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On the nature of transference interpretation and why only it can bring about analytic change

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ABSTRACT

Transference interpretation has always been regarded as very important to psychoanalytic practice. However, analysts differ on its centrality relative to other forms of intervention. This paper argues that transference interpretation as introduced by Freud and then taken up and developed by Klein ("transference interpretation proper") is, in fact, the only form of intervention that could bring about essentially analytic change. To understand why, a taxonomy of different forms of intervention commonly practiced within the analytic situation is presented, including interventions that relate to transference, but do not constitute transference interpretation proper. The latter kind is then described in detail. Next, the paper defines analytic change. It relies on a particular perspective on what it is to come to know psychic truth; one that sees such knowing as a lived state of mind, rather than a state of having knowledge about one's dynamics. This foundational Freudian perspective has been especially advanced through Klein's notion of phantasy. Given this view of analytic change it becomes clear that it can only be brought about through transference interpretation proper. The paper also addresses reasons why it seems especially difficult to embrace this view in contemporary psychoanalytic culture, while stressing how crucial it is to do so.

KEYWORDS

Klein, Freud; transference; transference interpretation; psychic change; analytic cure; psychic truth

Introduction

This paper clarifies the nature of transference interpretation through its comparison with other kinds of interventions that some analysts offer within the analytic situation, some of which relate to the transference or make use of it, but do not in fact constitute a transference interpretation per se. I will then explain why only transference interpretation can bring about analytic change. It should be noted that by "analytic change" I do not mean merely positive change in the person's mental health that takes place during analysis, but rather a specific kind of change that is brought about through an analytic process. That is, while many things in life (e.g. developing relationships, receiving advice, engaging in sports) and forms of therapy (involving medical, cognitive, behavioural and supportive interventions etc.) may bring about changes that allow the person to feel and function

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better, psychoanalysis as I understand it aims at a specific kind of change which is best and almost exclusively attained through an analytic process. This aim has to do with the integration of unconscious psychic truth in a certain sense of this term. Transference interpretation is, I argue, what allows for this integration.

Within analytic discourse there are many views on the aims of analysis, on what the analytic process is, and how it allows for them to be attained. The view I present here is a traditional London Kleinian approach. And while its emphasis on transference interpretation is a hallmark of this approach, the present paper highlights what this emphasis means in practice – i.e. what constitutes a true transference interpretation relative to other kinds of interventions – a matter which I think has been blurred with the growing interest in Kleinian analysis around the world. The paper also explains the logic of this emphasis.

Transference interpretation is not merely a traditional feature of Kleinian practice that happens to have been passed down over generations. Rather it is a necessary consequence of maintaining a certain perspective on what psychoanalysis is and specifically what it aims for. In other words, I am arguing here not only that transference interpretation characterizes Kleinian psychoanalysis, but also that, if we understand the essence of analytic change, it becomes clear that it can only be brought about by transference interpretation. I have found that understanding this impacts practice; it supports commitment to the analytic task of transference interpretation in the face of the difficulties that doing so inevitably present, especially in places where very different views of this task prevail.

This paper will be structured as follows. I will first present different forms of intervention which are commonly practised within analytic situations, some of which make use of the transference. I contrast these with the Kleinian understanding and use of transference interpretation, bringing to the fore its specific meanings and qualities. I will then show that the Kleinian emphasis on this form of transference interpretation is inherently tied to a certain perspective on truth and the role of analysis in pursuing it. I will first present this perspective as it finds expression in Freud's thinking and will point to how it involves insights regarding the meaning of knowing and the possibility of coming to know oneself within the analytic situation that Freud struggled to articulate. I will then show how Klein's thinking advances the articulation of Freud's ideas, and that this allows not only for their clarification, but also for a richer understanding of the implications of Freud's thinking for analytic practice and specifically for the practice of transference interpretation.

Throughout the presentation of these ideas brief clinical illustrations are offered. They are not intended to demonstrate the efficacy of transference interpretations (which is not within the scope of the present paper), but rather to clarify the nature of such interpretations and to provide a context for reflection on the logic of giving them.

The paper concludes by considering why a complete reliance on transference interpretation such as Kleinians advocate has not been readily accepted by all analysts. It is suggested that theoretical and psychological obstacles stand in the way of this.

The distinctive Kleinian focus on transference

As has been noted, what characterizes Kleinian technique is the complete and pure reliance on transference interpretation. Perhaps most analytic approaches include transference interpretation but, in the London Kleinian approach all interventions will, in

essence, be transference interpretations (or geared towards them). It is the sole mutative factor. What are the widely used alternatives?

Non-transference-focused alternatives

Non-classical alternatives

(a) *Opening to experience*: In some approaches the focus is on an invitation to the patient to reflect, to open to his feelings, *to expand his experience*. This finds various forms, today most notably in some "late Bion" approaches. We see this, for example, in the work of Ferro and his followers, such as Vermote, who speak of various ways of creating a space within the analytic framework for patients to present themselves, for O or the unknown to emerge. Various Winnicottian approaches also refer to the presence of the analyst and interventions that allow for the patient to feel (and it is in that secure space the true self will emerge). Some of the American relational approaches go in this direction as well. Analysis provides a context in which, with the analyst's encouragement and thoughtful dialogue, including self-disclosure, the patient can come to a richer way of being. Transference interpretation is not at the heart of things but rather a certain kind of silence, openness, reassurance direct or indirect, sharing, an empathic and inviting stance, etc.

(b) *Developmental deficits*: From another direction, one more directly focused on *developmental deficits*, it is thought that the analyst should offer what are thought to be missing developmental nutriments – a kind of good mothering that was absent during development (for Winnicott), attachment (for Bowlby), self-object relationships (for Kohut) or the provision of symbolizing capacities (in mentalization-based and also some Bion-based approaches). Central in these latter approaches is a kind of empathic putting into words of what the patient is feeling on an emotional level – almost a kind of teaching. This is sometimes used also to evoke in the patient a cathartic reaction or more realistic functioning.

(c) *Validation*: Another direction of intervention that one sees in the analytic world is focused on trauma, with the idea that when patients have been subject to this what they need from the analyst is witnessing or validation of their experiences, support and reassurance that indeed what they have undergone was bad. It is sometimes emphasized that these kinds of interventions are needed in special cases, or pathologies, but they are usually applied more broadly.

Traditional/classical non-transference approaches

However, it is also in what are regarded as more traditional analytic approaches, conflict-oriented ones, which emphasize understanding and interpretation that interventions other than transference interpretation take place. In such "traditional" contexts the focus is on bringing out conflictual dynamics, oftentimes unconscious ones, and showing them to the patient, making the patient aware of them. This can take the form of pointing to the dynamics as they emerge in the events that the patient relays regarding, work, family, politics, etc.

Someone may speak of the distress that he is feeling with his spouse, who does not express enough attention. Clearly, it is possible to wonder about this in a non-

transferential way. One might wonder: why did he choose such an unempathic wife, or perhaps why does he interpret what she does as so unempathic ("sounds ok to me"; is he especially needy, demanding, narcissistic?), or why does he get so upset about his unempathic wife (does it touch on sensitive experiences from the past?), or if this is upsetting, why doesn't he leave? (is he too dependent, too fearful of his aggression?), etc. With all this in mind one may offer non-transferential interventions. An analyst may relate to how the patient feels he deserves more from his wife and his fear of demanding this, or how he enjoys the distress, or how he projects his own inability into his spouse and may tie this to the patient's broader Oedipal dynamics or family history, real or phantasized.

Similarly, the patient may speak of his concerns with the political situation and the analyst may relate this to the patient's conflicts in relation to authority and power, in general or in the patient's personal history, that is, without mentioning the transference, without mentioning what is going on unconsciously in the analytic relationship. Often this approach is combined with an opening to experience approach. The analyst first exposes feelings (e.g. "you say you're happy but sound sad …") and then interprets in this way ("you feel that your wife is neglecting you as did your mother").

Use of transference without giving a transference interpretation

The analyst's intervention may make different uses of transference without it resulting in a transference interpretation. This may take different forms. I focus on two:

(a) *Using transference to inform about dynamics*: The analyst may use the transference as a source of information regarding what is going on in the patient and his relationships; the analyst may infer about the unconscious dynamics from the demands and feelings towards the analyst and then interpret in terms of the dynamics without mention of the analytic relationship. For instance, the patient may speak of the analyst not giving enough attention, or the analyst may feel this without the patient saying so; the analyst may feel that the patient is projecting his own lack of concern into the analyst and that this may be a reaction to what the patient perceives as the analyst's authority. But the intervention, the interpretation, may speak of the patient's dynamics independently of the transference. And this insight may be conveyed in a more general way. For example: "When you feel stressed you would rather see others as not giving you …", etc.

Or the analyst may use the information that becomes available through the transference to understand and then describe to the patient what must or may have happened in the patient's past ("as a child you felt you were not loved"). The idea is that this would give the patient helpful self-understanding. In a different way, developmental approaches also make use of the transference for information. In this case the transference provides information regarding the kind of support (not interpretation) that the analyst should give.

(b) *Informing the patient about the transference*: The analyst may directly relate to the transference but what they do is actually tell the patient *about* the transference. Here I am emphasizing a fine distinction between informing the patient about the transference, describing to a conscious, observing ego, part of the patient *about*

what's going on in his unconscious, and interpreting from *within* the transference. It is only the latter that I would consider to be transference interpretation per se.

One form of this informative approach occurs when the analyst stays close to what the patient is experiencing in the transference, without addressing the underlying dynamics. In this case the analyst's intervention may simply tell the patient what they are feeling, now in relation to the analyst – for example, "you feel that I am not attending to you", "you feel that I enjoy my authority", "you feel that we are getting nowhere, or that you need me", etc. While this may be a preliminary step towards making an actual transference interpretation, if it remains merely descriptive in this way it will not get there; it will only make more conscious what is known within the transference.

The intervention may alternatively go beyond the experience, tying it to a more general understanding of the patient's dynamics or to past events, for example, "here too you feel that I don't listen to you, don't care about you as you feel elsewhere" or " … as you felt in the past that your mother didn't". Here the patient's conscious reflection is drawn into play. The patient is invited to consider connections between what they are experiencing in relation to the analyst and other life experiences past and present. Sometimes this contains a kind of explanation regarding the transference (e.g. "you are construing our relationship as one in which I don't listen to you").

I think that informing the patient of the transference in this way may also have some other latent aims. First it helps to create conviction. The patient may be convinced that indeed their problem is maternal neglect, because now too (as the analyst is pointing out) in the analysis this dynamic is repeating itself. Another possible aim, tied to this, is that it may emphasize that the dynamic that is being relived is not reality oriented, it is ultimately irrational. That is, the analyst, in pointing to the fact that the patient thinks that the analyst is not attentive, just as the patient has felt in relation to others, may in effect imply "and there is no real contemporary reason for this". It is rather an expression of a mindset shaped by past experience. Moreover, the analyst also may imply (without saying so explicitly) that there are better more rational ways of seeing things. "There's no real contemporary reason for this, so you could see things otherwise … . Others too may be more attentive than you think … you may want to consider this".

In other words, while this is not necessarily the case, what we may have here is not only a clarification of dynamics via the transference instead of a transference interpretation per se, but rather also a clarification of reality, a comment on how the world is and how it could or should be related to. Such implicit clarifications of reality are very common (going, for instance, in the direction of things are not as bad as they seem – for example, "you feel that if you are demanding, you don't deserve to be loved" – the implication being, "so maybe you could be loved" or that the patient has unrealistic expectations – for example, "you feel that everyone should be concerned with you" – the implication being "that will never happen".)

A similar "aboutness" of interventions occurs when the analyst refers to the analytic relationship but from a distance, as though it is a hypothesis for consideration, not something that is actually happening (e.g. "your feeling that I'm inattentive may be tied to your fear of punishment").

Transference interpretation proper

Transference interpretation proper, in contrast, as developed by Klein (and, as I will argue, grounded in Freud) is focused on directly relating to what is unconsciously going on at this particular moment in the relationship between the patient and analyst with a special emphasis on the patient's motives, actual or projected, that are coming into play. This has several important implications.

(a) The patient's feelings would be taken up as they emerge in the analytic relationship even if the patient is speaking of extra-analytic events. So, the patient may speak about current events at work or at home or in his dreams. To stay with an earlier example, the patient could come in and complain about how his wife is not properly empathic to him and how this is a source of distress, and yet the analyst would be concerned with what is happening within the analytic couple at this moment. This, I should stress, does not mean that if the patient says that his wife is not attentive, the analyst should infer directly into the transference that he feels that the analyst is not attentive. It is possible, but the analyst would have to hear that directly within what is transpiring with the patient. It could be, for example, that the analyst is experienced by the patient as particularly attentive, as the source of all the empathy that, in the patient's mind, is now described as lacking in the wife. The analyst may feel this in the way the patient is telling the story that he is expecting support or understanding.

But there may be additional levels. For example, the analyst may feel that the patient is anticipating that the analyst will be very empathic, but without warrant. Suppose the patient brings as the major instance of his wife's lack of empathy the fact that she doesn't prepare coffee as he likes it. Does the patient really believe that the analyst too must agree with him that he deserves very special care and therefore will be empathic to the notion that his wife is harmful for not properly preparing coffee? Or is he hoping, deep in his unconscious mind, that the analyst too will fail him; that on one level he feels that the analyst should be empathic and expects this, but knowing that it is not possible to be so under these conditions, he is setting himself up for disappointment and the analyst for failure? Or perhaps he would like for the analyst to be a hypocrite, offering empathy that he cannot really stand behind? There are infinite options here.

One may take note here that once the focus shifts to the analytic relationship, the factuality of the external events described becomes rather secondary. It is more important what the patient is conveying through what he is saying than the accuracy of the events. In a sense all becomes dream-like. Of course, some very basic facts of the story may be relevant. For example, I would understand things differently if I realized that the patient in the last example did not have a wife. But other factual matters, such as the actual degree to which his wife was empathic, we might never know, and it might not be important to know this. And to take this a step further, it may be seen that within this approach the factuality of the patient's reported experience is also not to be taken for granted. Indeed, the patient may report disappointment at what he describes as a lack of empathy, but as we have seen here, it is not the disappointment in face of lack of empathy per se that the

analyst necessarily must understand and interpret, but rather the meanings and motives for feeling and/or reporting the disappointment at this moment in the analysis. (I will return to this from different angles in some of the points below.)

(b) It should be stressed that to address what is going on unconsciously in the analytic relationship means to address the underlying motives that are coming into play, to understand and interpret the "why" of what is going on. Why would the patient want to see me as attentive and his wife as not? Why would he seek disappointment, failure, support in the analytic relationship? How might these serve him? That is, any description of what is happening must relate to why this is happening.

Why in the unconscious sense of the term. From this perspective, to relate to the patient's desire for empathy, without relating to the unconscious reasons why, is to say very little about what is going on. It is like saying that tears seem to be falling from someone's eyes, without saying whether this is related to a sad event, a happy one, physical exercise, the cutting of an onion, etc. Relating to an event or experience, even a denied one (e.g. hatred concealed by affection, or sadness concealed by indifference), without relating to the why, what is feeding in and determining it, leaves things at a limited descriptive level. And, as we will soon discuss, it can do little towards bringing about analytic change. Moreover, when the analyst refers to a negative event or experience (e.g. attacks on the analyst's thinking or projection of destructiveness), a failure to refer to the motivational context may make the description seem more like a reproach.

I should add here that this "why" is not something that could be simply asked of the patient. If it is unconscious, then it is indeed unconscious. The patient's thoughts on his motives may be interesting, but they cannot be regarded as informative of the actual underlying motives. Rather they themselves are an additional act or event within the analysis regarding which the motives underlying them need to be understood by the analyst. For example the patient may explain that he is trying to arouse empathy in the analyst because he lacked it as a child – this could be so. But like his search for empathy this explanation and his desire to share it are something for the analyst to come to understand and to interpret. It is not only that the patient cannot provide good answers to questions regarding his unconscious motives, and, moreover, it would be misleading to suggest to him that he could, but turning to the patient for answers prevents the analyst from opening his own mind to the exploration of the patient's unconscious. It is precisely in our struggle to understand that this opening takes place, that ideas about what is going on in the patient begin to emerge.

Here we can also see that answers to the "why" question can take place at different levels. The desire for empathy may on one level be because of an unconscious wish to receive from the analyst constant confirmation of goodness or to deny the analyst's independent thinking, but the psychoanalytically relevant level would go further, to the unconscious reasons for seeking such constant confirmation or denial, ultimately touching on early phantasies (e.g. the idea that one has destroyed the object out of envy).

(c) Focusing on what is actually going on unconsciously in the present moment also means that any interpretation would directly address the analytic relationship, as a live, singular event – what's happening *now* between patient and analyst. To stay

with some of our examples, this would take the form of one or more of the following elements: you feel, or would like me to believe that you feel, that I'm not really listening to you now, that I don't care, that it is I who am wiping you out, because … (and here the motive comes into play) because I want to punish you for neglecting me now, or because I can't deal with my envy of you that arose in this situation, or because you have just wiped me out since you feel that I *am* now listening to you and that's unbearable, etc.

This interpretation does not remain with the mere immediate experience, merely putting it into words, but at the same time it does not go on to generalize. There is no "you always … " or "you tend to … ". It stays in the moment, delves into it, including all the meanings and motives that come into play within that moment, of which the patient does not wish to know. That is, the interpretation goes beyond what the patient says or knows consciously or preconsciously, opens the patient to that inner reality, by going into the depths of the moment, not by pointing to the fact that the patient is expressing a tendency of some kind or by tying what the patient says to realties external to him (e.g. by commenting on the reality of his sense of neglect or how it is tied to past events).

The necessity to stay in the present rather than generalize is especially important because understanding, in one sense of the term, does commonly involve generalization. The statement: "The patient fears dependency, so in situations where they feel dependent, they become detached and then tend to project the detachment onto others" expresses an understanding of the patient's dynamics, of the workings of their psyche. In contrast, the statement, "now the patient is feeling dependent and becoming detached", etc. describes an event, but not an understanding of how their psyche works in the common sense of the term. The analyst may therefore be inclined to convey to the patient generalizations in order to provide them with understanding.

This, however, would be a mistake as it would take the patient out of the singular live moment. The generalization is finding expression in that moment, and there is a kind of understanding that is made possible through transference interpretation that comes from truly knowing what is happening in that moment. This is different from the understanding that comes from knowing about the generalization, which requires standing outside it and reflecting on it. It is only the knowing from within, made possible by transference interpretation, that can transform the generalization. We will soon come back to this point.

(d) It should be noted that what is happening now in the analytic relationships is usually a complex, multidimensional psychic state. This is true in a number of ways, and I mention here two. First, the state tends to be filled with ambivalence and conflict. The patient may feel the analyst is inattentive and at the same time know that she is. In fact, the patient may openly feel both and furthermore maintain that the feeling of her being inattentive seems irrational. To stay within the moment is *not* to follow up on the more rational options, nor is to address *all* the present options, *all* the different facets of the experience that are there in the moment, which in effect requires standing outside them all. Rather it involves interpreting some of the feelings and their meanings in a way that opens the patient up to a knowing encounter with parts of their psyche which they would rather not know of.

And choices must be made. For example, in this instance, the patient's emphasis of the irrationality may be a defence against the feeling of the inattentiveness; or the feeling of attentiveness may be what is dangerous; or the irrationality may be what is central in the patient's psyche, and his presentation of it may be in such a way that confirms his phantasy that it's the analyst (not he) who cannot bear irrationality and feels a need to quickly resolve it. The possibilities are numerous.

Additionally, the psychic state within the analytic relationship involves different layers of unconscious events. The patient experiences the analyst as inattentive, but at another layer this experience may be an expression of an attack on the analyst's mind, or an attempt to project deadness into the analyst. And this in turn may be an expression of self-love and a desire to save oneself from inner destructiveness. The latter levels, more removed from conscious experience may, in a certain sense, be regarded as the motive behind what is more consciously experienced within the analytic relationship.

(e) Although what is happening now in the analytic relationships is complex and multidimensional, its interpretation should be in the simplest and most direct words. Any use of conceptual terms makes what is happening now more distant, abstract and general. And in this context, even words such as "love", "hate", "feeling of superiority", "guilt", "defence", etc. may be regarded as too conceptual. What we mean by such terms would have to find expression in more concrete ones.

In this context the concept of defence is of special interest. Indeed, it may be interpreted simply and concretely, relating, for example, to how the patient is wiping out parts of his mind so as to not know something that he knows. However, in the service of simplicity and immediacy it may often be sufficient, when possible, to relate to that underlying something without reference to the patient's efforts to not know it. That is, touching the content or motives behind the defence may make superfluous reference to the defence, however concretely described. (See Blass 2017, 856, for a discussion of additional specific characteristics of the Kleinian interpretation that are employed to maintain its quality of immediacy.)

(f) It is important to further clarify that the analytic focus of the transference interpretation in the singular reality of the analytic relationship is on *the patient*. As I have described here the analyst makes use of his own feelings to discern what is going on at this moment in the patient's inner world, how the patient is construing the analytic relationship and the patient's motives for doing so. It would therefore be correct to say that part of what is actually going on in the moment is that the patient is arousing these feelings in the analyst. But it is important to distinguish between the fact that these feelings are aroused in the analyst and what is going on in the patient – the facts of the patient's desire to arouse these feelings, his sense that he is succeeding in doing so (which may be tied, although not necessarily so, to the reality that he did) and his reactions to the feelings aroused.

For example, the analyst may feel hurt or unappreciated when the patient regards her as inattentive to his patient's needs and this may have some impact on the analyst's interventions (e.g. she may become more passive, or on the contrary actively try to prove her attentiveness). All this is going on in the analyst. It is her countertransference. In the patient what is going on may be the desire to arouse these feelings (or not), his awareness (or lack thereof) that the analyst feels hurt and is acting on it, and

his reactions to his notion that the analyst is hurt and responding to it.

The transference interpretation, as I see it, is concerned only with what is going on in the patient, including what is going on in the patient in relation to what the patient imagines (rightly or wrongly) is going on in the analyst. Technically it is the difference between saying "it hurts me" or "since you hurt me, you feel I'm taking revenge" (which may be accurate) and "you wish to make me feel hurt" or "when you feel that you have hurt me …". Both approaches relate to the emotional reality happening in the analytic relationship at the moment in the room, but only the latter stays centred on the patient and his inner world, which, from the perspective I am describing, is essential to the transference interpretation.

More generally, the interpretation focuses not on what the analyst sees or experiences, but what is going on in the patient. Accordingly, even when the analyst interprets the patient's denial of what is happening at the moment, the focus is not on what is being denied as the analyst sees it, but on what is going on in the patient. That is, the transferential interpretation would not tell the patient of his denied love for the analyst while attacking her (e.g. "you berate me and, in this way, you could deny that you love me"), but to the fact that the patient is feeling love, that while he knows of it, he is keeping it out of his mind ("as you feel these loving feelings, you tell yourself they must not be"). While subtle, the difference is significant and in part defines the nature of transference interpretation proper.

Having clarified the nature of transference interpretation we can now address the question of why only it could be thought to be able to bring about analytic change. This returns us to the issue of the essential nature of this analytic process, the analytic task and what we are hoping to bring about via transference interpretation.

The essential notion of change through truth

The essential nature of the analytic process and task as I understand it centres on the notion of truth. More specifically, it centres on what I consider to be Freud's unique and most important contribution, namely, his notion that coming to know previously denied psychic truth, cures. And in turn Freud offers a practice that facilitates knowledge of this kind of truth, the truth that on some level the person wishes not to know. Indeed, Freud offered many theories and models over the years, and his clinical case presentations point to different ways in which he actually practised analysis. But his thinking on how coming to know psychic truth cures psychic disorder is in my view the heart of all his work – the models and theories clarify the nature of this truth, why the person denies it, the obstacles to it becoming known and what facilitates meaningful knowledge. Central here is also the question of what it means to know – Freud as we shall soon see, continually struggled to articulate this.

I think it is clear that while for Freud truth was at the heart of the analytic process, this was not fully taken up by all his followers. In an invitation I received a few years ago (Blass 2016a) to participate in a special issue of the *Psychoanalytic Quarterly* titled "Is truth relevant?", Jay Greenberg referred to a shift that has occurred in psychoanalytic practice

"from an emphasis on what has been known but lost to repression – actual events, fantasies, and so on – to a focus on what has never and could never be known" (305). This "unknown" is explained in terms of "developmental restrictions on our cognitive or emotional capacities", such as "protoexperience that could not be symbolized or represented or transcribed at the time when it was lived" (305–306). This, he suggests, has changed the aims of psychoanalysis: "We become less interested in helping our analysands to find the truths that they have not allowed themselves to know and more interested in helping them to develop the capacities that would make knowing possible" (306). A mixture of mentalization theories and those of late Bion are combined here; and attaining the capacity to know – which I agree is important – is presented as a kind of learning process, necessitated by developmental limitations, rather than a result of coming to be able to tolerate those truths we prefer to deny, which we wish not to know.[1]

But objections to the view of analysis as concerned with the attainment of truth is not only a contemporary issue. Hanna Segal in her 2006 paper "Reflections on Truth, Tradition, and the Psychoanalytic Tradition of Truth" speaks of an opposition between the truth-centred models of Freud, Klein and their followers and the model put forth by Ferenczi and developed by Balint, Winnicott, and, later in the USA, by Kohut, and I imagine that she would include here also the American relational analysts. The second model, she maintains, aims to provide parental care, rather than attain psychic truth. It should be added here that when truth is referred to by this model the concern is, as a rule, with environmental truth, the truth about the traumatic or difficult realities that the child was actually subject to.

This is not what Freud had in mind. I turn now to briefly describe what I think he did have in mind and how it is tied to the necessity of transference interpretation.

Freud on truth[2]

Truth as cure

Freud's basic insight on truth, his foundational perspective, is clear and very well known. Coming to know denied truth cures because pathology in essence is a state of denial of truth, or directly emerges from it. We repress, split off, deny what causes unpleasure, anxiety or guilt – we hold that what we don't know won't hurt us. But what we deny continues to have an unconscious influence, impacting how we think and act, and since the influence is unknown to us, our thinking and acting becomes irrational and distorted – pathological. To come to know would be painful and frightening but would correct and prevent distortion. Freud repeats this basic idea throughout his writings. It is important to emphasize that, from this perspective, what we repress are psychic truths, for ultimately what we cannot bear to know are not facts (about ourselves or the world) per se, but what these facts mean to us (e.g. that we are bad or unloved and why so). This repression or denial is regarded by Freud as a kind of choice that the individual makes, even if

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[1]Such denial can also shape the analysand's phantasies in relation to the act of knowing (e.g. that it is invasive and forbidden) and in this way more generally limit the capacity to know.

[2]Here I rely on an understanding of Freud's thinking that I have developed in several articles (see Blass 1992; 2001, 2002, 2003, 2006a, 2006b, 2014, 2016a, 2016b, 2019, 2020, 2023).

not consciously. As Freud explains, psychoanalysis has the following to say to the ego of the neurotic bewildered by their strange incapacities:

> The blame … lies with yourself … . Turn your eyes inward, look into your own depth, learn first to know yourself! Then you will understand why you were bound to fall ill; and perhaps, you will avoid falling ill in the future. (Freud 1917, 142–143)

While neurosis *happens* to us, in a significant sense we are responsible for it and can change it. That is, we can overcome our refusal to know, our desire and motivated choice to not know what goes on in our mind because we find these contents unbearable, harmful, offensive.

Accordingly, many of Freud's writings deal with what determines this choice. Central here is his articulation of his model of the Oedipus complex, which Freud regarded as "the shibboleth that distinguishes the adherents of psychoanalysis from its opponents" (1905, 226). Through this model he describes how man is inherently conflicted (this being one of the main developments from Freud's pre-psychoanalytic writings on trauma to his psychoanalytic writings proper). Father is beloved but, as an obstacle to receiving all mother's love, he is hated too. The hatred of the loved object (or the love of the hated object) is unbearably painful, and so we conceal from ourselves the hate or the love or the conflict or the feelings that the conflict arouses. We deny reality; we modify the world to fit our needs. In a sense, we destroy it "as it is" in order to serve our own interests. This drama has many variants and plays out in many ways throughout our lives, but at the heart of it, there is a struggle with the pain inherent to our desires, which seek more than there is, more than we feel we deserve, and thus arouse painful feelings of anger and guilt, which we conceal from ourselves through perverting both the world around us and our own minds.

The problem with Freud's idea of truth as cure

So, the analytic task is to stop the denial, recognize the difficult psychic reality for what it is, own up to it. And here is precisely where things become complicated. If the person does not want to know something, has "decided" to repress it, how could they come to know it? Why would providing knowledge in the analysis change anything? The person would still want to repress it. This is the main complaint against traditional Freudian psychoanalysis. Critics will say: Freudian interpretations may be interesting, but they are useless. They may advance the intellect; through them the person could come to know about their own dynamics, but for change a more active presence is needed. This in part leads to the popularity of the alternative approaches in which the analyst is actively involved in advancing the patient (supporting, offering missing developmental interactions), not merely providing knowledge, or "saturated interpretation" as it is sometimes negatively called.

Freud's response

Freud was well-aware of this problem. For example, in 1910 he writes:

> If knowledge about the unconscious were as important for the patient as people inexperienced in psychoanalysis imagine, listening to lectures or reading books would be enough to cure him. Such measures, however, have as much influence on the symptoms of

> nervous illness as a distribution of menu-cards in a time of famine has upon hunger. The analogy goes even further than its immediate application; for informing the patient of his unconscious regularly results in an intensification of the conflict in him and an exacerbation of his troubles. (225)

In other words, being informed of one's dynamics expands the conscious mind but does not touch the forces of repression (one can know consciously and repress unconsciously at the same time). It may, however, be seen that throughout his writing Freud, in effect, responds to these objections, truly struggles with them, and the struggle is not easy.

I will very briefly summarize Freud's response (which is implicitly spread throughout all his writings). It is based on his elaboration of some basic aspects of his thinking regarding truth and especially the following ones.

1) There is another kind of knowing relevant to analysis that is not mere conscious awareness: Freud in effect proposes that what allows for change is another kind of knowing, that is not mere conscious awareness, but rather a kind of grasping of reality. He introduced various terms in order to try to capture this other knowing. He spoke of it, for example, in terms of parts of the mind coming under the domination of the ego (e.g. "where id was there ego shall be"). At other times he referred to it in terms of the unconscious drives "being brought into the harmony of the ego" and thus becoming "accessible to all the influence of the other trends in the ego and no longer seek[ing] to go its independent way to satisfaction" (Freud 1937, 224).

   In my own attempt to articulate this complex process, I have referred to it as one whereby the underlying unconscious trends come to know other trends active in the individual (Blass 2002). That is, it is not that the individual is consciously informed about the trends of their unconscious, but rather that the trends come to "know" each other. For example, the individual's hatred of the Oedipal father comes to "know," so to speak, about the love of this father. Hatred informed by love is lived differently from hatred in isolation.
2) The truths that need to be known in analysis are not cold facts. In Freud's early, pre-analytic writing what needed to become known to the patient in the course of treatment (broadly speaking) were memories, events that had to be recalled. Freud at points recognizes the importance of encountering these events in an experiential way – but what is encountered are the facts of what happened. In later discussions of what takes place through analysis Freud sometimes continued to refer to a process in relation to memories and to speak of "filling the gap in memory", but it is clear that his thinking in this regard evolved. He came to maintain that what needs to be known are what he refers to in his 1914 "Remembering, Repeating and Working-Through" as "a piece of real life", essentially referring to lived inner dynamics.

   In that same paper Freud uses the verb to "remember" to refer to what happens in the analytic process, but he gives it new and broader meaning. It now includes, according to Freud, bringing to mind ("reproducing … in the psychical field" [153]) "phantasies, processes of reference, emotional impulses, thought connections, … [which are] purely internal acts [and thus] … could have never been 'forgotten'" (148–149). In other words, the truths that the person must come in touch with are not actual events, but meanings, mental attitudes, underlying trends at work in the patient's mind, and libidinal impulses that shape the way they think and perceive the world.

3) People are inherently open to truth and love it. Interestingly, to deny reality, we would first have had to know it. And indeed, basic to Freud's approach to truth is the idea that the person is open to it from the start. In part this is because reality leaves its mark on our minds. In this context, "Totem and Taboo" (1912–1913) may be seen as a text in which Freud most strongly puts forth the idea that reality, and especially the truth of the conflicted Oedipal reality, the "prehistorical fact" of the killing of the father and of the guilt associated with it, is marked on our minds and shapes it at the moment we come into the world (Blass 2006a).

Moreover, in Freud's notion that denied truth finds expression in symptoms, truth is portrayed as motivated, driven. It seeks to be known. This suggests that the patient's efforts to lift repression are not merely pragmatically geared toward symptom relief. Rather, in part, they express the force of the desire to know, Wissbegeirde, as Freud referred to it at times[3] – a force that stands in direct conflict with the desire not to know. In his "Remembering, Repeating and Working Through" (1914) Freud speaks of an "impulsion to remember".

In an earlier paper (Blass 2006b) on Freud's struggle to grasp Leonardo da Vinci's intellectual aspirations, including his *instinct for research* (Strachey's translation of Forschertriebe), I argued that although Freud did not explicitly discuss this connection, his view of the passionate, instinctual desire to know is very consistent with his view of eros, the life instinct, with both described as seeking to bind things together into greater unities (Freud 1920, 1933). To love and to know are thus drawn closely together in Freud's thinking.[4] As I explained (Blass 2006b), the erotic love that Freud implicitly posits at the foundation of the desire to know is not self-serving (as are our unconscious wishes) and can thus be regarded as a force that opens to reality, rather than one that distorts it.

With these ideas in mind – that knowledge is integrative, not intellectual, that what needs to be known are not events, but more broadly states of mind, and that despite the pain involved the person basically desires truth – Freud can support his foundational perspective that truth cures. Coming to know truth is not learning facts through intellectual knowledge, which can not impact the unconscious repressed and repressive forces. Rather truth is lived and, if encountered in a live and immediate way, can be impacted, its place in our mind and life can change. This is what happens, Freud explains (especially in his papers on technique), when transference is properly interpreted. In the transference the patient "seeks to put his passions into action" and the transference interpretation engages them directly, rather than conveying knowledge about them (like giving a menu to the famished). The transference interpretation speaks to what is already known to the patient in the depths of their unconscious mind and brings it into play. In so doing it invokes the patient's inherent desire to love and therefore know despite pain.

To return to the earlier example, the analyst, in addressing the patient's complaints of inattentiveness as part of the transference, in relating to the associated dynamics

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[3]Wissbegeirde is more often associated with Bion and secondarily with Klein but is actually inherent in Freud's thinking. He also took note of the epistemophilic instinct and, for a short time (1908–1915), he also spoke of a related Forschertriebe.

[4]As Freud suggests in "Ego and the Id" (1923, 44–45): "the activity of thinking is … supplied from the sublimation of erotic motive forces".

coming into play in the moment with the analyst, engages latent aspects of those dynamics. For example, the patient's repressed fear that what he experiences as inattentiveness is a punishment for his having wiped out rivals for attention (e.g. the analyst's partner/children) may come alive, and with it a more live knowledge and integration of his desire to wipe out the rivals and in turn of his guilt for doing so and of his love behind the guilt, which too was stifled by the repression. These trends would all be brought into what Freud referred to as "the harmony of the ego" and would need no longer find reality-distorting ways of expression. As Freud concludes at the end of his 1912 paper on the "Dynamics of Transference", the transference interpretation is "almost exclusively" the vehicle of analytic change and cure "For when all is said and done, it is impossible to destroy anyone in *absentia* or *effigie*" (1912, 108, original emphasis).

And here again it is important to stress that it is only when the analyst engages with the transference in a live way as I am suggesting here and does not merely inform the patient about it, or about the dynamics that govern the patient's psyche, that the inner world can come alive and be integrated in this way. The difference is like the difference between the impact of an encounter one may have with a work of art and that of reading an explanation about the meaning of that work of art.

In sum, we have seen here how and why, given Freud's view of truth, the kind of truth that is of concern in analysis and the kind of cure sought, that transference interpretation is what cures, "almost exclusively".

Klein's contribution to Freudian thinking on truth and transference

Of all his followers Klein is, I believe, the one to take up Freud's position or perspective on truth most clearly, which, I think, should therefore be referred to as Freudian-Kleinian (Blass, 2016a, 2020); and it is because of the devotion to this perspective that Klein and her followers practise "almost exclusively" transference interpretation. That is, Klein and her followers have clearly added new ideas (e.g. regarding the positions, reparation and projective identification) and "radical" conceptions (as I have argued in regard to her notion of phantasy), and these have had important clinical implications (Blass 2017). However, the far-reaching reliance on transference interpretation of the kind that characterizes Kleinian technique emerges from embracing the essence of Freud's analytic thinking, from the logic of his thinking regarding analytic cure.[5]

[5]This view, while perhaps subject to neglect in recent years, underlies James Strachey's very influential "The Nature of the Therapeutic Action of Psychoanalysis" (1934), notably written while Freud was alive. There Strachey offers an understanding of what is essentially mutative in analytic interventions. He firmly grounds this understanding in the development of Freud's thinking on the curative process, on its logic, but describes it in Klein's terms and considers it to be in accord with her thinking. This understanding presents transference interpretation as the sole mutative factor in analysis. Strachey writes: "If we now turn back and consider for a little the picture I have given of a mutative interpretation with its various characteristics, we shall notice that my description appears to exclude every kind of interpretation except those of a single class—the class, namely, of transference interpretations. Is it to be understood that no extra-transference interpretation can set in motion the chain of events which I have suggested as being the essence of psycho-analytical therapy? That is indeed my opinion" (1934, 154). More generally this view is in line with how Klein and many of her followers think of their relationship with Freud, a point which Hanna Segal states most explicitly in her paper "Melanie Klein's Technique" (1981[1967]). This paper opens with the statement that "The Kleinian Technique is psychoanalytical and strictly based on Freudian psychoanalytic concepts" (3). She goes on to specify what this means, stressing that the analyst only interprets and that "the interpretations are centered on the transference

Klein not only most faithfully practised Freud's essential thinking in this context (clearly more so than did Freud himself in his published case studies), but also may be seen to have better articulated it. First, she made the desire to know, the desire for truth, much more explicit, directly tying it to the life instincts and to love (e.g., Klein 1952, 57). Second, she better conceptualized the special state of knowing of truth that analysis strives for. As we have seen this is not an easy task, and it was especially not easy for Freud, having started out from his pre-psychoanalytic ideas that what treatment should strive for is missing memories in a simpler more objective sense of recollection of traumas. Freud's descriptions of the truth to be discovered in analysis ultimately remained somewhat incomplete and vague (regarding the ego and harmony and memory), and it is here that Klein has a very significant impact. This impact comes through the development of her notion of phantasy.

Phantasy as an articulation of Freud's ideas on knowledge

One major feature that characterizes Klein's notion of phantasy is that phantasies are considered to be the basic building blocks of our mind (Isaacs 1943). Phantasies about objects and about the relationships between them are not merely thoughts entertained *in* our mind that affect how we feel and act, but rather are the material of the ego and of the mind itself; I am constituted of my phantasies both of myself and of my objects, and changes in our phantasies have a direct and concrete impact on our states of mind.

We can see here that the phantasy *is* in a certain sense a kind of proposition or a thought (e.g. mother doesn't love me because I'm attacking her, trying to take her feeding breast because its absence is too horrible for me), but it is a thought with instinctual force that shapes not just how one sees the world, but its very nature; it shapes the mind of the one who sees. "Mother does not love me" is not an intellectual conclusion or an emotional experience, but a state of affairs in one's psyche, in the inner world made up of objects – a state in which there is a hole, emptiness, death, destruction of the maternal object which constitutes the person.

And in this destructive state, one's own mental abilities, which rely on the maternal object, are damaged too. The stolen feeding breast also shapes experience and motives. It may manifest in the person having an experience of ability, of fullness, which may also be accompanied by a sense of superficiality (because the breast does not really belong to its thief), or a sense of hurt (as revenge for theft), or depression (for having hurt the maternal object), or a tendency to do kindness to others (as reparation). Klein describes the *real* impact of the phantasy on the mind and writes:

> It is in phantasy that the infant splits the object and the self, but the effect of this phantasy is a very real one, because it leads to feelings and relations (and later on, thought-processes) being in fact cut off from one another. (1946, 6)

In other words, Klein's notion of phantasy provides missing theoretical articulation of that kind of non-factual lived knowledge that needs to be attained through analysis, the kinds

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situation" (3). She concludes that Kleinians have followed Freud's technique "with greatest exactitude, more so indeed than most other Freudian analysts" (4), which leads her to wonder: "Could it be said, therefore, that there is no room for the term *Kleinian technique*?" (4). Her answer, of course, is that there *is* room for this term because Klein opened us to the understanding of new dynamics that required new kinds of interpretation. But the basic focus on transference interpretation is regarded as grounded in Freud. Klein herself expresses similar views (e.g. in the second of her "Lectures on Technique", in Steiner 2017).

of truth that need to be integrated in the analytic process. It is these very alive, motivational thoughts of the phantasy that make the person who they are.

Implications for transference interpretation

Klein's notion of phantasy also further highlights the importance of transference interpretation and shows us ways of making it ever more alive and immediate, allowing for the interpretations to touch more directly and have a more profound impact. When the gap narrows between psychical reality and states of mind (e.g. between the dynamics around the fear of destruction of the object and the actual destruction of parts of one's mind – in which the object is located; between the dynamics of desiring the mother and actually having the mother [as an object] in one's mind), then it becomes clearer that the patient's psychic reality can be most fully grasped and transformed by engaging the mind through live and immediate interpretation.

The person's dynamic self may be seen to be a kind of lived thought, and as such can be touched by the truth of the transference interpretation. Indeed, there were actual events that determined one's psychic reality (e.g. interactions with the mother in infancy that aroused feelings of destruction and desire), and there are memories of these events and thoughts about them. It is possible to talk with patients about these and reflect on them. But in the patient's mind his psychic reality itself is a real and lived truth, just as real and alive as it was in infancy; there the fears and desires are not and never were things of the past to be reflected on. And this is why interpretation, relating to the truth of the mind as it finds immediate expression in the transference, can directly touch the person and change him.

Moreover, since the psychic reality finds expression so directly in the mind, transference and its interpretation will naturally relate (in part) to the mind itself. In the transference what would find expression are not only relationships with parental objects, but also relationships with parts of one's mind, with the processes of thinking and knowing themselves, and the body parts associated with these. For example, as I recognize that the patient is regarding me in the transference as a certain kind of maternal object, I am also listening to how that projection impacts his mind and what he believes in phantasy that he's doing to mine – emptying, destroying, feeding off, etc.

Of special interest in this regard is what the patient is doing to the interpretation itself; how he regards the very act of conveying of knowledge that it involves. Does he swallow what's fed, spit it out, feel poisoned by it, keep it in his mouth and chew on it until it loses all taste (e.g. through endless comments on it), outwardly reject it but actually steal it and proudly feed it to himself the following day, become nourished or remain starved or at least make me think so. In other words, the patient treats the analyst's words as actions (e.g. feedings, attacks) and the patient's own words not only convey meaning in their content, but also are actions aimed at impacting the analyst's mind. They can be an effort to confuse, to draw the analyst to follow him obsessively, to penetrate his mind, to make him think in certain ways (e.g. that he is guilty, has nothing to say etc.).

As an example, we can think of Mr A., a patient whose inner world is dominated by a denied envy of his maternal object and her procreative and nourishing capacities. This had a pervasive influence on his life, for example on whether he can allow himself to be creative, how he feels when he is or isn't creative, how he relates to women and

the nature of his relationships with them, etc. Mr A., a successful businessman, was having numerous extramarital affairs with married women. It could be seen that the specific nature of his success and his affairs, the meaning of them to him, was driven and shaped by an effort to have confirmed that he had procreative abilities that surpassed those of his maternal object – his dependence on her and his envy of her being unbearable to him. This unconscious dynamic was lived out, projected into the world all the time, and found expression also in an exceptionally high self-evaluation of his attractiveness, in the quality of his depression when he felt rejected, and in an apparent absence of concern for all the women in his life whom he supposedly loved, which only thinly veiled strong feelings of guilt in regard to them. In his analysis, the patient lived the same inner world, transferred it, so to speak, there too; for example, he repeatedly sought to create situations that would allow him to feel that the analyst (a woman) recognized that his maternal qualities were superior to hers, so that he could go on denying his envy of what he felt she (as the maternal object) had, and he lacked. But this left him bored (empty and dead), uncreative and guilty.

In light of this discussion of different types of analytic intervention one may think of various kinds of non-transferential responses to what this patient presents: empathic responsivity, developmental support, clarification of the dynamics in the life events described and their tie to family history; as well as transference interpretations which are either partial ("you are feeling envy towards me") or explanatory in an objective way ("you envy my maternal capacities and so deny them", "you are here repeating past dynamics", "you are making me into a bad object and we can wonder why").

In contrast, transference interpretation proper, as I understand it, would, in a live and immediate way, go into the heart of the dynamic, in its particularity. This would involve addressing at specific moments, as they arise, Mr A.'s feeling that, out of her envy, the analyst is denying his superior nurturing capacities and that he, in turn, will feed her anyway because she needs him so badly. It will directly address the moments of feeling of loss, emptiness and guilt which Mr A. at certain moments would feel because of attack on the analyst in the transference and in his mind. (Depending on the situation this may include some parts of the following: "when you now told me that I'm repeating myself, you feel that you have put me to shame, that I can't bear it and am thus no longer here for you. You've asserted your value, but lost me and feel lost, and bad … You console yourself, with the feeling that I brought this upon myself by failing to simply accept that I don't have the richness and creativity of thought that you do … ").

It is not that the alternative kinds of intervention cannot have a positive impact on one's life. But it is not the positive impact that analysis, as I understand it, seeks. Conscious knowing about what one fears, denies and splits off, and how they came to be, does not in itself change the fears, denials and splits, and it is this change that analysis aims for. This change takes place as the truths of the mind are directly engaged through in-depth interpretation of the transferential relationship.[6] This is Freud's legacy, a legacy regarding the aliveness of truth in our mind, its personal nature; this is a legacy which Freud (understandably) struggled to describe and struggled to pass down to future generations of

[6]And yet, one may allow for the possibility that on special occasions a process akin to analytic mutative knowing may happen in other ways; that it may be set into motion by some event or reflection of a self-analytic kind. This is exemplified in Klein's description of the case of Mrs. A. and the transformation of her relationship with her parental objects that takes place following the death of her son (Klein 1940).

analysts. Melanie Klein and her followers, however, welcomed this legacy of truth, and, as I have argued, it is her adherence to it that explains and grounds her insistence on the "almost exclusive" practice of transference interpretation.

So why not transference interpretation?

If there is value in my argument in favour of the essential nature of transference interpretation, if it is convincing, the question arises as to why this approach to analytic practice has not already been embraced and implemented by all analysts. I think that there are both theoretical and psychological reasons. On the theoretical level we have seen that the psychoanalytic notion of truth, that lived truth, is not easy to grasp. Even here its articulation and clarification are complex (and more work is still needed in this context). Freud himself struggled with it. On the psychological level there are several factors.

At the end of James Strachey's famous 1934 paper "The Nature of the Therapeutic Action of Psychoanalysis", he reports that "Mrs. Klein has suggested … that there must be some quite special internal difficulty to be overcome by the analyst in giving [transference/mutative] interpretations … " (158) and he continues:

> It may be rationalized into the difficulty of deciding whether or not the particular moment has come for making an interpretation. But behind this there is sometimes a lurking difficulty in the actual *giving* of the interpretation, for there seems to be a constant temptation for the analyst to do something else instead. He may ask questions, or he may give reassurances or advice or discourses upon theory, or he may give interpretations – but interpretations that are not mutative, extra-transference interpretations, interpretations that are non-immediate. (158–159, original emphasis)

Strachey concludes that the reluctance to interpret in a transference-focused way is tied to the personal danger that the analyst experiences when, in the transference interpretation, they must encounter the patient's unconscious drives, while they are "alive and actual and unambiguous and aimed directly at himself" (1934, 159). He adds, "Such a moment must above all others put to the test his relations with his own unconscious impulses."

Other psychological reasons have to do with patients' demands and expectations. Many patients come to analysis to seek help for their problems with family or work, with bad feelings in their relationships or in regard to themselves. They do not come seeking an exploration of their inner world; they want to know what's best to do or how to see things differently. They seek sympathy and support for their suffering and the wrongs that they feel they have undergone. Analysts may wish to directly respond to these requests, as we naturally do in the face of such requests from friends and family in non-analytic situations. Some may feel self-centred or narcissistic when, instead of doing so, they offer their patients transference interpretations, or they may fear that this is how patients will see them. They fear that patients will think that they neglect life and its difficulties to focus on the analytic relationship, as though it is the most important, and maintain that this is to serve the analysts' needs, not the patients'. Moreover, they fear the patients' complaints that in the place of relief of pain they are offered a context in which to experience it more profoundly; that in the place of expressed sympathy for their situation they are held responsible for it, which, in turn, may be experienced as being blamed. Many contemporary

psychodynamic approaches concur with such critical views and put additional pressure on the analyst, a kind of social pressure to avoid transference interpretation.

To provide our patients not just with help, but with analytic help, these psychological and social pressures must be faced. I believe that a profound understanding of the analytic task and its value is essential to this. Through this understanding the necessity of transference interpretation, despite all the difficulties it entails, becomes apparent.

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