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, archetically 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 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, archetically 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 embroiled by the psychosocial viewpoint and the 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 present 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, superordinate 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
adaption 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 confictual 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 analyst 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 extra-transference 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 selfobject 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 resist-
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 archetypal 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 self-object 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 self-object 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 differentiation and integration that were aborted and arrested during the patient'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 experiences 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 developmental or selfobject dimension, that lends to interpretations their mutative 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 discernible therapeutic result unless the analyst is also able to identify the subjective 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 imagoes—that conflictual regions of the patient's subjective life can emerge more freely.

The term transference cure has traditionally been applied pejoratively to indicate that a patient has "recovered" because of the unanalyzed 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 significant element of selfobject transference cure.

Resolution of Transference

What is the ultimate fate of the transference in a successful psychoanalysis? Various authors have recommended that in the termination phase of an analysis the transference (especially the positive transference) 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 without residual transference feelings remaining seems to us to be unwarranted. 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 autonomy and that any residual transference feelings would constitute an infantilizing element, potentially undermining independence and object choices. In contrast, when transference is viewed as an expression of a universal human organizing tendency, analysis aims not for renunciation, but rather for the acceptance and integration of the transference experience into the fabric of the patient's analytically expanded 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 renounced. Within an expanded and more evolved psychological organization, they can be welcomed, just as any valued possession can find a place on the mantelpiece, to be used on special occasions. The remaining 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, differentiated, and richly experienced life.

CONCLUSION

Transference in its essence refers neither to regression, displacement, projection, nor distortion, but rather to the assimilation of the analytic 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.

4

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].