Empirical Studies of Transference Interpretation: Implications for Freud's Concept of Transference

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Abstract

The concept of transference is central to theoretical and clinical psychoanalysis and psychodynamic psychotherapy. We summarize Freud's concept of transference, and then review, providing samples, the concepts of transference interpretation of O.F. Kernberg and P. Høglend, the two most prominent empirical investigators of transference interpretation. Analytic clinicians widely regard transference interpretations as unreliable. Kernberg did not report empirical estimates of reliability, either for the patient-therapist interaction aspect of transference or for Freud's concept of transference. Although Høglend reported that measures of the patient-therapist interaction aspect of transference were measured reliably, he found no evidence that Freud's concept of transference interpretation was measured reliably. Neither investigator assessed the validity of Freud's basis for transference interpretation; he hypothesized that the effects of some childhood experience or relationship persisted unchanged and caused a particular adult response. Further, since therapeutic action, and presumably transference as well, varies with each patient-analyst dyad, the fact that Kernberg and Høglend studied groups of individual patients, rather than dyads, makes it unlikely they could accurately assess the validity of transference interpretation.

Absent both empirical reliability and validity of Freud's transference interpretation, if such a transference interpretation is presented to a patient it should be acknowledged to be at best an hypothesis, evaluated with humility, and held lightly by the therapist.

Keywords: transference interpretation, reliability, validity, empirical measures, hypothesis

Introduction

In their once standard text on "Theory of Psychoanalytic Technique" Menninger & Holzman (1958) differentiated three situations as main constituents of the patient´s "triple life" being in psychoanalytic treatment. 1. "Reality, i.e. the sum of ongoing relationships to his present family, his friends, colleagues, employers and so on. 2: The childhood situation, which reflects the fact that "a portion of his personality is a continuance of his infancy and represents an unjustifiably prolonged extension of his infantile period", and 3. The analytic situation itself.

The concept of transference is central to clinical and theoretical psychoanalysis and psychodynamic psychotherapy. Psychoanalytic Electronic Publishing (PEP) reports 1182 papers on transference, and Høglend and Gabbard (2012) report that more than 8000 papers and book chapters have discussed the concept of transference. Although “analyze the transference” has long been a shibboleth for conducting analytic treatment, the concept of transference and the use of transference interpretation remain highly controversial topics (Frances & Perry, 1983; Gabbard et al., 1994; Gunderson et al., 1997; Schachter, 2002).

We have selected the two most prominent empirical investigators of transference interpretation, O.F. Kernberg and P. Høglend, and will review their concept of transference and provide samples of their transference interpretations. We will follow this by discussion of clinicians’ critiques of the concept of transference, and then by review of the reliability and validity of Kernberg’s and Hoglend’s concepts of transference interpretation. We will conclude by discussing the implications of these findings for the concept of transference.

First a brief review of Freud’s concept of transference.

A Summary of Freud’s Concept of Transference

In the postscript to the Dora case Freud (1905) presented his first thorough description of transference:

What are transferences? They are new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the process of the analysis, but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician … To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment (p.116).

He restated his understanding of transferences in 1910:

The part of the patient's emotional life which he can no longer recall to memory is re-experienced by him in his relation to the physician; and it is only this re-experiencing in the transference that convinces him of the existence and of the power of these unconscious sexual impulses. (p.51).

He elaborated his conception in 1912:

Transference to the doctor is suitable for resistance to the treatment only insofar as it is a negative transference or a positive transference of repressed erotic impulses. . If we "remove" the transference by making it conscious, we are detaching only these two components of the emotional act from the person of the doctor; the other component which is admissible to consciousness and unobjectionable persists and is the vehicle of success in psychoanalysis exactly as it is in other methods of treatment". (p.105).

Freud (1914) then stated that anyone who worked with transference and resistance was practicing psychoanalysis (p.16).

He reiterated his view in 1926:

The transference is made conscious to the patient by the analyst, and it is resolved by convincing him that in his transference attitude he is re-experiencing emotional relations which had their origin in his earliest object-attachments during the repressed period of his childhood. (p.43).

Freud's last comments on transference (1940).

The most remarkable thing is this. The patient is not satisfied with regarding the analyst in the light of reality as a helper and adviser who, moreover, is remunerated for the trouble he takes and who would himself be content with some such role as that of a guide on a difficult mountain climb. On the contrary, the patient sees in him the return, the reincarnation, of some important figure out of his childhood or past, and consequently transfers onto him feelings and reactions which undoubtedly applied to the prototype.

This fact of transference soon proves to be a factor of undreamt of importance, on the one hand an instrument of irreplaceable value and on the other hand a source of serious dangers (pp.174-176).

The Concept of Transference Used in Clinical Practice

To provide a context for evaluating Kernberg's and Høglend's definition of transference, we explored how the concept of transference is now used in clinical practice extracted from the illuminating and comprehensive paper by Kernberg (2007b) which summarizes the concepts of therapeutic action in psychoanalysis utilized by eight selected psychoanalysts: R. Lauder, M. Aisenstein, C.L. Eizirik, R.D. Hinshelwood, S.M. Abend, O. Renik, K. Newman and C. Spezzano. Although all but Spezzano mentioned "transference", none provided a definition of transference, leading us to conclude that the concept of transference, though widely used in clinical practice and alluded to in the literature, lacks clear definition. In addition, the reviewed approaches to therapeutic action were extremely heterogeneous. Spezzano, cognizant of this marked heterogeneity, soothingly suggested that analysts of different persuasion play the analytic game differently, but that whatever each does, each provides the patient with a chance to get better. Unfortunately, we lack the empirical evidence that each of the different conceptions of the eight analysts reviewed by Kernberg is as likely to benefit a comparable proportion of patients as any other. Therapeutic action is left in limbo.

Kernberg's Concept of Transference

Transference Focused Psychotherapy (TFP) was designed to treat patients with Borderline Personality Disorder. "The main strategy in TFP "consists in the facilitation of the (re) activation … of the patient's split-off internalized object relations that are then observed and interpreted in the transference." (Kernberg et al., 2008, p. 603). "Transference analysis differs from the analysis of the transference in standard psychoanalysis in that … it is always closely linked with the analysis of the patient's problems in external reality, in order to avoid the dissociation of the psychotherapy sessions from the patient's external life. Transference analysis also includes an implied concern for the long-range treatment goals that, characteristically,

are not focused upon in standard psychoanalysis, except if they emerge in the transference." (Kernberg et al., 2008, p. 609). Transference for these purposes is defined "as a tendency in which representational aspects of important and formative relationships (such as with parents and siblings) can be both consciously experienced and/or unconsciously ascribed to other relationships (Levy, 2009). However, Levy and Scala (2012) add that in TFP, "the connection to early experiences with caregivers is not always explicitly mentioned, particularly when working with certain patients who find such links disorganizing (e.g., patients with personality disorders)." (Levy & Scala, 2012, p.394). In such instances the concept of transference is limited to interpretation of patient-therapist interaction.

Kernberg's Studies of Transference Interpretation

A clinical illustration: "Ms. N, thirty years old and single, had been fired from her job as a waitress; still unemployed, she was living in her mother's home. At the insistence of her mother, Ms. N applied and was accepted to a randomized clinical trial for treatment of borderline personality disorder. Ms. Was large, overweight and overbearing. She dressed in baggy sweat pants and presented herself in an imposing and threatening fashion. As the weeks passed, Ms. N. became openly hostile and paranoid. Her feelings seemed to be organized around the requirement to attend sessions regularly and to begin and end on time. Eventually, she began to skip sessions. When she did attend, she generally arrived late and left early.

A month into the treatment, Ms. N began a session by immediately launching into a description of a fight she was having with her mother. From what the analyst (a woman) could gather, Ms. N was angry at her mother, who had decided to fence their cat out of the living room. The analyst was having difficulty understanding what was happening at home, and felt unclear how Ms. N was experiencing her mother. When the analyst asked for clarification, Ms. N became agitated. It turned out that the cat was old, now incontinent, and that Ms. N's mother was trying to avoid the cats soiling her rugs. Ms. N began to rant about her mother's inconsiderate behavior, calling her a "sefish bitch" and saying "she doesn't give a shit about the cat or about anyone else's needs or feelings". Ms. N. became increasingly agitated, and the analyst realized she felt threatened; she was

acutely aware that Ms. N quite easily could physically overpower her. Ms. N glared at the analyst and went on to explain, "I can't live in her house, even if she's supporting me. I can't stand her, selfish fucking bitch. If it were my house I could do whatever I want." Ms. N went on to say she wasn't going to let her mother "get away with it". She planned to open the gate and let the cat back into the living room as soon as her mother left the house to go to work.

The analyst responded by pointing out to Ms. N that she seemed to see her mother as someone who had power and abused it, doing whatever she wanted while caring nothing about the needs of others; her mother didn't care about the cats needs, and when she insisted Ms. N stick with her therapy, it seemed she didn't care about Ms. N either. The analyst could see that Ms. N had been listening to her, and sensed that she was feeling less agitated. The analyst pointed out that what was happening between Ms. N and her mother seemed also to be happening between Ms. N and herself, perceived as another person who was abusing power.

To this Ms. N replied, "That is *exactly* what I've been telling you! You make me come twice a week when I only want to come once – twice a week is too stressful for me. I keep telling you, but you don't listen." The analyst responded that she could see that meeting twice weekly was difficult, but that it seemed the problem went beyond the analyst's asking Ms. N to do something difficult. When the analyst insisted on regular appointments and on starting and stopping on time, she became in Ms. N's eyes just like Ms. N's mother with the cat – selfish, controlling, and caring about only her own needs. In this situation, Ms. N had only two choices: she could feel powerless and afraid, like the cat, or rebel by coming late and skipping sessions. (Caligor et al., 2009, pp. 282-284).

"We think of this kind of intervention, describing and elaborating the patient's experience of the analyst, as providing cognitive containment of the patient's experience of the analyst in the transference, while at the same time providing the patient the experience of being understood … and of the analyst as genuinely attempting to understand …" (p.286).

P. Høglend's Concept of Transference

Hoglend (2014) operationalizes the concept of transference for research purposes into five categories:

1. The therapist addresses transactions in the patient-therapist relationship:
   Therapist: It sounds important what you're saying now. When you say you feel it in your body … that makes me curious.
2. The therapist encourages exploration of thoughts or feelings about the therapy, therapist, and the therapist's style and behavior:
   Patient: Well, … in a way its just words. I feel it's silly to be that positive. Myself, I don't want to say something positive unless it's fully justified.
   Therapist: You think I'm too positive?
   Patient: Yes, I do think that … to be perfectly honest.
   Therapist: So you feel I'm not always truthful?
   Patient: Not exactly, but …
   Therapist: Manipulative?
   Patient: Maybe a little bit. Like in a therapeutic way.
   Therapist: I say things I don't mean?
   Patient: I think you do.
   Therapist: How do you feel about going to a therapist like that for help?
3. The therapist encourages the patient to discuss how he or she believes the therapist might feel or think about the patient:
   Patient: I always try to be my best around other people. My biggest problem is letting anyone see me sad and helpless.
   Therapist: I noticed! So … how do you think I should respond when you show me that side of yourself?
4. The therapist includes him- or herself explicitly in interpretive linking of dynamic elements (conflicts), direct manifestations of transference, and allusions to the transference:
   Patient: Others have shown me genuine care, and my reaction is to feel sad. I don't know if I want care or if it scares me. I don't like to be dependent on anyone, but …

Therapist: Are you afraid our relationship will become so important to you that you run the risk of being terribly disappointed?
Patient: It's different here …, but … I have been thinking a lot about the end of therapy. How will I manage on my own?
5. The therapist interprets repetitive interpersonal patterns (including relationships to parents) and links these patterns to transactions between the patient and the therapist.
Therapist: What should I expect?
Patient: That I show up on time, or else you'll get frustrated …, even angry.
Therapist: Like your father or your new boss?
Patient: Yes … (sigh) … I feel others expect things of me, and that I have to fulfill their expectations immediately. Even when I know it's not really like that, that it's mostly in my own head.

Høglend's Studies of Transference Interpretation

The following vignette illustrates how work within the transference may promote insight (Høglend, 2014, p. 7).

Therapist: So, here we are now (category 1)
Therapist: What effect do you think our conversations have had on your relationship to your mother? (category 2).
Patient: I'm still struggling. My mother called this morning. I interrupted her right away and told her that if it wasn't super important , I couldn't talk now. I hung up, but felt terrible afterward.
Therapist: When you tell me this, what do you think I feel about you? (category 3).
Patient: You think I'm a selfish person.
Therapist. Could that be how you feel about yourself?
Patient: I get a bad conscience, even for the smallest things.
Therapist: You have talked about how hard it is to say "no" at work and think of your own needs. You've had problems setting limits with colleagues, your mother, and father, because you were afraid of being rejected or punished. But today you managed to tell me that our next session had to be changed because of your meetings at school and work. (category 5).

Patient: I have to be focused here. Forty sessions is not a very long time. I can see I do hesitate to trust other people, but my husband is supportive, and I try to talk some sense into myself.
Therapist: And now – this morning you were able to hang up on your mother, and you got me to change our next appointment. Maybe you are developing less fear and more trust? (category 4).

Reliability of Transference Interpretation

Rubovitz-Seitz (1998) notes that the problem of the reliability of interpretation did not surface clearly until Glover (1952) recognized that there is "no effective control of conclusions based on interpretation, [and this fact] is the Achilles heel of psychoanalytic research" (p.405). Rapaport (1960), too, asserted ""There is [as now] no established canon [in psychoanalysis] for the interpretation of clinical observations" (p.113). Responding to that concern, a group of psychoanalysts in Chicago including T.M. French, W.C. Lewis, J.G. Kopecs, G.H. Pollock, F.P. Robbins , L.B. Shapiro, R.M. Whitman and P. Rubovitz-Seitz undertook a systematic investigation of that problem (Seitz, 1966) and reported that, despite working together for over three years and employing various amounts and kinds of clinical data, they were never able to reach satisfactory agreement on the blind interpretation of the same case material. Other investigators who have documented the reliability problem include Sklansky et al. (1966), Weber et al. (1966), Thomä et al. (1976), Fisher and Greenberg (1977). Werman (1979), Runyon (1981), Spence (1982), DeWitt et al. (1983) Peterfreund (1983). Rosenbaum & Muroff (1984), Fosshage & Lowe (1987), and Bernardi (1989). Further, there is poor agreement between individual clinicians' transference formulations and observers CCRT-guided formulations, while CCRT formulation itself showed moderately good agreement between observers (Luborsky & Schaffler, 1990). Aron (1999), sounding a similar note, declared that it is not possible to determine whether a given interpretation or intervention is "correct", because numerous other analysts and supervisors will propose a different interpretation or intervention.

Reliability of Kernberg's Transference Interpretation

Review of Kernberg's papers (Clarkin, et al., 2001; Clarkin et al., 2004; Clarkin et al., 2006a; Clarkin et al., 2007; Kernberg, 2007a; Kernberg, 2007b; Levy et al. 2006a) indicate that reliability of his concept of transference was referred to only in Levy et al. (2006b) who tested reliability of the Psychotherapy Process Rating Scale for Borderline Personality Disorder designed (1) to assess therapist adherence and competence vis-à-vis the TFP manual; (2) to differentiate TFP from other psychotherapeutic approaches; and (3) to assess specific observable key therapeutic approaches and facilitative behaviors in the psychotherapy process with patients diagnosed with BPD to allow for the examination of the relationship between psychotherapy techniques and outcome." (p.1328). They concluded that this study "provides preliminary support for the inter-rater reliability of the Psychotherapy Process Rating Scale for Borderline Personality Disorder (PPRS-BPD) for identifying the specific, nonspecific, patient and therapist factors in psychodynamic psychotherapy for Borderline Personality Disorder" (p. 1329). There is no indication that this PPRS-BPD provides any assessment specifically of the reliability of transference interpretation.

Reliability of Høglend's Transference Interpretation

Review of Høglend's papers (Høglend, 1993a; Høglend, 1993b; Høglend et al., 1993c; Høglend & Piper, 1995; Høglend et al., 2000; Høglend 2004; Høglend et al., 2006; Høglend et al., 2007; Høglend et al., 2008; Høglend et al, 2011a; Høglend et al., 2011b; Høglend & Gabbard, 2012; Høglend et al., 2014) indicated that reliability of Høglend's concept of transference interpretation was reported in only two papers. In Høglend et al., (2008) reliability of four scales including the Specific Transference Technique Scales (P. Høglend, unpublished 1995 manual) was based "on average four or five full sessions of each therapy (452 sessions) were rated by three clinicians who were blind to the group to which the patient belonged. With two raters per session, inter-rater reliability coefficients were generally high (range=0.70 to 0.97 for all the process scales." (p.766). However, the following critical detail had been published only in (Bøgwald et al., 1999): "*Four of the five individual items of the STT-transference*

subscale were measured with acceptable to excellent reliability" (p.268, italics added).

Høglend's inclusive concept of transference has a total of five elements, four elements that refer to patient-therapist interaction while only one element retains the essential feature of Freud's concept of transference; the analysis of disturbing effects that originate in earlier relationships. This latter, fifth element, is distinguishable from the other four, and while not so identified, probably represents the fifth element, Freud's conception, that failed to be reliable. Although the four measures of current patient-therapist interaction are different from the fifth element, Freud's concept of transference, Høglend lumps together those four with Freud's concept, and calls them all, "transference," without providing a rationale for doing so. An epistemological analogy to Høglend's conception would be that oranges and apples are different and readily distinguishable, so they would not be lumped together and all called by the name of one of them, "oranges," unless there was some rationale for doing so. Høglend had an alternative option, which was to combine all five items but to label them "patient-therapist interaction". By including four measures of current patient-therapist interaction plus the item which includes past relationships in his category of transference, Høglend creates such a broad definition of transference, that all patient-therapist interaction becomes transference; *there is nothing that is not transference,* which reduces the value of the term. Cooper (1987) had proposed a similar expansion of Freud's concept of transference in clinical work, but he acknowledged that the result would be that "we are no longer sure what in analysis is not transference, and if it is not, what it is." (p.97).

Høglend provides no rationale for this expansion, except, perhaps, his statement, "the use of classical linking interpretations seems to have fallen out of fashion …" (2014, p.8). Contemporary Freudian psychoanalysts such as S. Abend (2005) and H. Blum (1983), clearly employ numerous interpretations linking to the patient's earlier relationships, as does Davanloo (Johansson, Town & Abbas, 2014.

Høglend (2014) recently reported that "more than 30 studies have reported significant associations between transference work and outcome. … that transference work interventions are indeed active ingredients (*for better or for worse)* (italics added) (p.1). It may be that unless transference

interpretations can be reliably assessed, that the effects of transference interpretation will remain inconsistent.

The Validity of Transference Interpretation

We turn now from the issue of reliability of transference interpretation to the validity of transference interpretation. Transference research customarily has been conducted on *groups of patients* despite the conclusions of numerous analysts that therapeutic action *varies with and is specific to each patient-therapist dyad* (Boesky, 1990; Kantrowitz, 1993b; Levine, 1994; Kantrowitz, 1995; Kantrowiz et al., 1989; Ablon & Jones, 2005; Gabbard & Westen, 2003; Bacal, 2011). Westen and Gabbard (2002) appear to agree when they urge that the most productive analytic stance is a function of "how the specific dyad can create a useful therapeutic process" (p. 126). It seems likely that transference interpretation, so intimately involved in therapeutic action, will also vary with each dyad. Lumping together the patients of dyads, despite our awareness of the varying transference-therapeutic outcome relationships in each dyad, may yield results for the group of patients that obfuscate specific transference-therapeutic outcome relationships.

An illuminating comparison between the concept of transference and our current understanding of the microbiome comes to mind. The microbiome – the trillions of microbes that share our lives (Yong, 2014) "is the sum of our experiences throughout our lives: the genes we inherited, the drugs we took, the food we ate, the hands we shook. … The microbiome is complex, varied, ever changing and context-dependent – qualities that are the enemy of easy categorization. " (p.4). Much the same can be said about the concept of transference.

On the other hand, studies of groups of *individual analytic or psychotherapy patients* have generated interesting findings in areas other than transference research. Both patient-therapist "fit" or "match" (Shapiro, 1976; Kantrowitz, 1986; Kantrowitz, 1990; Kantrowitz, 1993; Levine, 1994; Kantrowitz, 1995; Leuzinger-Bohleber, 2002; & Tessman, 2003) and therapeutic alliance (Samstag et al., 1998; Martin et. al., 2000; Curtis, R.C. 2001; Horvath & Bedi, 2002; Safran, 2003; Cooper et al., 2004; Meissner, 2007; Horvath et al., 2010; & Huggler, 2012) have been found to have

significant, positive relationships to therapeutic benefit. Thus, a recent study (Leuchter et al., 2014) reports that therapeutic alliance predicted response to medication and placebo expectation of medication effectiveness. Why are these relationships demonstrable across different dyads? We don't know, but we speculate that the positive effect on treatment outcome of "fit" and of "therapeutic alliance" shifts "levels" and encompasses a more universal bed rock relationship evoking common, fundamental attachment attitudes, while the factors responsible for individual therapeutic action, such as those involved in transference interpretation, are unique to each patient-therapist dyad.

Evaluation of the Validity of Freud's Transference Interpretation

Diamond et al. (2014) approached the problem of validity of transference interpretation by comparing patients with co-morbid Narcissistic Personality Disorder (NPD) and Borderline Personality Disorder (BPD) with patients with Borderline Personality Disorder without Narcissistic Personality Disorder. Their findings "raise the question of whether the NPD/BPD group experienced *less frequent* childhood trauma, or whether they were *better defended* and/or more reflective about childhood loss and trauma." (p.187). These patients' reports are current views, and there are no ways to check the validity of their reports of childhood experiences.

Another critique that undermines efforts to validate transference interpretation is Gabbard and Westen's (2003) assertion that "single mechanism theories [such as transference interpretation] of therapeutic action, no matter how complex, are unlikely to prove useful at this point because of the variety of targets of change and the variety of methods useful in effecting change in those targets …" (p.823). "The mechanisms of change in analysis will always be individualized according to the characteristics of patient and analyst (p.824).

Schachter (2002) asserted that "Freud's "transference" was conceived as a "false connection" identifiable by the distorted or unrealistic nature of the patient's reaction. A most important, overt theoretical change occurred when Gill and Hoffman [1982] asserted that "transference" does not involve distortion, but utilizes realistic elements of the analyst; this removes the

basis for categorizing the patient's reaction as a "false connection" or "transference," rather than as a newly created, realistic response to the analyst. … The attempt to substantiate the theory of "transference" by patient recall is fraught with problems, and Freud's tally argument fails to validate the hypothesis that a current feeling or fantasy is caused by a childhood feeling or impulse. Just as "transference" is influenced and shaped by interaction with the analyst, it is likely that the alleged infantile templates of "transference" have also been affected by other significant figures. Consequently, the effects of childhood experiences are likely to have been substantially modified by subsequent relationships; they would not have persisted unchanged and directly caused adult characteristics." (pp. 69, 70.)

Our failure to find evidence of the validity of transference interpretation does not indicate that such interpretations may not be valid. The absence of evidence is not the same as the evidence of absence! The interpretations may still be valid, and our conclusion neither should, nor will, result in therapists discontinuing the use of transference interpretations. However, our conclusion should lead therapists to acknowledge the lack of evidence for the validity of transference interpretation and to recognize that a transference interpretation is an hypothesis which probably can't be validated. Belief in the efficacy of transference interpretation should be held lightly. Gabbard and Westen (2003) agree since "we no longer have a consensus in psychoanalysis about what works and why. In general, the current psychoanalytic scene is witnessing movement toward greater humility. This humility is reflected in tolerance for uncertainty … (p.826). "There is no single path to, or target of therapeutic change" (p.837).

Conclusion

Kernberg and Høglend have reported numerous empirical studies of transference interpretation. Kernberg did not report significant evidence of reliability either for the patient-therapist interaction aspect of transference or for Freud's concept of transference. Although Høglend reported that measures of the patient-therapist interaction aspect of transference were measured reliably, there was no evidence that the measure based on Freud's transference interpretation was reliable. Clinically, many analysts have asserted the unreliability of Freud's transference interpretation, and

empirically there is no evidence to support reliability. Neither investigator attempted to assess the validity of transference interpretation. Absent reliability, plus the little likelihood of validating such an interpretation, if such an interpretation is presented to a patient it should be acknowledged to be at best an hypothesis, evaluated with humility, and held lightly by the therapist.

Many years ago Luborsky (1969) commented on the report of Strupp and Bergin (1969) by stating: "Research cannot yet influence clinical practice." Are we now in a different position today, do we encounter a fruitful collaboration between clinical practice and research now, or do we have to accept that the survival range of a basic notion of Freud's transference concept has outlived its acceptance in the field?

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