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THE BABY AND THE BATHWATER

Nina Coltart

Foreword by

Christopher Bollas



Nina Coltart

London
KARNAC BOOKS

that"—one of those ill-judged, pseudo-analytic responses that rightly make people new to analysis grit their teeth with frustration. And not only people new to analysis—long-in-the-tooth old practitioners like me, too. I did not contribute, because I was pretty sure I would give myself away if I did. I understand that some interest centres on large groups currently and much is being thought and written about them. But I never read the texts suggested to us, even on small groups. I had never intended to run a group, or "do" anything further about it, and I wanted the whole course to be as purely experiential as possible for me. I thought it would be only too easy to become a "student" again, as opposed to a "patient", and there would have been a certain appeal in that. Reading would certainly have added to the possibility of that happening, and I did not want it to. The whole experience was absorbing anyway, and I did not want it clothed in intellectualizing and theory. All the events and phenomena of that year were massively interesting to me, in all sorts of different ways, and I am tremendously glad I did it. Even the tedium of the large groups held its own sort of fascination: for example, I was interested in the acute anxiety that some members of my small group manifested during and immediately after the large group, particularly when they would say fiercely: "I will say something next week, I'll make myself do it." The importance of "saying something", no matter what, seemed to become paramount. It made me think of the new young corporal who was being trained by his Sergeant Major to give orders to the platoon. He got them to attention smartly enough, with arms presented, and he got them marching briskly along, with himself at the rear and his big, tough Sergeant Major marching watchfully and critically alongside. Unfortunately, the camp was on the coast, and they were marching briskly towards the cliff, which, from being distant, came ever nearer. The corporal gaped and stammered. But nothing came out. He had forgotten the command to make them stop. Eventually the Sergeant Major bellowed at him: "Well, go on, Jones—say something, even if it's only good-bye!"

CHAPTER FOUR

Handling the transference

So many developments in the study of transference and countertransference have occurred in the last half-century that it is sometimes forgotten how much we owe to Freud. I propose to consider the papers written between 1911 and 1915 and often referred to collectively as "The Technique Papers". I do not mean to go over them in detail—I would rather people read them time and again for themselves; they invariably come across as fresh, lively, and packed with helpful advice; and his formulations are equally valuable for the beginner and the experienced practitioner. I mean only to view them for what they have to tell us about the transference, its theory and use; the use of the countertransference was not yet developed, and its detailed study really post-dates Freud by many years. It is of course referred to by implication several times, but it was not really studied as a subject in its own right until Paula Heimann focused directly on it in a now-famous paper in 1950. While we are refreshing our memories of the Technique papers, I will add some

thoughts of my own on subsequent developments and personal experience.

The first paper is called "The Dynamics of Transference" (Freud, 1912b). It is worth adding here that I think this one should be read in conjunction with two of the *Introductory Lectures on Psycho-Analysis* (1916-17, Nos. XXVII and XXVIII, which Freud produced a little later, in 1916. There are some useful, connected passages in them. In "The Dynamics of Transference", Freud explicitly broaches, for the first time, his understanding that, from one's earliest years, there are stereotypical templates in every individual, created both by genetic structure and by primary experience, which will forever underpin one's erotic pattern. All individuals strive to satisfy certain instinctual needs, meet their own preconditions for falling in love, and, more or less unconsciously, organize the means by which they try to reach their own ends. Essentially, this pattern cannot be rooted out or radically changed, but—especially where certain elements of it may never have been satisfied by reality, or have been held up in the course of development or only experienced in fantasy—it can, through analysis of the transference, be modified, sometimes to a considerable extent.

In fact, patients who have never consciously experienced certain sorts of feeling—say, quirks or depths of being in love, or ways of reacting when they feel cared for, or angry and hostile and critical emotions towards their nearest and dearest—may be difficult to work with, because the defences are so strong; but they may also be rewarding. Once the analyst is sure of a piece of transference and has an understanding of its value and how it is manifesting, one can plug away at it patiently until the strangeness of it (to patients) is minimized and they have a good feeling of their whole range of emotional capacity being expanded by experiencing something new. But it should not be forced. One should never push something—even something one is sure of—in the transference until one senses that patients are on the very edge of being able to know it fully for themselves. We come to Freud's warnings about this in a later chapter, but I stress it here as it is such a common error of technique. There is a saying: "A man convinced against his will / Retains his old conviction still", and this is true of all analytic therapy. Furthermore, there is a common countertransference failing that goes with it: this concerns

the sort of situation in which one may have been repeating an interpretation, perhaps in slightly varied ways, for many weeks or even months, encountering only resistance, or rejection, or ignoring of the therapist by the patient, until one day the patient tells the therapist this very piece of insight as if it is completely new, and has never been alluded to before, and furthermore is the patient's own discovery. And in a sense it is all those things. One should resist the temptation, if humanly possible, to say, in a peevish voice: "But I've been saying that for ages", or something similar. The practice of analytic therapy, far more than most professions—and more than any lay-person could believe—requires a real worked-through capacity to be humble and self-effacing. What matters is—has the patient truly grasped the insight? Not whether one was bright enough to have seen it long since. The art is to learn sharply and fully to rejoice in the steps forward a patient takes; this has to be one of the primary sources of gratification for an analytic therapist. And it is certainly not advisable to seek for gratification—the narcissistic one of being seen to be smart or intellectually several jumps ahead.

The individual erotic patterns, which Strachey translated from Freud's German as the person's "instinctual cathexes", are the source of transference. In analytic treatment, which exerts a negative pull on the patient through the direction of interpretations and the focusing of an intense beam of scrutiny on the patient's neuroses, the person of the therapist becomes increasingly important to the patient, and "finally every conflict has to be fought out in the sphere of transference". Here is one of the most important features of this first paper: clearly, at that time, transference tended to be thought of as if it were always positive, and this is a mistake that young therapists are still inclined to make today, probably because (whatever people may say about their technique) the all-important early stages of treatment do rather concentrate on building a good rapport and a solid therapeutic, or working, alliance; and it is, in fact, positive elements of transference that blend with hope and trust to create and maintain the alliance. In fact, there are some analysts, notably Kleinians, who maintain that the concept of the "therapeutic alliance", and any theory that may derive from it, are superfluous to our needs, as it is all transference, and should be treated as such. A Day Symposium organized by the British Society a few years ago made this

very clear. Freud stresses here, not only that the genetic roots of affection and sympathy are always, if traced right back, sexual in origin (by his definition, that is), but also that negative elements of transference, which lead to conflict and therefore to resistance, are *always* found side by side with the more socially acceptable, more easily accessible positive ones. Freud *for the first time* here introduces the actual term "Ambivalence".

Also *for the first time* in this paper Freud refers to what is now called "The Golden Rule". He is describing how the transference becomes, for the patient, such a genuine affective experience that fantasy turns into real longing and recovery of memory into acting-out or -in. In other words, the transference is the source, not only of pleasant cooperation, but also of strong resistance, so that the patient begins "to disregard the fundamental rules of psychoanalysis". The patient ceases to be frank and open and becomes secretive and withholding, or passionate and angrily demanding. He/she may seem to be a bit mad temporarily, or at least very different from the agreeable and compliant creature we knew at the beginning of treatment. Thus, through the transference work, the core of the neurosis is gradually revealed, and "it is on this field—of the phenomenon of transference—that the victory (that is the cure of the neurosis) must be won". Freud ends the paper engagingly by reminding us that such transference work is *extremely difficult*. We have been stuck, in the dark, trying to exercise negative capability as creatively as possible, and have thought: "Oh, if only I could see the transference." And when one does, it is as if a light had begun to shine on the hitherto baffling situations. Freud adds—and we soon begin to recognize this for ourselves—that it carries the greatest conviction to the patient, and hence to us as we do it.

In the paper called "On Beginning the Treatment", Freud (1913c) is at pains to demonstrate that, in a neurotic patient, transference will always develop: the therapist does not have to assist it by any particular efforts; so long as we instruct the patient about free associations—i.e. the golden rule—it will unfold of itself, and the "delicate procedure", as Freud calls it, will continue unaided until it encounters a resistance. Sometimes this will take quite a long time. But there is also a type of patient who almost at once will open by announcing that he/she has nothing to say. Freud handles this, in the first instance, by

instructing the patient—yet again—in the fundamental rule. We have to remember that he was didactic by nature and still had a greater faith, not only in education, but in being obeyed, than we might have today. But he also indicates that transference is *already in existence*, stating that a strong transference resistance has already come to the fore in order to defend the neurosis. This, he implies, he would tackle, after encouraging the golden rule, by transference interpretation, if he possibly could; he insists that if "the patient looks into his mind again, then early transference signals will appear".

However, the most usual primary task is "attaching the patient to the person of the doctor in order to establish" what Freud calls "effective transference", and on the whole he advises that this sort of interpretation should not begin until a strong rapport exists. By this, we would now realize that he is referring to the treatment alliance. One further quotation at this point: "To ensure a strong attachment, nothing need be done but giving the patient time. If one exhibits a serious interest in him, carefully clears away the resistances that crop up at the beginning and avoids making certain mistakes, he will of himself form such an attachment; and will link the doctor up with one of the images of the people by whom he was accustomed to be treated with affection." He adds that one should not moralize, fling diagnoses at him, make clever lightning guesses when the patient is nowhere near ready for them, nor use intellectual reasoning, which will all fall on deaf ears. These, I think, would be what he meant by "certain mistakes".

It is important to try to remember, while reading these papers, that psychoanalysis was still tremendously NEW: I believe it is almost impossible for us to imagine fully that for a therapist to sit behind a patient, restraining himself from diagnosing or being clever or putting forward his own personality—even from talking at all for long periods—was not only revolutionary and amazing, but quite alarming, especially when practically the only person writing about it was listened to, and faithfully copied by, those who were interested or were struggling to do it. Freud himself used his written papers to work things out as he went along, which accounts for certain self-contradictions that crop up (and which I think deserve admiration rather than criticism, which has lately become fashionable). To this day, there are two large

categories of patients from whom Freud was probably gathering most of the material on which he based his ideas on transference: those who are extremely anxious and need quite a lot of careful work, with some informed guessing at transference colouring, before they can settle into treatment; and, at the other extreme, those—often hysterics, of whom Freud saw far more, and more florid examples, than we do now—who come in to treatment with what is called a "readiness for transference", or even with a fantasy-laden transference thoroughly established, based perhaps only on a short preliminary interview or even purely on imagination. It is important not to leave this uninterpreted, but to welcome it and begin to work with it straight away.

I would like to insert here, in this chapter on handling the transference, something about which I have always felt strongly, and which I have learned more about from doing clinical seminars with many generations of students. It is a matter on which there are quite sharply divided opinions, certainly within the British Society; I have encountered arguments when teaching abroad, but views are less definite, for example in the United States. The subject whether—or not—to take a history during the preliminary interview. My view is as follows: If one is sent a patient by an assessor who has taken a good history and made notes about it, it is valuable to ask to see those notes and to memorize a considerable amount of the history before one starts the treatment. Or, in one's own preliminary interview with a prospective patient, some detailed history should be taken by oneself. Or both. It is essential, I believe, for the smooth development and effective handling of the transference, that the therapist has a firm grasp on the patient's view of the main object-relationships of his/her early life—and by that I mean up to late adolescence, not just the first two or three years. If one is going to understand the individual transference, rather than impose a theoretical structure on it—which is then inevitably similar for everyone—one needs to know a lot about what it was like to have been the patient as a child, the details of the relationships to his/her mother, father, siblings, or their surrogates—whoever played important influential roles in the development. Interpretations that allude to recognizable nuances of what the patient's own life was like—such as, "You are feeling anxious and lonely the way you did when you were left alone in the house with both your

parents out at work", or "You seem to have the same jealous feelings about the next patient as you did about your little brother"—carry more weight and are therefore more effective agents for insight and change, than are more theoretical part-object interpretations that have no particular meaning to this patient.

A clinical seminar in which some of the students have no knowledge of the personal history of their own patients and rely entirely on theoretical transference work from the beginning can be, in my experience, a lamentable event. I recall one in which it became clear to me, while listening to several sessions of a particular patient's material, that the patient's mother must have abandoned him, suddenly, and probably through dying, at an early age. I asked the student. She did not know; she did not even know whether the patient's mother was alive or dead now, or, if dead, when. She was not skilled yet in handling transference, and the session she presented was literally embarrassing, as she came out with ill-digested theory and tried to push it into the unhappy and bewildered patient. This is one of the points I want to stress; a very experienced analyst can handle a patient's offerings entirely in the here and now of the transference with a skill and sensitivity that can make the reporting of a session a convincing pleasure to listen to. A student or an inexperienced (or even simply a not very good) analyst cannot. It takes years of experience to train the third ear, the intuition, the sum-total of all the analytic skills, in fact, to carry out this most delicate task. I believe the sort of clumsy ineptitude that I have often heard from beginners trained in the school of thought that ascribes all value to early theory and fantasy, and none to the individual and his history, can do real psychic harm to patients. Also, when we consider the vast amount of work that has been done on details of child development, with, in relation to the example I have given, special reference to parental loss in childhood—I think we may at least understand why I consider this point important, and why I am stressing that each patient is a human being with a highly personalized history, and that it is our job to treat this with respect and understanding; we must therefore be familiar with the details of the history, and we must use it.

There is one more thing to be said about the 1913 paper, "On Beginning the Treatment", viewing it from where we can elicit

information about transference. Right at the end, Freud rather tantalizingly refers to the phenomenon of "transference cure", really only to say that it can happen but that it will not last. "Transference cure", which many people will not have seen, is an odd and usually temporary mixture of the cheering effects of very positive transference, with an underpinning of strong resistance. In other words, a patient is so energized and perked up by the beneficent effects of being in love with a reliable parental figure (only he or she probably would not see it like that) that the symptoms vanish, and the patient may leave the treatment prematurely, assuring the therapist and themselves—and others—that everything in the garden is now lovely. Freud states fairly categorically that it will not last, and I think this may be linked with the extreme nature of some of the hysterical symptoms, including conversions, that he encountered. The resistance, in this phenomenon, consists in the splitting, the denial of the negative and the ignoring of the self-deception; and in taking the slightly manic state to be true happiness. An apparent change from a symptom such as a conversion, which has been fed by a lot of psychic energy—if it is not worked through and thoroughly understood—simply squashes the pathological structure, splits off and temporarily represses it, but does not eliminate it; and the energy, or distorted libido, forces its way out somewhere else pretty soon in the shape of another symptom. The patient is then disappointed and angry and probably blames psychoanalysis and the therapist, who may him/herself have used a lot of energy to try, fruitlessly, to stop the patient leaving. Having said that, it is important to add that we now know that, just occasionally, "transference cure" does last. Perhaps it was not a "transference cure" at all—the label may be a misnomer. But a patient who quite rapidly forms a largely positive, loving, idealizing relationship with the therapist may thus mobilize energies that have simply been untapped for years, and the self-image may, as a result, improve so greatly that real ego expansion occurs, and the patient conceivably begins to build creatively on this and to maintain the core of the improvement thus initiated. Certain religious conversions show this persistence, and I have seen it in at least three patients, who were followed up—without interpretation!

One of these patients was a really ghastly late-middle-aged woman sent to me for assessment and referral (to see if I thought therapy possible), by her G.P., who was at his wits' end. The woman was known in his practice as Miss Heartsink. She wasn't exactly a hypochondriac—she was not on a grand-enough scale for that. True hypochondriasis is a serious diagnosis of a usually monosymptomatic paranoid psychosis and is in fact quite rare. But she was what gets called a hypochondriac. Spinsters (the feminist side of me is reluctant to use this adjective, but the sad fact remains that, politically incorrect as it may be, it does still convey a wealth of meaning), somewhat paranoid, obsessional, priggish as they often are (and which shows their narcissistic contempt for the inept doctors), she visited the surgery regularly with a succession of shifting, indecisive symptoms on which she dwelt with fanatical intensity while they lasted and did not seem to notice when they changed. The gratification obtained from them remained constant. The G.P., an excellent one, was kind but tough with this lady; and also, thinking she might well be presenting an involutional depression, quite properly treated her with three courses of different anti-depressants, none of which helped at all. The patient was a late Catholic convert and was attached in some way to a convent of Dominican nuns, who also got a lot of her complaints and dependence. She did a humble job and often went off sick. I saw her four times as a sort of extended consultation-cum-brief-therapy. I did not do anything much. She was totally urpsycholegically minded, and a few attempts at interpretation from me met with complete incomprehension. I thought she was quite unsuitable to refer on for therapy. But she fell in love with me. In a quiet, devoted, fortunately un-clinging way, she unconsciously arranged to channel all her frustrated libido onto me—fixated, as it was, at a homosexual, primitive level, on an early imago of a long-dead mother. This was twenty years ago. She changed massively and has maintained the change. She stopped "doctoring" and instead took up voluntary work—again in a humble capacity—with a Catholic orphans' charity. She writes to me—neat, quite humorous little letters, about three times a year. I always write back to her. Now the food is the right food, she seems able to subsist on remarkably small quantities of it. She is one of the proofs to me that what I believe to be

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"transference cure" does exist and can last. She also proves to me something I have long believed and sometimes written and spoken about: that it is healthier and more beneficial to the whole system to love rather than to be loved. There is a potent myth to the contrary, but this way of looking at it is true nevertheless and can be tested by long-term observation.

Back to Freud: there were two papers in 1914. The title of the first, "Remembering, Repeating and Working Through" (1914g), tells us a good deal. The paper is one of my favourites, because Freud is very self-revealing in it, in a way that shows us a kind, and almost tender, aspect of himself, which is an unusual view of the didactic, patriarchal genius. The emphasis throughout could have lengthened the title somewhat and made it even more accurate. Freud is concentrating on remembering, repeating, and working through in *the transference*. He is pointing out that even in insightful patients, repressed emotions and early experiences incapable of coming straight into memory may appear as transference feelings and behaviour that then enable the analyst to make accurate translations and thus broaden the self-experience of the patient. Christopher Bollas later wrote about this in his excellent first book, *The Shadow of the Object* (1987). Here Freud introduces the concept of the "compulsion to repeat", which is so clearly demonstrated in people's erotic patterns, and which we must know from ourselves as well as from studying patients.

In this connection, there is a particular quotation from the paper, which reminds us that it was written about fifty years before Winnicott brought in his notion of the "need to play". Freud says:

We admit the compulsion to repeat harmlessly into the transference as a playground in which it is allowed to expand in almost complete freedom; thus we give the symptoms a new transference meaning and create the transference neurosis.

The transference neurosis is to this day extremely important, and technically it is where most of the effective transference work takes place: it is an intermediate region between the incomprehensible neurotic illness and real life—most often it has an unpleasantness and tension to it, which removes the early happy basking in positive transference, and it is much more accessible

to interpretation, and is ultimately more easily resolved, than straight positive or negative transference. It is focused entirely on the therapist.

This is where the young therapist really learns to develop patient endurance and negative capability: the transference neurosis may be, in a sense, an artificial illness, partly created by human nature and partly by the interpretative guiding skill of the analyst. But patients have to become conversant with their own resistances and their need to go on repeating; and time is required before working-through is completed, and, almost in defiance of the patients' wish to keep something alive and real—as it seems, and is to them—they also have to go on siding with the analyst's therapeutic work if they are honest and if they can, and stick to the golden rule. It is only gradually that patients become convinced that, for example, fierce anger, red-hot jealousy, sexual longing, and so forth are no longer directed at their true (i.e. original) object, but at the analyst, and that the analyst is an inappropriate object; then the patients can slowly put such feelings in their true perspective and leave them behind in their own emotional histories where they belong. In a nutshell, this is really the aim of an analytic therapy. Economical, pointed interpretations, often repeated times without number until a true light of insight finally dawns, are the order of the day here. There is nothing to be alarmed about when a florid transference neurosis appears. It is a gift to be worked with. Young therapists do sometimes feel frightened at the strength of the emotional turmoil they have unleashed; here it is important to remember, and to cultivate faith, that the *analytic process is trustworthy*. Skillful interpretation is required, of course, especially in the case of a heatedly eroticized transference: it may be a good idea to obtain some supervision for a while to assist the process.

Freud continues with this subject in another paper, which is called "Observations on Transference Love" (1915a [1914]). Freud thought this was the best of them, and certainly it has life and vigour to it. It is in this paper that Freud delivers himself of his warning, which remains as vital to take in and learn today as ever it was then: "The analyst must recognize that the patient's falling in love with him is induced by the analytic situation and is *not to be attributed to the charms of his own person*" (my italics). How often have I heard therapists who should know better, as well as

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inexperienced ones and students, describing the passionate positive transference of a patient in a complacent, slightly fatuous way, sucking narcissistic juice from it, which yet again makes one realize that the therapist has fallen into the old error that Freud was so caustically warning against—namely, that the patient loves him because he is loveable, or admires her because she is admirable. It is nothing of the sort. It is transference.

Some of Freud's best metaphors appear in this paper—for example:

The patient loses all understanding of "transference" for a while; it is as though a piece of make-believe had been stopped by the sudden irruption of reality—as when, for instance, a cry of FIRE is raised during a theatrical performance.

Effectively, this loss of grip by the patient constitutes a resistance to treatment—the flowing continuum of interpretative therapy is interrupted by the patient's protest that he really is in love with the analyst, or really does need to be in touch at weekends, or really has ceased to trust and admire the analyst because he has seen through him: the variations are infinite. Another excellent metaphor comes into view as Freud deals with the difficult tasks that face the analyst, especially if the analyst personally loses grip and starts to share the illusion, or gets very anxious. Freud is saying that all phenomena must be accepted, as when the tone of the whole transference relationship was more muted and amiable; he is warning against trying to turn off the patient's intensity by any means whatsoever:

To urge the patient to suppress, renounce or sublimate her instincts the moment she has admitted her erotic transference would be, not an analytic way of dealing with them, but a senseless one. It would be just as though, after summoning up a spirit from the underworld by cunning spells, one were to send him down again without having asked him a single question. One would have brought the Repressed into consciousness, only to repress it once more in fright. The patient would feel humiliated and would take revenge.

Nor does Freud advocate a middle course, such as guiding the relationship into calmer channels or raising it to a higher intellectual level. Always Freud returns to the baseline—that it is

dangerous (his word) to depart from the foundation of psychoanalysis, which is *truthfulness*; we must take what comes, and sit it out.

Here he moves on to another famous, and still completely applicable, piece of teaching. If anyone thinks this is old-fashioned or out of date, then further reflection is required. Analytic therapy must be carried out in abstinence. One has only to know the analytic world well and keep up with the ethico-legal history of our movement to realize that, even more today than in 1914, Freud is right to use the word "danger". In the whole known world of analytic therapy, there are about 100 cases that *come to light*, every two years or so, of analysts and therapists who, probably, have sexual affairs with their patients. Some appear to get away with it—for some reason, *marrying* the patient gives it a cloak of respectability, though the marriages are unlikely to last. Sometimes this problem presents chronic headaches to analytic societies, who may know and yet have to *not know* what is happening, lacking proof, or, frequently, lacking the bold mouse who would volunteer to bell the cat. Gossip may spread information, but making good use of it is extremely tricky and difficult. I think a piece of useful advice is that it is better not to gossip at all if it can be avoided; but analytic societies, perhaps because of the extremes of confidentiality and aloneness necessary in the work, seem to be peculiarly liable to become hothouses for gossip about each other.

Here I would attempt to consolidate the importance of Freud's view by adding that our fundamental ethic can be summed up in one sentence: patients are vulnerable, and under no circumstances whatsoever should we exploit, or act out with them, financially, practically, emotionally, or sexually. Talents for self-deception, so common in human nature, do not exclude analytic therapists. Let us return to Freud, whose compelling clarity of thought and style is unbeatable (the patient under discussion is female):

It is a fundamental principle that the patient's need and longing be allowed to persist in her as long as is necessary, in order that they may serve as forces impelling her to do work and to make changes; and that we must beware of appeasing those forces by means of surrogates; and anything we could offer would be surrogate because, until her regressions are

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removed, she is incapable of getting real satisfaction. Acting out of any description by the analyst even with the highest aims would only achieve the patient's neurotic aims, and *never* the analyst's therapeutic aims. It is disastrous for the analysis, and the patient, if her erotic transference needs are met; she will be acting out what she ought only to have remembered and kept within the sphere of psychical events.

And one may add that it is the analyst's task to see to it that it is kept within the sphere of psychical events. Freud, then, with great skill, elucidates that there is no model in real life for what analytic therapists actually have to do; they have to let it be quietly but constantly known to the patient, by their whole manner, that while they can take and work with anything the patient manifests, they are also "proof against any temptation" as they gradually trace the maybe violently passionate transference back to its unconscious origins and bring it slowly into consciousness by means of consistent interpretation. We have to demonstrate, slowly, that there are no new elements in this current love, or hate, but that it is entirely composed of repetitive patterns, which, slowly, come to seem incongruous in the here and now and are mainly from childhood in origin. Thus we aim to uncover the patient's infantile object choice, the preconditions the patient sets upon gratification, and the often intricate fantasies woven around it. This is the undoing of the neurosis.

Freud, with his usual honesty, does point out at the end of this paper that we cannot truly say that this analytic in-loveness is "not real"—it is sometimes shatteringly real for the patient. All we can do is hone our language skilfully so that we work on the incongruity of it rather than the unreality. Freud says that, in any case, the state of being in love, wherever it happens, is more abnormal than normal, and in another paper—"On Narcissism" (1914c)—he compares it to a kind of lunacy. But it is certainly isolated and intensified in analytic therapy by the very special attention paid to it, and it is on its lack of regard for reality that any attempt at a real relationship that may evolve out of it founders. The patient's state of transference demands can never be gratified; the analyst who sets up a real-life relationship with the patient is not only sharing a delusion but has allowed his/her narcissism to rule the day, believing that he/she can match the fantasy. Omnipotence says that it can make it work this time:

real-life testing says it cannot. This brave and excellent and, in the context of its time, quite startling paper of Freud's is a warning that there can be real dangers in the handling of transference. If ever one is in doubt about one's own responses or course of action, some supervision, or even one discussion, with a senior analyst whom one trusts and who is generally known through the network of analysts as having integrity and having no shadowy gossip attached to his or her name is an excellent plan.

If the doubt is primarily about one's technique, and one is uncomfortably aware that one does not know how to handle the kinds of interpretation that are waiting to be made, a useful technical hint is as follows: when an erotic, passionate, or very intense emotional transference is in evidence in the here and now, one can, without suppressing the maternal or warning the patient off, take the interpretations *backward in time*. An attempt should be made to pick up some historical patterning that is recognizable—for example, a reference may be made to a powerful person in the past who has been important in this aspect of the patient's love relationships; an appropriate "genetic" interpretation may be constructed. This will re-focus the patient, who is still, in spite of the resistance of the current strong feelings for the analyst, probably trying to work; it will temporarily introduce a longitudinal theme-note even to a patient who is completely caught up in the transference neurosis and has ceased to acknowledge it for what it is. If, on the other hand (and this is very different from the erotic situation), the patient seems very stuck in the past, perseverating about a hated figure of childhood and unable to leave a preoccupation with a really unhappy, deprived, traumatized period of his/her life, the transference work may be brought *forward in time* into the here and now; the therapist should try to get in on the act somehow, even if only by the simple device of saying something like: "I believe you're very anxious about whether I could hurt you like that"—or—"about getting so upset and angry with me", and sticking with the manoeuvre in spite of protests.

In the *Introductory Lectures* (XXVII and XXVIII), Freud (1916-17) makes a few remarks about suggestion. A critic who is hostile may say: But surely you are simply operating on suggestion and hypnotizing the patient. Suggestion inevitably is theoretical: the moment a therapeutic intervention begins to be

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personalized, directly connected up with an event or an emotional situation in the patient's life, it is becoming an interpretation—or at least, a technically permissible comment—and is not a suggestion at all. Furthermore, one cannot "suggest" a memory, especially of an aggressive or erotic impulse, or an experience; one would be doing wild analysis; that field is wide open to the analyst's fantasy. And although there is much to be said for letting our own fantasies run free in our own minds while we are receiving patients' communications—in the same open free-associative state that we enjoin on them—this is quite different from letting fantasy rule our attempts at interpretation.

Suggestion only produces a combination of intellectual theorizing and fantasy, whereas interpretation gets down to the nuts and bolts of an individual's psychic structure. Interpretation goes far deeper, because it is accurately aimed; it opens out conflict areas and brings the unconscious nearer to consciousness. Thus it produces movement in the therapy, whereas suggestion does not; suggestion only blurs things, covers up, and, in fact, reinforces resistance. This is partly because it is instantly recognizable. It is hard to demonstrate this by example, but if one catches oneself doing it, one will know at once, and so will patients. They may continue to listen, but they will, especially if they are psychologically minded, give it the scant respect it deserves and temporarily be shaken in their reliance on the analyst. The same goes for interventions that are too vague and generalized.

Finally, and logically here, it seems important to add something about Strachey's famous remark, in his 1934 paper, that "only the transference interpretation is mutative". Sometimes I think it is a pity that this statement was ever made; it sort of hypnotizes people, especially young analysts at the beginning of their careers, and it gets linked up with the superego. Beginners get anxious if they find they cannot by any means construct a transference interpretation and have not yet developed the verbal knack of making an appropriate transference interpretation out of practically anything or nothing. This is a skill to be learned, but it is not an easy one, and meanwhile Strachey's dictum hangs about accusingly on the edges of the therapeutic situation. What is hardly ever recalled is what the rest of Strachey's paper is about: that is, the *need for*, and *value of*, *extra-transference interpretations*. He uses a metaphor to the effect that most of the daily work

we do is in the realm of comment, clarification, and extra-transference interpretation. This he compares to a body of soldiers making their plans, covering the ground, clearing away obstacles—until, finally, as a result of all these preparatory moves, the enemy outpost itself yields and is taken. This is the moment of the effective transference interpretation. A considerable amount of any patient's material presents opportunities for telling extra-transference interpretations, and it is a great pity to waste it, or distort it out of all recognition in order to drag it into the transference. The classic example is when one has one spouse of a warring couple in treatment; one will hear, in the patient's accounts of the latest battle, references that show his own patterns and echoes of his early relationships, and he is going to be much more struck if one can point this out clearly than if one makes a slavish attempt to produce a clumsy transference interpretation of a "you-mean-me" type; it may, just, be a valid attempt, but more likely it will sound idiotic, as there are no accessible levels at all at which the patient *does* mean you. He is talking about his wife, and he needs as much help as he can get with that, by your shining a torch into the recesses of what is affecting his emotions and behaviour *there*. He may also have a dominant neurotic pattern, of which the marital conflict is only a part, and the opportunities for the transference approach lie in one's long-term tackling of that.

There is always stimulation and refreshment in returning to papers of Freud's, and I hope that these reflections on re-reading what Freud was writing about, eighty years ago, may assist in reminding us what an enjoyable and worthwhile undertaking such re-visiting is.

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The discovery of psycho-analysis is intimately bound up with the personal exploration that Freud undertook of himself (see 'Self-Analysis'). It seemed to Freud right from the start that to practise analysis successfully one must be armed with a knowledge of one's own unconscious. At the 1910 Nuremberg Congress he maintained that what he called a 'self-analysis' was an indispensable requirement if the physician was to 'recognise [the] counter-transference in himself and overcome it' (1). It is not possible, however, to be sure from the term Freud used on this occasion—'*Selbstanalyse*'—whether he meant a true self-analysis or an analysis conducted by another person. The context would seem to suggest the former meaning, but according to Otto Rank's report of the Congress (2) Freud was certainly also envisaging the institution of the training analysis. At all events, it would seem that at this date the nature of the training analysis as distinct from a self-analysis was not yet clear to Freud.

The formative value of a personal analysis is more clearly acknowledged in Freud's 'Recommendations to Physicians Practising Psycho-Analysis' (1912e). Such an analysis is here brought into relation with the theory that the analyst 'must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient' (3a). In order to do this, the analyst must be able to communicate more freely with his own unconscious (see 'Attention'), and this is precisely what the training analysis aims to facilitate. Freud praises the Zurich school for their stress on 'the demand that everyone who wishes to carry out analyses on other people shall first himself undergo an analysis by someone with expert knowledge' (3b).

It was in 1922, at the Congress of the International Psycho-Analytical Association, two years after the foundation of the Berlin Institute of Psycho-Analysis, that a training analysis was made obligatory for every would-be analyst.

Ferenczi apparently contributed the most to bringing out the value of the training analysis, which in his eyes constitutes the 'second fundamental rule of psycho-analysis' (4). For Ferenczi the training analysis is no less thoroughgoing, no less profound than therapeutic analysis: 'To stand firm against this general assault by the patient the analyst requires to have been fully and completely analysed himself. I mention this because it is often held to be sufficient if a candidate spends, say, a year gaining acquaintance with the principal mechanisms in his so-called training analysis. His further development is left to what he learns in the course of his own experience. I have often stated on previous occasions that in principle I can admit no difference between a therapeutic and a training analysis, and I now wish to supplement this by suggesting that, while every case undertaken for therapeutic reasons need not be carried to the depth we mean when we talk of a complete ending of the analysis, the analyst himself, on whom the fate of so many other people depends, must know and be in control of even the most recondite weaknesses of his own character; and this is impossible without a fully completed analysis' (5).

The requirements formulated by Ferenczi are very generally accepted today (a): they tend to make the personal analysis of the future psycho-analyst into a procedure in which the acquisition of knowledge through experience takes second place—in fact to speak of 'training' is to lay unjustified emphasis on this aspect.

A problem at once theoretical and practical is inherent to the notion itself

Transference

and to the institutionalisation of the training analysis: how can an analysis be directed from the outset towards a specific goal, towards such a preconceived 'purposive idea' as the derivation, from an instituted procedure in which the training analyst's assessment plays an important part, of the capacity to exercise the profession? This question is the subject of ongoing debate within the psycho-analytical movement (β).

(α) Freud himself adopted a rather reserved position on the possibilities held out by the training analysis: In 'Analysis Terminable and Intermittent' (1937c), he holds to the view that 'for practical reasons' such an analysis 'can only be short and incomplete. Its main object is to enable the teacher to make a judgement as to whether the candidate can be accepted for further training. It has accomplished its purpose if it gives the learner a firm conviction of the existence of the unconscious, if it enables him, when repressed material emerges, to perceive in himself things which would otherwise be incredible to him, and if it shows him a first sampling of the technique which has proved to be the only effective one in psycho-analytic work' (6).

(β) For the problems posed by analytic training and their history in the movement, see especially Balint, 'On the Psycho-Analytic Training System' (7).

- (1) FREUD, S., 'The Future Prospects of Psycho-Analytic Therapy' (1910d), G.W., VIII, 108; S.E., XI, 144-45.
- (2) Cited by KOVACS, B., 'Training and Control Analysis', *I.J.P.*, 1936, XVII, 346-54.
- (3) FREUD, S.: a) G.W., VIII, 381; S.E., XII, 115. b) G.W., VIII, 382; S.E., XII, 116.
- (4) FERENCZI, S., 'Die Elastizität der psychoanalytischen Technik', *Intern. Zeit. für Psychoanalyse*, 1928, XIV, in *Final Contributions*, 88-89.
- (5) FERENCZI, S., 'Das Problem der Beendigung der Analyse' (1928). In *Final Contributions*, 83-84.
- (6) FREUD, S., G.W., XVI, 94-95; S.E., XXIII, 248.
- (7) BALINT, M., *I.J.P.*, 1948, 29, 163-73.

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Transference

= D.: Übertragung. - Es.: transference. - Fr.: transfert. - I.: traslazione or transfert. - P.: transferencia.

For psycho-analysis, a process of actualisation of unconscious wishes. Transference uses specific objects and operates in the framework of a specific relationship established with these objects. Its context *par excellence* is the analytic situation. In the transference, infantile prototypes re-emerge and are experienced with a strong sensation of immediacy.

As a rule what psycho-analysis mean by the unqualified use of the term 'transference' is *transference during treatment*.

Classically, the transference is acknowledged to be the terrain on which all the basic problems of a given analysis play themselves out: the establishment, modalities, interpretation and resolution of the transference are in fact what define the cure.

The use of the term 'transference' has on the whole been confined to psycho-analysis, and it should not be confused with the various psychological uses of 'transfer' (1).

The reason it is so difficult to propose a definition of transference is that for many authors the notion has taken on a very broad extension, even coming to connote all the phenomena which constitute the patient's relationship with the psycho-analyst. As a result the concept is burdened down more than any other with each analyst's particular views on the treatment—on its objective, dynamics, tactics, scope, etc. The question of the transference is thus beset by a whole series of difficulties which have been the subject of debate in classical psychoanalysis:

- a. As regards the specificity of the transference to the analysis: does not the analytic situation, given the strictness and constancy of its conditions, merely offer an especially favourable ground for the emergence and the observation of phenomena that are actually present elsewhere?
- b. As regards the relations between the transference and reality: when we have to decide whether a particular phenomenon occurring during the treatment is adapted to reality or not, whether it indicates transference or not, what help can we get from so controversial a notion as 'derisive' or 'unrealistic', or from an idea as hard to tie down as the reality of the analytic situation?
- c. As regards the *function* of the transference in treatment: what is the therapeutic value of remembering and lived-out repetition, respectively?
- d. As regards the nature of *what is transferred*: are we concerned with behaviour patterns, with types of object-relation, with positive or negative feelings, with affects, with libidinal cathexis, with phantasies, with a whole *imago* or with a specific trait of an *imago*—or even with 'agencies' in the sense this term has in the final theory of the psychical apparatus?

* * *

The encounter with the signs of transference in psycho-analysis—an event whose strangeness Freud never tired of emphasising (2)—was what cleared the way for the recognition of the operation of this process in *other* situations, whether as the actual foundation of the type of relationship concerned (hypnosis, suggestion), or as a factor in the relationship between doctor and patient, but also those between case (primarily the relation between doctor and patient, but also those between teacher and pupil, confessor and penitent, etc.). Similarly, among the developments immediately preceding the invention of analysis, transference had displayed its far-reaching effects in the case of Anna O., whom Breuer treated by the 'cathartic method', long before the therapist could either identify the process or—most importantly—make use of it (2). Furthermore, there is a discrepancy in the development of the concept of transference—in Freud's work between his stated views and his actual experience—an inconsistency whose unfortunate consequences he himself suffered, as he noted *apropos* of the case of 'Dora'. So anyone wishing to trace the evolution of this concept must be ready to extrapolate—to recognise the action of the transference in those case-histories left to us by Freud by reading between the lines.

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When Freud speaks of 'transference' or 'transference thoughts' in connection with dreams, he is referring to a mode of *displacement** in which the unconscious wish is expressed in masked form through the material furnished by the pre-

conscious residues* of the day before (1909). . . . distinct from the mechanism Freud postulated to account for his experiences in treatment: . . . an unconscious idea is as such quite incapable of entering the preconscious and [...] it can only exercise any effect there by establishing a connection with an idea which already belongs to the preconscious, by transferring its intensity on to it and by getting itself "covered" by it. Here we have the fact of "transference", which provides an explanation of so many striking phenomena of the mental life of neurotics' (36). In the *Studies on Hysteria* (1895d), Freud had described in similar terms cases where the patient transfers unconscious ideas on to the person of his physician: 'The content of the wish had appeared first of all in the patient's consciousness without any memories of the surrounding circumstances which would have assigned it to a past time. The wish which was present was then, owing to the compulsion to associate which was dominant in her consciousness, linked to my person, with which the patient was legitimately concerned; and as the result of this *métalliance*—which I describe as a "false connection"—the same affect was provoked which had forced the patient long before to repudiate this forbidden wish' (4d).

To begin with, Freud looks upon transference—theoretically at any rate—as just a particular instance of displacement of affect from one idea to another. If the idea of the analyst enjoys a special status this is, first, because it constitutes a type of 'day's residue' that is always available to the subject; and secondly, because this kind of transference aids resistance* in that it is particularly hard to admit the repressed wish when this acknowledgement has to be made to the very person the wish concerns (4b, 5d). It is clear too that at this period Freud considers transference to be a highly localised phenomenon. Each transference is to be treated like any other symptom (4c), the aim being to keep up or restore a therapeutic relationship based on a trusting cooperation. Among other factors contributing to such a relationship, Freud names the personal influence of the doctor (4d) without in any way relating this to transference.

It would therefore seem that transference as initially described by Freud is not an essential part of the therapeutic relationship. This view is confirmed even by Freud's account of the case of 'Dora', notwithstanding the clearly major part played in it by the transference: in the critical commentary added to the *résumé* of his clinical notes, Freud goes so far as to blame the premature curtailment of Dora's treatment on a faulty interpretation of the transference. Numerous turns of phrase reveal that Freud does not look upon the treatment as a whole, in its structure and dynamics, as a transference relationship: 'What are transferences? They are new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress 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' (6). Freud remarks that these transferences (note the plural) do not differ in nature whether they are directed towards the analyst or towards some other person, and further that they do not constitute aids to cure except in so far as they are explicated and 'destroyed' one by one.

The gradual incorporation of the discovery of the Oedipus complex* was bound to affect the way Freud viewed the transference. As early as 1909 Ferenczi

had shown how in analysis—as also in the earlier techniques of suggestion and hypnosis—the patient unconsciously made the doctor play the role of loved or feared parental figures (7). In his first general exposition of transference (1912*b*), Freud stresses that it is connected with 'prototypes' or *imagos** (chiefly the *imago* of the father, but also of the mother, brother, etc.): the doctor is inserted 'into one of the psychical "series" which the patient has already formed' (5*b*).

Freud reveals how it is the subject's relationship to parental figures that is once again lived out in the transference—a relationship still characterised, notably, by instinctual ambivalence*: '... it was only along the painful road of transference that [the Rat Man] was able to reach a conviction that his relation to his father really necessitated the postulation of this unconscious complement' (8). In this context Freud distinguishes between two kinds of transference—one positive, the other negative: a transference of affectionate feelings and a transference of hostile ones (9). The kinship between these terms and the 'positive' and 'negative' components of the Oedipus complex should be noted.

This extension of the notion of transference so that it becomes a process structuring the whole treatment around prototypical infantile conflicts culminates with Freud's introduction of a new concept—that of transference neurosis*: '... we regularly succeed in giving all the symptoms of the illness a new transference meaning and in replacing the patient's ordinary neurosis by a "transference-neurosis" of which he can be cured by the therapeutic work' (9).

* * *

As for its *function in the treatment*, Freud at first classes transference, in the most explicit fashion, among the 'obstacles' which impede the remembering of the repressed material (4*e*). But—also from the outset—he indicates that its occurrence is frequent if not general: 'We can [...] reckon on meeting it in every comparatively serious analysis' (4*f*). Similarly, Freud establishes at this point in his thinking that the mechanism of transference on to the person of the physician is triggered off precisely at the moment when particularly important repressed contents are in danger of being revealed. Seen in this light, transference appears as a form of resistance, while at the same time testifying to the proximity of the unconscious conflict. Thus, right from the start, Freud ran up against the essential contradiction of transference—the reason for the great divergence in his formulations regarding its function: transference in one sense—seen in relation to verbalised recollection—is 'transference-resistance' (*Übertragungswiderstand*). Yet in another sense, inasmuch as it offers a superlative way for the subject as for the analyst to grasp the elements of the infantile conflict *in vitro* and *in statu nascendi*, the transference becomes the terrain upon which the patient's unique set of problems is played out with an ineluctable immediacy, the area where the subject finds himself face to face with the existence, the permanence and the force of his unconscious wishes and phantasies: 'It is on that field that the victory must be won [...]. It cannot be disputed that controlling the phenomena of transference presents the psycho-analyst 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. For when all is said and done, it is impossible to destroy anyone *in absentia* or *in effigie*' (5*c*).

Irresistibly, this second aspect of transference takes on more and more importance for Freud: 'This *transference* alike in its positive and negative form is used as a weapon by the resistance; but in the hands of the physician it becomes the most powerful therapeutic instrument and it plays a part scarcely to be overestimated in the dynamics of the process of cure' (10).

But on the other hand it must be borne in mind that even where Freud goes farthest in acknowledging the special status of transference repetition—even when he writes: 'The patient cannot remember the whole of what is repressed in him, and what he cannot remember may be precisely the essential part of it' [...]. He is obliged to *repeat* the repressed material as a contemporary experience' (11*a*)—he nevertheless immediately stresses the need for the analyst 'to keep this transference neurosis within the narrowest limits: to force as much as possible into the channel of memory and to allow as little as possible to emerge as repetition' (11*b*).

Thus Freud never abandons the view that the ideal of the treatment is complete *recollection*, and in cases where this turns out to be unattainable he falls back on 'constructions'* to fill in the gaps in the infantile history. Furthermore, he never esteems the transference relationship for its own sake, either from the point of view of the abreaction* of childhood experiences or from that of the rectification of unrealistic modes of object-relationship.

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In the *Studies on Hysteria*, Freud writes apropos of the manifestations of transference that 'this new symptom that has been produced on the old model must be treated in the same way as the old symptoms' (4*g*). Again, when he later describes transference neurosis as an 'artificial illness', he is surely making the assumption that transference reactions are both economically and structurally equivalent to ordinary symptoms.

And indeed Freud does sometimes explain the emergence of the transference in terms of 'a compromise between [the] demands [of the resistance] and those of the work of investigation' (5*d*). But he is aware from the beginning that the signs of the transference become more and more insistent the closer one gets to the 'pathogenic complex', and when he relates these manifestations to a repetition compulsion* he states that such a compulsion can only express itself in the transference 'after the work of treatment has gone halfway to meet it and has loosened the repression' (11*c*). All the way from the case-history of 'Dora', where Freud likens transferences to actual 'new impressions', often quite undistorted by comparison with the corresponding unconscious phantasies, to *Beyond the Pleasure Principle* (1920*g*), where he says of reproductions in the transference that they 'emerge with unaltered-for exactitude—always have as their subject some portion of infantile sexual life—of the Oedipus complex, that is, and its derivatives' (11*d*)—all the way, the idea that transference actualises the essence of the childhood conflict is constantly gaining ground.

As we know, transference repetition is one of the facts invoked by Freud in *Beyond the Pleasure Principle* to justify bringing the repetition compulsion to the fore: situations and emotions are repeated in the treatment which ultimately express the indestructibility of unconscious phantasies.

It may therefore be asked what sense we ought to give to what Freud calls

transference-resistance. In *Inhibitions, Symptoms and Anxiety* (1926d), he ascribes it to the ego-resistances in that it reactivates the mechanism of a past repression, which mere recollection does not do. It is worth pointing out, however, that in this same work the repetition compulsion is described as basically id-resistance (see 'Repetition Compulsion').

Finally, when Freud speaks of the transference repetition of past experiences, of attitudes towards parents, etc., this repetition should not be understood in the literal sense that restricts such actualisation to really lived relationships. For one thing, what is transferred, essentially, is psychical reality*—that is to say, at the deepest level, unconscious wishes and the phantasies associated with them. And further, manifestations of transference are not verbatim repetitions but rather symbolic equivalents of what is being transferred.

* * *

One of the classical criticisms directed at self-analysis* as regards its therapeutic efficacy is that by definition it prevents any interpersonal relationship from coming into being or playing a part.

Freud himself pointed out the limited character of self-analysis; he stressed further that an interpretation* is often only accepted in so far as the transference, operating like suggestion, has conferred a special authority upon the analyst. All the same, it is true to say that the task of thoroughly clarifying the role played in the treatment by the analyst *qua* other has fallen to Freud's successors. In so doing they have followed several paths:

a. As an expansion of the second Freudian theory of the psychical apparatus, the analytic treatment may be deemed to provide the ground on which intra-subjective conflicts—themselves the relics of the real or phantasied intersubjective relationships of childhood—can once more find expression in a relationship where communication is possible. As Freud noted, the analyst may for example find himself placed in the position of the super-ego; more generally, the whole interplay of identifications* is given free rein to develop and to become 'unbound'.

b. Following the line of thought that has brought the idea of object-relationships* to the fore, there has been an attempt to treat the transference *relationship* (y) as an expression of the particular modalities of the subject's relations with his different types of (partial or whole) object. As Michael Balint has remarked, such an approach ends by 'interpreting every detail of the patient's transference in terms of object-relations' (12). This orientation may even encourage an attempt to recognise the successive genetic stages in the development of the treatment.

c. Another orientation lays the emphasis upon the special importance of the spoken word in the analysis—and hence in the transference relationship. This approach can trace its ancestry to the very origins of psycho-analysis, for the cathartic method* holds the verbalisation of repressed (talking cure) to be at least as important as the abreaction of affects. But it is a surprising fact that when Freud describes the most incontestable signs of transference he places them under the heading of 'acting out*' (*Agieren*), contrasting recollection with repetition on the grounds that the latter alone is lived-out experience. It may

legitimately be asked whether such a contrast really helps us get a clearer picture of the transference in its two dimensions—actualisation of the past and displacement on to the person of the analyst.

Indeed it is hard to see why the analyst should be any less implicated when the subject is *recounting* some event of his past to him, or *telling* him some dream (d), than he is when the patient involves him in his *actions*.

The patient's words express a relational mode just as his acts do: their aim, for example, may be to please the analyst, to keep him at arm's length, etc.; and, just like words, acts carry messages (e.g. parapraxes*).

d. Lastly, reacting against an extreme thesis which looks upon transference as a purely spontaneous phenomenon—a projection on to the screen constituted by the analyst—some authors have sought to pursue to its logical conclusion the theory which has transference depend essentially upon a factor specific to the subject, namely the *predisposition to transference*. These authors highlight whatever in the analytic situation tends to facilitate the emergence of such a predisposition.

Some, like Ida Macalpine (13), have accentuated the concrete elements of the analytic environment (constancy of conditions, frustration, the patient's infantile position). Others have looked to the relationship of *demand* that analysis institutes from the outset, and by virtue of which 'the whole past opens up, back to the farthest reaches of earliest infancy. The subject has never done anything but make demands, only by doing so has been able to live, and we carry on this pattern. [...] Regression indicates nothing more than the re-emergence, in the present, of signifiers used in demands that can be filled' (14).

Freud did not ignore the existence of a correlation between the analytic situation as such and the transference. He even pointed out that, although various types of transference can be identified (maternal, fraternal, etc.), 'the real relations of the subject to his doctor' mean that 'the "father-image" [...] is the decisive factor' (5e).

(a) For the consequences of this episode, see Ernest Jones's *Sigmund Freud*, I.

(b) It will be noted that 'positive' and 'negative' here refer to the nature of the affects transferred, not to the favourable or unfavourable long-term effects of the transference on the treatment. According to Daniel Lagache, 'it would be more comprehensive and more precise to speak of the positive or negative effects of the transference. We know that the transference of positive feelings may have negative effects; on the other hand, the expression of negative feelings may constitute a decisive advance' (15).

(y) The use of this term by Freud is worth noting (16).

(d) Cf. what are called 'dreams of compliance'—meaning dreams whose analysis reveals that the wish they fulfil is that of satisfying the analyst, confirming his interpretations, etc.

(1) Cf. ENGLISH, H. B. and ENGLISH, A. C. *A Comprehensive Dictionary of Psychological and Psychoanalytical Terms* (1958), articles on 'Transfer' and 'Transference'.

(2) Cf. FREUD, S. *An Outline of Psycho-Analysis* (1940a [1938]), G.W., XVII, 100; S.E., XXIII, 174–75.

(3) FREUD, S. *The Interpretation of Dreams* (1900a): a) Cf. G.W., II–III, 568; S.E., V, 562. b) G.W., II–III, 568; S.E., V, 562.

(4) FREUD, S. 'The Psychotherapy of Hysteria', in *Studies on Hysteria* (1895d): a) G.W., I, 309; S.E., II, 303. b) Cf. G.W., I, 308–9; S.E., II, 303. c) Cf. G.W., I, 308–9; S.E., II, 303.

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- 7, 301. b) G.W., I, 309; S.E., II, 303.
- (5) FREUD, S. 'The Dynamics of Transference' (1912b): a) Cf. G.W., VIII, 370; S.E., XII, 4. b) G.W., VIII, 365; S.E., XII, 100. c) G.W., VIII, 374; S.E., XII, 108. d) G.W., VIII, 369; S.E., XII, 103. e) G.W., VIII, 365-66; S.E., XII, 100.
- (6) FREUD, S. 'Fragment of an Analysis of a Case of Hysteria' (1905e [1901]), G.W., V, 279; S.E., VII, 116.
- (7) Cf. FERENCZI, S. 'Introjection and Transference' (1909), in *First Contributions*, 35-93.
- (8) FREUD, S. 'Notes upon a Case of Obsessional Neurosis' (1909d), G.W., VII, 429; S.E., X, 209.
- (9) FREUD, S. 'Remembering, Repeating and Working-Through' (1914g), G.W., X, 134-35; S.E., XII, 154.
- (10) FREUD, S. 'Two Encyclopaedia Articles' (1923a), G.W., XII, 223; S.E., XVIII, 247.
- (11) FREUD, S. *Beyond the Pleasure Principle* (1920g): a) G.W., XII, 16; S.E., XVIII, 18. b) G.W., XIII, 17; S.E., XVIII, 19. c) G.W., XIII, 18; S.E., XVIII, 20. d) G.W., XII, 16-17 S.E., XVIII, 18.
- (12) BALINT, M. *Primary Love and Psycho-Analytic Technique* (London: Hogarth Press, 1952), 225; 2nd edition (London: Tavistock, 1965), 212.
- (13) Cf. MACALPINE, I. 'The Development of the Transference', *P.Q.*, 1950, XIX, 4.
- (14) LACAN, J. 'La direction de la cure et les principes de son pouvoir', *La Psychanalyse*, 1961, VI, 180. Reprinted in *Écrits* (Paris: Seuil, 1967), 617-18.
- (15) LAGACHE, D. 'Le problème du transfert', *R.F.P.*, 1952, XVI, 102.
- (16) Cf., for example, FREUD, S. 'Constructions in Analysis' (1937d), G.W., XVI, 44; S.E., XXIII, 258.

Transference Neurosis

= *D.*: Übertragungsneurose. — *Es.*: neurosis de transferencia. — *Fr.*: névrose de transfert. — *It.*: nevrosi di transfert. — *P.*: neurose de transferência.

I. Nosographically, a category of neuroses—comprising anxiety hysteria*, conversion hysteria* and obsessional neurosis*—which Freud distinguishes from the narcissistic neuroses* within the group of psychoneuroses*. In contrast to the narcissistic neuroses, the transference neuroses are characterised by the libido's always being displaced on to real or imaginary objects instead of being withdrawn from these and directed on to the ego. They are consequently more amenable to psycho-analytic treatment, for they lend themselves to the constitution, during the treatment, of a transference neurosis in sense II.

II. In the theory of the psycho-analytic cure, this term refers to an artificial neurosis into which the manifestations of the transference tend to become organised. It is built around the relationship with the analyst and it is a new edition of the clinical neurosis; its elucidation leads to the uncovering of the infantile neurosis.

I. In sense I, the term 'transference neurosis' was introduced by Jung as the opposite of 'psychosis' (1). In psychosis, libido was said to be 'introverted' (Jung) or to collect the ego (Abraham (2) and Freud (3)). This reduces the patient's capacity to transfer his libido on to objects, and he is consequently not

462 *very amenable to a form of treatment founded on transference. The upshot was*

was that those neuroses to which psycho-analytic treatment was first applied were defined as conditions in which this transference capacity exists, and they were called 'transference neuroses'.

Freud's system of classification—as set out, for example, in the *Introductory Lectures on Psycho-Analysis* (1916-17)—can be summarised as follows: transference and narcissistic neuroses stand in opposition to one another within the group of psychoneuroses. This group as a whole is in turn contrasted with the group of actual neuroses* (whose mechanism is deemed to be essentially somatic) in that psychoneurotic symptoms are the symbolic expression of a psychical conflict.

It may be remarked that, although the distinction between the two categories of the psychoneuroses still retains its validity, it is no longer accepted that this distinction can be drawn purely and simply on the grounds of the presence or absence of transference. On the contrary, the accepted view today is that the apparent absence of transference in psychoneurotic conditions is in most cases merely one trait (which may be very pronounced) of that mode of transference peculiar to psychotics.

II. Freud introduces the notion of transference neurosis in sense II in 'Remembering, Repeating and Working-Through' (1914g), where it is related to the idea that the patient *repeats* his infantile conflicts within the transference. 'Provided only that the patient shows compliance enough to respect the necessary conditions of the analysis, we regularly succeed in giving all the symptoms of the illness a new transference meaning and in replacing his ordinary neurosis by a "transference-neurosis" of which he can be cured by the therapeutic work' (4a).

The lesson of this passage would seem to be that the difference between transference reactions and transference neurosis proper is that in such a neurosis the whole of the patient's pathological behaviour comes to be re-orientated around his relationship to the analyst. The transference neurosis could be said to do two jobs: first, it coordinates formerly disparate transference reactions (Glover's 'floating transference'), and, secondly, it allows the whole of the symptoms and pathological behaviour of the patient to take on a new function by becoming related to the analytic situation.

Freud sees the establishment of a transference neurosis as a positive factor in the dynamics of the cure: 'The new condition has taken over all the features of the illness; but it represents an artificial illness which is at every point accessible to our intervention' (4b).

From this standpoint, the following pattern of development constitutes the ideal model of the course of the cure: the clinical neurosis is transformed into a transference neurosis, whose elucidation leads to the uncovering of the infantile neurosis (α).

It must nevertheless be noted that Freud later put forward a less one-sided view of the transference neurosis when, in stressing the sway of the compulsion to repeat, he draws attention to the risks run if its development is allowed to get out of hand: 'It has been the physician's endeavour to keep this transference neurosis within the narrowest limits: to force as much as possible into the channel of memory and to allow as little as possible to emerge as repetition. [...] The physician cannot as a rule spare his patient this phase of the treatment.

Transitional Object

He must get him to re-experience some portion of his forgotten life, but must see to it, on the other hand, that the patient retains some degree of aloofness, which will enable him, in spite of everything, to recognise that what appears to be reality is in fact only a reflection of a forgotten past' (5).

(α) S. Rado, in his communication to the Salzburg Congress of 1924 on the theory of the cure, 'The Economic Principle in Psycho-Analytic Technique' (6), described the 'therapeutic neurosis' in preanalytic techniques (hypnosis and catharsis), as distinct from the transference which arises in psycho-analytic treatment: only in psycho-analysis can the transference neurosis be analysed and resolved.

- (1) Cf. JUNG, C. G. *Über die Psychologie der Dementia praecox* (Halle, 1907); 'Vandlungen und Symbole der Libido', *Jahrbuch Psy.-Forsch.*, 1911, 1912.
- (2) Cf. ABRAHAM, K. 'The Psycho-Sexual Differences between Hysteria and Dementia Praecox', *Selected Papers* (London: Hogarth, 1927; New York: Basic Books, 1953).
- (3) Cf. FREUD, S. 'On Narcissism: An Introduction' (1914c).
- (4) FREUD, S.: a) G.W., X, 134-35; S.E., XII, 154. b) G.W., X, 135; S.E., XII, 154.
- (5) FREUD, S. *Beyond the Pleasure Principle* (1920g), G.W., XIII, 17; S.E., XVIII, 18-19.
- (6) Cf. RADO, S., in *I.J.P.*, 1925, VI, 35-44.

Transitional Object

= D.: Übergangsobjekt. -Es.: objeto transicional. -Fr.: objet transitionnel. -
I.: oggetto transizionale. -P.: objeto transicional.

Term introduced by D. W. Winnicott to designate a material object with a special value for the suckling and young child, particularly when it is on the point of falling asleep (e.g. the corner of a blanket or napkin that is sucked).

Reliance on such objects, according to Winnicott, is a normal phenomenon which allows the child to make the transition from the first oral relationship with the mother to the 'true object-relationship'.

The gist of Winnicott's ideas on the transitional object will be found in an article entitled 'Transitional Objects and Transitional Phenomena' (1953).

a. On the level of clinical description, Winnicott brings out a type of behaviour often observed in the infant which he calls the relationship with the transitional object.

Between the ages of four and twelve months, the infant is frequently seen to form an attachment to a specific object such as a bundle of wool or the corner of a blanket or elderdown, etc., which it sucks and holds close to itself and which becomes especially vital to it at the time of going to sleep. This 'transitional object' retains its significance for a long time before gradually losing it; it may re-emerge later, notably with the approach of a period of depression.

Winnicott subsumes certain gestures and various oral activities (e.g. babbling) under one heading—the heading of *transitional phenomena*.

b. Genetically speaking, the transitional object lies 'between the thumb and the teddy bear' (1d). For while this object is 'an almost inseparable part of the

infant' (1b), distinct in this sense from the future toy, it is also 'the first not-me possession'.

From the libidinal point of view, the activity we are concerned with here is still oral in character. What has changed is the status of the object. In the very earliest oral activity (relationship to the breast) we find what Winnicott calls a 'primary creativity' . . . the breast is created by the infant over and over again out of the infant's capacity to love or (one can say) out of need. [...] The mother places the actual breast just where the infant is ready to create, and at the right moment' (1c). Later on, reality-testing* will come into operation. Between these two phases lies the relationship to the transitional object—a halfway house between subjective and objective in which the object 'comes from without from one point of view, but not so from the point of view of the baby. Neither does it come from within; it is not an hallucination' (1d).

c. The transitional object, although it constitutes an intermediate step towards the perception of an object clearly differentiated from the subject—towards a 'true object-relationship'—is not for all that destined to see its function abolished by the subject's later development: 'The transitional object and the transitional phenomena start each human being off with what will always be important for them, i.e. a neutral area of experience which will not be challenged' (1e). According to Winnicott, they belong to the sphere of *illusion*: 'This intermediate area of experience, unchallenged in respect of its belonging to inner or external (shared) reality, constitutes the greater part of the infant's experience and throughout life is retained in the intense experiencing that belongs to the arts and to religion and to imaginative living, and to creative scientific work' (1f).

- (1) WINNICOTT, D. W. 'Transitional Objects and Transitional Phenomena', *I.J.P.*, 1953, XXXIV, 2: a) 89. b) 92. c) 95. d) 91. e) 95. f) 97.

Trauma (Psychical)

= D.: Trauma. -Es.: trauma, traumatismo. -Fr.: trauma, traumatisme. -I.: trauma. -
P.: trauma, traumatismo.

An event in the subject's life defined by its intensity, by the subject's incapacity to respond adequately to it, and by the upheaval and long-lasting effects that it brings about in the psychical organisation.

In economic terms, the trauma is characterised by an influx of excitations that is excessive by the standard of the subject's tolerance and capacity to master such excitations and work them out psychically.

'Trauma' is a term that has long been used in medicine and surgery. It comes from the Greek *τραῦμα*, meaning wound, which in turn derives from *τρίνωσκα*, to pierce. It generally means any injury where the skin is broken as a consequence of external violence, and the effects of such an injury upon the organism as a whole; the implication of the skin being broken is not always present, however—we may speak, for example, of 'closed head and brain traumas'.