

TRANSFERENCE: THE TOTAL SITUATION

BETTY JOSEPH, LONDON

My intention in this paper is to discuss how we are using the concept of transference in our clinical work today. My stress will be on the idea of transference as a framework, in which something is always going on, where there is always movement and activity.

Freud's ideas developed from seeing transference as an obstacle, to seeing it as an essential tool of the analytic process, observing how the patient's relationships to their original objects were transferred, with all their richness, to the person of the analyst. Strachey (1934), using Melanie Klein's discoveries on the way in which projection and introjection colour and build up the individual's inner objects, showed that what is being transferred is not primarily the external objects of the child's past, but the internal objects, and that the way that these objects are constructed help us to understand how the analytic process can produce change.

Melanie Klein, through her continued work on early object relationships and early mental mechanisms, perhaps particularly projective identification, extended our understanding of the nature of transference and the process of transferring. In her (1952) paper 'The origins of transference' she wrote: 'It is my experience that in unravelling the details of the transference it is essential to think in terms of *total situations* transferred from the past into the present as well as emotion defences and object relations'. She went on to describe how for many years transference had been understood in terms of direct references to the analyst, and how only later had it been realized that, for example, such things as reports about everyday life, etc. gave a clue to the unconscious anxieties stirred up in the transference situation. It seems to me that the notion of total situations is fundamental to our understanding and our use of the transference

today, and it is this I want to explore further. By definition it must include everything that the patient brings into the relationship. What he brings in can best be gauged by our focusing our attention on what is going on within the relationship, how he is using the analyst, alongside and beyond what he is saying. Much of our understanding of the transference comes through our understanding of how our patients act on us to feel things for many varied reasons; how they try to draw us into their defensive systems; how they unconsciously act out with us in the transference, trying to get us to act out with them; how they convey aspects of their inner world built up from infancy—elaborated in childhood and adulthood, experiences often beyond the use of words, which we can often only capture through the feelings aroused in us, through our countertransference, used in the broad sense of the word.

Countertransference, the feelings aroused in the analyst, like transference itself, was originally seen as an obstacle to the analytic work, but now, used in this broader sense, we would see it, too, no longer as an obstacle, but as an essential tool of the analytic process. Further, the notion of our being used and of something constantly going on, if only we can become aware of it, opens up many other aspects of transference, which I shall want to discuss later. For example, that movement and change is an essential aspect of transference—so that no interpretation can be seen as a pure interpretation or explanation but must resonate in the patient in a way which is specific to him and his way of functioning; that the level at which a patient is functioning at any given moment and the nature of his anxieties can best be gauged by trying to be aware of how the transference is actively being used; that shifts that become visible in the transference are an essential part of what should eventually lead to real psychic change.

Such points emerge more clearly if we are thinking in terms of total situations being transferred.

I want to exemplify this by bringing a short piece of material in which we can see how the patient's immediate anxieties and the nature of her relationship with her internal figures emerge in the whole situation lived out in the transference, although individual associations and references to many people came up in the material as if asking to be interpreted. This material comes from the discussion of a case at a recent post-graduate seminar of mine. The analyst brought material from a patient who seemed very difficult to help adequately: schizoid, angry, an unhappy childhood with probably emotionally unavailable parents. The analyst was dissatisfied with the work of a particular session which she brought, and with its results. The patient had brought details of individual people and situations.

The seminar felt that many of the interpretations about this were sensitive and seemed very adequate. Then the seminar started to work very hard to understand more. Different points of view about various aspects were put forward, but no one felt quite happy about their own or other people's ideas. Slowly it dawned on us that probably this was the clue, that our problem in the seminar was reflecting the analyst's problem in the transference, and that what was probably going on in the transference was a projection of the patient's inner world, in which she, the patient, could not understand and, more, could not make sense of what was going on. She was demonstrating what it felt like to have a mother who could not tune into the child and, we suspected, could not make sense of the child's feelings either, but behaved as if she could, as we, the seminar, were doing. So the patient had developed defences in which she argued or put forward apparently logical ideas, which really satisfied no one, but which silenced the experience of incomprehensibility and gave her something to hold on to. If the analyst actually struggles in such situations to give detailed interpretations of the meaning of individual associations, then she is living out the patient's own defensive system, making pseudo-sense of the incomprehensible, rather than trying to make contact with the patient's experience of living in an incomprehensible world. The latter can be a very disturbing experience for the

analyst, too. It is more comfortable to believe that one understands 'material' than to live out the role of a mother who cannot understand the infant/patient.

I think that the clue to the transference here (assuming that what I am describing is correct) lay in our taking seriously the striking phenomenon in the seminar, of our struggling to understand and our desperate need to understand instead of getting stuck on the individual associations brought up by the patient, which in themselves would appear to make a lot of possible sense. This we got more through our counter-transference of needing to guess, feeling pressurized to understand at all costs, which enabled us, we thought, to sense a projective identification of a part of the patient's inner world and the distress, of which we got a taste in the seminar.

I am assuming that this type of projective identification is deeply unconscious and not verbalized. If we work only with the part that is verbalized, we do not really take into account the object relationships being acted out in the transference; here, for example, the relationship between the uncomprehending mother and the infant who feels unable to be understood, and it is this that forms the bedrock of her personality. If we do not get through to this, we shall, I suspect, achieve areas of understanding, even apparent shifts in the material, but real psychic change, which can last beyond the treatment will, I think, not be possible. I suspect that what has happened in such cases is that something has gone seriously wrong in the patient's very early relationships, but that on top of this has been built up a character structure of apparent or pseudo-normality, so that the patient has been able to get into adulthood without actually breaking down and apparently functioning more or less well in many areas of her life. Interpretations dealing only with the individual associations would touch only the more adult part of the personality, while the part that is really needing to be understood is communicated through the pressures brought on the analyst. We can sense here the living out in the transference of something of the nature of the patient's early object relationships, her defensive organization, and her method of communicating her whole conflict.

I want now to continue this point by bringing

material from a patient of my own, to show first how the transference was being experienced in a partially idealized way conveyed through the atmosphere that he built up, and linked with his own history. Then how, when this broke down, primitive aspects of his early object relationships and defences emerged and were lived out in the transference and he attempted to draw the analyst into the acting out. Then how work on this led to more movement and some temporary change in his internal objects.

This patient, whom I shall call N, had been in analysis many years and had made some very satisfactory progress, which was, however, never adequately consolidated, and one could never quite see the working through of any particular problem, let alone visualize the termination of treatment. I noticed a vaguely comfortable feeling, as if I quite liked this patient's sessions and as if I found them rather gratifying, despite the fact I always had to work very hard with him. When I started to rethink my countertransference and his material, I realized that my rather gratified experience must correspond to an inner conviction on the patient's part that whatever I interpreted he was somehow all right. Whatever difficulties, even tormenting qualities in him, the work might show, there was an inner certainty that he had some very special place, that my interpretations were, as it were, 'only interpretations'. His place was assured and he had no need to change. One could, therefore, have gone on and on making quasi-correct and not unuseful interpretations, exploring and explaining things, but if the deeper unconscious conviction remained unexamined, the whole treatment could have become falsified. This conviction of his special place and no need to change had an additional quality because it included the notion that I, the analyst, had a particular attachment to or love for him, and that for my own sake I would not wish to let him go—which I think was basic to my comfortable countertransference experience.

I want to make a further brief point about this material, concerning the nature of interpretation. If one sees transference and interpretations as basically living, experiencing and shifting—as movement—then our interpretations have to express this. N's insight into his unconscious conviction of his special place, of the vague unreality of much of our work, of my attachment

to him and so on, emerged painfully. It would have been more comfortable to link this quickly with his history—the youngest child, the favourite of his mother, who had a very unhappy relationship with his father, a rather cruel man, though the parents remained together throughout their lives. But had I done this, it would have played into my patient's conviction again that interpretations were 'only interpretations' and that I did not really believe what I was saying. To my mind the important thing was first to get the underlying assumptions into the open, so that, however painful, they could be experienced in the transference as his psychic reality, and only later and slowly to link them up with his history. We shall need to return to the issue of linking with history later.

I shall now bring further material from N from a period soon after the time I have just discussed, to show how when the omnipotent, special place fantasies were no longer dominating the transference, early anxieties and, as I said, the living out of further psychic conflict came into the transference, emerged in a dream, and how the stuff of the dream was lived out in the transference. At this period, N, despite insight, was still liable to get caught up into a kind of passive despairing masochism. On a Monday he brought the following dream. (I am only giving the dream and my understanding of it, not the whole session nor his associations.)

The dream was: *there was a kind of war going on. My patient was attending a meeting in a room at the seaside. People were sitting round a table when they heard a helicopter outside and knew from the sound that there was something wrong with it. My patient and a major left the table where the meeting was going on and went to the window to look out. The helicopter was in trouble and the pilot had baled out in a parachute. There were two planes, as if watching over the helicopter, but so high up that they looked extremely small and unable to do anything to help. The pilot fell into the water, my patient was wondering whether he would have time to inflate his suit, was he already dead, and so on.*

I am not giving the material on which I based my interpretations, but broadly I showed him how we could see the war that is constantly raging between the patient and myself, which is shown by the way in which he tends to turn his

back, in the dream, on the meeting going on at the table, on the work going on from session to session here. When he does look out knowing that something is wrong (as with the helicopter) he sees that there is an analyst, myself, the two planes, the two arms, the breasts, watching over to try to help him, but he is absorbed watching the other aspect, that is the part of himself, the pilot, that is in trouble, is falling out, dying—which is the fascinating world of his masochism. Here I mean that he shows his preference for getting absorbed into situations of painful collapse rather than turning to and enjoying help and progress.

At the time, he seemed, as the session went on, to get well into touch with these interpretations, and to feel the importance of this fascination with his masochism. On the following day he came, saying that he had felt disturbed after the session and the work on the dream. He spoke in various ways about the session and his concern about the fight, how he felt awful, that whatever goes on in the analysis he seemed somehow to get caught up in this rejection and fight; he went on to speak about his awareness of the importance of the excitement when he gets involved in this way. And then he talked about various things that had happened during the day. This sounded like insight, almost concern. In a way it was insight, but I had the impression from the tone of his voice, speaking in a flat, almost boring, way, that all that he was saying was now second-hand, almost as if the apparent insight was being used against progress in the session, as if a particular silent kind of war against me was going on, which I showed him. My patient replied in a gloomy voice: 'There seems to be no part of me that really wants to work, to co-operate' and so on ... I heard myself starting to show him that this could not be quite true, since he actually comes to analysis—and then realized, of course, that I was acting as a positive part of himself, as if the part that was capable of knowing and working had been projected into me and so I was trapped into either living out this positive part, so that he was not responsible for it, or for the recognition of it, or I had to agree that there was no part of him that really wanted to co-operate, etc. So either way there was no way out.

My patient saw this, said he could do nothing about it, he quite understood, but he felt

depressed, he could see what I meant ... More and more the session became locked in the notion of his understanding but not being able to do anything about or with it. (This picture is, I think, in part what the previous day's dream was describing when he became fascinated watching the pilot about to drown, and I myself, as the plane high up, was unable to help, and he was now fascinated with his own words like 'I understand, but it cannot help'. The dream is now lived out in the transference.)

I showed him that he was actively trapping me, by this kind of remark—which was in itself a demonstration of the war going on between us. After some more going to and fro about this, my patient remembered for 'no apparent reason', as he put it, a memory about a cigarette box; how when he was at boarding school and very miserable, he would take a tin, or a cardboard box, and cover it extremely carefully with canvas. Then he would dig out the pages of a book and hide his cigarette box inside the cover. He would then go into the countryside alone, sit, for example, behind an elder bush and smoke; this was the beginning of his smoking. He was lonely, it was very vivid. He subsequently added that there seemed to be no real pleasure in the cigarettes.

I showed him that I thought the difficulty lay in his response to my showing him about how he was trapping me with the remarks such as 'there seems to be no part of me that wants to co-operate', etc. He realized that he felt some kind of excitement in the fight and the trapping, but that what was really significant was that this excitement had very much lessened during the last sessions and indeed the last year; he was much less addicted to it now, but could not give it up, it would mean giving in to the elders, myself (the reference to sitting behind the elder bush), but he was not really getting much pleasure from the smoking, which, however, he silently, secretly, had to do. The problem now, therefore, in the transference, was not so much that he got such pleasure from the excitement, the problem lay in the recognition and the acknowledgement of his improvement, which would also mean his being willing to give up some of the pleasure in defeating me. He was willing to talk about bad things about himself, sadism or excitement, you will remember, at the beginning of the session, but

not his improvement, and he was not yet willing to give in on this point and enjoy feeling better (in terms of yesterday's dream to acknowledge and use the helping hands, the planes).

My patient tended to agree with this and then said that things had changed in the last bit of the session, he realized his mood had altered, the locked and blocked sense had gone, now he felt sadness, perhaps resentment, as if I, the analyst, had not given sufficient attention to the actual memory of the cigarette box incident, which seemed to him vivid and important, as if I had gone away from it too quickly. I went back to the cigarette box memory, and had a look at his feelings that I had missed something of its importance; I also reminded him of the stress he had put on his excitement while I felt that a lot of pleasure had really gone out of this now, as in the non-pleasure in the smoking. But I also showed him his resentment at the fact that his feelings had shifted, he had lost the uncomfortable blocked mood.

N agreed, but said: 'Still I think you have gone too fast'. He could accept that part of the resentment might be connected with the shift that the analysis had enabled him to make—to undo the blocked feeling—but 'too fast' he explained was as if I, the analyst, had become a kind of Pied Piper and he had allowed himself to be pulled along with me.

I pointed out that it sounded as if he felt that I had not really analysed his problem about being stuck, but had pulled and seduced him out of his position. It was my initiative that had pulled him out, as he felt seduced by his mother as a child. (You will remember the earlier material in which he was convinced I and his mother had a special feeling for him.) He quickly, very quickly, added that there was also the other fear at that moment, the fear of getting caught up into excited warm feelings, like the feeling he used to call puppyish.

I now showed my patient that these two anxieties, that of my seducing him out of his previous state of mind and his fear of his own positive, excited, infantile or puppyish feelings, might both need further consideration—both were old anxieties that had come up before as important—but I thought they were being used at that moment so that he could project them into me in order not to have to contain and experience and express the actual good feelings

and particularly the warmth and gratitude which had been emerging in the latter part of the session (and was linked, I believe, with the awareness in the dream of a helpful quality in the planes overhead). At this point, very near the end of the session, my patient agreed with me and went off, clearly rather moved.

I am bringing this apparently rather straightforward material to stress a number of points that I find of interest in the use of the transference. First, the way in which a dream can reveal its meaning in a fairly precise way by being lived out in the session, where we can see the patient's specific and willing involvement with misery and problems rather than meeting up with his helpful and lively objects, the planes, which are minimized, small. The analysis, interpretations, breasts are turned away from, when they are recognized as nourishing and helpful. The helpfulness is recognized specifically, but old problems are mobilized against it—called excitement, badness, non-cooperation. Positive aspects of the personality are seen, but his own capacity to move warmly towards an object is quickly distorted and projected into me, it is I who pull and seduce. But the whole thing is cleverly hidden, like the cigarette box in the book (probably bookish old interpretations, now no longer so meaningful). But he really knows that he doesn't get pleasure from the activity. We have here the specific meaning of the symbols and we can locate them in the transference. The patient gets insight, I believe, into what is almost a choice between moving towards a helpful object or indulging in despair—his defences are mobilized and he goes the latter way and tries to draw the analyst into criticizing and reproaching—into his masochistic defensive organization. Then followed further work and we can see that these defences lessen until he can actually acknowledge relief and warmth. Further, as he can acknowledge a helpful object, he can relate to it and internalize it, which leads to further internal shifts.

I think in addition we can see here how the transference is full of meaning and history—the story of how the patient turns away, and I suspect always has done, from his good feeding objects. We can get an indication of one way in which, by projecting his loving into his mother and twisting it, he has helped to consolidate the picture of her as so seductive, an anxiety which still to some

extent persists about women. Of course we can add that she well may have been a seductive woman towards her youngest son, but we can see how this has been used by him. The question of when and whether to interpret these matters is a technical one that I can only touch on here. My stress throughout this contribution has been on the transference as a relationship in which something is all the time going on, but we know that this something is essentially based on the patient's past and the relationship with his internal objects or his belief about them and what they were like.

I think that we need to make links for our patients from the transference to the past in order to help to build a sense of their own continuity and individuality, to achieve some detachment, and thus to help to free them from their earlier and more distorted sense of the past. About these issues many problems arise, theoretical and technical. For example, is a patient capable of discovering in the transference an object with good qualities if he had never experienced this in his infancy? About this I am doubtful; I suspect that, if the patient has met up with no object in his infancy on whom he can place some, however little, love and trust, he will not come to us in analysis. He will pursue a psychotic path alone. But what we can do, by tracing the movement and conflict within the transference, is bring alive again feelings within a relationship that have been deeply defended against or only fleetingly experienced, and we enable them to get firmer roots in the transference. We are not completely new objects, but, I think, greatly strengthened objects, because stronger and deeper emotions have been worked through in the transference. This type of movement I have tried to demonstrate in N, whose warmth and valuing have, over time, apparently come alive, but I am convinced that they were weakly there before, but much warded off. Now, I think, the emotions have been freed and have been strengthened, and the picture of his objects has shifted accordingly.

There is also the issue as to when and how it is useful to interpret the relation to the past, to reconstruct. I feel that it is important not to make these links if the linking disrupts what is going on in the session and leads to a kind of explanatory discussion or exercise, but rather to wait until the heat is no longer on and the patient has sufficient

contact with himself and the situation to want to understand and to help to make links. Even this, of course, can be used in a defensive way. These, however, are technical issues which do not really belong to this contribution.

I want now to return to a point that I mentioned earlier on, when I spoke of the transference as being the place where we can see not only the nature of the defences being used, but the level of psychic organization within which the patient is operating. To demonstrate this, I shall bring a fragment of material from a patient whom I shall call C, who is a somewhat obsessional personality, with severe limitations in his life, the extent of which he had not realized until he started treatment. I began to gain the impression that beneath the obsessional structure, controlling, superior and rigid, there was a basically phobic organization. I shall try to reduce the piece of material that I am bringing to its bare bones.

C had asked during the week to come a quarter of an hour earlier on the Friday, my first session in the day, in order to catch a train, as he had to go to Manchester for work. Then he described in great and obsessional detail on the Friday his worries about catching the train, getting through the traffic, etc., and how he had safeguarded these problems. He also discussed an anxiety about losing his membership in a club because of non-attendance, and spoke about a friend being slightly unfriendly on the phone. Detailed interpretations about his feeling unwanted related to the weekend, feeling shut out, and a need not to go away but rather to remain here or shut inside, did not seem to make real contact or to help him. But in relation to my showing him his need to be inside and safe he started to talk, now in a very different and smooth way, about how similar this problem was to his difficulty in changing jobs, moving his office, getting new clothes, how he stuck to the old ones, although by now he was short of clothes. Then there was the same problem about changing cars ...

At this point I think that an interesting thing had occurred. While all that he was saying seemed accurate and important in itself, the thoughts were no longer being thought, they had become words, concrete analytic objects into which he could sink, get drawn in, as if they were the mental concomitant of a physical body into

which he was withdrawing in the session. The question of separating off, mentally as physically, could be evaded since our ideas could now be experienced as completely in tune and he had withdrawn into them. When I pointed this out to C, he was shocked, saying: 'When you said that, Manchester came into my mind, it was like sticking a knife into me'. I thought that the knife that goes in was not just my pushing reality back into his mind, but a knife that goes in between himself and me, separating us off and making him aware of being different and outside, and this aroused immediate anxiety.

I bring this material to show how the interpretations about his obsessional control and his reassuring himself and me, then the interpretations about his needing to avoid separation, new things, etc. and to be inside, were not experienced as helpful explanations, but were used as concrete objects, as parts of myself that he could get inside defensively, warding off psychotic anxieties of a more agoraphobic type associated with separation. Thus the two levels of operating—obsessional defending against phobic—could be seen to be lived out in the transference, and when the deeper layer was tackled, when I showed him the smooth defensive use of my words, my interpretations were felt as knife-like, and the anxieties re-emerged in the transference. In one sense this material is comparable with the case we discussed in the seminar. In such situations, if interpretations and understanding remain on the level of the individual associations, as contrasted with the total situation and the way that the analyst and his words are used, we shall find that we are being drawn into a pseudo-mature or more neurotic organization and missing the more psychotic anxieties and defences, which manifest themselves once we take into account the total situation—which is being acted out in the transference.

In this paper, I am concentrating on what is being lived in the transference and in this last example, as at the beginning, I tried to show how interpretations are rarely heard purely as interpretations, except when the patient is near to the depressive position. Then interpretations and the transference itself becomes more realistic and less loaded with fantasy meaning. Patients operating with more primitive defences of splitting and projective identification tend to 'hear' our inter-

pretations or 'use' them differently and how they 'use' or 'hear' and the difference between these two concepts needs to be distinguished if we are to clarify the transference situation and the state of the patient's ego and the correctness or not of his perceptions. Sometimes our patients hear our interpretations in a more paranoid way, for example, as a criticism or as an attack. C, after getting absorbed in my thoughts, heard my interpretations about Manchester as a knife that cut into him—between us. Sometimes the situation looks similar, the patient seems disturbed by an interpretation, but has, in fact, heard it, understood it, correctly, but unconsciously used it in an active way, thus involving the analyst.

N, I believe, did not hear my interpretations about his dream of the helicopter as cruel or harsh, but he unconsciously used them to reproach, beat and torment himself masochistically, thus in his fantasy using me as the beater. Or, to return to C: having heard certain of my interpretations and their meaning correctly, he used the words and thoughts not to think with, but unconsciously to act with, to get into and try to involve me in this activity, spinning words but not really communicating with them. Such activities not only colour but structure the transference situation and have important implications for technique.

SUMMARY

I have tried in this paper to discuss how I think we are tending to use the concept of transference today. I have stressed the importance of seeing transference as a living relationship in which there is constant movement and change. I have indicated how everything of importance in the patient's psychic organization based on his early and habitual ways of functioning, his fantasies, impulses, defences and conflicts, will be lived out in some way in the transference. In addition, everything that the analyst is or says is likely to be responded to according to the patient's own psychic make-up, rather than the analyst's intentions and the meaning he gives to his interpretations. I have thus tried to discuss how the way in which our patients communicate their problems to us is frequently beyond their indi-

vidual associations and beyond their words, and can often only be gauged by means of the countertransference. These are some of the points that I think we need to consider under the rubric of the total situations which are transferred from the past.

TRANSLATIONS OF SUMMARY

Dans ce rapport, j'ai essayé de mettre en discussion le concept du transfert comme - à mon avis - il est employé aujourd'hui. J'ai souligné l'importance d'envisager le transfert comme une relation vivante dans laquelle il y a constamment du mouvement et des variations. J'ai signalé comment, d'une façon ou d'une autre, on va vivre dans le transfert tout ce qui est important dans l'organisation psychique du patient originée dans les méthodes de fonctionnement précoces et habituelles, ses fantasmes, ses instincts, ses défenses et ses conflits. En outre, tout ce que l'analyste est ou dit aura probablement une réponse par rapport à la structure psychique du patient plutôt que par rapport aux intentions de l'analyste et la signification qu'il donne à ses interprétations. J'ai, donc, essayé de mettre en discussion comment les moyens par lesquels les patients nous font savoir leurs problèmes sont fréquemment au delà de leurs associations individuelles et au delà de leurs paroles et peuvent souvent être mesurés uniquement par la signification du contretransfert. J'ai souligné les points qu'on a - à mon avis - besoin de considérer sous le titre de situations totales qui sont transférées du passé.

In dieser Arbeit habe ich versucht, zu besprechen wie, meiner Ansicht nach, heutzutage der Begriff der Übertragung benutzt zu werden neigt. Ich habe die Bedeutung hervorgehoben, die Übertragung als eine leben-

dige Beziehung zu betrachten, in der ständige Bewegung und Veränderungen statt finden. Ich habe darauf hingewiesen wie alles, was in der psychischen Organisation des Patienten von Bedeutung ist, auf seiner frühen und gewohnten Lebensweise basiert, wie seine Phantasien, Impulse, Abwehrmechanismen und Konflikte auf irgend eine Weise in der Übertragung ausgelebt werden. Ausserdem wird die Reaktion des Patienten auf all das, was der Analytiker ist oder sagt, sich wahrscheinlich eher nach der psychischen Struktur des Patienten richten, als den Intentionen des Analytikers, und der Bedeutung die er seinen Interpretationen gibt. Somit habe ich versucht, die Art und Weise zu besprechen, in der unsere Patienten uns ihre Probleme mitteilen, die oft jenseits ihrer individuellen Assoziationen und Worte liegt und oft nur mit Hilfe der Gegenübertragung erfasst werden kann. Dies sind einige der Punkte, die meiner Ansicht nach unter der Rubrik der gesamten Situationen, die von der Vergangenheit übertragen werden, berücksichtigt werden müssen.

En este artículo he intentado dar una idea de cómo creo que tendemos a usar el concepto de transferencia hoy en día. He subrayado la importancia que tiene el ver la transferencia como una relación viva en la que hay continuo movimiento y cambio. He indicado que todo aquello que tiene importancia en la organización psíquica del paciente y que está basado en sus modos de funcionamiento habituales de su infancia, sus fantasías, sus impulsos, sus defensas y sus conflictos, serán revividos de algún modo en la transferencia. Además, todo lo que el analista es o dice recibirá seguramente una respuesta acorde con la hechura psíquica del paciente y no con las intenciones del analista y el significado que da a sus interpretaciones. Concluyo por ello que el modo en que los pacientes nos comunican sus problemas sobrepasa frecuentemente sus asociaciones individuales y sus palabras, y a menudo solo se puede calibrar mediante la contratransferencia. Estos son algunos de los aspectos que creo que tenemos que tener en cuenta bajo el enunciado general de las situaciones globales transferidas del pasado.

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36 Clifton Hill
London NW8 0QG
(MS. received November 1984)

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