance comes to the fore in the analytic situation in the same way as the patient’s reasonable ego, the observing, analyzing ego is separated from his experiencing ego. The analyst’s interventions disengage the working attitudes from the neurotic transference phenomena just as his interventions separate the reasonable ego from the irrational ego. These two sets of phenomena are parallel to each other and express analogous psychic events from different points of reference. Patients who cannot set apart a reasonable, observing ego will not be able to maintain a working relationship and vice versa.

However, this differentiation between transference reactions and working alliance is not an absolute one since the working alliance may contain elements of the infantile neurosis which will eventually require analysis. For example, the patient may work well temporarily in order to gain the analyst’s love, and this ultimately will lead to strong resistances; or the overevaluation of the analyst’s character and ability can also serve the working alliance well in the beginning of the analysis, only to become a source of strong resistance later on. Not only can the transference neurosis invade the working alliance, but the working alliance itself can be misused defensively to ward off the more regressive transference phenomena.

A clinical illustration of this point occurred in a patient of mine who maintained a persistent reasonableness toward me and the analytic situation. Although she knew little about psychoanalysis, she accepted the frustrations and restrictions goodnaturedly and with no trace of conscious annoyance or anger. However, the occasional dreams she could remember were full of unmistakable evidence of fury and rage. When this was pointed out to her, the patient reacted as though that was “only” a dream and she was not “responsible” for her dreams. Even when she forgot her analytic hour she considered it a “natural” mistake, and took my interpretation of her fear of her underlying hostility as the musings of an eccentric which she tolerated with good grace. Only after her superficial associations and rationalizations petered out and silence reigned, did her more regressive hostile and sexual impulses become unmistakably clear to her. Then she recognized how she had clung to the working alliance as a defensive façade.
Despite the internmixtures, the separation of the patient's reactions to the analyst into these two groupings, neurotic transference and working alliance, seems to have clinical and technical value. Before going on to additional case material, I would like to sketch briefly some of the psychoanalytic literature on this subject.

3.52 Survey of the Literature

Freud (1912a, p. 105) spoke of the friendly and affectionate aspects of the transference which are admissible to consciousness and which are "the vehicle of success in psycho-analysis...." He wrote of rapport as follows: "It remains the first aim of the treatment to attach him [the patient] to it and to the person of the doctor. To ensure this, nothing need be done but to give him time. If one exhibits a serious interest in him, carefully clears away the resistances that crop up at the beginning and avoids making certain mistakes, he will of himself form such an attachment.... It is certainly possible to forfeit this first success if from the start one takes up any standpoint other than one of sympathetic understanding" (Freud, 1913b, pp. 139-140).

Sterba (1929) wrote about the patient's identification with the analyst which leads to the patients' concern with the work they have to accomplish in common—but he gave this aspect of the transference no special designation. Fenichel (1941, p. 27) described the "rational transference," an aim-inhibited positive transference which is necessary for analysis. Elizabeth Zetzel's emphasis on the importance of the "therapeutic alliance" was discussed above. Loewald's (1960) paper on the therapeutic action of psychoanalysis is a penetrating and sensitive study of the different kinds of relationships the patient develops toward the analyst during psychoanalysis. Some of his ideas are directly concerned with what I call the working alliance. Leo Stone's book is devoted to the complexities in the relationship between analyst and patient. In it he referred to the "mature transference" which he believed to be: (a) in opposition to the "primordial transference" reactions and (b) essential for a successful analysis (p. 106).

The Symposium on "The Curative Factors in Psycho-Analysis" presented before the 22nd Congress of the International Psycho-Analytical Association (see Gitelson, et al., 1962) contained many references to the special transference reactions which make for a therapeutic alliance and also some discussion of the analyst's contribution to the "good" analytic situation. Gitelson talked of the rapport on which we depend in the beginning of analysis and which eventuates in transference. He stressed the necessity for the analyst to present himself as a good object and as an auxiliary ego. Myerson (see Gitelson, p. 202 n.), Nacht, Segal, Kuiper, Garma, King, and Heimann took issue with him on one or another aspect of his approach. In some measure the disagreement seems to be due to the failure to distinguish clearly between the working alliance and the more regressive transference phenomena.

This brief and incomplete survey reveals that many analysts, including Freud, recognized that in psychoanalytic treatment another kind of relationship to the analyst was necessary besides the more regressive transference reactions.

3.53 Development of the Working Alliance

3.531 Aberrations in the Working Alliance

I shall begin by describing some clinical examples in which the course of development of the working alliance deviated markedly from that of the usual psychoanalytic patient. My reason for beginning this way stems from the fact that in the classical analytic patient the working alliance develops almost imperceptibly, relatively silently, and seemingly independently of any special activity on my part. The irregular cases highlight different processes and procedures which take place almost invisibly in the usual analytic patient.

A few years ago an analyst from another city sent me an intelligent middle-aged man who had had over six years of previous analysis. Certain general conditions had improved in the patient's life, but his first analyst felt the patient needed some additional analysis because he was still unable to get married and he was very lonely. From the very beginning of the therapy I was struck by the fact that he was absolutely passive about recognizing and working with his own resistances. It turned out that he expected me to point them out as his previous analyst had continued to do throughout that analysis.

Then I was impressed by the fact that the moment I made some intervention he had an immediate response, although often an incomprehensible one. I discovered that he felt it was his duty to reply immediately.
to every intervention since he believed it would be a sign of resistance, and therefore had, to keep silent for a moment or so and to mull over what I had said. Apparently his previous analyst had never recognized his fear of being silent as a resistance. In free association the patient searched actively for things to talk about, and if more than one thing occurred to him he chose what seemed to be the item he thought I was looking for without mentioning the multiple choices he had. When I would request some information from him, he often answered by doing free association so that the result was often bizarre. For example, when I asked him what his middle name was he answered: "Raskolnikov," the first name that occurred to him. When I recovered my composure and questioned this, he defended himself by saying that he thought he was supposed to associate freely.

I soon gained the distinct impression that this man had never really established a working relationship with his first analyst. He did not know what he was supposed to do in the analytic situation. He had been lying down in front of an analyst for many years, meekly submitting to what he imagined the previous analyst had demanded, namely, constant and instant free association. Patient and analyst had been indulging in a caricature of psychoanalysis. True, the patient had developed some regressive transference reactions, some of which had been interpreted, but the lack of a constant working alliance left the whole procedure amorphous, confused, and ineffectual.

Although I recognized that the magnitude of the patient's problems could not be due solely or even mainly to the first analyst's technical shortcomings, I felt the patient ought to be given a fair opportunity to see whether he might be able to work in an analytic situation. Besides, this clarification would also expose the patient's pathology more vividly. Therefore, in the very first months of our working together, I carefully explained to the patient, whenever it seemed appropriate, the different tasks that psychoanalytic therapy requires of the patient. The patient reacted to this information as though it were all new to him and he seemed eager to try to work in the way I described. However, it soon became clear that he could not just say what came to his mind, he felt compelled to find out what I was looking for. He could not keep silent and mull over what I said; he was afraid of the blank spaces, they signified some awful danger. If he were silent he might think, and if he thought he might disagree with me, and to disagree was tantamount to killing me. His striking passivity and compliance were revealed as a form of ingratiating, covering up an inner emptiness, an satiable infantile hunger, and a terrible rage. In a period of six months it became abundantly clear that this man was a schizoid "as if" character who could not bear the deprivations of classical psychoanalysis (H. Deutsch, 1942; Weiss, 1966). I therefore helped him obtain supportive psychotherapy with a woman therapist.

A woman I had analyzed for some four years resumed analysis with me after an interval of six years. We both knew when she had interrupted that there was a great deal of unfinished analysis, but we agreed that an analysis-free interval might clarify the unusual obscurities and difficulties we encountered in trying to achieve a better resolution of her highly ambivalent, complaining, clinging, sadomasochistic transference to me. I had suggested her going to another analyst since, in general, I have found a change in analyst is more productive than a return to the former analyst. It usually offers new insights into the old transference reactions and adds new transference possibilities as well. However, for external reasons this was not feasible, and I undertook the resumption of her analysis, albeit with some reservations.

In her very first hours on the couch I was struck by the strange way the patient worked in the analysis. Then I quickly recalled this had often happened in the past, only now it struck me more strongly because I was no longer accustomed to it; it seemed almost bizarre. After a certain moment in the hour the patient would speak almost incessantly, there would be disconnected sentences, a part of a recital of a recent event, an occasional obscene phrase with no mention of its strangeness, or that it was an obsessive thought, and then back to the recital of a past event. The patient seemed to be completely oblivious to her strange way of speaking and never spontaneously mentioned this. When I confronted her on this matter, she seemed at first unknowing and then felt attacked.

I realized that in the old analysis there were many such hours or parts of hours whenever the patient was very anxious and trying to ward off her awareness of the anxiety as well as the analysis of the anxiety. I even recalled that we had uncovered some of the meanings and historical determinants of such behavior. For example, her mother had been a great chatterer, had talked to the child as a grownup before she could understand. Her incomprehensible talking to me was an identification with her mother and an acting out in the analytic situation. Furthermore, the mother had used a stream of talk to express both anxiety and hostility to her husband, who was essentially a quiet man. The patient took over this pattern from the mother and re-enacted it with me in the analytic hour whenever she was anxious and hostile and when she was torn between hurting me and holding on to me.

In addition, we came to understand that this mode of behavior also denoted a regression in ego functions from secondary process toward
primary process, a kind of "sleep-talking" with me, a re-enactment of sleeping with the parents. This strange way of talking had occurred many times during the first analysis and although different determinants had been analyzed, it still persisted to some degree up to the interruption of that analysis. Whenever I tried to confront the patient with a misuse of one of the procedures of the analysis, we would get sidetracked by her reactions to my confrontation or by some new material coming up. She might recall some past historical event which seemed relevant, or in the next hours some dreams or new memories would appear and we never really got back to the subject of how she was not able to do some part of the psychoanalytic work.

In her second analysis, I was not to be put off. Whenever the merest trace of the same disconnected way of talking appeared, or whenever it seemed relevant, I would confront her with this particular problem and keep her to this subject until she at least acknowledged what was under discussion. The patient attempted to use all her old methods of defense against my confrontations of her resistances. I would listen for only a short time to her protestations and evasions and repeatedly point out its resistive function. I did not work with any new material unless I was convinced the patient was in a good working alliance with me.

Slowly the patient began to face her misuse of the basic rule. She herself became aware of how she at times consciously, at times preconsciously, and at still other times unconsciously, blurred the real purpose of free association. It became clear that when the patient felt anxious in her relationship to me, she would let herself slip into this regressive "sleep-talking" manner of speech. It was a kind of "spiteful obedience." It was spiteful insofar as she knew it was an evasion of true free association. It was obedience inasmuch as she submitted to this regressive, i.e., incontinent, way of talking. This would arise whenever she felt a certain kind of hostility to me. She felt this as an urge to pour out a stream of poison upon me. This led her to feel I would be destroyed and lost to her and she would feel alone and frightened. Then she would quickly dive down into her sleep-talking which was like saying to me: "I am a little child who is partly asleep and is not responsible for what is coming out of her. Don't leave me; let me sleep on with you; it is just harmless urine that is coming out of me." (Other determinants will not be discussed since that would lead us too far afield.)

It was a fascinating experience to see how differently this analysis proceeded from the previous one. I do not mean to imply that this patient's tendency to misuse her ability to regress in ego functioning completely disappeared. However, my vigorous pursuit of the analysis of the defective working alliance, my constant attention to the maintenance of a good working relationship, my refusal to be misled into analyzing other aspects of her transference neurosis had its effects. The second analysis had a completely different flavor and atmosphere. In the first analysis I had an interesting and whimsical patient who was very frustrating because I was so often lost by her capricious wanderings. In the second analysis I still had a whimsical patient, but I also had an ally who not only helped me when I was lost but who also pointed out I was being led astray even before I realized it.

A young man, Mr. Z., came to me for analysis after having spent two and a half years with an analyst in another city in an analysis which had left him almost completely untouched. He had obtained certain insights, but he had the distinct impression that his former analyst really disapproved of infantile sexuality, even though the young man realized that analysts were not supposed to be contemptuous of it. In the preliminary interviews the young man told me that he had the greatest difficulty in talking about masturbation and often consciously withheld this information from his previous analyst. He had informed the latter about the existence of many conscious secrets, but nevertheless stubbornly refused to divulge them. He never wholeheartedly gave himself up to free association, and there were many hours of long silence in which he and his analyst both remained mute. The patient's manner of relating to me, however, his history, and my general clinical impression led me to believe that he was analyzable, despite the fact that he had not been able to form a working alliance with his first analyst.

I undertook to analyze Mr. Z. and learned a great deal about his negative reactions to his previous analyst, some of which stemmed from his way of conducting the analysis. For example, in one of the first hours on the couch the patient took out a cigarette and lit it. I asked him what he was feeling when he decided to light the cigarette. He answered petulantly that he knew he was not supposed to smoke in his previous analysis and how he supposed that I too would forbid this. I told Mr. Z. that I wanted to know what feelings, ideas, and sensations were going on in him at the moment that he decided to light the cigarette. He then revealed that he had become somewhat frightened in the hour and to shield this anxiety from my view he decided to light the cigarette.

I replied that it was preferable for such feelings and ideas to be expressed in words instead of actions because then I would understand more precisely what was going on in him. He realized then that I was not forbidding him to smoke but only pointing out that it was more helpful to the process of being analyzed if he expressed himself in words and

\[4\] See Sections 2.52, 2.54, and 2.71.
feelings. He contrasted this with his first analyst who told him before he went to the couch that it was customary not to smoke on the couch. There was no explanation for this and the patient felt that his first analyst was being arbitrary.

In a later hour Mr. Z. asked me whether I was married. I countered by asking him what did he imagine about that. He hesitantly revealed that he was torn between two sets of fantasies, one that I was a bachelor who loved his work and lived only for his patients; the other fantasy was that I was a happily married man with many children. He then went on spontaneously to tell me that he hoped I was happily married because then I would be in a better position to help him with his sexual problems. Then Mr. Z. corrected himself and said it was painful to think of me as having sexual relations with my wife because that was embarrassing and none of his business. I then pointed out to him how, by not answering his question and by asking him instead to tell his fantasies about the answer, he revealed to us what his curiosity was about. I told him I would not answer questions when I felt that more was to be gained by my keeping silent and letting him associate to his own question.

At this point Mr. Z. became somewhat tearful and after a short pause told me that in the beginning of his previous analysis he had asked many questions. His former analyst never answered, nor did he ever explain why he was silent. He felt his analyst's silence as a degradation and humiliation and now realized that his own later silences were a retaliation for this imagined injustice. Somewhat later he realized that he had identified with his first analyst's supposed contempt. Mr. Z. felt disdain for his analyst's prudishness and at the same time was full of severe self-reproach for his own sexual practices which he then projected back onto the analyst.

It was very instructive to me to see how an identification with the previous analyst based on fear and hostility led to a distortion of the working relationship instead of an effective working alliance. The whole atmosphere of the first analysis was contaminated by hostile, mistrustful, retaliative feelings and attitudes. This turned out to be a repetition of the patient's behavior toward his father, a point the first analyst had recognized and interpreted. The analysis of this transference resistance, however, was ineffectual due in part to the fact that the former analyst worked in such a way as to constantly justify the patient's infantile neurotic behavior and so furthered the invasion of the working alliance by the transference neurosis.

I worked with Mr. Z. for approximately four years and almost from the very beginning a relatively effective working alliance was established. However, my manner of conducting analysis, which seemed to him to indicate some genuine human concern for his welfare and respect for his position as a patient also mobilized important transference resistances in a later phase of the analysis. In the third year of his analysis with me I began to realize that despite what seemed to be a good working alliance and a strong transference neurosis, there were many areas of the patient's outside life which did not seem to change commensurate with the analytic work. Eventually I was able to discover that the patient had developed a subtle but specific inhibition in doing analytic work outside of the analytic hour. When Mr. Z. became upset outside the hour, he would ask himself what upset him. Usually he would succeed in recalling the situation in question. Sometimes he even might recall the meaning of that event which I had given him at some previous point, but this insight would be relatively meaningless to him; it felt foreign, artificial, and remembered by rote. It was not his insight; it was mine, and therefore had no living significance for him. He was therefore relatively blank about the meaning of the events which upset him.

Apparently, although he seemed to have established a working alliance with me in the analytic situation, this did not remain outside of the hour. Analysis revealed that the patient did not allow himself to assume any attitude, approach, or point of view that was like mine outside of the analytic hour. He felt that to permit himself to do so would be tantamount to admitting that I had entered into him. This was intolerable because Mr. Z. felt this to be a homosexual assault, a repetition of several childhood and adolescent traumata. Slowly we were able to uncover how the patient had sexualized and aggressed the process of introjection.

This new insight was the starting point for the patient to begin to learn to discriminate among the different varieties of "taking in." Gradually the patient was able to re-establish a homosexual-free identification with me in terms of adopting an analytic point of view. Thus, a working relationship which had been invaded by the transference neurosis was once again relatively free of infantile neurotic features. The previous insights which had remained ineffectual eventually led to a significant and lasting change. The case of Mr. Z. will be described in greater detail in Volume II.

Finally I want to return to those patients who cling tenaciously to the working alliance because they are terrified of the regressive features of the transference neurosis. These patients develop a reasonable relationship to the analyst and do not allow themselves to feel anything irrational, be it sexual, or aggressive, or both. Prolonged reasonableness in analysis is a pseudo reasonableness, the
patient is unconsciously holding on to the reasonableness for a variety of unconscious neurotic motives. Let me illustrate.

For about two years a young professional man, who had an intellectual knowledge of psychoanalysis, maintained a positive and reasonable attitude to me, his analyst. If his dreams indicated hostility or homosexuality, he acknowledged it but claimed that he knew he was supposed to feel such things to his analyst, but "he really didn't." If he came late or forgot to pay his bill, he again admitted that it might seem that he did not want to come or pay his bill, but "actually" it was not so. He had violent anger reactions to other psychiatrists he knew, but insisted they deserved it and I was different. He became infatuated with another male analyst for a period of time and he "guessed" he must remind him of me, but this was said playfully.

All my attempts to get the patient to recognize his persistent reasonableness as a means of avoiding or belittling his deeper feelings and impulses failed. Even my attempts to trace the historical origins of this mode of behavior were unproductive. He had adopted the role of "odd ball," clown, harmless nonconformist, in his high school years and was repeating this in the analysis. Since I could not get the patient to work further or consistently with this material, I finally told the patient that we had to face the fact that we were getting nowhere and we ought to consider some other alternative besides continuing psychoanalysis with me. The patient was silent for a few moments and said "frankly" he was disappointed. He sighed and then went on to make a free-association-like remark. I stopped him and asked him what in the world he was doing. He replied that he "guessed" I sounded somewhat annoyed. I assured him it was no guess. Then slowly he looked at me and asked if he could sit up. I nodded and he did. He was quite shaken, sober, pale, and in obvious distress.

After some moments of silence he said that maybe he would be able to work better if he could look at me. He had to be sure I was not laughing at him, or angry, or getting sexually excited. The last point seemed striking and I asked him about it. He told me that he often fantasied that perhaps I was being sexually excited by his material and hid it from him. This he never brought up before, it was just a fleeting idea. But this "fleeting idea" led quickly to many memories of his father repeatedly and unnecessarily taking his temperature rectally. This then led to a host of fantasies of a homosexual and sadomasochistic nature. The persistent reasonableness was a defense against these as well as a playful attempt to tease me into acting out with him. My behavior, in the hour described above, was not well controlled, but it led to a realization that the patient's working alliance was being used to ward off the transference neurosis.

The working alliance had become the façade for the transference neurosis. It was his neurotic character structure hiding as well as expressing his underlying neurosis. Only when the patient's acting out was interrupted and he realized he was about to lose the transference object did his rigidly reasonable behavior become ego alien and accessible to therapy. He needed several weeks of being able to look at me, to test out whether my reactions could be trusted. Then he became able to distinguish between genuine reasonableness and the teasing, spiteful reasonableness of his character neurosis and the analysis began to move.

3.532 The Working Alliance in the Classical Analytic Patient

The term classical in this connection refers to a heterogeneous group of patients who are analyzable by the classical psychoanalytic technique without major modifications. They suffer from some form of transference neurosis, a symptom or character neurosis, without any appreciable defect in ego functions. In such psychoanalytic patients the working alliance develops almost imperceptibly, relatively silently, and seemingly independently of any special activity or intervention on the part of the analyst. Usually I can see the first signs of the working alliance in about the third to sixth month of analysis. Most frequently the first indications of this development are: the patient becomes silent and then instead of waiting for me to intervene, he himself ventures the opinion that he seems to be avoiding something. Or he interrupts a rather desultory report of some event and comments that he must be running away from something. If I remain silent, he will then spontaneously ask himself what it can be that is making him so evasive and he will let his thoughts drift into free association which he will say aloud.

It is obvious that the patient has made a partial and temporary identification with me and now is working with himself in the same way that I had been working on his resistances day by day. If I review the situation, I will usually find that prior to this development the patient will have experienced some sporadic sexual or hostile transference reaction which had temporarily caused a strong resistance. Patiently and tactfully I have to demonstrate this resist-
ance, then clarify how it operated, what its purpose was, and eventually interpret and reconstruct its probable historical source. Only after some effective piece of transference-resistance analysis does it seem that the patient is able to develop a partial working alliance. However, it is necessary to go back to the very beginning of the analysis in order to get a more detailed view of its development.

There is great variety in the manner in which a patient enters into the preliminary interviews. This is in part determined by his past history in regard to psychoanalysts, physicians, authority figures, and strangers as well as by his reactions to being sick, needing and asking for help, etc. (Gill, Newman, and Redlich, 1954). Furthermore, his knowledge or lack of knowledge about the procedures of psychoanalysis and the reputation of the psychoanalyst will also influence his initial responses. Thus the patient comes to the initial interview with a preformed relationship to me, partly transference and partly realistic, depending on how much he fills in the unknowns with his inappropriate past.

The preliminary interviews heavily color the patient’s reactions to the analyst. This is determined mainly by the patient’s feelings about exposing himself as well as by his responses to my method of approach and my personality. Here too I believe we see a mixture of transference and realistic reactions. Exposure of one’s self is apt to stir up reverberations of past undressings in front of parents or doctors, etc., and is therefore prone to produce transference reactions. My technique of conducting the interviews will do the same the more it seems strange, painful, or incomprehensible to the patient. Only those methods of approach which seem understandable to the patient may lead to realistic reactions in the patient. My “analyst” personality as it is manifested in the first interviews may also stir up both transference and realistic reactions. It is my impression that those qualities which seem strange or threatening or nonprofessional will evoke strong transference reactions along with anxiety. Those traits which the patient believes indicate a therapeutic intent, compassion, and expertness may produce realistic responses as well as positive transference reactions. The clinical material from the case of Mr. Z. indicates how the manner, attitude, and technique of the analyst in the beginning of both analyses decisively colored the analytic situation.

By the time I have decided that psychoanalysis is the treatment of choice, I will have gained the impression that the patient in question seems to have the potential for forming a working alliance with me along with his transference neurosis. My discussion with the patient of why I believe psychoanalysis is the best method of therapy for him, the explanations of the frequency of visits, duration, fee, etc., and the patient’s own appraisal of his capacity to meet these requirements will be of additional value in revealing the patient’s ability to form a working alliance.

The first few months of analysis proper with the patient lying on the couch attempting free association can best be epitomized as a combination of testing and confessing. The patient tests out his ability to do free association and to expose his guilt- and anxiety-producing experience. Simultaneously he is probing his analyst’s reactions to these productions (Freud, 1915a; Gitelson, 1962). There is a good deal of history telling and reporting of everyday events. My interventions are aimed at pointing out and exploring fairly obvious resistances and inappropriate affects. When the material is quite clear, I try to make connections between past and present behavior patterns. As a consequence, the patient will usually begin to feel that perhaps I understand him. Then the patient dares to regress, to let himself experience some transient aspect of his neurosis in the transference, in regard to my person. When I succeed in analyzing this effectively, then I have at least temporarily succeeded in establishing a reasonable ego and a working alliance alongside of the experiencing ego and the transference neurosis. Once the patient has experienced this oscillation between transference neurosis and working alliance in regard to one area, the patient becomes more willing to risk future regressions in that same area of the transference neurosis. However, every new aspect of the transference neurosis may bring about an impairment or a temporary loss of the working alliance.

A middle-aged, unsophisticated housewife was entering the second year of analysis. In the first year she had experienced great difficulty in acknowledging that at times she experienced romantic and sexual feelings toward me, although there was unmistakable evidence of this in her behavior and in her undisguised dreams. She considered herself happily married and felt that erotic fantasies about the analyst would indicate she was dissatisfied with her marriage. This frightened her because she was extremely dependent on her husband, unconsciously hostile to him,
and terrified of losing him. My attempts to get the patient to face her sexual transference and her fear of it would turn this usually good-natured, cooperative woman into a stubborn, spiteful grumbler. In such a state she would respond to my interventions by saying: "Wouldn't anybody, wouldn't everybody react this way? Isn't it natural? Wouldn't you react this way if you were in my place?"

As we worked out some of the fears which made her resist the insights I was trying to convey, the patient gradually became able to face up to her positive feelings for me and did not have to resort to her defense of "wouldn't everyone" and "wouldn't you." At the same time the patient was able to admit to herself and to me that there were shortcomings in her marriage without feeling this heralded the end of her security. She also began to understand and accept my interpretations of some of the origins of the sexual feelings she was feeling for her analyst. The patient was able to cope with the idea that some of her feelings to me stemmed from her childhood sexual love for her father and her older brother. The patient had developed a fairly stable working alliance with me in regard to heterosexual matters.

However, the situation reverted to the early days of her analysis when aggression began to intrude itself significantly into the analytic hour. For example, the patient became unusually silent when I interpreted that her feeling of rejection by me was related to her forgetting to pay her fee at the end of the month. She developed severe gastrointestinal colic with explosive diarrhea and a fear that she was deadly ill with cancer. When I pointed out that this was an expression of her repressed rage to me, she at first denied it. When I told her that her feeling of dependency on me was shaken by my attempts to interpret instead of gratifying her or reassuring her, she responded by "Wouldn't everybody, wouldn't anybody react this way? Isn't this natural? Wouldn't you react this way if you were in my place?" Then she added, "I think I better go to the Mayo Clinic and have myself examined." The working alliance which she had established with regard to heterosexual matters had vanished when the subject of hostility came into the clinical picture. It took weeks of patient, painstaking interpretation of resistances to re-establish a utilizable working alliance. The same sequence of events occurred when homosexuality came into the analytic situation.

3.54 The Origins of the Working Alliance

3.541 The Contributions of the Patient

For a working alliance to take place, the patient must have the capacity to form a special variety of object relationship. People who are essentially narcissistic will not be able to do so. The working alliance is a relatively rational, desexualized, and de-aggressified transference phenomenon. Patients must have been able to have formed such sublimated, aim-inhibited relationships in their outside lives. In the course of analysis the patient is expected to be able to regress to the more primitive and irrational transference reactions which are under the influence of the primary process. To achieve a working alliance, however, the patient has to be able to re-establish the secondary process, to split off a relatively reasonable object relationship to the analyst from the more regressive transference reactions. People who suffer from a severe lack of or impairment in ego functions may well be able to experience regressive transference reactions but will have difficulty in maintaining a working alliance. On the other hand, those who dare not give up their reality testing even temporarily and partially and those who must cling to a fixed form of object relationship are also poor subjects for psychoanalysis. This is confirmed by the clinical finding that psychotics, borderline cases, impulse-ridden characters, and young children usually require modifications in psychoanalytic technique (Glover, 1955; Gill, 1954; Garma [see Gitelson, et al., 1962]). Freud had this in mind when he distinguished the transference neuroses which are readily analyzable from the narcissistic neuroses which are not.

As stated previously, the patient's susceptibility to transference reactions stems from his state of instinctual dissatisfaction and his resultant need for discharge opportunities (Ferenczi, 1929). The awareness of neurotic suffering also compels the patient to establish a relationship to the analyst. On a conscious and rational level the therapist offers a realistic hope of alleviating the neurotic misery. However, the patient's helplessness in regard to his suffering mobilizes early longings for an omnipotent parent. The working alliance has both a rational and an irrational component. All the above indicates that the analyzable patient must have the need for transference reactions, must have the capacity to regress and permit neurotic transference reactions, and then have the ego strength or that particular form of ego resilience which enables him to interrupt his regression in order to reinstitute the reasonable and purposeful working alliance (Loewald, 1960).

The patient's ego functions play an important part in the implementation of the working alliance in addition to its role in object
relationships. In order to do the analytic work the patient has to be able to communicate in a variety of ways, in words, with feelings, and yet with restraint in regard to his actions. He must be able to express himself in words, intelligibly with order and logic, give information when indicated, and also be able to partially regress and do some amount of free association. He has to be able to listen to the analyst, comprehend, reflect, mull over, and introspect. To some degree he must also be able to remember, to observe himself, to fantasy, and to report this. This is only a partial list of ego functions that play a role in the patient’s capacity to establish and maintain a working alliance; we also expect the patient simultaneously to develop a transference neurosis. Thus the patient’s contribution to the working alliance depends on two antithetical properties; his capacity to maintain contact with the reality of the analytic situation and his willingness to risk regressing into his fantasy world. It is the oscillation between these two positions that is essential for the analytic work.

3.542 The Contribution of the Analytic Situation

Greenacre (1954), Macalpine (1950), and Spitz (1956b) have pointed out how different elements of the analytic setting and procedures promote regression and the transference neurosis. Some of these same elements also aid in the formation of the working alliance. The high frequency of visits and long duration of the treatment not only encourage regression but also indicate the long-range objectives and the importance of detailed intimate communication. The couch and the silence give opportunity for introspection and reflection as well as fantasy production. The fact that the patient is troubled and unknowing and is being looked after by someone relatively untroubled and expert stirs up in the patient the wish to learn and to emulate. Above all the analyst’s constant emphasis on attempting to gain understanding of all that goes on in the patient, the fact that nothing is too small or obscure, ugly or beautiful to escape the analyst’s search for comprehension; all of this tends to evoke in the patient the wish to know, to find answers, to find causes. This does not deny that the analyst’s probing stirs up resistances; it merely asserts that it also stirs up the patient’s curiosity and his search for causality.

In addition, I would add that the constant scrutiny of how the patient and the analyst seem to be working together, the mutual concern with the working alliance, are themselves factors that serve to enhance the working alliance. It encourages self-scrutiny and trust in the analyst.

3.543 The Contributions of the Analyst

I have already suggested that the personality and theoretical orientation of the analyst contribute to the working alliance. It is interesting to observe how some analysts take theoretical positions which are apparently in accord with their manifest personality and how others subscribe to theories which seem to contradict their character traits. Some use technique to project, others to protect, their personality. This finding is not meant as a criticism of either group, since I have seen happy and unhappy unions in both. I have seen rigid analysts who advocate the strictest adherence to the “rule of abstinence” and who at the same time attempt to practice the most crass kind of manipulative, gratifying, “corrective emotional experience” type of psychotherapy. I have seen many apparently carefree and easygoing analysts practicing a strict “rule of abstinence” brand of therapy, and also some of similar character who provoke their patients to act out or indulge their patients in some kind of mutual-gratification therapy. Some analysts practice analysis which suits their personality; some use their patients to discharge their repressed desires. Be that as it may, these considerations are relevant to the problems inherent in the establishment of the working alliance. At this point, however, only a brief outline of the problems can be attempted. The basic issue revolves around the question: What theoretical orientation in the analyst and what characteristics of our analytic personality will insure the development of a working alliance as well as the development of a full-blown transference neurosis?

I have already briefly indicated how certain aspects of the analytic situation facilitate the production of a transference neurosis. This can be condensed down to the following: we induce the patient to regress and to develop a transference neurosis by providing a situation which consists of a mixture of deprivation, a sleeplike condition, and constancy. I have seen patients develop a transference neurosis in their work with a variety of different analysts as long as the analytic situation provided a goodly amount of depriva-
tion administered in a predictable manner over a suitable length of
time. For a good therapeutic result, however, one must also achieve
a good working relationship.

Now to the question: what kind of attitudes in the analyst is
most likely to produce a good working alliance? The case of Mr. Z.
indicated how the patient identified with his previous analyst on
the basis of identification with the aggressor, on a hostile basis (see
Section 3.531). This identification did not produce a therapeutic
alliance; it produced a combination of spite and defiance and inter-
fered with the psychoanalytic work. The reason for this was that
the personality of the first analyst seemed cold and aloof, traits
which resembled the patient’s father, and Mr. Z. was not able to
differentiate his first analyst from his regressive transference feel-
ings. How differently he reacted to me in the beginning. He was
clearly able to differentiate me from his parent and therefore he
was able to make a temporary and partial identification with me
and thus to do the analytic work.

The most important contribution that the psychoanalyst makes
to a good working relationship comes from his daily work with the
patient. The analyst’s consistent and unwavering pursuit of insight
in dealing with any and all of the patient’s material and behavior
is the crucial factor. Regular and orderly work routines help the
patient adjust to some of the strangeness of the psychoanalytic pro-
dcedures and processes (Gill, 1954; Stone, 1961). This does not mean
that the analyst should carry out his various daily analytic tasks with
compulsive exactitude or monotonous ritualism. Such rigidity makes
for predictability but not for a feeling of trust toward a human being.
Other inconsistencies may cause the patient pain, but they do not interfere significantly with the establishment of a working
alliance. The importance the analyst gives to each hour and the
rarity of his absences stress the significance of the single hour as
well as of the continuity of hours, thus helping to impress the patient
with the need for serious cooperation. The analyst’s willingness to
devote years of work to the patient’s welfare aids in a similar way.
All the work characteristics described above are of basic importance.
I do not believe it possible to do therapeutic psychoanalysis if they
are lacking. But there are additional requirements for an effective
working alliance.

Some analysts work consistently and seriously and still have
difficulty in inducing their patients to develop a working alliance.
Their patients develop an attitude of submissiveness and compli-
ance instead of a feeling of alliance and participation. The atmos-
phere of the analysis is pervaded by a subtle but constant undercurrent of anxiety and awe in regard to the analyst and the
working relationship. The patient may be aware of this state of
affairs only fleetingly and sporadically because it expresses itself
in subtle nuances rather than in overt, ego-alien fantasies and
actions. This compliant attitude may also be ego syntonic to the
analytic work, who thus often fails to recognize it and bring it up for
analytic scrutiny.

I have often had the opportunity to see such instances clinically,
when I have been the second or third analyst of a given patient.

For example, a middle-aged male patient, a university professor, who
had over five years of previous analysis, did not dare to look at his watch
during the analytic hour. He told me early in the session that he would
have to leave five minutes earlier than usual. During the hour I saw him
trying to catch a glimpse at his watch out of the corner of his eye. He
even rubbed his forehead while surreptitiously stealing a glance at the
time. When I pointed out the obvious evasiveness, the patient was
startled. On the one hand, he was frightened by the confrontation. On
the other hand, he himself was dismayed at his own timidity. Then he
realized that this anxiety had remained undetected and unanalyzed
throughout his previous analysis.

There is no doubt that the above illustration indicates some
countertransference reactions in the analyst, but this may be com-
licated by the analyst’s too literal acceptance of two technical sug-
gestions made by Freud. I am referring here to the concept of the
analyst as a mirror and the so-called rule of abstinence, which will
be discussed more fully in Sections 3.921 and 3.922 (Freud, 1912b,
1915a, 1919a). These two rules of thumb by Freud have led many
analysts to adopt an austere, aloof, and even authoritarian attitude
toward their patients. I believe this to be a misunderstanding of
Freud’s intention, at best, an attitude incompatible with the forma-
tion of an effective working alliance.

The references to the mirror and the rule of abstinence were
suggested to help the analyst safeguard the transference from exces-
sive contamination, a point Greenacre (1954) has amplified. The
mirror refers to the notion that the analyst should be “opaque” to the patient, nonintrusive in terms of imposing his values and standards upon the patient. It does not mean that the analyst shall be inanimate, cold, and unresponsive. The rule of abstinence refers to the importance of not gratifying the patient’s infantile and neurotic wishes. It does not mean that all the patient’s wishes are to be frustrated. Sometimes one may have to gratify a neurotic wish temporarily. Even the frustration of the neurotic wishes has to be carried on in a way so as not to demean or traumatize the patient.

While it is true that Freud stressed the deprival aspects of the analytic situation in his writings, I believe he did so because at that time (1912-1919) the big danger was that analysts would permit themselves to overreact and to act out with their patients. Incidentally, if one reads Freud’s case histories, one does not get the impression that the analytic atmosphere of his analyses was one of coldness or austerity. In the original record of the case of the Rat Man, for example, appended to the published paper Freud (1909) has a note about the patient dated December 28, “He was hungry and was fed” (p. 303). Then on January 2: “Besides this he apparently only had trivialities to report and I was able to say a great deal to him to-day” (p. 308).

I think it is obvious that if we want the patient to develop a relatively realistic and reasonable working alliance, we have to work in a manner that is both realistic and reasonable, keeping in mind the fact that the procedures and processes of psychoanalysis are strange, unique, and even artificial. Neither smugness, ritualism, timidity, authoritarianism, aloofness, nor indulgence have a place in the analytic situation.

The patient will be influenced not only by the content of our work but by how we work, the attitude, the manner, the mood, the atmosphere in which we work. He will react to and identify particularly with those aspects which are not necessarily conscious to us. Freud (1913b) stated that in order to establish a rapport one needs time and an attitude of sympathetic understanding. Stern (1929) stressed the identificatory processes. The fact that the analyst continuously observes and interprets reality to the patient leads the patient partially to identify with this aspect of the analyst. The invitation to this identification comes from the analyst. From the beginning of the treatment, the analyst comments about the work they

will have to accomplish in common. The use of phrases such as “let us look at this,” or “we can see,” etc., promotes this tendency.

Glover (1955) emphasized the need of the analyst to be natural and straightforward, decried the pretense, for example, that all arrangements about time and fee are made exclusively for the patient’s benefit. Fenichel (1941) stressed that above all the analyst should be human and was appalled that so many of his patients were surprised at his naturalness and freedom. He believed it is the analytic atmosphere which is the most important factor in persuading the patient to accept on trial something formerly rejected. Loewald (1960) pointed out how the analyst’s concern for the patient’s potentials stimulates growth and new developments. Stone (1961) goes even further in emphasizing the legitimate gratifications and also the therapeutic attitude and intention of the psychoanalyst which are necessary for the patient.

All analysts recognize the need for deprivations in the procedure of psychoanalysis; they would agree in principle about the analyst’s need to be human. The problem arises, however, in determining what is meant by the term humanness in the analytic situation and how one reconciles this with the principle of deprivation. This subject will be discussed further in Sections 3.9, 3.10, 4.22, and 4.23. Here I shall sketch only what I consider to be the main points.

Essentially the humanness of the analyst is expressed in his compassion, his concern, and his therapeutic intent toward his patient. It matters to him how the patient fares, he is neither just an observer nor a research worker. He is a physician and a therapist, a master of the sick and suffering, and his aim is to help the patient get well. However, the “medicine” he prescribes is insight, carefully regulating the dosage, keeping his eye on the long-range goal, sacrificing temporary and quick results for longer and lasting changes. The humanness is also expressed in the attitude that the patient has rights and is to be respected as an individual. He is to be treated with ordinary courtesy; rudeness has no place in psychoanalytic therapy. If we want the patient to work with us as a co-worker on the regressive material that he produces, we must take care that the mature aspects of the patient are consistently nurtured in the course of our analytic work.

We must not forget that for the patient the procedures and processes of psychoanalysis are odd, irrational, and artificial. No matter
how much he may know about it intellectually, the actual experience is strange and new and will produce anxiety. He is motivated, however, by his neurotic troubles, and he considers us expert; so he submits and attempts to comply with the analyst's instructions and requests, at least consciously.

The patient coming for treatment is at least temporarily and partially overwhelmed by his neurotic pathology, and in this state of relative helplessness he is inclined to accept uncritically whatever promises to be of benefit to him. The helplessness has forced the patient to a rather indiscriminate reaching out for help. This is the “tilted” or “uneven” relationship Greenacre (1954) and Stone (1961) have described. In order to counteract the patient’s tendency to submit out of anxiety or masochism, it is necessary that the analyst concern himself with the patient’s need for self-esteem, self-respect, and dignity in the course of being psychoanalyzed. The compliant patient will often bury his feelings of humiliation and anger out of fear of losing love or incurring hostility. This the analyst may not always be able to prevent, but he should be alert to the possibility of it.

We cannot repeatedly demean a patient by imposing rules and regulations upon him without explanation and then expect him to work with us as an adult. If we treat him as a child by behaving with imperious and arbitrary attitudes and expectations, he will remain fixated to some form of infantile neurotic transference reaction. For a working alliance it is imperative that the analyst show consistent concern for the rights of the patient throughout the course of the analysis. This means that we indicate our concern not only for the neurotic misery the patient brought into the analysis and suffers outside of the analysis, but also for the pain that the analytic situation imposes on him. Aloofness, authoritarianism, coldness, extravagance, complacency, and rigidity do not belong in the analytic situation. Let me illustrate with some typical examples.

All new or strange procedures are explained to the patient. I always explain to the patient why we ask him to try to associate freely and why we prefer to use the couch. I wait for the patient’s questions or responses before I suggest that he try the couch. All my utterances to the patient are spoken with a tone of voice which indicates my awareness and my respect for the patient’s predicament. I do not talk down to the patient, but I make sure he understands my ideas and my intention. I use ordinary language, avoiding technical terms and intellectualized modes of speech. I treat him as an adult whose cooperation I need and who will soon be experiencing serious difficulties in working with the psychoanalytic material.

I explain to the patient that I will charge him for canceled hours which I cannot use for other patients. I tell him that in order not to interfere with his productions I shall be relatively silent. The first time he asks a question I explain why I do not answer it; I am silent the next time. If I do not understand the meaning of an hour, I tell him precisely that; I do not dismiss a patient without a word. If he has great feelings of embarrassment in talking about a particular subject for the first time, I acknowledge that it is painful for him but that it is necessary for the treatment that he try to be as open as possible. When he rails against me for not reacting to some of his feelings, I may tell him that I do my job better by showing him what I understand than by showing him my emotions.

I reply to his requests for reassurance by telling him that I know he feels miserable but that reassurance is only a temporary and deceptive aid. The next time he requests it I will most likely keep silent. I am ready to admit the possibility that I may be wrong in interpretation and will modify it if the clinical material indicates I should. I admit the possibility that he may be right if he thinks my words are tinged with annoyance or sharpness, but I insist that we work analytically on the incident and his reaction to it.

I do not break off an hour when he is in the middle of an anecdote or an intense emotional reaction; I allow the hour to go beyond the usual 50 minutes. If I am late, I try to make up the time in that hour or in the succeeding hours. I inform him of my vacation plans well in advance, and ask him to try to arrange his to coincide. (Similar problems will be discussed at greater length in Volume II.) If he tells a joke, I allow myself to show some pleasure or mirth, but I will nevertheless try to analyze why he told the story and I will feel free to analyze how he felt about my laughter. I will do the same if I react with sadness or annoyance to something he recounts. I do not answer the phone during the hour. If there is an exception, I apologize and ask for his reactions. From time to time I ask him how he thinks he is working with me and how he feels the work is progressing. I usually tell him my general impressions after he is finished, and then analyze his reactions to them.

I believe this is a fairly typical sample of how I safeguard the
patient's rights, a factor which is a basic element in the working alliance. I want to stress that the safeguarding of the patient's rights does not do away with or nullify the necessary deprivations. Although the working alliance is an essential part of the process of psychoanalysis, there must be a predominance of deprivations if we expect the patient to be able to regress to the infantile transference neurosis.

The analyst must be able to oscillate between imposing deprivations and showing concern. Sometimes he must compromise between these two positions by inflicting pain with an interpretation but indicating compassion by his tone of voice thus making the pain bearable. The oscillation between deprivational incognito and concern for the patient's rights is another of the several dialectical requirements made of the psychoanalyst.

Though I let my patient see that I am involved with him and concerned, my reactions have to be nonintrusive. I try not to take sides in any of his conflicts except that I am working against his resistances, against his damaging neurotic behavior, and against his self-destructiveness. Basically, however, I am the bearer of understanding and insight conveyed in an atmosphere of serious work, straightforwardness, compassion, and restraint (Greenson, 1958b).

This outline is my personal view of how I attempt to resolve the conflict between the maintenance of distance and the closeness necessary for the analytic work. I realize this is a highly personal matter and I do not offer this as an exact prescription for all analysts. However, I do maintain that despite the great variations in the analyst's personality, these two antithetical elements have to be adequately taken into account and handled if we expect to obtain good analytic results. The transference neurosis and the working alliance are parallel antithetical forces in transference phenomena. Each of these elements is of equal importance for the optimal analytic situation. This problem will be pursued in Chapter 4.

3.6 The Real Relationship between Patient and Analyst

The transference reactions and the working alliance are clinically the two most important varieties of object relations that take place in the analytic situation. More archaic types of human interaction also occur, antecedents of transference as well as transitions to transference phenomena. Such primitive responses are prone to arise in severely regressive states and require more "management" than insight therapy (Winnicott, 1955, 1956b; James, 1964). They will, therefore, not be discussed here. On the other hand, a "real relationship" also comes about in the course of analysis. Before returning to the subject of transference phenomena it is necessary to discuss and clarify the concept of the "real relationship" between patient and analyst. This is not as simple as it might appear at first glance, because the term "real" has essentially two different meanings and usages, each of which may have a dissimilar connotation in the patient and in the psychoanalyst. This topic has been touched upon by many authors, but their astute clinical findings suffer from the lack of a clear definition (Stone, 1954b, 1961; A. Freud, 1954a, 1965).

The term "real" in the phrase "real relationship" may mean realistic, reality oriented, or undistorted as contrasted to the term "transference" which connotes unrealistic, distorted, and inappropriate. The word real may also refer to genuine, authentic, and true in contrast to artificial, synthetic or assumed. At this point, I intend to use the term real to refer to the realistic and genuine relationship between analyst and patient. This distinction is of importance because it enables us to compare what is real in the patient's relationship to what is real in the analyst's. In both the patient and analyst, transference reactions are unrealistic and inappropriate, but they are genuine, truly felt. In both, the working alliance is realistic and appropriate, but it is an artifact of the treatment situation. In both, the real relationship is genuine and real. The patient utilizes the working alliance in order to comprehend the analyst's point of view, but his transference responses take precedence if they intrude. In the analyst, the working alliance has to take precedence over all his other overt responses to the patient. I shall try to clarify these points by clinical illustrations from patients and analysts.

A young man, in the terminal phase of his five-year analysis, hesitates after I have made an interpretation and then tells me that he has something to say which is very difficult for him. He was about to skip over it when he realized he had been doing just that for years. He takes a deep
breath and says: "You always talk a little bit too much. You tend to exaggerate. It would be much easier for me to get mad at you and say you're cockeyed or wrong or off the point or just not answer. It's terribly hard to say what I mean because I know it will hurt your feelings."

I believe the patient has correctly perceived some traits of mine and it was somewhat painful for me to have them pointed out. I told him he was right, but I wanted to know why it was harder for him to tell it to me simply and directly as he had just done than to become enraged. He answered that he knew from experience that I would not get upset by his temper, that was obviously his neurosis and I wouldn't be touched by it. Telling me about my talking too much and exaggerating was a personal criticism and that would be hurtful. He knew I took pride in my skill as a therapist. In the past he would have been worried that I might retaliate, but he now knew it was not likely. Besides, it wouldn't kill him.

I submit this clinical example as a realistic reaction to the analyst. The patient had made some accurate perceptions and had also been able to predict my reactions without distortions. In the past his perceptions had been correct, but his fantasies about my reactions were fantastic, i.e., transference distortions. He had felt I would retaliate and it might kill him. In the past he had developed a good working alliance in regard to temper outbursts at me, but the alliance did not maintain itself as far as realistic criticism of me. That was acquired only in the terminal phase. Thus we can see the value of distinguishing between realism in regard to perceptions and to reactions. Either or both may be realistic or inappropriate.

As I stated in the previous subsection, the patient's capacity to form a working alliance stems from his realistic motive of wanting to obtain help by cooperating with the analyst who is an expert in the field. In addition, the patient must have had, to some extent, the ability to form realistic and deinstinctualized object relations in his past life. The psychoanalyst's devotion and skill contribute realistically to the formation of the working alliance. The analyst's consistent attitude of acceptance and tolerance, his constant search for insight, his straightforwardness, therapeutic intent, and restraint serve as the nucleus upon which the patient builds a realistic object relationship. These trustworthy traits in the analyst induce the patient to form the various identifications which become the core of the working alliance. The analyst's objectionable traits usually lead to realistic reactions as well as transference. In either case they interfere with the formation of a working alliance. The clinical vignette I cited above demonstrates how my talkativeness and exaggerations led to his realistic appraisal that I took narcissistic pride in my interpretive skill. It also led to transference phenomena. After years of analysis these traits of mine no longer produced transference in the patient but were perceived as faults which the patient was able to accept realistically. He could form a working alliance with me despite my weakness.

In adults, all relationships to people consist of a varying mixture of transference and reality. There is no transference reaction, no matter how fantastic, without a germ of truth, and there is no realistic relationship without some trace of a transference fantasy. All patients in psychoanalytic treatment have realistic and objective perceptions and reactions to their analyst alongside of their transference reactions and their working alliance. These three modes of relating to the analyst are interrelated. They influence one another, blend into each other, and can cover one another. Despite the overlapping, it is clinically and practically valuable to separate these three reactions. The patient has realistic perceptions and reactions from the beginning of treatment, but usually finds it hard to express the negative ones. These quickly become the trigger for transference reactions, but they are not analyzable until some degree of a working alliance is established despite the patient's misgivings. This may not be possible if the objectionable traits of the analyst concern an area which is realistically of great importance to the patient.

A young analyst I was supervising told me that one of his patients, a young mother, had spent most of her hour describing her terrible anxieties about the sudden illness of her infant son in the preceding night. The baby had a high fever with convulsions and the mother was frantic until she was able to reach the pediatrician. As she recounted the events to my student she wept several times. After she finished her story the analyst remained silent. When she became silent, he told her, after a few minutes of more silence on both their parts, that she must be resisting. The patient said nothing. Shortly thereafter the hour ended. With this remark, the young analyst concluded his description of the hour in question.

I then asked him whether in retrospect he was satisfied with his work in the hour; was there anything further he might have done. He replied
that he thought her long silence might have meant she felt guilty for her repressed death wishes toward her son, but he thought he would wait before bringing that up. I told him that there might have been some deeply buried death wishes in the patient toward the boy, but I felt that her anxiety and sadness were far more obvious and merited some response from him in the course of the hour. The student primly reminded me that Freud had said we are not supposed to gratify our patient's instinctual and narcissistic wishes.

I restrained myself from further comment at this point and asked him what had happened in the next hour. The student replied that the patient had come to the hour, had said absolutely nothing, and had silently mopped the tears that were streaming down her face. From time to time he had asked her what was she thinking. The hour ended with no other words being exchanged. Again I asked the young analyst whether he had any second thoughts about what else he might have done. He shrugged. I asked him whether he had found out what had happened to the baby. He told me the patient had said nothing and he had not asked. The last hour he had reported was the patient's last hour of the week and he was not to see her again until after his supervisory session.

I shook my head in disbelief. I asked the student whether he himself had no concern or curiosity about the baby's welfare. I added that perhaps the young woman's silent tears indicated the baby's condition had worsened. Or perhaps it indicated that she felt the analyst's behavior as a cold and hostile emotional uninvolved with her. The student retorted that I might be right, but he felt I was overly emotional. I ended the session by telling the young man I felt his emotional unresponsiveness would prevent the formation of a working alliance. Unless he could feel some compassion for his patient and indicate this to her, within limits, he would not be able to analyze her. I predicted that even were she to return, I feared the treatment would not work out. When a patient is in such a state of misery, it is not only natural, but imperative to indicate some compassion.

The next week the young analyst reported his patient had come in on Monday morning and had announced she was quitting. When he asked why, she had replied that he was sicker than she was. She had paid her bill and left. After a while I asked him what had happened to her baby. The young man flushed and shamefacedly admitted he had "forgotten" to ask her. I utilized his forgetting and his flushing as an opportunity to demonstrate to him that he must have some problems in this area. I then suggested that he might benefit from some further analysis. The young man agreed.

These clinical data demonstrate the fact that an objectionable trait in the analyst can produce realistic reactions in the patient which preclude successful psychoanalytic treatment. (See Volume II for a fuller discussion of this and related problems.) In my opinion, the behavior of the young woman patient was realistic and appropriate. This is not to deny that the analyst's behavior also stirred up transference reactions, but they are of secondary importance in this situation. I submit that the analyst's behavior was detrimental to the formation of a working alliance because the patient could sense that this behavior indicated a hostile withdrawal or a fear of a countertransference involvement. I contend that it should be possible for the analyst to indicate some sympathy for the patient's misery without it becoming an overly pleasing transference gratification. For example, he might have simply asked the patient: How's the baby? What did the doctor say? Only later would it be feasible to analyze the patient's reactions, and then in dosages that would be compatible with the patient's capacity to bear additional pain. Many analysts have stressed the dangers of excessive or superfluous frustrations and deprivations (Glover, 1955; G. Bibring, 1935; Menninger, 1958).

Another illustration of this problem is to be seen in how the analyst handles his minor errors in technique which are detected by the patient. I have known analysts who believe it is wrong to admit to a patient that they have made a mistake. They hide behind the impervious cloak of the "analytic silence." I have known others who not only acknowledge their blunders but burden the patient by confessing the unconscious motives for their error. It seems to me that it is authoritarian, unfair, and demeaning to hide the making of an error from a patient who is aware of it. Such behavior by the analyst will provoke justifiable mistrust which can become unanalyzable and can lead to intractable submissiveness or the breaking off of treatment. The outpouring of the analyst's unconscious motivations for an error is a caricature of honesty. The analyst is taking advantage of the patient's predicament for his own personal instinctual gratification or his need for punishment. How different these reactions are from the straightforward and frank admission of error followed by asking the patient to describe his feelings and associations to your mistake as well as to your admission of the error. The analytic situation is an unequal one in the sense that
one party is the sick and helpless one and the other is the therapist and expert. But it should be equal in the sense that both the patient and analyst have human rights that should be safeguarded.

If a patient were to ask me why I made an error, I would first ask for his fantasies and then tell him that my reasons for the error do not belong in his analysis but in mine. I would answer in the same way all questions about my intimate life. I ask for associations and then I give my reasons for not answering.

For the analyst to work effectively and happily in the field of psychoanalysis it is important that his analytic and physician attitudes be derived essentially from his real relationship to the patient. As I stated in Sections 1.33 and 3.5 and will discuss further in Chapter 4, one cannot work analytically unless one can oscillate between the relatively detached analytic position and the more involved physician one. The analyst must be a person who can empathize and feel compassion sincerely and yet use restraint. It is necessary at times to inflict pain, to allow the patient to endure suffering. Yet psychoanalytic treatment cannot be accomplished in an atmosphere of unabated grimness, icy detachment, or prolonged cheeriness. The analyst must be able to blend and oscillate between his bipolar functions of analyzer of data and treater of the sick and suffering.

The analyst's genuine feelings for the patient must be subversive to his working alliance. It is his task to restrain those responses that will be detrimental to the therapeutic process. This does not mean that he is consciously to assume a role that is foreign to him. It means that if he keeps in focus the picture of the patient as the producer of analytic material as well as a suffering neurotic, the analyst will be able to reciprocate by reaching the patient as the analyzer or as the therapist or as a mixture of both. Countertransference reactions have to be detected and restrained. Realistic and strong reactions also have to be restrained, but their nature may indicate the possibility of having selected a patient one cannot work with. Artificial reactions should be necessary only as temporary measures until one can mobilize one's genuine analytic and physician attitudes. If this is accomplished, the patient will have the opportunity to experience and gain insight from a unique kind of object relationship in which many varieties of love and hate become constructive instrumentalities and not merely opportunities for pleasure and pain (Winnicott, 1949; Stone, 1961; Greenson, 1966).

Although the patient and the analyst develop transference reactions, a working alliance, and a real relationship to each other, the proportions and sequence differ. In the patient, the transference reactions predominate in the long middle phase of analysis. The real relationship is in the foreground early and gains prominence again in the terminal phase (A. Freud, 1954a, 1965). The working alliance develops toward the end of the introductory phase but recedes periodically until the patient approaches the terminal phase.

In the psychoanalyst, the working alliance should predominate from the beginning to the end. The countertransference should always be in the background. The real relationship should be permitted more leeway only in the terminal phase. There are times, however, when special considerations require that the analyst permit his real feelings to be expressed earlier. The situation of the young analyst quoted above is one where I would have openly indicated my concern about the patient's baby. I do not see how anyone could allow himself to be deeply analyzed by an analyst who would maintain an icy detachment in such a situation. Such humane reactions in the psychoanalyst are a prerequisite for the formation of a working alliance in the patient. Some patients may want a computerlike analyst, but they are really trying to evade a genuine psychoanalytic experience.

There are patients who try to isolate the psychoanalyst from real life and imagine he only exists in his office and his emotional responses are always well tempered and controlled. In such cases I have found it useful to show the patient otherwise. Saying it in words is often not sufficient. I have permitted the patient at times to feel my disappointment in his lack of progress or to see that world events do concern me. I try to restrict the intensity of my reactions, but I do not open the door every day with the same expression on my face or close the session in the same way. I don't plan these variations. I allow myself to be flexible in such matters. I am of the opinion that it is of importance to demonstrate in certain actions and behavior that the analyst is truly a human being. This includes permitting some of his human frailties to be visible at times. Stone's (1961) book contains many interesting comments on this and related matters.

There is still one other area which requires an unusual amount of outspokenness on the analyst's part. I am referring to the situation which arises when the analyst detects that he and his patient are
in basic disagreement on a political or social issue which is important to each of them. For example, I know from experience that I cannot work effectively with some patients who are very reactionary in their political or social point of view. In such instances, I have found it advisable to tell such a patient of my feelings quite openly and as early in the treatment as possible. I suggest that he should feel free to seek another analyst if he finds my point of view too disturbing. If my own feelings on the matter are very intense and the patient’s other qualities do not suffice to make him likable, I tell the patient that I am not able to work with him and insist that he find another analyst. I also admit that it is a shortcoming in me, so as not to traumatize the patient.

There is a great deal more to be said about the real relationship that goes on between the patient and the analyst. Chapter 4 will touch on additional problems and there will be further illustrations throughout the book.

3.7 Clinical Classification of Transference Reactions

There is no way of classifying transference phenomena that would do justice to all the different varieties. No matter how one tries to separate the many clinical forms of transference, one ends up either with an unsystematic classification with a great many important clinical types omitted, or else one may cover the clinically significant varieties but there is a great deal of overlapping. The lesser evil is to sacrifice the systematic in favor of completeness. I shall attempt to describe the most important forms of transference reactions and classify or label them in accordance with what seems to be the most useful approach clinically.

It should be borne in mind that one method of classification does not rule out another. For example, one might describe a situation as representing a positive transference, and with equal validity label the same phenomenon as a mother transference, etc. Another point: these transference reactions will not be differentiated from the standpoint of whether they are sporadic, transient transference reactions or whether they are manifestations of the transference neurosis. Such a differentiation has already been described in the theoretical section and all categories of transference reactions should be under-

stood as existing in both forms. Finally, one should realize that a great number of transference feelings occur simultaneously, just as they do in object relations in general. Theoretically one could describe different layerings or hierarchies of emotions and defense coexisting in any given relationship between people. In the ensuing description of types of transference reactions, I shall limit myself to a discussion of what is predominant, what is clinically significant for a given period of time in an analysis.

3.71 The Positive and Negative Transference

Although Freud (1912a) recognized very early that all transference phenomena are ambivalent in nature, the label of positive and negative transference remained his favorite means of designation. Despite all the ambiguities and shortcomings this mode of classification entails, it has remained the most frequently used designation among practicing psychoanalysts.

3.711 The Positive Transference

The term positive transference is shorthand for describing transference reactions which are composed predominantly of love in any of its forms or any of its forerunners and derivatives. We consider a positive transference to exist when the patient feels toward his analyst any of the following: Love, fondness, trust, amorousness, liking, concern, devotion, admiration, infatuation, passion, hunger, yearning, tenderness, or respect. The nonsexual, nonromantic, mild forms of love make for the working alliance. I am referring here to feelings akin to liking, trust, and respect in particular.

Another important form of positive transference takes place when the patient falls in love with the analyst. This is a regular occurrence in working with patients of the opposite sex, but I have never seen it happen with patients of the same sex with the exception of patients who were overtly homosexual. This falling in love in analysis bears a remarkable resemblance to falling in love in real life. It happens so regularly in analysis because our patients have had painful experiences in this regard in their past life. It is repressed and emerges as transference love during the analysis. It is perhaps, in degree, more irrational and infantile in its manifestations