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TOWARD RECONCEPTUALISING TRANSFERENCE: THEORETICAL AND CLINICAL CONSIDERATIONS

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Two fundamentally different models of transference have emerged, designated herein as the displacement and organisation models. The purpose of this paper is to compare the fundamental features of these two models and to contribute to the development and cohesiveness of the organisation model through the consideration of certain theoretical and clinical issues. Transference is defined here to refer to the primary organising patterns or schemas with which the analysand constructs and assimilates his or her experience of the analytic relationship. While repetitive pathological transference organisations that are based on traumatogetic experiences invariably impede a person developmentally and in conflict-resolution, other transference organisations are forward-looking crystallisations of developmentally-needed experiences (selfobject transferences). Transference (and countertransference) is viewed as variably co-determined by analysand and analyst. Clinical issues are delineated concerning the process of illuminating the transference in light of the variable contributions of the analyst to the transference, implications for extra-transference, and the differentiation of process and content to determine the meaning of the transference.

Transference is one of the pivotal, yet most controversial, concepts in psychoanalysis. It is pivotal in that the establishment and interpretation of transference, however defined, typically receives centre stage in psychoanalytic treatment and is considered to be at the core of therapeutic action. Psychoanalysts agree that certain phenomena occur within the psychoanalytic arena that can be called transference. The question of how to describe and explain these psychological processes, however, has generated considerable controversy. How does past conscious and unconscious experience continue to affect the present and, more specifically, the analytic relationship? Our understanding of transference is fundamental because it affects the entire psychoanalytic endeavour in shaping the goals for treatment, the analyst's activity, the timing and content of interpretations, and the range of analytic technique.

In their initial observations, in the Studies on Hysteria, Breuer & Freud (1893-5) reported patients making a 'false connection' by transferring 'on to the figure of the physician the distressing ideas which arise from the content of the analysis' (p. 302). Subsequently, in delineating the formation of dreams, Freud (1900) conceptualised transference as a process wherein an unconscious idea seeking expression (drive-derivatives seeking discharge) gets itself 'covered' by transferring its intensity (displacing) to a preconscious idea (day-residue). This formulation of the process of transference that corresponds with his later, fully developed conceptualisation, wherein transference refers to the transfer or displacement of feelings, wishes and attitudes related to infantile objects on to

Portions of this paper were presented at the annual meeting of the Division of Psychoanalysis of the American Psychological Association on 5 April 1990, New York City.
later objects, especially on to the analyst (Loewald, 1960).

In an often-quoted passage, Greenson summarises what became the classical model of transference:

Transference is the experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which are inappropriate to the person and are a repetition, a displacement of reactions originating in regard to significant persons of early childhood (1965, p. 156, my italics).

The repetitive occurrence of displacements and projections (the latter emphasised by Melanie Klein and those influenced by her, for example, Racker [1968] and Kernberg [1975]) of infantile attitudes and images on to others is seen as resolvable through the establishment and interpretation of the transference within the analysis. Displacements and projection distort ‘realistic’ perceptions of the analyst, who through ‘anonymity’ and ‘neutrality’ attempts to provide a ‘blank screen’ to reflect those displacements and projections. Thus, transference is viewed as inappropriate and solely the intrapsychic product of the patient, remaining unaffected by the personhood or activity of the analyst as long as the analyst remains neutral and anonymous.

The classical model has been amended by many and, recently, radically altered (for a comprehensive review, see Hoffman, 1983). These emendations generally resulted from the increasing recognition of the complexity of the analytic relationship as a two-person interactive field. Specifically, certain aspects of the analytic relationship and the patient’s perceptions could not be attributed to distorting displacements and projections and, therefore, did not properly fall under the rubric of transference. For example, while Freud (1912) referred to the patient’s willingness to work with the analyst, in that it was based on the past, as the ‘unobjectionable positive transference’, Sterba (1934), Zetzel (1956), Greenson (1965), and Loewenstein (1969) all concluded that as the patient’s willingness to work was realistically-based and transference referred to unrealistic or distorted feelings, it could not properly be considered as part of the transference. In turn, they designated it the ‘therapeutic’ or ‘working alliance’. Greenson (1971) referred to other relational dimensions between analyst and analysand as part of the ‘real relationship’, for they did not involve distortions and were to be differentiated from the transference.

Gill (1982) has persuasively argued that, with the inclusion of both the unobjectionable positive and negative transference, Freud’s concept of transference was broader and referred to the ‘“stereotype plate” of the person’s way of relating’ (p. 9), an emphasis shared by Gill. While Gill’s point has validity, Freud’s energy-based theory that transference involved displacements of infantile wishes and feelings laid the foundation for what became the prevalent use of the term, to refer to unrealistic and inappropriate attitudes (see Brenner, 1982, p. 196) that were primarily intrapsychically (not relationally) generated.

In recognising the contribution of the analyst to the ‘transferential’ reaction, Stone (1961) noted that strict adherence to the ‘rule of abstinence’ supplied not a ‘blank screen’, but impactful stimuli that could evoke powerful reactions in the patient. Loewald’s (1960) emphasis on the analyst’s availability as a new object and on the new-object experience addressed a fundamental analytic process that was not a repetition of the past and, therefore, could not be called ‘transference’. Kohut (1971) observed what he at first called ‘transference-like phenomena’ in the patient’s use of the analyst to consolidate and regulate a sense of self and, subsequently, termed this the ‘self-object transference’ (Kohut, 1977, 1984). Since the central feature of the self-object transference is not the repetition of the past, but an expression of current developmental and regulatory needs and strivings, it too does not fit comfortably under the traditional rubric of transference, and has required an expansion of the concept. These finely-honed distinctions were stretching the classical model of transference to the point of jeopardising its fundamental features.

More recently, partially as a continuation of these changes and specifically through extricating transference from drive and energy theory, through increasingly recognising the contribution of both the analyst and the analysand to
the analytic field, through assimilating contemporary theoretical development especially in object-relations theory, self psychology and interpersonal theory, through integrating cognitive psychology and particularly Piagetian theory, and through gradually shifting from a positivistic to a relativistic (or perspectivistic) scientific outlook, a fundamentally new model of transference, albeit with many variations, has emerged and continues to evolve. Although many, including those ‘amenders’ mentioned above, have contributed to the evolution of this model (Gill, 1982; Hoffman, 1983, 1991; Hoffman & Gill, 1988; Kohut, 1971, 1984; Lichtenberg, 1989; McLaughlin, 1981; Racker, 1968; Sandler, 1976; Schwaber, 1981, 1983; Searles, 1978-9; Stolorow & Lachmann, 1984-5; and Wachtel, 1980, to name some of the most notable), I wish to draw particularly on the similar, overlapping Piagetian-influenced models delineated by Gill (1982), Hoffman (1983, 1991), Hoffman & Gill (1988), Stolorow & Lachmann (1984-5), and Wachtel (1980). The models these authors propose are by no means unitary, but they share in some of their fundamental elements. The purpose of this paper is to contribute to the development and cohesiveness of an emergent model of transference, which I call the organisation model, through bringing together some of the common elements and through further exploration of certain theoretical and clinical issues. Specifically, I will delineate and compare the fundamental features of this model with the ‘classical’ model of transference and address some of the theoretical and clinical ramifications.

**TRANSFERENCE AS ORGANISING ACTIVITY**

The emergent model of transference centres on the on-going perceptual-cognitive-affective organisation of our lives. Cognitive psychology has clarified that ‘neither as children nor as adults do we respond directly to stimuli per se. We are always constructing reality every bit as much as we are perceiving it’ (Wachtel, 1980, p. 62). The predominant ways in which we have come to see ourselves and ourselves in relation to others are the affect-laden thematic organisations that variably shape our experience. These affect-laden organising principles or schemas (I use the terms as equivalent) do not distort a supposed ‘objective reality’, but are always contributing to the construction of a subjectively-experienced ‘reality’. The perceiver, whether patient or analyst, always contributes to the perceived, both through the perceptual process itself and through affecting the interpersonal process. Transference is the patient’s assimilation (Piaget, 1954) of the analytic relationship into the thematic structures of his personal subjective world ... transference is neither a regression to nor a displacement from the past, but rather an expression of the continuing influence of organising principles and imagery that crystallized out of the patient’s formative years (Stolorow & Lachmann, 1984-5, p. 26).

The thematic affect-laden organisations of experience usually operate unconsciously, that is, outside-of-awareness, and are illuminated as they emerge within the analytic relationship.

Regarding the definition of transference, Gill & Hoffman (1982) (and Hoffman & Gill, 1988) equate transference with ‘the patient’s experience of the [analytic] relationship’ (p. 4). Although the patient’s perceptual-affective-cognitive organisation of the relationship is implicitly imbedded in ‘the patient’s experience’, their definition of transference does not highlight the patient’s affective-cognitive schemas activated within the analytic relationship. Moreover, I believe that the singular relationship focus in their definition is a more limiting conceptualisation and positions us clinically to frame, in an overly-restrictive fashion, the patient’s associations as consistently referring to the analytic relationship. To define transference

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1 Stone (1981) and Wallerstein (1984), in a critical examination of Gill’s work, conclude that his recognition of the contribution of the analyst to the transference and emphasis on the here-and-now experience of the analytic relationship are but differences of emphasis, not expressions of a new model. In contrast, I believe, in concurrence with Gill (1982), Hoffman (1983, 1991), and Stolorow & Lachmann (1984-5) that a detailed comparison of the various dimensions of transference (to follow) reveals a fundamentally new model. The arguments for this position are developed throughout the paper.
in terms of activated schemas can include more comprehensively all experiences that emerge in the analytic process, in which the analytic relationship may or may not be in the foreground. For example, when the analysand is feeling criticised (an organised experience), he may experience this as emanating from either himself or the analyst. The analysand’s discussion of extratransferential material may or may not have a direct bearing on the analytic relationship (to be discussed). Moreover, while Gill & Hoffman’s (1982) definition ties transfer to the analytic relationship, to refer to on-going organising activity and schemas provides a definition that more easily bridges the analytic relationship with relationships at large.

**TRANSFERENCE: TWO MODELS**

To reflect the core process posited in each model of transference, I have selected the terms displacement and organisation to designate the two respective models. I present what I consider to be the most fundamental features that distinguish these two models as follows:

1) **Core Process:**

*Displacement model:* through displacement, the patient inappropriately transfers feelings, wishes and attitudes that belong to past figures to the analyst.

*Organisation model:* through the use of primary organising principles, established through past experience, the patient perceptually and cognitively shapes (for example, through selective attention and giving affect-laden meanings) the experience of the analytic relationship.

2) **The Nature of Reality:**

*Displacement model:* through displacements, the patient distorts the reality of the analyst, based on the proposition that there is an objective reality.

*Organisation model:* through organising principles, the patient (as well as the analyst) perceives and organises the experience of the analytic relationship that becomes his/her subjective reality, based on the proposition that ‘reality’ is relative to and always partially determined by the perceiver.

3) **Scientific Paradigm:**

*Displacement model:* is fundamentally based on positivistic science, in which an objective reality and an objective observer are posited.

*Organisation model:* is fundamentally based on relativistic science, in which it is understood that reality is relative to the observer, for the observer shapes that which is observed.

4) **Structural Features:**

*Displacement model:* transference is a temporally and structurally regressive process.

*Organisation model:* primary organising principles are always potentially operative and subject to change more or less through accommodation to new experiences; more structurally-regressed schemas (that is, less complex and more immature psychological organisations) are often triggered in analysis.

5) **Motivational Model:**

*Displacement model:* transference is fuelled by libidinal and aggressive drives and, specifically, by drive-derivatives related to infantile wishes and fears and conflicts around same; the repetition (compulsion) of the childhood conflict in relation to the analyst serves as a resistance.

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2 Wachtel, Gill, Hoffman, and Stolorow & Lachmann have each addressed some of these features with some overlap, but without unanimity. In addition to significant differences and emphases regarding the definition of transference, an area of considerable disagreement is the motivational model underlying perceptual-cognitive processes.

3 When the concept of displacement is extricated from a drive-energy substratum, it still denotes a defensive process (for example, transference is viewed as a defence against remembering). In contrast, within the organisation model, schemas may serve, but are not limited to, defensive functions. Displacement refers to a defensive organisation.

4 Hoffman (1983) and Gill (1984) stress that the patient’s experience is ‘plausible’, namely, the patient selects cues in the analytic relationship that make the experience ‘plausible’ from the patient’s perspective. While Kohut (1971, 1977, 1984) combined old and new elements in his conception of transference, his emphasis on the empathic mode of observation similarly places the patient’s subjective experience and the patient’s vantage-point (which is always plausible to the patient) into the forefront of the field of investigation.

5 Relativistic (or perspectivistic) science, initiated by the formulation of Heisenberg’s Uncertainty Principle, takes into account that the observer affects the ‘reality’ observed. The ‘reality’ exists, but is always variably shaped by and, therefore, relative to the perceiver. Relativistic science is not to be confused with the philosophical theory of relativism in which the world is viewed, as Goldberg (1988) puts it, ‘as a variable thing that need have no inherent composition, but is shaped by the perspective of the observer’—what Orange (1992) calls ‘perspectival realism’ or ‘perspectivalism’.
to remembering and, as Freud conceived it, is, principally, biologically-driven by aggression (and, ultimately, the death instinct).

Organisation model: perceptual-affective-cognitive organisation of experience and its maintenance is a fundamental human striving. A striving to organise experience or to create meaning is experientially validable but, in my view, is not sufficient to account for the various and complex strivings in our lives. To capture these strivings, Lichtenberg (1989) has posited a comprehensive motivational theory involving five motivational systems: the physiological, attachment-affiliation, exploratory-assertive, aversive, and sensual-sexual systems. These motivational systems are integral to the overall development, maintenance, and restoration of a vital, cohesive sense of self. Each system affects, developmentally as well as from moment-to-moment, the emergence and dominance of a particular schema.

6) The Analyst’s Contribution:

Displacement model: as long as the analyst maintains, through neutrality and anonymity, a blank-screen position, he/she is viewed as not contributing to the transference.

Organisation model: transference is co-determined by the analysand and analyst through their respective subjectivities and interaction.

7) Illuminating the Transference:

Displacement model: to illuminate the transference, the analyst, through providing a blank screen, reflects, understands, and explains the distorting influence of the patient’s displacements and projections on to the analyst.

Organisation model: to illuminate the transference, the analyst, through his/her participation in the analytic field, reflects, understands and explains how the patient experiences and organises the analytic relationship with particular emphasis on primary problematic schemas. (Self psychologists also emphasise the selfobject or vitalising organisations, to be discussed.) The contribution of the analyst is frequently acknowledged.

8) The Nature of Change:

Displacement model: resolution of the transference entails renunciation of infantile wishes and fears, which enables less distorted and more realistic perceptions.

Organisation model: the primary problematic schemas gradually become less dominant, either through modification (that is, through a process of accommodation) and/or through the establishment of additional organising principles, increasing the range and complexity of experience (decreasing the frequency of use of primary problematic schemas).

Some theorists span these two basic models. For example, Brenner views transferance as both a compromise formation (displacement model) and a type of object relation, namely, a ‘new edition of the first, definitive attachments of childhood’ (1982, p. 194)—the emphasis is not on displacement, but on relational patterns, which corresponds with the organisation model wherein attachment is the primary motivation that evokes particular schemas. Transference derives from ‘drive derivatives of early childhood’ (p. 195)—the displacement model; but it is operative in all object relations, corresponding with either the displacement or organisation models. Transference is not inappropriate, but is an aspect of every relationship—a fundamental feature of the organisation model.

During a time of conceptual change, analysts often practise variably in a transitional area somewhere between the old and emergent models. An analyst, for example, using the displacement model may consider himself a perspectivist and disagree with the description of the traditional model as currently positivistically-based. Recognising that the perspectives of the analyst and analysand are different, however, tends to enable the analyst to explore and assess, at least initially, the transferential experience from ‘within’ the perspective of the analysand. From this ‘within’ perspective the plausibility of the analysand’s organised experience becomes comprehensible. When the analyst begins to describe the transference as distorting the ‘reality’ of the analyst and as inappropriate, the analyst crosses over into a positivistically-based ‘objective’ observer position, judging from the ‘outside’, that is, outside of the analysand’s perspective and from the analyst’s perspective—what Schwaber (1981) has called the ‘two realities’. These subtle, yet substantial, shifts often occur without awareness and emanate from a rapid crossover between models.
An example of the shifting utilisation of these models occurs in Roth & Segal’s (1990) discussion of the case of P (Fosshage, 1990), wherein they change, without noting, from the patient’s viewpoint—‘felt-to-be-exploitative, felt-to-be-invasive aspects’ (p. 547)—to an external or ‘objective’ perspective—‘this patient does exploit her objects, feels badly about it’ (p. 545). The first description portrays a self-organisation, allegedly as experienced by the analysand. The second statement is phrased as an ‘objective’ judgement (which, from a perspectivist position, is the analysist’s perspective), followed by the analysand’s presumed feelings. Listening from an ‘objective’ position, as opposed to the ‘within’ perspective, core differences between the two models, crucially shapes the analyst’s readings of the patient’s moment-to-moment transference and the analyst’s interpretive interventions. In this instance, even what was presented as the patient’s viewpoint was actually emanating from the analyst’s perspective, in the sense that, in the transcribed sessions, P described her experience of others as exploitative and invasive—a schema of the other—and did not refer to herself as exploitative and invasive. Even when the focus is presumed to be on the analysand’s experience, the ‘objective’ position, in addition to the emphases on intrapsychic genesis and distortion within the displacement model, enabled the discussants to replace P’s expressed experience of others as exploitative and invasive with their view (or perspective) of her as feeling exploitative and invasive. In other words, P’s articulations were viewed as a distorting projection. The perspectivist, in contrast, would attempt to understand the plausibility of P’s experience as expressed and, therefore, would tend to explore the origins of her expressed relational experience of others as exploitative and invasive.

Similarly, today many recognise that the analyst is not just a blank screen and does contribute to the transference. Analysts differ remarkably, however, in utilising the ‘blank screen’ or ‘co-determined’ models. An example of the blank-screen model is evident in Burland’s (1990) discussion of the case of P. Burland, sketching a picture of the analyst as not participating in eliciting P’s negative reactions, states: ‘that the patient’s perceptions of me as cold and ungiving are transference projections ... not related to the actuality of my feelings for the patient or my efforts at silently and internally affectively tuning in’ (p. 513). As Burland rejects P’s perspective and assesses from his own perspective, he views himself, as the analyst, as not contributing to the negative transference—a blank-screen model. In contrast, I viewed P as highly sensitive and attentive to those moments in which I was withholding (ungiving) or was misattuned—that is, both the analyst and analysand contributed to the latter’s transferential experience (see Fosshage, 1990, p. 618). (The variability in the co-determination of the transference will be discussed.)

While many of us find ourselves functioning somewhere within the transitional area between these two models, clarification of the fundamental features of each model and their clinical implications facilitates understanding of the origins of our analytic perceptions and subsequent interventions.

TRANSFERENCE AND NON-TRANSFERENCE

If transference is an expression of our universal striving to organise experience, what is non-transference? Can we distinguish between transference and non-transference?

The conceptualisation of transference as an organising activity nullifies the clear dichotomy between distorted and realistic perceptions and the use of this dichotomy to differentiate transference from non-transference. Gill deals with this theoretical conundrum by differentiating between ‘pathological and non-pathological transference’ (1984, p. 513), referring to the patient’s pathological and non-pathological experience of the analytic relationship. He uses the term transference ‘[where] not further qualified ... to mean pathological transference’ (p. 513). In a similar effort, Hoffman details

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6 Dreaming, as I have spelled out in a revised model of dream formation (Fosshage, 1993, and with Loew, 1987), is a mentational process, which also provides, through primary (re-defined as imagistic mentation) and secondary process, a supraordinate organising function (in contrast to an energy-discharge function).
the distinguishing features of what he calls the 'neurotic transference' as follows:

the patient is selectively attentive to certain facets of the therapist's behavior and personality; that he is compelled to choose one set of interpretations rather than others; that his emotional life and adaptation are unconsciously governed by and governed of the particular viewpoint he has adopted; and, perhaps most importantly, that he has behaved in such a way as to actually elicit overt and covert responses that are consistent with his viewpoint and expectations (1983, p. 394).

When viewing transference as organising activity, wherein current experience is assimilated into previously-established schemas, the features Hoffman describes more or less apply to all transferential activity, not just to 'neurotic' activity. These features apply *variably* to all organising activity in the analytic setting. How compelling a particular schema is will vary; but this variance is quantitative along a continuum. All of these features are best viewed not as dichotomous categories, but as *continuous and quantitatively-variable dimensions of organising activity*. Other dimensions of a schema that vary quantitatively are frequency of use, modifiability (rigidity), and conscious awareness.\(^7\)

As we make the conceptual shift, to viewing transference as continuous organising activity, we need to delineate further dimensions of that activity and to focus our study intensively on how schemas become established, operate, and change. For example, what makes it so difficult for a person to alter the dominance of a negative self-schema, even with awareness of it and of its origins?

While the term transference valuably addresses the linkage between the genetic past and the present, its terminological emphasis on 'transferring' the past to the present does not adequately embrace the conceptualisation of on-going perceptual-affective-cognitive organising activity. *Schemas are activated, not transferred*. Moreover, transference specifically refers to a discrete category of experience, whereas organising activity is continuous. To refer directly to the patient's *organising activity* and *schemas* reflects the new model more adequately and more easily. Yet transference has always been a central construct in psychoanalysis and its continued usage with the new model provides the necessary historical linkage. Therefore, I use the term *transference to refer to the primary organising patterns or schemas with which the analysand constructs and assimilates his or her experience of the analytic relationship*.

Schemas can be activated internally (with shifts in motivation and self-states), or externally (by the analyst and others). While repetitive pathological schemas (what Weiss & Sampson [1986] refer to as pathogenic beliefs) based on traumatogenic experiences variably impede a person developmentally and in conflict-resolution, other transferential organisations are forward-looking crystallisations of developmentally-needed experiences (for example, mirroring, and idealising selfobject transferences, see Kohut, 1971, 1977, 1984). The concept of transference is expanded here to include the full range of thematic organisational activity, from the pathological to the healthy and to the strivings for vitalising (selfobject) experience (Lachmann & Beebe, 1992; Lichtenberg, 1990; Lichtenberg et al., 1992; Stolorow et al., 1987).

**TRANSFERENCE WITHIN AN INTERSUBJECTIVE CONTEXT**

The classical conceptualisation of transference, emphasising the patient's fantasies as reflected by the blank screen of the analyst, minimises the contribution of the analyst. Transference conceptualised as organising activity that occurs within the analytic arena accentuates the importance of the intersubjective field and both the patient's and the analyst's contribution to the events occurring within that field. Patient and analyst variably co-determine

\(^7\) Modifiability of a schema corresponds, as Wachtel (1980) points out, with Piaget's description of the tendency toward accommodation (modifying the schema) or assimilation (the data being integrated into a pre-existing schema without modifying the schema).
the patient's transference or activated schemas. For example, the 'personal presence' of the analyst facilitates or encumbers a patient's establishment of selfobject transference (Kohut, 1984). 'Different weights', as Gill (1982, p. 178) notes, can be assigned to the patient and analyst as the two sources of determinants of the transference. The range of contribution for each varies from minimal to considerable.

While using the displacement model, the origins of the patient's current experience of the analytic relationship is usually ascribed to the distorting perceptions of the patient and misses the contribution of the analyst; using the organisational model, there is a tendency to assume that the analyst is always significantly contributing to the patient's momentary construction. This latter assumption is challenged on those occasions, for example, when patients assert that their expectations are quite contrary to what they know the analyst's response will be (I am speaking here of those times when the patient is not defensive, but is able to maintain a new perspective side by side with the old). While the analyst's responses, over time, have provided the basis for a 'new' experience and for a patient's emergent perspective, the patient's more typical expectations at a given moment may primarily be generated intrapsychically. These moments of primarily intrapsychically-generated constructions correspond best with the so-called 'distortions' of the displacement model, because the latter is pre-eminently an intrapsychic model. Recognising that both the patient's and analyst's contributions to the patient's transference vary provides us with a more flexible approach to understanding the triggers of the 'here-and-now' experience.

With transference variably co-determined, it follows that each analyst, by the nature of his/her personality, will tend to elicit certain transferential configurations and not others. These differences undoubtedly contribute to their differing clinical findings and theoretical inductions. Friedman provides an example, from Gill's work, of the impact of a technical stance:

Very generally, as a good analyst, Gill tends to behave like someone who neither wants nor appreciates any one attitude from his patient more than any other, and that by itself demolishes a lot of transferences! (1984, p. 174).

COUNTERTRANSFERENCE

Countertransference, terminologically, emphasises reactions to the transference, and thereby fails to capture the complexity of the analyst's involvement (see Aron, 1991, for a similar assessment). In its emphasis on reactions to the transference, the term implies that the patient is always the primary elicitor—what McLaughlin (1981) refers to as 'the patient-centered focus' of the term. Instead, analyst and analysand enter the analytic arena with their respective subjectivities, with which they interactively construct their experience (Atwood & Stolorow, 1984; Stolorow et al., 1989). Patient and analyst variably co-determine the countertransference and, as with transference, the contribution of each can range from minimal to considerable. Each analyst will react somewhat differently to the 'transference pull'; and, as I have discussed, each transference and, therefore, transference pull, will vary according to the influence of the analyst.

The same arguments previously set forth, with regard to the fallacious dichotomy between transference and non-transference, likewise apply to the dichotomy between countertransference and non-countertransference. For these reasons, McLaughlin (1981) suggests that we use the term 'transference' to address both the patient's and the analyst's experiences. The analyst's experience could be called transference in that the analyst's organising activity is involved; yet, in my judgement, it is not the analyst's organising activity per se that concerns us most, but, more specifically, the analyst's experience of the patient. For this reason and for clarity of communication, I retain the term 'transference' to address solely the patient's experience. In contrast to the term 'countertransference', I propose that simply to refer to the analyst's experience of the patient, with its phenomenological emphasis and inclusion of the full participation of the analyst's subjectivity, is both a more comprehensive and clinically heuristic rubric.
In contrast, Hoffman (1991) suggests that the terms ‘transference’ and ‘countertransference’ be retained, for they reflect the asymmetrical arrangement of the analytic relationship and refer appropriately to the patient’s and analyst’s respective experience of the relationship (p. 100). The asymmetry refers to the two (that is, patient and analyst), unequal, directions of influence. Despite the cogency of Hoffman’s point, the variability in patient and analyst influence is, in my judgement, not adequately reflected in the transference–countertransference terminology. The analyst, just like the patient, may compellingly and selectively attend to minimal cues in organising his/her experience of the patient. Although the analyst’s focus is the illumination of the patient’s transference, each analyst brings to the task not only his/her particular schemas, but also fluctuating motivations, needs and self-states. The analytic relationship is an ongoing complex system of variably mutual interactive influence (Beebe & Lachmann, 1988; Lichtenberg et al., 1992) between the analysand and analyst. 8

The transference–countertransference equation does not, terminologically, adequately capture this interactional matrix and tends, through its connotative as well as its denotative meaning, to mislead us in our attempts to understand this matrix.

THE ANONYMITY OF THE ANALYST

Within the classical model of transference, the anonymity of the analyst is maintained for the purpose of providing a blank screen. Recognising that the analyst’s attempts at anonymity are, in fact, revealing of communicative actions, which impact the patient and the patient’s transference, seriously undermines the viability of the concept. To attempt to maintain anonymity in the clinical arena is futile (Singer, 1977). Despite our attempts to remain anonymous by withholding details of our personal lives (itself a communicative action), we reveal ourselves significantly through overtures of greeting, tonality, facial expressions, dress, management of fees, sitting position in relationship to the patient, and ending of sessions, to mention only a few. In addition, we reveal our subjectivity through our lines of investigation and the thematic organisations of the clinical material. As revelations of the analyst as a person are inevitable, the notion of anonymity within a two-person field model is neither valid nor a viable technical stance. Even to speak of relative anonymity does not adequately describe this complex relational matrix. What do we place in its stead?

The analytic process primarily entails placing the patient and the patient’s experience in the foreground of focus, while the analyst’s concerns (and personal life) recede into the background. The function of this asymmetrical arrangement is not to conceal the analyst’s identity in order to provide a blank screen, but to maintain the patient’s experience in the foreground of attention for the purposes of analysis. It is assumed that both participants contribute variably to the patient’s experience (and to the analyst’s experience).

While analysts use general ‘rules’ (which vary according to the model) for guiding the analytic process, each analysis, through the deep engagement of both participants, as Ornstein (1990) has pointed out, ‘is always highly idiosyncratic for both participants’. A wide range of interventions not only occur

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8 In a recent paper on countertransference (1992a), I attempted to spell out some of the factors contributing to the analyst’s experience of the patient, focusing particularly on the impact of two principal listening perspectives. The analyst can resonate experientially with the patient’s affect and experience from the patient’s vantage-point, that is, from what I call the ‘within’ or subject-centred listening perspective (self-psychology’s emphasis); and the analyst can experience the patient from the vantage-point of the other person in a relationship with the patient, what I call the ‘as-the-other’, or other-centred listening perspective (frequently the emphasis of interpersonal and object-relations approaches).

9 The interactive influence of two subjectivities is substantially imbedded in Kohut’s work and was clarified and further elaborated in Stolorow et al.’s (1987) theory of intersubjectivity.

Stolorow et al. (1987) use the concept of intersubjectivity, as I use it in this paper, to emphasise the interaction of two subjectivities in the analytic arena (in contrast to Stern’s [1983] ‘intersubjective relatedness’, a form of relatedness). Gill (1984) uses the terms ‘interpersonal’ and ‘interactive’ as equivalent with the term ‘intersubjectivity’ (p. 509).
(Wallerstein, 1986), but are required in psychoanalysis (Fosshage, 1990; Lichtenberg et al., 1992). Interventions range from investigatory and reflectively-interpretive remarks to spontaneous supportive, educative, and self-disclosing responses. What and how much is revealed or expressed, or how direct a response is given, or the nature of the interpretive formulation, will all be shaped by the analyst’s subjectivity, as well as the patient’s, and, therefore, will vary from analyst to analyst.

Apart from general technical guidelines, I find the analyst’s authenticity—meaning a non-defensive presence—to be an overriding factor that proves essential for the continuation and facilitation of the analytic process. For example, on those occasions when a patient needs a more direct and self-revealing response (there would, of course, already be disagreement around the issue of ‘need’), the analyst’s authentic interaction enables the analyst to be more comfortably related to the patient and vice versa. When the analyst’s response is insufficient from the patient’s vantage-point, the patient will undoubtedly react, and at times most intensely, potentially jeopardising the analyst’s equilibrium. If the analyst has behaved in a way that is more comfortably ‘his/hers’, then the analyst will be less likely to resort to self-protective or self-restorative operations and, in turn, will be better able to sustain both self-reflectiveness and empathic immersion in the patient’s subjectivity.

**IDENTIFICATION OF THE PATIENT’S PRIMARY SCHEMAS**

As both patient and analyst contribute variably to the activation of the patient’s primary schemas, the patient will only be able to observe and identify a particular organizing principle when the contribution of the analyst is sufficiently minimal that alternative interpretations, from the patient’s vantage-point, are feasible. Sketching a clinical illustration, Hoffman (1983) points out that a patient may have a readiness to feel used, may detect and be selectively attentive and sensitive to whatever qualifies as a plausible indication of an exploitative motive on the part of the particular analyst he is seeing (pp. 409-10).

To extend Hoffman’s view, I would suggest that the degree of exploitativeness of the analyst (ultimately, as assessed by the patient) will determine on a given occasion whether the transferential experience becomes simply a replication of the traumatogenic experience, and thereby confirming of the particular schema (in this instance, that others are exploitative), or becomes analysable and helpful in illuminating the patient’s schema.

When the analyst’s contribution is relatively minimal, as assessed from the vantage-points of analyst and patient respectively, the analyst is probably able to maintain a more neutral (non-defensive) investigatory stance in illuminating the particular schema and the patient is in a better position to note his/her proclivities for particular constructions of experience. In contrast, if the analyst’s contribution is considerable, from the patient’s perspective, alternative constructions of the experience will, typically, not be possible. If the analyst persists in attempting to identify the schema in this circumstance, the patient can easily experience the analyst’s activity as defensive and/or as invalidating of the patient’s own experience. The patient’s proneness to view the other as exploitative will not be illuminated, but the view will be confirmed once again. In Piagetian language, the degree of convergence of the data with the prevailing schema, as assessed by the patient, will determine in large measure the patient’s assimilation of the data into the schema, or the patient’s accommodation of the schema. 10

Using the displacement model, it follows that a change in the analyst’s stance (apart from ‘parameters’) would be viewed as altering the blank screen, as interfering with the development of the transference, and probably as countertransferentially-derived. Using the organisation model, it follows from the notion of co-determination of transference that the

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10 Using a different model, Strachey similarly noted that the analysis of the superego projection in the transference was made possible through the patient contrasting his/her feelings with that of the analyst (1934).
analyst can justifiably alter his/her behaviour to vary his/her contribution. For example, when a problematic schema is easily triggered (for instance, if the analysand is quick to feel intruded upon, and consequently feels obliterated), the analyst will initially need to take special care not to contribute ‘too much’ to the activation of the schema. To avoid certain behaviour, at least temporarily, can convey understanding through actions and facilitate a new relational experience, providing sufficient leverage (contrast) for the illumination of the schema.

When there are transferential reactions, it is essential, as Stolorow & Lachmann write, 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 ... (1984-5, p. 27).

Furthermore, it is the analyst’s act of illuminating these events and correspondent meanings that contributes substantially to the patient’s experience of the analyst in a new way (the new relational experience), such that the old schema is not simply confirmed but is identified and gradually transformed (Fosshage, 1992b).

When the analyst’s contribution has been considerable or when the patient is attempting to consolidate belief in the ‘validity’ of his/her perceptions, the analyst’s continued attempts to stay exclusively focused on the patient’s experience (that is, a sustained empathic immersion) will encounter difficulty.11 The patient may require acknowledgement of the analyst’s contribution to feel ‘heard’ and validated and to understand his/her experience within the intersubjective field. For example, in those cases where the patient’s parents consistently denied responsibility for troubled encounters and blamed the patient, implicit or explicit acknowledgement from the analyst is especially important. To focus exclusively on the patient’s subjectivity will not only impede illumination of the interaction, but may create a potential danger for some patients of replicating (to the point of unanalyzability) the traumagenic experience outlined above, as well as contributing to an isolating solipsistically-experienced world.

TRANSFERENCE AND EXTRATRANSFERENCE

Some posit that all communications, including extravasal transferents, as to be viewed as containing transferential referents that need to be continuously examined. Gill, a forceful proponent of this position, has ‘retreat[ed] from saying “always”’, but adds ‘that what should usually ... get first attention is the meaning the associations have for the transference’ (1984, p. 492). In so doing, the analyst places the analytic relationship consistently into the forefront of the analysis, a procedure criticised by others for potentially provoking persistently disruptive resistances and impasses (see Wallerstein, 1984, for a review).

This technical recommendation is based on an assumption that all transferrential configurations will ultimately emerge in the analytic relationship. When transference is viewed as co-determined by analyst and analysand (interestingly, a view that Gill holds), it follows that each analyst will affect the transference differently. It is quite possible that a particular analyst might not directly elicit all of a patient’s primary problematic organising principles. Clinically, perhaps most, but not necessarily all, problematic schemas emerge directly in relationship to the analyst. Apart from the analyst’s variable contribution, activation of the schema is potentiated by anticipatory fantasies or minimal cues. To assume, however, that all problematic transversional configurations will be activated directly in relationship to the analyst imposes an unrealistic and burdensome agenda on both analyst and patient.

For example, at a major conference several

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11 Bacal & Newman make the same point: ‘A predetermined attitude on the part of the therapist that his only function is to offer sustained empathic enquiry ... will not always enable his patient to feel understood and may even be experienced as an invalidation of his perceptions (1990, p. 258).
years ago, an esteemed analyst presented detailed case material in which the male patient excoriated his wife for her ‘deadness’. The analyst was essentially dealing with the material ‘extratransferentially’. Another esteemed analyst criticised the first for ‘countertransferentially blocking’ the emergence of this material within the transference. Most striking to me was the fact that the treating analyst was an energetic and ‘alive’ woman, whose personality would offer few cues for the activation of this particular schema (that is, ‘deadness’ in a woman).

The assumption and expectation that all transferential configurations will emerge directly in the analytic relationship can also conceal recognition of and disrupt the momentarily new relational experiences that occur during the analysis, just at those times when the patient is experiencing being heard and understood in a new way as he/she describes an extra-analytic situation. To assume that extratransferential material refers directly to the analytic relationship can easily blur differential experiences and inadvertently rivet the patient to the particular transference configuration. All communications within the analytic setting have transferential meaning; the meaning, however, may not be related to the content but to the process of communicating. For example, a patient may be recounting an abusive experience with another person, not because he/she is ‘latently’ experiencing the analyst as abusive (that is, interpreting the content as applicable to the transference), but because he/she is experiencing the analyst at that moment as sufficiently safe and protective as to enable him/her to communicate the painful experience (that is, interpreting the communicative process as having transferential meaning). To distinguish between content and process is essential in ferreting out the repetitive from the new relational experiences.

While Gill’s emphasis on the here-and-now transference is invaluable, I believe his failure to make the distinction between process and content in his view ‘that “an unconscious transference situation” is always present in the analysis and should be searched for in the indirect allusions to the transference’ (1982, p. 54) often results in strained, constrictive and inaccurate interpretations, evident in some of the clinical illustrations (also in Gill & Hoffman, 1982).

Moreover, the complexity of human relations and the vast range of experience outside the analytic scene, as Stone (1981) and Rangell (1981) have elucidated well, cannot be condensed into one relationship without losing the richness and variety of extra-analytic experiences.

THE DEVELOPMENTAL DIMENSION OF ORGANISING ACTIVITY

In describing the analyst’s task, Rangell paraphrases Anna Freud:

The analyst hovers, equidistant not only from the three psychic structures but between intrapsychic and interpersonal, the internal and external world, past and present, transference and original objects (1981, p. 678).

What is missing in the time sequence is the concept of the future—what is the patient developmentally striving toward? This emerges as a fundamental motivational question.

The initial trust of the analyst that enables a person to enter treatment has been referred to as the ‘unobjectionable positive transference’ (Freud, 1912), the ‘facilitative transference’ (Gill, 1982), and the ‘therapeutic’ or ‘working alliance’ (Greenson, 1965; Loewenstein, 1969; Sterba, 1934; Zetzel, 1956). While only the unobjectionable positive transference and facilitative transference are viewed as dependent on the past, all three concepts refer to the realistic, conscious, reasonable and reflective capacity of the patient that joins with the analyst in the analytic endeavour. What these concepts omit, primarily because of the drive model, are the patient’s developmental strivings, which are engaged in treatment and serve as a fundamental motivation for treatment. Classical analysts, for example Greenson (1967), clinically recognise a ‘striving for health’, or ‘recovery’ (p. 74), but the strength of these
strivings, in my judgement, is insufficiently recognised, either clinically or theoretically, because they are not given primary motivational status (Fosshage, 1992b).

Others have delineated the ‘new beginning’ (Balint, 1968) and the curative impact of the new relational experience that occurs within analysis (for example, Alexander, Ferenczi, Guntrip, Loewald and Winnicott). These new relational experiences and corresponding developmental movements are, typically, not placed under the rubric of transference because they are not repetitions of the past.

Kohut (1971, 1977, 1984) explained more specifically how the patient developmentally uses the analyst for the provision of particular functions pertaining to the consolidation and maintenance of the self. Although Kohut (1971) originally described these mirroring, idealising and alter-ego phenomena as ‘transference-like’, because they were not viewed as repetitions of the past, he subsequently (1977) referred to them as ‘selfobject transferences’. I believe he chose the rubric of ‘transference’ to create a status for selfobject experiences equal to that of the repetitive transferences. While selfobject transferences are related to the past, in that they involve the re-establishment of prematurely-ruptured (in the past) selfobject connections, the selfobject concept within the analytic arena emphasises the emergence of previously-aborted developmental need and the use of the analyst to further development. Hence, the concept of transference was expanded.

In emphasising self development, Kohut (1984) gave developmental strivings basic motivational status in postulating an inherent striving, an ‘enduring wish to complete his development and to realize the nuclear program of his self’ (p. 148). Positing a developmental motivational model and a selfobject dimension of organising activity (that is, experiences of the analytic relationship can either be vitalising or devitalising [Lichtenberg, 1991]; what Stolorow & Lachmann [1984-5] call the selfobject dimension of the analytic relationship) alerts the analyst to a different and important realm of the patient’s experience—that which the patient is developmentally striving toward, or the ‘leading edge’ of the clinical material (Miller, 1985).

The analysand’s strivings for the developmentally-required selfobject (vitalising) experiences oscillate from foreground to background with the activation of problematic schemas (Stolorow & Lachmann, 1984-5). These dimensions of the analytic experience are far more intricately interwoven than previously conceptualised. For example, when the patient is experiencing the analyst as affectively attuned and understanding of his/her experience (that is, the selfobject connection is stable and either in the foreground or background), the problematic repetitious relational configurations (schemas) will not be operative in the analytic relationship (although they may be operative in extra-analytic situations). If the analyst fails to understand, becomes misattuned, or the patient’s stress increases, a repetitious relational configuration involving a selfobject rupture (a schema) may be precipitated in relationship to the analyst. Problematic schemas entail selfobject failures or, more simply, are devitalising organisations.

The analyst will experience powerful transferential ‘pulls’ that emanate both from the patient’s repetitious, pathological relational configurations and from the patient’s strivings for the needed vitalising (selfobject) experiences. While, technically, our general guideline is to illuminate and interpret both the repetitively problematic and developmental configurations, when the selfobject-seeking dimension is in the foreground, the analyst must resonate at the deepest layers of his/her personality (Kohut, 1977, p. 252) to be sufficiently available and responsive to the patient’s developmental and self-regulatory needs (a topic of great complexity). The analyst’s subjectivity (for example, how the analyst responds to being idealised, experienced as an equal, or as a worthy competitor) once again will substantially shape his/her reactions to the selfobject dimension of the analytic relationship and, in turn, the analysand’s experience. The analysand’s strivings for the developmentally-required selfobject experiences, together with the problematic schemas, receive primary focus in analysis.
TRANSLATIONS OF SUMMARY

Deux modèles de transfert fondamentalement différents émergent, désignés en ceci comme les modèles de déplacement et d’organisation. Le but de cet article est de comparer les traits fondamentaux de ces deux modèles et de contribuer au développement et à la cohésion du modèle de l’organisation à travers la considération de certaines problématiques théoriques et cliniques.

Je définis ici le transfert comme les patterns ou schémas organisationnels primaires qui sont activés au sein de la relation analytique. Alors que les organisations transférentielles pathologiques répétitives qui sont basées sur les expériences traumatogéniques entravent diversément le développement et la résolution de conflit d’une personne, d’autres organisations transférentielles sont des cristallisations tournées vers l’avenir des expériences développementalement nécessaires (transfert d’objet du soi). Le transfert (et le contre-transfert) est perçu comme diversement déterminé par le patient et l’analyste.

Je délinéé les questions cliniques en ce qui concerne le processus de l’illumination du transfert au jour des contributions variables de l’analyste dans le transfert, ainsi que les implications qui en découlent pour l’extratransfert, et la différenciation du processus et contenu pour déterminer ce que signifie le transfert.

Zwei fundamental verschiedene Modelle der Übertragung, hier als Verdrängungs- und Organisationsmodell bezeichnet, haben sich entwickelt. Der Zweck dieses Beitrags bestand darin, die fundamentalen Eigenschaften dieser zwei Modelle miteinanber zu vergleichen und durch Erwägung gewisser theoretischer und klinischer Fragen zur Entwicklung und Kohäsion des Organisationsmodells beizutragen. Übertragung wird hier als die primären Organisationsmuster oder -schemata definiert, die im Rahmen der analytischen Beziehung aktiviert werden. Während sich wiederholende pathologische Übertragungsstrukturen, die auf traumato-


Han surgido dos modelos de transferencia fundamentalmente diferentes, designados aquí como el modelo de desplazamiento y el de organización. El objetivo de este trabajo era comparar las características fundamentales de estos dos modelos y contribuir al desarrollo y cohesión del modelo de organización mediante la consideración de ciertas cuestiones teóricas y clínicas.

La definición de transferencia que aquí se da es la de modelos o esquemas organizadores primarios con los que el analizado construye y asimila su experiencia de la relación analítica. A diferencia de las organizaciones transferenciales patológicas repetitivas basadas en experiencias traumáticas que en uno u otro grado son un obstáculo para la evolución de la persona y la resolución de sus conflictos, hay otras organizaciones transferenciales que son cristalizaciones progresivas de experiencias evolutivamente necesarias (transferencias del objeto-self). La transferencia y la contraterencia se consideran codeterminadas, en grado variable, por el analista y el analizado.

Se delinean cuestiones clínicas sobre el proceso de aclaración de la transferencia a la luz de las contribuciones variables del analista a ésta, de las implicaciones extra-transferenciales, y de la diferenciación entre proceso y contenido en la determinación del significado de la transferencia.

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