

## XXVIII

THE DYNAMICS OF THE TRANSFERENCE<sup>1</sup>

(1912)

THE almost inexhaustible subject of 'transference' has recently been dealt with in this Journal by W. Stekel in a descriptive manner.<sup>2</sup> I wish to add a few remarks in order to make clear how it happens that the transference inevitably arises during the analysis and comes to play its well-known part in the treatment.

Let us bear clearly in mind that every human being has acquired, by the combined operation of inherent disposition and of external influences in childhood, a special individuality in the exercise of his capacity to love—that is, in the conditions which he sets up for loving, in the impulses he gratifies by it, and in the aims he sets out to achieve in it.<sup>3</sup> This

<sup>1</sup> First published in the *Zentralblatt*, Bd. II., 1912; reprinted in *Sammlung*, Vierte Folge. [Translated by Joan Riviere.]

<sup>2</sup> *Zentralblatt*, Bd. II., Nr. II. S. 26.

<sup>3</sup> We will here provide against misconceptions and reproaches to the effect that we have denied the importance of the inborn (constitutional) factor because we have emphasized the importance of infantile impressions. Such an accusation arises out of the narrowness with which mankind looks for causes, inasmuch as one single causal factor satisfies him, in spite of the many commonly underlying the face of reality. Psycho-Analysis has said much about the 'accidental' component in ætiology and little about the constitutional, but only because it could throw new light upon the former, whereas of the latter it knows no more so far than is already known. We deprecate the assumption of an essential opposition between the two series of ætiological factors; we presume rather a perpetual interchange of both in producing the results observed. *δαιμων και τυχη* determine the fate of man; seldom, perhaps never, one of these powers alone. The relative ætiological effectiveness of each is only to be measured individually and in single instances. In a series comprising varying degrees of both factors extreme cases will certainly also be found. According to the knowledge we possess we shall estimate the parts played by the forces of heredity and of environment differently in each case, and retain the right to modify our opinion in consequence

forms a *cliché* or stereotype in him, so to speak (or even several), which perpetually repeats and reproduces itself as life goes on, in so far as external circumstances and the nature of the accessible love-objects permit, and is indeed itself to some extent modifiable by later impressions. Now our experience has shown that of these feelings which determine the capacity to love only a part has undergone full psychological development; this part is directed towards reality, and can be made use of by the conscious personality, of which it forms part. The other part of these libidinal impulses has been held up in development, withheld from the conscious personality and from reality, and may either expend itself only in phantasy, or may remain completely buried in the unconscious so that the conscious personality is unaware of its existence. Expectant libidinal impulses will inevitably be roused, in anyone whose need for love is not being satisfactorily gratified in reality, by each new person coming upon the scene, and it is more than probable that both parts of the libido, the conscious and the unconscious, will participate in this attitude.

It is therefore entirely normal and comprehensible that the libido-cathexes, expectant and in readiness as they are in those who have not adequate gratification, should be turned also towards the person of the physician. As we should expect, this accumulation of libido will be attached to prototypes, bound up with one of the *clichés* already established in the mind of the person concerned, or, to put it in another way, the patient will weave the figure of the physician into one of the 'series' already constructed in his mind. If the physician should be specially connected in this way with the father-*imago* (as Jung has happily named<sup>1</sup> it) it is quite in accordance with his actual

of new knowledge. Further, we may venture to regard the constitution itself as a residue from the effects of accidental influences upon the endless procession of our forefathers.

<sup>1</sup> *Symbole und Wandlungen der Libido*.

relationship to the patient; but the transference is not bound to this prototype; it can also proceed from the mother- or brother-*imago* and so on. The peculiarity of the transference to the physician lies in its excess, in both character and degree, over what is rational and justifiable—a peculiarity which becomes comprehensible when we consider that in this situation the transference is effected not merely by the conscious ideas and expectations of the patient, but also by those that are under suppression, or unconscious.

Nothing more would need to be said or would perplex us concerning this characteristic of the transference, if it were not that two points which are of particular interest to psycho-analysts still remain unexplained by it. First, it is not clear why neurotic subjects under analysis develop the transference so much more intensely than those who are not being analysed; and secondly, it remains a mystery why in analysis the transference provides the *strongest resistance* to the cure, whereas in other forms of treatment we recognize it as the vehicle of the healing process, the necessary condition for success. Experience shows, and a test will always confirm it, that when the patient's free associations fail<sup>1</sup> the obstacle can be removed every time by an assurance that he is now possessed by a thought which concerns the person of the physician or something relating to him. No sooner is this explanation given than the obstacle is removed, or at least the absence of thoughts has been transformed into a refusal to speak.

It appears at the first glance to be an enormous disadvantage in psycho-analysis as compared with other methods that in it the transference, elsewhere such a powerful instrument for success, should become here the most formidable ally of the resistance. On closer consideration, however, the first of these difficulties at least will disappear. It is not the fact that the

<sup>1</sup> I mean here, when really nothing comes to his mind, and not when he keeps silence on account of some slight disagreeable feeling.

transference in psycho-analysis develops more intensely and immoderately than outside it. Institutions and homes for the treatment of nervous patients by methods other than analysis provide instances of transference in its most excessive and unworthy forms, extending even to complete subjection, which also show its erotic character unmistakably. A sensitive observer, Gabriele Reuter, depicted these facts at a time when psycho-analysis hardly existed, in a remarkable book<sup>1</sup> which altogether reveals great insight into the nature and causes of the neuroses. This peculiarity of the transference is not, therefore, to be placed to the account of psycho-analysis but is to be ascribed to the neurosis itself. The second problem still remains unexplained.

This problem must now be tackled at close quarters: Why does the transference in analysis confront us as resistance? Let us call to mind the psychological situation in the treatment. One of the invariable and indispensable preliminary conditions in every case of psychoneurosis is the process which Jung has aptly named *introversion* of the libido.<sup>2</sup> This means that the quantity of libido which is capable of becoming conscious, and is directed towards reality, has become diminished, while the part which is unconscious and turned away from reality (and, although it may still nourish phantasies in the person concerned, belongs to the unconscious) is by so much increased. The libido (entirely or in part) has found its way back into regression and has re-animated the infantile *imagos*<sup>3</sup>;

<sup>1</sup> *Aus guter Familie*, 1895.

<sup>2</sup> Although many of Jung's utterances give the impression that he sees introversion as something characteristic of dementia præcox and not observable to the same extent in the other neuroses.

<sup>3</sup> It would be easy to say: the libido has re-invested the infantile 'complexes'. But this would be erroneous; it would be correct only if expressed thus: 'the unconscious part of these complexes'. The exceptional intricacy of the theme dealt with in this essay tempts one to discuss further a number of adjunct problems, which require elucidation before one can speak definitely enough about the psychical processes here described. Such problems are: The definition of the boundary between introversion and regression; the incorporation of the complex-doctrine into the libido-theory; the relationship of

and thither we pursue it in the analytic treatment, aiming always at unearthing it, making it accessible to consciousness and at last serviceable to reality. Wherever in our analytic delving we come upon one of the hiding-places of the withdrawn libido, there ensues a battle; all the forces which have brought about the regression of the libido will rise up as 'resistances' against our efforts in order to maintain the new condition. For if the introversion or regression of the libido had not been justified by some relation to the outer world (in the broadest terms, by a frustration of some desired gratification) and at the time been even expedient, it would never have taken place at all. Yet the resistances which have this origin are not the only ones, nor even the most powerful. The libido at the disposal of the personality had always been exposed to the attraction of unconscious complexes (strictly speaking, of that part of those complexes which belongs to the unconscious), and underwent regression because the attraction of reality had weakened. In order to free it, this attraction of the unconscious must now be overcome; that is, the repression of the unconscious impulses and their derivatives, which has subsequently developed in the mind of the person concerned, must be lifted. Here arises by far the greater part of the resistances, which so often succeed in upholding the illness, even though the original grounds for the recoil from reality have now disappeared. From both these sources come the resistances with which the analysis has to struggle. Every step of the treatment is accompanied by resistance; every single thought, every mental act of the patient's, must pay toll to the resistance, and represents a compromise between the forces urging towards the cure and those gathered to oppose it.

Now as we follow a pathogenic complex from its

phantasy-creation to the conscious, the unconscious, and to reality; etc. I need not apologize for having resisted these temptations here.

representative in consciousness (whether this be a conspicuous symptom or something apparently quite harmless) back to its root in the unconscious, we soon come to a place where the resistance makes itself felt so strongly that it affects the next association, which has to appear as a compromise between the demands of this resistance and those of the work of exploration. Experience shows that this is where the transference enters on the scene. When there is anything in the complex-material (the content of the complex) which can at all suitably be transferred on to the person of the physician such a transference will be effected, and from it will arise the next association; it will then manifest itself by the signs of resistance—for instance, a cessation in the flow of associations. We conclude from such experiences that this transferred idea is able to force itself through to consciousness in preference to all other possible associations, just *because* it also satisfies resistance. This type of incident is repeated innumerable times during an analysis. Over and over again, when one draws near to a pathogenic complex, that part of it which is first thrust forward into consciousness will be some aspect of it which can be transferred; having been so, it will then be defended with the utmost obstinacy by the patient.<sup>1</sup>

Once this point is won, the elements of that complex which are still unresolved cause little further difficulty. The longer the analysis lasts, and the more clearly the patient has recognized that distortions of the pathogenic material in themselves offer no protection against disclosure, the more consistently he makes use of that variety of distortion which obviously brings him the greatest advantage, the distortion by transference.

<sup>1</sup> From which, however, one need not infer in general any very particular pathogenic importance in the point selected for resistance by transference. In warfare, when a bitter fight is raging over the possession of some little chapel or a single farmhouse, we do not necessarily assume that the church is a national monument, or that the barns contain the military funds. Their value may be merely tactical; in the next onslaught they will very likely be of no importance.

These incidents all converge towards a situation in which eventually all the conflicts must be fought out on the field of transference.

Transference in analysis thus always seems at first to be only the strongest weapon of the resistance, and we are entitled to draw the inference that the intensity and duration of the transference are an effect and expression of the resistance. The mechanism of transference is indeed explained by the state of readiness in which the libido that has remained accumulated about the infantile imagos exists, but the part played by it in the process of cure is only intelligible in the light of its relation to the resistance.

How does it come about that the transference is so pre-eminently suitable as a weapon of resistance? One might think that this could easily be answered. It is surely clear enough that it must become peculiarly difficult to own up to any particular reprehended wish when the confession must be made to the very person with whom that feeling is most concerned. To proceed at all in such situations as this necessity produces would appear hardly possible in real life. This impossibility is precisely what the patient is aiming at when he merges the physician with the object of his emotions. Yet on closer consideration we see that this apparent gain cannot supply the answer to the riddle, for, on the contrary, an attitude of affectionate and devoted attachment can surmount any difficulty in confession; in analogous situations in real life we say: 'I don't feel ashamed with you; I can tell you everything'. The transference to the physician might quite as well relieve the difficulties of confession, and we still do not understand why it aggravates them.

The answer to this reiterated problem will not be found by pondering it any further, but must be sought in the experience gained by examination of individual instances of transference-resistance occurring in the course of an analysis. From these one perceives eventually that the use of the transference for resistance

cannot be understood so long as one thinks simply of 'transference'. One is forced to distinguish 'positive' transference from 'negative' transference, the transference of affectionate feeling from that of hostile feeling, and to deal separately with the two varieties of the transference to the physician. Positive transference can then be divided further into such friendly or affectionate feelings as are capable of becoming conscious and the extensions of these in the unconscious. Of these last, analysis shows that they invariably rest ultimately on an erotic basis; so that we have to conclude that all the feelings of sympathy, friendship, trust and so forth which we expend in life are genetically connected with sexuality and have developed out of purely sexual desires by an enfeebling of their sexual aim, however pure and non-sensual they may appear in the forms they take on to our conscious self-perception. To begin with we knew none but sexual objects; psycho-analysis shows us that those persons whom in real life we merely respect or are fond of may be sexual objects to us in our unconscious minds still.

So the answer to the riddle is this, that the transference to the physician is only suited for resistance in so far as it consists in *negative* feeling or in the repressed *erotic* elements of positive feeling. As we 'raise' the transference by making it conscious we detach only these two components of the emotional relationship from the person of the physician; the conscious and unobjectionable component of it remains, and brings about the successful result in psycho-analysis as in all other remedial methods. In so far we readily admit that the results of psycho-analysis rest upon a basis of suggestion; only by suggestion we must be understood to mean that which we, with Ferenczi,<sup>1</sup> find that it consists of—influence on a person through and by means of the transference-manifestations of which he is capable. The eventual independence of the patient is our ultimate object when we use suggestion to bring

<sup>1</sup> Ferenczi, *Introjection and Transference*.

him to carry out a mental operation that will necessarily result in a lasting improvement in his mental condition.

The next question is, Why do these manifestations of transference-resistance appear only in psycho-analysis and not in other forms of treatment, in institutions, for example? The answer is that they do appear there also, but they need to be recognized for what they are. The outbreak of negative transference is a very common occurrence in institutions; as soon as he is seized by it the patient leaves, uncured or worse. The erotic transference has not such an inhibitory effect in institutions, since there, as otherwise in life, it is decorously glossed over, instead of being exposed; nevertheless, it betrays itself unequivocally as resistance to the cure, not, indeed, by driving the patient out of the place—on the contrary, it binds him to the spot—but just as certainly by keeping him away from real life. Actually it is quite unimportant for his cure whether or not the patient can overcome this or that anxiety or inhibition in the institution; what is of importance, on the contrary, is whether or not he will be free from them in real life.

The negative transference requires a more thorough elucidation than is possible within the limits of this paper. It is found in the curable forms of the psychoneuroses alongside the affectionate transference, often both directed on to the same person at the same time, a condition for which Bleuler has coined the useful term ambivalence.<sup>1</sup> This ambivalence of the feelings appears to be normal up to a point, but a high degree of it is certainly a special peculiarity of neurotics. In the obsessional neurosis an early 'splitting of the pairs of opposites' seems to characterize the instinctual life and to form one of the constitutional conditions of

<sup>1</sup> E. Bleuler, *Dementia Praecox oder Gruppe der Schizophrenien*, in Aschaffenburg's *Handbuch der Psychiatrie*, 1911; also a Lecture on Ambivalence in Berne, 1910, abstracted in *Zentralblatt für Psychoanalyse*, Bd. I., S. 266. W. Stökel had previously suggested the term *bipolarity* for the same phenomenon.

this disease. The ability of neurotics to make the transference a form of resistance is most easily accounted for by ambivalence in the flow of feelings. Where the capacity to transfer feeling has come to be of an essentially negative order, as with paranoids, the possibility of influence or cure ceases.

After all this investigation we have so far considered one aspect only of transference-phenomena; some attention must be given to another side of this question. Those who have formed a true impression of the effect of an extreme transference-resistance on the patient, of the way in which as soon as he comes under its influence he is hurled out of all reality in his relation to the physician—how he then arrogates to himself freedom to ignore the psycho-analytic rule (to communicate without reserve whatever goes through his mind), how all the resolutions with which he entered upon the analysis then become obliterated, and how the logical connections and conclusions which just before had impressed him deeply then become matters of indifference to him—will need some further explanation than that supplied by the factors mentioned above to account for this effect, and these other factors are, indeed, not far to seek; they lie again in the psychological situation in which the analysis has placed the patient.

In following up the libido that is withdrawn from consciousness we penetrate into the region of the unconscious, and this provokes reactions which bring with them to light many of the characteristics of unconscious processes as we have learnt to know them from the study of dreams. The unconscious feelings strive to avoid the recognition which the cure demands; they seek instead for reproduction, with all the power of hallucination and the inappreciation of time characteristic of the unconscious. The patient ascribes, just as in dreams, currency and reality to what results from the awakening of his unconscious feelings; he seeks to discharge his emotions, regardless of the reality

of the situation. The physician requires of him that he shall fit these emotions into their place in the treatment and in his life-history, subject them to rational consideration, and appraise them at their true psychical value. This struggle between physician and patient, between intellect and the forces of instinct, between recognition and the striving for discharge, is fought out almost entirely over the transference-manifestations. This is the ground on which the victory must be won, the final expression of which is lasting recovery from the neurosis. It is undeniable that the subjugation of the transference-manifestations provides the greatest difficulties for the psycho-analyst; but it must not be forgotten that they, and they only, render the invaluable service of making the patient's buried and forgotten love-emotions actual and manifest; for in the last resort no one can be slain *in absentia* or *in effigie*.

## XXIX

RECOMMENDATIONS FOR PHYSICIANS ON  
THE PSYCHO-ANALYTIC METHOD OF  
TREATMENT<sup>1</sup>

(1912)

THE technical rules which I bring forward here have been evolved out of my own experience in the course of many years, after I had renounced other methods which had cost me dear. It will easily be seen that they may be summed up, or at least many of them, in one single injunction. My hope is that compliance with them will spare physicians practising analysis much unavailing effort and warn them of various possibilities which they might otherwise overlook. I must, however, expressly state that this technique has proved to be the only method suited to my individuality; I do not venture to deny that a physician quite differently constituted might feel impelled to adopt a different attitude to his patients and to the task before him.

(a) To the analyst who is treating more than one patient in the day, the first necessity with which he is faced will seem the hardest. It is, of course, that of keeping in mind all the innumerable names, dates, detailed reminiscences, associations, and effects of the disease which each patient communicates during the treatment in the course of months or years, and not confounding them with similar material proceeding from other patients treated simultaneously or previously. When one is required to analyse six, eight, or even more patients daily, the effort of memory

<sup>1</sup> First published in *Zentralblatt*, Bd. II., 1912; reprinted in *Sammlung*, Vierte Folge. [Translated by Joan Riviere.]