The Position and Value of Extratransference Interpretation

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EXTRATRANSFERENCE INTERPRETATION IN psychoanalysis seems to have been relegated to a psychoanalytic limbo in discussions of the theory and practice of psychoanalysis. The theory of technique has appropriately centered on the transference, and our technical precepts have not, for the most part, explicitly engaged analytic work outside the transference. Numerous panels have been held on the subject of transference and transference neurosis while, to my knowledge, there has been no specific panel discussion of extratransference interpretation. Similarly, in teaching and supervision, the focus is very likely to be on transference and transference resistance, which remain at the heart of psychoanalysis. Little attention is given to distinguishing interventions and interpretive efforts directed outside the orbit of the transference. Books on clinical psychoanalysis and psychoanalytic technique have extensive discussions of transference and transference interpretation but devote scant attention to the special problems of extratransference interpretation. The problems and indications, value and validity of extratransference interpretation have been insufficiently explored.

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The nontransference sphere of analytic relationship has received increasing attention over the years, particularly with respect to select areas such as the "real relationship" and the analytic pact (Freud, 1940) and alliance. However, the understanding of the patient's object relations and reality outside the analytic situation is a very complex part of psychoanalysis. External reality is never entirely objective and absolute; it is jointly and gradually defined and redefined by analysts and patients.

The nontransference sphere, like the patient's conscious history, has also been viewed in terms of defense and personal myth. The patient's history and object relations are subject to defensive distortions, fantasy falsifications, and rationalized revisions. Analysts are careful not to be seduced again by the patient's subjective reports of seduction and victimization. After all, we know the patient through the analytic situation. This is the microcosm from which we build models of the patient's present and past. Analysis was first defined by Freud (1914c) in terms of transference and resistance, and nontransference interpretation might have seemed nonanalytic. To not always deal with the transference might seem to be a technical error or counterresistance. Tacitly, nontransference interpretation might seem to be a poor relation and preparatory, subordinate, and supplementary to transference interpretation.

The transference is paradoxically the carrying vehicle and dynamism of the analytic process, while simultaneously a center of resistance. Clinical psychoanalysis depends essentially on the analytic formation and resolution of an artificial treatment illness, the transference neurosis. However, the analytic process deals with the patient's unconscious intrapsychic conflicts and neurotic problems as they manifest themselves anew in the transference neurosis, but also in extratransference phenomena. Derivatives of unconscious conflict (and their interpretation) are not limited to transference. Transference analysis can become exclusive, all-inclusive, and overidealized.

The formulation of the transference neurosis is an ideal construct: "when … the treatment has obtained mastery over
the patient … the whole of his illness's new production is concentrated upon a single point—his relation to the doctor… All the patient's symptoms have abandoned their original meaning and have taken on a new sense which lies in relation to the transference; or only such symptoms have persisted as are capable of undergoing such a transformation" (Freud, 1916-1917 p. 444). This ideal construction is quite removed from clinical transference neurosis as it actually appears both alongside and as a transformation of the adult neurosis. Freud abandoned the term "transference neurosis" after 1922, possibly because of the disparity between the ideal construct and the complex nature of transference-neurotic phenomena and continuation of extratransference manifestations of unconscious intrapsychic conflict.

Correlated to the ideal illness of the transference neurosis and preceding the ideal technique of "interpretation only" (Eissler, 1953), Strachey (1934) delineated an ideal interpretation, namely, transference interpretation. For Strachey, the only mutative interpretation was a transference interpretation. This meant that only transference interpretation could produce authentic analytic insight leading to structural change and new integration of what was hitherto unavailable to the ego because of defense. Certain tendencies toward idealization (and conversely toward denigration of opposite trends) develop within our formulations and models of psychoanalytic technique. The transference (succeeding the dream) became the "royal road" to clinical interpretation. These developments have great value; they represent the distilled experience of analysts who, along with patients, may have gained their greatest conviction about the significance of unconscious conflict in the human condition in their daily work with transference and countertransference.

At this point, however, a number of problems arise. Concepts of the transference neurosis and its link to the present and to the infantile neurosis have changed over the years (Blum, 1971). The nature of the transference as Freud (1937) noted, is determined by the repetition of the past, a "return" of repressed
conflicts which are active in the immediate present. Not all conflicts may be expressed in any one transference situation at a given point in the analysis and in the patient's life. Personality structure and intrapsychic conflict may have undergone various developmental transformations. Present events may have special significance, or the present life situation may provide special support or stress which may obscure their full significance from the analyst or which only would be understandable as the contemporary life of the patient is reconstructed in relation to the transference (Kanzer, 1953). This is how we understand the current influence of birth and death, success or failure, the onset of postpartum depression or fate neurosis. The reality changes need not be dramatic, and their relation to unconscious fantasy and danger situations may be very subtle and highly disguised.

The manifestations of certain conflicts may appear in transference but may evade analytic understanding based only on transference. Conversely, certain conflicts may be sharply reactivated, as in the case of separation anxiety and depression, during termination of analysis or following a divorce or a death in the family. Relatives may resist or assist the patient's analysis, and familial change may provide secondary gain or mature gratification. Each patient reacts to the significant real events of life in his own particular fashion, based on his total personality, and some ego-syntonic character patterns may remain distant from transference conflict and analysis.

The analytic process reflects the past, repeats the past, and reviews a past that is given new meaning and definition in the present; the transference itself becomes a major vehicle for reconstructing the past. The task of analysis, Freud (1937) stated, is to reconstruct the patient's childhood from its traces, and in analysis we reconstruct a past no longer directly accessible in the immediate present and that never existed in the way it is reconstructed in analysis. We use the technique of extratransference reconstruction to understand the sources and determinants of the transference, to aid in the resolution of the
transference, just as we use the transference itself as our main guide to the patient's childhood conflicts and pathogenic patterns. Transference and extratransference interpretation can be complementary and synergistic. In a broad sense, all interpretation involves transference since there is a transference dimension to all analytic process and all analytic data. Without transference attachment, there could be no analytic alliance and acceptance of interpretation.

Transference is omnipresent, and what appears to be extratransference material is nevertheless invested with transference meaning. As with the patient's associations and symptoms, the analyst's interpretations themselves acquire transference meaning. Interpretations may mean feeding, attention, competition with or penetration of the patient. The patient's mode, manner, timing, and content of reported memories and the concomitant feelings themselves are all subject to transference. The transference is probably never missing, only defended against and unrecognized in varying degree.

This position should not be used to obscure what it is meant to clarify. All attitudes and reactions are subject to the principle of multiple function. Transference does not subsume object relations, but current objects are misperceived and reacted to in terms of fantasied infantile object relationships. All relationships are admixtures of the new and the old, of transference and reality. Freud (1914a) illustrated this particular point when he showed the close relation between transference love and actual object love in ordinary life. Indeed, Freud (1926) noted that transference occurs outside the analytic situation and could dominate the whole of a patient's relation to the environment. The transference is obscured in ordinary object relations, but not absent. Extratransference interpretation is not necessarily nontransference, but it does not deal with the transference to the analyst. Extratransference interpretation may include transference to objects other than the analyst, the real relationship to the analyst or other objects, or may refer to the sphere of external reality rather than the psychic reality of transference.
fantasy. The extratransference sphere is different from but clinically often amalgamated with the acting out, displacement, and splitting of transference outside the analytic situation. The realities of the patient's life and of the analytic situation are of course invested with transference, but they may also influence the transference as well as reality importance. Strictly speaking, transference and reality, past and present, also determine, define, and interpret each other's domain. In addition to concurrent and mutual influences, it is well to consider that all current associations and reactions of the patient are not necessarily primarily transference, that other forms of neurotic repetition coexist with analytic transference, and that transference is not the sole source of analytic insight or locus of analytic work (which includes, e.g., reconstruction of the past).

Analytic patients have some capacity to free-associate. Their associations will, of necessity, include their thoughts, feelings, and fantasies, their interests and activities, so that we will get to know them as people and form a picture of their day-to-day lives as well as their functioning in the analytic situation. Analysis depends not only on free association, but on a capacity to observe, report, test, and adapt to reality, to assimilate interpretation, and other critical ego functions. When patients tell us about their mothers, fathers, and siblings; whether they are married or divorced; the age, number, sex of their children; the basic facts of their family life and work; we expect there to be a certain veridical statement in the framework from which we can begin to detect omissions, distortions, and inconsistencies. These omissions and distortions become part of the work of defense analysis and are eventually seen in connection with the unraveling of the transference resistance. Self and object representations become more coherent, consistent, and realistic. The analyst will point out a variety of contexts in which the patient has denied reality or isolated affect or has been timid and fearful, just as the patient now deals with the analyst. The patient who is dependent on his mother and then his wife may become similarly dependent on the analyst. He wants the analyst
to make decisions for him, complains about the frequency of sessions, becomes angry when there are interruptions in treatment. How can such a patient benefit fully from analytic treatment without connecting the dependent transference to the reliance on his wife?

The extratransference interpretation not only drives home transference interpretation, but often the two are organically connected and deal with different manifestations and localizations of the same unconscious conflict constellations. Either form of interpretation may support resistance or analytic progress, or may maintain or violate analytic neutrality. So-called extratransference interpretation should not be a disguised form of transference manipulation of the patient, directive therapy, or judgment of the patient's life and love objects.

Though transference is of inestimable value, analytic technique, as represented in all of Freud's cases, always includes an extratransference dimension. The present and past life, the familial and cultural background, the social setting, developmental phase, and constitutional endowments are all taken into account. To further understand the transference neurosis, to empathize with patients in all the different areas of their psychological problems and conflicts, requires continued attention to the interface between fantasy and reality, past and present, conscious and unconscious, and recall and repression. The adult neurosis is never entirely within the transference; conflict derivatives and important compromise formations also appear outside the transference. Elements of the transference neurosis may be displaced, split off, or enacted outside the analytic situation, and the blending or condensation of transference and nontransference derivatives may be exceedingly difficult to disentangle.

Analysts are not immune to idealization which historically occurred, for example, in the idealization of dream interpretation and the early conceptualization of the transference neurosis in the analytic process. Strachey's (1934) formulation of the "mutative interpretation" was a very valuable, stimulating,
and incisive idealization which was, nevertheless, misleading in its sweeping charismatic absolutism. Although Strachey's influence has been pervasive, it should not and probably has not dominated technical theory and practice. "All-transference" analysis with only transference interpretation has probably been more honored in the breach than the observance. It is, in essence, impossible to do analysis purely on the basis of transference without attention to current conflicts and realities and without reconstruction of the past in which the transference is rooted. Transference analysis only is an ideal fiction like the normal ego and would leave the analysis quite isolated from reality, with danger that the reality principle would not be strengthened but, in the long run, undermined. The analysis might be encapsulated without awareness of its severe limitations. Not all patients are able to translate the transference model of their neurosis into their everyday conflicts. Interpretation, as Loewenstein (1957) indicated, usually moves from conflicts expressed in relation to the analyst, to an understanding of conflicts and symptoms in current life, to their derivation from the infantile neurosis. Freud (1905) understood Dora's unconscious identifications in her hysterical symptoms of aphonia and tussis nervosa and her own seduction and collusion with her parents and the K.'s. Transference could not be fully understood without elucidation of the whole network of shared fantasies and activities and inferences about her object relations and identifications. Dora's "real" life situation became clear concurrent with the discovery of transference and its genetic sources. Freud later scrutinized the influence of the analyst's own conflicts and interventions on the analytic process, so evident now from the Dora case in his early, rapid interpretation and his prior treatment of Dora's father.

I shall return to the realities of the analytic situation and to the activation and validation, gratification or frustration, clarification or contamination of transference fantasies at a later point. Here I want to emphasize that transference conflicts and fantasies can never be isolated or segregated entirely from other
realities and from conflict expression that is not primarily transference.

Strachey's extreme position on "the mutative interpretation" was not directly challenged at the time. Strachey was influenced by the prevailing technical approach of his day, but in his only and major contribution to the psychoanalytic literature he left an enduring influence in an essay which has become a classic. Strachey's views were certainly derived from Freud's early statement that the struggle between doctor and patient is waged in the transference and that "It is on that field that the victory must be won... For when all is said and done, it is impossible to destroy anyone in absentia or in effigie" (Freud, 1912p. 108). However, in the very same paragraph, what often goes unnoticed is Freud's attention to the entire psychic field and to considerations that utilized the transference and went beyond it. Freud noted that although the patient regarded the products of "the awakening of his unconscious impulses as contemporaneous and real... The doctor tries to compel him to fit these emotional impulses into the nexus of the treatment and of his life-history..." (p. 108). Freud (1914bp. 152) called attention to the importance of the patient coming to grips with his illness so that it is not denied or despised, and so that its true importance for his life can be assayed. It was in connection with the phenomena of illness to which the patient must attend (rather than deny) that he then stated: "one cannot overcome an enemy who is absent." His recommendations included construction of the conditions under which symptoms such as a phobia were precipitated in life. He advised mastery of phobia in the life situation as part of the final process of working through. Rather than relying solely on the transference, Freud suggested that unless the patient confronts the phobic situation in life, "He will never ... bring into the analysis the material indispensable for a convincing resolution of the phobia" (Freud, 1919pp. 165-166). Surveying the nature of analytic work long after the publication of the technical papers, Freud (1937) referred to the significant material the patient puts at the analyst's
disposal, and he included "hints of repetitions of ... the repressed material to be found in actions performed by the patient ... both inside and outside the analytic situation" (p. 258). "The analyst ... has at his disposal material which can have no counterpart in excavations, such as the repetitions of reactions dating from infancy and all that is indicated by the transference in connection with these repetitions" (p. 259). These remarks appeared after Strachey's paper, and Strachey's position was not affirmed by Freud (who particularly emphasized the importance of reconstruction).

In psychoanalysis, the transference has the indispensable value of being immediate and manifest, of what we today call "the here-and-now." Transference interpretation by the object of transference strips transference illusion from that object (Stone, 1967) and separates the infantile from current object in a permissive, meaningful experience (cf. Strachey, 1934). In psychoanalysis, the here-and-now distortions of the doctor-patient relationship, the regressive personality alterations and symptoms, need to be linked to related patterns in life and traced to their childhood roots by a circuitous route which takes into account developmental changes in both the neurotic and healthy portions of the patient's personality. Genetic interpretation and reconstruction restore and establish connections between past and present, concurrent with finding new solutions to hitherto unresolved infantile pathogenic conflicts. A purely here-and-now approach would become a form of "new encounter," an existential or experiential psychotherapy. This approach would not permit full contact with the childish fantasies and feelings which continue to excessively influence or even dominate the patient's reactions, as in transference. The childhood origin and childish character of transference would remain unexplained (Blum, 1980).

Analysis of the patient's central conflicts may be furthered by extratransference interpretation. Not everything in analysis is transference, and the transference is not always the most salient point of interpretation (Leites, 1977). This point of view
was actually espoused by Stone (1961), who stated that although the most effective interpretations would be related to transference conflicts, "… interpretations other than those directly and demonstrably impinging on the transference can be significant and effective" (p. 141n.). Stone (1967) later remarked, "the extra-analytic life of the patient often provides indispensable data for the understanding of detailed complexities of his psychic functioning, because of the sheer variety of its references, some of which cannot be reproduced in the relationship to the analyst … extratransference interpretations cannot be set aside or underestimated in importance" (pp. 34-35). The subtle and multiform expressions of the total personality are not always reproduced in the transference and may be altered in the transference regression. Nontransference observations may enlarge and correct analytic transference perspectives.

Brenner (1976p. 128) also recognized the appropriate use of extratransference interpretation. He observed, "It seems unlikely that it is either correct or useful to take the extreme position that Strachey advocated." He went on to state, "Transference should be neither ignored nor focused on to the exclusion of all else; it should be neither excluded from the analytic work nor dragged in by the heels… Its influence often is greater even than one assumed it to be… Nevertheless, it remains but one factor among many in any analytic situation. An analyst has always the task of deciding as best he can from the available evidence which factors are the most important at a particular time in the analysis. If his conjecture … is that something other than transference is most important at the moment, he will interpret whatever the 'something other' may be" (p. 128). I would emphasize the importance of the appropriate "surface" area of interpretation, not including all material as transference or excluding nontransference considerations.

A "pure transference" position in analytic work will lead to distortions of analytic process and explanation. Such a position of only valuing transference interpretation will tend to
become "all transference" and mold or artificially force all material into the transference, leading to inappropriate, excessive transference interpretation. Surveying contemporary issues in the theory of therapy, Rangell (1979) called attention to the fact that transference analysis, though indispensable, has also been overdone. "The analysis of transference over a period of some years and prominently today, is often allowed to obscure all other important and necessary elements of the analytic process. A good thing has become hypertrophied and the source of complications" (p. 84). Rangell noted the era of the transference becoming the end rather than the means, with the result that antecedents and genetic roots not only are out of reach but regarded as unnecessary or of ancillary importance. Rangell referred to Fenichel's earlier position that transference and extratransference analysis both go on and are necessary, and that patients may comply with what Fenichel called a monomania of the analyst where an exclusive focus of interpretations is utilized for defensive purposes.

Leites (1977) reviewed the literature on "transference interpretations" only, and noted that many authors were critical of such an extreme position but that their objections took the form of very concise, constricted, and inhibited commentary. Anna Freud (1965, p. 37) noted the exclusive role given to the transference as one of the subjects of controversy in psychoanalysis, warning against the analyst's overinvolvement with the transference. Her statement of the controversy was not taken up by her or other authors in relation to her work on defense analysis. In relation to defense, "transference only" may foster isolation of analysis from life, denial of areas of reality, and continuation of infantile amnesia.

Gray (1973) described the analyst's intrapsychic perspective, the need for continual scrutiny of the patient's psychic reality, and the roles in which the events and experiences the patient reports are given unconscious meaning, in the immediacy of the analytic situation. Excessive concern with reality, traditional in the obsessional preoccupation with trivial and insignificant
details of life, is a defensive function and may disguise underlying transference fantasies. Put another way, the day residue is a point of attachment for the latent content of the dream, and excessive attention to the day residue may diminish appreciation of the latent unconscious childhood conflicts. Manifest dream and transference fantasy are compromise formations that disguise the return of the repressed past. Gray, I believe, would give transference priority to other considerations; he recommends an analytic focus "to observe data limited essentially to inside the analytic situation" (p. 492). However, this is not necessarily a priority to working from the surface since the surface and "point of urgency" (Strachey, 1934) are not always transference. The "point of urgency" may be denial of current illness or failure, genetic interpretation of denial of a parent's alcoholism, reconstruction of a parent's psychosis and the patient's identification with the psychotic parent, etc.

Psychoanalytic technique has not abandoned the goal of lifting infantile amnesia and recovering childhood memories (Kris, 1956). The memories often turn out to be screen memories, and the discrete memories in themselves are of less importance than the transference patterns in which they become imbricated. Nonetheless, as in overeating, there can be too much of a good thing; and an exclusive preoccupation with the transference and analytic relationship may actually lead to the omission of significant material or connections from the patient's life that will diminish and distort rather than enrich and deepen the analysis.

Not all conflicts are represented solely, wholly, or primarily at any one point in the transference; and the transference representation may be diminished in intensity and fragmented when one of the important parts of the configuration is lived out. The living out (or acting out) of fantasies may have occurred before the analysis with the pattern continuing and gradually acquiring transference meaning only as the analysis takes effect. Insight may be gained and consolidated in shared analytic work on extratransference issues, such as the patient's reactions.
not only to the analyst, but to his spouse and children. Consider a female analysand with a persistent central fantasy of performing fellatio on the analyst, a fantasy linked to a childhood seduction experience and to unconscious incestuous conflicts (Dewald, 1972). This patient was also a new mother, caring for a neonate who barely appears in the associations. The transference paradigm of seduction is also a transference resistance against other very important transference and extratransference considerations. The baby who is conspicuously absent probably is partially represented via identification and replacement in the mother's oral demands in the transference. The fantasy replaces the realities of nurturant motherhood, the demands of her own infant, the patient's need to be nurtured in order to be nurturant. New motherhood has revived the mother's own oral-maternal conflicts and has altered familial relationships and psychic equilibrium. That her associations do not include the emotional investment in her infant, reactions to the baby's sex, appearance, temperament, etc., whether mother and child are doing well, or are up all night, even whether the baby was wanted by both parents, leaves such crucial issues conspicuous by their absence. The transference cannot be understood without knowledge of the nontransference reality spheres and their transference implications. Both transference and extratransference interpretation of her maternal conflicts, envy of and identification with her infant, etc., would be necessary and complementary. Extratransference interpretation could focus directly on her ambivalent attitudes and feelings toward her infant (rather than only on the transference to the analyst), loosening defenses against the unconscious dangers associated with mothering and furthering analytic work and understanding of the patient's conflicts.

Childhood patterns of collusive denial and avoidance of reality tend to be continued in later life. It is necessary to interpret the collusion as a defense as well as a hidden gratification, and the anxiety and guilt associated with a conspiracy of silence. Such collusion may be unwittingly repeated in the
analytic situation. In analysis there is a continuous reciprocal understanding of the transference and resistance, current extratransference influences and manifestations of neurotic patterns, and reconstruction of the past. The study of neurotic patterns and of character traits in the transference and in life is an important arena of analytic clarification and of complementary types of interpretation. A patient's pattern of passivity and impotence in life, leading to psychoanalysis, will be related to blocking in free association, fear of transference regression, and eventually to the underlying intrapsychic conflicts related to both the passive character and sexual symptom. Some of the extratransference interpretations may be regarded as confirmations and extensions of the transference; other extratransference interventions are preparatory steps which culminate in a transference interpretation; and extratransference interpretation may be necessary and valuable in its own effect on the analytic process. The transference interpretation may usually be our most valuable tool, but it is supplemented, complemented, and regularly used in conjunction with other technical agents, and with the here-and-now of the patient's life and continuing childish reactions.

It is true that attention away from the transference may serve resistance, but exclusive transference interpretation will also serve resistance. Nontransference interpretation may pave the way for analyzing resistance and for conviction about the meaning of symptoms, e.g., predisposition, precipitation, anniversary reactions, etc., before and during analysis (Arlow, 1963). A patient's sleep disturbance and depression were precipitated by the anniversary of his father's death. These problems can be correlated with his denial and fetishistic use of pornography, his fears of death and concern for the analyst's health, his need to expiate his guilt by an act of charity while demanding immediate restitution and reparation for loss through fiscal manipulation.

Extratransference interpretation also concerns the repression of real traumatic experience so often seen in anniversary
reactions. Traumatic experience tends to be repeated not only in transference, but in dreams, screen memories, symptoms, and neurotic behavior. The anniversary reactions precede analysis and continue during analysis. We are concerned with the patient's intrapsychic experience, the coordination between fantasy and reality, and the effects of the patient's adult and infantile traumata on conflict, structure, and subsequent development. Each patient defends and adapts in his own way. Some patients who abuse, overstimulate, and seduce their children are repeating the aggressive and sexual abuse they experienced with their own parents. These patterns appear in the transference, and the patient may attempt to use the transference in terms of active mastery of the passively experienced childhood traumata. Nonetheless, the behavior of parents (in analysis) with their children is inundated with meaning and has also to be seen in terms of the meaning, not only of the analyst, but of the child for that particular parent. The past is repeated with their own children before and during the analysis. Of course, the analyst cannot represent all transference figures at any one time and represents more than one object because of condensation and overdetermination. The analyst might represent a parent and the child, an ambivalently loved sibling. The adult parent patient has to see the relation between the transference manifestations during the analysis and the repetitive patterns which have gone on during his own childhood and which are now continued in derivative form with his own children. Sometimes what appears to be a revival of infantile object relations in the transference may not be a simple revival at all. Pathological familial patterns may have been continued throughout life with provocations and seductions going on during family contacts and visits, telephone calls, etc.

If a crucial part of a pathological constellation is acted out, the complete pattern may not be available for analysis. A patient may be defensively masochistic in analysis and a sadistic tyrant at home. Moreover, certain forms of acting out may have serious consequences and sequelae as in the accident-prone patient. With
an accident-prone patient, the analyst must understand the form and content of the prior and repeated accidents, what is enacted outside rather than recalled and verbalized in the analytic situation, and the relation between unconscious fantasies of transgression and actual self-punishment. The primal scene may be evoked by transference revival, but may also be stimulated by visits of parents or children, overnight guests, dances, analytic lectures, and publications.

In training analysis, for example, real contacts with the analyst and information about the analyst from the analytic scene in which both analyst and analysand are immersed lead to activation, reinforcement, contamination, and diffusion of certain transference fantasies. The metaphor of the training analysis being conducted in a goldfish bowl applies to the entire range of interplay between fantasy and reality and the necessity to ferret out the grains of truth around which transference fantasies (like delusions) tend to crystallize. Reality, transference, and countertransference have to be differentiated in the analysis and professional life of a candidate with recognition that the training analyst may be a real authority for a candidate. The analytic situation is influenced by the complexities of institutionalization, e.g., extra-analytic contact and information; the process of selection, progression, and supervision; the goal of graduation, etc., and these factors all have transference repercussions. Additionally, the negative transference in training analysis may be less available than extratransference hostility. The candidate's countertransference problems to his own patients are not simply reflections of his transference to his training analyst, but are additional areas of analytic work and potential insight.

What about those times where the transference may be superseded in significance at a given moment by attention to extratransference material? Again, it is not a matter of either transference or extratransference, that is, of either-or, but of balance and of what seems to be the optimal choice. The patient's material is always overdetermined, subject to the principle

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1 I am indebted to Dr. Jacob A. Arlow for this clinical illustration.

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of multiple function, and there is often a layering of potential interpretations with no easy solutions and no simple technical choices. Consider a mother who manages to be provocative, with behavior inappropriate to her children's needs. Her conscious devotion expresses her love, but it is also a reaction formation occasionally breached by her sadistic impulses. She reported that her child was getting out of the car, when she had failed to bring the car to a full stop. The analyst interpreted this mother's murderous conflicts involving her child, an interpretation that had a very favorable effect on the course of the analysis. Notice that the analyst did not say to the patient that the patient wanted to kill the analyst or that the patient wanted the analyst to throw her out of treatment prematurely, or that the patient was identified with the child and wished to leave impulsively before the hour was over, or any number of other possible transference interpretations. What was meaningful to the patient at this particular moment was in the area of the parent-child relationship. This could then be related to the transference and to the genetic determinants which led to such neurotic attitudes and behavior inside and outside the analysis.¹

An analysis of this patient's superego would also entail a study of the patient's identifications. Any attempt to understand a patient's superego structure and function will require investigation of the genetic origins of the superego. Superego regression and progression can be clearly seen in dreams and transference, but the understanding also depends on reconstruction of the patient's infantile object relations and crucial identifications with his objects.

Another possible effect of failure of analytic attention to both the patient's current and past experience is to have the analysis in isolation from all else. The analysis is in danger of becoming an empty ritual, an artificial dramatization, or a narcissistic system, the particular configuration depending on the dominant transference.
Lampl-de Groot (1976) commented that extreme devotion to analytic transference interpretation could support hidden analytic grandiosity. The analyst could seriously overestimate his importance to the patient. If the analyst pays no attention to reality and to the patient's extratransference relations, the implication is that only the analyst, the analytic process, and the patient as analysand are of importance. Analysis is aggrandized and external life belittled. Analysis could unwittingly become a Folie à deux. A. Freud (1965) observed that the adult analyst may overemphasize psychic as opposed to external reality. She stated, "If anything he is too eager to see during his therapeutic work all current happenings in terms of transference and of resistance, and thereby to discount their value in reality" (p. 50). It is of historical significance that Fenichel (1942) had noted, "But the patient's life does not consist in transference alone, and often the analyst's resistance is shown in his neglect of the patient's life outside the transference. The patient who responded to a transference interpretation with the words, 'But doctor, you are conceited—everything I say you refer to yourself only!' sometimes may be correct" (p. 31).²

The patient's external life is not simply displaced or extended transference. The invaluable formation of the transference neurosis still leaves aspects of character, symptoms, and action not then available in transference in the same form or intensity. Neither the neurosis nor the healthy personality may be completely expressed in the transference in the analytic situation.

Exclusive focus on transference with a tendency to belittle external life is an analytic position communicated to the patient. This may have subtle effects on free association; the compliant patient may produce profuse transference fantasies, like the patient who provides dreams for the analyst who especially favors and savors dream work. This is a special form of transference resistance which may also be related to flight into fantasy. Some borderline patients may too readily regress into

² I am indebted to Dr. Eugene Halpert for this citation.
archaic transference fantasy, and may derive excessive gratification from the analysis compared to their meager gratifications in life. Such patients may attempt to use the analysis to defend against reality disappointments and injuries.

Still another problem engendered by the isolation of analysis from external reality concerns the working through of conflicts in life. This occurs in conjunction with working through in analysis and in the wider application of analytic insight in life during and after analysis. I have already alluded to Freud's comments about the necessity of working through phobia in life; similar considerations apply to other symptoms and character disorder. The working through of the denial of a parent's psychosis or alcoholism, the need to see a spouse as distant and unloving in order to defend against incestuously tinged cravings for love, lead to the appreciation of object relations in a more rational and mature perspective. The analytic picture of the patient's life newly being constructed, which transforms the personal and familial mythical distortions (Kris, 1956), emerges from the transference analysis, but also from extratransference illustrations which show the patient what is being repeated, how it is a repetition, and what elements of the pattern are not repeated but have been developmentally transformed. Neurotic patterns have often undergone transformations during development. Early separation anxiety, for example, may be manifest in an infantile sleep disturbance, a childhood travel phobia, adult insomnia and fears of death. Patients can then apply insight to their life, and psychologically minded patients will begin to show greater awareness, empathy, and even insight in their personal and familial relationships. Patients should understand their adaptation to the various facets of life. As parents, they should gain insight into neurotic reactions with each other and their children. As patients, their appreciation of the real qualities of the analyst should grow so that at termination the real or nontransference relationship is relatively undistorted by transference-neurotic fantasy (E. Ticho, 1972).

An important by-product of analysis is not only more successful
but more insightful adaptation to life. One patient brought increasingly clear
derivatives of primal-scene fantasy and experience into the analysis. She was
very shy, socially and sexually inhibited, had rather puritanical attitudes
toward life with an emphasis on decorum and propriety in dress, speech,
manner, and behavior. She was defending herself against primal-scene
excitement and experience extending through her childhood. Her curiosity was
inhibited, she was afraid to explore, and was in constant danger of being seen
in and outside the analysis as exposed. Dreams and transference fantasies of
erotic nudity in the analysis, the public library, the concert hall, etc., emerged
with associated shame and guilt. Her interest in clothes and what was
underneath clothes appeared with increasing clarity. The patient then began to
discuss how she had dressed her children and the mode of dress and undress
within the family. She would want the children, particularly her daughters, to
be nicely and neatly dressed and to stand, sit, and carry themselves like
ladies. These values did not apply in the same way to her husband, whose
own style was what he considered to be relaxed informality at home. He was
fond of going into his daughters' room in his underwear, inviting the children
into the bedroom when they were partially undressed or in night clothes, and
still later, we learned that her husband insisted on keeping the door to the
parental bedroom open at night. As the analysis progressed, her husband's
behavior led to serious marital discord. He resented her imposing her values
on him, unfairly interfering with his lifestyle, and he resented her analysis.

The patient began to understand the implications of the seduction of her
own children by their parents in which she was a passive participant. She
unconsciously assigned responsibility and guilt to her husband. The primal
scene was continued from the past into the present and was actually being
enacted in her adult life before and during her analysis. As her own
incestuous attachments were clarified, she understood her husband's behavior
in an entirely new way and attempted to shift the whole
family interaction to what she considered to be a constructive direction. She was able to use the analytic work to show her husband that his discussion of the sexual abuse of patients by dentists and doctors was connected to an unrecognized abuse of his children. Having tried to insist that the door be open during their nocturnal sexual relations, he had, the next day, exploded at their daughter for having gone out of the house into the cold without a coat. She came to understand that he attempted to make the daughter feel guilty about exposure rather than himself, choosing to present himself as offering guidance and concern rather than abuse and exploitation. The mother's resources and strength in being able to confront these conflicts had positive effects on her children's development, and in the long run upon her husband's functioning as well. Interpretations have multiple appeal which extends beyond the transference situation and personality reorganization to the wider spheres of life. Such effects can be detrimental if extratransference interpretation is abused by patients who then engage in wild analysis of family and friends. Patients may evade self-scrutiny by shifting analytic inquiry to the unconscious motivation of others (Greenacre, 1959). Authentic understanding and insight tend to be applied in life as beneficial intrafamilial influences rather than in the service of regression or provocation.

A pure transference position tends to treat extratransference relations as those "objectionable others" (Anthony, 1980) who figure so importantly in our patients' lives in adult and child analysis. It would be interesting to know if child analysts are more comfortable, more at ease with extratransference interpretations and if this technical position complements or competes with essential analysis of the transference. Child analysis has helped to elucidate different dimensions of the analytic relationship and to understand the child in his own developmental phase as well as in his family, social, and cultural setting. Current conflicts are introduced into the analytic situation just as revived unconscious conflicts tend to be reenacted with the
original objects at home. Past and present meet and interact in the interpretation of transference and in reconstruction. Within the zone of interaction, there is a redefinition of the past as presently understood and of the present shadowed and shaped by the living past. The past may be used as a defense against the present and the present may be used as a defense against the past (Kris, 1956).

The relationship of transference to the realities of the analytic situation is significant and of particular contemporary interest. The patient reacts to all features, cues, and communications in the analytic situation and process. I refer here to the realities of the analytic situation and the real attributes, style, and function as well as possible malfunction of the analyst (Blum, 1971). This includes the analyst's age, sex, character, attitude, silence, and the whole range of accurate, inexact, and erroneous interpretations. There are scattered references to these issues in the literature. Greenson (1972) explored the nontransference relationship and pointed to the patient's realistic perception of the analyst's style, taste, temperament, and technique. He offered suggestions about the mutual recognition and management of the analyst's technical errors. This is no place to explore, in depth, Greenson's challenging, controversial formulations, but I do not believe that the issues are beyond interpretation. They are beyond pure transference interpretation.

The analyst is a participant observer and not a pure receiving and reflecting mirror. There are transference reactions to his real personality and his unconscious cues and his interventions which should be understood. Gill (1979), giving early and top priority to transference interpretation, emphasizes the "analytic situation residue" as a current stimulus for transference. The analyst's real behavior might make the irrational transference seem plausible, and this should also apply to premature and exclusive transference interpretation. To my mind, if the "analytic situation residue" were truly plausible, it would tend to obscure, contaminate, or validate the transference. Transference
repetition of the past would remain confused with the present. Reality inside and outside the analytic situation may provide an important anchor, a "grain of truth," for transference fantasy. Clinic analysis, supervision, insurance payment, etc., all tend to activate or lend reality to transference fantasy and transference gratifications. The patient consciously and unconsciously perceives the analytic situation realities—which are not transference distortions. These realities may influence the transference and its full analysis. In contrast to transference displacement, these realities may be displaced so that the patient's distortions of other objects may contain accurate referents to the analyst.

These current or "day residue" influences on the activation of the transference are not restricted to analytic situation residues (nor do such residues "explain" transference fantasy or repetition). They can be compared to a dream "from above" (Freud, 1923) where the dream is interpreted with the link between the current stimulus and its reinforcement from the unconscious latent content. In analysis, the current stimulus may or may not be of great significance, but the transference issues are always significant (Stone, 1981). The transference, however, is not in its core externally or iatrogenically determined, and the patient is responsible for his transference as for his neurosis.

The realities of the analytic situation cannot be "analyzed away," but the linked transference meanings and reactions, rooted in the past, should be ascertained insofar as possible. The transference meanings will be shown to be childish and ultimately reduced to their genetic origins. The effects of countertransference—parameters, errors, supervision—will be present, but may not be fully analyzable. The realities of the analytic situation should not be denied or overlooked in their possible influence on the analytic process. Not all that a patient thinks or feels about his analyst or analysis is due to transference (Heimann, 1950).

It does make a difference if the analyst is anxious or angry,
humorous or serious. If the analyst tends to be caustic and critical, the
patient's fears of disapproval and punishment in the transference cannot be
analyzed in depth without recognition of the reality which tends to validate the
transference fantasy. The transference may be obscured or "contaminated."
The patient's fears of disapproval, criticism, punishment, insofar as they are
transference, stem from the past and from his own superego. Each patient
reacts to the same analyst in his own way. A sadomasochistic patient might
enjoy the opportunity for battle; a guilty patient might exploit the analytic
situation for self-punitive purposes.

Reciprocal provocations inside the analytic situation may promote acting
out. Some analysts may instigate, encourage, or enjoy the patient's acting-out
tendencies. If an analyst forgets to unlock the waiting-room door, leaving the
patient locked out of a session, we are not surprised to hear, in the next
session, about an insolent waiter who kept the patient waiting for the meal and
provided terrible service. The patient vowed never to return to the restaurant
but returned to the analytic session, without any direct reference to the
lockout. The patient was afraid of her intense disappointment and rage and
could not discuss her thoughts of quitting or her fears of being thrown out by
the analyst. A different patient might not have so defended her own feelings
toward the analyst and might have reacted with overt outrage; yet another
patient might have reacted with glee over the analyst's fallibility. This
masochistically provocative patient elicited a sadomasochistic
countertransference. The patient's final quitting of treatment was
overdetermined, but it included an element of acting out of the
countertransference fantasy, like a child who tends to act out the unconscious
fantasies of the parents. A malignant cycle of unresolved
transference-countertransference issues may supervene with mutual negative
feedback. The hypercritical analysand may fear, invite, and finally incite
analytic criticism. Efforts at mastery of these complicated problems are
immeasurably assisted by their clarification and insightful interpretation
(Kanzer, 1953); (Brenner, 1976). This requires an understanding of the entire psychic field, including the "reality" inside and outside the analytic situation.

The problem of the analyst who abuses interpretation for shock effect or to compete, criticize, erotize, etc., is not resolved by compounding problems with parameters. The analytic solution is still one of interpretation which has to include the countertransference. We may distinguish here among the analyst's protracted countertransference, e.g., critical of a particular patient; countertransference at a particular point, as in response to a patient's criticism; and the analyst's character, e.g., a generally exacting, critical attitude with all patients. The countertransference belongs to the nontransference sphere and, though they interact, should not be confused with the transference. The transference cannot be analyzed through the countertransference any more than self-analysis can substitute for analysis of the patient.

That the countertransference may be constructively analyzed and utilized for the benefit of both the analyst and the patient (Heimann, 1950); (Kernberg, 1965) does not mean that countertransference will not have its own transference consequences. The patient's unconscious response to the countertransference is likely to be missed (Little, 1951). A particular countertransference may obscure, resist, or reinforce certain transference constellations, may provide hidden transference gratifications, and may elicit certain transference reactions. The analyst should be able to recognize his own contribution to the patient's particular transference response; it is now readily noted in case of a change in fee, time, or office situation. Patient and analyst are likely to have exquisitely sensitive transference-countertransference reactions to the analyst's illness (Dewald, 1982), injury, bereavement, etc.

Analytic problems cannot be solved by a blurring of boundaries between psychic and external reality, between transference and nontransference reactions of analyst and patient. In this connection, A. Freud (1954) noted that analyst and patient are
of equal adult status in a real personal relationship, and that neglect of this reality may be responsible for hostile reactions from patients which are ascribed only to transference. Reality is usually invoked to avoid recognition of transference, but transference can also be used to evade reality. The sleeping analyst of the sardonic joke, awakened, attributes the patient's negative transference and indignation to the patient's narcissistic need for constant attention.

Compared to countertransference, little has been said about the patient's unconscious response to the analyst's personality. It would be helpful for both analyst and patient to delineate the more subtle transference response to an analyst's ego-syntonic character trends, e.g., his precision of speech and the careful arrangement of his desk and office decor, or tendencies to be sarcastic or witty. The analyst's character and style, his own variations within correct analytic technique, are often overlooked as influencing the analytic process or treated as part of the analytic frame or atmosphere. Because of differences, however subtle, in the patient's reactions to the analyst's age and sex, character, style, and temperament (Blum, 1971), each analytic "match" could influence the analytic process. It might make a difference if the analyst is an ordinary clinician or an authority, married or divorced, parent or childless. The patient will react to the candidate's supervision, or to the status of the senior analyst, with fear of murderous aggression against the latter. Analysts could treat a wide range of patients with similar but not necessarily identical findings and results.

Strachey (1934), toward the end of his paper, tended to retreat from and correct his rather extreme position. He noted that by giving extratransference interpretations the analyst might prepare for a "mutative interpretation." His concluding comments concerning extratransference interpretation are surprisingly little known: "It must not be supposed that because I am attributing these special qualities to transference interpretation I am, therefore, maintaining that no others should be made. On the contrary, it is possible that a large majority of
our interpretations are outside the transference—though it should be added that it often happens that when one is ostensibly given extratransference interpretation one is implicitly given a transference one. A cake cannot be made of nothing but currants; and, though it is true that extratransference interpretations are not for the most part mutative, and do not themselves bring about the crucial result … they are nonetheless essential. If I may take an analogy from trench warfare, the acceptance of the transference interpretation corresponds to the capture of a key position, while extratransference interpretation corresponds to the general advance… An oscillation of this kind between transference and extratransference interpretations will represent the normal course of events in analysis" (p. 125).

What is analytically indicated is a consistent analytic attitude with a balanced, holistic process of interpretation. Transference analysis is central and essential, but extratransference interpretation, including genetic interpretation and reconstruction, is also necessary and complementary. Reconstruction of the past and transference analysis in the "here-and-now" are mutually explanatory, circular, and synergistic. Analysis progresses beyond interpretation of transference distortions of the doctor-patient relationship and requires genetic interpretation to fully differentiate transference and reality, past and present, as Freud (1940) indicated, to show the patient "… again and again that what he takes to be new real life is a reflection of the past" (p. 177). Extratransference interpretation is not reducible to resistance, to transference, or a poor relation of and replacement for transference interpretation.

I conclude there is no royal road to analytic interpretation. The transference is the main road but not the only road to mutative interpretation, and we do not analyze just transference or dreams, we analyze the patient.

SUMMARY

The role of extratransference interpretation in the theory of technique has been insufficiently defined and only tangentially
discussed. Extratransference interpretation refers to interpretation that is relatively outside the analytic transference relationship. Although interpretive resolution of the transference neurosis is the central area of analytic work, transference is not the sole or whole focus of interpretation, or the only effective "mutative" interpretation, or always the most significant interpretation. Extratransference interpretation has a position and value which is not simply ancillary, preparatory, and supplementary to transference interpretation. Transference analysis is essential, but extratransference interpretation, including genetic interpretation and reconstruction, is also necessary, complementary, and synergistic. Transference is a repetition that requires analysis of its genetic sources in childhood conflict and fixation. Transference and reality, past and present, are newly defined, understood, and integrated in the analytic process.

Transference fantasy cannot be clarified without understanding the "grains of truth" to which it may be anchored in reality inside and outside the analytic situation. The analyst's real attitudes and attributes may influence the transference and transference analysis. Countertransference also tends to evoke transference reactions which are unique to each patient, so that there are contributions from both parties to the analytic process and the analytic data. Analytic understanding should encompass the overlapping transference and extratransference spheres, fantasy and reality, past and present. A "transference only" position is theoretically untenable and could lead to an artificial reduction of all associations and interpretations into a transference mold and to an idealized Folie à deux.

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