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Basic Psychoanalytic Concepts: VIII. Special Forms of Transference

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The concept of transference, as developed by Freud, arose within the context of the psychoanalytic treatment of neurotic patients. The extension of the techniques of psychoanalysis to a wider range of patients, including psychotics, has led to the introduction of a number of terms to describe special and additional forms of transference. This paper is concerned with aspects of the relationship between patient and doctor which are discussed in the literature under such headings as *erotic transference* (Saul, 1962), *erotized transference* (E. Rappaport, 1956; Greenson, 1967), *transference psychosis* (Rosenfeld, 1952, 1954, 1969; Searles, 1961, 1963; Wallerstein, 1967) and *delusional transference* (Little, 1958, 1960, 1966; Hammett, 1961).

In our previous paper on the concept of transference (Sandler, Dare and Holder, 1970) we were concerned with transference in the usual forms in which it develops in neurotic and normal subjects. Following a review of the main trends in the literature it was seen that the concept was understood and applied in a number of ways. We concluded that a useful statement of the transference concept would be to regard it as 'a specific illusion which develops in regard to the other person, one which, unbeknown to the subject, represents, in some of its features, a repetition of a relationship towards an important figure in the person's past. It should be emphasized that this is felt by the subject, not as a repetition of the past, but as strictly appropriate to the present and to the particular person involved.' We added that 'transference need not be restricted to the illusory apperception of another person . . . but can be taken to include the unconscious (and often subtle) attempts to manipulate or to provoke situations with others which are a concealed repetition of earlier experiences and relationships.'

The literature which has grown around the special forms of transference discussed in the present paper implies, fairly consistently, that the phenomena described are some form of repetition of past psychological situations or relationships, occurring in the course of psychoanalysis or psychoanalytically-orientated psychotherapy, and can consequently be regarded as transferences. However, these transferences have the quality of appearing so grossly unrealistic and inappropriate as to warrant special designation. Authors writing on these topics usually regard such transferences as consequences of regression (i.e. a return to a more primitive and anachronistic mode of functioning) which is thought to occur either as part of the patient's psychopathology or because it is fostered by the particular characteristics of the psychoanalytic treatment situation (or both). Whereas it is generally accepted by psychoanalysts that psychoanalytic treatment normally creates suitable conditions for regression—and some analysts (e.g. Waelder, 1956) link the normal development of transference with regression in the analytic situation—the extent of the regression, and its form in certain types of patient, is regarded as leading to special forms of transference.*

Erotic transference and Eroticized (or Erotized) Transference

In 1915 Freud described certain cases of 'transference love' in which the patient under-

*Many psychoanalysts subscribe to the view that severe psychiatric disturbances, in particular the psychoses, can be seen as reflections of earlier, infantile modes of functioning revived as consequences of regression. This view is open to substantial criticism.

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going psychoanalytic treatment declared herself to be 'in love' with the analyst. Such patients may refuse to carry on the usual work of treatment, reject interpretations relating the present feelings to the past, and seek no further enlightenment as to the meaning and cause of the symptoms of which they had previously complained. The analytic sessions are used for the expression of love, for gratification through the presence of the beloved, and these patients beseech the analyst for a return of their love. Although Freud did not necessarily regard such patients as suffering from unusually severe neurotic disturbance and did not see the emergence of this form of transference as an inevitable contra-indication to psychoanalytic therapy, he suggested that sometimes a transfer to another analyst might be necessary. He spoke of such patients as possessing 'an elemental passionateness', as being 'children of nature'.

It seems that in the course of time psychoanalysts have not come to expect their patients to fall in love with them so frequently and to such a degree, or perhaps they are more skilled in seeing and interpreting such feelings as resistance (*see* Sandler, Holder and Dare, 1970a) against other, less acceptable feelings and impulses.*

However, when it does occur to the extent that there is an intense demand for gratification, and productive analytic work ceases, then serious psychopathology is thought to be present. Alexander (1950) has drawn attention to the problem of the dependent patient, both demanding love and wishing to give it. Blitzsten (whose unpublished remarks are quoted by Rappaport, 1956, and Greenson, 1967) is regarded as the first to have linked a highly sexualized attitude to the doctor with serious pathology. Rappaport (1956), in an extensive discussion of the subject, comments that 'Blitzsten noted that in a transference situation the analyst is seen *as if* he were the parent, while in erotization of the transference *he is* the parent.* The patient does not even acknowledge the "as if".' The difficulties inherent in such a formulation are obvious, and we shall return to this point later.

Rappaport suggests that such patients, who overplay the erotic component in the transference, 'insist unequivocally, from the very beginning, that they want the analyst to behave toward them as the parent'. The patients are not embarrassed or ashamed by such wishes. They express their anger openly when the analyst does not comply with their demands. Rappaport correlates such intensely sexual demanding reactions in analysis with the severity of the patient's pathology. 'Such an erotization of transference corresponding to a severe disturbance of the sense of reality is indicative of the severity of the illness. These patients are not neurotics, they are 'borderline' cases or ambulatory schizophrenics'. He comments that 'though the analytic situation is especially liable to such distortion, these patients try to convert every significant person into a parent'.

Rappaport, in expressing his agreement with Blitzsten that for such patients the analyst *is* the parent, nevertheless does not maintain that these patients are deluded or hallucinated to the degree that the analyst is *believed* to be the actual parent. However, it seems clear that there is a special quality to their transferences. Here the transference is not hidden, 'the patient screams out that he wants his fantasy to be reality'. The patient believes that in his analyst he can get a parent (presumably someone who will *act and be like* a real or wished-for parent in the patient's life). The view of the analyst *qua* analyst is completely lost.

It could be argued that this does not reflect transference at all. In our previous paper on transference (1970) we spoke of the 'concealed' repetition of earlier experiences and relationships. Moreover, Nunberg (1951) has argued that transference does not include the patient's attempts to transform the analyst into the parent. However, it is entirely possible for a patient to have an erotized transference of

*In our own experience, patients who habitually 'sexualize' (through flirtation and subtle sexual provocation), particularly those with a so-called 'hysterical character', are often found to be defending against the possibility of becoming depressed.

*A form of over-statement not uncommon in psychoanalytic writings.

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the sort described by Rappaport without being aware that a repetition of the past is involved.

Rappaport's main theme relates to the management of the patient who wishes to give sexual love to, and receive it from, a therapist, and such technical considerations are the central concern of a paper by Saul (1962). He connects this type of transference, more specifically than Rappaport, with real frustration in relationships in early life, suggesting that the hostility and anger engendered by such frustration may also be repeated in relation to the person of the doctor. Moreover, the extreme love is postulated to be, in part, a means of protecting the doctor from hostile feelings. The hostility and destructiveness in such patients has been noted by others (Nunberg, 1951; Greenson, 1967). Greenson relates the erotic transference to other areas of disturbance, and comments: 'Patients who suffer from what is called an 'eroticized' transference are prone to very destructive acting out. . . . All these patients have transference resistances that stem from underlying impulses of hatred. They seek only to discharge these feelings and oppose the analytic work'. In speaking of his own experience of such cases he comments that 'they came to the sessions eagerly, but not for insight, only to enjoy the physical proximity. My interventions seemed irrelevant to them'. Greenson considers such patients to be unsuitable for classical psychoanalytic treatment. In his view they cannot tolerate the demands of classical psychoanalysis (Wexler, 1960), and cannot maintain an adequate treatment alliance.

Transference in psychotics, transference psychosis and delusional transference

The work of Rappaport (1956), Wallerstein (1967) and Greenson (1967) appears to refer to forms of transference intermediate between the cases discussed by Freud and the cases of psychotic transference or transference psychosis described by such authors as Rosenfeld (1952, 1954, 1969) and Searles (1961, 1963), in which frankly psychotic features appear in the patient's relationship to his therapist.

We have previously pointed out (1970) that Freud (1911, 1914a) took the view that transference did not occur in what he called the 'narcissistic neuroses' (functional psychoses). He believed that psychotic psychopathology represented a return, in part, to a very early level of psychological functioning, a level at which the capacity to relate to and love others as distinct from oneself had not developed. The withdrawal of interest in the outside world in psychotics was thought of as an outcome of a return (regression) to the early 'narcissistic' level. Abraham (1908) also believed that transference phenomena were absent in schizophrenia.

As Rosenfeld (1952, 1969) has shown, beginning with Nunberg's observations (1920) of transference phenomena in a patient with catatonic schizophrenia, an increasing number of psychoanalysts have disputed Freud's original contention and make the point that transference does occur in psychotics. Notable among these have been Harry Stack Sullivan (1931), Federn (1943), and Rosen (1946). More recently, Searles (1961, 1963), Rosenfeld (1952, 1965, 1969), and Balint (1968) have, from their different theoretical viewpoints, denied that the earliest stages of psychological development (which they believe to be recapitulated in aspects of the symptoms of schizophrenic patients) are free from the investment of emotional interest in others. Thus, Rosenfeld comments (1952): 'we are dealing here not with an absence of transference but with the difficult problem of recognizing and interpreting schizophrenic transference-phenomena'. He ascribes this difficulty to the fact that 'as soon as the schizophrenic approaches *any* object in love or hate he seems to become confused with this object . . .—[which] throws some light on the infant's difficulty in distinguishing between the "me" and the "not me".' The view that misidentifications and delusional ideas develop within the psychotic's relation to his doctor is extended and elaborated by Searles (1963), Little (1960) and Balint (1968). Balint appears to be the only one of these authors who is alert to the dangers of reconstructing early psychological functioning on the basis of the behaviour of disturbed adults in psychoanalytic therapy.

It seems very likely that the transference

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concept can legitimately be applied to aspects of the psychotic's interaction with his therapist. Even the most withdrawn catatonic may, after recovery of rationality, show evidence of considerable perceptiveness of events involving others at the time of his illness. Moreover, there is little doubt that some disturbed behaviour arises in response to perceptions of others. (In this context, the social psychiatric surveys of Brown *et al.* (1966), which show that the symptomatology of schizophrenia has cultural determinants, are relevant). Doctors and ward personnel alike are taken into the content of disordered thought processes. What Searles, Rosenfeld and others (e.g. Fromm-Reichmann, 1950), seek to show by their detailed case presentations is that such thought processes represent repetitions of earlier interpersonal relationships. Searles writes of the chronic schizophrenic patient (1963): 'He is so incompletely differentiated in his ego-functioning that he tends to feel, not that the therapist reminds him of, or is like, his mother or father (or whomever, from his early life), but rather his functioning towards the therapist is couched in the unscrutinized assumption that the therapist *is* the mother or father.' But he adds, in line with Rosenfeld, that 'one of the great reasons for our underestimating the role of transference is that it may require a very long time for the transference to become not only sufficiently differentiated but also sufficiently integrated, sufficiently coherent, to be identifiable'.

Just as Freud thought that in the treatment of neurotic patients the internal problems which result in the neurosis become concentrated within the analytic treatment situation as a 'transference neurosis' (1914b, 1920), so Rosenfeld and Searles believe that a parallel 'transference psychosis' can be discerned. Searles (1963), designates four varieties of transference psychosis

1. Transference situations in which the therapist feels unrelated to the patient.

2. Situations in which a clear-cut relatedness has been established between patient and therapist, and the therapist no longer feels unrelated to the patient; but the relatedness is a deeply ambivalent one.

3. Instances in which the patient's psychosis represents, in the transference, an effort to complement the therapist's personality, or to help the therapist-parent to become established as a separate and whole person.

4. Situations where a chronically and deeply disturbed patient tries to get the therapist to do his thinking for him, but at the same time tries to get away from such a close relationship.

Searles is here emphasizing counter-transference (*see* Sandler, Holder and Dare, 1970b) perceptions by the doctor as a basis for assessing the type of psychotic disturbance. He relates each of the types of 'transference psychosis' to actually damaging (although perhaps misperceived and misinterpreted) family patterns. Here he allies himself with the 'family theorists' of schizophrenia (Wynne and Singer, 1963; Bateson *et al.*, 1956; Lidz *et al.*, 1965; Mishler and Waxler, 1966). Rosenfeld suggests that what is reproduced in the treatment situation is not an actual parent-child situation but a version of that situation distorted by fantasy.

There does not, in our view, appear to be sufficient evidence that the *content* of the psychotic's transference is characteristic. The evidence that the psychotic can relate to people (albeit in a psychotic way) is strong, as is the evidence that aspects of childhood relationships, whether these be real or fantasied, enter into the content of the transference. Nor is there reason to doubt the observation that the psychotic's relationship to his therapist may become extremely intense, and the concept of 'transference psychosis' may in this context be a useful one.* What seems to be the distinguishing feature in the transference of psychotic patients is the *form* which it takes, a form which is closely related to the psychotic mental state of the patient. A transference wish which might be resisted in the neurotic, or produced

*The fact that transferences occur in psychotic patients, that these transferences can be interpreted, and that the patient may react to transference interpretations, has led certain analysts (e.g. Rosenfeld and Searles) to conclude that psychotics can be more effectively treated by psychoanalytic methods than by other techniques. In our view the evidence for this is unconvincing, although it appears to be true that close daily contact with a therapist can bring about an improvement in the chronic psychotic's condition.

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in a disguised form, might in the psychotic find expression as a delusional conviction. From a psychoanalytic point of view the differences could be attributed to defective functioning of the controlling and organizing part of the personality (the ego), in particular those functions connected with distinguishing 'real' from 'imaginary'. To put it very simply, everything which has been described in regard to the form of the transference in psychotics can be attributed to the general features of the psychosis.

Thus far we have been concerned, in this section of the paper, with the concept of psychotic transference and transference psychosis as forms found in psychotic patients. There is a completely different usage of the term 'transference psychosis' in the literature. In 1912 Ferenczi described transitory psychotic or near-psychotic symptoms occurring during the analytic session in patients who were not otherwise psychotic. These included, in rare cases, true hallucinations evoked by the analytic session. In 1957 Reider published a paper on 'Transference psychosis' in which he described the appearance of psychotic and delusional features in the transferences of a non-psychotic patient. The literature on this topic has been ably summarized by Wallerstein, (1967), who, like Reider, confined the usage of the term to 'patients deemed wholly within the neurotic range in terms of character structure and adjudged appropriate for classical analysis, in whom nevertheless a disorganizing reaction of psychotic intensity occurred within the transference'. Such symptoms as delusional hypochondriasis (Atkins, 1967), 'delusional fantasies' (Wallerstein, 1967) and paranoid delusional states (Romm, 1957) are most commonly described. While it may be possible to attribute the appearance of these psychotic features to the regression-inducing qualities of the analytic situation, they nevertheless only appear in certain patients. The concepts of a transitory psychotic mental 'posture' might be useful here (Hill, 1968; Sandler and Joffe, 1970).

Little (1958), and Hammett (1961), make use of the term 'delusional transference' to describe a situation in which gross anomalies of the patient-therapist relationship develop; they consider that what is observed is a distorted but nonetheless discernible recapitulation of aspects of very early mother-child relationships. The problems posed by the assumption (made by a number of authors) of phases of 'childhood psychosis' as explanations of psychotic-like beliefs arising during analysis have been discussed by Frosch (1967).

A number of analysts, including Winnicott (1954, 1955), Khan (1960) and Little (1960, 1966), have advised that the analyst should, with some patients, permit the development of disturbed (and disturbing) infantile dependent behaviour and of associated intense and primitive feelings. They have suggested (with Balint, 1968) that only in such states is it possible to relive and hence undo earlier failures of maternal care. This latter-day version of the so-called 'corrective emotional experience' (Alexander and French, 1946) is not accepted as a valid technical approach by many analysts.

The notion of repetition of the past appears to be common to all concepts of transference, but it is clear that the form in which the past is reproduced shows substantial variation. In the 'ordinary' transferences of neurotic and 'normal' patients, the capacity to test the transference illusion against reality exists, and the patient is able to view himself to some extent as if he were another person. Interpretations which take the form of 'you are reacting to me *as if* I were your father' are normally understood by the patient who can bring his reasonable and self-observing capacities to bear on what is happening. In such cases the patient possesses and employs the elements which make for a successful treatment alliance (Sandler, Holder and Dare, 1970c).

In the special forms of transference described in this paper the patient either does not possess or does not use these self-critical and self-scrutinizing elements, and it is of interest that writers on both the erotic and psychotic forms of transference refer to the disappearance of the 'as if' quality of the transference. In our view what distinguishes such types of transference from the more usual forms is the patient's attitude towards his own analytic behaviour.

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The same transference content may emerge in the analysis of a neurotic, who may bring it in a roundabout way (e.g. via a dream), while patients who are psychotic (even if only appearing temporarily so during the analytic hour) bring it more directly, perhaps in the form of a delusional belief. The difference would appear to reside in the formal aspects of the current mental state of the patient.

Statements to the effect that the patient with one or other form of erotic or psychotic transference sees and treats the analyst like the real parent could only be correct if the patient held the delusional conviction that the analyst *was in fact* his parent. Cases of this sort must be extremely rare, but it would appear that what is meant by such statements is that the patient loses sight of the professional role and function of the therapist, and is unable to maintain a normal 'distance' from, and the capcity for insight into, what has been going on. Further, it should be noted that the content of the transference, whatever its form, should not be regarded as a simple repetition of the past. Thus a patient who develops a homosexual transference towards his analyst may react, if he is a neurotic, with anxiety and resistance. If he is psychotic, he might react with delusions of persecution. In both cases he would be defending against unacceptable impulses and wishes in himself.

It is impressive that the varieties of transference content described by certain psychoanalytic authors (e.g. Rosenfeld, 1965) in regard to schizophrenia are extremely similar to those that may be found in psychoses which are undoubtedly of organic origin. This lends support to the view that psychotic productions, including transference manifestations of the sort discussed in this paper, are not a consequence of need to repeat inadequately resolved infantile psychotic states. It seems to us perfectly plausible to say that the distinguishing features in different types of transference relate to the way in which unconscious thoughts, impulses and wishes, which might partly originate in childhood, tend to come into consciousness, and the way in which they are accepted, rejected, acted upon or modified. It would seem likely, therefore, that the specific defects which lead to psychosis and to psychotic transferences lie in such areas as the controlling, organizing, synthesizing, analysing and perceptual functions of the personality. This view would allow us to understand why psychotic transferences can emerge in certain patients with organic brain disease.

There may well be particular family situations which predispose subjects at risk to schizophrenic breakdown. The 'double bind' phenomenon (Bateson *et al.*, 1956) is certainly observable, and attempts may be made to re-enact it in the transference. However, similar modes of relating are seen in families which do not contain a schizophrenic member.

In our previous paper on transference (1970) we suggested that the concept was capable of extension outside the classical psychoanalytic situation, and that the differentiation between transference and non-transference elements in any patient-doctor relationship would be useful clinically. Similarly, the various special forms of the transference concept discussed in this paper may be extended outside psychoanalysis, for they can be traced in a whole variety of relationships. There appears to be sufficient clinical evidence to conclude that erotization of transference elements can occur outside the psychoanalytic situation, that psychotic patients can show psychotic and delusional features in their relations with others, and that special situations may produce or release transient psychotic reactions in certain individuals.

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