Medium, Messenger, Transmission

Published by Amsterdam University Press

Amsterdam University Press, 2015.
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Psychoanalysis: Transmission through Affective Resonance

‘The present is only intelligible in the light of the past.’ That is a truism, but within the framework of psychoanalysis the orientation of the present towards the past takes on a surprising and also serious life of its own. It could be expressed as follows: The present can be scarred by something in the past that is forgotten or repressed. The practice of psychoanalysis focuses on people whose lives in this sense were not only formed but also deformed by their experiences – mostly in childhood. Psychoanalytic transference is the process of bringing these deformations to light so they can thus also be traced and ‘corrected’. A special relationship between the patient and the analyst emerges through transference, as the patient’s acquired affective patterns, which mostly remain unconscious, are projected onto the doctor such that the relationship to the doctor becomes a substitute for the patient’s primary, mostly early childhood object relations. The point here is that the psychoanalytic dialogue not only opens up the possibility of reviving and acting out frozen ‘inner’ patterns of experience by exteriorizing and transferring them onto the doctor, but rather it also contains the possibility of remembering the original context of these affective patterns; in this way, psychoanalysis is also able to relieve the patient of the burdensome implications of past experience.

The repetition of past experience becomes an act in which the repeated is therefore recreated and reshaped. The goal of psychoanalysis is more than simply to ‘raise’ the unconscious to consciousness through verbalization and memory: Its goal is to transform a cliché-ridden pattern of feeling, and transference is the process by which a mutation of the repeated takes place. The analyst is thus the mediator and medium of transference.

The Psychoanalyst: ‘Neutral Medium’ or Actor?
That is – in a few brief strokes – the basic idea of psychoanalytic transference, which is incidentally also furnished with a particular ‘manner of speaking that is impregnated by the past and also mechanistic’, whose justification and relativization will be the aim of the following.

The psychoanalytic concept of transference is interesting because it promises to reveal new aspects of the phenomenon of medial mediation. Paradoxically, however, the notion that the analyst is a medium and a mediator in the transmission event is precisely repressed or represented as a problem to be overcome in psychoanalytic literature. There is an obvious turning point in the meta-psychological discourse of psychoanalysis, which emphasizes precisely the non-mechanical, intersubjective, interactive
character of the transmission event: Psychoanalytic transference can become what Sigmund Freud intended it to be – not a disruption of analysis, but rather its most valuable tool – only when the idea of the therapist as a neutral, impersonal, affectless mediator is replaced by the idea of the analyst as a participating, interacting person, when the past experience of the patient encounters the here and now of an emotional, intersubjective relationship with the doctor, and when the analyst not only mirrors the projections of the patient but also encounters the patient as an incommensurable Other and thus becomes a sounding board for the patient.

While this shift from a mechanically-oriented explanation of transference to an intersubjective, social-constructivist approach is interpreted in the literature as surmounting the neutral mediator function of the analyst, I will show conversely that this ‘interactivity perspective’ provides a ground-breaking answer to the question of how medial passivity can at the same time be conceived as a genuine form of activity. The doctor is a medium of transmission, but he alters the transmission event, which thus remains more than simply a repetition of the past. The goal of the following considerations is to work out this active potential as something that does not defeat or suspend but rather embodies the psychoanalyst’s position as mediator.

The Genesis of Psychoanalysis Out of the Spirit of Exorcism and Hypnosis

Psychoanalysis was not the first to discover that the relationship between someone who is spiritually or psychologically ill and his healer is a kind of transmission event. In the framework of the pathology of ‘possession’, which was practically ubiquitous in the nineteenth century, the exorcist would address the ‘evil spirit’ inhabiting the invalid not in his own but rather in the name of a higher being, which eventually resulted in the spirit’s expulsion. At the same time, however, the exorcist would also talk with the invalid himself, whom he encouraged and bolstered. This dual character of exorcizing communication, which addressed both the spirit that parasitically possessed the invalid as well as the real person of the invalid, is remarkable as these ‘two voices’ anticipate the dualism of psychoanalytic transference, which is related to both the ‘past unconscious’ (the ‘child within the adult’) and the ‘present unconscious’ (‘the dominant conflict in the here-and-now’) of the patient.

This brief reference to exorcism as an early form of ‘spiritual healing’ already outlines an interesting constellation: The medium – the exorcist who is commissioned by a higher being to relay communication with the invisible, disease-causing spirit – functions at the same time as a non-medium
insofar as he personally engages the patient in actual communication as an interacting partner. The healer stands apart from the patient in that he talks to spirits – both good and evil – but he also gets close to the patient in that he refers to him as a concrete person: ‘The structure of the exorcistic technique creates both closeness and distance between the therapist and the patient, which remains a function of every psychotherapeutic technique to this day.’

The relationship between the hypnotizer and the hypnotized can also be considered a precursor to psychoanalytic treatment. For early mesmerists the hypnotic relationship was defined by the concept of ‘rapport’, which Freud described as a ‘prototype of transference’. The ‘rapport’ established by the hypnotic relationship also incorporates elements of ‘réciprocité magnétique’. In this sense it was already clear early on that hypnotizability is dependent on a reciprocally affective relationship between the hypnotherapist and the hypnotized subject, a relationship that extends far beyond the scope of the mesmeric session.

Janet explored this ‘hypnotic’ relationship between therapist and patient in depth at the end of the nineteenth century. In the second phase of this therapy, the patient developed a ‘somnambulistic passion’ for his hypnotizer, which was a combination of love, jealousy, fear, and respect. This love could be erotic, childish, or motherly, but it hardly had any effect on the hypnotherapist. The principle of transference and countertransference therefore already informed the analysis of the hypnotic relationship and, for Janet at least, it was also reflected in the therapeutic technique.

After the turn of the century, however, this understanding of affective reciprocity as the condition of possibility for the hypnotic treatment of diseases was replaced by a non-reciprocal concept of hypnosis, in which the hypnotherapist once again assumed the position of a neutral mediator and hypnosis became first and foremost the one-sided performance of the hypnotized.

In his analysis of Anna O., a patient suffering from hysteria, Sigmund Freud’s colleague Dr. Joseph Breuer experienced the impossibility of actually maintaining such a neutral position: In the course of analysis Anna O. fell in love with Breuer and openly revealed her sexual desire for the analyst, whereupon Breuer abruptly ‘took flight’. He terminated the analysis, stopped treating her, and refused to treat any other hysterical patients. In the commenting literature this reaction was assessed in such a way that Breuer could not even admit to himself how much he in turn also desired his patient. He could only give an indirect signal of his own libidinal confusion: The following day he took his wife to Venice for a second
honeymoon!” Sigmund Freud was an observer and witness of Breuer's analysis of Anna O. Is it an accident that Freud's first thoughts concerning the psychological transference from patient to doctor and the irrefutable phenomenon of countertransference from doctor to patient occurred at the same time as Breuer's reactions to Anna O.? In any case, Peters concludes that ‘the history of psychoanalysis thus begins clearly with an uncontrolled transference-countertransference relationship’.

Before turning to Freud's views on transference, it is necessary to try once again to attempt to understand more precisely the ‘initial spark’ that motivated Breuer's elaboration of Freud's psychoanalytic technique.

Breuer's work as a neurologist was part of the tradition of hypnotic suggestion, which offered an alternative to electrotherapy and was remarkably successful in the last decades of the nineteenth century. Breuer observed that Anna O. could escape her psychological state of confusion as soon as she was able to verbalize her psychological conditions. Breuer subsequently asked his patient, under hypnosis, to describe what moved her internally. As soon as Anna O. was able to remember the offending and hurtful feelings and experiences that had previously been repressed, which resulted in her hysterical ‘symptoms’, she was then able to release these repressed feelings and her neurotic symptoms disappeared: The ‘cathartic method’ of the abreaction of the repressed was thus born.

Freud adopted this cathartic method from Breuer, although he found an alternative to hypnosis in the psychoanalytic technique of free association, whereby patients are induced to speak and the analyst then deciphers and interprets their verbal communication as an expression of repressed impulses, ideas, and feelings.

This search for a suggestive technique that employed speech rather than hypnosis represented the birth of the ‘psychoanalytic cure’, and it was also the context in which Freud first came across the phenomenon of transference.

But once again: What was the ‘initial spark’ of Breuer's psychoanalytic method? The simplest answer is the following: He discovered that through the verbalization of painful feelings in the past these feelings can once again be experienced, acted out, and thus also consciously remembered, which results in a release from the unconscious symptoms of repressed suffering. Yet there is also a more subtle answer, which is related to Freud's experience of the relationship between Breuer and Anna O. Freud is an uninvolved observer of this event, which he undoubtedly knew to interpret as a transmission event – and actually on both sides. The word ‘transference’ first appears in the theoretical section he wrote for Studies on Hysteria,
which he published together with Breuer. However, at the same time Freud observed that Breuer, who was entangled in a thoroughly two-sided ‘emotional rapport’ with his patient, was not able to recognize or controllably avoid this situation. As a result, this relationship reflected the same duplicity of distance and engagement that already informed the exorcistic and hypnotic precursors of psychoanalysis. Freud then developed a concept of psychoanalysis in which, on the one hand, the doctor assumed a strict, ascetic, and so to speak ‘uninvolved’ observer position, but which, on the other hand, also acknowledged that the patient-doctor relationship was reciprocal and inevitably libidinal. The idea of psychic transference, which Freud develops into a fundamental theorem of his metapsychology and as the core process of the psychoanalytic technique, constitutes – and this is my primary hypothesis – the theoretical and technical foundation for the double role that is attributed to and demanded from the analyst in psychoanalysis: to be able to be both a neutral medium and an affective sounding board at the same time. But how can the concept of transference fulfil this function?

On Transference as Theory and Technique: A Hypothesis
From an objective perspective, psychoanalytic therapy involves a person who seeks help from an analyst to cope with problems that limit and cloud his life and experience. Not only does a ‘working bond’ develop between then, but this bond also arises in an extremely intimate situation: They regularly meet each other entirely alone and – usually – over a long period of time. The patient begins to reveal his innermost and hardly acknowledged emotions to the analyst. The physician listens and also appears to belong entirely to the patient: His attention to the patient is undivided. The analyst makes every effort to establish a trusting relationship, which allows for the most embarrassing feelings and most intimate confessions to be put into words without shame. The physician understands his patient – probably more than anyone else. Do we ever experience conversations in our everyday lives that are so intimate, impulsive, and intense, particularly for neurotic patients?

The physician becomes a libidinal object for the patient, mostly desired, sometimes also feared and repelled – but always with a certain inescapability, not to mention inevitability. But what is it like from the reverse perspective? What does the patient represent for the analyst? Is he not a libidinal object?

In his commentary on Breuer’s abrupt escape from Anna O’s desire, Freud notes that Breuer did not understand the ‘impersonal nature’ of ‘his patient’s transference on to her physician’, which was ‘never absent’;
furthermore, Breuer could not admit to himself that he was also preoccupied with his relationship to his patient. Freud’s concept of transference thus lays the groundwork for this necessary depersonalization of the emotional relationship between physician and patient. The idea of transference makes the physician aware of the emotions that the patient shares with him, but at the same time it also reveals that these emotions are not to be taken personally, as they are not directed at the analyst as a concrete, real individual, but rather only as a symbol of previous attachment figures. Freud described transference as follows: ‘This new fact, which we thus recognize so unwillingly, is known by us as transference. We mean a transference of feelings on to the person of the doctor, since we do not believe that the situation in the treatment could justify the development of such feelings. We suspect, on the contrary, that the whole readiness for these feelings is derived from elsewhere [...] and, upon the opportunity offered by the analytic treatment, are transferred on to the person of the doctor.’

While the transference ‘seemed in every case to constitute the greatest threat to the treatment’, it also ‘becomes its best tool, by whose help the most secret compartments of mental life can be opened’. By virtue of transference, rigidified emotional conflicts from the past are actualized as symptoms and in their libidinal orientation towards the physician they take on a new meaning. If the physician does not succeed in deciphering this meaning, tracing the patient’s positive and negative feelings of love, hate, anger, and fear back to their infantile origins, and thus ‘pointing out to the patient that his feelings [...] are repeating something that happened to him earlier’, then this repetitive acting out can be transformed into conscious memory so that the neurotic symptoms are reduced.

Nevertheless, this is not the whole ‘story’ concerning Freud’s observations of Breuer, for where there is transference from patient to physician there are also emotions that flow in the opposite direction. ‘Other innovations in technique relate to the physician himself. We have become aware of the “counter-transference”, which arises in him as a result of the patient’s influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it.'
I will now attempt to sort through the aspects that are essential for understanding ‘transference’:

(1) **Affection**: Transference involves the transmission of feelings and therefore mental conditions or attitudes.

(2) **Orientation towards the past**: These feelings are not new, but rather they originate from the patient’s past.\(^{206}\) They are acquired emotional patterns – Freud also refers to them as ‘stereotype plates’.\(^{207}\)

(3) **Unconsciousness**: These past feelings are not simply remembered, but rather they are revived and re-experienced through the patient’s relationship to the physician.\(^{208}\) They are affective schemata rooted in the ‘unconscious’, which are then acted out.

(4) **Symbolism/Irreality**: The transferential nature of these emotional clichés implies that they are directed towards the analyst as a ‘substitute’ for past object relations; the analyst becomes a symbol and a representative of primary attachment figures from the past, with whom the patient was involved in conflict-laden emotional relationships. These feelings, which are now projected onto the physician, are – for Freud at least – ‘not founded on a real relationship’.\(^{209}\)

(5) **Interpretation instead of experience**: While the patient experiences these feelings, it is the analyst’s task not to respond to them emotionally but rather to interpret them. In order to interpret them effectively, the physician must be consciously aware of the illusory character and thus the inappropriateness of the ‘transference feelings’ directed towards him.

(6) **Countertransference**: Although his role is that of an interpreter, the analyst not only interprets but rather also experiences: He also always responds to the patient emotionally and unconsciously. He is not only an observer and an instrument of transference, but rather he himself enters into a transference relationship with the patient.

By viewing the intimacy of the psychoanalytic dialogue from an ‘objective perspective’ and then comparing these observations to Freud’s explanations of the concept of transference, it is revealed that the psychoanalytic constellation has two meanings: (i) The patient should be able to act out long-forgotten and above all repressed emotions in the here and now of the analytic dialogue. Yet at the same time it is clear that this does not simply involve repetition, but rather repetition under *altered* conditions, which (should) open up the possibility that the reproduced emotions are at the same time altered through their repetition in that they are articulated, remembered, and thus made conscious. Transference is a process not only of regression, but also of progression. (ii) The psychoanalytic dialogue is emotionally intimate and intense (for both the patient and the physician,
as the concept of ‘countertransference’ implies), yet it takes place within a particular context where things are only spoken but never acted upon. Thomas Szasz thus characterized the analytic situation as a paradox: ‘It stimulates, and at the same time frustrates, the development of an intense human relationship [...] The analytic situation requires that each participant have strong experiences, and yet not act on them.’ I am proposing that transference (in conjunction with countertransference) can be interpreted as a process that enables this ambivalence.

The above-mentioned considerations can be consolidated into a hypothesis that contains two parts: (1) As a theory, the concept of transference/countertransference explains and justifies the double role of the physician: namely, his function within the psychoanalytic constellation as both a neutral medium and an engaged participant. (2) As a technique and a process, transference introduces the possibility of circumventing the paradoxical tension between neutrality and intimacy or between impersonal abstinence and personal engagement.

**Transference as a Two-Way Process**

First, I want to clarify what it means to describe the physician as a neutral medium within the context of the concept of transference. Transference actually constitutes a ‘liminal realm’; it is a bridge and a mediator between the patient’s past and the present. It generates a separate world between mental illness and mental health, between the ‘real’ and the merely ‘symbolic’ relationship of the patient to the physician. Freud himself used the expression ‘liminal realm’ to describe transference, and he emphasized that it is this feature that enables the ‘transition’ from illness to life. This localization of transference in an in-between space also enables the physician to occupy a double role:

(i) On the one hand, he is a projection surface for the patient’s repressed conflicts, and the more he is able to bring out these infantile conflicts and focus them on himself like a concave mirror, the more he succeeds in withdrawing as an individual, real, present person – in becoming a blank space, if you will, which can then be ‘filled’ by the patient. From the patient’s perspective, the analyst actually takes the place of infantile object relations and becomes a supplement to the patient’s past attachment figures. The analyst is thus an ‘embodied carrier’ or ‘material signifier’ with a merely symbolic and impersonal meaning. He becomes a stage on which the dramas experienced by the patient can be re-enacted. In order to focus the wishes and conflicts of the neurotic patient onto himself, the physician must act as a neutral medium.
(2) However, at the same time Freud also conceded the phenomenon of countertransference: Remaining within the same language game – namely that of transferability – he recognized with the concept of countertransference that the physician is not only a passive projection surface for the patient’s ‘inner child’, but rather the physician in turn also externalizes and to a certain extent acts out his own unconscious emotions. The physician thus suspends his neutral status: He is no longer a non-responsive medium, but rather he becomes a reacting and interacting sounding board.

Freud thus conceived of transference as a two-sided process, as the rudimentary form of an interactive event. From the physician’s neutral (media) perspective it appears that illusory, distorted, and inappropriate feelings are constantly being directed at the ‘wrong person’ in the form of the physician, but from the patient’s perspective they can be real, ‘true’ feelings, which are directed towards the physician as an individual person and not only as a substitute for infantile attachment figures. Freud wondered whether the infatuations that manifest during analysis should be considered real, as he explained: ‘We have no right to dispute that the state of being in love which makes its appearance in the course of analytic treatment has the character of a “genuine” love.’ Concerning the relationship of the analyst to the patient, on the other hand, Freud wrote in a letter to Oskar Pfister on June 5, 1910: ‘In general I agree with Stekel that the patient should be kept in a state of abstinence or unhappy love, which is naturally not entirely possible. The more the physician allows the patient to find love, the more he develops the patient’s complexes.’

Although Freud originally recognized it ‘only’ in terms of countertransference, he claimed that insight is available or at least prepared in the real and not only the symbolic, in the interactive and not only the reflecting-receiving relationship between physician and patient.

You will recall that with Breuer Freud witnessed how the emotional involvement of the analyst can undermine and threaten analysis if these emotions are not consciously processed and controlled. When it ‘goes off the tracks’, countertransference can be disastrous for therapy. Because he recognized the double role of the physician as medium and actor, as an intellectual organ of perception and an affective sounding board, it seems only logical that Freud’s concept of transference was designed to ensure theoretically as well as practically that the physician’s function as a medium during analysis remains the organizing centre of the psychoanalytic process.

This was ensured theoretically in that according to the Freudian approach all transference feelings, whether originating from the patient or the physician, are in a sense misguided and therefore ‘inappropriate’,...
‘illusory’, and ‘distorted’ insofar as they remain quasi-mechanical repetition procedures and constraining structures. Freud thus describes transference as both a ‘false connection’ and a ‘new edition’. From a pragmatic point of view, this emphasis on the reality distorting, repetitive, and regressive character of transference – which has incidentally been discredited by many psychoanalytic authors as an egological, solipsistic, and psychic-technical dimension in Freud’s approach – proves to be a tool or ‘safeguard’ that serves to prevent the internal dynamics of the paradoxical tension between intimacy and technicity, affectivity and recognition from threatening the implementation of psychoanalysis. To know that he is not the receiver, but rather the mediator of the intensive feelings directed towards him helps the physician to maintain a sense of distance with regard to the seductive involvements or repulsive entanglements involved in these emotions.

This was ensured practically in that the spatial constellation of the psychoanalytic dialogue as shaped by Freud provided for the staging of a depersonalization if not ‘anonymization’ of the analyst: The analyst sits behind the patient and thus remains beyond his field of vision, while the patient in turn lies on the couch. ‘Like an infant, the patient cannot be active’ and is ‘restricted to his couch/crib’. These rules of the analytic dialogue situation evoke associations with early childhood relationships. Precisely because Freud presumes that the transference of infantile attachment figures onto the analyst serves as a positive, indispensable aid, he requires and establishes a set-up for the dialogue situation, in which the physician positions himself as mediator and ambassador of the patient’s past. This can already be seen in his seating arrangement, as the analyst literally ‘withdraws’ and the patient speaks into the blank space of his projections.

The concept of transference thus does not simply discredit the interactive productivity and mutual affectivity of the psychoanalytic dialogue, but rather it guarantees that the emotional contact of the physician does not undermine his role as the analyst. This shows that the ‘mechanics’ of the transference process, which are notoriously rooted in the past of the patient, at least implicitly point to the reciprocally binding forces and emotions that come into effect in the presence of the therapeutic situation. The precepts of transference ensure that the physician, insofar as he reacts emotionally to the patient, at the same time knows that his patient in turn assumes the role of a medium and becomes a projection surface, on which the unconscious emotions of the analyst are ‘registered’. In countertransference the physician subverts his own neutral position as mediator only in order to reconstitute it in the patient; he mutates from mediator to agent in order at the same
time to turn the acting (out) patient into the ‘ambassador’ and ‘mirror’ of the physicians’ emotions. If the analyst is both a de-individualized mediator and an affected individual he can ‘play’ his role as an individual person precisely because he transfers his depersonalized mediator function to the patient. This contradicts the unidirectionality and asymmetry underlying the notion that the patient ‘sends’ neurotic signals, which the analyst then ‘receives’ and interprets, insofar as these positions prove to be interchangeable in the here and now of psychoanalysis. However, in the psychoanalytic constellation there is always a divide between the position of a non-acting, neutral medium and the position of an engaged, acting non-medium.

**A Conjecture: Is the Psychoanalytic Dialogue Beyond Dialogue?**

The foregoing discussion prompts the following conjecture: Freud describes transference as the core event of the psychoanalytic dialogue, and according to Freud this transference constitutes an irresolvable asymmetry between the speaker who acts (out) and the speaker who is ‘only’ a medium; furthermore, Freud concedes that these roles are indeed interchangeable, but they are not abolishable: Doesn’t this suggest that the psychoanalytic dialogue – if Freud is actually taken seriously – cannot be understood according to the model of a dialogue? I am using the word ‘dialogue’ here in the elementary sense of a symmetrical two-way conversation, in which the participants are on equal terms. I thus propose the following conjecture: Wherever transference takes place, there is also no dialogue (in the ‘strict’ sense of the word).

When interpreted in a literal sense, this statement may seem trivial. Based on the fact that it concerns psychoanalytic dialogue, however, the conjecture of a non-dialogism is quite remarkable. You will recall that Freud’s ‘discovery’ of psychoanalysis was the result of his efforts to replace suggestion, for example, through hypnosis, with talk and nothing but talk. Yet now it has been established that by making transference the core event in the psychoanalytic dialogue Freud precisely revoked the psychoanalytic dialogue’s status as ‘a dialogue’. Nothing illustrates this denial more clearly than the rules governing the seating arrangements during psychoanalytic sessions, which impose conditions on speech that are constitutively unequal.

At this point it is useful to cast a side glance at Jacques Lacan, who assumes a fundamental bipolarity in speech: Depending on whether the speaker employs the ‘moi’ of an egological self-relation or the ‘Je’ of a desire oriented towards the other, speech is either a declaration or a remark, it is either a representation or an evocation, it either refers to something that is objectively accurate or to an existential truth. Indeed, we always speak
with these two voices – not only in psychoanalytic dialogue – and for Lacan it is the task of the analyst to make the mostly submerged or repressed voice of the ‘Je’ talk. For return to Freud’s idea of transference, the more the analyst becomes the medium of transference for the patient, the more he succeeds in making this repressed voice talk, because in this way the desire of the patient towards the other can focus on the analyst without any inhibitions or distractions. From Lacan’s perspective, the ‘dialogism’ that Freud withheld from the psychoanalytic ‘talking cure’ precisely opens up the way for a form of speech oriented towards desire. I will now turn to this dialogism; and for this purpose it will help to look at newer developments in transference theory, which must nevertheless be read ‘against the grain’.

A Dialogical Revision of Freudian Transference Theory?
In the metatheory of psychoanalysis there has been a change regarding the theorization of the concept of transference. In conscious opposition to the theory that was just developed, this change involves the designation and reconstruction of ‘transference’ as precisely a dialogical process. Transfer-ence is no longer conceived as more than (1) a monolinear, one-sided process that (2) revives past emotional clichés in an almost mechanical way, which (3) distorts the present by referring to the ‘wrong’ objects at the ‘wrong’ time and which (4) receives no response from the analyst but is simply observed, interpreted, and recognized by the analyst from his position as a neutral medium, such that (5) with analyst’s help the patient’s unconscious, repressed past is translated into conscious memory and the patient is thus able to free himself from the neurotic symptoms of confrontational experiences from childhood.

I will now recap how the quasi-mechanical concept of transference, allegedly laid out by Freud, has been corrected.

(i) Reciprocity instead of one-sidedness: The heart of the dialogical revision is the recognition of the reciprocity of transference. Balint observed already in 1949 that Freud had created a one-body-psychology, a quasi-physics of the psychic apparatus, such that his metapsychology precisely neglected the intersubjective character of the psychoanalytic situation. Transference is now considered the form of a relationship between people that is based on two-sidedness and reciprocity.

(2) Intersubjectivity: What is always brought to light as ‘important’ in the psychoanalytic dialogue is not simply the repetition of a meaning that was buried in the subconscious in the past. Nor is it an action that arises from the quasi-solipsistic isolation of the patient. Rather, it is an activity that is due to the reciprocal interactivity of the analytic dialogue: The meaning
of transference is therefore always an intersubjective phenomenon. It is not the past of the patient that is to be interpreted in light of transference; rather, it is the existing relationship between the physician and the patient in the present. The unconscious of the patient thus does not itself exist as an absolute fact – according to Paul Ricoeur at least – but rather it only exists relative to the ‘dialogical’ process of therapy: It is the analyst’s act of witnessing that constitutes the patient’s subconscious in the first place.\(^\text{223}\)

(3) \textit{Relation to reality:} Instead of the inappropriate, illusory, and distorted character of transference feelings it is emphasized instead that what occurs during the process of transference represents to a certain extent a thoroughly realistic and appropriate reaction of the patient to the here and now of the therapeutic situation. This effectively eliminates the demarcation line separating the patient’s ‘deceptive’ form of transference and the physician’s ‘realistic’ insights into the ‘true nature’ of this transference.

(4) \textit{Beyond the analyst as medium of perception:} Contrary to an intellectually constraining view of the analyst who remains in the position of the observer and performs the functions of recognition and interpretation, it is emphasized instead that the physician is emotionally involved in the transference event and must be in order to be able to establish a connection between the unconscious of the patient and his own unconscious. Wyss thus observes that the therapist’s sphere of experience is constitutive for mutual understanding.\(^\text{224}\) Racker emphasizes the fundamentally libidinal character of transference: For him, love becomes the very condition of possibility for a successful psychoanalysis.\(^\text{225}\) Weiß also agrees with this concept, as he sees transference ‘above all as a manifestation of love’.\(^\text{226}\) What is required is not recognition and hermeneutics, but rather a ‘scenic understanding’ that – as Lorenzer emphasizes – is only possible insofar as the analyst actively participates in what the patient performs in his language game.\(^\text{227}\) The physician is therefore precisely not a medium; he does not function as a reflecting mirror or as an empty screen for neurotic projections.\(^\text{228}\) His self-withdrawing anonymization and depersonalization also remains an illusion.

(5) The healing effect of psychoanalysis does not simply consist in clothing a forgotten past in words and thus being able to bring back memories. Rather, if the analyst recognizes and accepts the patient’s feelings without fulfilling their imaginary claim, then the patient is confronted with his own desire in a new way: The ‘object’ of his desire no longer remains a plaything of his own projections. Rather, through the reciprocal action of acceptance and accommodation in the analyst’s real relationship to the patient, on the one hand, and the analyst’s otherness and hiddenness with regard to
the patient’s imaginary claims, on the other hand, the analyst becomes a focal point for a new kind of ‘relationship experience’ for the patient. The solidified clichés of traumatic experiences can thus liquefy and finally also disappear. *The experience of a new kind of relationship, not merely recognition or memory, heals the patient.*

Allow me to try once again to explain in a different way the logic of the revision of the classical concept of transference that was just sketched out: The classical concept of transference assumes that an inappropriate, conflict-laden, and deformed emotional pattern acquired in the past is transferred to the present, where it can then be deciphered and treated. An interactive and post-classical concept of transference, on the other hand, assumes that an emotional constellation acquired in the past is transformed over the course of transference, insofar as the patient can have a self-altering relationship to the physician: The patient’s emotional clichés are thus subject to a *mutation and transmutation.* According to the classical perspective, therefore, the physician serves as a recording medium and an observing perceptual organ that helps the patient to ‘translate’ an unconscious potential for conflict into verbalizing memory; the physician thus mediates between the patient’s past and present. According to the post-classical perspective the physician is an interactive partner who always also has an emotional and not only interpretive relationship to the patient; together they are able to establish a new kind of relationship, which is real rather than illusory, and through this relationship the patient is able to free himself from his neurotic symptoms. This reconstruction of an ‘interactive turning point’ in the theory of transference emphasizes the differences between these approaches, and it presents a paradoxical situation for this media-theoretical project: Freud’s concept of transference is groundbreaking insofar as the analyst represents a mediating figure that is able to cast a new perspective on media in relation to transmission. However, the interactive concept of transference fundamentally challenges precisely the *medial* status of the analyst. The reason for this is the supposition that the relationship between the patient and the physician represents an entirely interactive and communicative relationship, which thus gives rise to a collectively ‘shared’ reality in the here and now of the analytic situation. For Freud the physician plays a double role: he is a more or less neutral medium in transference and at the same time an emotionally involved person in countertransference. In the post-Freudian theory of transference, however, this difference disappears and the boundaries between transference and countertransference are blurred.

My method now consists in drawing together aspects of the classical and the post-classical theories, as the question arises: Would it not be possible to
combine what Freud constructed as a kind of exclusive relationship between the analyst as, on the one hand, an observing, reflecting, and interpreting medium and, on the other hand, an emotional person acting out his own subconscious feelings? Doesn't this difference help to explain the productivity of transference, which includes the mutation and metamorphosis of what is transferred and thus reflects one of the central concerns of post-classical theory?

In order to connect both elements it is necessary to 'de-discursify' the communicative interaction between the patient and the analyst. The reciprocity, two-sidedness, interactivity, and intersubjectivity that post-classical theory rightfully emphasizes actually exists, but they precisely do not correspond to the universally pragmatic model of communication taken from speech act theory, which is based on the assumption of the formal-rational equality of conversation partners. In order to give an idea of this 'de-discursified interaction' I will now go back to the considerations of René Spitz, who examined pre-linguistic 'dialogue' in the interactions between mothers and children.

‘Dialogue’ as Circular Affective Resonance
René Spitz researched the early forms of dialogue that occur in childhood interactions before the child is capable of speech. For Spitz, a depth psychologist, this orientation towards early childhood interaction was not an end in itself; rather, he assumed that there were analogies between the analytic situation and early childhood relationships to primary caregivers.229 This notion implies that the structures of extra-linguistic interaction and their ‘criteria for success’ also reveal the structures of psychoanalytic dialogue and their ‘options for success’. Furthermore, it reflects the insight that although psychoanalysis understands itself as a pure ‘talking cure’ its ‘asymmetrical nature’ fundamentally distinguishes it from the model of communication taken from speech act theory and it is therefore more than just ‘talk’.

Spitz introduces the concept of ‘dialogue’ to describe early pre-verbal action sequences, and by replacing the usual psychoanalytic concept of the ‘object relation’ of the patient to the analyst with the term ‘dialogue’ he also becomes a proponent of the tendency towards the ‘dialogization’ of psychoanalysis. At the same time, however, there are also indications that this kind of dialogue is involved in psycho-sexual development and it is thus instrumentalized through the manner in which the child's wishes relate to the animate and inanimate object world. The dialogical character of the interaction between mother and child is not conceptualized according to
the model of linguistic understanding; rather, it constitutes a matrix for all human communication phenomena and identity processes and thus also for psychoanalytic dialogue.

Here is what this ‘dialogic interaction, which precedes language’, looks like: Spitz identifies three stages that occur within the first 18 months, up to the point when the child acquires his mother tongue: (i) An ‘objectless stage’ during which the I and the not-I remain inseparable, although at the end of the second month human beings occupy a position above all other things, as they are consistently smiled at.  

(ii) A stage when others are perceived as distinct from the self and the child – obviously experiencing the ‘fear of separation’ at eight months, which constitutes a counterpart to the ‘smiling response’ of the earlier stage – is able to distinguish between strangers and people who are familiar.  

(iii) And finally the training of the first ‘semantic gestures’ – especially head shaking to indicate ‘no’ – which the child experiences and adopts through his interaction with and emulation of others, such that his self is constituted by the behaviour of others, the non-self: “The “no” thus becomes the identifying stamp of social relations on a human level.”  

I cannot pursue the details of this fascinating reconstruction of the evolution of communication in the preliminary stages of linguisticality. What matters here is that the development of these early forms of dialogicity is tied to the active interplay between mother and child, and it is crucially shaped by the facilitation or inhibition of this interaction. According to Spitz, what emerges in the relationship between mother and child in the first months is a ‘circular resonance process’ that engenders a ‘quasi-magical sensibility’. It is a process that is not organized through the medium of signs, but rather it constitutes the very origin of this sign function. And yet it does involve a medium, which is the person who interacts with the child. One could also say that the child needs and uses the mother as a medium for the training of his I in relation to others. But the mother can only be such a medium insofar as she constitutes an emotional sounding board for her child. This early childhood interaction must therefore be understood as a series of reciprocal actions, as an exchange of looks that can pose questions and answers, as physical proximity and contact, as sounds resembling ‘twitters of delight’ that are exchanged as reciprocal signals of acceptance and resistance. For Spitz the ‘essence’ of this dialogue lies in the ‘expectation that something will happen’. For him, this reciprocity fundamentally distinguishes the living from the dead. But it is a reciprocity that, like the mother-child structure, not only involves but virtually presupposes an asymmetry between the interacting partners. It
is the productive resonance of the emotional sphere that makes an unequal relationship with one another possible. What Spitz means by ‘dialogue’, therefore, is the formation of an emotional echo of the I in the not-I. In this sense, for Spitz and also for Weiß psychoanalytic transference is based on ‘dialogic resonance phenomena’.237

At this point it makes sense to visualize the actual meaning of ‘resonance’ (Latin ‘resonare’: resound). In a physical sense, it refers to the resonating of a system whose movement is induced by another system. The reacting system thus has a resonant frequency, which is nevertheless ‘amplified’ by external stimulation. Niklas Luhmann employs ‘resonance’ as a term for social transmission, thereby emphasizing that a system can only resonate insofar as it already has its own vibrations; at the same time he also stresses that transmission through resonance is only possible between similar kinds of system zones, when there is therefore a similarity between both systems.238 Resonance thus requires that there is a fundamental difference as well as a similarity between two systems. It causes the movement of one system to be transmitted to another system, but at the same time the resonant frequency of the affected system is changed and converted by this transmission.

So how might it be possible to connect the notion of the analyst as a medium and the notion of the analyst as an actor, which Freud conceived as separate functions? The ‘dialogization’ that the post-classical theory of transference has in mind – at the expense of the analyst’s medial function – manifests itself as something that is embedded in the way the analyst becomes a medium. The transference of past experiences onto the analyst occurs in such a way that the patient’s ‘reoccurring’ trauma is ‘processed’ insofar as the analyst becomes a sounding board for the emotions experienced by the patient. The vibrations emanating from the patient are thus not only recorded but also transformed through the analyst’s own vibrations. This ‘self-oscillation’ consists in not only the physician’s own emotions, but also the fact that he is removed and is thus capable of observing and interpreting. The double role of being at the same time both an observer and an actor is inscribed in the actions of the analyst. This is the joke of psychoanalytic resonance. The ‘echo of the I in the not-I’ is precisely for this reason not only an echo, but also a transformation, because the analyst embodies the difference between participating and not participating. The analyst both empathizes and observes; he is both similar to and at the same time different from the patient. The analyst can become a (non-participating) medium of psychic transference precisely because he enters into a (participating) emotional relationship with the patient.
Transference through ‘Affective Resonance’: A Conclusion

(1) ‘Transference’ is a psychoanalytic term that describes the kind of connection that emerges in the psychoanalytic situation. With this concept Freud points to the unconscious repetition of earlier experiences in the current relationship of the patient to the analyst. He concedes that transference is usually accompanied by countertransference on the part of the physician towards the patient, yet it remains important for him that transference functions as a therapeutic ‘tool’, as the analyst withdraws as a person in order to act as a medium that can become a ‘projection surface’ for the patient's unconscious. Nevertheless, it is also an undeniable fact for Freud that the analyst is always also emotionally involved with the patient. The activity of the analyst thus embodies two aspects: He is an observer, interpreter, and analyzer and at the same time a participant and an actor. Post-classical theories emphasize that transference not only represents a repetition of the past, but rather it is also shaped by the present of the psychoanalytic situation, and it can therefore be understood as a completely interactive event that occurs between the physician and the patient. However, the insight into the role of the analyst as a medium for transference is largely missing in these theories.

(2) The fundamental question is how the passivity and the activity of the analyst, his function as a medium and his role as an actor, can in each case be understood as two dimensions of the transference event. This implicitly explains how ‘repetition’ can always also be conceived as an act of ‘reshaping’. Nevertheless, questioning this duplicity of transferring and creating is only meaningful so long as one holds onto the Freudian insight that being an analyst also means offering oneself as a medium for the repressed feelings of the patient precisely by remaining ‘neutral’ and withdrawn.

(3) The key to understanding the creative dimension of the transference event is the phenomenon of affective resonance. Being a sounding board means reacting to a vibration. It is important that this ‘physics of vibration’ is here only a metaphorical expression for the reciprocity of emotions, or affects, which enable a reciprocity between the unequal. René Spitz explained the resonating ability of the dialogic using the example of pre-verbal mother-child interaction, and he thus at the same time attributed a meaning to the function of language in psychoanalytic dialogue that precisely cannot be compared to a dialogical speech act.