

had shown how in analysis—as also in the earlier techniques of suggestion and hypnosis—the patient unconsciously made the doctor play the role of loved or feared parental figures (7). In his first general exposition of transference (1912b), Freud stresses that it is connected with ‘prototypes’ or imagos* (chiefly the imago of the father, but also of the mother, brother, etc.): the doctor is inserted ‘into one of the psychical “series” which the patient has already formed’ (5b).

Freud reveals how it is the subject’s relationship to parental figures that is once again lived out in the transference—a relationship still characterised, notably, by instinctual ambivalence* . . . It was only along the painful road of transference that [the Rat Man] was able to reach a conviction that his relation to his father really necessitated the postulation of this unconscious complement’ (8). In this context Freud distinguishes between two kinds of transference—one positive, the other negative: a transference of affectionate feelings and a transference of hostile ones (β). The kinship between these terms and the ‘positive’ and ‘negative’ components of the Oedipus complex should be noted.

This extension of the notion of transference so that it becomes a process structuring the whole treatment around prototypical/infantile conflicts culminates with Freud’s introduction of a new concept—that of ‘transference neurosis’* . . . we regularly succeed in giving all the symptoms of the illness a new transference meaning and in replacing the patient’s ordinary neurosis by a “transference-neurosis” of which he can be cured by the therapeutic work’ (9).

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As for its *function in the treatment*, Freud at first classes transference, in the most explicit fashion, among the ‘obstacles’ which impede the remembering of the repressed material (4e). But—also from the outset—he indicates that its occurrence is frequent if not general: ‘We can [...] reckon on meeting it in every comparatively serious analysis’ (4f). Similarly, Freud establishes at this point in his thinking that the mechanism of transference on to the person of the physician is triggered off precisely at the moment when particularly important repressed contents are in danger of being revealed. Seen in this light, transference appears as a form of resistance, while at the same time testifying to the proximity of the unconscious conflict. Thus, right from the start, Freud ran up against the essential contradiction of transference—the reason for the great divergence in his formulations regarding its function: transference in one sense—seen in relation to verbalised recollection—is ‘transference-resistance’ (*Übertragungswiderstand*). Yet in another sense, inasmuch as it offers a superlative way for the subject as for the analyst to grasp the elements of the infantile conflict *in vitro* and *in statu nascendi*, the transference becomes the terrain upon which the patient’s unique set of problems is played out with an ineluctable immediacy: the area where the subject finds himself face to face with the existence, the permanence and the force of his unconscious wishes and phantasies: ‘It is on that field that the victory must be won [...] It cannot be disputed that controlling the phenomena of transference presents the psycho-analyst with the greatest difficulties. But it should not be forgotten that it is precisely they that do us the inestimable service of making the patient’s hidden and forgotten erotic impulses immediate and manifest. For when all is said and done, it is impossible to destroy anyone *in absentia* or *in effigie*’ (5c).

Irresistibly, this second aspect of transference takes on more and more importance for Freud: ‘This *transference* alike in its positive and negative form is used as a weapon by the resistance; but in the hands of the physician it becomes the most powerful therapeutic instrument and it plays a part scarcely to be overestimated in the dynamics of the process of cure’ (10).

But on the other hand it must be borne in mind that even where Freud goes farthest in acknowledging the special status of transference repetition—even when he writes: ‘The patient cannot remember the whole of what is repressed in him, and what he cannot remember may be precisely the essential part of it. [...] He is obliged to *repeat* the repressed material as a contemporary experience’ (11a) - he nevertheless immediately stresses the need for the analyst ‘to keep this transference neurosis within the narrowest limits: to force as much as possible into the channel of memory and to allow as little as possible to emerge as repetition’ (11b).

Thus Freud never abandons the view that the ideal of the treatment is complete *recollection*, and in cases where this turns out to be unattainable he falls back on ‘constructions’* to fill in the gaps in the infantile history. Furthermore, he never esteems the transference relationship for its own sake, either from the point of view of the abreaction* of childhood experiences or from that of the rectification of unrealistic modes of object-relationship.

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In the *Studies on Hysteria*, Freud writes apropos of the manifestations of transference that ‘this new symptom that has been produced on the old model must be treated in the same way as the old symptoms’ (14g). Again, when he later describes transference neurosis as an ‘artificial illness’, he is surely making the assumption that transference reactions are both economically and structurally equivalent to ordinary symptoms.

And indeed Freud does sometimes explain the emergence of the transference in terms of a compromise between [his] demands [of the resistance] and those of the work of investigation’ (5d). But he is aware from the beginning that the signs of the transference become more and more insistent the closer one gets to the ‘pathogenic complex’, and when he relates these manifestations to a repetition compulsion* he states that such a compulsion can only express itself in the transference ‘after the work of treatment has gone halfway to meet it and has loosened the repression’ (11e). All the way from the case-history of ‘Dora’, where Freud likens transferences to actual ‘new impressions’, often quite undistorted by comparison with the corresponding unconscious phantasies, to *Beyond the Pleasure Principle* (1920g), where he says of reproductions in the transference that they ‘emerge with unwhished-for exactitude, always have as their subject some portion of infantile sexual life—of the Oedipus complex, that is, and its derivatives’ (11d)—all the way, the idea that transference actualises the essence of the childhood conflict is constantly gaining ground.

As we know, transference repetition is one of the facts invoked by Freud in *Beyond the Pleasure Principle* to justify bringing the repetition compulsion to the fore: situations and emotions are repeated in the treatment which ultimately express the indestructibility of unconscious phantasies.

It may therefore be asked what sense we ought to give to what Freud calls