

S. Freud: THE DYNAMICS OF TRANSFERENCE (1912)

The almost inexhaustible topic of transference has recently been dealt with by Wilhelm Stekel in this journal on descriptive lines. I should like in the following pages to add a few remarks to explain how it is that transference is necessarily brought about during a psycho-analytic treatment, and how it comes to play its familiar part in it.

It must be understood that each individual, through the combined operation of his innate disposition and the influences brought to bear on him during his early years, has acquired a specific method of his own in his conduct of his erotic life - that is, in the preconditions to falling in love which he lays down, in the instincts he satisfies and the aims he sets himself in the course of it.¹ This produces what might be described as a stereotype plate (or several such), which is constantly repeated - constantly reprinted afresh - in the course of the person's life, so far as external circumstances and the nature of the love objects accessible to him permit, and which is certainly not entirely unsusceptible to change in the face of recent experiences. Now, our observations have shown that only a portion of these impulses which determine the course of erotic life have passed through the full process of psychical development. That portion is directed towards reality, is at the disposal of the conscious personality, and forms a part of it. Another portion of the libidinal impulses has been held up in the course of development; it has been kept away from the conscious personality and from reality, and has either been prevented from further expansion except in phantasy or has remained wholly in the unconscious so that it is unknown to the personality's consciousness. If someone's need for love is not entirely satisfied by reality, he is bound to approach every new person whom he meets with libidinal anticipatory ideas; and it is highly probable that both portions of his libido, the portion that is capable of becoming conscious as well as the unconscious one, have a share in forming that attitude.

¹ I take this opportunity of defending myself against the mistaken charge of having denied the importance of innate (constitutional) factors because I have stressed that of infantile impressions. A charge such as this arises from the restricted nature of what men look for in the field of causation: in contrast to what ordinarily holds good in the real world, people prefer to be satisfied with a single causative factor. Psycho-analysis has talked a lot about the accidental factors in aetiology and little about the constitutional ones; but that is only because it was able to contribute something fresh to the former, while, to begin with, it knew no more than was commonly known about the latter. We refuse to posit any contrast in principle between the two sets of aetiological factors; on the contrary, we assume that the two sets regularly act jointly in bringing about the observed result. *Δαίμων και Τύχη* [Endowment and Chance] determine a man's fate - rarely or never one of these powers alone. The amount of aetiological effectiveness to be attributed to each of them can only be arrived at in every individual case separately. These cases may be arranged in a series according to the varying proportion in which the two factors are present, and this series will no doubt have its extreme cases. We shall estimate the share taken by constitution or experience differently in individual cases according to the stage reached by our knowledge; and we shall retain the right to modify our judgement along with changes in our understanding. Incidentally, one might venture to regard constitution itself as a precipitate from the accidental effects produced on the endlessly long chain of our ancestors.

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Thus it is a perfectly normal and intelligible thing that the libidinal cathexis of someone who is partly unsatisfied, a cathexis which is held ready in anticipation, should be directed as well to the figure of the doctor. It follows from our earlier hypothesis that this cathexis will have recourse to prototypes, will attach itself to one of the stereotype plates which are present in the subject; or, to put the position in another way, the cathexis will introduce the doctor into one of the psychical 'series' which the patient has already formed. If the 'father-*imago*', to use the apt term introduced by Jung (1911, 164) is the decisive factor in bringing this about, the outcome will tally with the real relations of the subject to his doctor. But the transference is not tied to this particular prototype: it may also come about on the lines of the mother-*imago* or brother-*imago*. The peculiarities of the transference to the doctor, thanks to which it exceeds, both in amount and nature, anything that could be justified on sensible or rational grounds, are made

intelligible if we bear in mind that this transference has precisely been set up not only by the *conscious* anticipatory ideas but also by those that have been held back or are unconscious.

There would be nothing more to discuss or worry about in this behaviour of transference, if it were not that two points remain unexplained about it which are of particular interest to psycho-analysis. Firstly, we do not understand why transference is so much more intense with neurotic subjects in analysis than it is with other such people who are not being analysed; and secondly, it remains a puzzle why in analysis transference emerges as *the most powerful resistance* to the treatment, whereas outside analysis it must be regarded as the vehicle of cure and the condition of success. For our experience has shown us - and the fact can be confirmed as often as we please - that if a patient's free associations fail¹ the stoppage can invariably be removed by an assurance that he is being dominated at the moment by an association which is concerned with the doctor himself or with something connected with him. As soon as this explanation is given, the stoppage is removed, or the situation is changed from one in which the associations fail into one in which they are being kept back. At first sight it appears to be an immense disadvantage in psycho-analysis as a method that what is elsewhere the strongest factor towards success is changed in it into the most powerful medium of resistance. If, however, we examine the situation more closely, we can at least clear away the first of our two problems. It is not a fact that transference emerges with greater intensity and lack of restraint during psycho-analysis than outside it. In institutions in which nerve patients are treated non-analytically, we can observe transference occurring with the greatest intensity and in the most unworthy forms, extending to nothing less than mental bondage, and moreover showing the plainest erotic colouring. Gabriele Reuter, with her sharp powers of observation, described this at a time when there was no such thing as psycho-analysis, in a remarkable book which betrays in every respect the clearest insight into the nature and genesis of neuroses.² These characteristics of transference are therefore to be attributed not to psycho-analysis but to neurosis itself.

¹ I mean when they really cease, and not when, for instance, the patient keeps them back owing to ordinary feelings of unpleasure.

² *Aus guter Familie*, Berlin, 1895.

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Our second problem - the problem of why transference appears in psycho-analysis as resistance - has been left for the moment untouched; and we must now approach it more closely. Let us picture the psychological situation during the treatment. An invariable and indispensable precondition of every onset of a psychoneurosis is the process to which Jung has given the appropriate name of 'introversion'.¹ That is to say: the portion of libido which is capable of becoming conscious and is directed towards reality is diminished, and the portion which is directed away from reality and is unconscious, and which, though it may still feed the subject's phantasies, nevertheless belongs to the unconscious, is proportionately increased. The libido (whether wholly or in part) has entered on a regressive course and has revived the subject's infantile imagos.² The analytic treatment now proceeds to follow it; it seeks to track down the libido, to make it accessible to consciousness and, in the end, serviceable for reality. Where the investigations of analysis come upon the libido withdrawn into its hiding-place, a struggle is bound to break out; all the forces which have caused the libido to regress will rise up as 'resistances' against the work of analysis, in order to conserve the new state of things. For if the libido's introversion or regression had not been justified by a particular relation between the subject and the external world - stated in the most general terms, by the frustration of satisfaction - and if it had not for the moment even become expedient, it could never have taken place at all. But the resistances from this source are not the only ones or indeed the most powerful. The libido at the disposal of the subject's personality had always been under the influence of the attraction of his unconscious complexes (or more correctly, of the portions of those complexes belonging to the unconscious), and it entered on a regressive course because the attraction of reality had diminished. In order to liberate it, this attraction of the unconscious has to be overcome; that is, the repression of the unconscious instincts and of their productions, which has

meanwhile been set up in the subject, must be removed. This is responsible for by far the largest part of the resistance, which so often causes the illness to persist even after the turning away from reality has lost its temporary justification. The analysis has to struggle against the resistances from both these sources. The resistance accompanies the treatment step by step. Every single association, every act of the person under treatment must reckon with the resistance and represents a compromise between the forces that are striving towards recovery and the opposing ones which I have described.

1 Even though some of Jung's remarks give the impression that he regards this introversion as something which is characteristic of dementia praecox and does not come into account in the same way in other neuroses.

2 It would be convenient if we could say 'it has recathected his infantile complexes'. But this would be incorrect: the only justifiable way of putting it would be 'the unconscious portions of those complexes'. The topics dealt with in this paper are so extraordinarily involved that it is tempting to embark on a number of contiguous problems whose clarification would in point of fact be necessary before it would be possible to speak in unambiguous terms of the psychical processes that are to be described here. These problems include the drawing of a line of distinction between introversion and regression, the fitting of the theory of complexes into the libido theory, the relations of phantasying to the conscious and the unconscious as well as to reality - and others besides. I need not apologize for having resisted this temptation in the present paper.

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If now we follow a pathogenic complex from its representation in the conscious (whether this is an obvious one in the form of a symptom or something quite inconspicuous) to its root in the unconscious, we shall soon enter a region in which the resistance makes itself felt so clearly that the next association must take account of it and appear as a compromise between its demands and those of the work of investigation. It is at this point, on the evidence of our experience, that transference enters on the scene. When anything in the complex material (in the subject-matter of the complex) is suitable for being transferred on to the figure of the doctor, that transference is carried out; it produces the next association, and announces itself by indications of a resistance - by a stoppage, for instance. We infer from this experience that the transference-idea has penetrated into consciousness in front of any other possible associations *because* it satisfies the resistance. An event of this sort is repeated on countless occasions in the course of an analysis. Over and over again, when we come near to a pathogenic complex, the portion of that complex which is capable of transference is first pushed forward into consciousness and defended with the greatest obstinacy.¹

1 This, however, should not lead us to conclude in general that the element selected for transference-resistance is of peculiar pathogenic importance. In the course of a battle there is a particularly embittered struggle over the possession of some little church or some individual farm, there is no need to suppose that the church is a national shrine perhaps, or that the house shelters the army's pay-chest. The value to the object may be a purely tactical one and may perhaps emerge only in this one battle.

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After it has been overcome, the overcoming of the other portions of the complex raises few further difficulties. The longer an analytic treatment lasts and the more clearly the patient realizes that distortions of the pathogenic material cannot by themselves offer any protection against its being uncovered, the more consistently does he make use of the one sort of distortion which obviously affords him the greatest advantages - distortion through transference. These circumstances tend towards a situation in which finally every conflict has to be fought out in the sphere of transference.

Thus transference in the analytic treatment invariably appears to us in the first instance as the strongest weapon of the resistance, and we may conclude that the intensity and persistence of the transference are an effect and an expression of the resistance. The *mechanism* of transference is, it is true, dealt with when we have traced it back to the state of readiness of the libido, which has remained in possession of infantile imagos; but the part transference plays in the treatment can only be explained if we enter into its relations with resistance.

How does it come about that transference is so admirably suited to be a means of resistance? It might be thought that the answer can be given without difficulty. For it is evident that it becomes particularly hard to admit to any proscribed wishful impulse if it has to be revealed in front of the very person to whom the impulse relates. Such a necessity gives rise to situations which in the real world seem scarcely possible. But it is precisely this that the patient is aiming at when he makes the object of his emotional impulses coincide with the doctor. Further consideration, however, shows that this apparent gain cannot provide the solution of the problem. Indeed, a relation of affectionate and devoted dependence can, on the contrary help a person over all the difficulties of making an admission. In analogous real situations people will usually say: 'I feel no shame in front of you: I can say anything to you.' Thus the transference to the doctor might just as easily serve to *facilitate* admissions, and it is not clear why it should make things more difficult.

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The answer to the question which has been repeated so often in these pages is not to be reached by further reflection but by what we discover when we examine individual transference resistances occurring during treatment. We find in the end that we cannot understand the employment of transference as resistance so long as we think simply of 'transference'. We must make up our minds to distinguish a 'positive' transference from a 'negative' one, the transference of affectionate feelings from that of hostile ones, and to treat the two sorts of transference to the doctor separately. Positive transference is then further divisible into transference of friendly or affectionate feelings which are admissible to consciousness and transference of prolongations of those feelings into the unconscious. As regards the latter, analysis shows that they invariably go back to erotic sources. And we are thus led to the discovery that all the emotional relations of sympathy, friendship, trust, and the like, which can be turned to good account in our lives, are genetically linked with sexuality and have developed from purely sexual desires through a softening of their sexual aim, however pure and unsensual they may appear to our conscious self-perception. Originally we knew only sexual objects; and psycho-analysis shows us that people who in our real life are merely admired or respected may still be sexual objects for our unconscious.

Thus the solution of the puzzle is that transference to the doctor is suitable for resistance to the treatment only in so far as it is a negative transference or a positive transference of repressed erotic impulses. If we 'remove' the transference by making it conscious, we are detaching only these two components of the emotional act from the person of the doctor; the other component, which is admissible to consciousness and unobjectionable, persists and is the vehicle of success in psycho-analysis exactly as it is in other methods of treatment. To this extent we readily admit that the results of psycho-analysis rest upon suggestion; by suggestion, however, we must understand, as Ferenczi (1909) does, the influencing of a person by means of the transference phenomena which are possible in his case. We take care of the patient's final independence by employing suggestion in order to get him to accomplish a piece of psychical work which has as its necessary result a permanent improvement in his psychical situation.

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The further question may be raised of why it is that the resistance phenomena of transference only appear in psycho-analysis and not in indifferent forms of treatment (e.g. in institutions) as well. The reply

is that they do show themselves in these other situations too, but they have to be recognized as such. The breaking out of a negative transference is actually quite a common event in institutions. As soon as a patient comes under the dominance of the negative transference he leaves the institution in an unchanged or relapsed condition. The erotic transference does not have such an inhibiting effect in institutions, since in them, just as in ordinary life, it is glossed over instead of being uncovered. But it is manifested quite clearly as a resistance to recovery, not, it is true, by driving the patient out of the institution - on the contrary, it holds him back in it - but by keeping him at a distance from life. For, from the point of view of recovery, it is a matter of complete indifference whether the patient overcomes this or that anxiety or inhibition in the institution; what matters is that he shall be free of it in his real life as well.

The negative transference deserves a detailed examination, which it cannot be given within the limits of the present paper. In the curable forms of psychoneurosis it is found side by side with the affectionate transference, often directed simultaneously towards the same person. Bleuler has coined the excellent term 'ambivalence' to describe this phenomenon.¹ Up to a point, ambivalence of feeling of this sort seems to be normal; but a high degree of it is certainly a special peculiarity of neurotic people. In obsessional neurotics an early separation of the 'pairs of opposites' seems to be characteristic of their instinctual life and to be one of their constitutional preconditions. Ambivalence in the emotional trends of neurotics is the best explanation of their ability to enlist their transferences in the service of resistance. Where the capacity for transference has become essentially limited to a negative one, as is the case with paranoics, there ceases to be any possibility of influence or cure.

¹ Bleuler, 1911, 43-4 and 305-6. - Cf. a lecture on ambivalence delivered by him in Berne in 1910, reported in the *Zentralblatt für Psychoanalyse*, 1, 266. - Stekel has proposed the term 'bipolarity' for the same phenomenon.

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In all these reflections, however, we have hitherto dealt only with one side of the phenomenon of transference; we must turn our attention to another aspect of the same subject. Anyone who forms a correct appreciation of the way in which a person in analysis, as soon as he comes under the dominance of any considerable transference-resistance, is flung out of his real relation to the doctor, how he feels at liberty then to disregard the fundamental rule of psycho-analysis which lays it down that whatever comes into one's head must be reported without criticizing it, how he forgets the intentions with which he started the treatment, and how he regards with indifference logical arguments and conclusions which only a short time before had made a great impression on him - anyone who has observed all this will feel it necessary to look for an explanation of his impression in other factors besides those that have already been adduced. Nor are such factors far to seek: they arise once again from the psychological situation in which the treatment places the patient.

In the process of seeking out the libido which has escaped from the patient's conscious, we have penetrated into the realm of the unconscious. The reactions which we bring about reveal at the same time some of the characteristics which we have come to know from the study of dreams. The unconscious impulses do not want to be remembered in the way the treatment desires them to be, but endeavour to reproduce themselves in accordance with the timelessness of the unconscious and its capacity for hallucination. Just as happens in dreams, the patient regards the products of the awakening of his unconscious impulses as contemporaneous and real; he seeks to put his passions into action without taking any account of the real situation. The doctor tries to compel him to fit these emotional impulses into the nexus of the treatment and of his life-history, to submit them to intellectual consideration and to understand them in the light of their psychical value. This struggle between the doctor and the patient, between intellect and instinctual life, between understanding and seeking to act, is played out almost exclusively in the phenomena of transference. It is on that field that the victory must be won - the victory whose expression is the permanent cure of the neurosis. It cannot be disputed that controlling the phenomena of transference presents the psycho-analyst with the greatest difficulties. But it should not be forgotten that it is precisely they that do us the inestimable service of making the patient's hidden and

forgotten erotic impulses immediate and manifest. For when all is said and done, it is impossible to destroy anyone *in absentia* or *in effigie*.