DISCOVERING TRANSFERENCE

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Today we are marking the one hundred and fiftieth anniversary of the birth of Sigmund Freud. Why? Because he founded a new clinical practice, named psychoanalysis. His radical step, which he himself described, retrospectively, as arising from "an insight such as... falls to one's lot but once in a lifetime", involved taking up a new clinical position in the treatment of his patients.[1] So radical was his step that one has to ask how a young medical doctor in the 1880's and 1890's found himself able to make it. What distinctions did Freud have to make to realise an innovative clinical position which could respond to his fundamental redefinition of hysteria? Central to his founding of a new clinical practice was his recognition of the phenomena of transference. In my paper I would like to present to you some details and some remarks on what I gather to be a key moment in his taking this step, namely his case history, *Fragment of an analysis of a case of hysteria*, otherwise known as the 'Dora' case.[2]

Before looking at this case history it is useful to consider a little bit of history. Freud's birth in 1856, even with the error in the date recorded by the Registrar, is easier to pinpoint than a moment when he recognised the transference and decided to respond to it in a new way. The dominant theories of hysteria in the 1880's were those of Jean Martin Charcot, Hippolyte Bernheim and Paul Briquet. Charcot had proposed a theory of hysteria as hereditary and due to mental degeneracy. This renowned French physician was less interested in treating or curing hysteria than in reproducing it by means of hypnosis for scientific study, which is an

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[1] S. Freud. *The Interpretation of Dreams*. S.E., IV, p. xxxii. Freud made this remark in the preface to the 6th English edition of *The Interpretation of Dreams* published in 1931. In other words at a time in his work when he was able to fully appreciate the significance of what he had written in the inaugural text of psychoanalysis.

[2] S. Freud. *Fragment of an analysis of a case of hysteria*. SE VII.

interesting approach to take. Although highly regarded by Freud, Charcot did not consider hysteria from a psychological point of view at all. Bernheim, for his part, was occupied more with treatment, which he based on suggestion facilitated by hypnosis and the trappings of charismatic healing. Paul Briquet wrote *Traite de l'Hysterie* in 1859 having carried out *'a comprehensive clinical and epidemiological study of 430 patients with hysteria.'* Briquet situated hysteria in the brain and therefore marks the beginning of the approach to hysteria as a neurological phenomenon. The young doctor Freud found himself amid these different theories and practices in the 1880's and engaged enthusiastically in their implementation. Along with his colleagues he had at his disposal a heterogeneous collection of forms of therapeutic intervention - hypnosis, pressure technique, electrotherapy, suggestion, medication.

While avoiding over-generalising this list does evoke comparisons with current practices, some of which are accepted as part of mainstream clinical intervention. Medication, needless to say, has become much more sophisticated and widely available but arguably the chloral of the nineteenth century is the benzodiazapine of today. While technically different in appearance, the functioning of suggestion in the hypnotic practices Freud engaged in during these years can be related to a requirement for gaining a therapeutic effect in CBT or Motivational Interviewing. The recent advances in neuroscience and neuro-imaging would have us adopting the neuro-biological approach inaugurated by Briquet. Interestingly the psycho-biological Briquet's Syndrome was one of the diagnoses which bumped the word hysteria out of the *DSM*.[3]

The case histories that make up *Studies on Hysteria*, published in 1895 and co-written with the eminent Viennese physician Dr. Josef Breuer, bear witness to Freud's trials and tribulations with responses to his "nerve patients" guided by a concoction of the clinical interventions of the time.

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[3] Hysteria was included as a diagnosis in the first two editions of the *DSM* but was omitted from *DSM III*, published in 1980 by the American Psychiatric Association. This edition of *DSM* saw the abandoning of psychodynamic co-ordinates in favour of biological criteria.

Apart from raising for us a question about our enthusiasm for mutli-disciplinary responses to mental health, it is from these case histories that questions and distinctions emerge which were fundamental to the development of the new practice of psychoanalysis.

The neurotic condition which troubled Freud the most and which led him to his discovery was, then, hysteria. Freud discovered phenomena of hysteria that had not been recognised previously. This discovery required the concept of the unconscious and the concept of transference both of which Freud found his way to as a result of his question regarding the work he was doing. The psychoanalyst Mustafa Safouan puts it clearly: *'Psychoanalysis began with hysteria, and psychoanalytic knowledge will always be worth only what our knowledge of this structure is worth.'*[4] Freud extracted what would become a psychoanalytic hysteria from the medical hysteria of his time. By so doing he produced a practice which could offer the possibility, in the face of impossibility, of articulating the structure of a fundamental way of human being.

This meant breaking with the received idea of the doctor's position in a clinical encounter. It meant being able to tolerate and manage the patient leading the way. The first psychoanalytic patient, Anna O., treated by Breuer, told the doctor to be quiet and listen. It was Anna O. who named this cathartic therapy "the talking cure".[5]

Freud's most famous case history of hysteria is noticeably less dramatic than that of Anna O. He describes it as: *'merely a case of petite hysterie with the commonest of all somatic and mental symptoms: dyspnoea [breathlessness], tussis nervosa [nervous cough], aphonia [loss of voice], and possibly migraines, together with depression, hysterical unsociability, and a*

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[4] M. Safouan. *In praise of Hysteria.* (1973). In S. Schneiderman (ed. & translator). *Returning to Freud.* Yale, Yale University Press, 1980. p. 55

[5] Ernest Jones captures the impact of the new method, or clinical position, when he says that his reading of the 'Dora' case in 1905 left him with "a deep impression of there being a man in Vienna who actually listened to every word his patients said to him." On account of this he recognised Freud as that "*rara avis*, a true psychologist." (E. Jones. *Free Associations: Memories of a Psycho-Analyst*, London, 1959; quoted in P. Gay. *Freud: a life for our time*, London, Macmillan, 1988, p. 184).

teadium vitae which was probably not entirely genuine.'[6] Let us not be distracted by the Latinate medicalising terms for everyday moments in our lives. At a push this kind of presentation just might come before a medical practitioner or therapist. Otherwise it just stays in the family. In Dora's case such a push came from her father who brought her to Dr. Freud, who had previously cured this successful captain of industry of a syphilitic infection. For Dora this was tantamount to her being handed over from one man to another. This happened after a change in Dora's behaviour: she was on very bad terms with her parents, withdrew from social life and occupied herself with studies to an unhealthy degree. The incident which precipitated her into treatment was her parent's finding a note containing "suicidal ideation". This is a very recognisable familial drama. And describing it as such should not lead to an underestimation of the real human suffering experienced when these situations arise.

For all that, the picture would not have us invoke the notion of mental illness. Dora presents as "approximately normal", to use Freud's description of himself in *The Interpretation of Dreams.*[7] Freud responds to her as a hysteric. That is, as a hysteric as defined by psychoanalysis. In other words he responds to the psychoanalytic hysteria which Dora presents as opposed to the hysteria of psychiatry, neurology or psychotherapy. Freud's position finds a difference of degree rather than a difference of kind between the normal and the pathological. As he wrote in 1906 *'... the frontier between the normal and the pathological is in part a conventional one and in part so fluctuating that each of us probably crosses it many times in the course of a day.'*[8] This makes a medical or therapeutic response to hysteria problematic. How does the therapist orient the work, given this shifting between the normal and the pathological? What is to be cured? At what point in this spectrum would a medical intervention be justified in so far as its remit is to treat mental illness? It raises the question

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[6] S. Freud. op.cit. S.E., VII, p. 24.

[7] S. Freud. op.cit. S.E., IV, p. 105.

[8] S. Freud. *Delusions and Dreams in Jensen's Gradiva.* S.E., IX, p. 24.

as to how much of a person's being is at stake and it certainly subverts any notion of the symptoms being extraneous to the hysteric's existence.

Despite the circumstances of her coming to attend Freud - the familiar scenario of a daughter being brought to the good doctor by her concerned father - Dora was not so inhibited - or furious - that it prevented her from addressing Freud with her complaints. They focussed mostly on her dissatisfaction with her father and his affair with a woman designated as Frau K. Herr K, her husband, had for his part courted Dora for a number of years in a very bourgeois arrangement. Dora's mother was left out of the picture largely, but received some reparation in the form of gifts from her wealthy husband. In what follows I am going to use as a framework Jacques Lacan's reading of the Dora case in his 1951 paper *Intervention on Transference.*[9]

In what Lacan terms the first development of truth Dora bemoans this most unacceptable situation. Common morality would probably agree with her and seek to take the father to task for this outrageous arrangement. Freud refuses that moralistic reaction and invites Dora to consider her part in the arrangement. It emerges that Dora had not always been so opposed to this *quadrille* - Lacan's striking term to describe the arrangement, or dance of four: the father, Frau K, Herr K and Dora. She had in fact for a long time been a willing accomplice in the arrangements necessary for her father and Frau K's dalliance. But then Dora had become all of a sudden unhappy, indeed extremely, pathologically intolerant of the situation. Freud directs the work to let it emerge that this reversal was due not to the girl's jealousy of her father's preferred woman but rather her interest in that woman. It turned out that Dora was besotted with Frau K, and even the fact that on one significant occasion the latter shopped her to her father, imputing lies and perversity to her young confidante and admirer, did not make Dora give up her loyalty to this woman. Why was this? What determined the position of this normal hysteric eighteen-year-

[9] It is Lacan who points out the bourgeois acceptability of the arrangement. See J. Lacan. *Intervention on transference.* (1951). In J. Mitchell, & J. Rose. (eds. and trans.) *Jacques Lacan and the Ecole Freudienne: Feminine Sexuality.* London, Macmillan, 1982.

old? Freud very evidently recognised what Lacan formulates as follows: Dora found in Frau K the embodiment of the question of her femininity, the question of her bodily womanliness. Frau K. represented for Dora the one to whom to address the fundamental question of the hysteric: "Am I, and in particular is my body, lovable as male or female?" This is how Cormac Gallagher formulates one of the two questions of the hysteric in his 1991 paper with the challenging title *Hysteria: Does it exist?*[10] It is from these questions that the hysteric elaborates, in unconscious functioning, with a greater or lesser extent of manifest psychopathology their position *vis-à-vis* sexuality. In Dora's case the coming and going of her symptoms was determined by the extent to which Frau K was immediately present to her; by the extent to which Dora found herself confronted with the representative of femininity she had made Frau K be for her; and by the extent to which she found herself without the intermediary, or attendant, male, which was the function Herr K and her father had served, at the level of narcissistic identification, in her approach to the question of her femininity. In order to assume her own femininity she had to be able to tolerate the conditions of holding the position of desiring to be, in her case, the object of desire for the man, again in her case, incarnated in the figure of her father.

Freud advises against returning the patient's love - and this does not require physical intimacy. Concern, preoccupation, interest, empathic care are enough to constitute the reciprocation of love. The practitioner may even reason that such reciprocation is necessary to draw the patient into compliance with the treatment. Freud is very clear on the outcome of taking up this position in a therapeutic relationship: the hysteric will show the one who cares that that is not enough, that he has failed to fulfil her need for love.

The phenomena of love, the sense of a need for love, the demands of love, for love, may all be made more palatable when couched in terms

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[10] C. Gallagher. *Hysteria: does it exist?* In, *The Letter*, issue 3, Spring 1995. The other question which the hysteric addresses to the Other, a place the analyst is supposed by the hysteric to occupy, is , I quote, : "In the light of these symptoms, who do you say I am?").

of 'interest', 'concern' and 'care'. What Freud discovered was that it is the dynamics of love which present the clinician with the greatest challenge in responding to hysteria. Transference-love is a *"phenomenon which occurs without fail."*[11] In his 1912 paper *The Dynamics of Transference* he puts it thus:

> *If someone's need for love is not entirely satisfied by reality, he is bound to approach every new person whom he meets with libidinal anticipatory ideas ... Thus it is a perfectly normal and intelligible thing that the libidinal cathexis*[12] *of someone who is partly unsatisfied should be directed as well to the figure of the doctor.*[13]

The psychoanalytic response involves, therefore, a refusal to provide satisfaction of the demand for love.

Introducing his discussion of transference Lacan says that he will focus on *'the case of Dora, because of what it stands for in the experience of transference when this experience was still new, this being the first case in which Freud recognised that the analyst played his part.'*[14] This comment has been the inspiration for this paper. Lacan's elucidation of this case history has us consider the relation between Freud's acknowledgement that in this case he missed the transference and his admission that at the time he was uncomfortable working with the homosexual trend in hysteria - which he was well able to identify but which threw him into a perplexity in the work. Freud's unease around this question at the time led him to adopt a counter-transferential position which had him champion the position of Herr K in the case. This identification on Freud's part led to him being dismissed from Dora's life as summarily as Herr K. The latter had received a slap on the face. With Freud she simply abandoned the

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[11] S. Freud. *Observations on Transference-Love*. S.E., XII, p. 160.

[12] This is Strachey's translation of Freud's word *Bezetsung*. The translation *investment* is more successful in its sense and evocation.

[13] S. Freud. *The Dynamics of Transference*. S.E., XII, p. 100.

[14] J. Lacan. op.cit. (1951) 1982. p. 64.

treatment. Freud on this occasion realised after the event that he had fallen into the error he had often warned against, namely *'that of wishing too much for the good of the patient.'*[15] Responding to the material Freud richly provides and guided by Freud's own comments on the management of the transference in the case Lacan suggests that the work might have continued if Freud had gone along with Dora's setting him up as a substitute for Herr K instead of *'over-insisting on the value of the marriage proposals of the latter.'*[16]To the benefit of our understanding of hysteria and transference and with the courage required for innovation, Freud has allowed us witness and learn from the progression of the case and its premature ending. It would have one wonder to what extent fear of litigation and professional or statutory guidelines preclude advancing the Freudian investigation of hysteria. In other words, have these become our alibis?

With Dora, then, Freud discovered more about the transference through recognising the way in which he had missed it. It is remarkable that this classic contribution to the understanding of hysteria and the transference was made possible by Freud's ability to articulate and, what is more, publish a case which was not a therapeutic success. This is the beginning of a distinction between the gaining of a therapeutic effect and advancing analytic insight. In other words, it was his therapeutic intent which led to the premature ending of the treatment. There is an interesting comment in the case history of the obsessional neurotic he names the Ratman. Referring to the phantasy life of the Ratman involving *'his sexual desires for his mother and sister'* Freud says that:

> *... it was impossible to unravel this tissue of phantasy thread by thread; the therapeutic success of the treatment was precisely what stood in the way of this. ... The scientific results of psycho-analysis are at present only a by-product of its therapeutic aims, and for*

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[15] ibid., p. 72.
[16] ibid., p. 71.

that reason it is often just in those cases where treatment fails that most discoveries are made.[17]

What brought the work with Dora to an end was not the position in the transference being assigned him by his patient but his own subjective response to that position. If by his own admission he missed the transference it would be more accurate to say that he missed managing a part of it. This was due to his unconsciously promoting a view of what would be best for this young hysterical woman. He recognised the perplexity caused him at the time by the appearance of the female homosexual tendency in his work with hysterics, a tendency he proposed strongly as inevitable. He was very clear indeed about his part in the work. This perplexity, he realised, had him identify with the position of Herr K. The result was being dealt with by Dora in a similar way. Freud opted for "wishing too much for the good of the patient..."[18]

Resistance, of course, makes use of the transference because it is particularly expedient for it to do so. Freud described it as a disturbance in the relation to the physician. Patients throughout the addiction treatment services, for example, can be occupied for years with dissatisfaction with their care, with the failure to respond to their need for love. Nobody listens, nobody cares, nobody stays around, its always a different doctor. The hysteric for her part does her work. He or she will have seen all the doctors, nurses, counsellors, the whole multi-disciplinary team will have disappointed - each having been engaged to care. Freud had observed that *'[t]he breaking out of a negative transference is actually quite a common event in institutions.'*[19] For those of us who are institutionalised the following observation should give us pause for thought: *'In institutions in which nerve patients are treated non-analytically, we can observe transference occurring with*

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[17] S. Freud. *Notes upon a case of obsessional neurosis.* S.E., X, p. 206, note 1.
[18] J. Lacan. op.cit. (1951) 1982. p. 72.
[19] S. Freud. op.cit. S.E., XII, p. 106.

the greatest intensity and in the most unworthy forms, extending to nothing less than mental bondage, and moreover showing the plainest erotic colouring.'[20]

Insofar as psychoanalysis invites the person to speak, the transference will direct the material that comes or falls to mind. *'When anything in the complexive material (in the subject matter of the complex) is suitable for being transferred onto the figure of the doctor, that transference is carried out; it produces the next association, and announces itself by indications of a resistance - by a stoppage, for instance.'*[21] This moment in the transference is all the more easily enacted when transparent and consistent rules of behaviour are there to be broken or a therapeutic contract is available to breach.

In his paper *Remembering, repeating and working through* Freud further indicates the importance of the transference as the locus of the work. The symptoms of the neurosis come to have a transference meaning thereby *'replacing ordinary neurosis by a 'transference-neurosis'*.[22] His patient the Ratman could not acknowledge his unconscious hostility towards the father he loved. *'And so,'* Freud tells us, *'it was only along the painful road of transference that he was able to reach a conviction that his relation to his father necessitated the postulation of this unconscious complement.'* It was only *'little by little in this school of suffering, the patient won the sense of conviction which he had lacked ..."*[23]

Discovering transference required recognition of the dynamics of hysteria in order to be in a position to refuse the demand for love in the transference and offer an alternative: the work of analysis.[24]

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[20] ibid., p. 101.

[21] ibid., p. 103

[22] S. Freud. *Remembering, repeating and working through.* S.E., XII, p. 154.

[23] S. Freud. op.cit. S.E., X, p. 209.

[24] This triad of demand, refusal and offer was made explicit by Lacan at various times in his Seminar. Cf. J. Lacan. *The Seminar of Jacques Lacan, Les non-dupes errent, 1973 -1974, Book XXI,* translated by Cormac Gallagher, for private circulation; J. Lacan. *The Seminar of Jacques Lacan, The Sinthome, 1975 -1976, Book XXIII,* translated by Cormac Gallagher, for private circulation. Also C. Gallagher. *'Nets to Knots: the odyssey to a beyond of barbarism'.* In, *The Letter,* issue 35, Autumn 2005.

Hysteria is, then, not accurately designated as a healthcare issue in the current sense of that term. Hysteria describes a way of being in the world which at different times brings greater or lesser degrees of suffering, from misery to unhappiness. Not being a healthcare problem will, of course not mean that hysteria will not present itself in healthcare settings... on both sides - service users and service providers. In order for psychoanalysis to most effectively make its singular clinical contribution it needs to be situated outside, perhaps on the margins, of the interactions that constitute healthcare work.

Hysteria is not a medical problem as such but it is a problem for medics. Freud himself articulates this in his *Five Lectures*:

> *.. all his knowledge - his training in anatomy, in physiology, and in pathology - leaves him in the lurch when he is confronted by the details of hysterical phenomena. He cannot understand hysteria, and in the face of it he is himself a layman. This is not a pleasant situation for anyone who as a rule sets so much store by his knowledge. So it comes about that hysterical patients forfeit his sympathy. He regards them as people who are transgressing the laws of science - like heretics in the eyes of the orthodox. He attributes every kind of wickedness to them, accuses them of exaggeration, of deliberate deceit, of malingering. And he punishes them by withdrawing his interest from them.*[25]

At the risk of provoking, but productively, for our discussion, I am drawn to ask the following: if it is the case that psychoanalysis offers the possibility of theorising and articulating a response to the hysteria uncovered by Freud, do we in our clinical practice choose to recognise or to refuse to recognise the dynamics of hysteria? What part, I wonder, along with others from the field of psychiatry itself, do the diagnostic categories of personality disorder play in this recognition or refusal? Can we acknowledge, without being overly censorial or punitive, our part in

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[25] S. Freud. *Five Lectures on Psychoanalysis*. S.E., XI, p. 106.

using these diagnostic categories? Do they constitute a clinical response or a personal reaction? I have seen it written in psychiatry textbooks for trainee medics that some diagnostic categories reflect the frustration of the practitioner and simply provide a veneer of scientific respectability for this frustration with certain forms of presentation. This scientific veneer speaks the language of the dominant discourse of body and mind of our epoch, namely the medical/healthcare discourse, which, of course, becomes the target for our most persistent, hysterical complaints.

As it was in Freud's time so it is now. The hysteric will present to the masters of the dominant discourse. Why? Because the symptoms are such that they will warrant being presented to the one who knows with the demand that they be put right, which does not necessarily mean removed. The doctor, and maybe to a lesser extent the healthcare professional, is put into the position of Master, of the one who knows. It is another question whether he or she is duped into believing that they actually are masters with no lack in their knowledge or, at least, the potential knowledge which will come into their hands in time. Putting this in a still more unsettling way, Freud tells us that *'[The practitioner] must recognise that the patient's falling in love is induced by the analytic situation and is not to be attributed to the charms of his own person; so that he has no grounds whatever for being proud of such a 'conquest' as it would be called outside analysis. And it is always well to be reminded of this.'*[26]

Finally, and only to indicate something, I ask the following: what did Freud discover in his studies on hysteria which required the new practice of psychoanalysis to reach? It could be said that he discovered the difference between love and desire. His new practice required the concept of the unconscious in order to allow the possibility of the articulation of desire. And that desire may be the desire for an unfulfilled desire, which characterises the desire of the hysteric. Psychotherapeutic interventions directed by motives of care, empathy and compassion preclude the articulation of desire. In so far as these very human acts are those of love they inevitably involve frustration, enthusiasm, and aggressivity.

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[26] S. Freud. op.cit. S.E., XII, pp. 160-161.

Psychoanalysis, of course, can have a therapeutic effect along the way but the work of articulating desire does not benefit from being reckoned in terms of health or well-being, success or normality. Freud discovered transference as the resistance to desire (with its necessary lack) provided by the possibilities of love, called transference-love. Mustafa Safouan tells us that the hysteric

> *... dreams of a desire that would be born of love ... desire always brings along with it a certain quantum of love; a little or a lot, repressed or no, it is not important. But the inverse is not true: despite all the praise that has been addressed to the little god of love, he has remained completely incapable of engendering the least little bit of desire.*[27]

Love is based on the logic of the illusion of it being satisfied. Lack of satisfaction will not be tolerated. Desire, on the other hand, is based on the impossibility of satisfaction, on the reality of the lack which is desire's prerequisite.

Cormac Gallagher in *Hysteria: Does it exist?* describes the trajectory of the formation of hysteria from the effects of the specific prematurity of birth of the human being to '*the refusal to submit to the castration required by the law governing relationships between the sexes*'. He proposes strongly that the dialectical sequence articulated by Lacan out of the case material of Freud '*helps to make sense of the two major clinical forms in which hysteria presents itself and between which individual hysterics often oscillate: the depressive form in which mental and physical suffering predominates and the sthenic form in which the hysteric appears with all the force and intolerance of the revolutionary or the inquisitor.*'[28]

In light of these slight indications I am giving of the difference between the object of psychoanalysis and the intentions of other forms of

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[27] M. Safouan. '*In praise of Hysteria*'. (1973). In, S. Schneiderman. (ed. & translator), *Returning to Freud* . Yale, Yale University Press, 1980. p. 58.
[28] C. Gallagher. op.cit. 1995. pp. 120-121.

therapeutic intervention it is worth returning to some remarks made by Freud and Lacan. In *Observations on Transference-Love* which Freud subtitled *Further recommendations [to physicians] on the technique of psychoanalysis III*, Freud tells us that *'the only really serious difficulties [the practitioner] has to meet lie in the management of the transference.'*[29] Elsewhere he writes that... *'controlling the phenomena of transference presents the psychoanalyst with the greatest difficulties. But it should not be forgotten that it is precisely they that do us the inestimable service of making the patient's hidden and forgotten erotic impulses immediate and manifest.'*[30] Jacques Lacan would later put it succinctly if challengingly: *'I believe .. that the transference always has this same meaning of indicating the moments where the analyst goes astray, and equally takes his or her bearings ...'*[31]

Last November here in this room the French psychoanalyst and psychiatrist Charles Melman, a great support to psychoanalysis here, contrasted the aim of psychotherapy with that of psychoanalysis. The former, he proposed, intends to re-introduce the person into the domain of common sense and fitting a norm. The latter, oriented radically differently, offers the possibility of animating the desire of the subject thereby giving him access to his existence.[32] Thank you.

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[29] S. Freud. op.cit. S.E., XII, p. 159.
[30] S. Freud. *The Dynamics of Transference*. S.E., XII, p. 108.
[31] J. Lacan. op.cit. (1951) 1982. p. 72.
[32] C. Melman. *'George Best and the names of the father'*, In, *The Letter*, Issue 36, Spring 2006, p. 66.