Of the concepts introduced by Freud to illuminate human nature, transference is the most encompassing. It occupies a pivotal position in every aspect of psychoanalysis. It is pictured as the tidal wave of the past that washes over the present, leaving its unmistakable residues. It is invoked to explain bizarre acts of aggression, painful pathological repetitions, and the tender and passionate sides of love and sex. First seen only as a resistance to psychoanalytic treatment, it was later acknowledged as its facilitator as well. Generations of analysts have sought to use transference to distinguish analyzable from nonanalyzable patients. Finally, the concept of transference has been used to disparage cures obtained by nonpsychoanalytic therapies and to excuse failures encountered in psychoanalytic treatments.

Initially, the idea of transference was applied far more modestly. Breuer and Freud (1893–95) ascribed what we now call transference to a “false connection” made by the patient. They noted that this was both frightening to the patient and a regular occurrence in some analyses, wherein the patient transferred “on to the figure of the physician the distressing ideas which arise from the content of the analysis” (p. 302).

The image of the transference “arising” was consistent with the “archeological” model implicit in much of Freud’s psychoanalytic theorizing, a model based on an assumption that the patient knew everything that was of any pathogenic significance (Bergmann and Hartman, 1976). Writing twenty years later, Freud (1913) still conceived of psychoanalysis as a technique whereby one digs into the unconscious and clears ever deeper layers. Psychoanalysis “consists in tracing back one psychological structure to another which preceded it in time and out of which it developed” (p. 183).

The archeological model has retained some hold on the clinical understanding of transference in general. More specifically, the very early notion of a “false connection” has been preserved in considering transference a “distortion” of reality. Other explanations of transference as regression, displacement, and projection, though consistent with a dynamic viewpoint, still retain a residue of the colorful imagery of archeological expeditions. The archeological model shows many of the disadvantages of Freud’s energy theory, in that psychological motivations and states are treated as though they were finite, palpable entities. How this has affected our understanding of transference was a central concern leading to this chapter.

Bergmann and Hartman (1976) wrote:

Following Freud’s emphasis on archeology as the model for psychoanalysis, psychoanalysts tended to see their work essentially as a reconstruction of what has once existed and was buried by repression. By contrast, Hartmann sees the work of interpretation not only, or not even primarily, as that of reconstruction, but rather as the establishment of a new connection, and therefore as a new creation [p. 466].

In contrast with the archeological viewpoint, this emphasis on new connections and new creations within the therapeutic process focuses attention on the contributions of both patient and analyst. The focus on the analyst’s contribution to the analytic process, which is made explicit in our conceptualization of the psychoanalytic situation as an intersubjective system, reflects a shift in psychoanalysis and in scientific thinking in general. How we study a phenomenon affects and alters it.

We turn now to a critical examination of formulations that traditionally have been employed to describe and explain transference.
CONCEPTUALIZATIONS OF TRANSFERENCE

Transference as Regression

The traditional psychoanalytic view of transference as regression was clearly enunciated by Waelder (1956): "Transference may be said to be an attempt of the patient to revive and re-enact, in the analytic situation and in relation to the analyst, situations and phantasies of his childhood. Hence, transference is a regressive process" (p. 367).

A survey of the uses of the term "regression" in psychoanalytic writings (see Arlow and Brenner, 1964) reflects the variety of ways, each with vastly different meanings and implications, in which this concept has been applied. Included are discussions of psychosexual regression, topographic regression, structural regression, genetic regression, etc. These different terms can be assigned to two general uses of the concept—regression as a diminution in the level of psychological organization and regression as retrogression along a time dimension. No doubt archaic modes of psychological organization in adults are related to the psychological organizations found in childhood. However, these archaic modes are not identical with their manifestations and occurrences in the young child. To confine the concept of regression solely to level of structuralization requires fewer unverifiable assumptions. With respect to transference, the concurrent influences of various modes and levels of organization can be addressed, with full recognition of their complex interplay, and with no assumption of a literal retrogression in time.

The assumption that adult relationships in their repetitive and conflictual aspects are isomorphic reenactments of traumatic relationships from the early history of the individual has enabled analysts to link the current psychopathology, the course of early development including its pathological variations, and the nuances of the patient-analyst relationship, the transference. Careful observations of patients' transferences and inferences based on these have provided analysts with data for reconstructions of specific genetic sequences and for formulating an epigenetic theory. For these assumptions with respect to temporal regression to be verified, it must be demonstrated that inferences about childhood derived from adult analyses can be validated independently and that modes of mental organization characteristic of early childhood are sufficiently similar to archaic modes of organization as they emerge in adult analyses to warrant inferential leaps from one epoch in the life cycle to the other.

Major challenges to the assumption that adult psychopathology reflects temporal regressions to infantile phases of development are found in recent observations of early infancy (Brody, 1982; Stern, 1985). There is now increasing evidence that the autism of adult schizophrenic patients has no counterpart in infancy. The postulation of an autistic phase or of an undifferentiated phase is not supported by the accumulating evidence. The adult psychopathology, therefore, cannot be accurately described as a temporal regression to an earlier normal phase (Silverman, 1986). Furthermore, when it appears that the autistic adult suffered from similar states in childhood, regression is again not an appropriate term, since the state has evidently remained present all along.

Consistent with the findings from the infancy literature is the hypothesis that the infant alternates between periods of oneness with its mother, as inferred from synchronous action patterns, and periods of disengagement (Stern, 1983; Beebe, 1986). Both patterns are characteristic of the young infant; neither is primary or a precondition for the other. Adult psychopathology that is characterized by a predominance of dependent clinging to maternal figures is often described as a regression to a phase of early infancy—for example, the symbiotic phase. However, prolonged or continuous periods of symbiosis are apparently neither typical nor normative for the infant. Thus, symbiotic-like wishes or fantasies may characterize adult motivation and may be related to an early developmental period, but what the adult imagines, yearns for, or enacts is not identical to what is typical of the young child.

The idea of temporal regression is most frequently used with respect to psychosexual development. Discussions in which psychopathology is understood as a regression to oral, anal, phallic, or oedipal phases presuppose that the predominant motivational priorities of the patient are identical to those of the child in the earlier phases. There are two questionable assumptions here. The first pertains to the linearity of psychosexual development—the notion that in the adult earlier motivations are normally renounced or relinquished in favor of later ones. It is assumed that maturity requires renunciation and that, indeed, such renunciation is possible. The concept of temporal regression, therefore, implies a failure in renunciation. The second questionable as-
sumption is that an adult whose motivations are dominated by psychosexual wishes and conflicts must be functioning like a child who is traversing the corresponding psychosexual phases.

Restricting the concept of regression to the level of psychological organization clarifies its relevance for the transference. Analysts are thereby alerted to the possibility that higher levels of organization, which include self-empathy, perspective, humor, wisdom, and differentiation between self and other, though not in evidence, can potentially be revived or achieved. Analysts can also then better assess whether more archaic organizations had previously been prematurely aborted, precluded, or disavowed, so that their emergence in treatment is a developmental achievement (Stolorow and Lachmann, 1980), or whether they serve to ward off other material. In all cases, the analytic stance toward the emergence of archaic modes of organization should be to promote their integration with other, more mature modes, thereby enriching psychological functioning, rather than to insist on their renunciation or elimination.

Included in the concept of structural regression are both defensive revivals of archaic states and the emergence in treatment of arrested aspects of early developmental phases. In neither case can the patient be said to have actually retrogressed to an infantile period. We can only say that the patient’s experiences, especially of the analytic relationship, are being shaped by archaic organizing principles, either for the purpose of defense, or in order to resume a developmental process that had become stalled.

**Transference as Displacement**

The repetition compulsion and displacement are two closely related concepts frequently invoked to explain the occurrence of transference. To Freud (1920), the repetition compulsion, a biologically inherent attribute of living matter, provided an explanation for the ubiquity of transference phenomena. We will consider the issue of repetition later. Displacement initially referred to a mechanism of the dream-work (Freud, 1900) and neurotic symptom formation (Freud, 1916–17). According to Nunberg (1951), the patient “displaces emotions belonging to an unconscious representation of a repressed object to a mental representation of an object of the external world” (p. 1).

Assumed within this concept of displacement is Freud’s economic theory—a cathexis being pushed along an associative path from an idea of greater emotional intensity to a more distant one of lesser intensity, from a place where discharge is conflictual and blocked to a place where discharge is possible. For example, hostility initially directed unconsciously toward the same-sexed parent in childhood may be displaced to a superior at work. The presumed repetitive reliving of the past in the present neither improves one’s current life nor alters one’s perspective on or memories of the past. On the contrary, such reliving of the past in displaced form is believed to perpetuate the archaic configuration, until it becomes engaged in the analytic transference and can be interpreted.

In our view of transference, there is nothing that is removed from the past and attached to the current situation. It is true that the organization of the transference gives the analyst a glimpse of what a childhood relationship was like or what the patient wished or feared it could have been like. However, this insight into the patient’s early history is possible not because an idea from the past has been displaced to the present, but because the structures that were organized in the past either continue to be functionally effective or remain available for periodic mobilization. That is, these themes have either remained overtly salient throughout the patient’s life prior to the beginning of treatment or have been providing a more subtle background organization which the analytic process has brought to the fore.

The concept of transference as displacement has perpetuated the view that the patient’s experience of the analytic relationship is solely a product of the patient’s past and psychopathology and has not been determined by the activity (or nonactivity) of the analyst. This viewpoint is consistent with Freud’s archeological metaphor. In neglecting the contribution of the analyst to the transference, it contains certain pitfalls. Suppose an archeologist unknowingly dropped a wristwatch into a dig. If the assumption is made that anything found in the dig must have been there beforehand, some woefully unwarranted conclusions would be reached.

**Transference as Projection**

Analysts who draw upon the theoretical ideas of Melanie Klein tend to conceptualize transference as a manifestation of the mechanism of projection. Racker (1954), for example, viewed transference as the projec-
tion of rejecting internal objects upon the analyst, whereby internal conflicts become converted into external ones. Similarly, Kernberg (1975) attributes certain archaic transference reactions to the operation of “projective identification,” a primitive form of projection whose main purpose is to externalize all-bad, aggressive self and object images.

We define projection as a defensive process in which an aspect of oneself is excluded from awareness by being attributed to an external object, in order to alleviate conflict and avoid danger. To view transference phenomena solely or primarily as defensive externalizations confines the explanation of transference to only one of its many possible functions and can lead to a serious neglect of its other dimensions and multiple meanings. Once the transference is established, projection may or may not emerge as a component, depending on the extent of its prominence as a characteristic mode of defense against the subjective dangers experienced at any particular juncture.

A particular difficulty with formulations of transference as an expression of projection is that they often obscure the developmental dimension of the transference. As we have stressed elsewhere (Stolorow and Lachmann, 1980), projection as a defense actively employed to ward off conflict can come into play only after a minimum of self-object differentiation has been reliably achieved. Defensive translocation of mental content across self-object boundaries requires that those boundaries have been partially consolidated. When states of confusion between self and object occur in the context of an archaic transference configuration, this developmental achievement in self-boundary formation cannot be presupposed. Such archaic transference states are most often best understood not as manifestations of projective mechanisms, but rather as remnants of developmental arrests at early modes of experience in which self and object are incompletely distinguished.

Transference as Distortion

Implicit in the conceptions of transference discussed so far (as temporal regression, displacement, or projection) is the idea that transference involves a distortion of “reality,” as the relationship with the analyst becomes cast in images from the patient’s unconscious infantile past or infiltrated by the patient’s endopsychic world of internal object relations. This idea was made explicit in Sullivan’s (1953) concept of “parataxic distortion,” a process by which a present relationship is presumed to be “warped” by earlier ones. Certain Freudian authors, too (e.g., Stein, 1966), have stated more or less directly that the goal of analysis is to correct the patient’s distortions of what the analyst “knows” to be objectively real.

In another context (Stolorow and Lachmann, 1980), we have cautioned against certain dangers embedded in the concept of a “real” relationship between analyst and patient, of which the transference is presumed to be a distortion. Such dangers lie in the fact that judgments about what is “really true” about the analyst and what is distortion of that “truth” are ordinarily left solely to the discretion of the analyst—hardly a disinterested party. We find that therapists often invoke the concept of distortion when the patient’s feelings, whether denigrating or admiring, contradict self-perceptions and expectations that the therapist requires for his own well-being.

Gill (1982), whose views on this subject are compatible with our own, criticizes the concept of transference as distortion because it implies “that the patient is manufacturing his experience out of whole cloth” (p. 117). “A more accurate formulation than ‘distortion,’” Gill argues, “is that the real situation is subject to interpretations other than the one the patient has reached . . . Indeed,” he continues, “seeing the issue in this way rather than as a ‘distortion’ helps prevent the error of assuming some absolute external reality of which the ‘true’ knowledge must be gained” (p. 118). As we noted in chapter 1, Schwaber (1983) also objects to the notion of transference as distortion because of its embeddedness in “a hierarchically ordered two-reality view” (p. 383)—one reality experienced by the patient and the other “known” by the analyst to be more objectively true.

Transference, fully established, is a sampling of psychic reality in purest culture. As such, it belongs to what Winnicott (1951) called “the realm of illusion,” an “intermediate area of experience, unchallenged in respect of its belonging to inner or external reality . . .” (p. 242, emphasis added). A prime example of this respect for illusory experience is the attuned parent’s attitude toward a child’s transitional object. “It is a matter of agreement between us and the baby,” Winnicott wrote, “that no decision on this point is expected. The important point is that no decision on this point is expected. The question is not to be formulated” (pp. 239–240, emphasis added). One could scarcely find a better descrip-
tion of the proper analytic attitude for facilitating the unfolding and illumination of the patient's transference experience.

**Transference as Organizing Activity: A Reformulation**

In our view, the concept of transference may be understood to refer to all the ways in which the patient's experience of the analytic relationship is shaped by his own psychological structures—by the distinctive, archaically rooted configurations of self and object that unconsciously organize his subjective universe. Thus transference, at the most general level of abstraction, is an instance of organizing activity—the patient assimilates (Piaget, 1954) the analytic relationship into the thematic structures of his personal subjective world. The transference is actually a microcosm of the patient's total psychological life, and the analysis of the transference provides a focal point around which the patterns dominating his existence as a whole can be clarified, understood, and thereby transformed.

From this perspective, transference is neither a regression to nor a displacement from the past, but rather an expression of the continuing influence of organizing principles and imagery that crystallized out of the patient's early formative experiences. Transference in its essence is not a product of defensive projection, although defensive aims and processes (including projection) certainly can and do contribute to its vicissitudes. The concept of transference as organizing activity does not imply that the patient's perceptions of the analytic relationship distort some more objectively true reality. Instead, it illuminates the specific shaping of these perceptions by the structures of meaning into which the analyst and his actions become assimilated.

The concept of transference as organizing activity offers an important clinical advantage over the other formulations in that it explicitly invites attention to both the patient's psychological structures and the input from the analyst that they assimilate (Wachtel, 1980). As Gill (1982) repeatedly observes, it is essential to the analysis of transference reactions to examine in detail the events occurring within the analytic situation that evoke them. The transference reactions become intelligible through comprehending the meanings that these events acquire by virtue of their assimilation by the patient's subjective frame of reference—by the affect-laden, archaically determined configurations of self and object that pervade his psychological life.

Another advantage of the concept of transference as organizing activity is that it is sufficiently general and inclusive to embrace the multiplicity of its dimensions, the subject to which we now turn.

**DIMENSIONS OF THE TRANSFERENCE**

**The Multiple Functions of Transference**

We have suggested a reformulation of the concept of transference from one that was encumbered by the psychoeconomic viewpoint and an outdated archeological metaphor to one emphasizing the psychological process of organizing current experience. This process occurs through the continual confluence of present events and previously formed psychological structures. Thus, what shapes the experience of a current situation, including the analytic situation, is derived from a multitude of sources in the person's history, as well as from properties of the current situation and the meanings into which these are assimilated. Transference must therefore be understood from a multidimensional perspective, on the assumption that a multiplicity of thematic structures and levels of psychological organization will have been mobilized by the analysis. Different dimensions of the transference will become salient at different points in the analysis.

The concept of transference as organizing activity is an alternative to the view that transference is the manifestation of a biologically rooted compulsion to repeat the past. In addition, transference as organizing activity focuses more narrowly on the specific patterning of experience within the analytic relationship, to which both patient and analyst contribute. Thus we have used the term in two ways. As a higher order, supraordinate psychological principle, it replaces the biological repetition compulsion. Transference is conceived, not as a biologically determined tendency to repeat the past ad infinitum for its own sake, but rather as the expression of a universal psychological striving to organize experience and construct meanings.

Within the narrower focus on the shaping of the analytic relationship, the transference can subserve the entire gamut of psychological functions that have been illuminated by clinical psychoanalysis. The organization of the transference can (1) fulfill cherished wishes and urgent desires, (2) provide moral restraint and self-punishment, (3) aid
adaptation to difficult realities, (4) maintain or restore precarious, disintegration-prone self and object images, and (5) defensively ward off configurations of experience that are felt to be conflictual or dangerous. Viewing the transference in terms of its multiple functions enables the analyst to examine what is most salient in the patient's motivational hierarchy at any particular juncture.

The Relationship of Transference to Resistance

The relationship of transference to resistance is a complex one and has been the source of disagreements among analysts since Freud's early papers on the subject. Both Racker (1954) and Gill (1982) have pointed out that embedded in Freud's writings on transference and resistance are two distinct and contradictory theoretical models of the relationship between them. Racker's (1954) discussion of these two different viewpoints deserves quotation at some length:

[In the first view the transference] is regarded and interpreted as a resistance to the work of remembrance, and is utilized as an instrument for remembering, but [in the second] the transference is itself regarded as the decisive field in which the work is to be accomplished. The primary aim is, in the first case, remembering; in the second, it is re-experiencing [p. 75].

The two points of view may also be said to differ in that in the former transference is regarded predominantly as arising from resistance, whereas in the latter resistance is mainly a product of transference. In the first, the analysand repeats so as not to remember; in the second, he repeats defences (resistances) so as not to repeat traumatic or anxious experiences [pp. 75-76].

The first model of the relationship between transference and resistance, in which repetition is a defense against remembering, is a relic of Freud's archeological metaphor for the analytic process. As such, it should be abandoned as a theoretical and therapeutic anachronism. The second model, in which the experience of transference is central to the analytic process (Strachey, 1934; Gill, 1982), is compatible with our own conception of the transference as equivalent to the patient's organizing activity and as a microcosm providing therapeutic access to the patient's psychological world and history.

From this latter perspective, what is the relationship of transference to resistance? Gill (1982), embracing as we do Freud's second model of this relationship, claims that "all resistance manifests itself by way of transference" (p. 29) and that "the analysis of resistance is in effect the analysis of transference" (p. 39). He then proposes two broad categories of relationship between transference and resistance: resistance to the transference and resistance to the resolution of the transference. Resistance to the transference is further subdivided into resistance to the awareness of transference, as when transference feelings must be inferred from allusions to them in extratransference material, and resistance to involvement in transference.

Kohut (1971) also discussed resistance to involvement in transference, specifically describing resistances to involvement in archaic idealizing and mirror transferences. Such resistance, triggered by disintegration anxiety and the need to preserve a fragmentation-prone self, was seen by Kohut to arise from two sources. First, the patient may resist involvement in the transference for fear that his emerging archaic needs will meet with traumatic disappointments, rejections, and deprivations similar to those he had experienced as a child. Second, the patient may resist the transference, sensing his own structural vulnerabilities, as when a need for merger is fended off for fear of the extinction of individual selfhood.

An important implication of Kohut's overall viewpoint for the analysis of resistance to involvement in transference is that such resistance cannot be viewed solely in terms of isolated intrapsychic mechanisms located within the patient. Resistance to the transference based on "the dread to repeat" (Ornstein, 1974) past traumas is always to some extent evoked by actions of the analyst that the patient experiences as unattuned to his emerging feelings or needs. Such experiences of self/object failure invariably trigger resistance because for the patient they signal the impending recurrence of traumatically damaging childhood experiences. Since resistance to involvement in transference is in part a product of the patient's organizing activity, it is actually already an expression of the transference.

Gill's second broad category of relationship between transference and resistance—resistance to the resolution of the transference—seems to us to embody an assumption that analysis seeks to enable the patient to "renounce" infantile fixations as these are worked through in the transference, and that this goal of renunciation engenders resis-
ance. Later we shall present our objections to this notion that transference is to be resolved or renounced. In the present context we wish to stress that, in our view, the persistence of transference is not primarily the product of resistance. It is the result of the continuing influence of established organizing principles when alternative modes of experiencing the self and object world have not yet evolved or become sufficiently consolidated. We would thus replace Gill's "resistance to the resolution of the transference" with the concept of resistance based on transference. This would encompass all of the anticipated dangers and resulting constrictions of the patient's psychological life that appear in direct consequence of the transference having become firmly established, including those forfeitures of self-experience that the patient believes are necessary to maintain the analytic relationship. As we elaborate in detail in the chapters that follow, such resistance cannot be understood psychoanalytically apart from the intersubjective contexts in which it arises and recedes.

The Developmental Dimension of Transference

Recent advances in psychoanalytic developmental psychology have highlighted the central importance of developmental transformations in the child's organizing activity, leading to the progressive articulation, differentiation, integration, and consolidation of the subjective world. The conception of transference as organizing activity can encompass this developmental dimension as an aspect of the analytic relationship in a way that earlier concepts of transference cannot. We refer to instances in which the patient seeks to establish with the analyst a nexus of archaic relatedness in which aborted structuralization processes can be resumed and arrested psychological growth can be completed.

A major contribution to our understanding of the developmental aspect of transference was Kohut's (1971, 1977) formulation of the selfobject transferences, wherein the patient attempts to reestablish with the analyst ties that were traumatically and phase-inappropriately ruptured during the formative years, and upon which he comes to rely once again for the restoration and maintenance of the sense of self. We have come to believe that it has been a conceptual error to consider the term selfobject transference to refer to a type of transference characteristic of a certain type of patient. Instead, we now use the phrase selfobject transference to refer to a dimension of all transference, which may fluctuate in the extent to which it occupies a position of figure or ground in the patient's experience of the analytic relationship. Kohut's work has illuminated the unique therapeutic importance of understanding and transforming those transference configurations in which the selfobject dimension is figure—in which, that is, the restoration or maintenance of self-organization is primary in motivating the patient's tie to the analyst. Even when this is not the case, however, and other dimensions of experience and human motivation—such as conflicts over loving, hating, desiring, and competing—emerge as most salient in structuring the transference, the selfobject dimension is never absent. So long as it is undisturbed, it operates silently in the background, enabling the patient to make contact with frightening and conflictual feelings.

An important implication of this conceptualization is that the analyst must continually assess the often subtly shifting figure-ground relationships among the selfobject and other dimensions of the transference that occur throughout the course of treatment. The assessment of what dimensions and psychological functions constitute figure and what constitute ground at any particular juncture of the analysis will directly determine the content and timing of transference interpretations (see Stolorow and Lachmann, 1980, 1981).

A second implication of this conceptualization is that the selfobject or developmental dimension of transference must be included in any effort to delineate the process of cure in psychoanalysis. We shall return to this issue later.

TRANSFERENCE AND THE THERAPEUTIC PROCESS

The Analyst's Contribution to the Transference

While a review of the voluminous literature on the role of the transference in the therapeutic relationship would take us beyond the intentions of this chapter, two broadly contrasting positions can be outlined. On one hand, transference has been understood as emanating entirely from the patient. The belief, implicit in the archeological model, that the patient makes a "false connection" or engages in "distortion" exemplifies this position. The analyst who adheres to this view
will exercise care lest the transference become “contaminated.” The recommendation that the analyst must avoid offering any gratification of the patient's infantile wishes will be strictly followed, so that these “frustrated” wishes can then emerge from repression and gain verbal expression. Abstinence is equated here with neutrality, on the assumption that the active frustration of the patient's wishes and needs constitutes a “neutral” act that neither colors the transference nor affects how these wishes and needs become manifest in the therapeutic relationship. Even Strachey's (1934) oft-quoted position that only transference interpretations are mutative is consistent with this viewpoint, because it implies that nontransference interpretations and other behaviors of the analyst will not alter the transference neurosis.

It is our view, by contrast, that any action, nonaction, or restrained action of the analyst can affect the transference on a variety of levels of psychological organization, according to its meanings for the patient. Furthermore, the analyst's attitudes and responses will influence which dimensions of the transference predominate at any given time. The relentlessly abstinent analyst, for example, who believes that the patient's infantile wishes must be exposed and renounced, will obstruct the developmental or selfobject dimension of the transference, and may in addition evoke intense conflicts over primitive hostility—an artifact of the therapeutic stance (Wolf, 1976). On the other hand, the analyst who strives actually to fulfill the patient's archaic needs may impede the development of more advanced modes of organization in the transference.

The contribution of the patient's transference to the production of the analyst's countertransference has found its place within psychoanalytic clinical theory. We are emphasizing here that the countertransference (broadly conceptualized as a manifestation of the analyst's psychological structures and organizing activity) has a decisive impact in shaping the transference and codetermining which of its specific dimensions will occupy the experiential foreground of the analysis. Transference and countertransference together form an intersubjective system of reciprocal mutual influence.

A second position, which arose in opposition to the view that transference is derived solely from the psychology of the patient, recommends that the analyst acknowledge his “actual” contribution to the transference. A typical example might involve a patient who reveals that he felt the analyst was angry with him during the prior session. An analyst who adheres to this second position might privately review the events of the previous session and determine for himself whether, indeed, he may have directly or indirectly conveyed annoyance to the patient. He might then acknowledge the “reality” of the patient's perception and then proceed to analyze the patient's reactions.

A disadvantage of the first position (that transference emanates entirely from the patient) is that it requires the patient to relinquish his organizing principles and psychic reality in favor of the analyst's. We object to the second view because, like the first, it places the analyst in the position of evaluating the veracity of the patient's perceptions, and the patient's experience is validated only because it coincides with that of the analyst. At its worst, this approach can tip the therapeutic balance in the direction of making the analyst's “reality” an explanation for the patient's reactions. The danger here lies in endowing the patient's perceptions with “truth” and “reality,” not through the analytic process, but through the analyst's judgments.

Our own view is different from each of the two foregoing positions. When transference is conceptualized as organizing activity, it is assumed that the patient's experience of the therapeutic relationship is always shaped both by inputs from the analyst and by the structures of meaning into which these are assimilated by the patient. We would therefore do away with the rule of abstinence and its corresponding concept of neutrality and replace them with an attitude of sustained empathic inquiry, which seeks understanding of the patient's expressions from within the perspective of the patient's subjective frame of reference. From this vantage point, the reality of the patient's perceptions of the analyst is neither debated nor confirmed. Instead, these perceptions serve as points of departure for an exploration of the meanings and organizing principles that structure the patient's psychic reality.

This investigatory stance will itself have an impact on the transference. The patient's feeling of being understood, for example, can revive archaic oneness or merger experiences, which in turn may produce therapeutic effects (Silverman, Lachmann, and Milich, 1982). This brings us once again to the developmental dimension of the transference and its therapeutic action.

Transference Cures

An understanding of the developmental or selfobject dimension of the transference sheds new light on the role of transference in the process
of psychoanalytic cure. Once established, the selfobject dimension of
the transference is experienced to some degree by the patient as a
"holding environment" (Winnicott, 1965), an archaic intersubjective
context reinstating developmental processes of psychological differenti­
ation and integration that were aborted and arrested during the pa­
tient's early formative years. Thus, when protected from protracted
disruptions, the transference bond in and of itself can directly promote
a process of psychological growth and structure formation. In our
view, therefore, the singular importance of analyzing the patient's ex­
periences of ruptures in the transference bond is found in the impact of
such analysis in consistently mending the broken archaic tie and
thereby permitting the arrested developmental process to resume once
again.

We contend that it is the transference, especially in its develop­
mental or selfobject dimension, that lends to interpretations their mu­
tative power. Consider, for example, the transference context in which
a traditional resistance analysis takes place. Experienced analysts
know that clarifying the nature of a patient's resistance has no discerni­
ble therapeutic result unless the analyst is also able to identify the sub­
jective danger or emotional conflict that makes the resistance a felt
necessity. It is only when the analyst shows that he knows the patient's
fear and anguish and thereby becomes established to some degree as a
calming, containing selfobject—a new object separate and distinct
from the dreaded parental images—that conflictual regions of the pa­
tient's subjective life can emerge more freely.

The term transference cure has traditionally been applied pejora­
tively to indicate that a patient has "recovered" because of the un­
analyzed influence of an unconscious instinctual tie to the analyst.
What we are stressing here, in contrast, is the ubiquitous curative role
played by the silent, at times unanalyzed selfobject dimension of the
transference. We hold that every mutative therapeutic moment, even
when based on interpretation of resistance and conflict, includes a sig­
nificant element of selfobject transference cure.

Resolution of Transference

What is the ultimate fate of the transference in a successful psycho­
analysis? Various authors have recommended that in the termination
phase of an analysis the transference (especially the positive transfer­
ence) must be resolved or dissolved through interpretation. Usually
this means that the infantile wishes toward the analyst must be
renounced.

The analytic relationship is a peculiar one in many respects. It is
unique in being formed for a specific purpose—a therapeutic purpose
for one of the participants. The requirement that it should end with­
out residual transference feelings remaining seems to us to be unwar­
ranted. Indeed, attempts to eliminate all traces of the transferences
that have evolved in the course of analysis can adversely affect and
even derail an otherwise successful treatment. Often it is believed that
the transference must be dissolved for the sake of the patient's auton­
omy and that any residual transference feelings would constitute an
infantilizing element, potentially undermining independence and ob­
ject choices. In contrast, when transference is viewed as an expression
of a universal human organizing tendency, analysis aims not for re­
nunciation, but rather for the acceptance and integration of the trans­
ference experience into the fabric of the patient's analytically ex­
panded psychological organization. The transference, thus integrated,
greatly enriches the patient's affective life and contributes a repertoire
of therapeutically achieved developmental attainments.

With regard to so-called infantile wishes, needs, and fantasies, it has
never been adequately demonstrated that they can or should be re­
nounced. Within an expanded and more evolved psychological organ­
ization, they can be welcomed, just as any valued possession can find a
place on the mantelpiece, to be used on special occasions. The re­
main ing love and hate for the analyst, including their archaic roots,
can thus be acknowledged and accepted, without their having either
to be requited or negated, or presumed to constitute an interference
with the patient's current living. Ordinarily, after treatment has
ended, the residual analytic transference will gradually recede from its
preeminent position, relatively central in the patient's psychological
world, to a position where it serves as a bridge to a more complex, dif­
ferentiated, and richly experienced life.

CONCLUSION

Transference in its essence refers neither to regression, displacement,
projection, nor distortion, but rather to the assimilation of the ana­
lytic relationship into the thematic structures of the patient's personal
subjective world. Thus conceived, transference is an expression of the universal psychological striving to organize experience and create meanings. This broad conceptualization of transference holds numerous advantages over earlier ones. It can encompass the multiple dimensions of transference, including especially its developmental dimension, and it sheds light on the relationship of transference to resistance. It clarifies the contributions of both analyst and patient in shaping the patient’s experience of the therapeutic relationship. It illuminates the role of the transference in the process of psychoanalytic cure and in the patient’s life after analysis is completed. Most important of all, the concept of transference as organizing activity, by encouraging an unwavering inquiry into the patient’s subjective frame of reference, opens a clear and unobstructed window to the patient’s psychological world, and to its expansion, evolution, and enrichment.

Bonds That Shackle, Ties That Free

Margaret Mahler’s pioneering work highlighted the central developmental importance of the process of self-differentiation—the evolving sense of oneself as a demarcated and distinctive human being with a unique affective life and an individualized array of personal values and aims. She observed that this process “reverberates throughout the life cycle. It is never finished; it remains always active; new phases of the life cycle see new derivatives of the earliest processes still at work” (Mahler, Pine, and Bergman, 1975, p. 3). Although, in her formal developmental scheme, the phase of separation-individuation begins at the age of four to five months, arising out of the matrix of an undifferentiated “symbiotic phase,” passages in her work point to the presence of self-differentiation processes at birth (see also Stern, 1985). Mahler’s observations support the view that a tenacious striving for self-delineation powerfully organizes the developmental process throughout its course.

Mahler also identified the specific affective states that color the self-differentiation process, as well as those that result from its derailment. The dominant mood accompanying self-differentiation was one of unmistakable elation, manifesting itself in a quasi-delusional but age-adequate sense of grandeur, omnipotence, and conquest. This mood of the junior toddler—at the crest of mastery of many of his autonomous functions, the paradigm of which is locomotion—necessarily had to give way to a more realistic appraisal of his smallness in relation to the outside world [Mahler et al., 1975, p. 213].