BOOK REVIEW

ANALYSIS OF THE TRANSFERENCE

Vol. I by MERTON GILL

Vol. II by MERTON GILL and IRWIN Z. HOFFMAN

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In the provocative two-volume study, *The Analysis of the Transference,* Merton Gill sets forth the thesis that the analysis of the transference, which he considers "the heart of psychoanalytic technique," has not been consistently pursued in psychoanalytic practice. By and large, Gill believes, analysts have concerned themselves with "classical genetic interpretation" at the expense of "the largely implicit manifestations of the transference in the current analytic situations" (p. 1). By way of explicating this claim, Gill offers analysts a cogent theoretical exposition in Volume I of his study followed by an attempt to provide validating clinical material in Volume II (co-authored with Irwin Z. Hoffman). The latter takes the form of Gill and Hoffman's critical commentary on a series of verbatim transcripts from tape-recorded analytic and psychotherapeutic sessions.

Gill's conviction about the preeminent role of the analysis of the transference proceeds from a definition of transference that encompasses virtually all aspects of the analyst-analysand interaction. Gill distinguishes, for example, between "conscious appropriate elements of the person's way of relating" as manifestations of transference and "inappropriate unconscious elements" (p. 10), adding that the so-called "unobjectionable" roots of transference cannot be excluded from clinical scrutiny. In this regard, he essentially takes issue with those analysts (e.g., Zetzel, Greenson) who believe that a so-called "therapeutic" or "working alliance" is exempt from analytic scrutiny. Gill similarly disputes Leo Stone's notion of the "mature transference" as something to be partially gratified rather than analyzed.

Gill's perspective on transference interpretation is comparably broad, encompassing (1) the interpretation of resistance to the awareness of transference and (2) the interpretation of resistance to the resolution of transference. It is particularly with respect to the first category of interpretation that Gill propounds his main thesis about the centrality of transference analysis to psychoanalytic technique. In pointing to the analysand's "resistance to the awareness of transference," Gill is referring to associations which contain implicit allusions to the transference which the analysand cannot or will not recognize. He believes that latently transferential associations of this sort are ubiquitous in analysis and it is the task of the analyst to decipher their hidden transference meanings. Gill's recommendation follows from his belief that analysts have to date stressed the analysis of transference resistance (i.e., resistance to the resolution of transference) while paying insufficient attention to the more pervasive resistance to the awareness of transference which encompasses what we have traditionally characterized as defense transference, transference of defense, and defense against the transference. In general, Gill's terminological proposal that we conceptualize transference phenomena in terms of "resistance to the awareness of transference," "resistance to the resolution of transference," and "resistance to involvement in transference" is a welcome advance over the present nomenclature. Gill's three categories, that is, are experience-near, readily verifiable, and integral to the conduct of analyses. I believe clarity is gained by substituting Gill's tripartite formulation for our present overlapping notions of transference resistance, transference of defense, and defense transference.

But although Gill's definitional proposals are uniformly helpful, his all-inclusive claim that resistance is "always expressed via transference" is problematic. Gill reminds us that resistance (unlike defense) is an interpersonal concept that becomes available only in the transference. Gill's estimation of the compulsion to repeat as it operates in therapy is integral to his argument about the centrality of transference analysis. Citing Freud, Gill argues that resistance manifests itself primarily by repetition "both inside and outside the analytic situation." Without the compulsion to repeat, that is, there would be no replication of the past and nothing for the analyst to analyze. Gill realizes, of course, that resistance may be rooted in either the id, ego, or superego; his point, rather, is that, whatever its source, *any* resistance becomes manifest in the analytic situation and with respect to the analyst. In adopting this position, Gill apparently wants to impress upon us that when the analysand articulates resistance to the discussion of a particular issue, thought, or fantasy, this resistance must take the form of a reluctance to relate the relevant information to the analyst. But what about the possibility that the analysand may be reluctant to acknowledge something to himself and the associated reluctance to relay the relevant material to the analyst is derivative, secondary rather than primary. Some patients, for example, may be unable to recall dreams not only because such recollection would involve reporting these dreams to their analysts, but also because the act of recollection itself would lead to painful (i.e., conflictual) self-awareness. Why would it be inappropriate to use the term "resistance" to characterize clinical situations of this type along with those envisioned by Gill?

Just as Gill's claim about the relationship between resistance and transference manifestations represents a perceptive if somewhat overdrawn insight, so does his core argument, related in chapter three about "The Centrality of Analysis of Transference." Pointing to the contributions of M. Bergmann and F. Hartmann, Gill contrasts the stance of the analyst as "an observer and purveyor of interpretation" (p. 43) with the stance of the analyst as an observer-participant who learns from the analytic interaction itself. In adopting the latter view of the analyst's role, Gill opts for a model of analysis in which the translation of the patient's presenting neurosis into the transference neurosis is primary. The offshoot of this position which, according to Gill and the sources on which he relies, conforms with Freud's theory of technique though not Freud's own technical practice, is a seeming depreciation of the need systematically to recover memories in analysis. Gill believes that if resistance to the awareness of the transference is overcome and the ensuing resistance to the resolution of the transference is worked through, then the relevant childhood memories will automatically achieve consciousness.

In subordinating the recovery of early memories to transference analysis and thereby conceptualizing the therapeutic action of analysis itself in terms of transference analysis, Gill allies himself with Strachey's position in his classic paper of 1934, "The Nature of the Therapeutic Action of Psychoanalysis." Like Strachey, that is, Gill believes that only transference interpretations can be truly mutative. But Gill departs from Strachey, and from Leo Stone as well, in contesting the importance of additional "extratransference" interpretations to the analytic process. Unlike these theorists, Gill rejects the theoretical possibility that in certain analyses the entire neurosis cannot be transformed into transference. He believes instead that the neurosis can *always* be

so translated, provided the analyst does what is clinically necessary to facilitate the expansion of the transference in the analytic situation. The precise way in which such expansion can be effected — through what particular analytic activities and through what *degree* of analytic activity — is the crucial issue raised by Gill's study. In general, Gill equates the expansion of the transference with the degree of the analyst's activity. He argues against an inactive stance which assumes that the transference will become clear spontaneously, quoting Glover's observation that "on the contrary, the transference neurosis in the first instance feeds on transference interpretation" (p. 62). Gill disclaims, to be sure, that his stress on transference interpretation is tantamount to a calculating disregard of other things in the patient's life, but he forcefully insists that "The analyst works on the premise that of the many things to which the patient could associate, his choice is often dictated by a topic which can serve as resistance to the transference and [it] is therefore the transference implication that matters for the process" (p. 64). In his insistence that the analyst continually exert himself to enlighten the patient as to the transferential "hidden meaning" of whatever is being said, then, Gill ultimately equates the analytic process itself with educating the patient to accept the notion that interpretation of the transference is the royal road to the understanding of psychopathology and hence to cure.

The criticisms to which Gill's prescriptions are subject are the criticisms intrinsic to any conceptual tour de force intent on underscoring the preeminent importance of a single perspective which, according to his proponents, has not received its just due in the past. Despite his illuminating terminological clarifications and his persuasive case for the importance of transference analysis, Gill fails to establish the "ubiquity" of transference meanings and, to this degree, fails to demonstrate that analysis is *tantamount* to transference interpretation. All anlaysts have worked with analysands for whom "transference" indeed seemed to be everywhere, but this clinical impression hardly implies that *everything* with which such patients are concerned relates to the transference. Moreover, we continue to deal with patients who apparently do not develop a transference neurosis; our understanding of such patients and the implications of this understanding for our theoretical conceptualizations as analysts continue to be hotly debated in the literature. Gill does seem to retreat from the extreme one-sidedness of his viewpoint in his chapter on "Transference and the Actual Analytic Situation." Here, he undertakes to differentiate between the "positive transference" rooted in the past and those "realistic" cognitive attitudes which, he recognizes, are indeed appropriate to the actual analytic situation. We now learn that such attitudes, which do not have the same interpersonally determined roots in the past must also be taken into account in matters of technique. Comparably, he points out that the distinction between the analyst's "technical" and "personal" roles should not be collapsed, reasoning that the analyst's "real behavior" and the patient's realistic attitude toward this behavior are also part of the psychoanalytic process. These somewhat paradoxical admissions stand out as a brief, pregnant counterpoise to Gill's contention that the analysand's "realistic" attitudes invariably mask transference meanings that the analyst is duty bound to uncover.

We may further consider the limitations of Gill's overall position by positing three extreme approaches to the analytic situation: (1) an approach which emphasizes the analyst's passivity, inaction, and silence; (2) an approach which involves the aggresive pursuit and uncovering of repressed childhood memories; and (3) an approach which involves the aggressive pursuit and interpretive uncovering of latent transference meanings in everything the patient has to say. I am in general sympathetic to the thrust of Gill's argument in the sense that I believe the pursuit of transference meaning exclusively to be the least dangerous of these three approaches to therapy. Gill correctly maintains that ultimately it is the transference which is the most difficult dimension of analysis for the patient to discuss as well as for the analyst to conceptualize. To this degree, Gill's work contains a valuable corrective function; he alerts us to the fact that analysts probably err more often by being too inactive or too intent on interpreting "deep" meanings than from an overzealous pursuit of transference meanings. This caveat notwithstanding, it is equally clear that an exclusive commitment to any one of these three analytic approaches will frequently interfere with the unfolding of the analytic process. These respective orientations are hardly mutually exclusive, a point that is particularly clear with respect to the integral relationship of the recovery of childhood memories to the development of the transference and, hence, to the analytic process. Clearly, the recovery of early memories facilitates the unfolding of the transference as well as the patient's understanding of the nature of the transference. But it is equally true that the experience of the here-and-now transference leads to the recovery of memories which are centrally implicated in the analysand's psychopathology. The analyst, we might say, functions from both inside *and* outside, simultaneously participating in the here-and-now interaction and providing interpretations from his "observer" vantage point; he is both observer *and* participant-observer or, to put it somewhat differently, he is not merely a participant-observer but simultaneously a participant *and* an observer. In Gill's presentation, it is the complex, interdependent nature of the analyst's *multiple* orientations toward the analysand that tends to be obscured.

The same criticism can be directed at Gill's repeated insistence that the translation of the presenting neurosis into a transference neuorsis is the "aim" of analysis and, as such, is central to its therapeutic efficacy. As an abstract commentary on the analytic process, this formulation is sound theoretically. But Gill's extreme position overlooks the fact that, as therapists, we are continually dealing with a "means-end" problem that requires flexible clinical judgment. The goal of psychoanalytic treatment is to provide the analysand with the insight that will enable him to achieve significant personality change on behalf of enhanced creativity and productivity in his work life and more satisfactory adaptation in his human relationships. Analysis of the transference is a central means to this end, certainly, but it is not *tantamount* to this end: the goal of analysis is not merely to leave the patient with a "resolved" relationship with his analyst. In view of the differing needs of different analysands, it is not self-evidently true that resistance to the awareness of transference is something which must be rigorously pursued, sought out, and "dogged" by the analyst as if every stone must be overturned to see if a hidden transference meaning will be found beneath it. Furthermore, it is simply not the case that anything short of such an aggressive approach is tantamount to "underplaying" resistance to the awareness of transference, as Gill believes. Rather, the analyst must be enjoined to retain a cautious, open-minded flexibility in the methods he is willing to adopt to effect the translation of the presenting neurosis into transference neurosis. Does such translation really require Gill's aggressive, dogged pursuit of transference meanings in virtually *everything*

that the analysand says in a given analytic session? In arguing that this is indeed the case, Gill seems unwarrantly presumptuous in his assurance that analysis is the preeminent activity and the analyst the preeminent object for every analysand throughout the course of treatment. While this situation may well obtain when the patient enters analysis, we overlook the significant others in the new analysand's childhood and current life only at great clinical peril. To be sure, attitudes toward childhood figures are inevitably transferred onto the analyst along with the strong affects associated with such attitudes, but the power underlying these affects originates from, and continues to be connected to, the important primary objects in the life of the analysand. The here-and-now transference can be pursued so vigorously and exclusively that the genetic roots of transference conflicts in infantile sexuality and aggression may ultimately get lost in the transferential shuffle.

This is merely by way of reiterating that it is always a test of clinical judgment to determine, in the context of the psychopathology and therapeutic requirements of different analysands, the relative degree to which analytic interventions should focus on these primary objects and the relative degree to which they should focus on the relationships to these objects mediated by the unfolding transference. This basic fact of clinical psychoanalytic life belies Gill's formulaic zeal as well as his associated belief that the patient can be "taught" that the interpretation of the transference is central to his psychopathology and ultimate cure. Such "learning" about the rationale of analytic technique can only ensue when a specific series of associations and interpretations makes it self-evident to the analysand that the transference and its analysis have indeed become crucial to his therapeutic progress. The analysand's estimate of the transference can only be the *outcome* of the analytic process; it is not an a priori *constituent of the process.*

II.

In Volume II of *The Analysis of the Transference*, Gill and his collaborator, Hoffman, analyze the transcripts of nine therapeutic sessions in an attempt to verify his claim that "transference is organized around significant contributions from the analyst in the here and now" (p.5). It should be noted at the outset that only six of these nine sessions come from analyses, and of the six analysed patients, one was seen sitting up. The remaining three patients were seen in therapy once a week. Of the five sessions conducted by therapists attempting to apply Gill's point of view, three involved the once-a-week therapy patients and one involved the analytic patient who did not use the couch. In sum, then, Gill and Hoffman present us with four "bad" analytic sessions, one "good" analytic session, one "good" analytic session in which the patient is seen sitting up, and three "good" psychotherapy sessions. They do not tell us how they arrived at this particular selection of sessions and they analyze the sessions without the benefit of any historical background material or clinical data from earlier or later sessions. It is particularly regrettable that we have but one "good" analytic case conducted on the couch to illustrate Gill's principles. It would have been much more illuminating to have several conventional analytic cases or several taped hours from the same case to illustrate the value of his approach. On the other hand, we must be grateful to Gill and Hoffman for providing us with this interesting verbatim material, even if it does not seem maximally suited to his purposes. We are at least able to see how they apply Gill's interpretive orientation to case material, even if the serious methodological problems involved in viewing individual sessions in isolation makes it impossible for him to be persuasive on this basis alone.

In general, Gill and Hoffman are more persuasive in criticizing "poor" analytic and therapy sessions from the standpoint of faulty technique than in demonstrating the unquestioned primacy of here-and-now transference interpretations in those sessions they deem successful. In their discussion of Patient B, for example, they have little difficulty pointing out the inappropriateness of a penis envy meaning artificially injected into the patient's dream associations by the analyst. More perceptively, they point to the analyst's failure to appreciate the importance for the analysis of a pregnant interaction at the analyst's door as the session began: the patient expressed her perception of the analyst as impatient and critical on opening the door. Rather than probing the meaning of this perception in terms of issues, say, of initiative and self-assertion, the analyst permitted the session to begin with a four-minute silence. In the case of Patient C, Gill and Hoffman also criticize the forced imputation of a castration wish on the productions of a woman patient. When this patient responded angrily to the interpretation, adding that she wished to knock all the analyst's books off the wall, the analyst responded in turn that this latter wish was really a wish to knock his penis off. Gill and Hoffman rank this remark "an almost unbelievably pat interpretation that exemplifies our point. Instead of finding out what she means by wanting to knock down his books, the analyst uses what she has said to reiterate his fixed conviction... which she has just characterized as unhelpful." (p. 58). Interestingly enough, the patient proceeds to relate books and reading to compensatory feelings for not having a penis, so as Gill subsequently acknowledges, the session may actually provide an example of a correct interpretation derived from faulty technique. Their point is that the analyst had in any event missed the fact that the patient experienced him as an unreasonable dictator and that this perception was based on the patient's actual experience of the analyst: he indeed seemed to foist interpretations on the patient without due concern for either the evidence or the latter's feelings. In the case of Patient D, Gill and Hoffman discuss a session in which the patient responded to the analyst's interpretation with the remark, "That's obvious now." They point to the analyst's failure to analyze this comment as "a significant and common flaw — the enactment in the process of the content of the interpretation without an interpretation of this enactment" (p. 89). Their insistence that analysts attend to the pseudo-complaint aspects of such seemingly facile acceptance of interpretations is certainly a useful technical proviso, but there is no way of determining whether their inference about Patient D is correct on the basis of the transcript of the single recorded session. Had the patient's "That's obvious now" generated relevant memories or associations or a modulation of the character trait which was then being explored, it might also have indicated a deepening of the analytic process and a working through of the patients comprehension.

It is with respect to Patient A that Gill and Hoffman provide examples of what they mean by inferring latent transference meaning from the overt products of the patient. To give but one example: the patient tells an involved story about her cat and the ASPCA. This agency temporized in treating the cat for an illness, and the animal subsequently died. The authors comment that "The cat died because they fooled around instead of operating. The latent meaning may be that the analyst's silence is doing nothing and the analysis may die. She may be growing increasingly angry at his inactivity" (p. 19). They feel it likely, in

other words, that the patient's story about her cat pertains to the analyst and the analysis. Now this interpretation is clearly one possibility, but is it really the only possibility? How can the analyst "know" this to be the case? The only technical stricture that follows from clinical data of this sort is that the analyst must "listen" to the patient's productions and attempt to "read" unconscious meanings and themes in them. These meanings and themes invariably pertain to wishes and fantasies which, to be sure, may include transference wishes and fantasies. But the analyst can hardly assume that such wishes and fastasies are primarily related to the patient's reactions to the analyst in the here and now. In many cases, the discernment of unconscious meanings will proceed from the analyst's sense of what has transpired in recent sessions, from his understanding of the latent content of a series of dreams, indeed, from his cumulative knowledge of the entire analysis up to that point. The analyst's resulting reading of unconscious meaning thereby proceeds from a complex process of "knowing" that must take into account the patient's obtained level of cognitive, intuitive, and empathic functioning. This knowing process presupposes continuing attentiveness to a whole host of nonverbal cues, bodily movements, and additional data processed by the so-called "analytic instrument." When the analyst, on the basis of all these data, undertakes to communicate his inference of unconscious meaning to the patient via an interpretation, he must synthesize knowledge from a variety of sources, adjudge the evidence he has available to make the presumed connection between current production and latent meaning persuasive to the patient, and further make a judgment as to the patient's readiness to assimilate the meaning he will impute.

The problem with Gill and Hoffman's clinical strategies, as well as with Gill's theoretical exposition, is that they seem to skew the interpretive process along a single dimension. The patient speaks and the analyst thinks, "What is the patient trying to say about me and the analytic situation?" It seems to me that the aggressive pursuit of transference meaning may actually impair the analyst's "hovering" attention, his ability to attend to the range of unconscious meanings which are intrinsic to the productions of the analysand. The result may well be a tendency to respond to the patient's productions in a stereotypical, automatic way. Transference fantasies and attitudes which pertain to the here-and-now reality of the analyst-analysand interaction are indeed important and may even warrant a certain priority in our interpretive strategies. They cannot, however, constitute the whole analytic endeavor. To the extent that the psychoanalytic theory of cure transcends the notion of a resolved transference relationship, one cannot spend an entire analysis analyzing the patient's feelings about the analyst's silence, missed sessions, vacations, aspects of the analyst's office, and the like. Ultimately, transference analysis must be absorbed in the broader attempt to uncover and understand those significant unconscious wishes and fantasies which took form in childhood and, via the compulsion to repeat, continue to affect the patient's current life adjustment. Successful adaptation, in the broadest and most multidimensional sense, is what constitutes the goal of analysis; adaptational failure is what motivates the patient to seek treatment. Optimally, the self-knowledge at which the analysand arrives at the conclusion of a successful analysis incorporates, but ultimately transcends, his understanding of the dynamics underlying his perceptions of, and interactions with, the analyst.

It is with this proviso in mind that we should assess Gill's closely reasoned principles of psychoanalytic interpretation. The issue of the relative importance of transference analysis with respect to, say, genetic interpretation and noninterpretive activities pursuant to the establishment of a holding environment, cannot be addressed in topical isolation; it is an issue that is essentially derivative to the more encompassing question of the nature of therapeutic change and the nature of the cure. Gill's stimulating presentation, cogent though it is, does not systematically address the precise role of transference analysis to the principal constituents of cure — i.e., structural change in the personality which includes the realignment and alteration of defenses, the removal of inhibitions, and the lifting of repressions. To this extent, he leaves us with a sweeping tour de force that is flawed by virtue of its narrow focus on transference analysis per se. The case material, interesting in itself, neither validates nor invalidates his proposals. As Gill acknowledges, to test these proposals with adequate rigor we really need more adequate clinical data, perhaps a combination of longitudinal case studies with transcripts of pivotal sessions. Indeed, the combination of these two approaches could prove to be a powerful validating tool for a number of clinical psychoanalytic hypotheses. In the meantime, we must be grateful to Gill for his impressive contribution to the literature. We are not yet in a position to confirm or deny his propositions about optimum psychoanalytic technique, but we are certainly obliged to give them the serious study they merit.

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aggression, which Dr. Stone sees in two predominant categories: debasement, degradation and allied phenomena; and killing, mutilation, and other primitive attacks.

3) Identification: Dr. Stone remarked briefly that he has very frequently seen blatant identification with the ambivalently held object, largely in a self-punitive mode, as compared with the more rare reconstruction of an original narcissistic regression in the more complete sense suggested by Freud's classic formulation of melancholia. He also stressed the potential or fact of such identification to exist under a strong reactive or counter-identification.

4) Narcissism: Although not all individuals who become depressed are "narcissistic personalities," certain narcissistic traits usually play a decisive role in the genesis of the more severe depressions. While the manifest or total personality may not generally bear a narcissistic stamp, the underlying or unconscious orientation toward life may contain crucial elements derived from narcissistic sources. For example, the ego ideal (conceived as a "residue of the individual's own megalomanic narcissism") which is found in these patients to be of such exigent character that it is likely to jeopardize self-esteem, albeit entirely through unconscious mechanisms. More directly, the unwavering thrust toward certain goals, however compatible with realities (or not), bears a strong narcissistic stamp.

Dr. Stone concluded his lecture by stressing that these four elements are of importance in most if not all cases of true depressive illness, often operating in powerful synergy that is all the more understandable in light of the closeness of the early infantile experiences from which these elements originated. The character derivative of these (infantile) elements and their patient analysis offer opportunities for "a significant psychoanalytic contribution to the reduction of the substrata of depressive illness." □