

Transference Analysis: Means or End?

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Over the years psychoanalysts have invoked different organizing frameworks as vehicles for theoretical and clinical discourse. The concept of “identity” was a prominent theme in the 1960s, to be supplanted by a focus on the “self” in the 1970s. Now, in the 1980s, preoccupation with the self and its vicissitudes is giving way to a revived interest in the psychoanalytic process per se. In part the result of a growing disillusionment with proliferating alternative theories, this renewed interest may have been kindled as well by the debate over Kohut's “self psychology” and its attentiveness to the role of empathy in the analytic transaction. Schafer's *The Analytic Attitude* (1983) and Anton Kris's *Free Association: Method and Process* (1983) exemplify this new focus on the psychoanalytic process. It is in this emerging tradition that Merton Gill's two-volume study, *The Analysis of the Transference* (Gill, 1982; Gill & Hoffman, 1982) must be situated as well. Like Schafer and Kris, Gill seeks to explicate the methods and goals of psychoanalysis by concentrating on a particular dimension of the analytic process. What narrative content is to Schafer and free association is to Kris, the analysis of transference is to Gill.

Gill's position is informed by the conviction that the analysis of the transference, which he considers “the heart of psychoanalytic technique,” has not been consistently pursued in practice. By and large, he believes, analysts have concerned themselves with “classical genetic interpretation” at the expense of “the largely implicit manifestations of the transference in the current analytic situation” (p. 1). His conviction regarding the preeminent role of transference analysis proceeds from a definition of transference that encompasses virtually all aspects of the analytic interaction. He 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. Here he takes issue with analysts like Zetzel (1956) and Greenson (1965) who believe that the “therapeutic” or “working” alliance is exempt from analytic scrutiny. He similarly disputes Leo Stone's notion of the “mature transference” (1961) as something to be partially gratified rather than analyzed.

Gill's perspective on transference interpretation is comparably broad, encompassing interpretations of resistance to the awareness of transference and interpretations of resistance to its resolution. It is mainly with respect to the first category that Gill propounds his main thesis regarding the technical centrality of transference analysis. In pointing to the analysand's “resistance to the awareness of transference,” Gill is referring to associations containing implicit allusions to the transference — allusions the analysand cannot or will not recognize. Holding latent transference associations of this sort to be ubiquitous in analysis, he enjoins analysts to decipher their hidden transference meanings. This recommendation follows from his belief that analysts have to date stressed the analysis of resistance to transference resolution while paying insufficient attention to the more pervasive resistance to transference awareness. The latter resistance encompasses what analysts have traditionally characterized, somewhat confusedly, as defense transference, transference of defense, and defense against the transference. Gill's terminological proposal that we henceforth 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 prevailing nomenclature; his categories are experience-near, readily verifiable, and integral to the conduct of analyses.

But if Gill's attempt at terminological revision would seem unexceptionable and indeed useful, the same cannot be said of his claim that resistance is always expressed via transference. Gill correctly reminds us that resistance (unlike defense) is an interpersonal phenomenon manifesting itself only in the transference. His estimation of the compulsion to repeat as it operates in therapy is integral to his argument here. Citing Freud, he argues that resistance manifests itself primarily by repetition “both inside and outside the analytic situation.” Without the compulsion to repeat, 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 id, ego, or superego; his point is that, whatever its source, resistance becomes evident and analyzable only in the analytic situation and with respect to the analyst. In adopting this position, Gill apparently wishes to impress upon us that when the analysand offers resistance to the discussion of a particular issue, thought, or fantasy, this resistance necessarily takes the form of a reluctance to relate the relevant information to the analyst. But Gill does not allow for the possibility that the analysand may be reluctant to acknowledge something to himself, with the reluctance to relay the relevant material to the analyst having a secondary, derivative quality. Certain patients, for example, may experience certain alterations in their ability to recall dreams, not simply because such recollections would involve reporting these dreams to their analysts, but also because the act of recollection involves painful (i.e., conflictual) self-awareness. Surely the term “resistance” may properly be applied to clinical situations of this sort as well as to those cited by Gill.

A similarly perceptive but overgeneralized insight is to be found in his core argument regarding the centrality of transference analysis. Pointing to the contributions of Bergmann and Hartman (1976), Gill contrasts the analytic stance of the “observer and purveyor of interpretation” with that of the participant observer who learns from the analytic interaction itself. In opting for the latter, Gill adopts a model of analysis based on the primacy of translating the patient's presenting neurosis into a transference neurosis. A consequence of this position (which, according to Gill and the sources he relies on, conforms to Freud's theory of technique though not to his technical practices) is a seeming depreciation of the analytic need to recover memories systematically. Gill believes that if resistance to awareness of the transference is overcome and the ensuing resistance to its resolution is worked through, then relevant childhood memories will automatically achieve consciousness.

In subordinating the recovery of early memories to transference analysis and thereby identifying the therapeutic action of analysis with the latter, Gill allies himself with Strachey's (1934) position. Like Strachey, Gill believes that only transference interpretations can be truly mutative. But Gill departs from Strachey, and from Leo Stone (1961) as well, in contesting the importance of additional, “extratransference” interpretations to the analytic process. Unlike Stone and Strachey, he rejects the theoretical possibility that in certain analyses the presenting neurosis might prove intractable to wholesale translation into the transference neurosis. He believes such translation can always be effected, without residue, provided the analyst does what is clinically necessary to facilitate expansion of the transference in the analytic situation. Just how this expansion is to occur — through what particular analytic activities and through what degree of analytic activity — is the crucial issue here. In general, he would seem to view this expansion as directly proportional to the degree of activity. He argues against an inactive stance

that assumes the transference will emerge and clarify itself spontaneously; “on the contrary,” he quotes Glover (1955, p. 130), “...the transference-neurosis in the first instance feeds on transference-interpretation” (p. 62). Gill disclaims, to be sure, any reading that would take his stress on transference interpretation as a calculating disregard of other elements of the patient's life; he forcefully insists, however, that it is necessary to work on the premise that of the many things the patient could associate to, his choice is often dictated by a topic which can serve as resistance to the transference. It is therefore the transference implication that matters for the process. Thus Gill does not view early interpretive activity as simply mobilizing a transference readiness (Nunberg, 1951), but rather as exposing and overcoming transference “resistances” intrinsic to the analytic transaction from the very outset. In his insistence that the analyst continually exert himself to enlighten the patient as to the transferential “hidden meaning” of everything being said, Gill ultimately equates the analytic process itself with educating the patient to accept transference interpretation as the royal road to understanding psychopathology — and hence to cure.

In the second volume of *The Analysis of Transference* Gill and his collaborator Hoffman attempt to verify their claim that “transference is organized around significant contributions from the analyst in the here and now.” To this end, they present, and offer commentary on, the transcripts of nine therapeutic sessions. It should be noted at the outset that only six of these sessions come from analyses, and one of these was with a patient seen sitting up. The remaining three patients were seen in therapy once a week. Of 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 was seen sitting up, and three “good” psychotherapy sessions. They do not tell us how they arrived at this selection of sessions, or why they elected to analyze the sessions in vacuo — i.e., 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. A rigorous test of their proposals would require more adequate clinical data, perhaps a combination of longitudinal case studies with verbatim transcripts of pivotal sessions.

As a result of these methodological problems, Gill and Hoffman are more persuasive in criticizing sessions evincing faulty technique than in demonstrating the unquestioned primacy of here-and-now transference interpretation in those they deem successful. In their discussion of Patient B, for example, they have little difficulty demonstrating the inappropriateness of a penis meaning arbitrarily imputed to the patient's dream associations by the analyst. More perceptively, they point to the analyst's failure to appreciate the import of a significant 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 criticize the similarly forced imputation of castration meaning 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 deem 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, however, this patient proceeded to relate books and reading to compensatory feelings for not having a penis; thus, as Gill and Hoffman subsequently acknowledge, the session may actually provide an example of a correct interpretation proceeding from faulty technique. Gill's 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 her 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 their comment as a “significant and common flaw.” Their insistence that analysts attend to the pseudocompliant 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 this single session. Had the patient's “That's obvious now” generated relevant memories or associations, or a modulation of the character trait being explored, it might well have betokened a deepening of the analytic process and a working through of the patient's comprehension of the issues.

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 delayed 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). Now this interpretation is surely one possibility, but it is the only one? How can the analyst know this to be the case? The only technical dictum 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 fantasies are necessarily limited 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 to that point. The analyst's imputation of unconscious meaning proceeds from a complex process of “knowing,” which must take into account the patient's achieved level of cognitive, intuitive, and empathic functioning. This presupposes an ongoing attentiveness to a whole host of nonverbal cues, bodily movements, and additional data processed by what is sometimes called the “analytic instrument.” When the analyst, on the basis of this material, undertakes to communicate his inference of unconscious meaning to the patient via an interpretation, he must synthesize knowledge from a variety of sources, judge the adequacy and persuasive force of the evidence for a connection between current productions and latent meaning, and make a further judgment as to the patient's readiness to assimilate the interpretation.

The problem with Gill and Hoffman's clinical strategies, 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 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 in the here-and-now are indeed important and may even warrant a certain priority in our interpretive strategies. An entire analysis, however, cannot be spent analyzing the patient's feelings about the analyst's silences, 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 significant unconscious wishes and fantasies which emerge in childhood and, via the compulsion to repeat, continue to affect the patient's current life adjustment.

It is with this caveat in mind that we must 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 secondary to the more encompassing question of the nature of therapeutic change. Gill's presentation, cogent though it is in certain respects, does not systematically address the precise relationship of transference analysis to the principal constituents of cure — i.e., structural changes in the personality. These include the realignment and alteration of defenses, the removal of inhibitions, and the lifting of repressions.

The criticism to which Gill's prescriptions are subject are those invited by any conceptual tour de force intent on establishing the preeminence of a perspective which, its proponents argue, has not received its just due. Despite his illuminating terminological suggestions and his persuasive case for the importance of transference analysis, Gill fails to prove the ubiquity of transference meanings or to demonstrate that analysis in fact amounts to transference interpretation. All analysts have worked with analysands for whom "transference" indeed seemed to lurk everywhere, but this clinical impression can hardly be taken as evidence that everything such patients are concerned with relates to the transference. Moreover, we often deal with patients who simply do not develop transference neuroses; our understanding of them and the implications of this understanding for our theoretical conceptualizations continue to be hotly debated. Even Gill seems to retreat from the extreme one-sidedness of his views in his chapter on "Transference and the Actual Analytic Situation." Here he attempts to differentiate between the "positive transference" rooted in the past and those "realistic" cognitive attitudes which, he admits, are 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. Similarly, 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 admissions, inconsistent with his basic views, stand out as a brief but telling exception to his otherwise continuing insistence that the analysand's "realistic" attitudes invariably mask transference meanings that the analyst is duty bound to uncover.

The strengths and limitations of Gill's position can be highlighted by positing three extreme approaches to the analytic situation: (1) an approach emphasizing the analyst's passivity, inaction, and silence; (2) an approach involving the aggressive pursuit and uncovering of repressed childhood memories; and (3) an approach involving the aggressive pursuit and interpretative uncovering of latent transference meanings in everything the patient says or does.

I am to a certain extent sympathetic to Gill's argument, for I believe the pursuit of transference meaning to be the least dangerous of the three to therapy. Gill is correct in maintaining that it is ultimately the transference that is the most difficult dimension of analysis for the patient to discuss and for the analyst to conceptualize. To this degree, Gill's work provides a valuable corrective; 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. Nonetheless, exclusive commitment to any one of these approaches will interfere with the unfolding analytic process. The three orientations are not mutually exclusive, a point that is particularly clear with respect to the integral relationship between the recovery of childhood memories and the development of the transference and the analytic process. Analysts are surely familiar with the ways in which the recovery of early memories facilitates both the unfolding of the transference and the patient's understanding of its nature. But it is equally true that the experience of the here-and-now transference leads to the recovery of memories 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 observer participant, or, to put it somewhat differently, he is not merely an observer participant 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 is occasionally obscured.

The same criticism may be leveled at Gill's repeated insistence that translation of the presenting neurosis into a transference neurosis is the "aim" of analysis and is, as such, central to its therapeutic efficacy. As an abstract commentary on the analytic process, this formulation is theoretically unassailable. But Gill's extreme position overlooks the fact that, as therapists, we are continually dealing with a means-end problem that calls for flexible clinical judgment. The goal of psychoanalytic treatment is to provide the analysand with insight that will enable him to achieve significant personality change on behalf of enhanced creativity and productivity in his work life, along with more satisfactory adaptation in his human relationships. Analysis of the transference is a central means to this end, certainly, but is not tantamount to it: 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 must be relentlessly pursued by the analyst, as if every stone must be turned to see if some hidden transference meaning might be found lurking beneath it. Does translation of the presenting neurosis into a transference neurosis really require this dogged pursuit of transference meanings in virtually everything the analysand says or does in a given session? In arguing that this is the case, Gill unwarrantedly assumes that throughout the course of treatment analysis is the preeminent activity — and the analyst the preeminent object — for every analysand. Although this situation may frequently obtain when a patient first enters analysis, even here 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.

In short, the here-and-now transference may be pursued so vigorously and exclusively that the genetic roots of transference conflicts in infantile sexuality and aggression may ultimately be lost in the transferential shuffle. It is always a test of clinical judgment to work out, in the context of the psychopathology and therapeutic requirements of a given analysand, an appropriate balance

between analytic interventions focusing on primary objects and those focusing on relationships to these objects as mediated by the unfolding transference. This basic fact of clinical psychoanalytic life belies Gill's formulaic zeal regarding the preeminence of transference interpretations; it further belies the associated belief that patients can be "taught" that analysis of the transference is central to their psychopathology and ultimate cure. Such "learning" can occur only 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 therapeutic progress. The analysand's appreciation of the transference can only be the dynamic by-product of a successful analytic process. If it were constitutive of that process, its necessary precondition, analysis could never begin nor, on Gill's assumptions, would it have to.

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