A COUNTERTHEORY OF TRANSFERENCE

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Transference or the "transference neurosis" is reexamined. This analysis suggests that transference is a defense mechanism used to deny or disguise the reality and natural consequences of the therapist's behavior. Two of these behaviors, understanding and misunderstanding, are featured as archetypical causes of love and hate, unnecessarily called "positive" and "negative" transference. The analysis starts with the uneasy origin of the concept illustrated in the case of Anna O. It continues through variations in definition and use of transference, and observations on the self-concept of the therapist. The repetition-logic of psychoanalysis is disputed, and a countertheory is proposed, based on clinical experience and phenomenal evidence of the normal human response to understanding. The act of understanding is described not only as the first cause of "transference" but also as the essential healing factor, the main contribution and the proper objective of all psychotherapies.

John M. Shlien received his first training in the field from a great but unknown therapist—a black laundress named Emma Smith. At age four, he turned the handle of the clothes wringer while she, a gifted listener, saved the sanity (and probably, in some families, even the lives) of women in the neighborhood. As a veteran of World War II, he was admitted on probation to graduate study at the University of Chicago. There he received a Ph.D. and served as Professor in the departments of Psychology and Human Development. In 1968 he moved to Harvard University, where he retired in 1984, Professor Emeritus, in the Graduate School of Education. He still teaches part-time in the program he founded, Counseling and Consulting Psychology. During other parts of the year he works in Europe with colleagues such as Charles Devonshire, Brian Thorne, and Alberto Zucconi.

"Transference" is a fiction, invented and maintained by therapists to protect themselves from the consequences of their own behavior.

Editor's Note: John M. Shlien has taken a provocative and controversial position on the issue of transference. While Shlien's ideas are likely to be acceptable to some, they will likely be unsettling to others. Whatever one's position on the phenomenon of transference, one's thinking about the client's seemingly unfounded reactions to the therapist will inevitably be stimulated. Since the issue is one of significance to therapists of all persuasions, notable therapists within and outside the client/person-centered approach have been invited to respond to Shlien's article. Their responses will be included in the next issue of the *Person-Centered Review*. Readers are encouraged to submit to the editor their own reactions to Shlien's article or to the articles of the respondents.

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To many, this assertion will seem an exaggeration, an outrage, an indictment. It is presented here as a serious hypothesis, charging a highly invested profession with the task of reexamining a fundamental concept in practice.

It is not entirely new to consider transference as a defense. Even its proponents cast it among the defense mechanisms when they term it a "projection." But they mean that the defense is on the part of the patient. My assertion suggests a different type of defense: denial or distortion, and on the part of the therapist.

Mine is not an official position in client-centered therapy. There is none. Carl Rogers has dealt with the subject succinctly, in about twenty pages (1951, pp. 198-217), a relatively brief treatment of a matter that has taken up volumes of the literature in the field.[1] "In client-centered therapy, this involved and persistent dependency relationship does not tend to develop" (p. 201), though such transference attitudes are evident in a considerable proportion of cases handled by client-centered therapists. Transference is not fostered or cultivated by this present-time oriented framework where intensive exploration of early childhood is not required, and where the therapist is visible and available for reality testing. While Rogers knows of the position taken here and has, I believe, been influenced by it since its first presentation in 1959, he has never treated the transference topic as an issue of dispute. This is partly so because of his lack of inclination for combat on controversial issues, where he prefers to do his own constructive work and let evidence accumulate with new experience.

Why then should client-centered therapy take a position on an issue of so little moment in its own development? For one reason, the concept of transference is ubiquitous. It has a powerful grip on the minds of professionals and the public. And, while client-centered practice has the popular image of a relatively self-effacing therapist, it holds to a standard of self-discipline and responsibility for the conditions and processes it fosters, and it could not fail to encounter those emotional and relational strains so often classed as transference.

There are many separate questions raised by the assertion at the start of this article. *What* behavior of the therapist? Leading to

which consequences? *Why* invent[2] such a concept? *How* does it protect? In reexamining the concept of transference how do we, to use Freud's words, "inquire into its source"?

Throughout we will consider only the male therapist/female patient data. Such was the critical situation when the term was invented. The first five case histories in the 1895 landmark *Studies on Hysteria* (Breuer & Freud, 1957) are Anna O., Emmy von N., Lucy R., Katharina, and Elisabeth. It set up the image of the most sensitive relationship (older man, younger woman) most suspect in the minds of the public (whether skeptic or enthusiast) and the combination most common for many decades.[3] Indeed it is possible that without the sexually charged atmosphere thus engendered, the concept of transference might not have developed as it has, if at all! For it is not insignificant that Breuer, and Freud, were particularly vulnerable. As Jewish physicians, admitted to the fringes of anti-Semitic Viennese society by virtue of their professional status, they could ill afford any jeopardy.

For psychoanalysis, transference seems to be the essential concept: "sine qua non," "an inevitable necessity," "the object of treatment," "the most important thing we (Freud and Breuer) have to make known to the world," without which "the physician and his arguments would never be listened to." In addition, it contains and subsumes all the elaborate support structures: the primary significance of sexual instincts, psychic determinism, the unconscious, psychogenetic theory, and the power of past experience. It is crucial in theory! In practice, it comforts, protects, and explains.

Transference is also supposed to distinguish psychoanalysis from other forms of therapy. Perhaps it is meant to do so, but this becomes moot through contradictions in the literature, which variously asserts that transference is peculiar to psychoanalysis while also common in everyday life. Whether unique or universal, it is in widespread use throughout most psychodynamic systems. One distinction it surely serves: that between professional and paraprofessional, or sophisticate and literalist, and in general between those in and out of power. If transference is no longer the singular hallmark of psychoanalysis, it at least marks those "in the know," whether novices or not.

It was in Freud's mind "a new fact which we are thus unwilling compelled to recognize" (1953, p. 385). "Unwilling" does not truly describe Freud's attitude. That word is an artful form of argument to make a welcome conjecture seem an unavoidable fact. Currently, "unwilling" more aptly describes the attitude of psychotherapists toward reexamination of the idea. But reexamination is necessary if we are to reevaluate the usefulness of the concept.

HISTORICAL CONTEXT

It seems most appropriate to begin this reevaluation with the early history of the concept. The case of Anna O. provides the cornerstone on which the theory of transference is generally thought to be based. More than a dramatic and moving affair, it is of momentous importance to the field, and its effects still influence the majority of theory and practice. Though psychoanalysis and/or other forms of psychotherapy would somehow have developed, all present forms owe much to these few pioneers and their struggles. To honor them properly, it is necessary to study these human points or origin.

The accounts begin in the *Studies of Hysteria* (Breuer & Freud, 1957), first published in 1895, thirteen years after treatment ended. Details of treatment were reported cautiously, out of respect for the still-living patient, and for other reasons having to do with questions about the outcome, and growing tensions between Freud and Breuer. Anna O. was, by all accounts, remarkable, and, for that time, so was her treatment. In her twenty-first year, she was described by Breuer and others as a person of great beauty, charm, and powerful intellect, with a quick grasp and surplus energy. Living in a comfortable but monotonous environment at home, she was hungry for intellectual stimulation. She was poetic and imaginative, fluent in German, English, Italian, and French. Much of her waking time was spent in daydreaming, her "private theatre." She was also sharp and critical, and therefore, Breuer notes, "completely

unsuggestable" (though he routinely used hypnosis), needing to be convinced by argument on every point. She was tenacious and obstinate, but also known for immensely sympathetic kindness, a quality that marked most of her life's work. She had never been in love. In short, she was young, attractive, intelligent, and lonely; it was she who named psychotherapy "the talking-cure," and she was a near-perfect companion for the also remarkable physician-pioneer in this form of treatment. (He was 38 at the time, admired, loved, respected, and of high professional and social status.) Both deserved all the tributes given, and Breuer perhaps even more. While Freud was the conceptual and literary genius without doubt, and Anna O. the central figure of the famous case, Breuer was probably the therapeutic genius of the time. And that in a new, dangerous exploration where there were few precedents, guidelines, or previous personal experiences.

Through the experience of Anna O. with Breuer, the material used as the basis for the theory of *transference-love* (as it was then called) was gathered, but it was Freud alone who later invented that theory to interpret that material to Breuer and the world. In the meantime, Freud's invention had been fostered by experience of his own with at least one other female patient.

The case of Anna O. is described in 1895 by Breuer (Breuer & Freud, 1957, pp. 21-47), who wrote that he had "suppressed a large number of quite interesting details" (true), and that she had left Vienna to travel for a while, free of her previous disturbances (not quite so true, for she was taken to a sanatorium where she "inflamed the heart of the psychiatrist in charge" [Jones, 1953, p. 225], and was temporarily addicted to morphine). By the time Breuer reported the *Studies* a decade later, he could write that "it was a considerable time before she regained her mental balance entirely" (p. 41). Even so, he had confided sorrowfully to Freud in an earlier discussion that he thought sometimes she were better off dead, to end her suffering. The "suppressed details" may in part be related to his sudden termination of the treatment and the patient's shocking emergency regarding her "pregnancy" and his "responsibility." James Strachey, editor of the 1957 translation of *Studies on Hysteria*, says Freud told him of the end of Anna O.'s

treatment: "The patient suddenly made manifest to Breuer the presence of a strong unanalysed positive transference of an unmistakably sexual nature" (Breuer & Freud, 1957, p. 41, fn.). This is a retroactive interpretation, of course, since at the time of its occurrence neither Breuer nor perhaps even Freud yet had any idea of "transference." That idea builds, and more complete information is released, as Freud describes the case in both oblique and direct references in lectures and other writings from 1905 to his autobiography in 1925. Still more explicit communications are released in Ernest Jones's (1953) biography of Freud. In 1972, Freeman, a well-known popular writer, published a "novelized" biography and report of Anna O. and her treatment. (None of these is exact, verbatim, or anything like "verification data.")

Even so, the somewhat guarded report by Breuer gives us a privileged view of his work. The editor of *Studies on Hysteria* tells us that Breuer had little need of hypnosis because Anna O. so readily "produced streams of material from her unconscious, and *all Breuer had to do was to sit by and listen to them without interrupting her*" (Breuer & Freud, 1957, p. xvii; emphasis added). That is *all*? As you will see later, I argue that this is no small thing. It may not seem much to that editor, himself a lay analyst in training, but to the lonely, grieving, and desperate young woman, it must have seemed a treasure. At that period, young ladies were given placebos, referred from one doctor to another, and generally treated with patronizing attention or benign neglect. Breuer and Freud were precious rarities in that they listened, took her seriously. Would that Breuer had done more of that, and had done it steadfastly *through the end.* Listening is behavior of great consequence. The pity is that he felt forced to cut it short at the critical last moments.

Meanwhile, there were many other behaviors and we can only estimate their consequences. He fed her. She was emaciated, and he alone was able to feed her. He could give her water when she otherwise would not drink. No doubt there were other nourishing figures in her life, but he was clearly one himself. He paid her daily visits. She held his hands in order to identify him at times when

she could not see. When she was exhausted, he put her to sleep, with narcotics or suggestion. He restored mobility to paralyzed limbs. He hypnotized her, sometimes twice a day, taught her self-hypnosis, and then "would relieve her of the whole stock of imaginative products she had accumulated since [his] last visit" (1957, p. 36). He took her for rides in his carriage with his daughter (named Berthe, which was also Anna O.'s real name). He read her diary—a notably tricky business either with or without her permission. He forced her to remember unpleasant experiences.

From this alone, would you think that Anna O. had reason (real, not imaginary) for feelings such as gratitude, hope, affection, trust, annoyance, intimacy, resentment, and fear of separation?

Finally, there was the ending. Breuer had been preoccupied with his patient, and his wife had become jealous and morose. There had been improvement, indeed. But also, according to Jones's account, Breuer confided to Freud that he decided to terminate treatment because he divined the meaning of his wife's 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" (Jones, 1953, p. 225).

Exactly how he announced this decision to Anna O. we do not know. That evening he was called back by the mother and found his patient "in a greatly excited state, apparently as ill as ever." She was "in the throes of an hysterical childbirth" (Jones, 1953, p. 224).

Certainly that is an interpretation of her "cramps" and utterances that might commonly occur. We have no firsthand information as to what the patient thought or meant. Every report is second- or thirdhand, *through* Freud *about* Breuer, and that usually through Jones, who wrote, "Freud has related to me a fuller account than he described in his writings," and some of that account is quoted as follows:

> The patient, who according to him (Breuer) had appeared as 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. . . .
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> 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 phantom pregnancy. The recurrence 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. (1953, pp. 224-226)

A somewhat more explicit (but still far from direct or verbatim) report is cited in Freeman (1972, p. 200). Freud writes to Stefan Zweig (a relative of Anna O. by marriage): "*What really happened* with Breuer I was able to *guess* later on, long after the break in our relations, when I *suddenly remembered* something Breuer had told me in another context before we had begun to collaborate and which he never repeated. On the evening of the day when all her symptoms had been disposed of, he was summoned to the patient again, found her confused and writhing in abdominal cramps. Asked what was wrong with her, she replied: 'Now Dr. B's child is coming!' " (emphasis added).[4]

Freud, speaking of Breuer, added, "At this moment he held in his hand the key," but "seized by conventional horror he took flight and abandoned his patient to a colleague" (Freeman, 1972, p. 200).[5]

Here is one final quotation from Breuer himself in his own report: "The element of sexuality was astonishingly undeveloped in her. The patient, whose life became known to me *to an extent to which one person's life is seldom known to another*, had never been in love" (Breuer & Freud, 1957, pp. 21-22; emphasis added).

What then "really happened"? We will never know. Two exceptional (in my opinion, magnificent) people of great intelligence and noble spirit came close to understanding. He knew her

well. Probably she knew him better than he thought. The knowing appears to have been precious to both. Understanding failed at a critical point. They dropped the key. It is tragic; so much was lost. Thankfully, we know that both carried on vital and constructive lives for many years.

If you are a woman, reading this will probably bring different reactions than those of the typical man. Perhaps you feel more sympathetic to the patient. If you put yourself in the therapist's place, supposing this could be your case, you know at least that you could think to yourself, and possibly say to Anna O., "Unlikely that it is my child in the physical sense, since I am a woman like yourself, but perhaps you mean that I am somehow parent to your pain, your growth, your condition, whatever." (If you think that logically a woman therapist would never face such a situation, because of the reality, consider the implications of *that* for transference theory!)

More difficult if you are a man, putting yourself in this imaginary situation. You might say, "I submitted to voluntary sterilization in order to make my life less anxious, as it were, so it is unlikely, etc." as above. Not only a condition with which few readers would identify, but in this case useless, since Anna knows Breuer has recently fathered a child. (There is another possible source of security, transference theory, but it had not yet been invented.)

Meanwhile, return to the fact that it is Dr. Breuer who is directly and immediately involved, and involved with Anna O. What might they be thinking, *meaning*, saying to each other in this perilous moment, at best and at worst? God knows what words she uttered in which four languages (for she was known to speak a "gibberish" of mixed tongues when ill), nor what she heard, what he said, or what he told Freud was said. Nor what Freud told Jones; nor how accurate Jones's translation (not always, we know). But let us take it that Freud's letter to Zweig is the most authentic; in it, Anna, on one page, says, "Now Dr. B's child is coming" (Freeman, 1972, p. 200) or, in a slightly different quotation from the same scene, same book, "Now Dr. Breuer's baby is coming. It is coming!" (p. 56).

Anna might have thought, felt, or said, for example:

Dr. B—a baby. I feel like a baby!

Would you abort my child? Then don't abort my treatment.

You know me so well, but you thought I was sexually underdeveloped, had never been in love, had no romantic feelings—although you knew, for instance, that I loved to dance. Well, I've grown. Thanks to you in good part. Now Dr. Breuer's child has become a woman. I'm ready at last for that sexual release. It is coming!

When you were late for our appointment one morning, you apologized and told me [as he had] that it had to be so because your wife was having a new baby and you had to stay up all night. If that is what is more important to you, look, I'm having one too.

Why did you tell me so suddenly that you could not continue to see me? Your reasons sounded false. I know so well your voice, your eyes. What is the real reason? If you must lie to me to leave me, I must lie to you to keep you.

Only hear me out. I mean you no harm as you leave. We have touched. You massaged me, fed me, gave me life, comfort, discipline; made me tell things I would not tell anyone else. I felt loved, and I must tell you in the ultimate way, I love you too. You are handsome, kind, distinguished. If all of this does not justify my excitement and love, what does? Life together is impossible, I know that. Sex is really not that important to me either. But love is. A child would be. I want *someone* to love. I am in great pain over it.

None of these possibilities begins to describe conversations to which they might have led. But meanwhile, Dr. Breuer, on his part, might have thought, felt, or said something like the following:

What did I do to deserve this?

My God, you are really out of your mind (again).

You cannot think that I . . . (or can you?)

We've never even discussed such a thing (which they hadn't).

It never entered my mind (if indeed it hadn't).

Is this more of your "private theatre"? Not amusing.

You are punishing me.

Damned embarrassing. I already have problems at home.

This is a trap! How to get out of it.

Here is the ruination of my reputation/family/livelihood/-method/hope/everything.[6]

Or, in a more benign mood:

You don't want me to leave you.

Perhaps I have been both too caring and careless, left you unfairly.

What are you growing, laboring to deliver?

What part did I play?

I am touched and honored that you choose me.

Have I led you to expect more than I can give?

Or, best of all:

You are in pain. Let's try to understand. I will postpone my trip and work with you.

Freud, as we already know, discussed this case with Breuer more than once. There is some evidence that Breuer felt not only uncertainty about it, but guilt and shame as well. In the late 1880s, years after *Studies in Hysteria* was written, Freud tried to persuade Breuer to write more about it. Breuer had declared the treatment of hysterics an ordeal he could not face again. Freud then described to Breuer one experience so well known now through his autobiography (1948, p. 48) in which he too had faced "untoward events." As Jones (1953, p. 250) described it:

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 his reasons for regarding such "untoward occurrences" as part of the transference phenomena characteristic of certain types of hysteria.[7] 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.

Momentarily this comforted, explained to, and protected Breuer, but only momentarily. At first, Breuer agreed to join in the publication and promotion of the idea of transference. As Freud writes many times, "I believe," he told me, "that this is the most important thing we two have to give the world" (Breuer & Freud, 1957, p. xxviii). But then, Breuer withdrew his support for the theory and the complete primacy of sexual etiology of neuroses—support Freud needed and urgently sought. "He [Breuer] might have crushed me . . . by pointing to his own patient [Anna O.] in whose case sexual factors had ostensibly played no part whatever" (Freud, 1948, p. 6).[8] That Breuer was ambivalent, that he neither crushed nor supported, Freud put down to Breuer's suppressed secret of the case. Breuer may have had serious and sincere doubts on other scores. They agreed to disagree, citing "the natural and justifiable differences between the opinions of two observers who are agreed upon the facts and their basic reading of them, but who are not invariably at one in their interpretations and conjectures." It was signed "J. Breuer / S. Freud, April 1895"; (Breuer & Freud, 1957, p. xxx). Breuer, quite possibly intimidated by the nature of his suppressed material and his loyalty to both colleague Freud and patient Anna O. did not press his arguments, whatever they might have been. Freud did, and swept the field. Now we have transference.

DEFINITIONS AND DEFINERS

A few definitions are in order. There are dozens. They change over time and between authors. The main theme is constant enough that the proponent of any form of "depth psychology" can sagely nod assent, though Orr (1954, p. 625) writes, "From about 1930 onward, there are too many variations of the concept of transference for systematic summary."

CIRCA 1905

> What are transferences? They are new editions or facsimiles of the tendencies and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment. Some of these transferences have a content which differs from that of their model in no respect whatever except for the substitution. These, then—to keep the same metaphor—are merely new impressions or reprints. Others are more ingeniously constructed; their content has been subjected to a moderating influence—to *sublimation*, as I call it—and they may even become conscious, by cleverly taking advantage of some real peculiarity in the physician's person or circumstances and attaching them to that.[9] These, then, will no longer be new impressions, but revised editions. (Freud, 1959, p. 139)
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> 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. (Freud, 1935, p. 384)
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> By transference is meant a striking peculiarity of neurotics. They develop toward their physician emotional reactions both of an affectionate and hostile character, which are not based upon the actual situation but are derived from their relations to their parents. (Freud, 1935, p. 391)
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> There can be no doubt that the hostile feelings against the analyst deserve the name of "transference" for the situation in the treatment gives no adequate occasion for them. (Freud, 1935, p. 385)

Why should anyone feel hostility toward Freud? "Actually I have never done a mean thing," wrote Freud to Putnam (Jones, 1957, p. 247). Not many can make this disclaimer, and not all believe it borne out by Freud's record (compare Roustang, 1982).

Still, if he only *thinks* this of himself it is more likely that hostile feelings toward him would be seen as unjustified by his behavior. What matters here is the analyst's proclamation of innocence—a stance that permeates transference theory throughout. While an *ad hominem* argument is of limited use, there is a principle to which readers in this field must surely subscribe. It is that *every honest theory of personality and psychotherapy must reflect the personality and experience of its author.* How could it be otherwise?

Freud (1935, p. 385) continues this definition:

> The necessity for regarding the negative transference in this light is a confirmation of our previous similar views of the positive or affectionate variety.

This "necessity" is part of that strange logic in which the second assertion confirms the first!

Is transference useful? Yes, it overcomes resistance, enables interpretation; it is your chief tactical ally. "The father-transference is only the battlefield where we conquer and take the libido prisoner" (Freud, 1935, p. 396).

In sum, the patient's feelings "*do not originate in the present* situation, and *they are not deserved by the personality of the physician*, but they repeat what has happened to him once before in his life" (Freud, 1927, p. 129; emphasis added). The "once before" is experience "in childhood, and usually in connection with one of his parents." As put most simply in *The Problem of Lay Analysis* (Freud, 1927, p. 129): "The attitude is, to put it bluntly, a kind of falling in love." We must not forget, "This affection is not accounted for by the physician's behavior nor the relationship nor situation" (1935, p. 383).

So, the analyst is not responsible, the situation is not responsible, even though there may be some "real peculiarities" visible in the physician or circumstances. Transference is a neurotic peculiarity. Whether it is a normal (common) trait also is unclear, but the transference neurosis is a feature of analysis—that is certain.

There are some updatings. They will not make a basic difference, but it is worth noting that Fenichel (1941, p. 95) tried to alter the absolute exemption of the therapist's responsibility when he wrote:

> Not everything is transference that is experienced by a patient in the form of affects and impulses during the course of the 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.

Later positions (Macalpine, 1950; Menninger, 1958) suggest that the analytic situation itself is regressive, and thus somewhat influential if not responsible. Waelder (1956, p. 367) says, "Hence transference is a regressive process. Transference develops *in consequence* of the conditions of the analytic situation and the analytic technique" (emphasis added). Waelder's statement directly contradicts some of Freud's basic definitions, but to what effect?

The qualifications make concessions and corrections, but no one anywhere questions the basic concept, per se. Oddly, they serve only to strengthen, never to cast doubt. The situation *is* regressive because it turns all the patient's attention inward and backward toward earliest experience, and the therapist is made to seem bland, neutral, indistinct, even invisible. It is like a form of sensory deprivation. Other forms are elevated into unusual prominence. So it is with the presence and with the pronouncements of the therapist in this regressive situation.

Or, if transference is considered as a matter of "projection," the question arises, *what is the screen*? The answer was implied, though it seemed not to be recognized, in the first deep crack in transference theory—"countertransference." The instant that concept was developed, it should have become clear that the analyst's presence was more than a blank. Presumably countertransference was to be kept at a minimum. Until recently, definitions of and attention to it have been relatively minimal

(except for one sector where it seems most nearly innocent, appropriate, and "natural": that is, work with children).

As Freud began to give attention to countertransference, he viewed it as responsive or reflexive rather than as an originating characteristic of the analyst. "We have become aware of the 'countertransference' which arises in [the physician] as a result of *the patient's influence*[10] on his unconscious feeling" (Freud, 1910, p. 122; emphasis added). This is a far cry from the notion of one of my students, who thinks that transference lies in wait with the therapist and his wishes or expectations, while the counter-transference is on the part of the patient! Not so farfetched as it first seems, for it may be only a reversal of Freud's statement just preceding. Which comes first?

The psychoanalytic positions on countertransference range from treating it as a hindrance to be overcome[11] to welcoming it as a sensory asset ("third ear") (Epstein & Feiner, 1974, p. 1). In any event, one can hardly claim "no responsibility" on a "nobody home" basis if it is admitted that *some*body, with *some* palpable characteristics, is there. The question now becomes, What is the nature of these characteristics?

The therapist is in truth a person of some distinctiveness, some identity, no matter how discreetly hidden. He has some self-concept—an image of what he is and wants to be. Perhaps the more truly modest and humble, the more he will be surprised by intense idealizations of himself by others. If plain (he thinks), how much more inappropriate for the patient to think him handsome.

But perhaps he is not really modest or humble. That may be only a professional attitude. When Freud wrote to his wife Martha, telling her of Anna O.'s strenuous affection for Dr. Breuer and of the consternation on the part of Breuer's wife, Martha replied that she hoped that would not happen to her (a common concern of the therapist's spouse). Freud "reproved her for her vanity in supposing that other women would fall in love with *her* husband: 'for that to happen one has to be a Breuer' " (Jones, 1953, p. 225). Yet it was not really *her* vanity at issue, it would seem, but her concern over *his* exposure. Having first miscast the problem, he then did not quite give the assurance that

she wanted,[12] and additionally, it *did* happen to her husband, as the theory predicted that it would. Perhaps it already had. At some point, reported in his autobiography, Freud had discontinued hypnosis after an "untoward event" of his own. The patient, being aroused from a trance, threw her arms around him "in a transport of affection." At any rate, Freud dropped the method of hypnosis (was "freed of it") shortly after, and took a position behind the couch. Some aspect of self-image certainly was a factor: Hypnosis he compared to the work of a "hod carrier" or "cosmetician," while analysis was "science," "surgery." Perhaps it was more dignity at stake than modesty.

Though modesty was a thread often pulled. He wrote to Martha, "To talk with Breuer was like sitting in the sun; he radiates light and warmth. He is such a sunny person, and I don't know what he sees in me to be so kind."

To Martha herself, "Can there be anything crazier, I said to myself. You have won the dearest girl in the world quite without any merit of your own"[13] (Jones, 1953, p. 110). Granted that this is the romantic hyperbole of courtship, and that there are fluctuations in mood and tone as situations change, so that we hear this humility from the same powerful genius who called his real nature that of the *conquistador*. Still, the literary license we give to "without merit" is like that we give to the supposedly indistinguishable therapist who receives what *he* says *he* does not deserve in the service of carrying out the conditions for transference.

"Can there be anything crazier, I said to myself." Yes, a few things. One is institutionalizing false modesty such as that, by denying the characteristics in the situation and the personality of the analyst—denying so completely that a neurosis is cultivated by and for both parties while it is the very object of treatment. And all in the name of sanity, clarity, and honest scrutiny.

INTERIM THOUGHTS

On the way to proposing a countertherapy, permit me to describe some experiences that, over the years, led me to depart

from the common beliefs in psychoanalytic theory that I once held.

(1) For 15 years, at the University of Chicago Counseling Center, I worked through the ranks from student-intern to senior faculty and chairman of the Interdepartmental Clinical Program, and occupied the office of my former mentor Carl Rogers after he left for Wisconsin. In such a position, one develops the reputation of a "therapist's therapist." It is a privileged learning opportunity. My clientele consisted largely of junior professionals. Three were interns on a psychiatric rotation from the university hospital. They were taught by their medical faculty a good deal about transference. They discussed their experiences as psychiatrists in training. One, a shy, diffident young man, was especially articulate about the onset of transference as he perceived it in a slightly older woman patient. He felt a rising excitement—"This is it." He also felt that he was being handed a power about which he was both pleased and embarrassed, and of course embarrassed by his pleasure and embarrassment. Not only was transference theory an "armor in his ordeal," but a source of *downright satisfaction.* He felt "as if I were wearing a mask. I smiled behind it. I could have taken it off. I thought of that, but I was too confused about what I'd have to uncover. Behind it, I could be detached, amused, be more thoughtful and responsive." It was a revealing bit of information on the inner experience of transference in a young adherent of the theory. I wondered how many therapists acknowledge their pleasure so honestly. Weeks later, I took a neighbor and his 4-year-old son to the emergency room. My client was on duty. I helped hold and soothe the little boy while Dr. G. sewed stitches in his head wound. We worked in a kind of harmonic unison over this child of French-Iranian extraction, who knew little English and was pained and frightened. We did it well. In our next session, Dr. G. told me that he had felt as if the boy were "our child." Did he mean his feminine qualities and my masculine ones (or the reverse)? No. If it must be put in familial terms, we were brothers, he thought. So did I (though neither of us actually had brothers). One might easily see in this an expression of transference and/or countertransference.

I found neither. We had an experience that made us feel like brothers.

(2) I attended a discussion of religion between Bruno Bettleheim and Paul Tillich. Bettleheim took the general position outlined in Freud's *Future of an Illusion* (1949) to the effect that the urge toward religious belief was a projection of the longing for a father. That seemed most plausible to me. Tillich answered, "But what is the screen?" Not a weighty reply, to my way of thinking at the time, but increasingly I realized that "it" cannot be nothing.

(3) One evening I overheard a client in the next office. She wept and shouted, "No one has ever treated me this way before. I love it, I can't believe it, but I'm afraid every time I come." I thought she was banging on the desk to emphasize her points. At the end of the evening I went to that counselor's office. "For God's sake, Russ, what were you doing?" He explained, and I heard fragments of a primitive audiodisc recording. The banging was the steam pipes. The client was saying, "No one has ever understood me this way before. No one. I can't believe it. I love the feeling of 'at last, someone knows, someone cares.' But when I come back next week, with the rest of my garbage, will you still understand? I couldn't bear it if you didn't." I do not know the content of what was understood, but was most struck by what understanding meant to her, and thought about it for a long time.

(4) I once taught a course with the prominent Adlerian Dr. Rudolph Dreikurs—a hearty, gruff bear of a man. In one class he seemed especially heavy-handed. Students were angry and critical. During the intermission, he said, "Do you notice the hostility? There is a lot of negative transference here." I told him my observations, and he was perplexed, crestfallen. He had taught hundreds, even thousands, and no one had complained. They usually loved him.

(5) In 1971, during the period of the "revolution in mental health" (community organization, demystification, "radical therapy" and politics to fit, and so on), a consulting psychiatrist and practicing analyst told me, "It is amazing. Some of these paraprofessionals I'm supervising can do anything we can do—except the handling of the transference." I wondered—what would he say if there *is* no "transference"?

(6) Over many years, I have been perceived in many different ways. Humble and proud, kind and cruel, loyal and unreliable, ugly and handsome, cowardly and brave, to name a few wide-ranging contradictions. Someone must be mistaken? No, they are all true. This sense of my self, sometimes selfish, sometimes generous, makes me hesitate before characterizing someone's perception as a distortion. One client dreamed of me as a little boy, one she held on her lap—and I a white-haired father of three grown children, as she knew. But she too was correct (and she had her own reasons for that caretaking dream). There is that childlike side of me. I could cast it off, but keep it for my enjoyment. I have been seen as a lion and a rabbit. True, I can be hard and soft. Is that unusual? Though happy to have been married for 40 years, I could, when young, have fallen in love frequently—with ease, passion, and tenderness. Seriously? Sometimes seriously enough to last another lifetime, probably, but not so seriously that I think I am the only man for this only woman for me.[14] While I do not respect the philanderer because of the damage he is likely to do, reading Jones's (1953, p. 139) judgment that "Freud was not only monogamous in a very unusual degree but for a time seemed to be well on the way to becoming uxorious" struck me as curious and doubtful. It is, however, a condition that would more readily incline one toward transference theory—at least as a supporting illusion. But if that is not my condition or my personality, should his theory be my theory?

Then, about my granddaughter. I dearly love this child. From what previous experience do I transfer this affection? Yes, I dearly loved my two daughters and my son when they were 3-year-olds, too—but whence came *that*? Sooner or later, experience has to be *de novo*, original. We know from work in comparative psychology that most women and many men show autonomic signs (such as pupillary change) of great attraction to the typical "configuration of infant" large head and small body. In short, it is an instinct, and it *produces its natural consequences each time for the same instinctive reasons, as if each time were the first*. This child knows, trusts, and loves me, too. Is *her* experience transference? Transfer of what? From where? Is mine transference and hers counter-

transference? Neither one; the trust is earned, the love is natural. That is the answer.

The real question is, what conditions bring about the original experience, the first of its kind without precedents? Then, what if those conditions again prevail? Put another way, if every perception depends on the past, what if there is no past?

THE NEXT STEP

History of its origins aside, transference is a shorthand term for qualities and characteristics of human interaction. Any shorthand will fail to represent the particulars of a unique relationship. Rather, the shorthand will obscure (in a sometimes comforting way) the realities of the relationship. The concept of "father figure," for instance, needs to be unraveled; what characteristics is it supposed to represent? What do such concepts as "parent" or "infantalizing" mean? In the remaining pages, an alternative view is presented to clarify the realities that the shorthand forms fail to represent.

A COUNTERTHEORY

If transference is a fiction to protect therapists from the consequences of their own behavior, it is time to examine some behaviors—and their normal consequences. This does not start with any implication of villainy. It is simply that since "transference-love" is the consequence most fraught with concern, and since that was the original instance in development of transference theory (from which all its extensions come), we should examine the behaviors responsible for the development of affectionate and erotic feelings. What is the truth? What are the facts?

First, there is the situation, its true conditions. Dependency is a built-in feature for the petitioner at the beginning, and the treatment itself often promotes further dependency. The patient (or client) is typically anxious, distressed, in need of help, and

often lonely. The therapist, presumably, is not. Instead, he holds a professional role (especially if a physician) that ranks at or near the top in sociological surveys of romantic attractiveness to women seeking husbands (ahead of astronauts and other celebrities).[15] The situation is set for intimacy, privacy, trust, frequent contact, and revelation of precious secrets.

Second, it is also the case that there is an ongoing search, on the part of most adolescents and adults, for sexual companionship. It requires only the opportunity for intimacy. One does not need to look into therapy for arcane and mysterious sources of erotic feelings. They are commonplace, everywhere, carried about from place to place. Psychotherapy will encounter sexual attraction as surely as it encounters nature. The simple combination of urge and situation is a formula for instant, if casual, romantic fantasy.

Third, there is a supremely important special factor in a behavior to which most therapists subscribe and try to provide. It is *understanding*. Freud put it bluntly, (of transference) "It is a kind of falling in love." Let me put this bluntly too: *Understanding is a form of lovemaking*. It may not be so intended, but that is one of its effects. The professional Don Juan knows and uses it to deliberate advantage. That alone may make it an embarrassment to the therapist who does not wish to take advantage and is hard pressed to deal in an accepting but nonpossessive way with natural feelings that conventionally call for either some response in kind or rejection. Such difficulty does not relieve him of the responsibility. Intentionally he has been understanding, and this alone will, over time, activate in the patient some object-seeking components of trust, gratitude, and quite possibly affection or sexual desire.

In this same context, *misunderstanding is a form of hatemaking*. It works equally well since being misunderstood in a generally understanding relation is a shock, betrayal, and frustration.[16]

Understanding and misunderstanding and their ambivalent interplay are the primary factors in this thesis about "positive and negative transference," but there are numerous supplementary behaviors. To supplement misunderstanding, for example: waiting, asking for the bathroom key, paying (possibly for missed

appointments), cigar smoke, and various other subordinating and infantalizing conditions.

The most convincing evidence for this simple but profoundly effective thesis probably lies in one's own experience. It was, however, called to my attention by a combination of events, such as that overheard client in the next office, and another fortuitous circumstance. A Catholic priest took a year of sabbatical study at the University of Chicago, and I was able to see some of the basic data on which he based his study of how it feels to be "really understood" (Van Kaam, 1959). A seemingly simple question, but of great significance. By chance, the first questionnaire respondent was an adolescent girl, a 17-year-old student in a parochial school. This midwestern bobby-sox type is hardly a match for the sophisticated European Anna O., but they are equally real and, I suspect, would have understood each other. As to how she feels, in substance and spirit, when she experiences understanding, she wrote:

> I felt as if he, my boyfriend, had reached into my heart and had really seen my fears and understood how much my religion meant to me. My whole being wanted to cry out how much I loved him for that understanding. My body felt so alive and I wanted to tell everyone how happy and exuberant I was. I wanted everyone to be happy with me. I wanted to hang on to that understanding and pray it would never be lost to me.
>
> Whenever I am understood by anyone, I feel a fresh onset of love for anyone or anything. I can't sleep right away because I don't want that understanding to fade, and somehow it seems to me that it will probably be lost in the morning.
>
> My body seems to have a terrific pounding sensation and I want to cry out something which I don't know how to express in words. I feel more sure of myself. I want to give. I want to give everything I have to make this person who understands happier. I want to live the full minute of every day. Life seems so much richer when you know someone understands, because to me, one who understands is the one who cares and loves me and I feel love and security and peace. (A. Van Kaam, personal communication, 1961)

I submit that this is not an atypical reaction, but simply one heightened by the enthusiastic vigor of an adolescent girl. She tells us how being understood affects a human being psychologically or physiologically. Why should such effects be labeled "transference"? They do in fact *originate in the situation* and through the performance of psychotherapy (when that is indeed benevolent). The reaction might better be called "originalance." It is not transferred, not inappropriate. It is the normal and appropriate reaction. It might come about in someone who had never been so understood before. Thus it might come from no past experience, but from a wish that the past had been different, or from the hopes and dreams of the future!

For example, there is the filmed interview between Carl Rogers and Gloria (Rogers, 1965), of which a portion is reproduced below. Near the final section, she feels deeply understood in a way that brings tears and a feeling she calls "precious." She wishes her father had been so understanding—but that had *not* been the case. The typical professional audience witnessing this becomes tense and alert. There is uneasy laughter. They have been taught what to think of this, and the moods range from scornful to sympathetic, for there is a general feeling that transference has reared its head (and the anticipation that Rogers might be caught in a dangerous "Freudian" situation). It can be read that way. It can equally be read as her response to understanding *such as she never had* from her father, her wish that she could have a father like that, not like her own. Is *that* transference?

Rogers, on display and well aware of this issue, makes certain that he does not deny or reject, and while his response may not be the perfect model, it acknowledges her admiring wistfulness, his appreciation in kind of her, and continues in an understanding mode.

Rogers: I sense that, in those utopian moments, you really feel kind of whole. You really feel all in one place.

Gloria: Yes. [Rogers: M-hm.] Yeah. It gives me a choked up feeling when you say that, because I don't get that feeling as often as I like.

[Rogers: M-hm.] I like that whole feeling. It's really precious to me.

Rogers: I suspect none of us gets it as often as we'd like, but I really do understand. [pause] M-hm, that [referring to her tears] really does touch you, doesn't it?

Gloria: Yeah, and you know what else, though, I was just thinking . . . I feel it's a dumb thing that, uhm, all of a sudden when I'm talking, gee, how nice I can talk to you, and I want you to approve of me, and I respect you, but I miss that my father couldn't talk to me like you are. I mean I'd like to say, gee, I'd like you for my father. [*Rogers*: M-hm.] [pause] [*Rogers*: You . . .] I don't even know why that came to me.[17]

Rogers: You look to me like a pretty nice daughter. [a long, long pause] But you really do miss the fact that you couldn't be open with your own dad.

Gloria: Yeah, I couldn't be open, but . . . I want to blame it on him. I think I'm more open than he'd allow me. I mean he would never listen to me talk like you are. And, ah, not disapprove, and not lower me down.

"ORIGINALANCE" VERSUS A FORM OF "REPETITION-COMPULSION" IN PSYCHOLOGICAL THOUGHT

Originalance is a not very good word for another way of thinking about the problem. It refers, if you can believe in such a possibility, to new experience. That could mean "fresh perceptions," or "first loves" and could also refer to an experience previously known or an act previously performed but new in spite of its appearance of being old. It is an orientation toward present or even future influences on behavior. "Originalance" is merely a word counterpart to "transference" and is not designed to "catch on" as a theory. The purpose here is to balance and then dispense with these particular theories so that the facts can once more be observed with what the phenomenologists call "sophisticated naivete."

One of the errors in transference theory is the illogical assumption that any response duplicating a prior similar response is necessarily replicating it. Similar responses are not always repetitions. They appear to us to be repetitions because, in our effort to comprehend quickly, we look for patterns, try to generalize. There is breathing as a general respiratory pattern, but my most recent breath is not taken because of the previous one: rather, for the same reason the previous breath was taken, and the first breath was taken. It is not habit. It is normal function, repeated but not repetition.

In the first instance, the original love of the child for the parent is not transferred from the past. There was no earlier instance. What then? This original love developed for the same sorts of reasons or conditions that will again produce it in later life. Provide those conditions again and they will produce (not reproduce) it again and again, each time on its own merits. The produced experience is mingled with memories and associations, but those are not the conditions. Memories may seem to *re*produce. If so, they reproduce the *conditions* (for fear or passion, for example), and it is again the *conditions*, not the memory, that account for the response.

How did any particular affect come into being in the first place? If love developed through the parents' understanding (of what the child needs in the way of care, in the development of its whole mental life from language to thought), further understanding should elicit love too; but consider, *every second instance might as well have been the first*. Warmth feels good to the body, not only because it felt good when one was an infant, but because it *always* feels good. The need is "wired in" as an innate physiological requirement. When one tastes a lemon at age 30, does it taste sour because it tasted that way at age 3? It *always* tastes sour, the first time at any age, whether or not it ever tasted so before, and all following times for the same but original reason each time.

A QUESTION OF LOGIC

This logic is functional; the logic of transference is historical. The difference is very great. Historical logic in psychoanalysis

goes even beyond looking into the past of an individual's life. Anna Freud writes: "Long ago the analytical study of the neuroses suggested that there is in human nature a disposition to repudiate certain instincts, in particular the sexual instincts, indiscriminately and independently of individual experience. This disposition appears to be a *phylogenetic inheritance, a kind of deposit accumulated from acts of regression practised by many generations and merely continued, not initiated, by individuals*" (1946, p. 171; emphasis added). In contrast, the logic of a present (or future) orientation does not deny the past, but looks at immediate experience, or even imagination.

From experiential evidence, this newer logic explicitly asserts that any therapist has an active and response-arousing set of roles and behaviors. Therapists are loved for what makes them lovable, hated for what makes them hateful, and all shades in between. *This should be the first hypothesis.* Whatever it does not account for may then be described as proof of another phenomenon, such as transference, but understanding and misunderstanding will, I believe, account for the major affects of love and hate.

This does not begin to analyze the complex interactions beyond understanding and misunderstanding. Whatever they are in any given case, there too therapists play their part. The first principle remains; for the therapist to eschew the pretense of innocent invisibility and to reflect upon what, in the situation and his or her behaviors, does in fact account for those "untoward events" that brought transference theory into being. Adoption of this principle may engender a sense of vulnerability and remove not only the shield but some of the most ornamental of therapeutic trappings as well. This is not the most inviting prospect for the contemporary psychotherapist. It is easier to have an exotic treatment for an intriguing disease. For the patient there may be some allure and pleasure in disguise as well.

Is there no transference, whatever, at any time? Of course there is, if you wish it. The material is there at the outset. It can be cultivated, and it can be forced. Emotional attitudes *will* be expressed, through indirect channels if open expression is discouraged. Like seeds, emotions and perceptions will grow straight and true in nourishing soil or crookedly through cracks in

the sidewalk. One can encourage distortions, and then analyze them. It is a matter of choice. As with any fiction, "transference" can be turned into a scenario to be acted out, creating a desired reality.

At the beginning, there is always incipient prejudice. Upon first meeting, stereotyped judgments and appraisals based on prior experience will be applied to the perception of the new unknown. Some call it "stimulus generalization." In a state of ignorance, what else can one do to make meaning?—unless it is the rare instance of those who are able and willing to approach new experience with suspended judgment, and a fresh, open view.

Except in such cases, prejudgment applies. Then if the reality of the new experience is concealed, attention turns inward to make meaning. If, however, the new reality is available to be known as needed, prejudice fades; judgments and appraisals appropriate to that reality will develop. For example, if red suspenders (and it could be blue eyes, swastikas, peace symbols, skin color) are worn by a person you meet, and if you have been mistreated by someone wearing red suspenders, you will be wary of this new person. If you are permitted to know more, and wish to do so, the effect of red suspenders will be canceled or supported or become trivial, depending upon your whole knowledge of the new reality. But if the new reality is concealed, attention searches for focus and meaning and, from a relationship standpoint, projections reign. Transference, or what passes for transference, can then be cultivated. Yet it is neither inevitable nor necessary. It is an obstruction.[18] That some derive benefit from its analysis may come from the concentrated self-examination and the presence of attentive intelligence on the part of the therapist—both of which are possible in at least equally pure form *without* the transference neurosis.

Will there be any change in basic transference theory? Is it possible to bring balance through corrective criticism? Not likely. Such "balance" is only a temporary concession. The theory itself does not allow for balance. It is too heavily weighted (nearly all or none) because its logic cannot bear disturbance. As for the basic position, it is as entrenched as ever. For the public, it is high

fashion and popular culture—diverting and entertaining. For the professional it is a tradition, a convenience, a shield, stock-in-trade, a revealed truth and a habit of thought.

How strong a habit of thought is illustrated by an instance described in the study by a sophisticated and sympathetic journalist, Janet Malcolm, under the title "Trouble in the Archives" (1983). It reports as "striking example of Eissler's[19] remarkable freedom from self-justification" (p. 132) a case history. "He treated a wealthy older woman during the years before her death, and was so helpful that, in gratitude, she changed her will and left him a huge amount of money." He could not accept it for himself and ordered it returned to beneficiaries or donated to charities. However, "the husband of a relative of the deceased whose legacy had been diminished because of the change in the will, formally objected to the probation of the will. He happend to be an analyst, and his argument was that Eissler had exercised 'undue influence' on the patient through 'the unconscious utilization of the transference' " (p. 132). Malcolm writes, "The case history ends with a wonderful twist." Since the matter had caused painful embarrassment, what had first been seen as a "loving gesture" was reinterpreted by Eissler as "an expression of her hatred of him—an expression of the negative transference that had never been allowed to emerge during treatment" (p. 137).

It can be interpreted in other ways as well. The ex-patient may indeed have wished him well, may even have expected that if he could not use the money for himself he could choose to support charitable interests of importance to him. On the other hand, she may have enjoyed the amusement afforded by anticipation of cleverly hurting both her analyst and her relatives with one stroke. Two other observations remain. First, she was treated, even after her death, like a psychiatric patient and therefore a minor or incompetent. She could not exercise her choice about what was, after all, her money, because (a) her judgment was forever suspect, (b) it dispensed something of considerable value to others, and (c) it did not suit those who survived her and who either could call upon or were called upon by transference theory. Second, everything suffers (not entirely without compensation)

except the concept of transference. One might think that since it was born of embarrassment, it might now die of embarrassment. But no, that is its charm. It merely changes color, never seriously questioned, only reconfirmed.

CONCLUSION

I have offered a brief for a countertheory, not in the sense of a complement or counterpart, as in "transference and counter-transference," but in the sense that *counter* means opposite, alternative. If transference is a theory, this is the counter: Personality and situation aside for the moment, *the therapist is responsible for two fundamental behaviors—understanding and misunderstanding—which account for love, or for hate*, and their associated affects. These, as well as other behaviors and the situation and personality of the therapist, may account—should first be held accountable—for the whole of what passes for transference.

The power of understanding has been featured to account for the phenomenon called "transference." That use should not hide the point that it is this very power of understanding (not the transference, transference-love, or love itself) that heals. Understanding makes for healing and growth; misunderstanding makes for injury and destruction.

The proposition that "understanding heals" does not make understanding the exclusive property of client-centered therapy. Far from it. Client-centered therapy has a constant theme in its focus on understanding: early, in its method of seeking confirmation from the client; later, in its stress on empathy (as a form of understanding and even a "way of being") and how such understanding is best achieved. That is its emphasis, not its proprietary claim.

The emphasis on understanding is stressed at this final point to indicate that, while love is a blessing, love is not enough. Ultimately, we are trying to account not only for transference-love, or for love in general, but for *healing*. Even romantic love

("falling in," or choosing to be in) gives promise of, and is given in the hopes of receiving, understanding (which may or may not be delivered). Being "in love" often assumes understanding to exist even where it does not. When love *is* present, it is an environment for or the consequence of *understanding*. Though the two are strongly associated, love does not heal. Understanding heals. It also makes one feel loved, or sustains love already felt, but the healing power is in the understanding.

Knowing that does not make the conduct of therapy easier in the slightest. It may, however, help us to separate therapy from the rest of life. It seems that we can quite well love, and take love from, those to whom we do not devote the considerable or sometimes near-consuming effort to understand fully. *That* is the difference between real life in ordinary relations and equally real life in therapy. If and to such extent as they could be brought together, so much the better; if not, so much the good in either case.

To conclude that it is not love that heals may be a disappointment to many. The role of the healer is appealing. So is that of the benefactor who dispenses love. Therapists and others find these roles all too gratifying. But no, the "healer" takes credit for a process inherent in the organism, if released, and love is therapeutic or enduringly beneficial only if expressed through understanding. The act of understanding may be the most difficult of any task we set ourselves—a seemingly mundane "service role" yet requiring kinds of intelligence and sensitivity so demanding that some people are truly seen as gifted. Even that is not the final cause. It still remains for the client to feel understood. Of course, in doing so, clients understand themselves—that is the source of their confirming the understanding.

To realize that it is the *understanding* that promotes the healing will direct us to the remaining problem for psychotherapy and psychology: We do not know the mechanisms by which understanding promotes healing or even the mechanisms of understanding itself. That knowledge cannot come from a theory such as transference, which has been a roadblock and a pointer in the wrong direction for almost a century. That knowledge may not

come from *any* present version of psychotherapy, but rather from more neutral realms of cognitive, social, and developmental psychology, or neuroscience, to the ultimate benefit of a new theory and practice.

AUTHOR'S NOTE

This article is a revised version of a chapter in the book *Client-Centered Therapy and the Person-Centered Approach* (Levant & Shlien, eds., 1984) and I would like to thank the publisher, CBS-Praeger, for permission to reprint it here. It has previously been translated into Italian, French and Hungarian. Working with translators taught me, too late for this chapter, that my writing should have been translated into better English at the beginning. I apologize for difficulties to the reader.

NOTES

1. Transference does not appear in the index of his earlier volume, *Counseling and Psychotherapy* (Rogers, 1942).

2. Inventions are human-made:Thus *invent* is used to offset Freud's use of the word *discovered*, which inaccurately implies a fact found or truth revealed.

3. Social and economic conditions that create anxiety neuroses in women and enable men to become physicians have changed enough to bring about some evening of opportunity. Fortunately, women can now more easily find female therapists. There are also more cross-sex, same-sex, bisex, and other permutations. We know relatively little of these many parallels of the transference model, but may be sure that the concept is now so well established that it will appear as a "demand characteristic" in its own right. It has become part of the pseudosophisticated belief system of informed clients.

4. One point must be stressed. There is only, but *only* Freud's reconstruction in this momentous history. No other source whatever. How much Freud wanted these data, how much and how often he pressed Breuer for them, we have a few hints. In his autobiography (1948, first published in 1925): "When I was back in Vienna I turned once more to Breuer's observation and made him tell me more about it" (p. 34). In 1925 he still speaks of "a veil of obscurity which Breuer never raised for me" (p. 36). This prodding, however, eventually cost them their friendship. How much Breuer's support meant to Freud we do know. How highly motivated to get this information, which he sometimes says Breuer would never repeat for him, we also know. Yet it is all Freud's reconstruction; and in 1932, when he wrote the cited letter to Stefan Zweig, he still seems wanting of confirmation: "I was so convinced of this reconstruction of mine that I published it somewhere. Breuer's youngest daughter read my account and asked her father about it shortly before his death. He confirmed my version, and she informed me about it later" (Freeman, 1972, p. 200). To what "reconstruction" does this refer, that he published "somewhere" (and *where*?)

because he was so convinced yet unconfirmed? Hot pursuit, without a doubt, but the facts are still reported with slight discrepancies, and never by anyone but Freud.

5. The key to what? Not necessarily the arcane lock Freud had in mind. Perhaps the door to a more literal and still more courageous exploration, and Breuer might have founded an enlightened form of psychotherapy to advance the field by decades. But he was frightened off by the event, his circumstances, and perhaps his colleague as well.

6. I have personally known psychologists and psychiatrists who far exceeded Breuer's relatively innocent transgressions, that is, their were "sins" by the informal definition, "included exchange of bodily fluids." Results included divorce, marriage to the patient, suicide, murderous thoughts and a probable attempt, career changes, and the development of new theories. The late O. H. Mowrer's therapy based on real guilt and compensation (1967) is an example of the latter, as he often announced to professional colleagues.

7. This is either the instance that Freud sometimes described in his autobiography and elsewhere, as the patient being just aroused from a hypnotic trance, and with a maid-servant unexpectedly knocking or entering, or it is a separate but prototypic scene.

8. Breuer knew better. Had he walked into this trap, it is he who would have been crushed.

9. Women are especially good at this, he writes. They "have a genius for it" (Freud, 1935, p. 384).

10. This too is the patient's doing? Does this material not reside in the being of the physician? Or, if an interactive quality, does the transference, in reverse, arise in the patient as a result of the *physician's* influence?

11. In a letter dated 1909 about a case now become infamous, Freud wrote to Jung, "After receiving your wire I wrote Fraulein Sp. a letter in which I affected ignorance" (McGuire, 1974, p. 230) and says of Jung's mishap, "I myself have never been taken in quite so badly, but I have come very close to it a number of times and had a '*narrow escape*' [in English]. I believe that only grim necessities weighing on my work and the fact that I was ten years older when I came to psychoanalysis saved me from similar experiences. But no lasting harm is done. They helped us to develop the thick skin we need and to dominate 'counter-transference' which is after all a permanent problem for us" (McGuire, 1974, p. 231).

12. "Later he assured her that the anatomy of the brain was the only rival she had or was likely to have" (Jones, 1953, p. 211).

13. "But a week later he asks why he should not for once get more than he deserved. Never has he imagined such happiness" (Jones, 1953, p. 110).

14. My wife, with good taste and judgment, advises ("after all, this is not your biography") omitting this entire section. I would like to, but a main point of the article is that theory is in part biographical, stemming from thought, observation, and self-concept.

15. A current viewpoint in social psychology suggests that love, especially sexual love, is the result of status and power factors—"a love relationship is one in which at least one actor gives (or is prepared to give) extremely high status to the other" (Kemper, 1978, p. 285).

16. This should not be overlooked: The therapist wants, and sometimes demands, to be understood by the patient, or client. Whether dealing in reflections, interpretations, or hypnotic suggestion, the therapist wants these understood—he or she feels good about it if they are, and inadequate and "resisted" if they are not. Indeed, *the therapist may have the same response to understanding as does the patient*—tempered, of course, by wisdom, maturity, self-awareness, and other (not always present) virtues.

17. The typical audience thinks it knows why—"looking for a father." Popular wisdom says that young women seek "father figures." A less popular and somewhat hidden knowledge is that men also may seek "daughter figures." Freud might have known this from his dream about "overaffectionate feelings" for his 10-year-old daughter Mathilde (letter to W. Fliess, May 31, 1897), but such reciprocity, or seeking from both directions, does not so readily fit to transference theory.

Whatever motives for either party—whether benign caring, dependency, exploitation, fulfillment or various hopes and desires—the seeking moves in *both* directions. So neither party may be justly accused of entirely uninvited or unrewarded responsibility. This is not necessarily to explain the particular case of Gloria, but to add a statement of general interest in the reanalysis of transference theory.

18. Without doubt, the transference neurosis is an illness, deliberately contrived to benefit the treatment. Perhaps this is part of what is meant by the statement, "Psychoanalysis is the disease it is trying to cure."

19. Kurt Eissler is a towering figure in the psychoanalytic movement, of whom one of his colleagues says, "Eissler is not loveable, and he knows it" (Malcolm, 1983, p. 152). Yet his patient may have found him so, and rightly, for the very reason of his understanding behavior—when, if, and inasmuch.

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