

## THE CONCEPT OF TRANSFERENCE

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### I. A LOGICAL ANALYSIS

Transference is one of the most significant concepts in psycho-analysis. It is therefore especially important that its meaning be clear, and its use precise. In this essay, my aim is to present a brief analysis of the principal meanings and uses of this concept. This contribution is part of a larger effort whose aim is to identify those activities that are specifically psycho-analytic, and thus distinguish psycho-analysis from other forms of psychotherapy (Szasz, 1957b, 1961).

Potentially, the subject of transference is as large as psycho-analysis itself. To make our task more manageable, I shall discuss transference under five separate headings as follows: (i) Transference and reality; (ii) transference in the analytic situation and outside it; (iii) transference and transference neurosis; (iv) transference as the analyst's judgement and as the patient's experience; (v) transference and learning.

#### *Transference and Reality*

Logically, transference is similar to such concepts as delusion, illusion, and phantasy: each is defined by contrasting it with 'reality'. Freud's (1914) classic paradigm of transference, it will be recalled, was the phenomenon of transference love—that is, the female patient's falling in love with the male therapist. Just what is this phenomenon? According to the patient, it is being in love with the analyst; according to Freud (1916–17), it is an illusion:

The new fact which we are thus unwillingly compelled to recognize we call *transference*. By this we mean a transference of feelings on to the person of the physician, because we do not believe that the situation in the treatment can account for the origin of such feelings (p. 384).

We have encountered this distinction else where: between imaginary and real pain, and between psychogenic and physical pain (Szasz, 1957a). In these cases there is a conflict of opinion between patient and physician, which is not resolved by examination of the merits of the two views, but rather by the physician's autocratic judgement: his view is correct, and is considered 'reality'; the patient's view is incorrect, and is considered 'transference'.

This idea is expressed by Nunberg (1951), when, in reply to the question, 'What is transference?' he asserts:

Transference is a projection. The term 'projection' means that the patient's inner and unconscious relations with his first libidinal objects are externalized. In the transference situation the analyst tries to unmask the projections or externalizations whenever they appear during the treatment (p. 1).

This view is uncritically repeated in every discussion of the subject. The most trivial examples of 'misidentification' are brought forward, again and again, as if they revealed something new. An excerpt from a recent paper by Spitz (1956) is illustrative:

Take the case of that female patient of mine who, after nearly a year's analysis with me, in connection with a dream, expressed the opinion that I was the owner of a head of rich, somewhat curly brown hair. Confronting her with the sorry *reality* made it easy to lead her to the insight that the proprietor of that tonsorial adornment was her father, and thus to achieve one little step in the clarification of her insight both in regard to the emotions she felt towards me and to those which she had

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originally felt towards her father (italics added; p. 384).

On the face of it, there is nothing wrong with this account. But this is so only because the analyst's perception of the 'facts' is so obviously more accurate than the patient's. This obscures the complexities and pitfalls inherent in the tactic of classifying the analyst's view as reality, and the patient's as unreality (Fenichel, 1941). Here is a more challenging situation: the analyst believes that he is kindly and sympathetic, but the patient thinks that he is arrogant and self-seeking. Who shall say now which is 'reality' and which 'transference'? The point is that the analyst does not find the patient's reactions pre-labelled, as it were; on the contrary, he must do the labelling himself. Hence, Nunberg's (1951) distinction between analytic and non-analytic work does not help much:

The psycho-analyst and the non-psycho-analyst differ in their treatment and understanding of this phenomenon, in that the former treats the transference symptoms as *illusions* while the latter takes them at their face value, i.e., as *realities* (italics added; p. 4).

There is no denying, however, that the distinction between transference and reality is useful for psycho-analytic work. But so is the distinction between real pain and imaginary pain for the work of the internist or the surgeon. Practical utility and epistemological clarity are two different matters. Workmanlike use of the concept of transference should not blind us to the fact that the term is not a neutral description but rather the analyst's judgement of the patient's behaviour.

*Transference in the Analytical Situation and outside it*

There has been much discussion in the psycho-analytic literature about the precise relation between transference and the analytic situation. Freud emphasized from the outset that man's tendency to form transferences is universal. Only the use we make of it is specific for analysis. Glover (1939) states this view succinctly:

As the transference develops, feelings originally associated with parental figures are displaced to the analyst, and the analytic situation is reacted to as an infantile one. The process of transference is of course not limited to the psycho-analytic situation. It plays a

part and a useful part in all human relations whether with concrete objects (both animate and inanimate) or abstract 'objects' (ideas). Hence, it is responsible for the most astonishing variations in the range of interest manifested by different individuals or by the same individual at different times (p. 75).

Despite the clarity and simplicity of this view, many analysts have tried to redefine transference as a uniquely analytic phenomenon. Two classes of transferences are thus created: one analytic, the other non-analytic.

Macalpine (1950) defines analytic transference as 'a person's gradual adaptation by regression to the infantile analytic setting'. Waelder (1956) also emphasizes the specificity of the analytic setting on the development of (analytic) transference:

Transference may be said to be an attempt of the patient to revive and re-enact, *in the analytic situation and in relation to the analyst*, situations and phantasies of his childhood. Hence transference is a regressive process. Transference develops *in consequence* of the conditions of the analytic experiment, viz., of the analytic situation and the analytic technique (italics added; p. 367).

Menninger (1958) limits transference to the analytic situation:

I define transference . . . as the unrealistic roles or identities unconsciously ascribed to a therapist by a patient in the regression of the psycho-analytic treatment and the patient's reactions to this representation derived from earlier experience (p. 81).

This interpretation, and others like it, are perhaps efforts at being 'operational'; but, if so, they overshoot the mark. To define transference in terms of the analytic situation is like defining microbes as little objects appearing under a microscope. The classic psycho-analytic position, exemplified by the writings of Freud, Fenichel, and Glover, though less pretentious, is more accurate. As the occurrence of bacteria is not limited to laboratories, so the occurrence of transference is not confined to the analytic situation; however, each is observed and studied best, not in its natural habitat, but under special circumstances.

This view does not imply that the analytic situation exerts no influence on the development of the transference. Of course it does. But so do

all other situations in which transferences play a part, such as the doctor-patient relationship, marriage, the work situation, and so forth. The analytic relationship differs from all others in two ways; first, it facilitates the development of relatively intense transference reactions in the patient; second, it is a situation in which transferences are supposed to be studied and learned from, not acted upon.

#### *Transference and Transference Neurosis*

The difference between transference and transference neurosis is one of degree. Analysts generally speak of transferences when referring to isolated ideas, affects, or patterns of conduct which the patient manifests towards the analyst and which are repetitions of similar experiences from the patient's childhood; and they speak of transference neurosis when referring to a more extensive and coherent set of transferences (Hoffer, 1956; Zetzel, 1956).

The imprecision in this usage stems from a lack of standards as regards the quantity of transferences required before one can legitimately speak of a transference neurosis. In other words, we deal here with a quantitative distinction, but possess neither measuring instruments nor standards of measurement for making quantitative estimates. Thus, the distinction between transference and transference neurosis remains arbitrary and impressionistic.

#### *Transference as the Analyst's Judgement and as the Patient's Experience*

Traditionally, transference has been treated as a concept formed by the analyst about some aspect of the patient's conduct. For example, the female patient's declarations of love for the male analyst may be interpreted as unrealistic and due to transference. In this usage, the term 'transference' refers to the analyst's judgement.

In addition, the word 'transference' is often used, and indeed should be used, to describe a certain kind of experience which the analytic patient has, and which people in certain other situations may also have. The analytic patient may feel—with or without being told so by the analyst—that his love of the therapist is exaggerated; or that this hatred of him is too intense; or that his anxiety about the therapist's health is unwarranted. In brief, the patient may be aware that the therapist is 'too important' to him. This phenomenon is what I mean by transference as experience and as self-judgement.

Although the experience of transference can

never be completely absent from analysis—if it were, how could it be analysed?—it has been curiously neglected in the theory of psychoanalytic treatment.

Fenichel (1941) mentions it, but fails to elaborate on it:

Not everything is transference that is experienced by a patient in the form of affects and impulses during the course of an analytic treatment. If the analysis appears to make no progress, the patient has, *in my opinion*, the right to be angry, and his anger need not be a transference from childhood—or rather, we will not succeed *in demonstrating* the transference component in it (*italics added*; p. 95).

The fact is that the analyst's judgement of whether or not the patient's behaviour is transference may be validated by the patient; and conversely, the patient's experience and self-judgement may be validated by the analyst. Let us review briefly what such a process of cross-validation might entail.

To repeat, our premise is that the term 'transference' expresses a judgement—formed either by the therapist or by the patient—about some aspects of the patient's behaviour. Thus, a patient's action or feeling may be judged as: (1) transference—if it is considered an expression of interest 'basically' directed towards childhood objects, deflected to the analyst or to other figures in the patient's current life; (2) reality-adapted behaviour—if it is considered a valid feeling about, or reaction to, the person towards whom it is directed.

Since the analytic situation involves two persons, and since each has a choice of two judgements about any particular occurrence, there will be four possible outcomes:

(a) Analyst and patient agree that the behaviour in question is transference. This allows the analyst to interpret the transference, and the patient to experience it and learn from it.

(b) The analyst considers the patient's behaviour transference, but the patient does not. Instances of so-called 'transference love' or 'erotized transference' are illustrative. Regardless of who is correct, analyst or patient, such disagreement precludes analysis of the transference. The commonest reasons for this impasse are: (i) that the analyst is mistaken in his judgement; (ii) that the patient, though exhibiting transference manifestations, is unaware of doing so.

(c) Analyst and patient agree that the patient's

behaviour is reality-oriented. This calls for no work that is specifically analytic. Needless to say, in this case as in all the others, both analyst and patient may be mistaken.

(d) The analyst may consider the patient's behaviour realistic, but the patient may know it is transference. This possibility, at least in this form, is rarely discussed in psycho-analysis. Consistent with its neglect, there are no formal examples—like 'transference love'—that could be cited to illustrate it. In general, the most common result is that the analyst 'acts out'. For example, he may engage in sexual acts with the patient, when in fact the patient was only testing him; or he may give up analysing—believing that the patient is too depressed, suicidal, or otherwise unanalysable—when, again, the patient was merely 'acting' difficult to test the analyst's perseverance in his efforts to analyse. This sort of occurrence cannot, of course, provide an opportunity for the analyst to make transference interpretations; it can, however, give the patient an opportunity to perform a piece of self-analysis, either during the analysis or, more often, afterwards.

The analysis outlined above helps to clarify the use of the word 'transference' in the treatment of so-called borderline or schizophrenic patients (Winnicott, 1956). In these cases, when analysts speak of transferences, they refer to constructions of their own which the patient does not share. On the contrary, to the patients, these experiences are invariably 'real'. The use of the term 'transference' in this context might be valid; but it is not valid to speak of 'analysing' such patients, because their so-called transferences can never be analysed (Szasz, 1957c).

#### *Transference and Learning*

The patient's task in analysis is to discriminate between two aspects of his relationships: those based on transferences, and those based on reality. In other words, the patient must learn to distinguish his reactions to the analyst as a symbol and as a real person. The analytic relationship, if properly conducted, affords a

particularly suitable—though not unique—situation for making this type of discrimination.

Phrased in terms of object relationships, we could say that the patient's task is to discriminate between the analyst as internal object and as external object. Internal objects can be dealt with only by intrapsychic defences; they can be tamed, but cannot be changed. To alter them, it is necessary to recognize the psychological existence of internal objects by their effects on actual, external objects. This can be accomplished only in the context of an actual human relationship. The analytic relationship—which allows the patient to invest the analyst with human qualities borrowed from others, but which the analyst neither accepts nor rejects, but only interprets—is thus designed to help the patient learn about his internal objects. This sort of psychotherapeutic learning must be distinguished from other learning experiences, such as suggestion or imitation. Only a theory based on the educational model can accommodate the role of transference in psycho-analytic treatment.

#### SUMMARY OF PART I

1. The terms 'transference' and 'reality' are evaluative judgements, not simple descriptions of patient behaviour.

2. Transferences occur in all human relationships. The analytic relationship differs from most others in (a) the ways in which it facilitates the development of transferences; and (b) the ways in which it deals with transferences.

3. The distinction between transference and transference neurosis is quantitative and arbitrary; there is no standard of the amount of transference required for a transference neurosis.

4. Human behaviour, especially in analysis, may be at once experienced and observed. Not only may the analyst consider the patient's behaviour either 'transference' or 'reality', but so may the patient himself. The analyst can interpret only what he recognizes as transference; the patient can learn only from what he experiences as and himself considers transference.

## II. THE CONCEPT OF TRANSFERENCE AS A DEFENCE FOR THE ANALYST

In the first part of my paper I have reviewed the role of the concept of transference in the theory of psycho-analytic treatment. The aim of this second part is to demonstrate an unrecognized function of this concept: protecting the analyst from the impact of the patient's

personality. In psycho-analytic *theory*, the concept of transference serves as an explanatory hypothesis; whereas in the psycho-analytic *situation*, it serves as a defence for the analyst. (Its function for the patient will not be considered in this essay.)

*Types of Data in the  
Psycho-analytic Situation*

It is often assumed, and sometimes stated, that the analyst's data are composed of the patient's verbal utterances and non-verbal behaviour. Not only is this view seriously over-simplified, but completely false.

To begin with, we must distinguish between two different types of data available to the analyst—observation and experience. This is a familiar distinction; we are accustomed to speaking of the analysand's ego as being split into two parts, one experiencing, the other observing. This double ego-orientation, however, is not specific for analysis; most adults with adequately developed personalities, unless intensely absorbed in an experience, are capable of assuming both a concrete and an abstract attitude towards their actions and experiences (Goldstein, 1951).

Even a solitary person, if self-reflective, has two classes of data about himself. First, his self-experience; for example: 'I feel anxious'. Second, his judgement of the experience: 'It is silly, there is nothing to be afraid of.'

In the analytic situation, the data—that is, who experiences, observes, and communicates what and to whom—are far more complex. The information available to the participants in a two-person situation may be arranged in a hierarchical fashion, as follows:

(i) Each participant's own experience. (This is sometimes called 'subjective experience', but the adjective is superfluous and misleading.)

(ii) Each participant's judgement of his experience; the observing ego takes its own experience as its object of study. For example: transference as an experience of the patient's, countertransference as an experience of the analyst's.

(iii) Each participant's judgement of his partner's experience. For example: the analyst's judgement that the patient's bodily experiences are hypochondriacal; or, the patient's judgement that the analyst's friendliness is a façade.

(iv) Each participant's reaction to the partner's judgement of his experience. For example: the patient's reaction to the analyst's view that the patient is suffering from hypochondriasis; or, the analyst's reaction to the patient's view that the analyst is the most understanding person in the world.

(v-n) Logically, one reaction may be superimposed on another, *ad infinitum*; in actuality,

we can experience and comprehend only a few back and forth movements in this sort of communicational situation.

Let us apply these considerations to the problem of transference in the practice of psychoanalysis. To start with the simplest example: the analyst decides that a certain behaviour by the patient is transference, and communicates this idea to him. The patient denies this, and claims that it is reality.

It is usually assumed that these two assertions contradict each other. Is this necessarily so? Only if each refers to the same object, occurrence, or relationship. This is the case when one person says, 'Boston is east of New York', and another says, 'No, Boston is west of New York'. In many other situations, however, where apparently contradictory statements are uttered, attention to detail reveals that the two speakers are not talking about the 'same thing'. For example, a hypochondriacal patient may say to his physician: 'I feel pains in my stomach'; the physician, having convinced himself that the patient is physically healthy, may counter with: 'No, you don't have any pains, you are just nervous'. These two people are talking about different things: the patient about his experiences, the physician about his medical judgement (Szasz, 1957a). Both statements may be true; both may also be false.

The point is that when the analyst communicates to the patient the idea that the latter has transferences, he is expressing a judgement; whereas when the patient denies this, he may be communicating one of two things: his experience, or his judgement of his experience. In the first instance, there is no contradiction between analyst and patient: they are not talking about the same thing. Only when the patient's denial refers to his own judgement of his allegedly transferential behaviour is there a contradiction between the assertions of the analyst and of the patient. But even then the two participants do not address themselves to and judge the 'same object': the analyst addresses himself to the patient's behaviour; whereas the patient addresses himself to (a) his own behaviour as experience, plus (b) his judgement of his own behaviour, plus (c) the analyst's interpretation of his behaviour as transference.

I think we are justified in concluding that the analytic situation is not a setting in which clearly formulated logical propositions are asserted, examined, and accepted as true or rejected as false. What may appear in the

analytic situation as logical contradiction may be resolved, by psychological and semantic analysis, into two or more non-contradictory propositions.

*Transference as Logical Construct  
and as Psychological Defence*

We are now ready for the thesis of this essay—namely, that although in psycho-analytic theory the main function of the concept of transference is to serve as a logical construct, in the psycho-analytic situation it is to serve as a psychological defence for the analyst. In other words, in the context of psycho-analytical treatment, transference has a specific *situational significance*, which is lost in the setting of a psycho-analytic journal or book. What is this specific role which the concept of transference plays in the analytic situation?

To answer this question, we must try to recreate the psychological mood of the analytic situation. It is, of course, a very intimate situation: two people meet alone, frequently, and over a long period of time; the patient discloses his most closely guarded secrets; and the analyst pledges to keep his patient's confidences. All this tends to make the relationship a close one. In technical terms, we say that the analyst becomes a libidinal object for the patient. But what is there to prevent the patient from becoming a libidinal object for the analyst? Not much. Patients do indeed become libidinal objects for analysts, up to a point. But if this were all that there was to analysis, the analytic relationship would not differ from that between trusted physician and patient, or legal adviser and client. What distinguishes the analytic relationship from all others is that patient as well as analyst are expected to make their relationship to each other an object of scientific scrutiny. How can they do this?

It is not as difficult as it is often made to seem. To begin with, the expectation of scrutiny of self and other is made explicit: the patient learns that it is not enough to immerse himself in the therapeutic relationship, and wait to be cured—as he might wait to have a tooth extracted. On the contrary, he is told (if he does not already know) that he must use to their utmost his powers of observation, analysis, and judgement. The analyst must do the same. We know, however, that human beings are not automatic thinking machines. Our powers of observation and analysis depend not only on our mental abilities, but also on our emotional state: power-

ful emotions are incentives to action, not to contemplation. When in severe pain, we want relief, not understanding of the causes of pain; when lonely, we want human warmth, not explanations of the causes of our loneliness; when sexually desirous, we want gratification, not rejection of our advances with the explanation that they are 'transferences'.

The analytic situation is thus a paradox: it stimulates, and at the same time frustrates, the development of an intense human relationship. In a sense, analyst and patient tease each other. The analytic situation requires that each participant have strong experiences, and yet not act on them. Perhaps this is one of the reasons that not only many patients, but also many therapists, cannot stand it: they prefer to seek encounters that are less taxing emotionally, or that offer better opportunities for discharging affective tensions in action.

Given this experientially intense character of the analytic encounter, the question is, how can the analyst deal with it? What enables him to withstand, without acting out, the impact of the patient's powerful feelings for and against him, as well as his own feelings for and against the patient? The answer lies in three sets of factors:

1. The personality of the therapist: he must be ascetic to an extent, for he must be able to bind powerful affects, and refrain from acting where others might not be able to do so.
2. The formal setting of analysis: regularly scheduled appointments in a professional office, payment of fees for services rendered, the use of the couch, and so forth.
3. The concept of transference: the patient's powerful affects are directed not towards the analyst, but towards internal objects.

In this essay, I shall discuss only the last element. The concept of transference serves two separate analytic purposes: it is a crucial part of the patient's therapeutic experience, and a successful defensive measure to protect the analyst from too intense affective and real-life involvement with the patient. For the idea of transference implies denial and repudiation of the patient's *experience qua experience*; in its place is substituted the more manageable construct of a *transference experience* (Freud, 1914).

Thus, if the patient loves or hates the analyst, and if the analyst can view these attitudes as transferences, then, in effect, the analyst has convinced himself that the patient does not have these feelings and dispositions towards *him*.

The patient does not really love or hate the analyst, but some one else. What could be more reassuring? This is why so-called transference interpretations are so easily and so often misused; they provide a ready-made opportunity for putting the patient at arm's length.

Recognizing the phenomenon of transference, and creating the concept, was perhaps Freud's greatest single contribution. Without it, the psychotherapist could never have brought scientific detachment to a situation in which he participates as a person. There is historical evidence, which we shall review presently, to support the thesis that this could not be done before the recognition of transference; nor, apparently, can it be done today by those who make no use of this concept.

Not only may the analyst use the concept of transference as a defence against the impact of the patient's relationship with him (as person, not as symbol), but he may also use the concept of a reality relationship with the patient as a defence against the threat of the patient's transferences! We see this most often in analysts who treat borderline or schizophrenic patients. Indeed, the defensive use of the reality relationship has become one of the hallmarks of the Sullivanian modification of psycho-analysis. There are good reasons for this.

In the analysis of the normal-neurotic individual, one of the great dangers to the therapist is a *temptation*: the patient may appear too inviting as a person, as a sexual object, and so forth. To resist this, convincing himself that the patient is not interested in him as a real person is eminently useful. In the therapy of the schizophrenic, however, one of the great dangers is *compassion*: the patient has suffered so horribly as a child that to recollect it might be too painful, not only for him but for the therapist as well. To counteract this danger, then, the therapist must convince himself that what the patient needs is not a review of his past misfortunes, but a good relationship with the therapist. This might be true in some instances; in others, it might be an example of the defensive use of the concept of a reality relationship (Szasz, 1957c).

To recapitulate: I have tried to show that in the analytic situation the concepts of 'transference' and 'reality'—as judgements of the patient's behaviour—may both be used defensively, one against the other. This phenomenon is similar to the defensive function of affects, for example of pain and anxiety: each may be used

by the ego to protect itself from being overwhelmed by the other (Szasz, 1957a).

#### *The Reactions of Breuer and Freud to Eroticism in the Therapeutic Situation*

The cathartic method, which was the precursor of analytic technique, brought out into the open the hysterical patient's ideas and feelings about herself and her 'illness'. This, in turn, led to the recognition of the patient's sexual feelings and needs.

So long as hysterical symptoms were undisturbed—or were only chased after with hypnosis—patients were left free to express their personal problems through bodily signs and other indirect communications. Indeed, the medical, including psychiatric, attitudes toward such patients invited them to continue this type of communicative behaviour. Similarly, pre-Breuerian physicians were expected to respond to hysterical symptoms only in terms of their overt, common sense meanings: if a woman was neurasthenic, it was the physician's job to make her more energetic; if a man was impotent, he was to be made potent. Period. No other questions were to be asked. This state of affairs presented few problems to physicians (except that their therapeutic efficiency was low, but no lower than in organic diseases!), and led, of course, to no great changes in the patients. It was this *psychotherapeutically homeostatic situation between patients and doctors* which Breuer disturbed. He initiated the translation of the patient's hysterical body-language into ordinary speech (Szasz, 1961).

But Breuer soon discovered that this was not at all like deciphering Egyptian hieroglyphics. The marble tablet remained unaffected by the translator's efforts, but the hysterical patient did not. Thus, as Breuer proceeded in translating Anna O.'s symptoms into the language of personal problems, he found it necessary to carry on a relationship with her without the protection previously afforded by the hysterical symptoms. For we ought not forget that the defences inherent in the hysterical symptoms (and in others as well) served not only the needs of the patient, but also of the physician. So long as the patient was unaware of disturbing affects and needs—especially aggressive and erotic—she could not openly disturb her physician with them. But once these inhibitions were lifted—or, as we might say, once the translation was effected—it became necessary for the therapist to deal with the new situation: a sexually

aroused attractive *woman*, rather than a pitifully disabled *patient*.

Breuer, as we know, could not cope with this new situation, and fled from it. Freud, however, could, and thereby established his just claim to scientific greatness.

My foregoing comments are based on the many historical sources of the origins of psychoanalysis made available to us, especially in the past decade. Instead of citing specific facts, most of which are familiar to analysts, I shall quote some passages from Jones's (1953) biography of Freud, which illustrate how the need for transference as a defence for the therapist arose, and the function it served for Breuer and Freud.

'Freud has related to me a fuller account than he described in his writing of the peculiar circumstances surrounding the end of this novel treatment. It would seem that Breuer had developed what we should nowadays call a strong counter-transference to his interesting patient. At all events he was so engrossed that his wife became bored at listening to no other topic, and before long jealous. She did not display this openly, but became unhappy and morose. It was a long time before Breuer, with his thoughts elsewhere, divined the meaning of her state of mind. It provoked a violent reaction in him, perhaps compounded of love and guilt, and he decided to bring the treatment to an end. He announced this to Anna O., who was by now much better, and bade her good-bye. But that evening he was fetched back to find her in a greatly excited state, apparently as ill as ever. The patient, who according to him had appeared to be an asexual being and had never made any allusion to such a forbidden topic throughout the treatment, was now in the throes of an hysterical childbirth (pseudocyesis), the logical termination of a phantom pregnancy that had been invisibly developing in response to Breuer's ministrations. Though profoundly shocked, he managed to calm her down by hypnotizing her, and then fled the house in a cold sweat. The next day he and his wife left for Venice to spend a second honeymoon, which resulted in the conception of a daughter; the girl born in these circumstances was nearly sixty years later to commit suicide in New York.

'Confirmation of this account may be found in a contemporary letter Freud wrote to Martha, which contains substantially the same story. She at once identified herself with Breuer's wife, and hoped the same thing would not ever happen to her, whereupon Freud reproved her vanity in supposing that other women would fall in love with *her* husband: "for that to happen one has to be a Breuer."

'The poor patient did not fare so well as one might gather from Breuer's published account. Relapses took place, and she was removed to an

institution in Gross Enzerdorf. A year after discontinuing the treatment, Breuer confided to Freud that she was quite unhinged and that he wished she would die and so be released from her suffering. She improved, however, and gave up morphia. A few years later Martha relates how "Anna O.," who happened to be an old friend of hers and later a connection by marriage, visited her more than once. She was then pretty well in the daytime, but still suffered from her hallucinatory states as evening grew on.

'Frl. Bertha (Anna O.) was not only highly intelligent, but extremely attractive in physique and personality; when removed to the sanatorium she inflamed the heart of the psychiatrist in charge. Her mother, who was somewhat of a dragon, came from Frankfurt and took her daughter back there for good at the end of the eighties. Bertha, who was born and brought up in Vienna, retained her Viennese grace, charm and humour. Some years before she died she composed five witty obituary notices of herself for different periodicals. A very serious side, however, developed when she was thirty, and she became the first social worker in Germany, one of the first in the world. She founded a periodical and several institutes where she trained students. A major part of her life's work was given to women's causes and emancipation, but work for children also ranked high. Among her exploits were several expeditions to Russia, Poland, and Roumania to rescue children whose parents had perished in pogroms. She never married, and she remained very devoted to God.

'Some ten years later, at a time when Breuer and Freud were studying cases together, Breuer called him into consultation over an hysterical patient. Before seeing her he described her symptoms, whereupon Freud pointed out that they were typical products of a phantasy pregnancy. The recurrency of the old situation was too much for Breuer. Without saying a word he took up his hat and stick and hurriedly left the house' (pp. 224-226).

I should like to underscore the following items in this account:

1. Having effected the translation from hysterical symptom directed impersonally to anyone, to sexual interest directed to the person of Breuer himself, Breuer panicked and fled. The relationship evidently became too intense for him.

2. Breuer protected himself from the danger of this relationship—that is, from his anxiety lest he succumb to Anna O.'s charms—first, by literally fleeing into the arms of his wife; and later, by convincing himself that his patient was 'very sick', and would be better off dead!

3. Freud, to whom Anna O.'s problem was essentially a theoretical one—he had no personal,



therapeutic relationship with her—dealt with the threat of a too intense involvement with female patients by convincing himself that this could happen only to Breuer. I shall comment on this later.

Let us now take a look at the events preceding the publication of *Studies on Hysteria* (1893–95).

In the late eighties, and still more in the early nineties, Freud kept trying to revive Breuer's interest in the problem of hysteria or to induce him at least to give to the world the discovery his patient, Frl. Anna O., had made. In this endeavour he met with a strong resistance, the reason for which he could not at first understand. Although Breuer was much his senior in rank, and fourteen years older, it was the younger man who—for the first time—was entirely taking the leading part. It gradually dawned on Freud that Breuer's reluctance was connected with his disturbing experience with Frl. Anna O. related earlier in this chapter. So Freud told him of his own experience with a female patient suddenly flinging her arms around his neck in a transport of affection, and he explained to him his reasons for regarding such untoward occurrences as part of the transference phenomena characteristic of certain types of hysteria. This seems to have had a calming effect on Breuer, who evidently had taken his own experience of the kind more personally and perhaps even reproached himself for indiscretion in the handling of his patient. At all events Freud ultimately secured Breuer's cooperation, it being understood that the theme of sexuality was to be kept in the background. Freud's remark had evidently made a deep impression, since when they were preparing *Studies* together, Breuer said apropos of the transference phenomenon, "I believe that is the most important thing we both have to make known to the world" (Jones, 1953, p. 250).

In this account, the following facts deserve emphasis:

(i) The psychotherapeutic material on which Freud discovered transference concerned not his own patient, but someone else's: the experiences were Anna O.'s and Breuer's, the observations Freud's.

(ii) A heavy thread of denial runs through Freud's thinking in formulating the concept of transference; for example: for it to happen, '... one has to be a Breuer'; when he found that one does not, he concluded that the patient's love transference is due to the nature of the hysterical illness—under no circumstances must the patient's attraction to the therapist be considered 'genuine'.

(iii) Freud's concept of transference was vastly reassuring to Breuer.

We shall examine each of these topics in greater detail.

#### *Transference as a Defence for the Analyst*

*Anna O., Breuer, and Freud*

The fact that Anna O. was not Freud's patient has, I think, not received the attention it deserves. Possibly, this was no lucky accident, but a necessary condition for the discovery of the basic insights of psycho-analysis. In other words, the sort of triangular situation which existed between Anna O., Breuer, and Freud may have been indispensable for effecting the original break-through for dealing scientifically with certain kinds of highly charged emotional materials; once this obstacle was hurdled, the outside observer could be dispensed with.

It seems highly probable that Freud's position *vis-à-vis* both Breuer and Anna O. helped him assume a contemplative, scientific attitude towards their relationship. Breuer was an older, revered colleague and friend, and Freud identified with him. He was thus in an ideal position to empathize with Breuer's feelings and thoughts about the treatment of Anna O. On the other hand, Freud had no significant relationship with Anna O. He thus had access to the kind of affective material (from Breuer), which had been unavailable to scientific observers until then; at the same time, he was able to maintain a scientific attitude towards the data (which impinged upon him only by proxy).

It is sometimes said that the psycho-analytic method was discovered by Anna O. Actually, she discovered only the cathartic method and—as it turned out—its limited therapeutic usefulness. She was, however, a truly important collaborator in a more important discovery: the concept of transference. This concept is the cornerstone of psycho-analytic method as well as theory, and was created through the delicate collaboration of three people—Anna O., Breuer, and Freud. Anna O. possessed the relevant basic facts; Breuer transformed them into usable scientific observations, first by responding to them in a personal way, and second by reporting them to Freud; Freud was the observer and theoretician.

Subsequently, Freud succeeded in uniting the latter two functions in himself. In his self-analysis, he was even able to supply all three roles from within the riches of his own personality. It is unfortunate that Freud's self-analysis is sometimes regarded as a uniquely heroic achievement. To be sure, he might have been

the first person ever to perform this sort of work (although one cannot be sure of this); he was certainly the first to describe and thus make public the methods he used. The discovery of Newton's laws and the principles of calculus were also heroic achievements; this does not prevent us from expecting high school students to master them and, indeed, to go beyond them. There is no reason to treat psycho-analysis differently.

To repeat: I have tried to show that because Anna O. was not Freud's patient it was easier for him to assume an observing role toward her sexual communications than if they had been directed towards himself.

#### *Denial and Transference*

Let us now examine Freud's attempt to reassure his fiancée, by writing her that female patients could fall in love 'only with a Breuer', never with him.

Freud may have believed this to be true; or if not, he may have thought it would reassure Martha; or, he may have toyed with both possibilities, believing now one, now the other. The evidence for the probability of each of these hypotheses, though only suggestive, is worth pondering.

We must start with a contradiction: Freud asserted that female hysterical patients have a 'natural' tendency to form love transferences towards their male therapists; if so, one surely does not have to be a Breuer for this to happen. But then why did he write to Martha as he did?

We can only guess. Perhaps it was, as already mentioned, merely a device to reassure his fiancée. He might have done this, however, more effectively by explaining his concept of transference to her; it was, as we know, very reassuring to Breuer. There may have been two reasons why he did not do this. First, his concept of transference was perhaps not as clearly formulated when he wrote to Martha in 1883, as when he used it on Breuer nearly ten years later. Second, Freud was under the influence of a powerful, positive father transference to Breuer. From this point of view, Freud's assertion that women fall in love 'only with a Breuer' assumes new importance. It means that Breuer is the father, Freud the son. Thus, his statement to Martha would mean that women fall in love only with fathers (adult males), not with children (immature boys).

I mention these things, not to analyse Freud, but to cast light on the function of the concept

of transference for the analyst. Freud's self-concept during the early days of psycho-analysis is relevant to our understanding of the work-task of the analyst. His self-deprecating remark is appropriate to the reconstruction offered above of the triangular relationship of Anna O., Breuer, and Freud. It seems that Freud had divided certain activities and roles between Breuer and himself: Breuer is the 'father', the active therapist, the heterosexually active male; Freud is the 'son', the onlooker or observer, the sexually inactive child. This, let us not forget, was the proper social-sexual role of the middle-class adolescent and young adult in the Vienna of the 1880s: aware of sexual desire, he was expected to master it by understanding, waiting, working, and so forth. The same type of mastery—not only of sexual tensions, but of all other kinds that may arise in the analytic situation—must be achieved by the analyst in his daily work.

When Freud was young—and presumably sexually most able and most frustrated—it may have been easier for him to believe that sexual activity with his female patients was impossible, than that it was possible but forbidden. After all, what is impossible does not have to be prohibited. A saving of defensive effort may thus be achieved by defining as impossible what is in fact possible.

Denial plays another role in the concept of transference. For, in developing this concept, Freud denied, and at the same time reaffirmed, the reality of the patient's experience. This paradox, which was discussed before, derives from the distinction between experience and judgement. To deny what the patient felt or said was not new in psychiatry; Freud carried on this tradition, but gave it a new twist.

According to traditional psychiatric opinion, when a patient asserts that he is Jesus Christ, the psychiatrist ought to consider this a delusion. In other words, what the patient says is treated as a logical proposition about the physical world; this proposition the psychiatrist brands as false. Psychiatrists and non-psychiatrists alike, however, have long been aware that the patient may, indeed, feel as though he were Jesus Christ, or be convinced that he is the Saviour; and they may agree with the fundamental distinction between affective experiences about the self, and logical propositions about the external world. The epistemological aspects of this problem, and their relevance to psychiatry, were discussed elsewhere (Szasz, 1961; and Part

I of this paper). What is important to us now is to recognize that, in the concept of transference, Freud introduced this fundamental distinction into psychiatry, without, however, clarifying the epistemological foundation of the concept.

Thus, when Freud introduced the concept of transference into psychiatry, he did not deny the patient's self-experience: if the patient declares that she is in love with the analyst, so be it. He emphatically repudiated, however, the action-implication of the experience: the patient's 'love' must be neither gratified nor spurned. In the analytic situation, both of these common-sense actions are misplaced; in their stead Freud offered 'analysis' (Freud, 1914). He thus took what modern philosophers have come to describe as a *meta position* toward the subject before him (Reichenbach, 1947).

#### *Transference and Reassurance*

The notion of transference is reassuring to therapists precisely because it implies a denial (or mitigation) of the 'personal' in the analytic situation. When Freud explained transference to Breuer, Breuer drew from it the idea that Anna O.'s sexual overtures were 'really' meant for others, not for him: he was merely a symbolic substitute for the patient's 'real' love objects. This interpretation reassured Breuer so much that he dropped his objections to publishing *Studies on Hysteria*.

The concept of transference was needed by Freud, no less than by Breuer, before either dared publish the sort of medico-psychological material never before presented by respectable scientists. The reaction of many medical groups confirmed Breuer's fears: this type of work was a matter for the police, not for doctors. More than just the prudery of German medical circles of the late nineteenth century is betrayed by this view; it suggests that, in psycho-analysis, what stands between obscenity and science is the concept of transference. This concept, and all it implies, renders the physician a non-participant with the patient in the latter's preoccupation with primary emotions (such as eroticism, aggression, etc.). Only by not responding to the patient on his own level of discourse and instead analysing his productions, does the analyst raise his relationship with the patient to a higher level of experience. Unable to comprehend the meaning of transference, Freud's early critics could not distinguish analytic work from indecent behaviour.

The concept of transference was reassuring for

another reason as well. It introduced into medicine and psychology the notion of the *therapist as symbol*: this renders the *therapist as person* essentially invulnerable.

When an object becomes a symbol (of another object) people no longer react to it as an object; hence, its features *qua* object become inscrutable. Consider the flag as the symbol of a nation. It may be defiled, captured by the enemy, even destroyed; national identity, which the flag symbolizes, lives on nevertheless.

The concept of transference performs a similar function: the analyst is only a symbol (therapist), for the object he represents (internal imago). If, however, the therapist is accepted as symbol—say, of the father—his specific individuality becomes inconsequential. As the flag, despite what happens to it, remains a symbol of the nation, so the analyst, regardless of what he does, remains a symbol of the father to the patient. Herein lies the danger. Just as the pre-Freudian physician was ineffective partly because he remained a fully 'real' person, so the psycho-analyst may be ineffective if he remains a fully 'symbolic' object. The analytic situation requires the therapist to function as both, and the patient to perceive him as both. Without these conditions, 'analysis' cannot take place.

The use of the concept of transference in psychotherapy thus led to two different results. On the one hand, it enabled the analyst to work where he could not otherwise have worked; on the other, it exposed him to the danger of being 'wrong' *vis-à-vis* his patient—and of abusing the analytic relationship—without anyone being able to demonstrate this to him.

If we agree that there is such an inherent error in psycho-analysis—and it is hard to see how anyone could dispute this today—it behoves us to try to correct it. Of course, there have been many suggestions, beginning with Freud's proposal that analysts should undergo a personal analysis, and ending with the current emphasis on so-called high standards in analytic institutes. All this is futile. No one, psycho-analysts included, has as yet discovered a method to make people behave with integrity when no one is watching. Yet this is the kind of integrity that analytic work requires of the analyst.

#### SUMMARY OF PART II

My aim in this part of my essay has been to develop the thesis that the concept of transference fulfils a dual function: it is a logical

construct for the psycho-analytic theoretician, and a psychological defence for the psycho-analytic therapist. To illustrate and support this thesis, the historical origins of the concept were re-examined. Breuer, it appears, was overcome by the 'reality' of his relationship with Anna O. The threat of the patient's eroticism was effectively tamed by Freud when he created the concept of transference: the analyst could henceforth tell himself that he was not the genuine object, but a mere symbol, of his patient's desire.

Transference is the pivot upon which the entire structure of psycho-analytic treatment

rests. It is an inspired and indispensable concept; yet it also harbours the seeds, not only of its own destruction, but of the destruction of psycho-analysis itself. Why? Because it tends to place the person of the analyst beyond the reality testing of patients, colleagues, and self. This hazard must be frankly recognized. Neither professionalization, nor the 'raising of standards', nor coerced training analyses can protect us from this danger. Only the integrity of the analyst and of the analytic situation can safeguard from extinction the unique dialogue between analysand and analyst.

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