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THE DEVELOPMENT OF THE TRANSFERENCE

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INTRODUCTION

Transference is an integral part of psychoanalysis. A vast, widely scattered literature exists on the subject. In most contributions on any psychoanalytic theme there is to be found, often tucked away from easy access, some reference to it. It forms of necessity the main topic of papers and treatises on psychoanalytic technique; but '. . . it is amazing how small a proportion of the very extensive psychoanalytic literature is devoted to psychoanalytic technique', states Fenichel *(1)*, 'and how much less to the theory of technique'. There is no single contribution which comprehends all the facts known and the various opinions. This is all the more remarkable as differing opinions are held about the mechanism of transference, and its mode of production seems particularly little understood. In the absence of a comprehensive critical evaluation, the student may well be bewildered at finding that most authors, before getting to their subject matter, deem it necessary to give their personal interpretations of what they mean by the 'transference' and 'transference neurosis'. This is well illustrated by Fenichel's book on the theory of the neuroses *(3)* which, containing more than one thousand six hundred and forty references, quotes only one reference in the section on Transference.

The lack of knowledge of the causation of transference appears largely to have gone unnoticed. It seems tacitly to be assumed that the subject is fully understood. Fenichel, for instance, writes *(3)*: 'Freud was at first surprised when he met with the phenomenon of transference; today, Freud's discoveries make it easy to understand it theoretically. The analytic situation induces the development of derivatives of the repressed, and at the same time a resistance is operative against it . . . the patient misunderstands the present in terms of the

past.' If one scrutinizes this frequently quoted reference, one realizes that it gives no theoretical explanation of the factors which produce transference. However illuminating and pointed this and other similes may be, they are descriptive rather than explanatory.

The causes of the limited understanding of transference are historical, inherent in the subject matter, and psychological.

REASONS FOR THE LACK OF RESEARCH

HISTORICAL

As psychoanalysis developed, there was a natural striving to differentiate it from hypnosis, its precursor, similarities between the two tending to be overlooked. The mode of production and the emergence of the transference (positive, negative, and the transference neurosis) were considered an entirely new phenomenon peculiar to psychoanalysis, and altogether distinct from what occurred in hypnosis.

In this differentiation from hypnosis, psychoanalysis had to come to terms with the concept of 'suggestion'. Many psychoanalytic writers, and more particularly others, have complained about the inaccurate and inexact use of this term. The great impetus toward research into 'suggestion' came from the study of hypnosis. With the appearance (1886) of Bernheim's book *(4)*, hypnosis ceased to be considered a symptom of hysteria, the nucleus of hypnosis was established as the effect of suggestion, and it is Bernheim's merit that he showed that all people are subject to the influence of suggestion and that the hysteric differs chiefly in his abnormal susceptibility to it. This seemed to Freud a great advance in recognizing the importance of a mental mechanism in the production of disease. In the introduction he wrote (1888) to his translation into German of Bernheim's book *(5)*, which is of historical interest because it is believed to be Freud's first publication on a psychological subject, Freud stresses the great importance of Bernheim's '. . . insistence upon the fact that hypnosis and hypnotic suggestion can be applied, not only to hysterics and to seriously neuropathic patients, but also to the majority of healthy per-

sons', and his belief that this 'is calculated to extend the interest of physicians in this therapeutic method far beyond the narrow circle of neuropathologists' *(6)*. The significance of suggestion was thus established, but its meaning had yet to be clarified. Freud tried to find a link between the physiological (somatic) and mental (psychological) phenomena in hypnosis: 'In my opinion', he stated, 'the shifting and ambiguous use of the word "suggestion" lends to this antithesis a deceptive sharpness which it does not in reality possess'. He then set out to give a definition of suggestion to embrace both its physiological and mental manifestations: 'It is worth while considering what it is we can legitimately call a "suggestion". No doubt some kind of mental influence is implied by the term; and I should like to put forward the view that what distinguishes a suggestion from other kinds of mental influence, such as a command or the giving of a piece of information or instruction, is that in the case of a suggestion an idea is aroused in another person's brain which is not examined in regard to its origin but is accepted just as though it had arisen spontaneously in that brain.' Freud did not succeed in giving the term a clear and unequivocal definition.

The physiological phenomena (vascular, muscular, etc.) had yet to be brought under the roof of suggestion, if hypnosis and hysteria were to be claimed for psychopathology. Physiological functions not subject to conscious control, and Freud's earlier definition of suggestion, did not cover them; hence, in this preanalytic paper, Freud widens the meaning of suggestion by introducing 'indirect suggestion'. He says, 'Indirect suggestions, in which a series of intermediate links out of the subject's own activity are inserted between the external stimulus and the result, are none the less mental processes; but they are no longer exposed to the full light of consciousness which falls upon direct suggestions'. It is important to note that the factor of an unconscious operation of suggestion is now introduced for the first time in Freud's writing. If, for example, it be suggested to a patient that he close his eyes, and if thereupon he fall asleep, he has added his own association (sleep follows

closing of the eyes) to the initial stimulus. The patient is then said to be subject to 'indirect suggestion' because the suggestive stimulus opened the door for a chain of associations in the patient's mind; in other words, the patient reacts to the suggestive stimulus by a series of autosuggestions. Freud in this paper, and later, uses the 'indirect suggestion' as synonymous with 'autosuggestion'.

When suggestion was found by Bernheim to be the basis of hypnosis, it remained to be explained why most but not all persons could be hypnotized, or were susceptible to suggestion, and why some were more readily hypnotizable than others; thus, beside the activity of the hypnotist, a factor inherent in the patient was established and had to be examined. This factor was referred to as the patient's suggestibility. The nature of what went on in the patient's mind during hypnosis was soon made the subject of extensive investigations, and interest was progressively concentrated on the subjective psychological process. Ferenczi *(7)* showed that the hypnotist when giving a command is replacing the subject's parental imagos and, more important, is so accepted by the patient. Freud *(8)* concluded that hypnosis constitutes a mutual libidinal tie. He found that the mechanism by which the patient becomes suggestible is a splitting from the ego of the ego-ideal which is transferred to the suggester. As the ego-ideal normally has the function of testing reality,[1] this faculty is greatly diminished in hypnosis, and this accounts both for the patient's credulity and his further regression from reality toward the pleasure principle. According to Freud, the degree of a person's suggestibility depends on the degree of maturity. The less distinction between ego and ego-ideal, the more ready the identification with authority. Thus we find that in the understanding of hypnosis and suggestion the subject's suggestibility came to outweigh the suggester's activities. Ernest Jones *(12)* shows that there is no fundamental difference between autosuggestion and allosuggestion; both constitute libidinal regression to nar-

[1] Freud later contradicted this statement in *The Ego and the Id,* Chapter III, p. 34, fn.

cissism. Abraham *(13)*, in his paper on Coué, shows that the subjects of this form of autosuggestion regressed to states of obsessional neurosis. McDougall *(14)* speaks of 'the subject's attitude of submissiveness as "suggestibility"'. As the common factor brought out by all these investigations is regression, it would seem justifiable to define suggestibility as adaptability by regression.

In the investigations of hypnosis, the stress has been placed at different times on extrinsic factors (the implanting of an idea or the hypnotist's activities); or on intrinsic factors (the patient's suggestibility). In fact, whereas the 'implantation' of a foreign idea, independent of any factors operative within the patient, was first considered to constitute the whole process of suggestion, the pendulum soon swung to the other extreme, and the endopsychic process (capacity to regress) was considered the essence of hypnosis. Through this historical development 'suggestion' and 'suggestibility' came to be confused, although it is quite clear that suggestibility distinctly implies a state or readiness as opposed to the actual process of suggestion. Unfortunately, however, these two terms have crept into psychoanalytic literature as having the same meaning. It is in part due to this fact that transference came to be considered a spontaneous manifestation to the neglect of precipitating factors. These ambiguities have never been overcome; moreover, they are to some extent responsible for the lack of understanding of the genesis and nature of transference.

To differentiate the new psychoanalytic technique from hypnosis there was a repudiation of suggestion in psychoanalysis. Later, however, this was questioned, and the term, suggestion, was reintroduced into psychoanalytic terminology. Freud *(15)* makes the arresting statements: '. . . and we have to admit that we have only abandoned hypnosis in our methods in order to discover suggestion again in the shape of transference'; and, in another paper *(21)*, 'Transference is equivalent to the force which is called "suggestion"'; still later *(23)*: 'It is quite true that psychoanalysis, like other psychotherapeutic methods, works *by means of suggestion,* the difference being,

however, that it (transference or suggestion) is not the decisive factor'. While Freud equates here transference and suggestion, he says a little earlier in the same paper *(23)*: 'One easily recognizes in transference the same factor which the hypnotists have called *"suggestibility"*, and which is the carrier of the hypnotic rapport'. In his Introductory Lectures *(18)* Freud also uses transference and suggestion interchangeably, but specifies the meaning of suggestion in psychoanalysis by stating that 'direct suggestion' was abandoned in psychoanalysis, and that it is used only to uncover instead of covering up. Ernest Jones *(25)* states that suggestion covers two processes: '. . . "verbal suggestion" and "affective suggestion", of which the latter is the more primary and is necessary for the action of the former. "Affective suggestion" is a rapport which depends on the transference *(Übertragung)* of certain positive affective processes in the unconscious region of the subject's mind. . . . suggestion plays a part in all methods of treatment of the psychoneuroses except the psychoanalytic one.' This new terminology does not seem clear. 'Affective suggestion' obviously represents 'suggestibility'. In the way it is expressed it plainly contradicts Freud's statement with regard to the role of 'suggestion' in psychoanalysis, although Freud and Jones were probably in full agreement about what they meant. But this confusing and haphazard use of terms could not but influence adversely the full understanding of analytic transference. One might even take it as proof that transference is not fully understood; if it were, it could be stated simply and clearly.

That Freud was dissatisfied about the definition of transference and suggestion is confirmed by his statement *(9)*: 'Having kept away from the riddle of suggestion for some thirty years, I find on approaching it again that there is no change in the situation. . . . The word is acquiring a more and more extended use, and a looser and looser meaning.' He introduces yet another differentiation of suggestion 'as used in psychoanalysis' from suggestion in all other psychotherapies. As used in psychoanalysis, argues Freud—and one is tempted to

say by way of special pleading—suggestion is distinct from its use in other therapies through the fact that transference is continually analyzed in psychoanalysis and so resolved, implying that the effects of suggestion are thereby undone. This statement found its way into psychoanalytic literature in many places, and gained acceptance as a standard valid argument: the factor of suggestion is held to be eliminated by the resolution of the transference, and this is regarded as the essential difference between psychoanalysis and all other psychotherapies. But it is dubiously scientific to include in the definition of suggestion the subsequent relation between therapist and patient; neither is it scientifically precise to qualify 'suggestion' by its function: whether the aim of suggestion be that of covering up or uncovering, it is either suggestion or it is not. Little methodological advantage could be gained by using 'suggestion' to fit the occasion, and then to treat the terms 'suggestion', 'suggestibility', and 'transference' as synonymous. It is therefore not surprising that the understanding of analytic transference has suffered from this persisting inexact and unscientific formulation.

One must agree with Dalbiez *(26)* when he says, 'The freudians' deplorable habit (which they owe, indeed, to Freud himself) of identifying transference with suggestion has largely contributed to discrediting psychoanalytic interpretations. The truth is that positive transference brings about the most favorable conditions for the intervention of suggestion, but it is by no means identical with it.' Dalbiez defines suggestion as '. . . unconscious and involuntary realization of the content of a representation'. This neatly condenses the factors which Freud postulated, namely, autosuggestion, direct and indirect suggestion, and their unconscious operation.

To summarize this historical review, it may be stated that, despite ambiguities, it may be generally accepted that in the classical technique of psychoanalysis, suggestion so defined is used only to induce the analysand to realize that he can be helped and that he can remember.

THE SUBJECT MATTER

An important factor responsible for the neglect of the theory of transference was the early preoccupation of analysts with demonstrating the various mechanisms involved in transference. Interest in the genesis of transference was sidetracked by focusing research on the manifestations of resistance and the mechanisms of defense. These mechanisms were often given as explanations of the phenomenon of transference, and their operation was taken to explain its nature and occurrence.

PSYCHOLOGICAL (COUNTERTRANSFERENCE)

The neglect of this subject may in part be the result of the personal anxieties of analysts. Edward Glover *(27)* comments on the absence of open discussion about psychoanalytic technique, and considers the possibility of subjective anxieties: '. . . this seems all the more likely in that so much technical discussion centers round the phenomena of transference and countertransference, both positive and negative'. There may in addition enter into it an unconscious endeavor to steer clear of any active 'interference' or, more exactly, to remove any suspicion of methods reminiscent of the hypnotist.

GENERAL SURVEY OF THE LITERATURE

A survey of the literature within the strict limits of the scope of this paper would simply summarize what has been said about the causation of psychoanalytic transference. But although this can be done easily, it is of doubtful value without a survey first of the literature about transference manifestations in general, and without a survey of what transference is held to be and to mean. It would then be obvious that many differences of opinion coexist and many differing interpretations have been given; but unfortunately, in the absence of a comprehensive critical survey of the subject, such a task is, in fact, impossible because there are no clear-cut definitions and many differences of opinion as to what transference is. This is in part attributable to the state of a growing science and to the

fact that most authors approach the subject from one angle only.

To begin with, there is no consensus of opinion about the use of the term 'transference' which is referred to variously as 'the transference', 'a transference', 'transferences', 'transference state', and sometimes as 'analytical rapport'.

Does transference embrace the whole affective relationship between analyst and analysand, or the more restricted 'neurotic transference' manifestations? Freud used the term in both senses. To this fact Silverberg *(28)* recently drew attention, and argued that transference should be limited to 'irrational' manifestations, maintaining that if the analysand says 'good morning' to his analyst it is unreasonable to include such behavior under the term transference. The contrary view is also expressed: that transference, after the opening stage, is everywhere, and the analysand's every action can be given a transference interpretation *(30)*.

Can transference be adjusted to reality, or are transference and reality mutually exclusive, so that some action can only be either the one or the other; or can they coexist so that behavior in accord with reality can be given a transference meaning as in forced transference interpretations? Alexander *(31)* comes to the conclusion that they are '. . . truly mutually exclusive, just as the more general concept "neurosis" is quite incompatible with that of reality adjusted behavior'.

Freud *(34)* divided transference into positive and negative. Fenichel *(2)* queries this subdivision, arguing that, 'Transference forms in neurotics are mostly ambivalent, or positive and negative simultaneously'. Fenichel *(2)* states further that manifestations of transference ought to be valued by their 'resistance value', noting that '. . . positive transference, although acting as a welcome motive for overcoming resistances, must be looked upon as a resistance in so far as it is *transference*'. Ferenczi *(37)*, on the contrary, after stating that a violent positive transference, especially in the early stages of analysis, is often nothing but resistance, emphasizes that in other cases, and particularly in the later stages of analysis, it is essentially the vehicle by which unconscious strivings can reach the surface. Most often

the inherent ambivalence of transference manifestations is stressed and looked upon as a typical exhibition of the neurotic personality.

The next query arises from one special aspect of transference: 'acting out' in analysis. Freud *(38)* introduced the term 'repetition compulsion' and he says: 'In the case of a patient in analysis . . . it is plain that the compulsion to repeat in analysis the occurrences of his infantile life disregards *in every way* the pleasure principle'. In a comprehensive critical survey of the subject, Kubie *(39)* comes to the conclusion that the whole conception of a compulsion to repeat for the sake of repetition is of questionable value as a scientific concept, and were better eliminated. He believes the conception of a 'repetition compulsion' involves the disputed death instinct, and that the term is used in psychoanalytic literature with such widely differing connotations that it has lost most, if not all, of its original meaning. Freud introduced the term for the one variety of transference reaction called acting out, but it is, in fact, applied to all transference manifestations. Anna Freud *(40)* defines transference as: '. . . all those impulses experienced by the patient in his relation with the analyst which are not newly created by the objective analytic situation but have their source in early . . . object relations and are now merely revived under the influence of the repetition compulsion'. Ought, then, the term 'repetition compulsion' be rejected or retained and, if retained, is it applicable to all transference reactions, or to acting out only?

This leads to the question of whether transference manifestations are essentially neurotic, as Freud *(22)* most often maintains: 'The striking peculiarity of neurotics to develop affectionate as well as hostile feelings toward their analyst is called "transference" '. Other authors, however, treat transference as an example of the mechanism of displacement, and hold it to be a 'normal' mechanism. Abraham *(42)* considers a capacity for transference identical with a capacity for adaptation which is 'sublimated sexual transference', and he believes that the sexual impulse in the neurotic is distinguishable from the nor-

mal only by its excessive strength. Glover *(44)* states: 'Accessibility to human influence depends on the patient's capacity to establish *transferences,* i.e., to repeat in current situations . . . attitudes developed in early family life'. Is transference, then, consequent to trauma, conflict, and repression, and so exclusively neurotic, or is it normal?

In answer to the question, is transference rational or irrational, Silverberg *(28)* maintains that transference should be defined as something having the two essential qualities: that it be 'irrational and disagreeable to the patient'. Fenichel *(2)* agrees that 'transference is bound up with the fact that a person does not react rationally to the influence of the outer world'. It is evident that no advantage or clarification of the term 'transference' has followed its assessment as 'rational' or otherwise. It is particularly unfortunate that the antithesis, 'rational' versus 'irrational', was introduced, as it was precisely psychoanalysis which demonstrated that rational behavior can be traced to 'irrational' roots. What is transferred: affects, emotions, ideas, conflicts, attitudes, experiences? Freud says only affects of love and hate are included; but Glover *(45)* finds that 'Up to that date [1937] discussion of transference was influenced for the most part by the understanding of one unconscious mechanism only, that of displacement', and he concludes 'that an adequate conception of transference must reflect *the totality* of the individual's development . . . he displaces onto the analyst, not merely affects and ideas but *all* he has ever learned or forgotten throughout his mental development.' Are these transferred to the person of the analyst, or also to the analytic situation; is extra-analytic behavior to be classed as transference?

Are positive and negative transferences felt by the analysand to be an 'intrusive foreign body', as Anna Freud states *(41)* in discussing the transference of libidinal impulses, or are they agreeable to the analysand, a gratification so great that they serve as resistances? Alexander *(32)* concludes that transference gratifications are the greatest source of unduly prolonging analysis; he reminds his readers that whereas Freud *(46)* initially

had the greatest difficulty in persuading his patients to continue analysis, he soon had equally great difficulty in persuading them to give it up.

Freud *(36)* divides positive transference into sympathetic and positive transference. The relation between the two is not clearly defined, and sympathetic transference is sometimes referred to as analytic rapport. Do the two merge, or remain distinct; is sympathetic transference resolved with positive and negative transference? Discussion of the importance of positive transference at the beginning of analysis and as carrier of the whole analysis has lately been revived among child analysts *(49, 50)*. This has extended to the question of whether or not a transference neurosis in children is desirable or even possible. While this dispute touches on the fundaments of psychoanalytic theory, the definitions offered as a basis for the discussion are not very precise.

The contradictions in the literature about transference could be multiplied, but as exemplifying the conspicuous absence of a unified conception they will suffice. Alexander *(33)* states: 'Although it is agreed that the central dynamic problem in psychoanalytic therapy is the handling of transference, there is a good deal of confusion as to what transference really means'. He comes to the conclusion that the transference relationship becomes identical with a transference neurosis, except that the transient neurotic transference reactions are not usually dignified with the name of 'transference neurosis'. He thus questions the need for the term transference neurosis altogether. As to the transference neurosis itself, there is a similar haziness of the conception. Definitions usually begin with 'When symptoms loosen up . . .', or 'When the level of conflict is reached . . .', or 'When the neurotic conflict is shifted to the analytic situation . . .', or 'When the productivity of illness becomes centered round one place only, the relation to the analyst . . .'; yet, strictly speaking, such pronouncements are descriptions, not definitions. Freud's *(16)* definition of transference neurosis implicitly and explicitly refers only to the neurotic person, so that one is left with the impression that only neurotics form

a transference neurosis. Sachs *(51)*, on the contrary, '. . . found the difference between the analyses of training candidates and of neurotic patients negligible'.

HISTORICAL SUMMARY OF THE LITERATURE

It may be held that many of the contradictions in the literature are largely semantic, that in enumerating them haphazardly, discrepancies are brought into false relief. A truer picture, it may be argued, would have been given if historical periods had been made the guiding principle. Developmental stages in psychoanalysis were of course reflected in current concepts of transference.

In the very first allusion (1895) to what later developed into the concept of transference *(70)*, Freud says that the patient made 'a false connection' to the person of the analyst, when an affect became conscious which related to memories which were still unconscious. This connection Freud thought to be due to 'the associative force prevailing in the conscious mind'. It is interesting to note that with this first observation Freud had already noted that the affect precedes the factual material emerging from repression. He adds that there is nothing disquieting in this because '. . . the patients gradually come to appreciate that in these transferences onto the person of the physician they are subject to a compulsion and a deception, which vanishes with the termination of analysis'.

In 1904 Freud stresses the sexual nature of these impulses which are felt toward the physician. 'What', he asks, 'are transferences? They are new editions or facsimiles of the tendencies and fantasies which are aroused and made conscious during the progress of the analysis . . .' *(71)*. Fantasies are now added to affects. 'If one goes into the theory of analytic technique', he continues, 'it becomes evident that transference is an inevitable necessity'. At this historic point Freud established the fundamental importance of transference in psychoanalysis with its specific technical meaning. The importance of this passage is confirmed by a footnote added in 1923. It is noteworthy that Freud mentions in this passage that transferred impulses

are not only sympathetic or affectionate, but that they can also be hostile.

About 1906 transference was regarded as a displacement of affect. Analysis was largely interested in unearthing forgotten traumata and in searching for complexes. Much of the theory was still influenced by the cathartic method. Psychoanalysis was then, says Freud, '. . . above all an art of interpretation' *(69)*. Freud stated later that '. . . the next aim was to compel the patient to confirm the reconstruction through his own memory. In this endeavor the chief emphasis was on the resistances of the patient; the art now lay in unveiling these as soon as possible, in calling the patient's attention to them . . . and teaching him to abandon these resistances. It then became increasingly clear, however, that the bringing into consciousness of unconscious material was not fully attainable by this method either. The patient cannot recall all that lies repressed . . . and so gains no conviction that the reconstruction is correct. He is obliged, rather, to repeat as a current experience what is repressed instead of recollecting it as a part of the past.' The importance of resistance in the form of acting out is now introduced (repetition compulsion).

Beyond the Pleasure Principle (1920) was followed by Group Psychology and the Analysis of the Ego (1921) and The Ego and the Id (1923). The new concepts introduced were the superego, the more specific function of the ego, and the conception of the id as containing not only repressed material (formerly Ucs) but also as a reservoir of instincts. Resistance was extended to ego and superego and id resistance. This gave rise to some confusion, because it can be used as meaning the resistance of one psychic instance to analysis, or the resistance of one psychic instance, say the ego, to another psychic instance, say the id; but the term resistance has been used chiefly as resistance to the progress of analysis generally. The id was shown to offer no resistance, but to lead to acting out, which in turn, however, is a resistance to recollection. At times, the unconscious can only be recovered in action, and while it is

therefore 'material' in the strict sense of the word, it is still resistance to verbalized recollection.

The mechanisms considered to be operative in transference were displacement, projection and introjection, identification, compulsion to repeat. The importance of 'working through' was stressed. In 1924 discussion took place about the relative values of intellectual insight versus affective re-experiencing as the essence of analytic experience, an issue of vital importance in interpreting the transference to the patient.

In the period following, this added knowledge was gradually integrated, but with overemphasis on some of the new aspects as they first arose. In the absence of a comprehensive critical survey of the subject, authors found it necessary to explain what they meant when they used the term 'transference'.

With this integration new factors of confusion arose. Viewed arbitrarily from, let us say 1946, the conception of transference has been influenced by 1, child analysis; 2, attempts at treating psychotics; 3, psychosomatic medicine; 4, the disproportion between the number of analysts and the growing number of patients seeking analysis, leading to attempts to shorten the process of analysis.

Direct interpretation of unconscious content is again being stressed by some analysts of children in such a way that the methods are reminiscent of the beginnings of psychoanalysis. But on closer examination, there seems to be a difference in principle: unconscious material which presents itself in play is given a direct transference meaning from the beginning. The therapist interprets forward, as it were. The interpretation is not from current material backward to Ucs content, but from the allegedly presented unconscious material to an alleged immediate transference significance. This, it should be noted, is a mental process of the therapist and not of the patient; hence in the strict scientific sense, it is a matter of countertransference rather than of transference. Something similar takes place in the classical technique when forced transference interpretations are given, the important difference be-

ing that these are used in the classical method only sparingly and never until the transference neurosis is well established, and analysis has become a compulsion. It is precisely at this theoretical point, in the writer's opinion, that the dispute is centered among child analysts about the possibility or existence of a transference neurosis among children.

In the treatment of psychotics the concept of transference is developing a new orientation. In some of these techniques the therapist interprets to himself the meaning of the psychotic fantasy and joins the patient in acting out. Strictly speaking, this is active countertransference.

In psychosomatic medicine, particularly in 'short therapy', transference is either disregarded or actively manipulated in a way which, from a theoretical point of view, amounts to an abandonment of Freud's 'spontaneous' manifestations.

All in all, changes in the concept of transference are not constructively progressive. Critical attention needs to be drawn to the fact that not only is there no consensus of opinion about the concept of transference, but there cannot be until transference is comprehensively studied as a dynamic process. The lack of precision is to some extent due to a disregard of its historical development. Nor can there be a consensus of opinion so long as the relation of transference manifestations to the three stages of analysis is neglected. It is to the detriment of scientific exactitude that divergent groups do not sharply define but rather gloss over fundamental differences. There is a tendency to claim orthodoxy, and to hide the deviations behind one tendentiously and arbitrarily selected quotation from Freud.

LITERATURE ON PRODUCTION OF TRANSFERENCE

In the face of such divergent opinions on the nature and manifestations of transference, one might well expect a multitude of hypotheses and opinions as to how these manifestations come about. But this is not the case. On the contrary, there is the nearest approach to full unanimity and accord throughout the psychoanalytic literature on this point. Transference manifestations are held to arise within the analysand spontaneously.

'This peculiarity of the transference is not, therefore', says Freud, 'to be placed to the account of psychoanalytic treatment, but is to be ascribed to the patient's neurosis itself' *(35)*. Elsewhere *(24)* he states: 'In every analytic treatment, the patient develops, without any activity on the part of the analyst, an intense affective relation to him. . . . It must not be assumed that analysis produces the transference. . . . The psychoanalytic treatment does not produce the transference, it only unmasks it.' Ferenczi, in discussing the positive and negative transference says: '. . . and it has particularly to be stressed that this process is the patient's own work and is hardly ever produced by the analyst' *(52)*. 'Analytical transference appears spontaneously; the analyst need only take care not to disturb this process' *(53)*. Rado states, 'The analyst did not deliberately set out to effect this new artificial formation [the transference neurosis]; he merely observed that such a process took place and forthwith made use of it for his own purposes' *(54)*. And Freud further states: 'The fact of the transference appearing, although neither desired nor induced by either physician or patient, in every neurotic who comes under treatment . . . has always seemed to me . . . proof that the source of the propelling forces of neurosis lies in the sexual life' *(57)*.

There is, however, a reference by Freud from which one has to infer that he had in mind some other factor in the genesis of transference apart from spontaneity—in fact, some outside influence: the analyst 'must recognize that the patient's falling in love is induced by the analytic situation . . .' *(58)*. 'He [the analyst] has evoked this love by undertaking analytic treatment in order to cure the neurosis; for him, it is an unavoidable consequence of a medical situation . . .' *(59)*. Freud did not amplify or specify what importance he attached to this casual remark.

Anna Freud *(48)* states that the child analyst has to woo the little patient to gain its love and affection before analysis can proceed, and she says, parenthetically, that something similar takes place in the analysis of adults.

Another reference to the effect that transference phenomena

are not completely spontaneous is found in a statement by Glover *(60)*, summarizing the effects of inexact interpretation. He says that the artificial phobic and hysterical formations resulting from incomplete or inexact interpretation are not an entirely new conception. Hypnotic manifestations had long been considered 'an induced hysteria' and Abraham considered that states of autosuggestion were induced obsessional systems. He proceeds, '. . . and of course the induction or development of a transference neurosis during analysis is regarded as an integral part of the process'. One is entitled from the context to assume that Glover commits himself to the view that some outside factors are operative which induce the transference neurosis. But it is hardly a coincidence that it is no more than a hint.

The impression gained from the literature on the whole is that the spontaneity of transference is considered established and generally accepted; in fact, this opinion seems jealously guarded for reasons referred to.

EXPOSITION OF PROBLEM

Psychoanalysis developed from hypnosis. A study of the older psychotherapeutic methods, therefore, may still yield data which are applicable to the understanding of psychoanalysis: 'One cannot overestimate the significance of hypnotism in the development of psychoanalysis. Theoretically and therapeutically, psychoanalysis is the trustee of hypnotism' *(61)*. It is in comparing hypnotic and analytic transference that the writer believes the clue to the phenomenon and the production of transference may be found. It was only after hypnosis had been practiced empirically for a long time that its mechanism was given explanations by Bernheim, Freud, and Ferenczi. Freud demonstrated that the hypnotist suddenly assumed a role of authority which instantly transformed the relationship for the patient (by way of traumata) into a parent-child relationship. Rado *(55)*, investigating hypnosis, came to the conclusion that '. . . the hypnotist is promoted from being an object of the ego to the position of a "parasitic superego" '. Freud

(10) stated, 'No one can doubt that the hypnotist has stepped into the place of the ego-ideal'. Later he says that '. . . the hypnotic relation is the devotion of someone in love to an unlimited degree but with sexual satisfaction excluded'*(11)*. In other places Freud stressed repeatedly and with great emphasis that in hypnosis factors of a 'coarsely sexual nature' were at work, and that the quantities of libido mobilized were focused on the hypnotist.

Psychoanalysis like hypnosis began empirically. One may speculate that analytic transference is a derivative of hypnosis, motivated by instinctual (libidinal) drives and, *mutatis mutandis*, produced in a way comparable to the hypnotic trance.

When one compares hypnosis and transference it appears that hypnotic 'rapport' contains the elements of transference condensed or superimposed. If what makes the patient go to the hypnotist is called sympathetic transference, hypnosis can be said to embrace positive transference and the transference neurosis,[2] and when the hypnotic 'rapport' is broken, the manifestations of negative transference. The analogy of course ends when transference is not resolved in hypnosis as it is in analysis, but is allowed to persist. To look upon it from another angle, analytic transference manifestations are a slow motion picture of hypnotic transference manifestations; they take some time to develop, unfold slowly and gradually, and not all at once as in hypnosis. If the hypnotist becomes the patient's 'parasitic superego', similarly, the modification of the analysand's superego has for some time been considered a standard feature of psychoanalysis.

Strachey *(63)* sees in the analyst 'an auxiliary superego'. Discussing this and examining projection and introjection of archaic superego formations to the analyst, he says *(62)*: the analyst '. . . hopes, in short, that he himself will be introjected by the patient as a superego, introjected, however, not at a

[2] Rado *(56)* says: 'It would not constitute, one imagines, a departure from customary analytical modes of expression to suggest that this transference of libido from the symptoms to the hypnotic experience represents the formation of a hypnotic transference neurosis'.

single gulp and as an archaic object, whether good or bad, but little by little, and as a real person'. Another possible similarity between the modes of action of hypnosis and analytic transference is to be found in the state of hysterical dissociation in hypnosis; in psychoanalysis a splitting of the ego into an experiencing and an observing part (which follows the projection of the superego to the analyst) also takes place. Sterba *(64, 65)*, stressing the usefulness of interpretation of transference resistances, shows that this takes place through a kind of dissociation of the ego at the precise moment when these transferences are interpreted. Both in hypnosis and psychoanalysis libido is mobilized and concentrated in the hypnotic and analytic situations, in hypnosis again condensed in one short experience, while in psychoanalysis a constant flow of libido in the analytic situation is aimed at. Ferenczi's 'active therapy' was intended to increase or keep steady this libidinal flow. Freud first encountered positive transference (love), and only later discovered the negative transference. This sequence is the rule in analysis, and in this there is another analogy to hypnosis. Finally, it is generally recognized that the same type of patient responds to hypnosis as to psychoanalysis; in fact, the hypnotizability of hysterics gave Freud the impetus to develop the psychoanalytic technique, and hysterics are still the paradigm for classical psychoanalytic technique.

It is comparatively easy today to get a bird's-eye view of the development of analytic transference from hypnotic reactions, and make a comparison between the two. Freud, who had to find his way gradually toward the creation of a new technique, was completely taken by surprise when he first encountered transference in his new technique. He stressed repeatedly and emphatically that these demonstrations of love and hate emanate from the patient unaided, that they are part and parcel of the 'neurotic', and that they have to be considered a 'new edition' of the patient's neurosis. He maintained that these manifestations appear without the analyst's endeavor, indeed, in spite of him (as they represent resistances), and that nothing will prevent their occurrence. Freud's view is still undisputed in

psychoanalytic literature; thus arose the conception that the analyst did nothing to evoke these reactions, in marked contradistinction to the hypnotist's direct activities; the analyst offered himself tacitly as a superego in contrast to the noisy machinations of the hypnotist.

Transference was, in the early days of psychoanalysis, believed to be a characteristic and pathognomonic sign of hysteria. This was a heritage from hypnosis. Later, these same manifestations were found in other neurotic conditions, in the psychoneuroses, or the transference neuroses. When in the course of time psychoanalysis was applied to an ever-widening circle of cases, it was found that students in psychoanalytic training, who did not openly fall into any of these categories, formed transferences in exactly the same way. This was explained by the fact that between 'normal' and 'neurotic' there is a gradual transition, that in point of fact we are all potentially neurotic. In this way, historically, the onus of responsibility for the appearance of transference was shifted imperceptibly from the hysteric to the psychoneurotic, and then to the normal personality. When this stage was reached, transference was held to be one of the many ways in which the universal mental mechanism of displacement was at work. The capacity to 'transfer' or 'displace' was demonstrated to operate in everybody to a greater or lesser degree; its use came to be looked upon as a normal, in fact, an indispensable mechanism. The significance of this shift of emphasis from a hysterical trait to a universal mechanism as the source of transference has, however, not received due attention. It has not aroused much comment nor an attempt to revise the fundamental principles underlying psychoanalytic procedure and understanding.

Transference is still held to arise spontaneously from within the analysand, just as when psychoanalytic experience embraced only hysterics. It is generally taught that the duty of the analyst is, at best, to allow sufficient time for transference to develop, and not to disturb this 'natural' process by early interpretation *(47)*. This role of the analyst is well illustrated

in the similes of the analyst as 'catalyst' (Ferenczi), or as a 'mirror' (Fenichel).

DISCUSSION

If transference is an example of a universal mental mechanism (displacement), or if, in Abraham's sense, it is equated with a capacity for adaptation of which everybody is capable and which everybody employs at times in varying degrees, why does it invariably occur with such great intensity in every analysis? The answer to this question appears to be that transference is induced from without in a manner comparable to the production of hypnosis. The analysand brings, in varying degrees, an inherent capacity, a readiness to form transferences, and this readiness is met by something which converts it into an actuality. In hypnosis the patient's inherent capacity to be hypnotized is induced by the command of the hypnotist, and the patient submits instantly. In psychoanalysis it is neither achieved in one session nor is it a matter of obeying. Psychoanalytic technique creates an infantile setting, of which the 'neutrality' of the analyst is but one feature among others. To this infantile setting the analysand—if he is analyzable—has to adapt, albeit by regression. In their aggregate, these factors, which go to constitute this infantile setting, amount to a reduction of the analysand's object world and denial of object relations in the analytic room. To this deprivation of object relation he responds by curtailing conscious ego functions and giving himself over to the pleasure principle; and following his free associations, he is thereby sent along the trek into infantile reactions and attitudes.

Before discussing in detail the factors which constitute this infantile analytic setting to which the analysand is exposed, it is necessary to appreciate the fact that it is common in psychoanalytic literature to find the analytic situation referred to as one to which the analysand reacts as if it were an infantile one. But it is generally understood that the analysand is alone responsible for this attitude. As an explanation of why he should regard it always as an infantile situation, one mostly

finds the explanation that the security, the absence of adverse criticism, the encouragement derived from the analyst's neutrality, the allaying of fears and anxieties, create an atmosphere which is conducive to regression. Yet it is well established in the literature that it is far from being the rule that the analytic couch allays anxieties, nor is the analytic situation always felt as a place of security: the projection of a more or less severe superego onto the analyst is not conducive to allaying fears. Many patients first react with increased anxieties, and analysis is frequently felt by the analysand as fraught with danger both from within and without. Many patients from the start have mutilation and castration anxieties, and at times analysis is equated in the analysand's mind with a sexual attack. The analyst's task is to overcome these resistances, but the analytic situation per se does not bring it about. In point of fact, the security of analysis as an explanation of the regression is paradoxical: as in life, security makes for stability, whereas stress, frustration, and insecurity initiate regressions. This trend of thought does not run counter to accepted and current psychoanalytic teaching; it is rather an exposition of Freud's established principles about the conception of neurosis. The self-contradictory statement, that the security of analysis induces the analysand to regress, is carried uncritically from one psychoanalytic publication to another.

The factors which constitute this infantile setting are manifold. They have been described singly by various authors at various times. It is not pretended that this thesis has anything new to add to them except in so far as the aggregate has never been described as amounting to a decisive outside influence on the patient. These factors are given here in outline, this description attempting only to establish the features of the standard psychoanalytic technique:

1. *Curtailment of object world.* External stimuli are reduced to a minimum (Freud at first asked his patients even to keep their eyes shut). Relaxation on the couch has also to be valued as a reduction of inner stimuli, and as an elimination

of any gratification from looking or being looked at. The position on the couch approximates the infantile posture.

2. *The constancy of environment,* which stimulates fantasy.

3. *The fixed routine* of the analytic 'ceremonial'; the 'discipline' to which the analysand has to conform and which is reminiscent of a strict infantile routine.

4. The single factor of *not receiving a reply* from the analyst is likely to be felt by the analysand as a repetition of infantile situations. The analysand—uninitiated in the technique—will not only expect answers to his questions but he will expect conversation, help, encouragement, and criticism.

5. The *timelessness* of the unconscious.[3]

6. *Interpretations* on an infantile level stimulate infantile behavior.

7. *Ego function* is reduced to a state intermediate between sleeping and waking.

8. *Diminished personal responsibility* in analytic sessions.

9. The analysand will approach the analyst in the first place much in the same way as the patient with an organic disease consults his physician; this relationship in itself contains a strong *element of magic (67),* a strong infantile element.

10. *Free association,* liberating unconscious fantasy from conscious control.

11. *Authority of the analyst* (parent): this projection is a loss, or severe restriction of object relations to the analyst, and the analysand is thus forced to fall back on fantasy.

12. In this setting, and having *the full sympathetic attention of another being,* the analysand will be led to expect, which according to the reality principle he is entitled to do, that he is dependent on and loved by the analyst. Disillusionment is quickly followed by regression.

13. The analysand at first gains an illusion of complete freedom; that he will be unable to select or guide his thoughts at will is one facet of infantile frustration.

14. *Frustration of every gratification* repeatedly mobilizes libido

[3] Nunberg *(66)* says: 'The patient's sense of time seems to be put out of action, the past becomes the present and the present becomes the past'.

and initiates further regressions to deeper levels. The continual denial of all gratification and object relations mobilizes libido for the recovery of memories, but its significance lies also in the fact that frustration as such is a repetition of infantile situations, and most likely the most important single factor. It would be true to say that we grow up by frustration.

15. Under these influences, the analysand becomes more and more divorced from the reality principle, and falls under the sway of the pleasure principle.

These features illustrate sufficiently that the analysand is exposed to an infantile setting in which he is led to believe that he has perfect freedom, that he is loved, and that he will be helped in a way he expects. The immutability of a constant, passive environment forces him to adapt, i.e., to regress to infantile levels. The reality value of the analytic session lies precisely in its unchanging unreality, and in its unyielding passivity lies the 'activity', the influence which the analytic atmosphere exerts. With this unexpected environment, the patient—if he has any adaptibility—has to come to terms, and he can do so only by regression. Frustration of all gratification pervades the analytic work. Freud *(68)* says: 'As far as his relations with the physician are concerned, the patient must have unfulfilled wishes in abundance. It is expedient to deny him precisely those satisfactions which he desires most intensely and expresses most importunately.' This is a description of the denial of object relation in the analytic room. The present thesis stresses the significance not only of the loss of object relation, but, as a factor of at least equal importance, the loss of object world in the analytic room, the various factors of which are set out above.

It is evident that all these factors working together constitute a definite environmental and emotional influence on the analysand. He is subjected to a rigid environment, not by any direct activity of the analyst, but by the analytic technique. This conception is far removed from the current teaching of complete passivity on the part of the analyst. One may legitimately go one step further and call to mind what Freud *(20)*

said about the etiology of the neuroses: '. . . people fall ill of a neurosis when the possibility of satisfaction for their libido is denied them—they fall ill in consequence of a "frustration" —and that their symptoms are actually substitutes for the missing satisfaction'.

Regression in the analysand is initiated and kept up by this selfsame mechanism and if, in actual life, a person falls ill of a neurosis because 'reality frustrates all gratification', the analysand likewise responds to the frustrating infantile setting by regressing and by developing a transference neurosis. In hypnosis the patient is suddenly confronted with a parent figure to which he instantly submits. Psychoanalysis places and keeps the analysand in an infantile setting, both environmental and emotional, and the analysand adapts to it gradually by regression.

The same may be said to be true of all psychotherapy; yet it appears peculiar to psychoanalysis that such an infantile setting is systematically created and its influence exerted on the analysand throughout the treatment. Unlike any other therapist, the analyst remains outside the play which the analysand is enacting; he watches and observes the analysand's reactions and attitudes in isolation. To have created such an instrument of investigation may well be looked upon as the most important stroke of Freud's genius.

It can no longer be maintained that the analysand's reactions in analysis occur spontaneously. His behavior is a response to the rigid infantile setting to which he is exposed. This poses many problems for further investigation. One of these is, how does it react on the patient? He must know it, consciously or unconsciously. It would be interesting to follow up whether perhaps the frequent feeling of being in danger, of losing something, of being coerced, or of being attacked, is a feeling provoked in the analysand in response to the emotional and environmental pressure exerted on him. It would be feasible to assume that this creates a negative transference, and as positive transference must exist as well (otherwise

treatment would be discontinued), a subsequent state of ambivalence must ensue. Here one might look for an explanation why ambivalent attitudes are prevalent in analysis. These are generally looked upon as spontaneous manifestations of the analysand's neurosis. Following the argument of this thesis, this double attitude of the analysand, the positive feelings toward the analyst and analysis, and a negative response to the pressure exerted on him by continual frustration and loss of object world and object relation, could be looked upon as the normal sequitur of analytic technique. It would not constitute ambivalence in its strict sense, because the patient is reacting to two different objects simultaneously and has not as in true ambivalence two attitudes to one and the same object. The common appearance of this pseudo ambivalence can then no longer be adduced as evidence of the existence or part of a preanalytic neurosis.

The patient comes to analysis with the hope and expectation of being helped. He thus expects gratification of some kind, but none of his expectations are fulfilled. He gives confidence and gets none in return; he works hard and expects praise in vain. He confesses his sins without absolution given or punishment proffered. He expects analysis to become a partnership, but he is left alone. He projects onto the analyst his superego and expects from him guidance and control of his instinctual drives in exchange, but he finds this hope, too, is illusory and that he himself has to learn to exercise these powers. It is quite true, assessing the process as a whole, that the analysand is misled and hoodwinked as analysis proceeds. The only safeguard he is given against rebelling and discontinuing treatment is the absolute certainty and continual proof that this procedure, with all the pressure and frustration it imposes, is necessary for his own good, and that it is an objective method with the sole aim of benefiting him and for no other purpose than his own. In particular, the disinterestedness of the analyst must assure the patient that no subjective factors enter into it. In this light, the moral integrity of the analyst, so often stressed, becomes a safeguard for the patient to proceed

with analysis; it is a technical device and not a moral precept.

A word might be added about the driving force of analysis in the light of this thesis. The libido necessary for continual regression and memory work is looked upon by Freud *(19)* as being derived from the relinquished symptoms. He says that the therapeutic task has two phases: 'In the first, libido is forced away from the symptoms into the transference and there concentrated; and in the second phase the battle rages round this new object and the libido is again disengaged from the transference object'. As so often in Freud's statements, this description applies to clinical neuroses; but psychoanalysis takes the same course in nonneurotics. The main driving force may be considered to be derived in every analysis from such libido as is continually freed by the denial of object world and by the frustration of libidinal impulses.

CONCLUSIONS

If the conception be accepted that analytic transference is actively induced in a 'transference-ready' analysand by exposing him to an infantile setting to which he has gradually to adapt by regression, certain conclusions follow.

STAGES IN ANALYSIS

Analysis can then be divided into stages, the first stage being the initial period in which the analysand gradually adapts to an infantile setting. Regressive, infantile reactions and attitudes manifest themselves with gathering momentum during what might be described as the induction of the transference neurosis. This stage corresponds to what Glover *(29)* has called the stage of 'floating transferences'. In the second stage his regression is well established and the analysand represents the infant at various stages of development with such intensity that all his actions—in and out of analysis—are imbued with reactivated infantile reactions, consciously or unconsciously. During this stage, under constant pressure of analytic frustration, he withdraws progressively to earlier, 'safer' infantile patterns of behavior, and the level of his conflict is sooner or later

reached. Reaching the level of his conflict is not, however, the touchstone of the existence of a transference neurosis. Further, the analysand transfers not only onto the analyst, but onto the situation as a whole; and he transfers not only affects, although these may be the most conspicuous, but in fact his whole mental development. This conception makes it easier to understand with what alacrity analysands fasten their love and hate drives onto the analyst regardless of sex and irrespective of suitability as an object.

The transference neurosis may be defined as the stage in analysis when the analysand has so far adapted to the infantile analytic setting—the main features of which are the denial of object relations and continual libidinal frustration—that his regressive trend is well established, and the various developmental levels reached, relived, and worked through.

A third, or terminal, stage represents the gradual retracing of the way back into adulthood toward newly won independence, freed from an archaic superego and weaned from the analytic superego. However great the distance from maturity back into childhood at the commencement of analysis, the duration of the first and second stages of analysis is as long and takes as much time as the return journey back into maturity and independence. Only part of this way back from infantile levels to maturity falls within the time limit of analysis in its third stage; the rest and the full adaptation to adulthood are most often completed by the analysand after termination of analysis. In this last postanalytic stage great improvements often occur. In this conception the answer may be found to the often discussed and not fully explained problem of improvements after termination of analysis.

It is superfluous to point out that these stages are theoretical, as in reality they never occur neatly separated but always overlap.

RESISTANCE

The initial aim of analysis is to induce a regression; whatever impedes it is a resistance. If instead of such a movement there occurs a standstill (whether in the form of acting out or

of direct transference gratifications), or if the movement instead of being regressive turns in the direction of apparent maturity (flight into health), one can speak of a resistance. Theoretically, acting out is a formidable variety of resistance because the analysand mistakes the unreality of the analytic relationship for reality and attempts to establish reality relations with the analyst. In this attitude he stultifies the analytic procedure for the time being, as he throws the motor force of analysis—the denial of all object relations in the analytic room and of the gratification of libido derived therefrom—out of action. In cases in which early 'transference successes' are won and the patient quickly relinquishes his symptoms, the analysis is in danger of terminating at this point. The mechanism of these transference successes is in a way the counterpart of acting out. The patient regresses rapidly to the level of childhood, and forms an unconscious fantasy of a mutual child-parent relationship. He mistakes such reality and object relation as exists as a basis in the analytic relationship wholly for an infantile one and unconsciously obeys (spites or obliges) the parent imago. What happens in these cases is in fact that the analysand has in fantasy formed a mutual hypnotic transference relation with the analyst; analytic interpretation was either not quick enough to prevent it, or the analysand's transference readiness was too strong. He could not be made to adapt gradually to the infantile setting. In other words, the analysand faced with the stimulus of an infantile situation proceeds by way of autosuggestion (or indirect suggestion) to rid himself of a symptom.

Transference has resistance value in so far as it impedes the recovery of memories and so stops the regressive orientation. Per se it is the only possible vehicle for unconscious content to come to consciousness. Transference should therefore not be indiscriminately equated with resistance as Fenichel did.

COUNTERTRANSFERENCE

The analyst himself is also subjected to the infantile setting of which he is a part. In fact, the infantile setting to which

he is exposed contains one more important infantile factor, the regressing analysand. The analyst's ego is also split into an observing and experiencing one. The analyst has had his own thorough analysis and knows what to expect, and furthermore, unlike the analysand, is in an authoritative position. Whereas it is the analysand's task to adapt actively to the infantile setting by regression, it is incumbent on the analyst to remain resistant to such adaptation. While the analysand has to experience the past and observe the present, the analyst has to experience the present and observe the past; he must resist any regressive trend within himself. If he fall victim to his own technique, and experience the past instead of observing it, he is subject to counterresistance. The phenomenon of countertransference may be best described by paraphrasing Fenichel's simile: the analyst misunderstands the past in terms of the present.

ACCESSIBILITY TO PSYCHOANALYTIC TREATMENT

If the thesis of this paper prove correct, a clue could be found to the accessibility of various types of patients to psychoanalytic treatment. To respond to the classical analytic technique, analysands must have some object relations intact, and must have at their disposal enough adaptability to meet the infantile analytic setting by further regression. For both hypnosis and psychoanalysis there is a sliding scale from the hysteric to the schizophrenic. Abraham *(43)* said: 'The negativism of dementia præcox is the most complete antithesis of transference. In contrast to hysteria these patients are only to a very slight degree accessible to hypnosis. In attempting to psychoanalyze them we notice the absence of transference again.' The high degree of suggestibility, i.e., the capacity to form transferences, is well known as a leading feature of hysteria. Hysteria, and the whole group belonging to the transference neuroses are distinguished by an impaired and immature adjustment to reality; their reactions are intermingled with infantile attitudes and mechanisms. Hence under pressure from the infantile analytic milieu they respond freely

and relatively quickly with increased infantile behavior to the loss of object world and object relations. The neurotic character responds less easily and less freely because its object relations are relatively firmly established (for instance, well-functioning sublimations), and hence are harder to resolve analytically. The denial of object relations and libidinal gratification in analysis is frequently parried by reinforced sublimations; but before analysis can proceed this 'sublimated object relationship' must first be reversed.

Psychotics are refractory to the classical technique, according to this thesis, because their object relations are deficient and slender, and nothing therefore remains of which the analytic pressure of the classical technique could deprive these patients; or their object relations are too slight for their denial to make any difference. Freud *(17)* says: '. . . on the basis of our clinical observations of these patients we stated that they must have abandoned the investment of objects with libido, and transformed the object libido into ego libido'. As the core of the classical technique is the denial of object relations of the patient through his exposure to an infantile milieu, the narcissistic regressives must consequently prove inaccessible to the classical approach. This does not, of course, exclude them from analytical methods which deviate from the classical form. The main change of approach for them will have to be an adjustment of the technique in the early stages of analytic treatment. This aspect has a bearing also on the problems of transference and particularly on the transference neurosis that are in dispute among child analysts.

DEFINITION OF ANALYTIC TRANSFERENCE

If a person with a certain degree of inherent suggestibility is subjected to a suggestive stimulus and reacts to it, he can be said to be under the influence of suggestion. To arrive at a definition of analytic transference, it is necessary first to introduce an analogous term for suggestibility in hypnosis and speak of a person's inherent capacity or readiness to form transferences. This readiness is precisely the same factor and may

be defined in the same way as suggestibility, namely, a capacity to adapt by regression. Whereas in hypnosis the precipitating factor is the suggestive stimulus, followed by suggestion, in psychoanalysis the person's adaptability by regression is met by the outside stimulus (or precipitating factor) of the infantile analytic setting. In psychoanalysis it is not followed by suggestion from the analyst, but by continued pressure to further regression through the exposure to the infantile analytic setting. If the person reacts to it he will form a transference relationship, i.e., he will regress and form relations to early imagos. Analytic transference may thus be defined as a person's gradual adaptation by regression to the infantile analytic setting.

SPONTANEITY OF TRANSFERENCE

Transference cannot be regarded as a spontaneous neurotic reaction. It can be said to be the resultant of two sets of forces: the analysand's inherent readiness for transference, and the external stimulus of the infantile setting. There are, then, to be distinguished in the mechanism of analytic transference intrinsic and extrinsic factors: the response to the analytic situation will vary in intensity with different types of analysands. The capacity to form a transference neurosis was found to be inherent—varying only in quantity—in all analysands who could be analyzed at all, whether they were neurotic or not. To account for this, the term 'neurotic' was extended until it lost most of its meaning because the precipitating factor, the infantile setting, was not perceived.

It is interesting historically to observe that in the heyday of hypnosis, hypnotizability was considered to be a characteristic trait of hysteria; hypnosis in fact was considered an 'artificial hysteria' (Charcot). Precisely the same situation has arisen in psychoanalysis with respect to the transference neurosis. When, to his amazement, Freud first encountered transference in his new technique, which he applied to neurotic patients only, he attributed 'this strange phenomenon of transference' to the patient's neurosis, and he saw in it 'a characteristic peculiar to

neurotics'. When he coined for the acute manifestations of transference the designation 'transference neurosis', it was explicitly affirmed that these manifestations were a 'new edition' of an old neurosis revealing itself within the framework of psychoanalytic treatment. Once the concept of transference neurosis had become a tenet in psychoanalytic teaching, the acute manifestations were without further questioning accepted as inseparably linked with the neurotic.

Thus historically the linkage of transference with neurosis is an exact replica of the early linkage of hypnosis with the hysteric. Freud, in his preanalytic period, hailed with enthusiasm Bernheim's demonstration that most people were hypnotizable and that hypnosis was no longer to be regarded as inseparable from hysteria. In the introduction to Bernheim's book, Freud *(6)* said: 'The achievement of Bernheim . . . consists precisely in having stripped the manifestations of hypnotism of their strangeness by linking them up with familiar phenomena of normal psychological life and of sleep'. In the face of this statement, it is extraordinary that psychoanalysis has never officially divorced transference from clinical neurosis.

RESOLUTION OF TRANSFERENCE

The resolution of transference has been considered the safeguard against and proof of the fact that suggestion plays no part in psychoanalysis. The validity of this argument was questioned earlier on the grounds that the meaning and definition of 'suggestion' is in itself vague and shifting and used with varying connotations. Additional weight is given to this caution when it is realized that the resolution itself of psychoanalytic transference is not understood in all its aspects. True enough, its manifestations are continually analyzed in psychoanalysis and an attempt is made to reduce them, but its ultimate resolution or even its ultimate fate is not clearly understood. Whenever it is finally resolved, it is during an ill-defined period after termination of analysis. By this feature alone it escapes strict scientific observation. It might even be argued

that analytic transference in some of its aspects must in the last resort resolve itself. In hypnosis, of course, no attempt is ever made to resolve the transference; but this should not be thought of as if it were bound to persist. More correctly it is left to look after itself. This trend of thought is followed here not in any way to distract from the essential difference in the resolution of hypnotic and analytic transferences respectively, but in order to emphasize that from the standpoint of theory the conception is not exact enough and hence likely to create confusion of fundamental issues instead of clarifying them. It seems important to stress this point as, by sheer weight of habit and repetition, ambiguous conceptions tend to assume the character and dignity of clear scientific concepts.

There is, however, another difference between hypnotic and analytic transference which is free from all ambiguity, and which may well be considered of more cardinal significance in demarcating psychoanalysis from all other psychotherapies. The hypothesis has been presented here that both hypnosis and psychoanalysis exploit infantile situations which they both create. But in hypnosis the transference is really and truly a mutual relationship existing between the hypnotist and the hypnotized. The hypnotic subject certainly transfers, but he is also transferred to. One is tempted to say that counter-transference is obligatory in and an essential part of hypnosis (and for that matter of all psychotherapies in which the patient is helped, encouraged, advised or criticized). This interaction between hypnotist and hypnotized made Freud describe hypnosis as a 'group formation of two'. The patient is subjected to direct suggestion against the symptom. In psychoanalytic therapy alone the analysand is not transferred to. The analyst has to resist all temptation to regress, he remains neutral, aloof, a spectator, and he is never a coactor. The analysand is induced to regress and to 'transfer' alone in response to the infantile analytic setting. The analytic transference relationship ought, strictly speaking, not to be referred to as a relationship between analysand and analyst, but more precisely as the analysand's relation to his analyst. Analysis keeps the analysand in isola-

tion. By its essential nature analysis, in contradistinction to hypnosis, is not a group formation of two. It is thereby not denied that analysis is a 'team work'; in so far as it is, an 'objective' relation exists between the analyst and the analysand. Because the analyst remains outside the regressive movement, because it is his duty to prove resistant to countertransference by virtue of his own analysis, suggestion can inherently play no part in the classical procedure of psychoanalytic technique.

It is of historical interest to look back upon the development of psychoanalysis and find that, although the theoretical basis as shown in this paper has never been advanced, the subject of countertransference was unconsciously felt to be the most vulnerable point and the most significant issue in psychoanalysis. The literature regarding the 'handling of transference' easily verifies this statement. Through this postulated immunity to regression the concept of the analyst's passivity rightly arose, but was wrongly allowed to be extended to a concept of passivity governing the whole of psychoanalytic technique.

To make transference and its development the essential difference between psychoanalysis and all other psychotherapies, psychoanalytic technique may be defined as the only psychotherapeutic method in which a one-sided, infantile regression —analytic transference—is induced in a patient (analysand), analyzed, worked through, and finally resolved.

SUMMARY

1. Attention is drawn to the absence of a clear understanding of the fundamental concept of analytic transference, and the reasons for this deficiency are outlined. 2. The discrepancies and uncertainties about the term are demonstrated. 3. Despite fundamental differences of opinion about the nature of transference there is a surprising unanimity and full accord about the causation of transference manifestations. These are held to arise spontaneously from within the analysand (the neurotic). 4. A hypothesis is presented disputing the spontaneous emer-

gence of transference. 5. From a close analogy drawn between hypnotic and analytic transferences it is inferred that the analogy extends to the production of these phenomena: that analytic transference is induced in a 'transference-ready' analysand actively, and from the analytic environment. 6. The analysand is exposed to a rigid infantile setting to which he has gradually to adapt by regression. 7. The factors which constitute this infantile setting are described and discussed; the problems arising out of this 'activity' and their influence on the patient are approached. 8. Conclusions are drawn from this conception regarding stages in analysis, and a definition of 'transference neurosis' is advanced. Resistance, countertransference, and accessibility to psychoanalytic treatment are discussed. Psychoanalytic transference is defined and its resolution critically surveyed.

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