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ROBERT WAELDER ON PSYCHOANALYTIC TECHNIQUE: FIVE LECTURES

EDITED BY SAMUEL A. GUTTMAN, M.D., PH.D., WITH THE ASSISTANCE OF IRENE KAGAN GUTTMAN

Biographical information regarding Robert Waelder is readily available (Guttman, 1986),[1] and this is not the place for it. The following is a rare and direct example of his "old-fashioned" teaching. "Old-fashioned" and "conservative" are criticisms often leveled at Waelder these days. Yet, "Old-fashioned is not precisely the word for Waelder. . . . He was a conservative in the best sense, as his later writings continued to prove, one who would not relinquish what is good for the sake of the supposed 'ideal' situation imagined by those restless for change. This was his ethic, and his conservatism was entirely humanitarian. He refused to idealize 'human nature' and tried to preserve the realism of his clinical sense in matters beyond the clinic" (Lewin, 1968, p. 9).

PREFACE

These lectures constitute a seminar presented by Robert Waelder to candidates at the Washington Psychoanalytic Institute in 1941-1942. They came into my possession upon his death, as part of his literary estate, of which I am executor. They were unsorted, undated notes. It took me a while to establish their origin, and then to fuss with them before deciding they should be published.

Although his English was far from perfect—he had emigrated to the United States only some three years before, in the

[1] See also *Bulletin of the Philadelphia Association for Psychoanalysis*, 1968, Vol. 18, No. 1.

spring of 1938—Waelder had acquired a well-deserved reputation as an excellent lecturer: he had an elegant way of discussing character types and psychopathology in the simplest jargon-free language, and he was able to master clinical and theoretical material and make it come alive. In Vienna, he was reputed to be the brightest student in Freud's circle; Anna Freud said of him, "He understood my father better than anyone else."

Waelder knew where he stood psychoanalytically, and he made his position very clear and plausible. He disliked and had little patience for the bewildered, confused psychoanalyst. He liked the clear, the brief, and the bold. He had a great distaste for ignorance, and an even greater one for attempts to compound it.

I resolved not to update or elaborate on this material in any way. The value here is to take these lessons from Waelder as a starting point for seminars, discussions, clinical and theoretical psychoanalytic work, and instruction. Of course, Waelder himself did elaborate on all these topics. A bibliography of his other work may be found elsewhere (Waelder, 1976). I shall cite but two examples. I chose them because they contain the final efforts of his years of clinical practice and theoretical excursions based on work with his patients in the psychoanalytic situation. He always concentrated on fundamentals, the essence of the matter, and basic concepts.

In his *Basic Theory of Psychoanalysis*, Waelder (1960) set down the psychoanalytic approach as focusing essentially on the unconscious (mental processes), the sexual (and aggressive) drives, and the lasting importance of seemingly trifling childhood experiences. He stated, "An alertness for the unconscious, the sexual, and the infantile may be called the *psychoanalytic point of view*" (p. 51). Later, in "Psychoanalysis, Scientific Method, and Philosophy," Waelder (1962) stated, "In speaking of psychoanalysis . . . one can distinguish between different parts which have different degrees of relevance." He cited levels of "observation," "clinical interpretation," "clinical generalizations,"

"clinical theory," "metapsychology," and "Freud's philosophy" (pp. 250-251). These basic tenets are as true today as they were a generation ago.

I take this opportunity to acknowledge my indebtedness to Robert Waelder for permitting me to learn so much first-hand. It took me a long time to become accustomed to the fact that by making me his literary executor, Waelder turned over everything, lock, stock, and barrel, for my discretionary use. I am very grateful to his widow, Mrs. Elsie Waelder, and especially to their children, Catherine Waelder Weiss and David Waelder, for giving me their complete trust, their confidence, and a free hand, with never a hard time.

SAMUEL A. GUTTMAN, M.D., PH.D.

I

THE START OF A PSYCHOANALYSIS

There have been quite a number of books and papers, of lectures and seminars, attempting to teach psychoanalytic technique. Yet, if the teacher is honest and knows what he is trying to teach, he will admit that actually only a very small part of psychoanalytic technique is teachable. Freud himself declared that, as in chess, it is merely the opening moves and some typical concluding situations that lend themselves to teaching. Everything else is practically unteachable.

I begin with some preliminary remarks. As you know, we may look at every science from a theoretical as well as a practical viewpoint. I want to emphasize that you will learn no theory at all in this course. There are excellent books and papers about the theoretical aspects. I will name two authors who are a "must" for every analyst not only to read, but to study very thoroughly. I want all of you to read very carefully the papers Freud (1911-1915) wrote about psychoanalytic technique, and I also want you to study very carefully Otto Fenichel's (1938-1939)

outstanding book titled *Problems of Psychoanalytic Technique.* These lectures are meant to complement these theoretical concepts; I shall illustrate theory with examples out of the experience gained in many years of work. It may well be that some of you—I do not know all of you very thoroughly—will find some of the things I am going to tell you rather elementary and primitive. Please do not take this as an expression of lacking appreciation of your knowledge. And believe me that it is rather the elementary that has to be said over and over again. The more complicated matters are easily recognized as important, whereas the simple ones frequently are considered negligible.

The problems I want to discuss are: How do we begin? How do we prepare the patient for what he is supposed to do and to experience—prepare him rather than frighten him or increase his normal resistance (because resistance is a normal thing; we shall come to this later on)? The next problem will be what to do in order to get the patient into analysis, that is, how to gain his cooperation and establish a situation in which he is tempted to cooperate rather than to indulge in being stubborn and hostile. Since this should be the first step in establishing a solid and helpful transference, this much-discussed topic will be next. And since transference is, as you know, not always working with the analysis, but very frequently against it, the matter of resistance, especially of transference resistance, will have to be taken up more thoroughly. An excellent means of demonstrating resistances (to the analyst as well as to the patient), and of dissolving them so that the analysis gets moving again, is the analysis of dreams. So, the handling of dreams will be the next subject. We shall then take up the matter of interpretation which will have to be followed by the topic of working through, too often neglected by inexperienced analysts. At the end of this course I shall want to talk about ways to end an analysis, although this is perhaps a subject which most of you will not be able to put to any use very soon.

Of course, we cannot cover all this in five lectures. I may have to continue this course in the next semester—if you want me

to—and I do not think we should hurry just for the purpose of finishing up in a few lectures what actually would require many more. So, we shall begin with what must be logically the start of every course on psychoanalytic technique, that is, with the correct start of treatment. I shall try to make these lectures as useful for you as possible, regardless of how far we get.

Now what do we do when a patient comes for the first time? Let us assume we do not know anything about him. Of course, it is important to see how the patient behaves under normal conditions—whether he is embarrassed or poised, or self-conscious, or arrogant, or reticent, or loquacious, whether he puts up a mask or at least tries to be frank. These are more or less general things. There are more specific ones. The patient may show you that what he actually wants is reassurance rather than psychoanalytic help. Or he may start out with a long list of doctors who could not help him and suggest that maybe you cannot help him either. He may perform some ritual in sitting down or in lighting a cigarette. He may be more interested in asking whether you are capable of helping him than in telling you anything about himself. He may, in this first interview when he asks to be taken on as an analytic patient, argue against psychoanalysis. He may tell you that his analysis certainly will not take long because he has read all the psychoanalytic literature and therefore understands his symptoms entirely. This last type has been rather frequent lately. Do not make statements like "Reading cannot help you." It is useless. With a patient such as this I usually ask: "Did it help you? Did you lose your symptoms after reading about them?" He has to confess that he did not. In other words, do not argue with generalities; say something that concerns him personally. Show him you are interested. Start with a question about him, about his particular case. Do not contradict his statement that his analysis will not take much time. Tell him the truth: that you do not know, that the length of his analysis will depend on his willingness and ability to cooperate.

Some patients try right from the beginning to put the whole relationship on a friendly, or rather a social basis. I remember one who started his first interview by saying, while seating himself: "I have always wanted to meet you; now, unfortunately, I am in rather a hurry today, I have to leave in ten minutes. But if it is all right with you, may I take you to dinner tonight? We can discuss everything while eating." This is, by the way, quite a good example of why it is so difficult to teach what to say to a patient in a given situation. You may ask, "What are we supposed to answer? Should we say that the analytic situation will not allow that?" I do not think this would be advisable, even if the patient knew about this analytic situation. I asked him—without a trace of reproach in my voice—why he was in a hurry; he had known, after all, for two weeks that I expected him. Why did he arrange his day in a way that would make this interview last only ten minutes? I was perfectly willing to make another appointment with him if he really had to leave. Oh no, it was not that important, of course he could stay. At the end of the hour he left very reluctantly. It was no surprise to me when he repeated his dinner invitation at the end of his third hour. But it was one for him when I reminded him of that first interview and could now, provided with some material, interpret his attempts to transform his analysis into a social situation. He always tried to prove to himself, whenever he felt some danger, either real or imagined: "See, we are good friends, so we shall not do anything harmful to each other; we shall not kill each other." Of course, the idea of killing was not interpreted at the end of the third hour; that came up much later. Now with another person, another answer would have been necessary. I could imagine people to whom the answer would have had to be: "Do you always invite people to dinner when you just meet them?" And to still others it would have been: "Why are you so afraid of this interview? It will not do you any harm." Again to others: "Why not wait and see whether you could stand it longer than ten minutes?"

What I mean to convey to you with this example is: During a

first interview we try to learn how the patient's ego behaves in a normal situation. That is why we have him sit up—because sitting in front of you is a more normal, everyday situation than lying on the couch with you behind him. We are aware of every attempt of the patient to make the situation less normal; an analytic interview at the dinner table is not normal either.

In this first interview we let him tell why he is looking for help and what his general situation is, and we show him that we are interested. Many patients, having heard people talk about analysis, try to limit what they say to a list of their childhood sexual experiences. I always react by asking about nonsexual matters. For instance, I ask how many children there were in the family, what kind of work he does. When, after having informed me about that, he returns to his recital, I ask where he went to school, or some such question. Usually, two or perhaps three such questions show him what he has to realize anyway—that we are interested not only in sex.

Do not try, in this first interview, to look for the patient's unconscious. He will betray some of it, certainly. But do not make use of it; do not interpret it; do not jump to conclusions. You can make use of it much later, when the patient is able to understand why you do it. I try to make it a point never to say anything the patient does not understand.

The first interview mainly serves as a means to determine whether the patient should or could be analyzed, whether psychoanalysis is the right treatment for him, or whether some other procedure would do more for him. Talk his situation over with him and try to find out what he expects (consciously) from his analysis. Explain to him that psychoanalysis is different from any other treatment in that he is expected to do most of the work and that it is a long and laborious enterprise. The psychoanalytic technique with patients who have been in psychoanalysis unsuccessfully before is, of course, somewhat different. They usually are very difficult to handle and constitute (together with character cases and perverts) the group of patients whose psychoanalyses take much longer than all the others.

If the patient decides to begin treatment, explain your method to him. Mention the couch and notice how he reacts to it. Finally, explain to him what he is supposed to do, that is, explain free association to him. You will have to repeat that many times during his analysis. Never take it for granted that he really understands it as long as you have no definite proof of his using it. Tell him you expect him to be perfectly frank, and do not forget to add that you will be frank with him.

You will also mention that other condition of a successful analysis, that the patient is not supposed to make vital decisions, or rather carry them out, as long as they are not fully discussed and understood in his psychoanalysis. There has been much discussion on this point. It was Fenichel who warned against saying it in the initial interview, that is, before we know the patient better, because it might, in the patient's mind, immediately place the analyst in the category of forbidding parents. I personally am very much for saying it as early as possible, but I always make it a point to formulate it as a mutual agreement rather than a prohibition. Since the patient is not yet familiar with the idea of acting out, we had better formulate it simply, backing it with our experience. We tell him that such vital decisions as marrying, divorcing, quitting a job, leaving home, and so forth, often are arrived at during an analysis only to be replaced by another decision a few weeks later, and that frequently an analytic patient is unable to judge whether his decision is based on sound grounds or is a mere consequence of the particular phase of analysis he is in.

In everything you tell the patient, avoid as much as possible the use of technical terms. I have conducted whole analyses without any of them, and I assure you that it is not only possible, but also contributes much to the success of the analysis. If you have not experienced it yourself, you have no idea how much you slow down an analysis by providing the patient with terms, instead of emotional experiences. This is particularly true for compulsion neurotics who are only too glad if you help them to label things, to speak of them or about them, instead of

living them—in other words, to put the whole process on an intellectual basis instead of an emotional one.

There are psychoanalysts who advocate a single, very brief interview before putting the patient on the couch. My experience makes me favor the opposite procedure. Usually, I see the patient twice before starting analysis proper, sometimes three times. Using this procedure not only helps to establish rapport between the patient and yourself, but gives you more opportunity to observe his behavior and attitudes in that rather normal situation I mentioned. As I said before, lying on the couch with you sitting behind it is not such a normal situation at all. This may be one of the reasons why some analysts abandon the idea of the couch altogether and prefer to have the patient sit in front of them. I personally am decidedly against the latter.

In some analyses, however, it so happens that the patient makes use of his position on the couch as a resistance. If you do not yet have enough material to interpret and thus eliminate this, it is a good idea to have him sit up for a while. I have done that several times, mostly with good results. But you must never forget to put him on the couch again at the right moment. Otherwise, the position in front of you will become just as effective a resistance as the other was. Just as on the couch he may have indulged in wallowing in childhood memories, now he will probably do the same with reports about his everyday life—if you do not time the change properly. In general, we can say that having him sit up is always a good idea in two instances: first, when you feel that he is starting to lose contact with reality, coming close to the borderline (toward psychosis) and experiencing more anxiety from his unconscious than he can stand (it is easier to keep him in contact with reality when he faces you); second, when you want to demonstrate to the patient that he uses his position on the couch as a resistance. Such resistance may have the meaning: "What I say here lying down is not true for the time I am standing up"; or, "This is part of a game I am playing with my analyst and not reality"; or, "As long as I am not allowed to look at my analyst, I am not going to say any-

thing." Placing such a patient in front of you would mean showing him (instead of merely telling him) what he is doing, because he would not be able to maintain his game or his "playing at telling the truth" or his stubbornness, or whatever it is.

Sometimes it happens that this stubbornness is very far-ranging. I remember a patient who in his first weeks of psychoanalysis talked almost without stopping, giving me an apparently complete report about his whole life history, speaking very fast, very low, and without any sign of feeling. I had repeatedly tried to stop him without success, tried to show him that this was not the way to do it. He did not understand at all. As soon as I stopped talking, he resumed in the same way. I called his attention to the difference between his speech now and in the first interview—to no avail. Then I decided to wait and see whether he would run dry. This happened very soon and quite suddenly—in the middle of an hour, he stopped and just did not start again. The situation was completely reversed. Now I had to try to make him talk, without success. He came on time, greeted me politely, lay down, and was silent. I thought of having him sit up, but decided against it. I tried to make him understand that it would be very important to find out at least why he behaved that way; it did not help a bit. I tried direct questions. Sometimes he said yes or no; sometimes he just nodded or shook his head. Once I asked him whether he would talk if he could. He began to weep, in an absolutely silent way, the tears rolling down for minutes. Of course he was afraid, terribly afraid. I told him so. He confirmed it by nodding his head. But I had no possibility to interpret this anxiety. Finally, I told him that perhaps it was not the right time for him to do his analysis, but that I would give him time. I would wait for three more months. If there was no change, we would know that it really was not the right time for him. This happened at the beginning of March, so I would wait until the end of May. The time went by without his saying anything. I tried everything I could. A few days before the three months were up, I asked him

whether he knew that the time was almost up. He nodded. The last day, I asked again. Then he opened his mouth. He said, very much under pressure, with a very low voice, "I cannot speak lying down." I pulled up a chair and had him sit down, with his back toward me. He immediately began to talk, but no longer the way he used to talk before his silent period. He did exactly what we expect our patients to do—free-associate. He began with the answer to the most important question—why he had been unable to talk. He said "it was forbidden." By means of free association he very soon told me why. He and his brother slept together when he was little and used to tell each other lots of things in bed. Then mother made it a strict rule that they were never to talk in bed. At first they did not quite follow the rule. But they were punished cruelly, and finally they managed to tell each other what they wanted before they got into bed. When they were lying down, they were silent. I asked him whether he followed the rule also when he was in bed with his wife. Yes, he never spoke while lying down. But, he added, he found a way out. Whenever he wanted to say anything to his wife at night, he sat up in bed. I told him that the most interesting fact was that he was able to talk for the first few weeks. I shall not go into the details now, but further analysis revealed that with this he acted out the hurriedly whispered things he and his brother had told each other before the prohibition had set in. The sudden stop occurred when, for the first time, he talked about the very tender relationship between his brother and himself.

I reported this incident because it provides a very good example not only of the apparent stubbornness of some patients, but also of what I meant when I said that psychoanalytic technique is not really teachable. During those three months, I repeatedly asked myself why I did not have this patient sit up, as I had done before with other patients. I felt somehow (and it is exactly this feeling which is not teachable) that his behavior would be understandable if I only waited long enough. It was understood and helped to make this analysis a successful one.

Having him sit up would probably have prolonged his analysis because his love for his brother, his mother's jealousy, that rule of his mother's—all that would not have come out. Of course, he would have started talking earlier. But he would not have remembered the conflict between his love for his brother and for his mother—which he repeated, by the way, all his life—and he would not have remembered the change of his love first into fear, and, much later, into hate. We shall come back to this example because it provides a good opportunity for demonstrating several points. But now we are still concerned with the start of an analysis.

I have found it useful to point out very early, during the first hours, any of those gross abnormalities in talking which give the impression of being part of the patient's character. Their real understanding, tracing them back to earlier attitudes, and their interpretation, of course, must come later.

I also call to the patient's attention—without interpreting it—any way of talking and wording, of gesturing, and so on, different from that in the first interviews. The purpose is obvious and simple: These things constitute the first steps in making the patient aware of certain emotional patterns, of automatized ways of behaving which he later will have to recognize as remnants of old fears. Much later, he will also have to recognize and to face the fact that in those remnants both sides of his conflicts are represented: instinct and defense.

The first real hour of analysis has to be handled very carefully. Resist the patient's understandable wish to have you give him hints as to where to start, but resist also your own wish to do so. The best thing to do, really, after having explained to him what you want him to do, is to let him start and go on. Watch out for planned hours, for "rehearsed performances," and when you are sure that he follows a preformed program, tell him so as soon as possible. Tell him you understand that free association may be difficult for him (I usually add something like "for most of us") but that it would be much more beneficial and would give his analysis the right start if he could

comply. In other words, try, without discouraging him, to get him really into analysis. I realize that all this sounds very elementary and certainly not very helpful. I can only emphasize that there is nothing more important than the correct handling of those first hours. It is also one of the most difficult things to teach. Each patient is different; each requires different handling. Perhaps the only thing that can be recommended is that whenever you feel, "this is a peculiar thing, but I cannot possibly tell him that," because he is too narcissistic, or too shy, or too embarrassed, or it will hurt his feelings, or something like that, say it. Say it without a trace of reproach or annoyance or anger or disappointment; say it as an interested spectator who objectively makes a statement. I like to combine such a statement with some question, the answer to which may (but does not have to) lead to more information. For instance, "I notice that you always interrupt your sentences; is that a general habit of yours?" Or, "You speak in a very low voice; are you aware of it?" Or, "I see that you keep your fists clenched; don't you think that you could relax physically also?" Never interpret such things at the beginning. Point them out, but do not interpret them. Not only is the patient not yet prepared for interpretations, but as long as you do not know more about him, your interpretation might either be wrong and thus give the patient the feeling (correctly so) that you do not really understand him, or you might hit a sore spot, perhaps the very spot that makes him suffer most. On the other hand, perhaps this is just what the patient wants you to think, and might strengthen his determination to fool you.

If, at the end of the first hour, there is not much you can say, say just this. Tell him frankly that first you have to become acquainted with him and especially with the course his thoughts are taking. Make him understand in this way that you have to *study him before you can tell him anything. But keep what he* said well in mind. Remember what experience has taught us about those first associations; they often give the very key to the patient's neurosis, and later, sometimes much later, you will be

able to use this key. It happened often that after a year or two of analysis I could remind a patient of his first hour, particularly of the first associations, and could show him that with those he gave a good picture of what went on in his analysis later. Several times I heard the patient say: "I can see it now, but I do not believe I would have understood it at that time."

See to it that the patient leaves at the right time. Of course, you want him to be punctual; but then you have to be on time too. I have found it useful to pause for ten minutes between hours, and always at the end of the hour instead of at the beginning as some analysts are used to doing. I begin immediately when the patient comes, never letting him wait. But I stop after fifty minutes and take a break, which I consider very important for the analyst. It sometimes happens that something extremely important comes up at the end of the session so that you cannot stop on time. Then these ten minutes give you an opportunity to stretch that particular hour without taking away time from the next patient. The tendency of the patient to bring important associations at the very end of an hour has to be taken up next time. Never let it pass unmentioned if you do not want to establish a new pattern of resistance.

You may ask when to start interpreting. Of course, that varies. I would say, not too early. But I know that I occasionally did start very early, even in the first hour. A patient once told me in his first hour that he had known and loved his wife for fifteen years before he married her. Later he said that he waited many years before he settled down in his profession. Still later he said that for six years he did not want to have children, although no marriage could be happy without them. Then he stated he had known for a long time that he needed dental work before going to the dentist. In his associations he related several other instances in which he waited for a long time before he did what had to be done. Now, you may ask whether (in his first hour) to interpret that. By no means should he have been told that this is an anal mechanism or that he was slow in making decisions. The first interpretation he would not have under-

stood; the second he probably knew anyway. Should I have said he was afraid of doing those things? He would have admitted that he was afraid of the dentist, perhaps also of settling down. But could he admit (in the first hour) that he had been afraid of marrying a girl he was in love with?

I was quite certain he did not even know that those associations belonged together. They were rather evenly distributed over the whole hour, with a lot of other material inbetween. So I did some interpretation, but not much. I lined up those statements—nothing else. He was bewildered to see that he acted the same way in so many different situations. Then I asked: "How long did you consider analysis before you came to see me?" He did not say anything for a long time. Finally he said: "I thought of it for the first time about seven years ago. Again and again I postponed it or forgot it." I thought he had understood, but he continued: "Why do you ask me?" So he still did not see what I meant, and I showed him that his analysis belonged to that series of things he postponed. I added: "Are you very much afraid of the dentist?" After a pause, he said slowly: "They are right." I asked, who. "The people who say that analysis is voodoo. But I did not think that I ever could believe in voodoo. Now I do. I remember that when I finally married my wife, I told her that I had hesitated so long because I was afraid of it. You are absolutely right in saying that I am afraid of analysis. I am, terribly." I had not said that. But of course it was implied in what I said.

As a general rule, I am against interpreting at the very beginning, in the first hour of analysis. Here I could do it because the interpretation itself concerned just this beginning—the act of beginning something important. The deeper layers involved had to be studied and interpreted much later.

I want to add that if I had asked whether he was afraid of psychoanalysis, he probably would have denied it. I deliberately asked whether he was afraid of the dentist because this was a fear he did not need to be ashamed of; many people are afraid of going to the dentist. My lining up dentist, business, marriage,

and psychoanalysis made him realize that I had said "dentist" but had meant psychoanalysis.

When I chose the start of analysis as our first topic, I did not mean just the first hour. I would say an analysis is at its start until at least two requirements are fulfilled. The first is that a definite relationship is established. By this, I do not mean that the transference has become specific, but that the patient has the confidence necessary to be truthful and frank and that the analyst can judge the patient's relation to his unconscious. Second, the analysis is only at its start until the patient has understood, but really understood, what he is supposed to do and that the analyst listens not only to the patient's words, but also to what is said between the words—that is, until the patient becomes at least a little bit familiar with his own unconscious.

This period is covered usually by what we call the trial analysis. I would go so far as to say that a patient who cannot or does not want to understand that there are thoughts, doubts, feelings, and fears within him which he does not know is either not suited for psychoanalysis or is still in the preparatory stage. You can reach this point in a few days with one person, in several months with another. You have to be patient, in any case. You may give superficial interpretations, but by no means deep ones. I recall a woman patient who complained bitterly about an analyst with whom she had started several years before, who made her stop the analysis through what she called sheer stupidity. In the first week with him the patient had brought in a dream in which she slept in the White House. There she had intercourse, she did not know with whom. Her first analyst said: "Of course with your father, with whom else? Isn't the man in the White House the father of his country?" And so on. When he had finished the patient got up and said thank you, she had enough. And although this analyst was probably right, the patient was, too. She was absolutely unprepared for a deep interpretation—particularly such a clumsy one—and unable to accept it. It took several years to try it again and at least a year or

more for her to be able to accept a parallel interpretation. I am certain this patient had responded to that premature interpretation with repressing her oedipal wishes deeper and deeper, so that she had a harder time getting to them than she would have had without that experience.

In most analyses you can notice signs of transference right at the very beginning. In accordance with this, the mistake most frequently made by inexperienced analysts is to interpret these first signs of transference. In the first place, you do not yet know enough about the patient. Furthermore, you not only destroy the transference instead of making use of it, but you often destroy the willingness of the patient to build it up again. Let the transference develop until you know exactly what the feelings or affects are which he is transferring onto you, why he does it, and, if possible, where they really belong. Another common mistake is that "transference" always means love or hate and should be interpreted as such. Do not forget that there are innumerable other emotions that can be transferred. It is true that at the very bottom of them you can, in most cases, find love or hate. But it always takes a long time to get to that bottom of any emotion. In other words, it would mean starting from the depth instead of from the surface, which is the thing you should avoid most in making interpretations. We shall discuss this in detail later.

The general "rules" and recommendations as to how the analyst should behave during his work (see Freud, 1911-1915) have been quoted repeatedly, but it seems to me that some of them are often misunderstood. The function of the analyst as a "mirror," for instance, has led to the notion that the analyst is supposed to act as if he did not live at all. No human reaction should be permitted. In other words, the analyst should do what, if the patient did it, we would always try to stop; he should isolate analysis from life and appear to the patient not as a human being, but as a stone image of one. I cannot emphasize enough that this is an entirely wrong notion. The analyst should never pretend to be what he really is not, or put on an act. What

is really meant by this comparison with a mirror is that the analyst should try to avoid influencing the emotions of the patient, and particularly that he should respond to the transference reactions of the patient in exactly the same way as he does to everything else expressed by the patient. He is not supposed to react emotionally, but analytically. He analyzes, that is, interprets the patient's attitude toward himself exactly as if this attitude were directed toward some other person, and thus exposes the infantile part of the patient's behavior.

It is true, however, that no analyst can ever completely avoid any influence. The analyst's appearance, clothing, language, room, everything connected with him or coming from him, may arouse some reactions on the part of the patient, and the analyst must, of course, differentiate between these and the true transference.

I believe that these personal qualities and characteristics of the analyst influence the patient's emotion to a noticeable degree only when they are the result of the analyst's own neurosis, that is, when the analyst himself is not sufficiently analyzed. I do not share the opinion of many analysts that the sex of the analyst is of great influence; of course, there may be patients for whom this is true, particularly homosexuals.

I remember a patient who answered a question I asked him with: "But a man like you must understand that." It is easy to see and to say that such words would mean a father transference. But making the correct transference interpretations at the right time is not so easy. Repeatedly, we hear of "transference interpretations" that consist of nothing more than telling the patient he does not mean his father, or mother, or whoever, but his analyst. This may sometimes be the correct thing to do, but you must never forget that transference interpretation has to work both ways, and that you can judge from the patient's behavior toward you how he had behaved toward his infantile love objects. But here we arrive at the next topic.

II

TRANSFERENCE

Let us examine closely the peculiar phenomenon which is apt to help the psychoanalysis or to make it impossible, which may be an extremely useful tool or a stumbling block, and which may be instrumental in bringing an analysis to a successful end or in ruining it completely. One must attempt to teach the skillful handling of this highly compound structure. I say "attempt," because, again, it is something that lends itself very little to real teaching. All we can do is to discuss it theoretically, to warn of the most frequent mistakes, and to give examples which the less experienced analyst may compare with his own cases. Now, as I said before, the theoretical side of this was taken care of in an excellent way in the writings of Freud (1911-1915) and in Fenichel's (1938-1939) book on technique.

If you study these theoretical considerations carefully you will recognize that transference is nothing but a special case of the much-discussed compulsion to repeat. Such repetitions, such transferences, accompany and complicate the life of every one of us, create and destroy friendships, and often make us do things we never would have done without those transferences. If and when the repetition compulsion concerns the patient's relation to his analyst, as it is bound to, it becomes the most important issue of the whole treatment. It is only with this transference proper (which we see germinate and grow during an analysis) that we shall concern ourselves. The patient responds to what his analyst does or says not according to reality, but according to old infantile automatic patterns, which were formed—out of necessity—in his relations with the persons of his environment during his early childhood. One of the most important aims of analytic treatment is to break those patterns and to replace them with the ability to respond to stimuli from the outside with reactions warranted by reality.

You may say that this is very different from what most people believe transference to be. It is. There is no part of psychoanalytic technique that lends itself to more misunderstandings. And, unfortunately, there is no psychoanalytic concept that is more discussed by uninformed people who may have read a few books or have seen a so-called "psychoanalytic movie" and are now convinced that the very core of analytic treatment is that the patient falls in love with his analyst or hates him so much that he wants to kill him. True, love and hate are among the feelings patients transfer to their analysts. But there are many more feelings, and among them are some that cannot easily be classified as loving or hating. How will you do that with a patient whose relation to his analyst consists of the belief that the analyst need only wave his magic wand and the patient recovers? There are others who consider their analysts as sort of personal servants. They have a maid and a cook and a laundress and a gardener and a chauffeur and an analyst, pay them well, and expect good service. Now is that love? Or hate? I do not mean that in such instances love and hate are merely mixed, that is, that the situation can be covered by the term ambivalence. These transference feelings are something quite different from love or hate; the only trait they have in common with transference love and transference hate is that they were transferred from the patient's childhood. What I mean will become clear perhaps when you realize that there are patients—rare specimens, however—who never were able to really develop any love. From such a patient you certainly cannot expect any love transference. If you succeed in analyzing him, he certainly will learn to love. But the love he will develop will not be transference, and it will very soon no longer be directed toward the analyst, but toward an outside object. Of course, I do not deny that in a great number of cases there is real love and real hate transferred to the analyst. But that is just the point; never forget that transference means the repetition of the feeling involved, not the first edition. In doing control work, I often hear of interpretations given to a patient, with the meaning: "You

speak of your mother (or father), but what you really mean is your analyst." Very seldom do I hear the interpretation in reverse, which is needed much more often: "You show me your feelings about me, but what you really mean is your father (or mother)."

It has been recommended by people who certainly do not understand what transference is to "encourage" the patient in developing his transference—as if the analyst should act in a way that will make the patient react emotionally. The idea is, for instance, to be unfriendly or ironical in order to "bring his anger to the surface."

I cannot warn you enough against this method. In the first place, the patient's reaction would certainly not be real transference (that is, a neurotic, automatic repetition of infantile attitudes), but justified, plain anger. And if you interpret this as transference, the patient will most probably feel that you are wrong (which you are) and not come back. I am decidedly against everything used as a "trick," and consider such advice as sheer nonsense. I have heard patients at the beginning of the analysis tell me that a relative, or sometimes a physician, had predicted they would have to fall in love with their analyst, and they ask me whether this is absolutely necessary. I always answer truthfully that patients react to the analyst according to their personalities and their neuroses and that such predictions show only that those relatives or that doctor did not know what they were talking about.

Now, what are the signs that show you the patient has formed a transference? They vary. They vary so much, in form as well as in intensity, that it is very difficult to mention all possibilities. It depends entirely on the personality, or rather on the history, of the patient. There are some whose transference (both positive and negative) is expressed merely in the fact that they come on time to their hours and pay punctually. Others act out scenes of melodramatic passion, send presents to the analyst, or break his windows. Still others use their symptoms: in getting worse, they may express their wish to be pitied or to make the analyst

feel guilty; in getting well (without the symptoms having been really understood), they may try to justify an early end of the treatment or may intend to please the analyst. In short, everything that can happen between two persons may become the expression of transference. Let us, however, examine the more typical manifestations that may indicate the beginning of transference.

At first, the patient will react to the analyst exactly as he reacts to anybody who has declared his willingness to help the patient. From submissiveness, to gratitude, to stubbornness, every shade of reaction is possible. But soon you will notice, either in his words or his behavior, that a change is taking place. While you realized in the beginning, "this is the way he behaves toward his dentist, lawyer, teacher . . . ," you will no longer be able to say so. You will realize that, in his mental life, you have been assigned a special role, which would be incompatible with his behavior toward his teacher, lawyer, or dentist. Needless to say, this is only true for patients who do not react to their teachers, lawyers, or dentists in a specific neurotic way.

The change may be that the patient pauses in his speech longer than usual, or that, having associated freely up to then, he starts talking along preformed lines, or more systematically. Or he comes in with downcast eyes, avoids looking at you when he greets you, is embarrassed and self-conscious. Or he starts to poke fun at you, at analysis, at "the whole procedure." Or he announces he has talked enough and now you should tell him about your own childhood. Or he describes new feelings, which he never had experienced. Or he tells you how he would handle a patient like himself if he were the analyst. Or he tries to "educate" you in some subject which is dear to him, be it politics or astronomy, woodwork or religion. All these and many other possible reactions have in common that they concern you personally, whether this is expressed in so many words or not. The long pauses for instance, which many patients make after the first few weeks of apparently uninhibited speaking, mostly cover up thoughts they do not dare utter. Patients sometimes

suddenly notice something in your office, which they never noticed before—the wallpaper or the ticking of a clock—something that belongs to you and that they can mention instead of mentioning you. Such reactions are signs of change in the relationship with the analyst, sometimes positive, sometimes negative. As soon as you notice it, watch out—but not too much. Do not forget to listen to everything else because you are on the alert. But do not pass over it, do not be satisfied with merely stating that something has changed. If the change is very conspicuous, that is, if you can be quite sure the patient is aware of it, you may ask him, not why he does or says this or that, but, for example, "Do you often feel [or act] this way?" With questions such as this you may accomplish two things: (1) you may make him realize that something has changed, that is, something in his attitude toward you, and (2) you may be able to confront the realistic part of his ego with the unrealistic, the infantile. Maybe it is too early, and he says, "What do you mean? What's wrong?"—showing you that he does not understand. But maybe he responds: "Yes, very often; but I do not know why. Only last week I said the same things to so-and-so." If he can see that, the first little step has been achieved.

I recommend this approach only "if the change is very conspicuous." Mostly it is not. As I said before, let the transference develop. Transference is not at all a simple structure, and it can be really understood only after careful study. In a certain sense, transference is always resistance insofar as an infantile mode of behavior has overruled the realistic one. In other words, the patient reacts to you as if you were not his doctor, but his father or whoever it is to whom his feelings belong.

Now, you have learned that transference has to be interpreted when it becomes a resistance, and you may ask, if it always is, why wait with interpreting?

Transference is always a resistance as far as it serves to support the neurosis. As long as it does not do more, do not interpret it. As soon as it turns against analysis, it has to be interpreted, and as soon as possible. Transference always turns

against the analysis when the patient does not only talk, but acts out. By then you probably will have enough material to interpret it, collected during the time the patient limited himself to talking. Let us look more closely at what happens when you do that.

I told you about the patient who, after a few weeks of continuous talking, suddenly grew silent and stayed silent for over three months, and I told you also how this very strange and peculiar behavior revealed itself, after these three months, as a magnificent example of acting out. I could not interpret it, as you will remember, because it was shortly after the beginning of the treatment and neither he nor I knew then what he was repeating. To recapitulate, during the first few weeks, the patient talked uninterruptedly, very fast, and in a low voice. I pointed out that he talked differently from the way he talked in the first interviews (when I had him sitting up), but he did answer, and he continued the way he had begun. Suddenly he stopped and just did not speak again, despite my attempts to induce him to do so. What had happened? He had, for the first time, mentioned that he liked his brother, with whom he used to sleep when he was a little boy. Afterward, the analysis revealed a very strong homosexual attachment between the two. You will remember that his mother prevented, by a strict prohibition, any further talk between them when they were in bed. The prohibition was: never to speak once they were lying down. When mention of his brother revived his feelings in that situation, he re-experienced the anxiety he had felt initially in relation to his mother. This time he felt anxiety in relation to me (whom he experienced as being his mother). He could not talk anymore because there was not only anxiety, there was also resentment and the wish for revenge. This was the moment when the transference resistance set in. Instead of remembering, he acted out, blocking the analysis completely.

Of course, the next question was why he had not told me before that he could not talk when he was lying down. First he said he did not know. Then he chuckled a little and said: "I

know that this doesn't belong to it [by the way, always watch out when a patient says that], but suddenly it occurred to me that sometimes I wished that something might happen, a burglar might come in, or the house might be on fire—and I would not call mother. Had she not said we should not open our mouths when we were lying down? It would serve her right, I thought, to be punished for this silly prohibition."

Now I could interpret the whole thing. Now it was clear that in not telling me earlier about his inhibition, he acted out not only his feelings in the childhood situation, but also his resentment in the analytic situation. What he wanted to express was: "What a silly procedure to have me lying down. What good can it do me? I'll show her [mother] how ridiculous it is. She soon will become bored. Let's see which one of us can stand it longer."

The patient was much relieved when I told him all this. He himself found the most concise and exact formulation of his resistance when he replied: "Oh, that's how it works! But then I must have done it in order to disrupt the treatment. How silly of me!"

This example also provides a lesson in interpretation. There are many ways of interpreting. The best is to take the interpretation just short of the last step and let the patient complete it. The patient experiences a narcissistic satisfaction which is a valuable counterweight to the equally narcissistic satisfaction of his resistance. The interpretation is much more convincing when the patient himself takes the last step. In the above example, I told the patient he wanted to annoy me, to see which of us could stand the silence longer. It was he who completed the interpretation by stating he must have wanted to disrupt the treatment, followed by some insight: "How silly of me!" From then on the analysis could move forward.

Finally, why could he tell me, at the very end of the three-month term, that he could not speak when lying down? The answer is very simple. He was convinced that this was his last day with me. He expected me to say: "Well, if you cannot speak

lying down, then you cannot be analyzed, good-bye." And he wanted me to know how silly I had acted; he wanted to put the blame on me, because I had asked the impossible. On the other hand, he was relieved that he could stop the analysis because he felt the tremendous aggression against his analyst (in this mother transference). He was afraid of his own aggression, which had risen to considerable intensity during those three silent months.

I consider this example very instructive. It would have been easy to tell this patient that he was silent because he wanted to keep back something, that there were facts he did not want to reveal, and so on. All this would not have accomplished anything. The thing to interpret was his attitude, his behavior, that which was done by his conscious ego. And the most conspicuous feature of this attitude was his transference, which had become a resistance. This transference had to be interpreted, not the contents. In general, whenever you are in doubt what to interpret first, contents or transference resistance, the latter should take precedence. You will see that frequently the interpretation of the resistance enables the patient to interpret the contents himself. Let me give you another brief example.

A young woman, very eager to be rid of her multiple phobias and trying hard to do exactly what she was supposed to, gradually developed a peculiar way of associating. She would emphasize that she had to make everything she said quite clear, and for this purpose she made numerous preliminary remarks about what she was going to say. It went something like this: "Something occurred to me just now, but I don't know how to say it so that you will understand. It is so difficult to understand. But after all, you will, undoubtedly, I know that you will. When I think of what I am going to tell you, a peculiar feeling comes up as if I just had to say it, and I know of course I will. Isn't it strange how such things work? I feel now I just have to say it and I feel the power, the tremendous power of this urge to say it, as if someone much stronger than I am were threatening to kill me if I didn't. But of course I will because you want me to

say everything, and after all I always say what I am thinking, and this is what will help me to get rid of my fears . . ."—and so on, for the rest of the hour, without really saying what started all this. It was not always fear (as it was, obviously, in this example) that prevented her from saying what was on her mind, because sometimes it went like this: "I had a peculiar thought this morning and right away I knew this was what I was going to tell you today. Each time I feel that way I am full of admiration for you because you always make me say such things finally, and I really don't know how you do it. It reminds me of a friend of mine who always says that she knows in the morning what she is going to do during the day. But this is different, because I don't know what I am going to do, I only know what I am going to tell you. . . ."

If I now tell you that the contents, around which all these conflicts revolved, repeatedly concerned minor matters such as she had told me about without any conflict before, you will understand at once that not these contents, but the talking around them must be interpreted. But the contents, irrelevant as they seemed to be, had a common denominator. They always concerned something she did not want her mother to know—small things, like a recipe that enabled her to bake a better cake than her mother, or that she had exchanged a dress her mother had given her as a present for a nicer one. As this became evident, these contents could have been interpreted. But that would not have eliminated this special type of resistance, consisting in "talking around." So I asked her simply: "Have you ever noticed what children do when they want to avoid admitting they have done something they were not supposed to?" "Of course," she said, "they talk about something else. I observed it the other day when my friend's little girl came home. I had never seen her so loquacious. She told stories, and she made fun of her friends and made cute little jokes, until her mother, my friend, said: "And what about the report card?" And I remember I did exactly the same thing. I really prepared myself and had a lot of stories and jokes ready for just such an occasion." Now I could

show her what she did—that she did not resort to stories any more, but that all those introductory and preliminary remarks served the same purpose. I give this example to emphasize that on such occasions it would be not only useless, but wrong to stress the content the patient wishes to hide. You have to interpret solely the means used for this purpose. Only in this way can you eliminate the resistance which is a result of the developed transference. Then, and no earlier, can you interpret the transference to the patient. In the case of my patient, I was able to show her that she reacted to her analyst in exactly the same way she once reacted to her mother. She herself had said: "I did exactly the same thing. I really prepared myself and had a lot of stories . . . ready." The transference character of her relation to me was so close to the surface that she could and did understand.

It is not always so easy. Sometimes patients do not reveal anything of their transference in their behavior or their associations, but their dreams show it very clearly, much to the embarrassment of the patient. A girl once brought me a dream, very early in her analysis, in which she was in bed with me and enjoyed it to such a degree that she was glad she awoke. She said: "It would have been terrible to go on dreaming. I don't understand how I can have such a dream. I never dreamed that way, not even something like that about my own mother."

If you do not want to jeopardize the entire treatment, never interpret such dreams at the beginning of an analysis. Merely say it is much too early to understand that dream; it will become understandable later on. With some patients, you may perhaps add that the dream must mean something the patient refuses to think about in the daytime. There are other patients who, after quite a stretch of analysis, still show no sign of transference, but keep dreaming about the analyst. If the associations to such dreams make it possible to interpret them, the patient most likely will admit having had thoughts or feelings or impulses like those expressed in the dreams, but they had not occurred to him in that hour. If you cannot interpret the dream, ask the

patient why he thinks he repeatedly dreams about something that has no place in his daytime thinking. While you cannot expect a rational answer, the question may serve as a stimulus for further associations closer to the subject he is avoiding.

The most important thing in handling the transference is not to play along with the patient, not to participate in the game he is trying to play. He gives you a part in this play. Do not accept it. But do not refuse it either. Analyze it, exactly as if he had assigned the role to some other person. By the way, I prefer to speak in the interpretation of transference in terms of "your analyst," not in terms of "me"; I reserve this "me" or "I" for situations that are highly emotionally charged for the patient or for when he tries to minimize his positive or negative feelings toward me personally.

Some young analysts find the transference the patient has formed unacceptable because it results in being cast in the role of villain. As a consequence, they do not recognize expressions of transference and will never be able to interpret them, in other words, to help the patient.

The counterpart of this attitude is the narcissistic satisfaction of the inexperienced analyst when the patient develops a transference with the meaning, "You are the most wonderful person. I love you and admire you, and you are the only one who understands me and can help me." This is in most cases a repetition of the child's attitude toward one of his parents. Do not forget that a positive transference also has to be dissolved, just like a negative one. The ultimate aim of handling the transference is to let the patient change it into an identification with the analyst. Of course, the patient can do this only after a long stretch of analysis, but the process can be prepared much earlier.

On the other hand, the analyst has to watch out for an early identification as a resistance. The real, healthy identification can only be the end result of the patient's transference, not a substitute for it. If, for instance, a woman patient makes an early identification with her male analyst, it mostly means just

another expression of her penis envy, which will soon develop into a stubborn resistance, meaning: "I know just as much as you do; you cannot help me; I alone can help myself." You can frequently notice an early identification in the attempts of the patient to analyze the persons of his environment. I said that the ultimate aim of handling the transference is to let the patient change it into an identification with his analyst. The patient does this by introjecting the analyst and letting the analyst become part of his superego. Perhaps it is unnecessary to say so, but I want at least to mention that this new part of the patient's superego finally has to be dissolved, too.

I mentioned only a few typical forms of transference. Innumerable other forms are possible. Among them is one I want to warn you about especially, because it may lead to critical and even dangerous situations (dangerous for the patient) if you do not handle it correctly. Some patients try to get their satisfaction in provoking the analyst; they, so to say, test whether he will react objectively. Whenever you notice this, say so, that is, interpret it. It usually represents something like this: "No wonder my analyst is nice and helpful to me. I always did what he wanted me to do, so he likes me. Let's see whether he really loves me, whether he remains nice and helpful also when I behave nastily." You see how double-edged this type of resistance is: if you do not interpret this but remain nice and helpful, then the patient is convinced you love him and probably will turn to transference demands which may prove to be very difficult to handle; if you react emotionally and reprimand him or start to argue, he will enjoy his triumph over your analytic attitude and make his analysis still more difficult for you. The only right way to handle such transference resistance is to interpret it. If you have enough material to trace it back to earlier attitudes, do it. If not, make a statement that he certainly may have tried to provoke his parents by similar behavior. You will always find that such patients had displayed the same behavior toward their parents and that these parents failed, that is, they reacted with too quick punishment, with unjust scolding, perhaps with

temper tantrums. Under the influence of the transference, the patient now wants to test whether you, too, can be fooled, or whether you maintain the same analytic attitude you kept until then. Be careful not to let yourself be provoked to do or to say anything unanalytic, to get angry, to respond with emotions. Hold the analytic mirror before the patient's eyes, showing him what he does, and why.

Maintaining the necessary objectivity in such situations may appear a hard task to the beginning analyst. Whether he will master it or not is dependent entirely on the degree to which he himself was analyzed. One can depend on the sensitivity of highly neurotic patients to spot every diversion from the true analytic attitude, much as they try to seduce the analyst to display emotional reactions. On the other hand, do not try always to watch yourself and to avoid natural attitudes. Adherence to the rules soon becomes automatic. The need to watch yourself suggests that there are vestiges of emotional problems which should have been resolved by your own analysis. If you have been sufficiently analyzed, you will not always think: "Do I follow all the rules?" "Was it really the surface I interpreted?" and so on. I remember how I felt when I learned how to drive: "What, all these gadgets—accelerator, clutch, brake, steering wheel, rear view mirror—I should think of them all the time? And at the same time watch for other cars and pedestrians, and for the white line, and for the speedometer, and for street signs —and give signals?" No really good driver ever thinks of all that any more, as all of you know.

Be on the alert for small lies. I do not mean those contradictions that turn up in every analysis as a result of repression. In every analysis you will find discrepancies or incongruities concerning dates, places, and so on. The patient may tell you of games he played at the age of three, games you know he could not possibly have played until very much later; or he may claim to have heard or seen things which you recognize as fantasies. This is not what I mean. And I do not mean a real *pseudologia phantastica* either. But many patients are fully aware of a ten-

dency to distort the truth in small measure. They say "a dozen" when they mean seven, they say they were furious when they were slightly annoyed, they falsify unimportant things, not because they are unimportant, but because they want to deviate from the truth just in small, unimportant matters. The analysis of these small lies inevitably leads to earlier big lies, which are represented and thus externalized by those petty ones.

If you suspect a patient is lying, do not hesitate to tell him so. Of course, you will be tactful in this, but never leave anything unsaid because of the risk that the patient might feel hurt or because you want to spare him unnecessary suffering. You cannot tell that it is really unnecessary. Furthermore, the ability to stand suffering is a part of analytic success. True, that there are exceptions. You certainly will not give a moral masochist the great satisfaction of making him suffer before his masochism has given way at least partially. But then you do not spare him the suffering—which you cannot entirely spare any analytic patient—but you withhold the pathological satisfaction from him. I mentioned the tendency of some patients to lie because it is one of the most frequent manifestations of a certain type of transference. There is scarcely anything else that children are punished for more frequently. Therefore it comes in handy when a patient in transference wants to provoke the analyst. Needless to say, you must not reproach him for lying. Merely point it out and watch for associations.

Another advice, particularly important for the beginner: when you are quite sure of an interpretation (of transference or anything else), never omit it because it might drive the patient away. A correct interpretation, given at the right time, will never do that. A correct interpretation must "click"; and usually the patient reacts with relief and a feeling of gratitude. If this does not happen, you may be sure the interpretation was either wrong or given at the wrong time. If you realize that an interpretation was wrong, try to learn from it for the next time, and do not be discouraged. With many patients, however, an inter-

pretation has to be repeated, sometimes again and again.[2] With others, you get no reaction at all, but the next day the patient comes, quite excited, and reports that after the hour or during the night he suddenly realized what you had said, and now he reacts to the interpretation the way he should have the day before. This latter behavior is a transference resistance, too, and mostly means that he begrudges you the satisfaction of having been successful. This "delayed reaction" must be interpreted at once.

Now, you may ask: "How can we be 'quite sure' of the correct transference interpretation, so that we feel justified in giving it?"

I guess you all are familiar with the technique of crossword puzzles. You know that when you have found some of the words in one direction, there are other words (in the other direction) that require no effort on your part. Perhaps there is one letter you have to add, perhaps two. But on the whole, the word is "given" by those previous ones which came to you in quite a different way: you had to guess those, trying out whether they fit or not. The feeling that accompanies the recognition of the correct word is the same "clicking" I mentioned as accompanying the correct interpretation—for the analyst as well as for the patient.

If the material given by the patient suggests a certain interpretation, but you are not quite sure of its correctness—which sometimes happens—make the interpretation in the form of a suggestion, a proposal, an assumption, a question. Never forget that our knowledge is limited and that not every denial on the part of the patient is a resistance. He may be right, after all. I say in such a situation: "I may be wrong, but it seems to me that. . . ." Or: "Do you think it possible that . . . ?" Or something on that order.

What is true for a transference interpretation is true for any

[2] For more about working through, see Lecture V.

other interpretation as well. Transference interpretation is only one specific application of our interpretative technique in general. I conclude with an example that, once again, demonstrates something that cannot really be taught.

Transference interpretation by no means always consists of telling the patient, "What you mean is. . . ." or "This indicates that. . . ." Sometimes you can achieve much more by reminding the patient, with your response to something he says, of something he said several hours or even weeks ago, and by making him accept this as an interpretation. Once I said to a patient: "If I did not know that you were an only child, what you said would indicate that you once were desperate because your mother had another baby." He said: "This time I'm sure you are wrong. Because the only other child my mother ever had was stillborn." He stopped and began to laugh. "I have no idea why I said that. Because, of course, there never was any other child." Well, later we learned that there really had been this stillborn baby, whose birth he remembered for a moment, only to repress it again immediately. I am quite sure that the so-called slip (which was really a momentary lift of his repression) made it easier for him later to remember this incident which took place when he was eight. I did not insist when he took back what he said. I kept it in mind and counted on the dynamic power of the loosening of analytic interpretations. Several weeks after he had said that, he met a young woman socially who mentioned that she knew me. He guessed immediately that she was my patient, and he became jealous. He told me about meeting her and added sneeringly: "So you have a daughter, too, eh?" This was exactly the moment for an interpretation of his acting out (instead of remembering), and I said only one word: "Stillborn?" This was enough at this moment to revive the old repressed memory. All his unhappiness about his mother's pregnancy came back to him, and with an enormous amount of emotion he could now recall all the details of this totally forgotten event.

From this example you can learn something which has been called the principle of minimum dosage. The one word "still-

born" brought the undoing of a repression which had held for many years. Had I made the same interpretation using many words, telling the patient that he acted toward the fact of my having other patients as he had acted when he was eight, had I added that he was not jealous of me but of his mother, perhaps his resistance would have prompted a renewal of his repression. He felt, at the moment, only jealousy against me, not against his mother. We also have to interpret the surface in transference interpretation. But the word "stillborn" implied the prototype for his jealousy. This was enough to make him ready to accept the truth.

I shall come back to this example later (Lecture IV). Here I want only to demonstrate that it is not always necessary to say: "What you really mean is not your analyst but your mother." Sometimes it is much better to interpret the transference by using elements from the original situation. The element "stillborn" did not all belong to the present transference situation. Using it interpreted the transference, without long explanation, as a repetition of the childhood situation, and left it to the patient to draw the necessary (and obvious) conclusions.

I want to add a few words about what we call countertransference, and some misconceptions about it.

You know that an analyst does not respond emotionally to the words and actions of the patient. He does not argue with him, is not offended by his insults, and is not flattered by admiration. I mean this literally; I do not mean that he merely does not show his feelings. Now, it frequently happens that the patient, in the course of his associations, speaks of his achievements and of things that happen to him outside his analysis. Does the analyst respond to them? Of course he does. If, for instance, the patient's young and much loved wife suddenly is killed in an automobile accident, it would be impossible and inhuman not to respond with pity and sympathy. The analyst should express this to the patient and not ask, "What occurs to you about this?" It would be wrong and unnecessarily cruel, and probably detrimental for his analysis. The right thing to do is to let him cry

and to listen sympathetically, even if it means that an hour or two are wasted. But this is not countertransference. Countertransference is not a first edition, but a repetition, based not on reality, but on a compulsion to repeat. The patient's tragedy is reality.

The reverse mistake is to react to tragic or lucky events in the patient's life by behaving as if that tragedy or that lucky event had happened to you or to a person very close to you. If you react this way, try to realize what makes you identify with your patient. Probably, you will find out that you really are repeating something, which obviously was not sufficiently analyzed. This is real countertransference.

Besides such extraordinary events, of course, countertransference may occur in analyses conducted by inexperienced analysts. Ask yourself whether you treat all your patients with the same amount of interest, of attention, and as a result, with the same amount of success. Examine your attitude carefully and do not tolerate "star patients" or "pets." It does not contribute to your quality as an analyst, and it is decidedly against the interests of your patients.

III

DREAMS

Taking up our next subject, we come to the handling of dreams. In general, there is very little to be said about dreams that would not have to be said about any other material the patient brings. Specifically, there is much to be said about the way to interpret them and about the way the patient uses them as resistance.

The resistance is expressed mostly in either having no dreams at all (or very few) or in having too many. That sounds very simple, but the analyst has to determine whether the extent to which the patient dreams is different from what it was before the analysis. As a matter of fact, there are people who almost

never dream; they are usually good sleepers. When they develop a positive transference in analysis, they start to dream, not very much, but a sufficient amount to help the analysis progress. On the other hand, there are people who dream almost every night, often with great anxiety. Usually, they are poor sleepers. With such patients you can judge the degree and the nature of their transference easily by the frequency of their dreams. When they are in resistance they bring six, eight dreams every day, so that there is scarcely any time left for associations and no time at all for interpretation. Whenever you feel that the patient floods you with dreams, you can always assume that his instinctual aim is an anal (mostly anal-sadistic) one, just as it is with too many memories or too much material in general. Of course, then you interpret this flooding, by no means the dream itself. This would be almost impossible anyway, as is always the case when resistance has made the patient overproductive. Again and again you have to point out the resistance quality of his high production rate. Do not let the patient seduce you into telling him about the contents of the dream if you do not want to make him stick to this flooding technique. The only exception to this rule of neglecting the contents in favor of the resistance is if the dream content itself has the same resistance meaning. If, for instance, the patient brings you as one of his many dreams that he throws dirt in your face, you first interpret his resistance and then use the manifest content of his dream as confirmation. If, on the contrary, you interpret the dream first and then deduce from it the patient's resistance, he will say, and rightly so: "But this was only one of fifteen dreams —what about the others?" So, if in such a situation you do interpret contents, use them as a confirmation of your resistance interpretation, not as its basis.

There was some discussion about whether we should let the patient know in so many words (before he starts) that we expect him to tell us his dreams. I think it is a good idea, but would not stress the issue. When I explain to the patient what I expect him to do, that is, when I explain free association to him, I usually

say: "When I say everything, I mean everything—regardless of whether it is important or not, whether it is pleasant or painful to say, whether it is a dream you had or how you feel at the moment, whether it is your secret or someone else's—whatever you think, you say out loud." This way I do mention dreams, but I do not emphasize them. As a matter of fact, for patients who really try to follow the basic rule, it is scarcely necessary; if they really say everything that enters their mind, dreams will come up very soon anyway.

There are some analysts who place much importance on the first dream, at the beginning of the analysis. It has the same kind of importance as the patient's first associations, the first topic he chooses to begin his analysis with. I could see in some cases, after quite some time in analysis, that the first dream actually concerned the patient's crucial problem, be that masturbation, or his dependency on his mother, or homosexuality, or exhibitionism, or whatever. But I found also that you never can use the information he gave you with the first dream at the beginning. Remember what I told you about those first associations (Lecture I). Later, much later, you may use them, and the same is true of the first dream. A real interpretation of it is almost always impossible at first—except when the dream obviously shows strong anxiety about beginning the treatment or the outspoken intention to resist it.

As to the technique of interpretation, I cannot emphasize enough the importance of the way Freud (1900) has shown us in his classic work, *The Interpretation of Dreams*. I have, in my work as a control analyst, often noted that candidates pay much too much attention to the manifest dream text and neglect the associations; in other words, they try to interpret the manifest dream instead of the latent dream thoughts. Let me give you an example of the difference.

A girl with an agoraphobia which made it difficult for her to enter stores and impossible to go into a department store, brought (very early in her psychoanalysis) the following dream:

> I am in a department store and want to buy seven and a half yards of material. The saleslady shows me samples, but I don't like them. I try to find something else. My anxiety overwhelms me, and I have to leave.

If you pay attention only to the manifest dream, of course you see that the dream concerns her chief symptom, her anxiety at being in department stores. If you tell her that, it will be of no use at all. She knows she is afraid of department stores; this is her conscious reason for coming to analysis.

Naturally, her first associations were about just that—about how she has suffered from her phobia, when she felt it for the first time, the attempts she has made to overcome it, and so on. Much later in the hour, she reported a series of minor symptoms (stomach trouble, sore throats) for which she had sought medical help unsuccessfully. She continued: "I may be silly, but I do hope that all these little things will be taken care of by this treatment. It is easy, isn't it, if you don't have to shop around for a good stomach or a clear throat and all the other little things, you can have all that at the same place." I said: "You don't have to shop around if you go to a department store." "That's right; that's what I mean. Oh, I do hope that you will straighten me out completely and that I'll lose all those little disturbances as well as my anxiety. By the way, the new schedule works out beautifully [she came at 3:30]. I can easily make it, leaving work at three and taking the bus." She was silent for a moment, and I said: "In your dream you were looking for seven and one-half yards?" "Yes, and just now I was trying to play a little game with words. You know half-seven [*halbsieben*, the German for 6:30], actually like half a seven. That would mean three and a half. Isn't that funny? Is it possible that even in my dreams I knew I was coming here at 3:30?"

I do not want to go very much further into this dream. What I wanted to show you is that this dream could by no means be interpreted as concerning her fear of department stores. It con-

cerned the start of a tendency to line up her analysis with places she was afraid of. The analysis was like a department store; you can get everything there. The number seven and a half was, in her little game with words, changed into 3:30, which designated her analytic hour. And the "material" (*Stoff*, in German, has the same double meaning) represents the psychoanalytic material she was bringing me, disguised in her dream as yardage.

I hope that you see what I mean. You sometimes have to wait a long time until the patient gives you the clue as to what the various dream elements really mean. As a general rule, do not give any interpretations if they do not tell the patient something he did not know before. I once gave this dream as an example in a dream seminar, and after telling the manifest dream text, I was asked by a candidate why we should wait for the association since the dream text alone said what was meant. I agreed that he may try to interpret, and he said: "Why, it is clear that she reveals in this dream why she has the phobia. She does not like the samples, meaning she does not get what she wants. So it is no use going to a department store because you do not get what you want anyway. Then her fear overwhelms her. That means she is afraid of the aggression she must feel when her wishes remain unfulfilled. Wouldn't that be enough to interpret?" By no means. On the contrary, such an interpretation would help her to rationalize her fears. Perhaps she would have, for resistance purposes, accepted the explanation that she did not want to go to department stores because she could not get what she wanted there. But would that help her? To begin with, it was not true. What she really feared was her homosexuality. The department store where you can get everything was her mother whom she suspected of being actually a man. To rob this phallic mother of her penis was the core of the wish she fought off in her phobia. But to get into these deep layers, one has first to go through the more superficial ones: she had repressed that in department stores she felt the temptation to steal, and she feared being caught shoplifting. All this could not be interpreted from the dream, of course. The thing to interpret was

what would have developed into a severe resistance if it was not interpreted: that something within her was trying to experience her analysis as a "department store," that is, as the thing she had to be afraid of. The analytic situation, being alone with me for an hour each day, made it easy for her to develop this fear, because it made her afraid of her homosexual desires. But had I interpreted this instead of saying what I did, she would only have looked for some other way to add the analysis to her list of places she had to avoid.

There is one mistake made frequently by analysts with little experience, which I want to mention. You can make this mistake with dreams as well as with any other material. It consists of interpreting the details without the necessary connections. The meaning of a dream can always be formulated in sentences such as: "I am afraid of my aggression against my mother"; or, "I want to keep my symptoms because it is easier than giving them up without having anything to replace them"; or, "I am confused because I do not know whom I should believe, father or mother"; or something on that order. Interpreting: "The tree, of course, means a penis"; "The little puppy means a baby": and "the bushes mean the pubic hair," etc. is not interpreting at all. It is reminiscent of a game people with a smattering of knowledge about psychoanalysis like to play. They single out an element and "interpret": e.g., "You speak of a tower; what you really mean is a penis." No experienced analyst does this. I know a man who reads all the analytic literature (instead of going into analysis) and who constantly shows off his analytic knowledge. He cannot see anybody rub his eyes or scratch his head, without saying: Masturbating again, eh?" When a woman buys a fountain pen, he remarks: "Need a new penis, I see." The budding analyst may be strongly tempted to interpret everything in everyday life. It is an absolutely sure sign that he is not yet through with his training.

But let us get back to the interpretation of dreams. I tried to show you that we should, and why we should, always start at the surface—that is, with the defenses, not with the instincts. You

may ask how to differentiate between the two groups, and it is true that sometimes instincts behave like defenses (and really serve as such), and defenses sometimes assume instinctual qualities. I do not think any rules can be given concerning this very important subject. You have to feel your way through, and there are very few points you can use for orientation. Sometimes you can get hold of the historical order in which the various impulses developed, but this is not always reliable; "faulting" is not only a geological, but also a psychological phenomenon. The only really reliable way to find out is through the analysis of transference dreams in which the events that have led to the development of the defense are repeated on the transference level. As far as I know, this is the only occasion when the patient, because he is asleep, is bound to let impulses slip through, against which, in his waking time, he marshals all his ego forces. Since such dreams have to be interpreted exactly as any other dreams are, there is no need for special technical advice on how to handle them.

You may have the experience that some patients obediently tell you their dreams but do not associate to them. The patient talks, apparently quite freely, but there is no connection with the dream whatsoever. I always think it a good idea to bring the patient back to the dream, but not without waiting long enough to be quite sure his associations really do not belong to that dream. You can usually be sure of that if the patient dodges the dream by delving into a favorite topic. Such associations are not always a means of resistance, but if you have caught him several times using this same topic to avoid something else, you may be reasonably sure its use is defensive this time also. I once had a patient who, whenever he wanted to change the subject, complained about his boss who treated him badly. Actually, he was complaining about me. But he really had a mean boss, and this was the patient's excuse. Invariably, after telling me a dream, he started talking about the boss and thus avoided letting anything occur to him that had to do with his dream. In such a situation, I would interrupt him with a repetition of some dream element.

I would say: "And in your dream you find a briefcase. Please continue." Patient: "Yes, a green briefcase. What I was going to say was that my boss. . . ." I let him go on for about a minute, then: "In your dream you open the briefcase. Please go on." He would say, "Yes, although it didn't belong to me. My boss . . . ," and on he went. This sort of thing can sometimes go on for a long time. But finally the patient realizes how ridiculous his behavior is. As soon as you notice that, you show him what he is doing: that he wastes his time and yours, that he does not make use of a dream that perhaps would have made the analysis progress, and that it would be useful to know why he avoids it. There are not many patients (although there are some) who can maintain their stubbornness any longer. It would be preferable to interpret this attitude, but that can be done only if you understand it, that is, if you have enough material to which you can connect his present so that you can either interpret his acting out or show him this same behavior in other life situations.

This technique, to repeat single elements of the dream text, is the best way to bring the patient back to the dream. In any case, I would never say, "Please associate to the dream," or "What occurs to you about the dream," or something like that. I just give him a small part of the dream (using his own words exactly) and leave him alone. If the patient is really cooperative, it works. Furthermore, it teaches the patient to begin by associating to a single element, not the dream as a whole. This is an extremely important feature of dream analysis because it is the only way a dream can be understood, to the extent that it can be interpreted.

The difference between what the patient admits when he is awake and what his dreams reveal is sometimes so striking that it seems as if the patient wanted to have an opportunity for a confession. Let me tell you about the analysis of a dream that became the turning point of the treatment because it brought such a confession.

The patient, a working-class girl, came because of a series of

hysterical symptoms. She was a factory worker, uneducated but very intelligent, and apparently honest in her desire to be rid of her symptoms and to obey the basic rule. In the third month of her analysis, she had the following dream:

> I am in a large building; it seems to be a sort of museum. Many things are displayed on long tables, standing in long, winding, tubelike corridors. All the things are old, antiques—statues, pictures, broken stone fragments of things dug out of the ground. I know that I am looking for something and cannot find it. A stout girl is there as a guide. Finally, I find it and I ask the girl how much I may buy it for. She gives the price, and I say that is too much. On my way out I think, "I must have it anyway." I turn back and ask again, hoping in the meantime it may have become cheaper. The girl repeats the same price. I say again that this is too much, and go out. Again I go back. The same scene is repeated several times, and I wake up with the words on my lips: "Oh, I wish I could get it!"

She starts associating and says: "The first thing I think of is a picture of the human brain that I saw last night. That's exactly the way those long winding corridors looked. But what has the brain to do with a museum? Well, come to think of it, there is a resemblance. All my memories, all those things out of my past, they are stored there, just like those old broken pictures and statues in the museum. And of course, the girl is you. You are leading me and showing me all those things." She stopped, and I said: "You are looking for something." "Yes, and I am all set to find it. It was this feeling with which I awoke: 'Oh, I wish I could get it!' I have thought this so often lately." "You have?" I said. "Oh, of course, it was what we are looking for here, what made me ill, the real cause of my illness. Oh, I do wish we could get it!" I said, "But in your dream the price is too high?" The end of the hour was near; she got up and said: "Please don't make me say it today. I have to be at work on time. But if I don't start with my answer tomorrow right at the beginning, please force me to say it, will you?" I let her go, but I was not quite sure she would not "forget" it by the next day. However, she came

and began to talk about it right away. "You may have wondered why I did not answer you yesterday. I felt somehow that it would upset me very much and I did not want to be upset when I came to work. It is not easy today, either. You remember when I came here for the first time? You explained to me what I should do, and I resolved to do it exactly as you wanted me to. But at the same time I solemnly swore in my mind that there was one thing I would never say—never, never, never. I knew I would give you all my thoughts—except this one thing. And to give you that one thing is, in my dream, a price too high to pay." She then told me about a homosexual experience she had with her younger sister; they were imitating what they had seen their parents do in bed so many times. The little one, who was only two, did not like it and began to cry. Mother came, separated the two, and gave her (the patient) a spanking. This incident, she said, darkened her whole childhood, branded her as a criminal. She never found a real relationship with her sister, always fearing that her sister might remember what she had done.

I do not think it would be useful to tell you more about this case. The deeper layers of the dream, the patient's identification with me (interpreting her own dream), just as she had identified herself with her mother in that childhood scene, were interpreted much later.

I have presented material from this case in order to demonstrate that dreams can act as a means of disclosing what the patient in his conscious mind does not want to reveal to us. Transference dreams show this very often. I mentioned dreams of affectionate situations with the analyst, dreamed by patients who in their thoughts never dare to get close to such situations. If, as in the case of the hysteric girl, the dream is so easily understood that the patient can interpret it himself, the result will confirm the "confession" immediately. If you have to interpret it, be careful not to say anything that would make the patient think that you disapprove. Such "confessions" are difficult to make, and the patient can, by a careless word, easily be fright-

ened into a strong and harmful resistance. By the way, I have found such "confession dreams" only in hysterics.

I call your attention again to the tiny bit of help I had to give. I merely repeated her own words to her, "the price is too high"—nothing more. This principle of the minimum dosage has many advantages (see also Lecture II). I prefer small doses to long explanations, whether I interpret dreams or associations or attitudes. They provide all the more emphasis to those longer explanations you do have to give sometimes in each analysis, showing the patient some connections or lining up various experiences he had during his life and never connected himself.

There are analysts who do not pay much attention to the dreams of their patients. They claim that the realities of the patient's life are more important and that we keep the analysis separate from reality if we analyze the dreams. I cannot warn you enough against such mistakes. Dreams are still what Freud (1900, p. 608) called them—the "royal road" to the patient's unconscious, and giving that road up would mean neglecting the patient's unconscious to a considerable degree. One of the intermediary aims of psychoanalysis is to show the patient that many situations where he felt passive, overwhelmed by something done from the outside, were in reality actively created or provoked by him. It is certainly difficult for the patient to recognize this; he will use all means to deny it and to withhold evidence that could prove it. But during his sleep, he cannot do that very effectively. He does not feel responsible for his dreams and therefore lets memories, feelings, affects, doubts, criticisms, and so on, slip into his dreams. We must use them to show him what (he cannot deny) is within himself. Be on the lookout for dream elements that contain what the patient denies in his associations, for they will sometimes provide the key to his true feeling.

There are patients, however, whom it is a good idea to discourage from bringing in too many dreams. I am not referring here to those who "flood" the analyst out of acute anal resistance (see beginning of this Lecture). I am referring to patients

who, in general, live more in their fantasies than in reality and who enjoy the atmosphere of dreams because it spares them reality. I would recommend you tell such patients that you are neglecting their dreams, and why. Make it clear to such patients that the treatment should make them able to stand reality rather than wallow in their fantasies, and that their dreams are so plentiful because they are afraid of real life.

Should we let the patient write down his dreams? This question has often been raised. There are analysts who claim to have seen good results from it; I have not. Some of my patients did bring me dreams written down, but I always had the impression that then they felt they had done everything they could. They brought the dream, and that was that; any further work with the dream was refused. So when a patient asks me whether he should write down his dreams, I usually say this is not necessary. When he brings me his dream already written down, I ask him to tell me what he remembers without reading, then let him look at the note. Mostly, there is something changed or left out. His associations to this changed or omitted part will be the most important ones.

The same purpose (of doing away with the dream as quickly as possible) is served by the attempts of many patients to interpret their own dreams. You have seen from the example of the museum dream that it is almost possible. I say "almost" because even in this case, the last part of the patient's interpretation did not come without my tiny bit of help, and the idea of identification was not touched upon at all. But mostly the patient tries to give his dream an innocuous meaning, far from such low and contemptible things as instincts, incestuous desires, or aggressions. The patient tries to lift dream interpretation into a sphere of pure and innocent thinking (hysterics do that) or into the realm of philosophy (more often found in compulsion), and I want to warn you not to follow him there. Simply ask him whether this particular dream has shown or taught him anything new. He cannot claim that. Then you suggest that he associate to his dream. You may even say: "Let us see whether

your associations will confirm your interpretation. You know, each dream should teach you something you did not know before. Otherwise, you would not need to dream it. You could just as well think it; it would be simpler." If he does really associate (and you probably will have to help him in repeating the single elements), interpret what he said and then confront his interpretation with yours. I doubt that he will often try again, because the contrast will be too great.

Finally, I want to make a remark about recurrent dreams. Maybe some of you have seen patients who claim that one particular dream kept coming back throughout the years, sometimes absolutely identical, sometimes with small changes. I know that this really happens, because I had opportunity to observe this fact in several analyses. A certain dream was repeated at irregular intervals, the changes seemed to be irrelevant, the text was always the same. Obviously the same instinctual demand made itself felt. This is explicable; it is the same way with almost all patients. The question is: "Why is the same façade always chosen to represent that instinctual demand?" I cannot say that I am able to answer this question generally. In one case I was able to understand it when I discovered that two sisters had approximately the same recurrent dream. I analyzed the older one without being able to understand the dream that recurred at half-year intervals both before and during psychoanalysis. Many years later I analyzed the younger sister and, to my amazement, the same dream appeared in her analysis. But in the latter case the analysis revealed that the scene in that dream was an actual historical event which had taken place when the younger one was five and the older one six, and which frightened both of them considerably. I mention this here because I think it would be worthwhile to investigate, when such recurrent dreams appear, whether they are always based on real happenings and repeated in the same manner as traumatic experiences are relived in traumatic neuroses. We certainly cannot do anything to force the patient to remember them.

IV

INTERPRETATION

If initially I outlined the various topics I was going to cover, I hope you did not expect me to take them up consecutively, one at a time of an evening. You may have noticed that one cannot possibly talk about the handling of transference without talking also about interpretation; and one cannot talk about resistance either, without taking into consideration the interpretation of, and the use of interpretation against, resistance. I know this does not make these lectures very systematic, but it seems to me that any teaching of psychoanalysis reflects somehow the way our unconscious works and, therefore, the manner in which an analysis should proceed: never along a straight road, but along a winding mountain path, with an outlook into a valley here, traversing a steep slope there, all the time keeping in mind the direction and the orientation, never losing sight of the thread that binds the single elements into a vivid picture of what we deal with in every analysis: a living organism.

Never forget this. You are not treating a phobia of knives or a fear of mice; you are treating a living being, with a history you have to know and with a great number of characteristics and capabilities which, all of them, show some trace of that fear and are influenced by it, and which can unfold to their healthy efficiency only if the fear is detached from them, or rather dissolved into its infantile elements and thus discarded.

When you follow that winding path, the worst mistake you can make is to lose your way in the abundance of the patient's material. If you do, try to find your way back, but refrain from making any content interpretations at all. It would confuse the situation still more and make it still harder for you to find your way. Each of us has made such mistakes, and it was always a bitter experience for both patient and analyst. When you give an interpretation, you have to know at which point to apply it, and you have to know what effect you expect the interpretation

to have. Unfortunately, this is again something that cannot be taught, but it can be learned from that best teacher of all—experience. Every mistake you make can teach you something, and a mistake in psychoanalysis is excusable only if it shows you how to avoid it when the situation turns up again.

Let us examine what interpretation really means and what part it has in the process of cure. If the patient follows the basic rule, he talks of all the things that are on his mind and also of those he actually does not consciously think of, but which show up in between as fleeting impressions, memory fragments, body sensations, and so on. All that, the intended communications as well as the elements that sneak in between, can be considered derivatives of his unconscious, very much disguised and distorted, made unrecognizable by the effects of the patient's defenses. Other such derivatives will show up in his behavior, his speech, his gestures, his relations with people, his whole attitude toward his environment and the world in general. When we understand their meaning, we point out to the patient those portions he is already able to understand, but has not.

The patient has to be made aware of the real meaning of his associations at the right moment, that is, the moment when he can be made aware of it, when you feel he is close to such awareness. What he says is full of allusions, of hints; we merely have to remove the camouflage and to show the patient what is behind it. There are many methods of camouflaging the unconscious. I shall give you some examples. (Depending on the diagnosis, you can even expect certain types, and you know that this also means certain types of resistances.) If, for instance, the whole hour, or the largest part of it, consisted of thoughts that all had something in common, but in their midst there was something seemingly far removed from that common denominator, you can with some certainty assume that this one association was the important one and that you can apply to it what the patient said about the other things. A young girl once came to her hour and asked me whether she might take off her shoes because they hurt her so much. I agreed, and she took them off.

"Oh, that's a relief. You know, they are new, I have them on for the first time. Once I had a new pair of shoes and I could not take them off, and did they hurt! I could not take them off because it was when I was at a dance. I enjoyed the dancing—it was the first time I went to a dance—but my feet hurt terribly. At this dance I met the boy who later became my first boy friend. He was a sweet boy, but very shy. It took him weeks till he first kissed me and about a year until we had intercourse. I hadn't had any sexual relations before and I was a little scared. I think I would have married that boy if I didn't know that he was going to live far away. It would have been the first time that I left my hometown, and I could not make up my mind to do that." She went on talking, the whole hour, and all her associations had in common that they concerned "firsts" in her life. You certainly noticed it in the material I quoted: the shoes she was wearing for the first time, the other new shoes, the first dance, the first time she saw the boy, her first boy friend, the first kiss, the first intercourse, the first time she would have to leave her hometown. All the other associations of that hour had the same connotation—all, but one. In the middle of the hour, she said: "A picture comes up, a funny one. I see myself as a very small child, walking from one chair to another. I am sure at that age I never was given any alcohol, but I walk as if drunk. I stumble, can scarcely keep my balance. I sit down on the ground suddenly, it hurts a little, but I get up clumsily and resume my way to the chair. I have no idea why I recall that; there isn't anything to it, but I always knew that scene." I need not describe this further because, of course, you realize what this scene meant. According to the other associations, it obviously was her first effort to walk—again a "first." Now it does not seem so important to establish the memory of a patient's first independent steps; it gains significance only if you know that this girl's chief symptom was a difficulty in walking. There was nothing wrong with her feet, but while walking, and only while walking, she had the feeling her feet did not belong to her. It was at least interesting to have her recover a memory of her first

steps. The interpretation that the scene represented her first independent steps was considered not more than a possibility by the patient, but was followed by recovery of numerous memories concerning the use of her feet, mostly in walking, some of them repressed for a long time. We may always consider this result of an interpretation as proof that the interpretation was correct.

Another example: a patient speaks about his father's death not only in a cool, matter-of-fact way, but says in so many words that it did not affect him at all. If this patient was on good terms with his father and was fond of him, this does not make sense. But if he, in the same hour, tells you of his deep mourning when, a little later, his dog was killed, the interpretation suggests itself that this affect of mourning took its strength from an occasion where it was not felt because the patient repressed it, out of fear, out of shame, perhaps out of the feeling he could not stand the impact of emotions. But if he mourned for his dog, he could comfort himself with the realization that it was, after all, only his dog. We meet with such displaced affects very frequently, as you know. If the interpretation that his mourning belonged to his father's death, is given at the right time, you will be amazed at the amount of feeling not yet done away with when he cried about his dog.

Other interpretations concern not the memories, but the behavior of the patient. When the first resistances come up, the patient starts to come late, or forgets his hour, or cancels it, or claims that nothing comes to his mind. Of course, you have to interpret this, that is, you have to show him that something within him is fighting the analysis. Never say "you are resisting" or "you do not want to get well." Rather, say "something in you" or "part of you." It makes it easier for the patient to fight his own resistance if you thus give him confirmation that partly he does not resist.

Training analysts are frequently asked in control hours: "When should I tell the patient what I understood his symptoms or associations to mean?" Providing the answer the

candidate wants and needs and expects is one of the most difficult tasks of a training analyst. He can give it only if he knows not only the patient, but also his inner situation, the stratification of his problem, and which stratum is nearest the surface. Only this, nothing else, has to be interpreted. But how can the training analyst tell when he hears about the patient once a week? And even if he heard about him every day, after each psychoanalytic hour, he did not hear how the patient talked, he did not see his tears, he did not sense the fear in back of his self-assured words. I want to make use of this opportunity to call to your attention the enormous importance of detailed descriptions, to be given in your control hours. Not only the patient benefits. It is, as far as I know, the only way of accumulating experience without making bad mistakes and by so doing losing a patient or ruining an analysis.

But do not be discouraged. We cannot provide rules when to give an interpretation, but we can warn against the most common mistakes. One, I mentioned already: do not interpret when you feel confused by the abundance of psychoanalytic material. The only thing you may and should interpret is the confusion created by that abundance, for instance, when the patient, in order to confuse you, brings forth material from all layers of his mind, without perceptible connections; when the deepest desires of his oedipus complex appear to be next to what he ate for supper last night, and his professional ambitions are lined up with gossip about his neighbor; when melodramatic childhood memories drown out everything else, for weeks on end. When you show him that, of course he will say: "But you want me to tell you what is on my mind, don't you? And this is what was on my mind, so I said it." Yes, he is right—only these things in their magnificent disorder or overabundance are on his mind in order to confuse you, to make it impossible for you to find your way to a correct interpretation. When a patient presents me with this type of association, I usually interrupt him and ask something like this: "Say, do you think the same way, the same things, when you are on your way to your hour?

Or when you are in bed about to fall asleep?" Of course, he does not. If you are lucky, he will tell you what he thought on his way to his hour or last night in bed. In other words, if the analysis seems to go too fast, apply the brake, because actually this analysis is not moving at all anyway. In such situations, meticulously avoid interpreting any contents; the only thing you should interpret is the patient's way of presenting them.

The first content interpretation should not be given too early, that is, not before the first essential resistances have appeared and can be understood. If you understand them, interpret them, and you will be amazed how different the patient's next hours will be. Then you may interpret contents, and only those which are close to the surface, so close that the patient can almost reach them himself.

What are the first essential resistances? Of course, they concern the fact that the patient is in analysis. If he really follows the basic rule, his neurotic equilibrium will very soon be disturbed. If he is really honest, he can no longer maintain his neurotic pretenses. It is only natural that he experiences this as very unpleasant and uncomfortable and that he not only resents it, but (correctly) blames the analyst for his unpleasant feelings. You must not think that the patient will tell you this. Those who do are rare exceptions. But if you feel the patient resents your interference with his neurotic satisfactions and is aware of it, interpret it. In a friendly but firm manner, tell him that he feels uneasy, that he resents it, and that he blames you for it. It is a good idea to start such an interpretation with: "It is only natural . . ." or "I can understand that . . . ," or some such remark.

I want to come back to what I mentioned about giving interpretations at the right time. I think it is necessary to stress this point because I know what a temptation it is when the analyst knows the significance of a symptom, a dream, a chain of associations, a slip of the tongue, or whatever it may be, to tell the patient. I know how it feels when one hears the patient groping around in the dark, and one knows the answer, and knows also

that the patient waits for it. I am aware that sometimes the wish to "show off," to show one's cleverness, makes it hard for the young analyst to wait with the interpretation. Do not give in to such wishes. It is not only better for the patient and his analyst to wait for the right moment, but it is also a much greater satisfaction to watch the patient come closer and closer to a certain point and then, when he is quite near it but cannot grasp it, but you feel he is ready to accept it, give your interpretation, and in so doing, clear the deck, wipe away his fears, and take the burden of guilt from his shoulders. Not every interpretation carries such importance. There are interpretations concerning minor matters, and there are others that the patient does not grope for at all, that hit him as a complete surprise (transference interpretations mostly). These also have to be given not as soon as the analyst knows them, but when the patient is capable of accepting them.

It is not only a mistake to give interpretations too early; to give them too late is wrong, too. The best means to combat both dangers is, once again, something that cannot be taught—empathy. Try to feel what the patient must feel; try to anticipate his reaction. This will probably show you how best to formulate your interpretation and when to give it. Empathy will also prevent you from giving incomplete interpretations, which do not help the patient because he cannot use them. The famous interpretation, "You don't want to lose your symptoms," belongs in this category. It is, unfortunately, used frequently. Obviously, this is no interpretation at all, but an accusation, which no patient can accept. It becomes an interpretation only if you can add why he does not want to lose those symptoms and can prove it by his association. Each interpretation, even when it apparently concerns only minor, unimportant matters, must surprise the patient, that is, it must tell him something he did not know before, it must enable him to bring up unconscious derivatives which are a little less distorted, a little bit closer to the original emotion or impulse he has repressed. This, and

only this, is why we give interpretations at all. If we did not need those less distorted derivatives, we could limit ourselves, as most psychotherapists do, to reassurance and "pep-talk."

It is a good idea to start with the patient's indirect communications, such as behavior, speech, general attitudes. What I mean is, do not start with: "It seems you love your mother more than you like your father," but perhaps: "I have the impression that your attitude toward your brother is very much like that of your father toward you." Begin with his attitude, not his oedipal feelings. What happens when this is correct? The patient will develop some emotion, will be surprised, will perhaps say only: "Well, I never thought of that." Then, he will continue to talk, and in his associations you will find confirmation and further evidence. He may, for instance, compare the two relationships. In doing so, he may mention a friend of his who is jealous of the admiration a young man shows toward the friend's wife. You will know that in the patient's attitude toward his brother, as well as the father's attitude toward the patient, jealousy has a part. In other words, the situation will become a little less disguised, it will come closer to the unconscious basis of these relationships. You will understand that not only is the patient jealous of his brother, but also that the father was and acted jealous of the patient.

I mentioned that interpretation must surprise the patient, must tell him something he did not know before. The same thing happens to the analyst when he grasps, for the first time, a really essential connection, when he is confronted for the first time with the real significance of an unusual and very much disguised symptom. I remember my surprise when it became clear to me what made a certain alcoholic patient go "on the wagon" and fall off again innumerable times, always celebrating his victory over his addiction and his freedom to drink again; I remember the surprise it gave me when I realized that the issue was not his drinking and it was not his struggle about it; it was this longing to celebrate his ability to sin and his pride in renouncing it. It was a continual repetition of the struggle within

his superego about who is stronger: I who want to trespass (no matter whether in drinking or sexual activities, or whatever) or I who can lick the demon within myself. The narcissistic satisfaction of either victory was much more important than drinking itself was, and so the mastery called for a celebration, sometimes in whiskey, sometimes in buttermilk. When I recognized this, my whole image of the patient changed. You will have the same experience of surprise whenever you find out essential new facts, facts that suddenly fill a gap or make other instances in the analysis understandable. And this surprise is the most reliable proof that what you found out was correct. The next step is to ascertain whether the patient can stand the impact of the interpretation, in other words, whether it is the right time to let him know about it. If so, his surprise will be as great as your own. The interpretation will "click" and will make it possible for the patient to bring up unconscious derivatives that will be much closer to reality, much less disguised. In the case of the alcoholic patient, it was his childhood struggle with masturbation, his repeated victories over his urge to masturbate and his periodic rebellions against the prohibition, presented now in the form of periodic changes between hard physical work and absolute laziness, spending his days in fantasies and doing nothing. You see that in this material the element of fantasies brought him closer to the dreaded subjects of masturbation fantasies and masturbation itself. Each correct interpretation has this effect, although it is not always as striking as it was in this case. Sometimes it manifests itself only in a new flow of material, in memories the patient had not touched upon until then, or in a new type of acting out. Another criterion of whether an interpretation is correct is change: If there is no change for the positive in the patient, it was not correct. "Positive" means the change helps the psychoanalysis progress. You must not feel discouraged if after an essential interpretation (which you feel was correct), you do not notice positive change. On occasion, you may not hear of it until weeks later.

I consider it important to give an interpretation only if and

when you are pretty sure it is correct. This allows for some exceptions, because sometimes you cannot be absolutely sure. Our knowledge is limited, in analysis more so than in any other situation, because in an analysis we have only one source of information, the patient himself, and he is certainly not interested only in informing us, but also in hiding from us what we are looking for.

I frequently have the impression that analysts with little experience try much too hard to avoid having an hour without interpretation. It is as if they were afraid the patient might feel hurt or deprived of something, or might accuse the analyst of not working hard enough. Something like: "I give you my thoughts and my time and my money, and you just sit there and do nothing—perhaps you don't even listen." I cannot repeat often enough that such fears should never determine whether you give an interpretation. If there is nothing to say, you may either say nothing or mention that there isn't anything. It depends entirely and exclusively on the patient's inner state whether you should say anything at all.

I want to say something about the form in which to give interpretations. I refer to the example in which I gave an interpretation that proved to be essential, in a single word (Lecture II). You remember the interpretation of the patient's transference resistance with the question, "Stillborn?" In other situations I feel that it is of great importance to give a detailed, step-by-step explanation of how you got from the patient's associations to the interpretation. Either of these methods may be right at a given moment in a given analysis. I cannot tell you when to use the one and when the other; I do not think this is teachable. I can only tell you that sometimes I feel it is essential to use the shortest form possible, whereas at other times I feel what is needed is a detailed explanation. This may depend on the type of person the patient is, or on the type of neurosis, or on what you want to achieve with the interpretation at exactly that moment. Perhaps all of these factors work together; I cannot tell. But in general I feel that by using only one or two words, you

give the patient only the starting point from which to go on with his thoughts or feelings; all directions are open to him. With a long explanation, you can better determine the direction the patient will take, so you must feel quite sure that this direction is best for him. May I remind you once more of the case where I said the one word "stillborn." The patient had become jealous because he had met a girl whom he suspected to be my patient. Some time earlier in his analysis he had to his amazement mentioned that his mother had a stillborn baby, had taken this back immediately, and claimed that it was a slip of the tongue. He was convinced he was her only child, just as he was convinced he was my only patient. After he met that girl, he said to me sneeringly: "So you have a daughter, too, eh?" Whereupon I said only, "Stillborn?" This one word was an interpretation and meant quite a number of things. It meant: "You are convinced that you are my only patient." It meant also: "You are jealous of that girl." It meant further: "Once you were jealous of the baby that was about to be born." And finally it meant: "You would rather that girl were dead than have her share your analyst with you." All this was condensed in that one word—and it had the effect I wanted: his repression broke down and he could feel the impact of the returning memory in all its force. With tears in his eyes he told me of the helpless rage he felt when he knew his mother would have another baby, of his guilt feeling when he learned the baby had died, and of his jealousy of his mother's grief. He could not understand how he could have forgotten this important event in his childhood.

In other cases, in other situations, one has to proceed quite differently. You line up what the patient told you, in this hour and in many others; you show him how he came closer and closer to something he dreaded to admit; you show him parallels out of his own life history, until finally you are able to say: "All this allows for only one conclusion." There are many patients who at this very point use the slightest pause you make to take the last step. They draw the conclusion you had built your remarks up to; they give that last, most effective part of the

interpretation. But even when the patient is not able to do that, even if you have to complete the interpretation—there are patients for whom you always have to explain at some length and in great detail in order to make them understand—this does not mean that you should give lectures.[3] With both methods, never push a patient. The more you push, the more he must reinforce his resistance, and the more you place yourself in line with his parents who pushed him, too.

There are analysts who believe that interpreting means showing the patient the apparently innocuous things he says are really of a sexual nature. This is entirely wrong. What they do is only one of the many facets of interpretation, and certainly not the one that has to be taken up at the very beginning. I know that it is not always possible to start with the most important interpretations—important for the success of the analysis. But if it is possible, start with something that helps to transform automatic ways of thinking and acting into the awareness of a conflict. You will find that transference always provides a good opportunity to do that (see also Lecture II).

I want to conclude with a few words about the effect of correct interpretations, without going too deeply into theory. What we achieve with interpretations is to side with the id against the defending ego. Thus we make it more difficult to keep instinctual impulses in repression. At the same time, we eliminate the danger to the ego, thus permitting the repressed contents to return to consciousness, establishing a more normal, healthy equilibrium.

V

WORKING THROUGH

I chose this topic for my final lecture because of its importance for the successful finish of an analysis. Yet, despite its special

[3] I know that some analysts recommend that, but I consider it a serious mistake and am convinced that it places the whole situation on an inappropriate level.

name, "working through" consists of nothing more than interpretation; everything I said about interpretation could and should be said about working through, also. So, insofar as technique is concerned, there is really nothing new. But there is one point that makes working through special. It is a specific type of interpretation capable of accomplishing what all the previous interpretations could not achieve: to finish the analysis. If skillfully handled, it gives assurance that this symptom, this character attitude, this neurosis, this patient, will not need further analysis. That is why I prefer to address this topic rather than "how to end an analysis." The really successful end of an analysis is equivalent with having successfully worked through the interpretations you had given previously. At the end of the analysis, everything else is of minor importance.

What does it look like? You know from experience that the interpretations you gave in an analysis concerned various matters, and perhaps you were baffled by the apparently inconsistent course the analysis took—turning from castration fear to sadistic impulses, from there to a desire for security, to cannibalistic fantasies, and so on. After a time, the picture changes. Sooner or later you discover that these varied and disconnected contents are part of a pattern that characterizes the patient's whole personality. They fit together, complete each other, support one another, make each other possible. Finally you realize that all these pieces are held together by something they have in common: they serve the same purpose, or they fight against the same danger, or they express the same desire or hope or fear. And once you have seen that, you discover this common denominator everywhere. You find that a certain defense you had analyzed in one, two, three contexts is still present in a series of others, and held firmly in place in those first ones by the very fact that they are still operating in these others. You observe the development of new attitudes, even new symptoms, which serve the same purpose you had analyzed in the original symptom and character attitudes. More and more you realize the resistance character of the whole process.

It is at this stage that the less experienced analyst very easily feels discouraged and may consider the case hopeless. Let me tell you that this situation develops in every analysis, more or less visibly, and represents the best occasion for working through defenses, not only at the places where you always saw them, where they were conspicuous and striking, but also where they found an apparently safe hiding place.

Anna Freud once said to me: "You know, analysis is like weeding a garden. You are glad that the weeds are so big you can spot them easily; but after having pulled them out you see smaller ones, and after them still smaller ones, and sometimes it looks as if the whole place was still full of them and as if you hadn't done anything. The more you keep weeding, the more weeds you find." This is certainly true for weeding out the defenses; but remember, they become smaller and smaller, that is, weaker and weaker; each batch is easier to pull up, that is, to interpret, than the foregoing one. The patient has more courage to show them, and your eyes are better adapted to see them. Do not give in to the temptation of saying, "Well, this little bit of defense can stay." Small weeds grow into big ones and seed themselves again to start a next crop.

This weeding consists solely of interpretation. We cannot do anything else, and we cannot do anything better than interpreting, again and again, indefatigably and consistently.

If you ask me what differentiates working through from any other interpretation, well—the difference lies in its function. An interpretation such as we have discussed before makes the patient conscious of the unconscious meaning hidden in his associations or actions. He realizes, for instance, that in his cruelty against small animals, impulses against his younger siblings break through, whereas the process of working through makes him realize that in other phases of his life the same cruelty (not a similar one but the same) is at work. Or, an interpretation may show him that his sexual aim was to be loved rather than to give love; working through has to show him that he repeats this in many life situations—his marriage, his analysis, his work, his

social behavior; his relationships with relatives, his sports partners, his children; and in many other phases of his everyday life. An interpretation may be summarized by: "What you really mean is . . . ," whereas working through has the meaning of: "there too," "there again."

Of course, periods of this type of interpretation occur in many phases of each analysis. Often you have to show the patient that his reaction to an interpretation in the analytic hour is exactly the same thing you have just interpreted. But in each analysis there comes a time when this "there too," "there again" is the main feature, the *Leitmotiv* of the whole treatment. This time provides an excellent opportunity to dissolve transference, because the main character attitudes of the patient, desires as well as fears, which he attaches to all his objects, are bound to come up in his transference to his analyst also, and are worked through as well. I would not mind saying that this is an ideal type of ending for an analysis, favorably differentiated from having the analysis peter out, weaning the patient, and pretending the analysis is finished when it has merely stopped.

Again I recommend to you Fenichel's (1938-1939) book on technique, in which the chapter on working through is particularly worthwhile. Since he gives you all there is to say about the theoretical aspects, let me give you a practical example.

You may remember the girl who, after five months of analysis, dreamed about a museum where she wanted to buy something that was too expensive (Lecture III). In this dream something came out which she called the cause of her illness and which she intended to keep out of her analysis: homosexual games with her younger sister. The very fact that she revealed this very much against her intentions showed that it was important. Homosexuality, however, did not play an important part in her analysis for a long time. Her analysis had been going on for almost a year when she told me that throughout her childhood she had a fantasy that accompanied her all the time. It began after she had experienced, first, several rejections from her mother, then, turning toward her father, was rebuked by

him, and finally, when she tried to make love to her younger sister, was punished for that, too. She remembered feeling: "If I am not allowed to love my mother, and not my father, and not my sister, then I have to love myself; that's the only way out." She began imagining that somewhere, above our visible world, there was another world, exactly like the real one. And in this "upper world" there was a little girl like her, who did everything she did, simultaneously. Whenever she laughed or cried or played, this little girl laughed or cried or played also. Fantasizing that, thinking that this little girl had to do everything she herself did, was her comfort and satisfaction, her secret which she shared with nobody. It was clear that this little fantasy-girl satisfied her need to deny that her sister was not as compliant, and her need for some narcissistic homosexual love in general.

This patient had many conversion hysteria symptoms; furthermore she had something which I never, up to then, considered hysterical—from her third year on she had double vision, one picture placed above the other. She was not bothered by it very much and used to close one eye when she had to write or read or sew. The fantasy of the upper world was related to her double vision. To my amazement, after I pointed this out, the double vision disappeared. She said, "I can't do it anymore." But soon it became obvious that this whole concept of an "upper world" had left its traces in everything she did or thought—sometimes quite obvious, sometimes hidden and disguised so that it was scarcely recognizable. And this is what I want to point up: all these traces had to be worked through. I had to show her that in everything she did she was trying to make this "upper world" real, not only in terms of space, but also in other forms. In most of her dreams she was at a lower and a higher level at the same time. For example: "I am in my analytic hour [my office was on the sixth floor], the window is open, and I step through it into a boat on the ocean." Or: "I am

on a mountain peak at the bottom of the river." Or: "I am in the first row in a theatre and look down at the actors." In her work she had to operate a machine that had to be worked partly by foot, partly by hand. All the other workers did first one, then the other, but she always tried to do both at the same time. When she made herself a dress, she started at the bottom of the skirt, then interrupted and sewed part of the top, then went back to the bottom, and so on. She was fanatic in her opposition to religion, although it would seem that religious concepts would fit her fantasy. But the religious "upper world" was a commonly accepted thing and could not be her secret, so it was rejected. This idea of being below and above at the same time could be found in nearly anything she did.

Certain dreams she had prompted me to ask her whether she had ever been afraid of some animal. No, she answered, she always loved animals. Gradually it began to dawn upon her that this had not been so all her life. "I don't know what that animal was," she said, "but I do remember that it appeared in my dreams and frightened me when I was little. It can't have been a real animal. It didn't have any legs; it didn't have an under- or upper-side. Is there such an animal? It seems to me that its back was on top, but when it turned over, there was a back again."

The point here is not to show you how a repressed memory sometimes gradually comes back; of course you guessed what this animal had been—her parents having intercourse. This was what was behind her idea of below and above. She had identified herself with the animal, that is, she had identified herself with her parents being together; she was both of them, below and above. In her later fantasies it was she and another girl, also herself, not having intercourse, but doing the same thing in her real and an upper world.

All that was interpreted as the analysis went along. It was interesting to see how, when one significance was interpreted, another instance came up in which the same idea was represented.

When this was interpreted, there was another again, and so on, for a long time. She even developed new transient symptoms and attitudes which expressed the below-above idea in some new form, in some unexpected context. Again and again, I had to show her that she had given up some of the old attitudes only to replace them by these new ones which served the same purpose. Even her main symptom, which made her come to an analyst, was finally revealed as belonging to these attempts to carry through the role of both parents. It consisted of feeling physically miserable on Sunday, and only on Sunday, with nausea, vomiting, and anxiety ending Sunday evening with a copious bowel movement, and afterward feeling particularly well, free, easy, and happy. It became quite clear that all week long she "was" father, doing hard physical labor in a sheet metal factory, and Sunday (she was born on a Sunday) she "was" mother, feeling all the discomforts of pregnancy until in the evening she gave birth to an anal child. When we had worked this through very thoroughly, she gave up—but not without trying a last time, on the level of transference, to create for herself a new situation to act out the old pattern. When the Sunday nausea disappeared, she began to play a new game with her mother. She told her she wanted to know more about her mother's childhood and had mother tell her all about it. In other words, she identified herself with me in, so to say, analyzing the mother. When she told me this, she added, "You need not tell me that there again I do what I did all my life. In acting your role, I try to act as if I were somebody far above me in education and social standing, again being at the same time myself, below, and you, above." She realized also that this was an interpretation and that in giving it she was doing the same thing again.

But this was really her last attempt. No longer was she compelled to play the old game. Now she was ready to be not man and woman, not continually vacillating between being below and above, but a woman with both feet on the firm ground of reality.

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THE DYNAMICS OF INTERPRETATION

BY JACOB A. ARLOW, M.D.

The patient's productions are a dynamic record of the conflicts of the past as they are recapitulated and re-experienced in the present. Much can be learned by closely studying the immediate effect of the analyst's interventions. Interpretation, especially of transference phenomena, will upset the equilibrium which has been effected and will enable the patient to understand how unconscious fantasies from the past continue to influence his perception and reactions in the present. Interpretation is a continuing process, unfolding in logical sequence. Transference may be an expression of the patient's resistance to recognizing an unconscious wish toward the original object.

In recent years the literature of psychoanalysis has grown enormously. Several interests contribute to this development—a continuing effort to clarify the theory of technique, the influence of new views concerning the origins of psychopathology, the ever-present desire to improve therapeutic results by making interpretations more precise and therefore more effective.

These discussions have focused renewed attention on the role the analyst plays in the conduct of treatment. Just how this role is perceived has varied in the course of the history of psychoanalysis. Originally Freud (1912b) recommended that the analyst behave like an opaque mirror, reflecting uncritically whatever had been focused on him. Emphasizing the transference, others saw the analyst as a substitute for the original objects of the patient's life, who affords the patient an effective, beneficial, therapeutic relationship. This may be accomplished either by means of a set of corrective experiences (Alexander, 1950) or by

enabling the patient to remold his superego, taking the analyst as a model (Strachey, 1934). Still others see the analyst filling the role of the good enough, nurturing mother (Winnicott, 1956, 1960) or the perfectly intuitive mother (Nacht, 1962), who sets the patient back on the track of normal development which had been disrupted by inadequate mothering. In their view of pathogenesis, the self psychologists concentrate on injured self-esteem and thwarted narcissism, the results of unempathic mothering. With these considerations uppermost in his mind, the analyst arranges his technical procedures, monitoring the vicissitudes of the patient's self-esteem. From this body of theory of technique emerges a number of very specific and clearcut directions for the management of the therapeutic process (Kohut, 1971).

Yet, in spite of all of these different conceptualizations of the therapeutic process and of pathogenesis, by and large all the proponents of the different views just mentioned share two things in common. They choose to operate within the framework of the psychoanalytic situation, and they regard the principal function of the psychoanalyst to be the giving of interpretations. But exactly what is an interpretation? Why is it given? How do we know if it is right? All of these issues have been the subject of lively debate for many decades.

The psychoanalytic situation is perhaps the greatest and most original of Freud's contributions to the study of human psychology. What distinguishes psychoanalysis from all other forms of psychotherapy is the use of the psychoanalytic situation. The psychoanalytic situation is both the investigative tool and the therapeutic instrument of psychoanalysis. It would seem logical, therefore, to anticipate that the basic principles of the psychoanalytic situation should illuminate the problems of technique just mentioned. The developments that led Freud to devise the psychoanalytic situation have been summarized often enough in the literature and do not have to be repeated; the principles underlying the psychoanalytic situation, however, do deserve repetition. The psychoanalytic situation epitomizes the

fundamental concept of the psychoanalytic theory of the mind. It expresses a dynamic, deterministic view of mental functioning, one that maintains that the human mind reflects the interaction of many interests, wishes, and tendencies, which may work together or in opposition to each other. Some of these trends are conscious; others elude awareness. Given the conditions of human existence, conflict among opposing tendencies becomes an inexorable aspect of mental life. It was such considerations that led Kris (1950) to say that psychoanalysis may be defined as human nature seen from the viewpoint of conflict.

The conditions determining the psychoanalytic situation, i.e., the neutrality of the analyst, a clearly defined set of practical arrangements, and, above all, the technique of free association are designed to take full advantage of the dynamic thrust of the elements in conflict. The stream of the patient's free associations is the record of the vicissitudes of the analysand's intrapsychic conflicts. It is the specimen presentation, the dynamic sample of the characteristic, one might say idiosyncratic, mode of the individual's mental functioning. This record, the product of many interacting forces, supplies the data for understanding the nature of the patient's problem and, therefore, for making appropriate interventions.

How to define the nature of the forces in conflict and to delineate their origin remains a continuing problem of theory building in psychoanalysis. Freud changed his views on the subject several times. The current literature abounds in alternative propositions. In the long run, these theories are of secondary importance when compared with the fundamental assumptions that form the basis of the psychoanalytic situation. Theories have to relate to observable data. It is the burden of theory to place data into the most meaningful, coherent, and consistent relationship. When theory fails to do so, it becomes dogma, no longer scientific principle. For example, during the actual practice of treating patients, it is not possible to prove whether a particular wish or mode of mental functioning derives from

some inherently biological source or whether it is the outcome exclusively of a particular set of interpersonal experiences effected during critical phases of development in childhood. What matters is the specific context in which derivative manifestations of the forces in conflict appear. What matters is the meaning of these derivatives in the syntax of the patient's free associations.

From the psychoanalytic point of view, what we observe of mental functioning represents a dynamic equilibrium effected among the various forces in conflict. This is by no means a stable or fixed equilibrium. Some of the solutions to intrapsychic conflicts may indeed represent relatively stable compromise formations. They may assume the character of fixed and predictable patterns of response and may come to be considered what are commonly known as "structures" of the mind. The mechanisms behind adaptive character traits would be one such example. For the most part, the dynamic equilibrium established among the various conflict elements in the mind tends to be unstable. It shifts and changes under the impact of experience.

The equilibrium may shift in favor of one or another of the forces participating in conflict. Consequently, the mental apparatus is required to recruit time-proven measures to re-establish the old equilibrium or to institute new methods to reconcile the pressures of the forces in conflict. When the conflict is severe and a satisfactory compromise solution is unattainable, psychological difficulties of all sorts may develop. This is the mental state of the patient as he presents himself for psychoanalytic treatment. He cannot resolve his inner conflicts, meaning that he cannot restore a reliable, favorable, dynamic equilibrium of the forces in conflict in his mind. Under the impact of differing influences, the unstable dynamic equilibrium may shift in such a way as to evoke painful psychological states in the form of anxiety or depressive affect, or it may force the patient to resort to patterns of behavior free of painful affect but undesirable for other reasons.

Up to this point, this presentation has been made in the most general of terms. In consequence, a certain tone of awkwardness or unnecessary circumlocution may have resulted. There was a definite purpose, however, to this mode of exposition. It was to demonstrate the all-pervasive significance of the concept of conflict of forces in the mind and how essential this concept is to appreciating the nature of the data obtainable in the psychoanalytic situation. In any investigation, the nature and validity of the findings bear a direct relationship to the instrument one employs. Since the data obtainable in the psychoanalytic situation hinge on the concept of forces in conflict, it should be clear why I find structural theory most appealing. In structural theory, every mental content is viewed according to the role it plays in intrapsychic conflict. In the psychoanalytic situation, the record of the patient's productions reflects the moment-to-moment interplay of the conflictual elements in the mind. Pragmatically and empirically, the delineation of these functions under the headings of id, ego, and superego seems most efficacious and theoretically the most parsimonious framework in which to interpret the dynamics of mental functioning.

The model of the psychic apparatus to which the analyst subscribes inevitably influences how he responds to the patient's productions. How he sees the material will result from his concept of the therapeutic goal. Historically, the topographic model, for example, conceptualized the findings derived from the investigation of hysteria and the interpretation of dreams. At that time the principal technical aim of analysis was the recovery of repressed memories. The goal of treatment was the undoing of the infantile amnesia. Even as he presented the rationale for introducing the technique of free association, Freud (1925) emphasized that he had now devised a method for circumventing resistances to recollection, that now he could gain access to repressed material and memories. The dynamic relationship prevailing among the contents of the various psychic agencies and reflected in the pattern of free associations was expressed in terms of a concrete metaphor. This was a meta-

phor of connecting chambers (or more recently, boxes [Sandler, 1983]). Communication between these chambers was closely monitored by the intrapsychic censors. In terms of this model, the problem consisted of how to get past the censor standing between the systems *Ucs.* and *Pcs.*, and from the systems *Pcs.* and *Cs.* into the open light of consciousness. Presumably, this becomes easier when the censor is off guard and can be deceived by disguises. During sleep the censors apparently do not function as efficiently as when the individual is awake. Their watchfulness is subject to lapses.

The technical implications follow logically enough. They pursue the premise that, if the patient suspends judgment, relaxes his watchfulness, and freely reports his thoughts as they occur to him, there will emerge from the depths of his mind hitherto unexpressed wishes and long forgotten memories of traumatic experiences. In a strikingly reductionistic manner, some analysts maintain that, if the patient were really associating freely, his productions would take on the nature indicative of primary process functioning, that is to say, communication would become disjointed, fragmented, incoherent, and symbolic, and thought would be experienced in terms of the primary sensory modalities, particularly vision. To put it starkly, the ideal type of free association for them should recapitulate the quality of mental functioning that characterizes the state of dreaming during sleep. It is not surprising, therefore, that analysts who adhere to the topographic model, even those who do not subscribe to the extreme level of regression just described, often tend to see free association during the analytic session as linked to altered states of consciousness. Therapeutically, this translates into the technical maxim of "helping the patient to regress," primarily by having the analyst assume an extremely passive stance.

Whether the analyst's behavior actually induces regression is a debatable proposition. The important point is that such an approach emphasizes the quest for content over the analysis of process. It emphasizes the importance of the recovery of memo-

ries at the expense of structural change. The recovery of memories is the product of effective analytic work, but per se not necessarily the instrument of cure. Besides, the record of repressed events is not always recovered. In one of his last contributions, Freud (1937) indicated how this material has to be put together from the remnants or traces of the original conflict that remain dynamically active in the patient's mind in the present. Kris (1956) stated the same thing from a slightly different point of view when he said that it would be an impossible task for psychoanalysts to attempt to recover the memory of precisely what had happened in the individual's childhood. What one deals with instead are the patterns of behavior and thought that remain as the dynamic record of those events and of the conflicts which they generated.

The analyst is not a passive witness to the patient's self-revelations. He is, as Kris (1951) so aptly expressed it, a participant-observer. His presence, whether acknowledged or not, is a constant dynamic factor in the psychoanalytic situation. He is not only privy to the details of the patient's experience; he also presides over the contest of forces arrayed in the patient's mind. He intervenes from time to time to delineate the nature of the forces involved and to explain the purpose they serve. He provides the opportunity, as it were, for each of the forces participating in the inner debate to have its say. The evidence and the indications for his interventions derive ultimately, and fundamentally, from the stream of the patient's associations. Once the connecting words or phrases are interpolated between the elements of the free associations, the text of the patient's thoughts may be read as a series of related sentences or paragraphs. It is as if the analyst were eavesdropping on the full record of the patient's conscious and unconscious preoccupations.

The stream of associations in the psychoanalytic situation is the dynamic record of the patient's past embedded in the present. Here emphasis should fall on the word "dynamic." It is not merely that events of the past are suggested by way of traces or allusions in the present-day material. The vicissitudes of the

conflicts of the past are recapitulated in the present. Examining the moment-to-moment variations of the sequence of thoughts as they emerge into consciousness, one gains insight not only into what forces of the mind are in conflict with each other, but also how the same efforts to resolve the conflicts in the past are repeated in the present. It is as if we were seeing, in a current setting, a replay of the individual's *inner* experience from the past and how it affects his behavior and object relations in the present.

There can be little doubt that the most effective, most dynamic interpretations are those relating to the analysis of transference. When the analyst interprets a transference phenomenon, he accomplishes several things at the same time. First of all, he demonstrates how unconscious wishes distort object relations in reality. He makes the patient aware of how unconscious fantasies intrude upon conscious experience, leading the patient to misperceive and misinterpret what is happening. As a result, the patient is prone to respond inappropriately to the situations confronting him. Secondly, in interpreting the genetic roots of transference phenomena, the analyst helps the patient grasp the concept of how the past is dynamically active in the present. Treatment, then, becomes a matter not of recollecting and purging one's self of a noxious memory from the past; it becomes instead a matter of knowing and mastering a persistently disturbing influence in the present. This is why transference interpretations are so effective in advancing the process of insight.

Two additional aspects of the analyst's activity bear directly on the dynamics of interpretation. Interpretation is not a "one-shot" experience. It is a process that unfolds in logical sequence, a process that involves the contingent relationships of various expressions of wish and defense. Between the manifest symptom or character trait and the underlying unconscious fantasy of which these are derivative expressions, there is interposed in the mind a whole series of compromise formations, reflecting the vicissitudes of the ego's attempts, over the course

of time, to effect an acceptable and stable resolution of the unconscious conflict. The analyst interprets the dynamic effect of each contributor to the patient's unconscious conflicts. He demonstrates how, at different times, considerations of guilt, fear of punishment, of loss of love, of realistic consequences, opposed or even took sides with the fantastic wishes of childhood. The analyst makes the patient aware of how the dynamic shifts in the patient's associations bear testimony to the influence of the many forces in conflict in the patient's mind. The process of interpretation, therefore, may extend over a considerable period of time, as the analyst proceeds in a measured fashion, responsive to the dynamic interplay between wish, defense, and guilt at each level of interpretation. There is a long road that leads, for example, from the analyst's understanding of why the patient idolizes him to the patient's awareness of its connection to his fear of being castrated.

Another aspect of the analyst's function concerns the dynamic role of transference as resistance. This is a concept that is frequently misunderstood. Originally, Freud (1912a) developed the idea in the context of resistance to recollection, but, in current structural theory, transference as resistance has additional and broader meanings. This, too, can be appreciated best in examining in detail the sequence of the patient's associations from a dynamic point of view. Close observation will most frequently demonstrate that, when derivatives of the unconscious wish toward the childhood object begin to appear with increasing clarity, at just such a point a switch takes place in the flow of the patient's associations. The original object suddenly seems to disappear, as it were, from the scene, and at the same time material conveying the identical unconscious wish, but now transposed onto the analyst, appears instead. Thus, transference makes its appearance not only as a resistance to recollection, but also as an acceptable compromise formation, involving the process of displacement. By this defensive maneuver, the anxiety connected with certain ideas and impulses may be fended off. Sexual wishes for the analyst, for example,

are not consciously barred by the incest taboo. A striking example of this process appears in the second half of this presentation.

The following material concerning the beginning analysis of a character trait of benevolent generosity may serve to illustrate some of the principles involved. The patient is a very successful man in a highly competitive field. He strives very hard for others, especially his subordinates, but finds it very difficult to make demands for himself. From humble origins, he has far exceeded his father, his siblings, and his many cousins. His presenting problem concerned difficulties between his wife and himself. She was trained in his field, but gave up pursuing her career in order to raise a family.

In the previous session, the patient had discussed some of his complaints about his wife's behavior. He described the various things she did or failed to do, which he interpreted as evidence of hostility. He recognized that she admires him greatly, but he was beginning to appreciate that she is envious of him. He spoke at some length about women of ability who resent their husbands. One of the women whom he mentioned had said, "I'm tired of playing second fiddle to my husband." He saw this as similar to his wife's attitude. She had said, "If it weren't for you, no one would pay attention to me at all. They wouldn't know me."

At the following session he renewed his complaints against his wife. In the kitchen that morning, he had done all the chores connected with the breakfast, while his wife sat by. These were things he felt she should be doing. The only contribution she made was some critical comment about something he failed to do. This infuriated him. In his anger, he complained that he does so much for her while she does hardly anything for him. He continued by outlining a long list of the many generous acts he has performed for her and her family. Finally, the patient said, "Enough of that. I want to talk of something else, something different."

The patient then proceeded to talk about his partner, who

seems to be diminishing the patient's role in various ways. He said, "My partner acts like he is already head of the company. He will be some day. What's his hurry? I'm not that old yet. I can't understand it. I have given him as much authority as possible. I have been very generous to him. Perhaps it's the generational gap. But it's more than that. He seems so impatient, so envious. He wants me out of the picture."

At this point I observed that the patient had not changed the subject. He feels angry and threatened by the hostile envy of both his wife and his partner, whom he sees as wanting to be in his place.

The patient responded, "But that's my disappointment. I have been so very generous. My company is known throughout the industry as one where everyone gets on so well. It goes back a long way. I have always been generous."

The patient's disappointment is understandable. Benevolent generosity, a method of coping he had adopted years back, is not accomplishing its purpose. People whom he has surpassed harbor hostile wishes toward him. He feels they want to eliminate him, so he is afraid of them. It is no surprise, therefore, that outstanding among his complaints is a fear of death. He associates his current competitors with competitors in the past, whom he has surpassed. Although he has not identified the latter in this material, he had done so previously. That the patient's father is to be included in the roster of defeated rivals stems from the patient's statement regarding the generation gap. Commenting on his partner's unseemly haste to dispose of him, the patient said, "I'm not that old yet." Thus the material suggests, although it does not necessarily establish, the origin of these conflicts in the generational struggle of the oedipal phase.

The reliability of the inferences drawn from this material depends upon the sequence of the patient's associations. The criteria employed have been described by me in a previous communication (Arlow, 1979). The *context* for the associations is furnished by the patient's unhappiness with his wife and his partner. A *common theme* runs through the associations, namely,

he fears the hostile wishes of his wife and partner, who envy him. The link is established by the *contiguity* of the thoughts concerning his wife and his partner. He associates one with the other, despite his defensive disclaimer, "Enough of that. I want to talk of something else, something different." These lead in turn to thoughts of the generation gap, to the idea of succession as a consequence of death. What he has perceived in the attitude of his wife and partner has upset the balance which he had established years earlier between his ambitious strivings and his fear of retaliation and punishment. Practicing generosity was the medium he had instituted to neutralize the hostility of his defeated rivals and to fend off the reproaches of his conscience, reproaches directed at the destructive implications of his ambition—and the technique is no longer effective.

In the intervention to the patient described in the previous section, the patient is made to confront his fear of retaliation from defeated rivals. The motive is then established for his character trait of generosity, and it is suggested that, since this trait is long-standing, it must have originated in similar situations earlier in his life. These interventions prepare the way for further elaboration of the origin of the patient's conflicts. At the same time, their appearance in the context of conflict between the generations suggests a hypothesis to be confirmed, namely, competition with the father, something of which the patient at this time is entirely unaware. Thus, the significance of the analyst's intervention goes far beyond elucidation, clarification, confrontation, affirmation, or whatever term may be used to describe the *content* of the intervention. Attention shifts to the *process*. The real significance lies in the dynamic potential of the intervention, in the way in which the equilibrium between impulse and defense is altered.

How the analyst intervenes is part of the art of psychoanalytic technique. Much of it is a question of timing, requiring a judgment on the part of the analyst as to whether the patient is prepared to respond in a dynamic way to his intervention. Responding in a dynamic way does not necessarily mean that the

patient is expected to accept the interpretation. What it does mean is that the analyst's intervention must be pertinent and close to the level of awareness at which the patient is experiencing the interplay of the forces involved in his unconscious conflict.

This raises the question as to just how one can characterize what the analyst does. Many authors have suggested different ways of looking at the analyst's actions. Perhaps the classification offered by Bibring (1954) is the most often quoted. He distinguished suggestion, manipulation, and clarification from interpretation, the latter being the essential medium of psychoanalytic technique, as opposed to the maneuvers used in psychoanalytic psychotherapy. Devereux (1951) discussed confrontation as distinct from interpretation. Gitelson (1952) described situations in which the analyst found it appropriate to acknowledge his personal motives for certain actions concerning the patient and, more recently, Greenson (1967) asserted that the real personal traits of the analyst are an important dimension of the psychoanalytic experience and deserve to be discussed with the patient at the appropriate time. It is well known that some form of encouragement or warning frequently enough enters into the message the analyst transmits. Really then, what the analyst says to his patient can be viewed in many different ways if one concentrates exclusively on the *contents* of the communication. It is not an uncommon experience during treatment, however, for the analyst's intervention to have an effect that is radically different from what he had expected. Often this arises because the patient does not understand the intervention in the same spirit that the analyst did when he made it. This is particularly true when interventions are made in a language that is general and open-ended. Such interventions frequently are quite effective, because of what Hartmann (1951) has called the "broad appeal" of interpretation.

The content of the analyst's communication is secondary to its dynamic potential. Technically, this means that what one should observe most carefully is how the analyst's intervention

alters the dynamic equilibrium that the patient has effected, as revealed in the stream of his free associations. Analytic technique has to be guided by an awareness of the vicissitudes of the changes in this interplay of forces. In "Constructions in Analysis," Freud (1937) noted that an unequivocal acceptance or rejection of interpretation by the patient is not in itself impressive. He was thinking in terms of long-range validation of the construction of a historical event that would be established by the subsequent course of the analysis. What I am trying to emphasize here is the immediate, short-range response of the patient, one that follows after the immediate reaction to the intervention. Since the analyst is a participant-observer, it behooves him to study the more immediate consequences of his intervention into the stream of the patient's associations. It is well known that sometimes even the most "innocuous" statement, or an adventitious sound from the outside, or a sound from the analyst which he had not intended to make may have a most powerful effect on the patient's productions. In the example which is to follow, a single word provided an effect as powerful as one would hope to get from the most carefully formulated interpretation.

In the session previous to the one that will be detailed, the woman analyst had informed her male analysand that she would be away for a week's vacation. The patient acknowledged the information and seemingly had no further response to it. At the next session, the patient began by giving a detailed account of his sexual experiences with several women during the past few days. He described at considerable length his sexual predilections, those of his partners, how he responded, how his partners responded. After a while, the analyst, feeling somewhat overwhelmed, suggested that this recital might have something to do with the patient's feelings for her. The patient responded that this could not be. He keeps her apart from his feelings and makes her unreal. He does not get attached to women, because if you do so, you can be disappointed, so he does not have continuing relationships with women. He does with men.

All of this was said in an offhand, detached way, and the patient continued as if he had been unnecessarily interrupted in pursuing his line of thought. Now, however, he concentrated on the practice of fellatio, detailing how the different women responded to his ejaculation. He noted particularly the pleasure he gets ejaculating on the woman's body or face. He feels there must be something hostile about it, because he recalls the disgust and anger he felt when he thought of the girlfriend who had been unfaithful to him and had relations with another man. The idea that this man's semen was being deposited in his girlfriend he found disgusting. (In fact, it was the feelings he had about this betrayal that had brought him into treatment.) At this point, the patient added, "Now that you are going away, I won't need to watch porno. Instead, I will use fantasies of oral sex, like I just described. I included X [one of his current girlfriends] in the fantasy in my masturbation."

The analyst asked, "When?"

The patient responded, "I don't remember. I think it was Saturday night. No, I don't know. Yes, it was Saturday night. *That reminds me.* Saturday night I took my parents to the theater. It was my mother's birthday. As I watched those seventeen- and eighteen-year-olds dancing, I almost began to cry. I used to be a very good dancer. I danced in contests with my sister and we won many medals. I felt like crying because I felt that I should be on the stage dancing instead of watching from the audience. Now I have a thought-memory. It is an image. Is it a memory or not? I can't be sure. I don't know. My mother and father are having intercourse and I am watching. My mother seems to be unwilling but she seems to like it anyway. When they finish, she rushes out to the bathroom to clean that dirty stuff out of her. I watch her as she goes by."

The analyst's first intervention took the form of a suggestion to the effect that the detailed recital of the patient's sexual experiences might have something to do with his feelings toward her. In spite of his denial, the patient's response was an exqui-

site elaboration of his transference feelings. In effect, the patient said, "I try not to have any feelings for you, or for other women, for that matter, because in the past I have been disappointed in love."

In a way similar to the manifest content of dreams, in free associations connecting words, like "before," "after," "therefore," "because," are usually omitted. The connecting link has to be inferred from the contiguity of elements (Arlow, 1979). In this instance, the text would continue to read, "I was so hurt by the betrayal that I vowed vengeance. It takes the form of using sex to humiliate women. I dirty them with my semen." Then, immediately after mentioning the woman who had betrayed him, the patient thinks of the analyst who is going away, which he links to a fantasy of oral sex while he masturbated.

At this point a most dramatic event occurs. The analyst makes an intervention that has a most profound and dynamic effect upon the flow of the material, but all she says is, "When?" Any system of clarifying interventions, as discussed above, would place this question under the heading of requests for information, but that is not how the patient understood the question. From the material which followed, to him it clearly meant, "What antecedent events may have influenced you to masturbate with this fantasy of humiliating a woman?" It was in this spirit that the patient responded to the question. After a bungling attempt to avoid making any such connection, the patient stated, "That reminds me. I took my parents to the theater," etc. It is more than an informed guess to venture that the analyst had an intuitive grasp of what might have led up to the masturbation. With his parents at his side, the patient experienced the theater production as a performance where he was relegated to the role of watcher, when actually he wanted to be in the center of the action. This was followed by what appears to be an intrusive thought-memory, but actually one which fits most accurately into the sequence and the general theme of the patient's thoughts. It is some vision of the primal scene. The affect that

pervaded the event in the past is recalled and re-experienced in the present in response to the stage show, namely, sadness at being excluded.

Betrayal is the organizing theme of the session, betrayal by the analyst, by the girlfriend, and, originally, by the mother. The mode of revenge is also suggested by the memory of the mother's reacting to the semen as something of which her body has to be cleansed as soon as possible. Thus the stage is set for the next level of interventions. There is sufficient evidence to validate interpretations concerning the traumatic effect of the primal scene and several of the behavioral and characterological consequences of that trauma in the form of not trusting women, anticipating betrayal, and seeking revenge in the form of humiliating the woman and inflicting pain by acting out a reversal of the primal scene (Arlow, 1980).

The subsequent session was dominated by material concerning the transference. Now the patient did indeed talk about the analyst's upcoming vacation. He was curious about where she was going and with whom. Is she married? Does she have a husband? Perhaps she is a widow. The re-emergence of the transference as a major element in the patient's associations illustrates an important point in the dynamics of interpretations of transference. Under favorable circumstances, the flow of the material in the analysis continues under the influence of the same dynamic conflict from one session to the other. The emergence of curiosity about the analyst's vacation and the thoughts of her husband's death constitute a classic example of what Freud (1912a) meant when he said that transference appears in the course of the analysis as a resistance. He was referring to transference as a resistance to recollection. Having reached the point where memories of the primal scene have begun to emerge, the patient now shifts his ground. Thoughts of how he felt about his father during the experience do not come to his mind. Instead, he thinks of the death of the analyst's husband. Instead of recalling wishes of the past, the patient entertains wishful fantasies in the present. This dynamic

shift should be the central focus of the interpretation. Linking the analyst's husband with the father undoes the defensive use of the mechanism of displacement.

This material, it is hoped, should clarify what the analyst does in therapy. His or her activity tends to upset the equilibrium effected among the several forces in conflict and represented by the compromise formation. As has been demonstrated, this is accomplished through various means, of which interpretation may be the most far-reaching but not the only one. When analysts intervene in any way, they articulate the influence or role played by one or another of the component elements in the conflict. Whether these are classified as representing id, ego, superego, or "reality" matters less than the fact that inevitably some reaction to the intervention occurs as the ego tries to reestablish the compromise formation it had effected. It should be the main task of the analyst, therefore, to follow the moment-to-moment variations in the sequence of elements in the stream of free associations, because this sequence reflects the interplay of the forces in conflict. In this context, it is understandable, as Freud (1937) indicated, that an immediate assent or rejection of an interpretation matters little. What matters is the subsequent sequence of events, i.e., the dynamic effect that the intervention has produced. It is this sequence, articulating the elements of context, contiguity, similarity, and repetition of theme, that has to be interpreted. In the example given above, the patient has to be made aware of how the appearance of manifest transference material was used to ward off emerging ideas of hostility concerning his father.

What is interpreted is the dynamic process, and, in this way, the patient comes to understand how his mind works. Recall of forgotten memories is ofttimes the reward for good interpretive work, but it is not the goal of treatment. There is the danger that, if one concentrates primarily on interpreting the transference in order to bring the forgotten past to light, the analysis of the conflictual compromise formations may be slighted. One may lose sight of the evolving pattern of the dynamic con-

flict. In a discussion of the ingredients of good interpretation, Schlesinger (1985) pointed out how frequently analysts fail to follow up the correct interpretations they have made.

SUMMARY

Psychoanalytic technique is often dominated by the attempt to recover repressed memories and to bring into consciousness the nature of the patient's unconscious conflictual wishes. If the vicissitudes of the patient's free associations are observed at close range, not only can one observe how a dynamic record of the patient's past is embedded in the present, but also one can discern the various methods the ego instituted in its attempt to resolve these conflicts, as well as the motives that dictated their use. Much can be learned from studying closely the immediate effect of the analyst's interventions. The interaction between the analyst's interventions and the patient's response exposes the nature of the compromise formations. This process deepens the patient's understanding of how his mind works and facilitates achieving insight. Therapeutically, this may lead to a realignment of the forces in conflict, eventuating in more adaptive, less conflictual compromise formations. As Brenner (1976) has pointed out, conflicts do not disappear as a result of treatment, but new, more effective, more adaptive kinds of compromise formations are instituted. The patient comes to understand most effectively how these compromises operate from the analysis of the dynamic effects of the analyst's interpretations.

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WORKING THROUGH: 1914-1984.

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This paper reviews the various meanings given to "working through" by Freud and others. The relation of "working through" to "analysis" is discussed and illustrated.

Freud introduced the term "working through" in a paper published in 1914: "Remembering, Repeating and Working-Through." The major portion of that paper is devoted to the first two of the topics listed in the title. Working through was dealt with only in the last two paragraphs of the paper. By it Freud meant the task of helping a patient to overcome resistance(s). Merely calling a patient's attention to resistance is not enough to make it disappear, he had found. In his words, "giving the resistance a name could not result in its immediate cessation. One must allow the patient time to . . . *work through* it. . . . Only when the resistance is at its height can the analyst, working in common with his patient, discover the repressed instinctual impulses which are feeding the resistance . . ." (1914, p. 155). Only then, after the process of working through, can an analysis be brought to a successful conclusion.

In 1914 many things about analysis were different from what they are today. At that time an analysis which lasted a year was a long analysis. Less than a year was the rule. What analysts thought of as analysis in 1914, and for many years thereafter, was to discover from a patient's dreams and associations, in the course of a few weeks, what the patient's libidinal fixations were, to communicate this knowledge to the patient, and to disclose to the patient his or her resistances, with the expectation that a cure would result. Moreover, to be thought suitable for analysis, a patient had to be able to free associate and to form a

transference. Those who could not do both were thought to be unsuitable for analysis. The concept of defense analysis was unknown then and for many years to come, and the concept of superego analysis was likewise far in the future. It could not have been otherwise, since both defense analysis and superego analysis depend on a correct appreciation of the role of anxiety in psychic conflict, an appreciation which was not achieved until after the publication of "Inhibitions, Symptoms and Anxiety" in 1926 (see Brenner, 1976, Chapters 3 and 4.) It was because so much about psychopathology was still to be learned that analysts in 1914 had a very different idea than do most analysts today of what the practical tasks of therapy are and of how long they should take. It was pertinent in 1914 for Freud to underline what is obvious today, that analysis takes time and that resistance does not disappear as soon as a patient is made aware that he or she is resisting. The concept of working through was, in effect, Freud's explanation of why analysis takes a longer time than it was first supposed it should.

From the article referred to it is not possible to be sure just what Freud meant in 1914 by the resistances which must be worked through in every analysis. As already noted, most of the article has to do with how and why patients repeat their repressed childhood wishes in the transference instead of remembering them as soon as they have been discovered and interpreted and/or reconstructed for them by the analyst. If one is to judge from the context, the most plausible guess would seem to be that Freud had in mind the resistance represented by the repetition of childhood wishes in the transference, since the sentence which immediately precedes the two paragraphs on working through reads as follows: "From the repetitive reactions which are exhibited in the transference we are led along the familiar paths to the awakening of the memories, which appear without difficulty, as it were, after the resistance has been overcome" (pp. 154-155).

This conclusion is supported by the description of psychoana-

lytic treatment which appears in the "Introductory Lectures" (Freud, 1916-1917, pp. 448-463). Freud wrote:

> . . . our therapeutic work falls into two phases. In the first, all the libido is forced from the symptoms into the transference and concentrated there [i.e., in Freud's words, a transference neurosis develops]; in the second, the struggle is waged around this new object and the libido is liberated from it. The change which is decisive for a favourable outcome is the elimination of repression in this renewed conflict [i.e., in the analysis of the transference neurosis], so that the libido cannot withdraw once more from the ego by flight into the unconscious. This is made possible by the alteration of the ego which is accomplished under the influence of the doctor's suggestion. By means of the work of interpretation . . . the ego is enlarged at the cost of this unconscious . . . (p. 455).

Earlier, in discussing the role of suggestion in analysis, Freud emphasized that it is used only to overcome a patient's resistances: "This work of overcoming resistances is the essential function of analytic treatment; the patient has to accomplish it and the doctor makes this possible for him with the help of suggestion operating in an *educative* sense" (p. 451).

It seems, then, that what Freud saw as resistances to be worked through in analysis are those which arise in connection with transference. Working through, in 1914-1917, was analysis of the transference. Arduous and time-consuming though it might be, said Freud, thorough analysis of the transference is not only necessary, it is of the greatest value to a patient.

By 1926, as one would expect, Freud's horizon had expanded considerably. In the Addenda to "Inhibitions, Symptoms and Anxiety" (1926a) and in Chapter 5 of "The Question of Lay Analysis" (1926b) he listed five sources of resistance or five kinds of resistance, if one prefers, which account for the length of analysis because they must be worked through. Three he attributed to the ego, one to the id, and one to the superego. The superego resistance takes the form of a need to punish oneself due to an unconscious sense of guilt. This he called the most

formidable of all, "the one most dreaded by us" (1926b, p. 224). The resistance which comes from the id Freud ascribed to an inertia of libido, manifested in the difficulty of giving up a libidinal fixation (1926b). Elsewhere (1926a) this was called a manifestation of the repetition compulsion. The three sources of resistance attributable to the ego, finally, were listed as the secondary gain from illness, the transference, and repression or defense in general.

The following passages are pertinent here. Freud wrote:

> The struggle against all these resistances is [the analyst's] main work during an analytic treatment; the task of making interpretations is nothing compared to it. But as a result of this struggle and of the overcoming of the resistances, the patient's ego is so much altered and strengthened that we can look forward calmly to his future behaviour when the treatment is over (1926b, p. 224).

A few pages later on he continued:

> There are cases in which one cannot master the unleashed transference [i.e., the transference neurosis] and the analysis has to be broken off; but one must at least have struggled with the evil spirits to the best of one's strength. . . . A neurotic cannot be cured [otherwise]. . . . The only possible way out of the transference situation is to trace it back to the patient's past . . . (p. 227).

And later,

> . . . the resistance that has to be overcome in analysis proceeds from the ego, which clings to its anticathexes (1926a, p. 159).

Finally:

> For we find that even after the ego has decided to relinquish its resistances, it still has difficulty in undoing the repressions; and we have called the period of strenuous effort which follows after its praiseworthy decision, the phase of 'working-through'. The dynamic factor which makes a working-through of this kind necessary and comprehensible is not far to seek. It

> must be that after the ego-resistance has been removed the power of the compulsion to repeat—the attraction exerted by the unconscious prototypes upon the repressed instinctual process—has still to be overcome. There is nothing to be said against describing this factor as the *resistance of the unconscious* (1926a, pp. 159-160).

In other words, according to Freud, it is in the last analysis the repetition compulsion which is responsible for the ego's reinstituting the repressions which were lifted by interpretation, a reinstitution which makes working through necessary.

Although his precise definition of working through varied from one presentation to another, as the quotations above show, it is clear that Freud, as noted earlier, was in each case attempting to answer the question, "Why does analysis take so long? Why doesn't a patient get well as soon as the analyst has understood correctly the nature and origins of the patient's unconscious wishes and correctly interpreted them to the patient?" It was in answer to this question that Freud first introduced the notion of working through and the question continued to be his main concern whenever he returned to the subject of working through of resistance in analysis.

His final views on the matter appeared in 1937 in "Analysis Terminable and Interminable." Written at the age of eighty, with his mental faculties undiminished despite the fact that he was dying of a slowly progressive cancer of the mouth, to which he succumbed in 1939, "Analysis Terminable and Interminable" has a testamentary character. It contains Freud's last words on the limitations and difficulties of psychoanalysis as a therapeutic technique, as well as his opinion of the reasons for them. In reading this paper, however, one should keep in mind the circumstances which prompted Freud at the time to ponder the problem of the therapeutic efficacy of psychoanalysis and to publish the results of his reflections. It was no secret from the analytic community of Europe in 1937 that "Analysis Terminable and Interminable" is a soul-searching response to Ferenczi's accusation that, when he was in analysis with Freud,

Freud had failed to analyze properly his negative transference. It was a response as well to the dismayed bewilderment of those who, like Jones, diagnosed Ferenczi as having become psychotic despite his having been analyzed by Freud as a younger man. In my opinion, it is this circumstance which accounts for the strong mood of therapeutic pessimism which pervades the paper, devoted as it is to the difficulties which beset analytic treatment.

In "Analysis Terminable and Interminable," Freud did not refer explicitly to working through. One cannot be certain whether he believed that some of the obstacles to analytic progress which he listed can and must be worked through in a successful analysis, while others are factors limiting the degree of success possible in any given case, regardless of the duration of analysis. Perhaps he believed that of all the obstacles he listed, if any was too great, it served as an insurmountable limitation to analytic success, while if not too great, it determined the length of time required to work through its manifestations in a patient's neurosis. I shall, therefore, merely summarize the list Freud gave, without presuming to decide which of the items on it are relevant to working through.

The list includes the following: (1) the balance in any case between traumatic and constitutional factors in neurosogenesis, (2) the constitutional strength of the drives, (3) the strength of the resistance shown to uncovering defenses, (4) constitutional abnormalities of the ego and, closely related, (5) an abnormal degree of either adhesiveness or mobility of the libido, (6) an excessive amount of free aggression, which Freud believed predisposes to psychic conflict, and (7) intense castration anxiety associated with passive wishes in men and its counterpart, insuperable penis envy in women.

In summary, one may say that when Freud introduced the concept of working through, he meant to counsel his colleagues to be patient in analyzing a patient's transference, then seen as resistance, and to urge the view that a neurosis is to be taken seriously, rather than looked upon as a bit of nonsense that can be expected to disappear as soon as one has shown a patient its

irrational nature. With increasing knowledge, born of experience, Freud's explication of why it is that analysis takes time became increasingly sophisticated. He brought in factors which are familiar parts of our own thoughts on the subject today: defense analysis, unconscious guilt, defective ego functioning, and the roles of castration anxiety and penis envy. It is as though to say that there is more to analyzing than even Freud himself clearly understood in 1914 and that to do more takes more time, in analysis as in most other things. In 1914 Freud was in the position of telling his colleagues and would-be colleagues that there was more to analysis than some of them realized. Ten and, perhaps, twenty years later he could say with perfect truth that there is more to analysis than even he realized in 1914 and that to do analysis well necessarily takes correspondingly more time.

The literature on the subject of working through by analysts other than Freud is not voluminous. It does, however, exhibit considerable diversity of opinion. The one common factor in the diversity is that each author addresses himself, as Freud had done, to the question, "What accounts for the fact that psychoanalysis takes so long?"

In *Problems of Psychoanalytic Technique* (Fenichel, 1938-1939) there is a chapter called, "Working Through and Some Special Technical Problems." Fenichel's discussion of the topic can be summarized as follows. In a properly conducted analysis, an analyst must deal first of all with the patient's defenses. The patient's defensive attitude must first be isolated from the judging part of the patient's ego; it must then be demonstrated to the patient that what is going on is something the patient is doing, not something that is happening independently of or even against his or her will, as the patient prefers to believe. That done, the analyst shows the patient that what has been recognized as a result of (unconscious) intent has a purpose and that the purpose, as Fenichel put it, is "to evade certain matters" (p. 77). The next step is to show the patient that both what is being evaded and the way chosen to evade it are historically deter-

mined, that the past, in other words, is being drawn into the present. When properly done, said Fenichel, this succeeds in freeing the patient from his or her neurosis, but only temporarily. "[T]he ego," Fenichel wrote, "does *not* completely relinquish its resistant attitude because of a single demonstration" (p. 79). Soon the symptom or neurotic character trait reappears and the entire process outlined above must be repeated. According to Fenichel, "The process that requires demonstrating to patients the same thing again and again at different times or in various connections is called, following Freud, 'working through' " (pp. 78-79).

Note that, for Fenichel, "the same thing" is a patient's defensive pattern. What must be worked through is the resistance every patient's ego shows to relinquishing its pathogenic defensive pattern.

Greenacre (1956) emphasized the importance of reconstructing, at least in certain cases, whatever actual traumatic events may have occurred in childhood if the working through process is to be thorough enough to achieve a satisfactory final result. In her earlier paper (1954), which was not focused on the problem of working through as was her later one, she mentioned in passing the connection between working through and transference analysis.

Novey (1962) had a different explanation for the same clinical data. He suggested that what he called the time lag between insight and change is due to the following. The core of every neurosis is, historically, infantile. In infancy, when that core is formed, mental functioning is largely affective, rather than intellectual, as is later the case. When the mind functions affectively, according to Novey, its functioning is automatized or rigidified. These automatized patterns resist change. They must be repeatedly interpreted in adult life before they show signs of change. It is not so much the ego's defenses which resist change, according to Novey. It is the affective, infantile core of every neurosis which takes so much time to work through.

Stewart (1963) inferred from Freud (1914, 1916-1917) that

the term "working through" was originally intended to apply only to changes involving the id (drive tensions). "The advantage of this narrower definition is that it emphasizes the distinction between repression resistance and another force also directed against cure—i.e., the tendency to repeat a pattern of instinctual discharge. The latter powerful force lies beyond the patient's will to change. It can only be 'discovered' by the patient when he continues the analytic work in defiance of the defense resistance and only changes as a result of being opposed by the equally 'biological' forces of maturation and development, which work toward cure" (p. 486). Thus in Stewart's view it is the patient who must actively work through infantile fixations, the analyst's labor being restricted to offering to a patient the optimum chance for doing so through interpretation and the development of insight. The working through, however, is what the patient does. We shall encounter an even greater emphasis on the patient's activity in the contributions of O'Shaughnessy, Sedler, and Valenstein.

It should be noted, however, that several pages later Stewart came much closer to the views of Fenichel, who related working through to defense, when he wrote that even in the analyses of patients who progress satisfactorily (so called "good" patients) there comes a time of heightened resistance as they approach their infantile conflicts: "In these circumstances, there must always be the fear that the revival and frustration of infantile wishes will be accompanied by a loss of the painfully earned stability of the ego functions and a re-experiencing of the traumatic state. This fear . . . produces a slowing down of what until then would seem to have been a well-progressing analysis" (p. 491).

Greenson (1965) suggested that *whatever* is necessary to overcome resistances which prevent insight from leading to change, i.e., to symptomatic and/or characterological improvement, be called working through. This is a definition which clearly implies that interpretation and insight can be expected to precede therapeutic improvement by a significant time interval.

Greenson considered that the core of working through is repetition, elaboration, and reconstruction. With respect to the importance of the first two of these, he saw himself in agreement with Fenichel and Greenacre, while he saw himself in agreement with Kris (1956) with respect to the importance of reconstruction in working through. What Greenson felt he added to the understanding of working through is that, if it is to be successful, a good working alliance must first be established between patient and analyst.

Ekstein (1966) saw working through as a form of learning. Like all learning, he said, it "requires endless repetition in the service of adaptation" (p. 228).

Brodsky (1967) suggested that the time lag which we call working through is the time it takes for a neurotic patient to become able to tolerate the intense unpleasure of anxiety or of severe narcissistic mortification.

Karush (1967) expressed the opinion that many factors are involved in working through. Among them "are recognition and assimilation of newly learned truths, altered balance among defenses, neutralization of resistance, formation of new identifications, and reconstruction of the ego ideal" (p. 530). The last, which is most important according to Karush, results from necessary and appropriate idealization of the analyst and identification with him "as an idealized object who influences by example" (p. 530).

Dewald (1976) wrote that, in every analysis, the analyst's tolerant, analytic attitude is a new, real experience for the patient. Experienced over and over, it leads to a progressive undoing of defenses against drive derivatives.

Glenn (1978), like Fenichel, described working through in terms of repeated undoing of defense. In addition, he called working through "a vehicle for mourning lost objects" (p. 44). This formulation derived from the following considerations. Freud (1917) described the normal process of mourning for a lost object as the step-by-step decathexis of the many highly cathected mental representations of the object. According to

Glenn, as analysis progresses, patients progressively decathect infantile (archaic) object representations (e.g., the father, mother, siblings, etc., of the patient's early childhood). Thus, according to Glenn, in analysis "working through becomes a vehicle for mourning lost objects" (p. 44). In a personal communication Glenn noted that both Fenichel (1938-1939, p. 80) and Lewin (1950, pp. 75-78) had earlier compared working through to mourning, without, however, equating the two as Glenn did.

Shane (1979) suggested that working through can best be understood via a developmental approach. By this he meant that the piecemeal improvement characteristic of a successful analysis is in fact a process of development. In this respect, it will be noted, Shane agreed with Stewart in thinking of analysis as essentially a maturational, developmental process. Analytic patients, wrote Shane, develop from the pathologically arrested stage of mental functioning in which we find them when they appear for analysis to the normal stage which they attain at the end of a successful analysis. This, according to Shane, is similar to what happens to children when, in the course of normal development, they progress from an early to a later stage of mental functioning. All development takes time, wrote Shane, and "it is the necessity for development which determines, at least in part, the observable lag between insight and mastery" (p. 375).

O'Shaughnessy, Sedler, and Valenstein all emphasized the activity of the patient in the process of working through, though by no means all in the same way.

To O'Shaughnessy (1983), saying the patient must be active meant that the patient must put what the analyst has interpreted into the patient's own meaningful, affect-laden words: ". . . mutative interpretations are not by themselves the agency of change. They put the patient in a position to change. He himself must do the active, mutative working through in his own words" (p. 288).

Sedler (1983) also emphasized the patient's role in working through: ". . . working through names that aspect of the [psy-

choanalytic] process which the analysand shall ultimately hold most dear, for it signifies his own triumph—and not ours—over the clandestine operations of neurotic life" (pp. 96-97). In Sedler's view, it seems that the analyst plays but little part in working through. The patient is the active one, not the analyst, the process of overcoming resistance being attributed to the patient's will to remember.

Valenstein (1983) also defined working through in terms of the patient's actions. According to his view, insight is (often) not enough to produce change. Patients must translate their insights into action and practice those actions if change is to result: ". . . analytically informed action . . . through habitual use, becomes ego-syntonically patterned and relatively autonomous. It is worked through into the character structure and becomes a reliable part of the ego" (p. 371). It may be added that, in Valenstein's opinion, the necessity for encouraging a patient to act in accordance with acquired insight is related to diagnosis. According to Valenstein, the conflict theory of neurosis, with its emphasis on insight as the curative factor, is satisfactory for "structural neuroses (formerly termed 'transference neuroses')," but many patients now treated psychoanalytically are genetically and dynamically different. They have "developmental neuroses (formerly termed 'narcissistic neuroses') for the most part" (p. 361). Such patients, Valenstein wrote, wish the analyst to do for them, rather than wishing to do for themselves. They must translate their insights into action and practice those actions if they are to change.

It is apparent from this review of the literature on working through that different authors have answered in different ways the question, "What accounts for the fact that psychoanalysis takes so long?" Freud emphasized the need for a thorough analysis of the transference viewed as resistance, a resistance attributable to a variety of factors which can be related in part to the drives, in part to the ego, and in part to the superego. Fenichel pointed to the process of defense analysis. Novey traced the need for working through to the affective nature of infantile

mental life. Greenson attributed it to the allied processes of defense analysis, reconstruction, and the establishment of a working alliance. Ekstein saw analysis as learning, while Shane viewed it as something similar to childhood growth and maturation. Brodsky pointed to the intolerable nature of anxiety, Dewald, to analysis as a real experience which helps counteract pathogenic, infantile ones, and Stewart, to fixation, while Sedler and Valenstein, each from his own perspective, stressed the role of the patient's activity in the process of analysis.

I think it is not difficult to understand why each of these authors had his own view of what working through is, i.e., of why analysis takes so long. It is because each focused his attention on a different aspect of clinical work, a different aspect of what analysis consists of.

Fenichel saw analysis mainly as defense analysis. For him it was defense analysis which makes analysis the long, arduous task we know it to be.

Novey saw analysis as a way of remedying the harmful effects of affective automatisms. For him, therefore, this is what takes so long, this is what working through is all about.

Greenson saw analysis pretty much as Fenichel did, in terms of defense analysis, but he added what were also of special importance to him, namely, reconstruction and the establishment of a dependable working alliance.

Ekstein, an educator, emphasized that analysis is a kind of learning. Brodsky pointed to the need to remedy the disorganizing effect of anxiety in mental life.

Stewart was impressed by the baneful effect of fixation. For him the major task of analysis was to undo fixations, to work them through.

In short, what each of the authors who has written on the subject saw analysis to be in its very essence was what each said must be worked through if analysis is to be successful: the will to remember, actions as well as words, the real relationship between patient and analyst, maturation and development, and so on. Thus everyone has said the same thing, to wit, "When I

analyze a patient, it takes a long time. Analysis is slow work. Patients are not cured by a single interpretation, however profound and correct it may be."

Every analyst will agree that analysis is slow work, but no one, to date, has given a satisfactory explanation of *why* it is slow work. It is no explanation to substitute another word for the word "analysis" and to say, instead of "Analysis is slow work" "Defense analysis is slow work," or, "Getting a patient to change infantile affective automatisms is slow work," or, "Changing psychic structure is slow work." All these are, if not mere rewordings, at best ad hoc explanations.

Neurotic symptoms and character traits which are accessible to analysis are results of psychic conflict originating in childhood. They are compromise formations among drive derivatives, defenses whose function is to avoid, to minimize, or to mitigate anxiety and depressive affect, and the moral aspects of mental functioning. In our usual shorthand, they are compromise formations among id, ego, and superego. When such compromise formations are so incapacitating, harmful, and/or painful to an individual as to call for psychoanalysis as the treatment of choice, the conflicts which underlie them are never trivial ones. Long experience has shown that they are, on the contrary, always serious conflicts. That is to say that they are of major proportions and that they yield to analysis slowly and with difficulty at best.

We do not know why this is so. We know only that it is so and that it is a sign of naïveté and inexperience to expect matters to be otherwise. Is it because of the rigidity of the defenses? Are the drives responsible? Is unconscious guilt so inaccessible to analysis? Does the mind learn but slowly? Does it shun unpleasure so incorrigibly? Are passive wishes so strong? No one knows. We can say, though only on an impressionistic basis, that the more severe a patient's symptoms and the more widespread their effect on his life, the more difficult analysis is likely to be and the more time it is likely to require. I do not think we can give any satisfactory answer when asked why a severe neurosis

should take more *time* than one less severe, however. At any rate, no one has yet given an answer which impresses me as satisfactory, nor have I one to offer that is any better than the ones offered so far by others in the field.

That does not mean, though, that there is nothing more to be said about working through which is worth saying at present. On the contrary, at least this much can be said.

In the light of present knowledge, working through is something which should be viewed differently from the way it was viewed when the term was introduced in 1914, just as our current views of transference or of acting out cannot be the same as the view of them which was first set forth at the same time.

In 1914 Freud had a twofold view of working through. On the one hand he conceived of it as a bother and a nuisance—as a regrettable delay in the process of cure. It was something that had to be done to overcome resistance, specifically, the resistance caused by transference. On the other hand, he viewed working through as therapeutically the most valuable part of psychoanalysis. Only working through leads to real insight and to dependable, lasting change in a patient, was his belief.

This double view of working through and of its role in psychoanalysis was the consequence of a similar view of transference. In those early years Freud thought of transference as an obstacle, as a form of resistance. Yet, at the same time, he realized that it is uniquely important and valuable. As he wrote in 1914, it is only by analyzing the transference that a real cure is possible and, in my opinion at least, what Freud originally meant by working through was analyzing the transference.

Today we understand that transference is neither simply a resistance in analysis nor a phenomenon of mental life which is unique to psychoanalysis as a form of therapy (Brenner, 1982, Chapter 12). Infantile drive derivatives and the conflicts they have given rise to affect every object relationship in a person's life. Their influence is by no means restricted to the psychoanalytic situation. It is ubiquitous. What is unique about transference in psychoanalysis is not its presence there. It is present

constantly and in every object relationship of one's life. What is unique about transference in psychoanalysis is how it is dealt with in analysis. It is the fact that the transference is analyzed which is special in psychoanalysis, not its presence there.

What I wish to emphasize by this is that one part of Freud's original view of transference in relation to psychoanalytic technique has gone by the board, as far as we are concerned today, while we still prize the other part as something of the utmost importance. That is to say, we no longer think of transference as resistance, but we continue to place a unique value on the therapeutic usefulness of analyzing the transference.

I believe that much the same thing is true of the concept of working through. Working through is not a regrettable delay in the process of analytic cure. It *is* analysis. It is the interpretative work which, as Freud wrote in 1914, leads to truly valuable insight and to dependable, lasting therapeutic change. It is not especially related to any one component of psychic conflict or of psychic functioning in general any more than it is to the others. Fenichel was correct in connecting working through with the analysis of defense, but he was wrong in connecting it especially with that aspect of the work of analysis. It has quite as much connection with superego analysis, with the recovery of infantile memories, with achieving insight, with re-experiencing anxiety and depressive affect, with overcoming fixations, with the persistence into adult life of childish patterns of psychic functioning, with penis envy, with castration anxiety, and so on. The analysis of psychic conflict in all of its aspects is what should properly be called working through.

A reference to clinical material will serve to illustrate my point. In his paper on working through, Greenson (1965) presented at some length the main features of a case with what he called a special problem of working through. The patient was a thirty-year-old man with depression, conversion symptoms, and obsessional symptoms, who had been in analysis with Greenson for four years. Greenson concluded the initial portion of his presentation with these words:

> All of the material I have condensed in this presentation *seemed* to have been satisfactorily worked through with the patient. The insights concerning his major conflicts were repeated, deepened and broadened. Reconstructions had traced the complicated interrelationship between the ambivalent mother fixation and the struggles with the homosexual impulses. The patient recognized how his self-image was distorted under certain conditions of stress. His anxiety in the analytic hour lessened; he dared to feel more and there was less defensiveness and more directness in his transference reactions. Yet, despite what seemed to be a satisfactory working through, the patient remained essentially unchanged in his outside life (p. 305).

Greenson then went on to describe how the resistance which was responsible for this state of affairs after four years of analysis was discovered and worked through. According to Greenson, the reason for the patient's failure to improve outside the analysis was this. The patient had a fantasy, largely unconscious, that to understand himself—to do a bit of self-analysis—when Greenson was not there was equivalent to having been penetrated by him. The patient had been seduced by a man when he was two and had been excited and terrified by homosexual wishes all his life thereafter. The fact that he had transferred to his analyst these wishes and the intense conflicts they aroused in him was well known to both the patient and Greenson by the time four years of analysis had passed. Every aspect of wish and conflict had been recognized and repeatedly analyzed by that time. Rather, I should say, nearly every aspect. It is apparent from the evidence Greenson presented that after four years of analysis one of the patient's symptoms was that he could analyze himself only in Greenson's presence and with Greenson's help. In his analyst's office he was fine as a patient and made steady progress in tolerating an increased awareness of his own wishes, fears, defenses, and superego derivatives. Outside Greenson's office he was unable to do any such thing. He still had the same, or nearly the same, severe symptoms he

had had at the start of the analysis. He could neither love a woman nor be friendly with a man.

What has all this to do with working through? Just this. When Greenson discovered what was responsible for his patient's lack of progress in his life outside the analyst's office, he saw in the situation something he believed required a special something that he called working through. Insight had already been achieved, said Greenson. The patient was already familiar with the dynamics as well as the childhood origins of his conflicts over his wish for Greenson to penetrate him. What he needed now, according to Greenson, was to work through the insight already achieved. In fact, in his discussion of his subsequent work with the patient, Greenson likened him to a phobic patient who must be encouraged to revisit "the old phobic situation" (p. 307) if analysis is to cure his phobia: something special must be done in each case—in the one, working through, in the other, to have the patient place himself in the situation he had, till then, shunned.

I believe that lack of progress of the sort reported by Greenson is best understood somewhat differently. Such lack of progress is not something special which requires a special kind of analysis called working through. It is a symptom or, better, a compromise formation which derives from the patient's infantile conflicts and which is being expressed in the transference. As such, it must be analyzed, but not in any special way. In the case just described, what the analyst did was to discover a piece of unanalyzed transference and to analyze it. That, as it turned out, was what was necessary to overcome the patient's resistance and permit the analysis to progress satisfactorily. What was necessary was not something special, something which deserves the special name, working through. What was necessary was to analyze the resistance, expressed in the transference.

Such situations are by no means rare in analysis, and the same formulation is true whenever failure to improve is motivated by a similar dynamic. I recall a patient, a man in his thirties, whose conflicts were similar to those of the patient just described and

whose life situation was also unimproved after several years of analysis. During those years my patient acquired a thorough conviction of the reality of his feminine wishes, of the terror they roused in him, of the ways in which he used competitive, masculine wishes to avoid anxiety, and of why it had all his life been so important to be a specially good boy and to avoid anger, jealousy, and rebellion. When his failure to improve was brought under analytic scrutiny, as eventually happened, the patient came to realize that it, too, was a pathological compromise formation. It was defensive in that it reassured him that he was not being just a compliant, namby pamby asshole to ingratiate himself with me. Thus it helped him to ward off his terrifying feminine wishes. At the same time, to remain ill gratified those same wishes. To be sick meant to be justified in wanting special attention as well, instead of guilty at being murderously jealous of his younger siblings, at least two of whom had, in fact, died *in utero*, a circumstance of which he had no conscious memory when he began his analysis. Drive derivatives, anxiety and depressive affect, defense, morality—all were blended in may patient's failure to improve as might have been expected.

The same is true in every such case, in my opinion. There is nothing special about a patient's failure to improve that requires anything other than good, solid, analytic work, usually—perhaps invariably—centered on the transference. Incidentally, this holds for phobic patients as well as for any others. Freud was wrong when he said that analysis by itself does not cure phobias—that after a degree of insight has been achieved, the patient has to be told to do what he feared and avoided and his reactions to doing it analyzed if a cure is to be achieved. In any analysis an apparent stalemate must be analyzed, not dealt with in some other, nonanalytic way, if one wishes to do the best that is possible for one's patient. When it is analyzed, it turns out to be a compromise formation, i.e., dynamically indistinguishable from a symptom.

To repeat, working through is not a special kind of analysis.

It is ordinary, run-of-the-mill analysis, as we know it today. Nor is it the analysis of one or another component of psychic conflict. It is the analysis of psychic conflict in all its aspects, now one and now another.

That such analysis takes time, all analysts know. Why it takes as much time as it does is a question which remains as yet unanswerable. However, we also know that when analytic work proceeds favorably—when working through is successful—it results in psychic changes which are of inestimable value to the patient and which no other form of psychotherapy can achieve.

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Psychoanalysis and Negotiation

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PSYCHOANALYSIS AND NEGOTIATION

BY ARNOLD GOLDBERG, M.D.

Somewhere between the image of psychoanalysis as suggestion and psychoanalysis as unearthing is that of analysis as negotiation. This is a picture of a mutual construction of reality by analyst and patient. Such an interaction allows for reciprocal input of the participants and a possible change in both. This paper sketches the role of negotiation throughout the entire process of treatment —from the initial rules, to the theory of the analyst, to the emergence of the transference, to the goal of the cure. The technique of psychoanalysis is said to lie in the process of negotiation.

INTRODUCTION

The technique of psychoanalysis has not followed a clear advance from a simple set of principles to a deepening and elaboration of those tenets. At times there seems to be a pluralistic approach to technique that borders on an "anything goes" or at least an "everyone does things differently" axiom (Lipton, 1983). A study of technique should focus more on the method or form than on the particulars of the content; this implies that we should divide the "what" that is said from the "how" it is said. Two analysts may share a set of theoretical ideas but differ in their conduct of an analysis primarily in terms of their personal style, which thereby determines much of the conduct of the treatment. This point of form over content, the music over the words, the way it is said rather than what is said, is often felt to be a distinguishing mark of, but not a crucial difference between, various types of analysis. The style of one analyst differs from that of another in ways that are often assumed to be idiosyncratic or personal, which makes them seem more facilitating

or enhancing to the conduct of an analysis than central and primary. However, we soon become forced to look at the form of analytic intervention as an integral part of the transaction since periodically it does appear to take precedence.

This paper will attempt to bring the issue of the "how" into a more central position by considering it as inextricable from content in its effect if not in our study of it. This claim can be supported by seeing it as operative at every level of an analysis, although often relegated to secondary status. It thus demands its own theoretical underpinning and its own principles of activity. The latter may be subsumed under the process of negotiation.

WHAT IS NEGOTIATION?

The word "negotiate" is so linked to adversarial situations, such as labor versus management, defense lawyers versus prosecution, and foreign powers in disagreement, that one might balk at considering it at all as a part of psychoanalysis. A less disagreeable definition is that it is a communication made to arrive at some settlement of a matter; this definition may relieve it of the negative note in the image of opponents trying to hammer out an agreement. I shall define it in the positive sense of a sharing of meanings.

Upon reading the case of the Rat Man, one sees that Freud (1909) fed his patient without feeling that this hampered or distracted from the analysis in any way. Yet no present-day psychoanalyst can help but wonder about the effects of that or of any other intrusion of the analyst into the process of analysis. The whole question of the analyst's input into the analytic work has undergone a series of scrutinies, arguments, and resolutions in the history of the technical management of analysis. Positions range from the extreme of espousing as total a non-involvement as possible, with any inadvertent intrusion to be carefully examined under the rubric of countertransference (Silverman, 1985), to another extreme of viewing the analyst's input as con-

stituting the main form and content of the analysis (Tower, 1956). Some, like Laing (1967), might hold that the patient is correct in his or her perception of a crazy world that is recreated in treatment. Some, like Melanie Klein (1952), would point to the child's impulses as primarily responsible for the pathology which is then recreated in the analytic setting. But whether or not one includes the issue of responsibility in considering the reappearance of the life of the child in the transference, there remains the question of whether the analyst can indeed be both a transference figure and an observer of the situation, or whether he or she must inevitably be a participant, witting or otherwise.

Freud's feeding the Rat Man could be seen as involving him in a real interaction to such an extent that the posture of detachment and its associated word, objectivity, was temporarily abandoned. This would correspond to the sort of intrusion that might interfere with a transference based primarily upon the patient's psychology; it might interfere even more with one that is a compound of a two-person relationship. The issue to be addressed is whether one can conduct an analysis with the desired objectivity of a detached yet interested participant, or whether every analysis is a mixture of the analysand's productions and the unpredictable input of the analyst. The first position at least allows for the hope of replicable and predictable data; the second portends a variable product that arises from a mixture of potentially idiosyncratic responses. Regardless of one's position on this matter, the method of exchange or interchange seems to warrant a study of the process of negotiation that goes on between patient and analyst. Only that term seems to capture the issue of two persons with distinct and separate interests working toward an agreement of sorts, and the nature of that agreement seems to depend on the process of its achievements. Thus considering psychoanalysis as negotiation would stand in contrast to the concept of it as an unearthing and so would modify the archaeological metaphor.

There is no doubt that most psychoanalysts would agree to

the fact that some minimal negotiation does take place in the treatment process but that it need not, perhaps should not, be much of a factor in the conduct of the analysis. We negotiate issues such as appointment times, fees, and vacation schedules at the start of treatment and often assume (or hope) that they will cease to be problems the remainder of the time. As Freud (1913, p. 134) said, "The conditions of treatment having been regulated in this manner, the question arises at what point . . . is the treatment to begin?" The conditions, however, do not remain static. On occasion these points become the source of major conflicts in the conduct of an analysis, and we then view them as caught up in the unconscious conflicts of the moment. They are subsequently handled less by negotiation than by interpretation and so belong more properly (and comfortably) within the activities allowed to psychoanalysis.

In truth, negotiation is such a symbolic carrier of action that it is felt to defeat the analyst's proper stance of abstinence. When Eissler (1953) discussed the introduction of parameters into analytic technique, he made it clear that, as necessary as they may sometimes be, they were always something of a nuisance, and one should as speedily as possible return to the single allowed activity: interpretation. The question to be posed is not only whether we have the obvious sorts of negotiations that are familiar to the conduct of analysis, but also whether the word properly belongs to the realm of interpretation as well.

NEGOTIATION AND RULES

Although there is but one basic rule in psychoanalysis, that of saying everything that comes to mind, in fact our patients must subscribe to a variety of rules in order to participate in the process. We set the fee, fix the time, determine the place, and talk when we desire. It is a rare patient who submits to all of our demands and constraints without some sort of reaction; a too willing compliance is even seen as a sign of the concealment of a more profound meaning. It is probably also a rare analyst who

has not either lost a patient because he or she could not fit into the analyst's constraints (regardless of their legitimacy) or bent the rules in order to allow an analysis to begin or to continue. Indeed, we often learn a great deal about a patient over this very issue of rules. Here is a clinical illustration:

A patient had had a sequence of negotiations about missing sessions. The analysis had begun with a fairly clear contract that the patient was responsible for all of her sessions and therefore would pay for any that she missed, whatever the reasons. She had no question about this point, although admittedly she was a patient who rarely took issue with anything. During one long vacation her husband had protested about paying for missed hours, and the patient had asked if we might renegotiate the agreement so that it would be like one that a friend had with her analyst. In the contract the analyst tried to fill the hours that were vacated in order to relieve the patient of full responsibility for them. I had deviated from my own rule with other patients. Now I felt that our efforts to analyze the meaning of this issue to this particular patient had been for the most part exhausted, and so I agreed. During the patient's next absence she was beside herself with anxiety over the hours that were taken away from her while she was away. There was no evidence of her feeling a victory over the analyst; instead, she seemed to have to feel that her hours remained hers. We tried to connect this to her childhood feelings concerning the birth of a brother when she was four. He turned out to be a very sickly child who required the concentrated attention of her parents until he died when he was eight years old. The patient felt that this explanation was unsatisfactory inasmuch as she was already in school when her brother became ill, and she could recall no memories of her place having been usurped. Rather, her fearfulness about losing her hours seemed to stem from a general fantasy of hers about dropping from sight in terms of me and my memory. She once noted that I turned away from her as soon as her hour ended to tend to some papers on the desk. She elaborated this into a fantasy that I wanted to be rid of her, or

perhaps that I forgot her as soon as she was gone. She wanted to keep her hours even while she was away, in order to stay alive in my mind. Here the issue of rule-making and rule-changing seemed to be of help in understanding the patient.

Examples of rule-setting and rule-changing can do no more than lend support to the idea that there is nothing inherently good or bad about any rule, save how we learn what it means to us and to the patient. We may feel that a good rule is one that follows Freud's (1913) recommendation that it be effective. I take that to mean that a good rule will not impede the development and resolution of the transference while a bad rule will work against that goal. This seems in keeping with the theme of Freud's recommendations, as opposed to the concept of the good or bad having some moral or ethical connotation. Even the fixed rule of free association was explained by Freud (1913) to a patient as being something quite beyond his control, and so he was relieved of insisting on conformity for his own sake. We often wish to extend a host of similar issues in psychoanalysis as belonging to the same category of "it's not up to me but is part of the rules," until re-examining these points betrays our personal investment.

Rules such as length of hours, frequency of visits, and personal contacts between patient and analyst are handled in a separate category having to do with facilitating the treatment. The story that is told of Jacques Lacan's ending some sessions after only a few minutes (Schneiderman, 1983) is reacted to as a breach of ethical standards much akin to those of the analyst who becomes overly familiar with his patient. Indeed, it is usually true of a rule that, because of its institutionalization in our profession, it becomes a part of the right or correct way to do things. Without pursuing the matter of such moral imperatives, it seems clear enough that our rules are or soon become our way of the world. They determine what should be done, how it should be done, and why it should be done. In short, they make up much of the analyst's reality. This particular view of the world then meets that of the patient; in this manner, a

situation evolves that calls for some form of meeting of the minds and re-evokes our concern with the matter of negotiation.

NEGOTIATION AND PSYCHIC REALITY

Once the matter of the rules of performance is put aside, we usually feel that we can step outside of participating with the patient in anything like an educative manner. Imagine a patient who tells you that he feels that the world is an awful place, filled with dirt and disease, peopled with evil individuals who wish only to hurt and exploit you, and destined to end in some sort of justified apocalypse. If we choose to treat such a patient, it is assumed that somehow we must be empathic with him and thus must enter his world and experience his reality. We cannot, however, be just another in a line of those who wish to set him straight or cheer him up or talk him out of it. Neither can we indulge in a total immersion in his dilemma and share his view of misery and sadness. It is folly to say that we must, or even can, completely shed our own preconceptions of the world in order to really understand another person. Our very preconceptions that insist that the world is not such a place allow us to begin an effort at what is certainly the goal of disabusing the patient of his forlorn picture of existence. Thus, we neither totally agree nor totally disagree but seek a workable stance for our later interpretive efforts.

If that patient or another patient tells us of a world of brightness and sunshine, happiness and joy, peopled with those who have only your best interests at heart, we should be equally skeptical and equally caught between reality and empathy. It seems that we always weigh the disparity between a sympathetic identification with the patient and some other background concept of how people should and/or do experience the world. Though we may choose to allow the optimistic viewpoint to reign unchallenged, we can never fail to match our own world view with the presentation of the patient. In short, we can listen

to patients only against a background of our own traditions and beliefs, and we pick and choose our interventions on the basis of what we consider proper versus what we feel is deviant. That is how we decide a theory of psychopathology as well as normality. Somehow we know just how people should feel about things, and we act accordingly.

But, of course, no analysis is a process of argument anymore than it is one of suggestion. It is in the crucible of the transference that we determine whatever we choose to see as deviations from a norm. Psychoanalysis claims a unique window on the world by assuming that patients will inevitably bring their childhood experiences into the treatment and the disparity between that set of experiences and the reality of the analytic situation will allow for ameliorative interpretations. Ideally, we should see a transference that follows a somewhat set program responding to a process of interpretation that allows only a minimum of latitude.

TRANSFERENCE AND NEGOTIATION

It soon becomes evident that the ideal equation of transference and interpretation is not easily achieved. One analyst told a story of seeing a patient who had had two previous analyses. She described to her new analyst a series of awful mistreatments bordering on malpractice in these analytic encounters. All the while, she professed her great relief that she had at last found a trustworthy person to help her. The about-to-be christened third analyst informed his patient that although he could not defend the analysts who had abused her, he had no doubt that he too would join the ranks of the oppressors. Being a profound believer in the repetition compulsion, he knew that a fixed program was operating in this patient's unconscious, and that he must allow this to unfold in a nonprejudicial way. And indeed he tells the story in the manner of one whose good judgment was confirmed. He, too, inevitably became the rascal that

this patient's psyche seemed to require. Thus the replicable and predictable feature of the transference.

But not all transferences are alike. The very fact that the analyst "knows" what to expect makes him or her a different person from a naïve or untutored partner in some other transaction. Another analyst (perhaps even one of this patient's former analysts) might be more willing to literally mistreat the patient, given her proclivity to call forth this behavior in others, while still another might even have kept these feelings to a minimum. Only in the most ideal of transference enactments are we able to claim a pure form of emergence of childhood experience, and even if that is the case, we do not all attend alike to what does emerge. Sooner, rather than later, every analyst seems to direct or focus the patient's productions by way of his or her own history and traditions, transference and countertransference, and theory and convictions.

Here is an illustration of an analytic intervention taken from Kohut's (1979) "The Two Analyses of Mr. Z." and concerning a dream interpreted differently over a period of years:

> In this dream—his associations pointed clearly to the time when the father rejoined the family—*he was in a house, at the inner side of a door which was a crack open. Outside was the father, loaded with giftwrapped packages, wanting to enter. The patient was intensely frightened and attempted to close the door in order to keep the father out.* . . . Our conclusion was that it referred to his ambivalent attitude towards the father. . . . I stressed . . . his hostility toward the returning father, the castration fear, *vis-à-vis* the strong, adult man; and, in addition, I pointed out his tendency to retreat from competitiveness and male assertiveness either to the old pre-oedipal attachment to his mother or to a defensively taken submissive and passive homosexual attitude toward the father (pp. 8-9).

In the discussion of the second analysis, Kohut wrote:

> The new meaning of the dream as elucidated by the patient via his associations . . . was not a portrayal of a child's aggres-

> sive impulse against the adult male accompanied by castration fear, but of the mental state of a boy who had been all-too-long without a father; of a boy deprived of the psychological substances from which, via innumerable observations of the father's assets and defects, he would build up, little by little, the core of an independent masculine self . . . the dream constitutes only a tame replica [of a traumatic state] (p. 23).

This is not the place to discuss the many reactions to this set of dream interpretations, which range from outright agreement to serious disagreement. Those who disagree state that the two interpretations are really one, or that the second should have preceded the first, or that either the one or the other was unnecessary, etc. It seems to be of little moment to the critics that for the analyst the dream had a "new meaning" which was in opposition to the previous one. Thus, at a minimum, this dream or any dream means nothing except as seen in the context of the timing, the transference position, and, most important, the theoretical stance of the analyst. Kohut would probably modify this by insisting that the patient's association led to his revised interpretation, but, contrary to Kris (1983), there are simply no observations possible without a theory to direct, guide, and elicit them. One never sees a pattern or follows a theme without a pre-existing schema, and it is simply impossible for any so-called theory-free data to emerge. It is therefore the case that one influences what is seen by the very act of seeing. Alas, we are not and never can be neutral observers. The associations of the patient seem more in the nature of a dialogue than a monologue.

Although the analyst may never openly direct the flow of associations, he participates in two ways. The first has to do with his choice of one meaning over another, since any given dream or bit of analytic material has multiple meanings. This, of course, is the nature of overdetermination. The second is due to the fact that every intervention resets the communication, just as every conversation is made unpredictable by virtue of each participant's need to respond to the input of the other. If we

choose to keep our interventions to an absolute minimum by silence, we soon learn that such silences represent an equally significant form of input. We may then choose to move the arena of our scrutiny to studying the effects of intervention or nonintervention upon the associations. In one sense, this concern with form rather than content, a concentration on how things are said rather than what is said, is a natural element in every analyst's armamentarium and is really a theory about a theory, or what may be called a metatheory.

Thus we see that psychoanalysis exists on two levels. The patient talks and we listen, and the patient makes something of our listening. We study what the patient says and how the patient reacts to our silences or our interventions according to our theoretical inclinations. If a patient mentions a common-sense term, such as "apple," we assume we know what it stands for until we may learn of the very special personal meaning it has for that patient. Much of our own sense of the term "apple" is shared by the patient while some part is always special and individual for each of us. In Rangell's (1985) words, "The analyst, by a more informed theory than the patient, produces in the latter further insight and understanding" (p. 83). The how of this process, the manner in which our theory, whatever it may be, is able to change that old apple to a new one is the process of negotiation. But now the question arises of just where the change takes place.

NEGOTIATION AND CHANGE

The theory of negotiation is a metatheory, one that concerns itself with the communicative process that goes on between persons so that they may achieve some sort of shared reality. It stands in marked opposition to a theory of indoctrination, which has associations to submission, compliance, and lack of participation. Results of negotiations are quite different from fixed beliefs which allow for no form of alteration. Rather the negotiating process is based on a modification of beliefs, and, in

analysis, consists of the interpretation of the unconscious content plus the process of working through. Merely naming the unconscious content before the patient is ready is of no import, just as doing it only once has a minimal effect. Psychoanalysis has a variety of ways to determine the effectiveness of interpretations: through further associations, increased or decreased resistance, etc. As Rangell (1985) indicated, the achievement of insight is essentially the capacity of the patient to gain a conviction of the truth of the "more informed theory" of the analyst.

There have been many attempts to explain the nature of the therapeutic change in psychoanalysis. It is important at the outset to differentiate such efforts at explanation from those that are descriptive in nature. Statements such as "Where id was, there ego shall be" (Freud, 1933, p. 80) or "corrective emotional experiences that occur are crucial . . . and may well be the single most important aspect of psychoanalytic effectiveness" (Peterfreund, 1983, p. 251) are not so much an explanation of a causal relationship as they are a rephrasing of an event. This may be sufficient for many, but usually we look for causal explanations.

Heinz Hartman (1951) offered such an explanation by positing the lifting of countercathexis from repressed material and the subsequent neutralization of the released energy which then became available to the ego. The satisfactoriness of this idea may be limited today, in view of the general lack of acceptance of the entire energy concept.

Heinz Kohut (1984), following Freud, utilized the model of mourning to explain the acquisition of structure that occurred in treatment. He stated that the two-phase process of understanding and explanation allows a partial merger followed by a disruption. This sequence leads to minute internalizations of functions and this is, in turn, explained as a furtherance of the process. Thus change results from structural growth.

Michael Basch (1981), following Piaget and theories of cognitive development, considers the cause of change in treatment to be due to the progressive movement from one state of cognitive development (say, sensorimotor) to another (e.g., concrete

operations). He relies on the Piagetian theory of a rather fixed program that will unfold in an appropriate environment. This formulation is similar to those suggested by analytic developmental theorists who liken analysis to a developmental experience.

Barratt (1985) argues against the concept that the curative factor in psychoanalysis resides merely in the new knowledge acquired. For him, the knowing of psychoanalysis is a change in one's being. He insists that one cannot approach or comprehend these changes within the framework of logical positivism. Rather, the method sets in motion what he terms knowing as being, and being as knowing. A change in knowing changes who you are, and a change in who you are alters what you may come to know.

Those who see analysis in developmental terms, including Kohut, feel that the analytic situation encourages and/or allows the maturational processes to unfold. These theorists range along a continuum depending upon what they feel are the proper conditions for development. Thus the analyst must create the climate, lend the language, or correct the deviations in order for the inherent program to be realized. But even the most austere of analytic approaches recognizes that the analyst affects the patient by his presence, his interpretations, and the state of the transference.

The rules of the process, the theory of the analyst, the communicative exchange or metatheory employed, all contribute to any psychoanalysis, and all may be quite different from analyst to analyst and from time to time with the same analyst. It would be folly to say that anything said by the analyst can be considered therapeutic; this would make the words meaningless. But it would also be naïve to say that there is but one true way to proceed. Different analysts do say quite different things at different times, and the fact that these diverse ways of analyzing seem to work demands some explanation that goes beyond the options of nihilism (anything goes) and fruitless comparisons (mine is better than yours). Donald Spence (1982) asks for some naturalization of our data in an effort to pin down some empir-

ical facts. Roy Schafer speaks for alternative narratives which may share equal claims for true historical records (Spence, 1982). What is being suggested here is that every interpretation and/or intervention is an *approximation* of some true state of belief and feeling of the patient. It is couched in the therapist's language, guided by the therapist's theory, colored by the prevailing transference, and open to correction by the therapist's capacity to negotiate. Patients and analysts learn a shared social reality, learn to communicate in a shared language, and learn what one another's expectations are. Inasmuch as we have a sometimes startling and bewildering array of therapeutic interventions, we should attend less to the truth of these propositions and more to the way some sort of agreement is reached between patient and analyst. This is negotiation, and this is what merits study.

THE PROCESS OF NEGOTIATION

A cursory study of Freud's notes on the Rat Man case demonstrates the nature of the negotiating process that went on between Freud and his patient. Freud asked him to bring a photo of his woman friend with him in order to give up his reticence about her. No matter that a modern-day analyst would be reticent about such a request: the words reveal the motive and goal of the analyst. Every page demonstrates some action of Freud's, ranging from "I could not restrain myself" to "I explained to him." Freud persuaded him to reveal things, he suffered through giving explanations that meant nothing to the patient, and he even delivered a lecture on perversion (1909, p. 283). These notes as presented are not to be considered as exemplars of good technique, but it would appear to some that today's analyst would do away with all but the interpretations. I suspect that is both a foolish and an impossible goal, since we, too, persuade, suffer, and lecture, but are perhaps a bit more alert to the consequences.

Many analysts have attempted to divide the components of the treatment into what may be termed the therapeutic or working or real relationship and the transference while others say that all belongs to the transference (Brenner, 1982) and perhaps still others claim the relationship encompasses everything. Some also wish to have this therapeutic relationship assume a background presence so that the real work of analysis may proceed. Putting this feature of analysis into such a framework and seeing it as a positive feature or an impediment seems to minimize the complexity of the process which goes on in every analysis and which underscores how patient and analyst agree or disagree about anything at all.

Brenner (1982), in his recent book, presents a vignette of a woman who argued with him over anything and everything in her analysis. As an analyst, he appropriately considers the question of whether *what* he says infuriates her and then studies the peculiar state that makes *whatever* he says or does not say serve as a stimulus for her irritation. The second consideration which is essentially about the first is of a different logical type, i.e., it is on a different level of inquiry than the first, just as the word fruit is of a higher order than the words apple, pear, and orange. The study of the content is the first level while the study of the exchange irrespective of the content is on a different level. We also say that the second is a metastudy which means no more than a study about something studied.

Brenner does not tell just how this impasse was resolved, but he does mention that the patient tried mightily not to so disagree. She ultimately realized the motives for her persistent arguing, and so we would assume it dissipated. We might also assume that interpretation alone was effective, but one can only wonder about the intermediary steps involved in getting the patient to listen, in convincing her of the truth of one's interventions, in achieving a state of agreement that was so antithetical to her nature. Just how was this negotiated other than by sheer repetition of an interpretation? At one point the patient is said to have resolved to keep quiet until her analyst had spoken. In

truth this is an attempt at a negotiated peace; but one which was unsuccessful. It seems that over time the patient was able to see what she was doing.

Heinz Kohut tells of a similar case (Kohut, 1984) of a patient who could not accept any interpretation from him even if it was a correct one (as the patient would later agree). He says that this pattern of refusal in the patient had to do with his own failure to see that the patient felt incompletely understood. When *that* was interpreted, then the analysis could proceed. This is a commentary on the transaction between analyst and analysand, and it coincides with Kohut's conviction that an understanding phase must precede the explanatory phase. But is it always the case that recognizing that something is wrong and interpreting why it is so leads to such prompt amelioration of the impasse? The burden seems to have shifted to the question of how one achieves empathy, i.e., how one manages to have the explanation be an effective one. For Kohut there seems to be a more immediate attention to this level of disagreement, and the analyst seems to be more active in its lifting. But this likewise seems to assume an ease which leaves something out.

To tease apart the factors involved in having the arguing (negative, resistant) patient accept an interpretation, we must recall that negotiation is a two-way process regardless of whether the analyst is silent or verbose. The patient responds to silence or to words by accepting either one as some sort of a negotiating position of the other and carries on from there. The silent analyst may be felt to allow less room for maneuver, but in the exchange between patient and analyst some acceptable compromise is achieved. Over time, the angry patient may agree to the repeated interpretations of the analyst or to the supposedly new and more empathic ones; but ultimately we hope to achieve agreement. What seems to transpire is that the patient, perhaps sooner rather than later, must learn to understand, i.e., be empathic with the analyst. Empathy is operant on both sides, and surely patients learn to comprehend their ana-

lyst in a like manner to what we usually say is required of analysts. The intermediate steps may consist of the patient's rephrasing the analyst's interpretation or modifying it or accepting a part and rejecting another part or some other variant. The analyst, in turn, may learn to present only certain parts or to put it in different words or to change the meaning in response to later associations. Together they aim to arrive at a shared meaning. It is a rare analyst who forms and delivers interpretations that need little reshaping, and it is never the case that a patient ends a successful analysis with the same view of his life and the world with which he began.

NEGOTIATION AND THE CHANGE IN THE ANALYST

If the analyst is a participant in the negotiations of an analysis which aim at a change in the patient's view of and theory about himself, can the analyst emerge unscathed? Participants in any negotiating process usually give and take except for those rare states involving fixed beliefs and indoctrinations. Analytic patients change, as noted above, in diverse ways, but we usually assume that the analyst gains only in experience, wisdom, and skill. Yet most of the elements of the analytic change do require some, at least temporary, capacity to see and believe something differently. It probably is difficult if not impossible to grade the potential changes in the analyst in a positive or negative direction, but one can offer the suggestion that each and every patient offers a world view that demands some sort of accommodation on the part of the analyst. Sometimes this is in the direction of changes in rules (Goldberg and Marcus, 1985), or in theory (Kohut, 1984), or in technique (Freud, 1909). It takes no imaginative leap to realize that these components are also aspects of a total personality, and so we might say that every analysis does indeed cause us to remake ourselves (Gadamer,

1975). The levels of change in the analyst may be primarily cognitive, as when we simply learn more about something from a patient, or they may be affective. The latter may be severe enough to warrant some personal analytic work. But another level would combine these to bring about a change in our science that corresponds to Freud's change of mind and heart about the seduction theory. Perhaps it is not too revolutionary a stand to insist that effective analyses are such meaningful negotiations that they demand that a new analyst emerge. We may or we may not be wiser, but we are (or should always be) different.

Of special moment here is the change in the patient's empathy for and understanding of the analyst. It would be naïve to withhold credit to our patients who teach us how to understand them, who are patient with our mistakes, and who tolerate some of our outlandish interpretations and theories; who sometimes are even quite therapeutic to us! Given the two-way street of empathy it probably means that we, too, are undergoing new experiences, in being understood if not always having things explained to us. Unless we grant this form of the potential for change in analysts, then we fall back on a mechanical version of offering interpretations that are universally and eternally valid; and that position may not be acceptable to many analysts.

SUMMARY

We negotiate the rules of the analytic procedure, our shared version of the world, the meaningfulness of the analytic transference, and the goals and method of cure. When Freud wrote up the case of the Rat Man, he decided, as does every analyst, to present certain facts and to omit others. Among the latter were the host of personal contacts that were felt not to be a part of the analysis. His friendly feeling toward his patient was noted but mainly discounted or subsumed under present-day concepts of the therapeutic relationship. But every analysis operates on at least two levels: what we talk about and the manner in which we do it. When the latter becomes the focus of

interest, as often occurs in the analysis of resistance, we still assume yet another level for that discourse. We can never escape the process of trying to reach common ground with our patients. We should agree that no part of the transaction between patient and analyst is ever immune from the effects of the one person upon the other, and no part of the analyst per se does not matter for one or another patient. The history of psychoanalytic techniques makes much of the particulars of allowing a patient to see things and to understand things and to master things that were previously unknown to him. Since we must choose never to suggest or to indoctrinate, we appeal to reason and good judgment in order to move from transference to reality. Each step of the process is suffused with our rules, our theories, and our world views, and each step must entail a negotiation to achieve a shared meaning. Thus the process of negotiations is another way of looking at the technique of psychoanalysis. There is no inherent essence to release that can reveal what a patient is "really like"; rather it is a mutual construction.

At its simplest, psychoanalysis is an effort to change someone else's mind. It is, of course, not confined to the level of conscious decisions but rather aims to reach to the depths to effect such a change. The mere seeing of the truths of the world never seems to be sufficient to convince someone of the folly of his or her position, but psychoanalysis lays claim to a powerful tool that expands one's vision: the transference. It would be a great relief if that were the sturdy platform on which we could all stand to enable insight to emerge, but it seems that our convictions about the transference are as contaminated as all of our other truths and convictions are. Thus we should move on to a study of just how mind changing takes place (while all the time knowing that this as well will be a prejudiced pursuit). The process of persuasion or understanding or gaining insight is a fruitful study in its own right. It consists of all the factors that we study about negotiating a meeting of the minds, i.e., examining the steps that allow for one person to reach agreement with another. This process essentially comprises the technique

of treatment, and it in turn includes the whole of our ideas about reality, psychopathology, and analytic theory. No step of the process of negotiation is free from this baggage of prejudices, cultural background, and training with which we enter the room, and it is probably equally simplistic to think that we are able to leave the room unchanged. Rather, the job of getting another person to change involves an empathic exchange wherein each participant becomes aware of the other's position. In this manner the technique of psychoanalysis demands that we not only understand our patients but that they understand us as well.

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ON THE TECHNIQUE OF ANALYSIS OF THE SUPEREGO—AN INTRODUCTION

BY PAUL GRAY, M.D.

As a result of Freud's ambiguity (and that of later analysts) regarding the nature of the superego and how to treat it in clinical practice, it has taken many years and many theoreticians to move from Freud's predilection to use it for purposes of "suggestion" in overcoming resistance, toward the concept of the superego as part of the ego's hierarchically mobilized defensive activities in the analytical process. Although much ambiguity persists, an attempt is made here to reduce it so that analytical technique may move forward to allow the superego to be analyzed as an unconscious conflict solution.

Much ambiguity surrounds the technical approach to the superego during the analytic process. I shall argue here that the cause lies in two related circumstances. First, there is the deeply ingrained tradition in technique that expediently, but productively mandated the use of transferred superego (not always so labeled) influences in order to overcome resistance. This was especially true during the years before the role of conflict in resistance was understood. Second, the superego itself was conceptualized before the revision of the theory of anxiety and the resulting recognition of the defensive ego's versatile complexity. By then the superego had achieved status as a structure superordinate to the ego, rather than as a manifestation of the ego's hierarchically activated defensive solutions to unconscious conflict. In addition to these two, I shall hypothesize about some less central influences.

As documentation, I intend to examine evidence in some of Freud's work. In attempting to reduce some of the ambiguity, I

shall draw on relevant literature from Freud's later contemporaries, as well as on more recent authors. There will follow some views of my own on what I mean by *analysis* of the superego and on the theory and practice of analytic technique in relation to the superego.

I

In 1919, Freud was on the verge of a decade of writings (1920, 1923, 1926a) that would turn around much of the comprehension of intrapsychic processes and eventually would change, in widely varying degrees, much of the technical access to those processes. Yet, in 1919, he stated the case for analytic methodology in the following manner:

> We have formulated our task as physicians thus: to bring to the patient's knowledge the unconscious, repressed impulses existing in him, and, for that purpose, to uncover the resistances that oppose this extension of his knowledge about himself. Does the uncovering of these resistances guarantee that they will also be overcome? Certainly not always; but our hope is to achieve this *by exploiting the patient's transference to the person of the physician, so as to induce him to adopt our conviction* of the inexpediency of the repressive process established in childhood and of the impossibility of conducting life on the pleasure principle (p. 159, italics added).

The essence of the analyst's power that makes the "inducing" possible was bestowed on him by a transfer to the analyst of images of parental authority from childhood that the patient had meanwhile internalized. Freud (1923) would later describe this primarily defensively motivated internalization as an "alteration" of ego function and name it *superego.* By 1919, the expedient of therapeutically "exploiting" this re-externalization (with whatever accompanying technical shortcomings) had become the most effective tool available in the analyst's repertoire for coping with the crucial obstacle to treatment, the resistance. Despite providing newer ways for himself and other analysts to

comprehend intrapsychic processes, Freud continued in many ways to hold fast to his technical mode of 1919, retaining that "remnant of the hypnotic method" (1913, p. 133). It is interesting to note here that Anna Freud (1969), in *Difficulties in the Path of Psychoanalysis*, reminded readers that in Freud's last decade he did begin to speak of *how* the analyst might go about the "undoing of alterations . . . present [in the ego] as results of the defensive process" (Strachey, 1964, p. 213). Freud either chose not to acknowledge or did not recognize (Gray, 1982) the important technical measures that Anna Freud (1936) had by then evolved with her perception of the undeveloped trends in her father's contributions.

Faced at times with a disappointing, but hard-earned and long-cherished technical orientation, Freud moved further into his quest of the mysteries of resistance. Impelled especially by the challenge of clinical observations of an apparently unconscious need for punishment, Freud (1920) grappled with what he saw as exceptions to the pleasure principle. As he proceeded in *Beyond the Pleasure Principle*, he created for himself as well as for his followers a not uncharacteristic dilemma: he stated two divergent points of view regarding the nature of instinctual drives in their movement toward consciousness and gratification. The distinction between them is important because, during the ensuing years, we have tried to accommodate to his inconsistency. What is significant here is that one's attitude toward superego function in analytic treatment can be influenced according to which point of view one follows. The first position is in keeping with the eventual conception of neurosis based on conflict between the ego and the instinctual drives, and it could have made the habitual *necessity* for suggestion in technique obsolete (Waelder, 1956). Freud's (1920) first position was that

> we must above all get rid of the mistaken notion that what we are dealing with in our struggle against resistances is resistance on the part of the *unconscious* . . . . that is to say, the 'repressed'—offers no resistance whatever to the efforts of the treatment. Indeed, it itself has no other endeavour than to

> break through the pressure *weighing down* [italics added] on it and force its way either to consciousness or to a discharge through some real action. Resistance during treatment arises from the *same higher strata* [italics added] and systems of the mind which originally carried out repression (p. 19).

This unequivocal statement is a precept with which most analysts might agree.

Freud was to repeat this near the end of his writings (1940): ". . . the unconscious . . . comes to our help, since it has a natural 'upward drive' and desires nothing better than to press forward across its settled frontiers into the ego and so to consciousness" (p. 179). Anna Freud (1936) echoed this point of view: "We know that the id impulses have of themselves no inclination to remain unconscious. They naturally tend upward and are perpetually striving to make their way into consciousness and so to achieve gratification . . ." (p. 29).

Freud's second position, on the other hand, binds suggestion as essential to analytic technique, in order to overcome "organic inertia." Freud's (1920) clinically complicating hypothesis, the death instinct, based as we know on the hypothesis of "*an urge inherent in organic life to restore an earlier [inorganic] state of things*" (p. 36), led to this second position.

Freud spent a major portion of the same paper, in which he had stated the first position, developing the theory which relegated a significant portion of the resistance to a factor "beyond" those that could be identified and analyzed by interpretation and which would require a "working through." This latter called for a continued essential use of suggestion, a "use" which depended on suspending the analysis of those aspects of the transference which, a few years later, would be specified as associated with the superego. This new "beyond" factor was the "repetition-compulsion" that Freud (1926a) also characterized as the "*resistance of the unconscious*" (p. 160). It is not well known that Freud specifically attached both of these concepts to his hypothesis of the "death instinct."

Although the idea of an "organic" element in repression was

actually not entirely new to Freud (1897), it burst forth in 1920 with great emphasis. At the same time, Freud had reservations that he did not particularly heed. His previous concept (1914) of "working through" appeared to be concerned only with "fixation" inertia. In this earlier observation, what Freud called a "compulsion to repeat," a "way of remembering" (1914, p. 150), was not contaminated by organic resistance and could have foreshadowed what eventually was conceptualized as conflict within a structural model. One needs to keep in mind here what Schur (1966) said about Strachey's translation:

> The distinction between "*compulsion to repeat*" and "*repetition compulsion*" gets lost, unfortunately, in Strachey's translation of the German word *Wiederholungszwang*. The term "compulsion to repeat" is used throughout without an editorial note explaining the distinction between these two concepts. There is a basic difference between the empirically valid observation of a compulsion to repeat and the theoretical concept of a repetition compulsion as an overriding regulatory principle of mental functioning (p. 159).

In 1914 Freud even included what I believe was a most far-reaching, even "modern" characterization of repetition, an essential portrayal of his eventual theory of intrapsychic conflict. I quote it here, and shall return to it later: ". . . as the analysis proceeds. . . . the patient brings out of the armoury of the past *the weapons with which he defends himself* . . ." (p. 151, italics added). Nevertheless, in *Beyond the Pleasure Principle* (1920), for better and/or worse, confronted by puzzling, tenacious resistances in analyses, Freud extended a life-long preoccupation with death into the far-reaching theory of the death instinct (Schur, 1972). His frustration at the time is clear: ". . . the analysis of the ego has made so little headway . . ." (Freud, 1920, p. 53). Understandably, he was driven to characterize certain chronic severe forms of resistance as having a "hint of . . . 'daemonic' power" (p. 36). He freely displayed his own ambivalence about this new and radical explanation: "What follows is . . .

often far-fetched speculation" (p. 24); "It may be asked whether and how far I am myself convinced of the truth of the hypotheses that have been set out in these pages. . . . I am not convinced myself . . ." (p. 59). Sterba (1982) quoted Freud's personal remarks: "It has been said that I am trying to force the death instinct upon analysts. However, I am . . . like someone who has to leave the house and leaves a toy behind so that the children will have something to play with while he is absent." (p. 116).

At the very end of *Beyond the Pleasure Principle*, Freud (1920), appearing unsatisfied with the hypothesis of his paper, sensed "a host of . . . questions to which we can at present find no answer. We must be patient and await fresh methods and occasions of research. We must be ready, too, to abandon a path that we have followed for a time, if it seems to be leading to no good end" (pp. 63-64).

However, Freud did not abandon the path he was following. In 1930, speaking of his ideas on the death instinct, he stated that although they were "only tentatively . . . put forward . . . in the course of time they have gained such a hold upon me that I can no longer think in any other way" (1930, p. 119).

Intrinsic to the concept of the death instinct was the simultaneous evolution of Freud's theory of aggression. We should not ignore Freud's prior, long-standing ambivalence about the presence of aggression as a primary drive. As he himself recognized, "I can no longer understand how we can have overlooked the ubiquity of non-erotic aggressivity and destructiveness and can have failed to give it its due place in our interpretation of life" (1930, p. 120). Although Freud in 1930 recognized and elaborated the relationship of suppression of aggression to the production of guilt, i.e., the essential aspect of the superego in its mechanism of turning aggression on the self, it is possible that his conflicting views on aggression acted as a determinant in his failure to bring the superego into sharper focus as exemplifying the major defense against aggression. For, if the superego were

to be truly analyzed, aggression would return with all its potential intensity to the jurisdiction of the ego. Freud may have been wary of this potential when he chose a theory that made aggression virtually an atypical, "secondary" instinct (Strachey, 1961, pp. 61-62), as its aim was thought primarily to serve the organism's "return to an inanimate state" (Freud, 1937, p. 246).

Characteristic of Freud's doubts over a primary role for aggression was his suggestion that, after all, "there *might* be such a thing as primary masochism" (1920, p. 55). To his very last months, he was still ambivalently preoccupied with the problem of aggression, writing in a letter to Marie Bonaparte, May 27, 1937:

> The whole topic [aggression] has not been treated carefully, and what I had to say about it in early writings was so premature and casual as hardly to deserve consideration (Jones, 1957, p. 464).

Then, as though tempted to let go of it finally, he wrote:

> The turning inward of the aggressive impulse is naturally the counterpart of turning outward of the libido when it passes over from ego to objects. One could imagine a pretty schematic idea of all libido being at the beginning of life directed inward and all aggression outward, and that this gradually changes in the course of life. *But perhaps that is not correct* (pp. 464-465, italics added).

In a subsequent letter to Bonaparte, June 17, 1937, he wrote: "Please do not overestimate my remarks about the destructive instinct. They were only tossed off and should be carefully thought over if you propose to use them publicly" (p. 465).

In summary, the death instinct theory, as we shall see later, was destined to continue to insinuate itself into psychoanalytic theory in a manner which contributed to an ambiguity regarding the degree of analyzability of the resistance. It lent an aura of "beyond" analyzability to elements which were to become associated with the superego. Guilt was seen partially as a

"natural" expression of an instinctual need, rather than as a defensive alternative to aggression.[1]

Beginning with "The Ego and the Id," Freud (1923) again made another hypothetical construct that he then developed in at least two ways, each with differing technical implications. This time it was the superego construct itself. With the structural theory, Freud indicated that he had "embarked upon the analysis of the ego" (p. 36). There is ample evidence that, in the first instance, Freud began by picturing the superego *as one of the functions of the ego.* Had he continued in this manner, I believe that he would have found a natural place in the scheme of the ego's versatile complexity for including the superego with the growing list of the ego's activities pertaining especially to defense.

In his most definitive approach to the superego, Freud (1923) spoke of that complex of functions as "a grade *in the ego*, a differentiation *within the ego*" (p. 28, italics added). In discussing the process of superego formation, he used the phrase "alteration *of his ego*" (p. 29, italics added). Later, Freud would speak of "alteration" in the ego as specifically resulting from the *ego's* "defensive mechanisms" (1937, p. 238), Describing the formation resulting from the identifications arising out of the oedipal conflict, Freud said: "*This modification of the ego . . . confronts the other contents of the ego as . . . super-ego*" (1923, p. 34); by 1927, "It [the ego] harbours *within it* . . . a special agency—the superego" (p. 164, italics added). However, Freud's indecision regarding the superego's status is clear: "The super-ego owes its

[1] Efforts to refute the death instinct theory and/or the repetition compulsion include Fenichel's (1938-1939) unequivocal statement that "after elimination of the defense, the energies of the warded off instincts accrue again to . . . the ego . . . and . . . the 'repetition compulsion' vanishes completely . . ." (p. 111). See also Brenner (1959); Grunberger (1971); Lichtenstein (1935); Novey (1962); Orgel (1974); Schur (1966, 1972); and Sternbach (1975). On the other hand, for those who continue to accept the death instinct, see Klein (1946-1963); Nunberg (1956); and Ostow (1958).

special position in the ego, *or* in relation to the ego . . ." (1923, p. 48, italics added).

In the second instance, Freud leaned more often toward "the differentiation we have made of the mind into an id, an ego, and a super-ego" (1923, p. 40, italics added). Later, Freud (1926) was to elaborate: ". . . the mental apparatus is composed of an '*id*', . . . of an '*ego*', . . . and of a '*super-ego*', *which develops out of the id*" (p. 266, italics added).

Further evidence of the degree to which Freud held the superego to be independent of the ego lies in his description of those resistances allegedly *not proceeding from the ego.* These two were a) "*the resistance of the unconscious* . . . arising from the id" (1926a, p. 160), which he had linked to the death instinct and the repetition compulsion (Freud, 1920) and for which he reserved the necessity for "working through,"[2] and b) resistance "*coming* from the *superego*" (1926a, p. 160). Similarities in his discussion of these two concepts of resistance again suggest the separation of the superego from the ego. There is an implication that at bottom, in its manifestations of "the need for punishment" (p. 160), Freud regarded superego resistance as also connected with the death instinct. In this regard, note Freud's comment (1923, p. 53): "[In melancholia] . . . the super-ego is, as it were, a pure culture of the death instinct. . . ."[3]

Although Freud eventually (1940) spoke of these two ostensibly non-ego resistances as having "different origins," he added: "They may both be embraced under the single name of the 'need to be ill or to suffer' [and] they are of a kindred nature" (p. 179).

[2] In a paper in this issue of *The Quarterly*, Brenner (1987) has, from a different perspective, developed reasons, with which I agree, for no longer needing the concept of "working through."

[3] Waelder (1937) was moved to counter specifically any connection between the superego and the death instinct. I believe that the early understanding of that concept as the specific reason for a "working through" process has, through the popularization of that phrase, contributed to maintaining homage to a silent "ghost" of the death instinct.

Yet, Freud did not entirely give up the hypothesis of superego as an ego function. Kanzer (1972), calling attention to analysts' relative neglect of Freud's last writings, observed that at that time Freud was "becoming increasingly aware that superego analysis constituted a new frontier for psychoanalysis . . ." (p. 262). Referring to the final paragraph of the unfinished "Outline," Kanzer noted that the superego was placed "in a position usually accorded the ego" (p. 262) when Freud (1940, p. 207) had stated that "the super-ego takes up a kind of intermediate position *between the id and the external world*" (italics added). Kanzer added Freud's observation that the severity of the superego "corresponds to the strength of the *defence* used against the temptation of the Oedipus complex" (Freud, 1940, p. 206; Kanzer, 1972, p. 263, italics added). "Defense" also suggests an ego function.

Thus, I see several consequences of the wide influence of Freud's predominant tendency to characterize the superego as a superordinate, ego-independent structure. a) It removed superego manifestations from the realm of well-focused scrutiny of conflict by the analyst, an undertaking more often carried out in respect to those defensive ego activities traditionally labeled "mechanisms of defense."[4] b) It essentially prevented closer examination of the use of superego as transference for personal influence, for suggestion, in overcoming resistances. c) It prolonged an implication that the superego's "connection" with the id is one which links it inseparably with instinctual qualities that defy analyzability, at least in the sense that the fears motivating the acknowledged defenses can be analyzed. Only once do I find that Freud, seemingly out of exasperation, approached the solution that specifically making the superego's processes conscious is analytically therapeutic. This referred to negative therapeutic reactions associated with unconscious guilt, the "severe neurosis" (1940, p. 180): "In warding off this

[4] For a view elaborating the limitations surrounding the concept of "mechanisms of defense," see Brenner (1982a).

resistance we are obliged to restrict ourselves to making it conscious and attempting to bring about the slow demolition of the hostile super-ego."

Freud's three monumental additions and revisions of theory (1920, 1923, 1926a), had little effect on bringing about a shift away from *using the influence* of transferred superego, toward *analyzing* the superego as a defense activity. Even after revising the problem of anxiety so that analysis of conflict and resistance became possible, and so that he was impelled to grant "a concession to the ego that it can exert a very extensive influence over processes in the id, and . . . is able to develop such surprising powers" (1926a, pp. 91-92), Freud said (1926b):

> . . . personal influence is our most powerful dynamic weapon. . . . The neurotic sets to work because he has faith in the analyst, and he believes him because he acquires a special emotional attitude towards the figure of the analyst. Children, too, only believe people they are attached to. . . . [We make use] of this particularly large 'suggestive' influence. Not for suppressing the symptoms . . . but as a motive force to induce the patient to overcome his resistances (pp. 224-225).

Freud obviously meant that suggestion is not used in the early sense for directly banishing symptoms by post-hypnotic suggestion. However, the statement fails to recognize that the patient's superego is rendered less effective by the use of suggestion. *Using suggestion to make a compromise formation less effective is, in fact, a form of symptom suppression.*

Confrontation by a new theory, especially psychoanalytic theory with its built-in difficulties of assimilation, creates ambiguity in comprehending simultaneously two competing ideas. Freud could manage this; ordinary analysts are less able to do so. In reviewing Sterba's *Reminiscences of a Viennese Psychoanalyst* (1982), Gero (1984) confirmed the presence of the troubled or rejecting reactions to new theory. Sterba gave a useful picture of the analytic atmosphere evoked by the introduction of Freud's newer theoretical perspectives. After years of being

educated to be instinct "hunters and detectives," especially for the "task of discovering the culprit libido" (Sterba, 1982, p. 75), analysts had not only to add the importance of aggression to their knowledge and to contemplate exposure to the unconscious ego, but also to confront the wrenching significance of the "new theory of the origin of anxiety" which "forced a complete turnabout of . . . theoretical thinking" (p. 77). The new perspective may even have threatened to undermine some of the sublimations that draw analysts to the work, and disturbed those individuals who could sense the implication that such a theory made certain of their hard-earned skills insufficient, maybe even at times counterproductive.

II

Freud's creative flow of ideas, while continuously enlarging his scope, gave relatively modest attention to details of revising his earlier positions. Since then, theorists have largely confined their efforts to bringing clarification and order to this body of psychoanalytic writings which often appear to contain "everything." Let us turn now to some of the contributors who tried to reduce the ambiguities with which we have been concerned.

Confronting better definition of the superego during the analytic process is intrinsically associated with the problems that have delayed more knowledge of the ego itself. Among Anna Freud's contributions, those central to a better understanding of the ego's defensive activities met a difficult road. The monograph (1936) she courageously introduced met with a cold reception (M. Katan, personal communication).

Anna Freud's concept of the "second kind of transference" (p. 19), the *transference of defense*, is most relevant to the comprehension and analysis of superego vicissitudes during the psychoanalytic process. Formally establishing another kind of transference ran counter to the familiar and still prevalent concept of regarding transference only as a drive cathexis with in-

stinctual gratification as its aim. The idea that objects may also become cathected because they provide "law and order" support for the child's attempts to inhibit conflicted impulses should long have been familiar. Anna Freud appeared aware of the problem of new theory that calls for a major change in analytic technique. In her acknowledgment of the traditional form of interpretation of "the first transference," transference of the id, she noted that, typically, after an analyst has interpreted a disturbing "passionate emotion" as "belonging" in the past, the patient "is quite willing to cooperate with us in our interpretation [because] we release him from an impulse in the present . . ." (p. 19). Since she knew that resistance is continuous, this description appears as a gentle criticism of prestructural technique, implying that such an interpretation inadvertently provided a new defense. She waited for decades (1981) to take credit for the concept of transference of defense. The essence of her progressive idea of transference of resistance is that the compulsion to repeat is a concept that should be extended "equally to former *defensive measures against* the instincts" (1936, p. 19, italics added).

It is precisely Anna Freud's (1936) concept of "transference of defense" that I regard as an early step on the way to analysis of the superego *primarily*[5] as a defensive function of the ego. It represents a further step when she equates the analysis of the defensive manifestations attributed to "the ego of the same infantile period in which the id impulse first arose" (p. 21), with the "not very felicitous term 'character analysis' " (p. 22).[6] This observation appears to provide a key to the eventual perception of the superego as an analyzable neurotic activity of the ego.

[5] By "primarily" I am suggesting that other motives for the formation of such compromise formations, at least *in the analytic situation*, are, from a practical, technical point of view, typically less important.

[6] In Lester Schwartz's (1971) report on the Kris Study Group on the superego, he said: "The consensus was that superego analysis was an aspect of character analysis and that . . . interpretation of resistances, defenses, and unconscious fantasy was of paramount importance" (p. 189).

Among those who sensed the lag in applying newer theory to older practice, Fenichel (1938-1939) lamented that, although much was being said about defenses, rarely did anyone speak about how to analyze them. In a rather neglected observation, highly relevant to this paper, he stated:

> In a certain sense it can be said that all defense is 'relative defense'; relative to one layer it is defense and at the same time, relative to another layer it is that which is warded off. There exists in the human psyche a particularly impressive example of this: the superego whose demands, *analogous* to instincts, are warded off, *is in essence itself a defense structure* (p. 62, italics added).

Sterba's introduction of the term and concept "ego split," created "a storm of indignation and rejection" (1982, p. 91). Nevertheless, his recognition that the patient's gradual achievement of a selectively available rational attention goes hand in hand with effective analysis has become a keystone in the entranceway that brings the unconscious conflict-solving ego activities into a usable awareness.

Gillman (1982) suggested that a recent increase in contributions specifically on the superego may reflect a reactive discontent with the state of theory in this area. As far as I know, Brenner (1976) is the only contemporary contributor to write about the analysis of the superego. Although he did not approach the superego as a hierarchical function of the ego, some of his conclusions come close to my own: "Superego analysis presents a variety of technical problems. . . . In essence they are no different from the problems of defense analysis in general" (p. 106); in *The Mind in Conflict* (1982b), ". . . the superego is both a consequence of psychic conflict and a component of it. . . . *The superego is a compromise formation* . . ." (p. 120); and more recently, ". . . a compromise formation [is] dynamically indistinguishable from a symptom" (1987, p. 106).

Space permits only a sampling of other contemporary contributions. Although not focused directly on superego analysis, they explore relevant incongruities in methodology created by

the persistance of superseded earlier phases of Freudian theory. Brenner (1984) has for years challenged a variety of persisting practices and provided reassessments. Schur's (1966) contribution on regulatory principles of mental functioning is most valuable. Although Gill (1963), in his early definition of the id and the ego, chooses to "not deal specifically with the superego" (p. 144), his discussions of hierarchical arrangements of defenses appear not to rule out superego manifestations as functions of the ego. At one point, he refers to the superego "as a primitive system of defence" (p. 144). He also draws attention to a relevant observation of Glover's: "A more elaborate differential of superego structure will, however, involve a closer study of the *relation of different ego systems to consciousness* (Glover, 1956, pp. 340-341).

Friedman (1969) specifically confronted "the paradox of having to rely on something in the patient which must be dissolved" (p. 142). Boesky (1983) has demonstrated how "character resistance as a concept is a theoretical and technical anachronism" (p. 24). Spiegel (1978) has shown that clinical manifestations traditionally viewed as "*unconscious* guilt" are more usefully understood as transferences of defense involving *ad hoc* regressions to masochistic solutions. The implications here are far-reaching. I anticipate that further study of details of superego functioning will lead to the identification of "*conscious* guilt" as an *ad hoc* defensive regressive solution to intrapsychic conflict. Collins (1980) provided a searching examination of Freud's own unending struggle with the issue of suggestibility in analysis.

III

It is important to psychoanalytic technique, I believe, that we reduce the ambiguity surrounding superego analysis. While it is true that analysts currently *deal* in various ways with the superego, they also still widely practice the therapeutic *use* of the superego in analysis. In my opinion, "dealing with" the su-

perego is often not analysis of the superego; "therapeutic use" of it is never analysis of it.

By *analysis* of the superego, I mean: systematically making available to consciousness those repetitions of defensive formations in the analytic situation—including pre- and post-internalizations—which were earlier mobilized, especially in connection with the oedipal situation, to the end that the compromised ego function components can be progressively reclaimed, from the beginning of the analysis, by the relatively autonomous ego. In particular, I have in mind the components of self-observing capacities and the conscious executive capacity over the instinctual investments co-opted by the superego, especially that of aggression.

I take the position that optimal analysis of the superego, as of resistance generally, is best achieved by perceiving and interpreting superego manifestations primarily as part of the *ego's* hierarchical defensive activities, mobilized *during the analytic situation*.

Reflecting on the continuum of the "normal" process of civilized development and neurotic development, it is easier to grasp how the superego is dynamically like a symptom. Let us take Freud's (1926a) description of the ego's strength and weakness in relation to the id and parenthetically try out the concept "superego" instead of the designations, "symptom" and "compromise formation."

> It does sometimes happen that the defensive struggle against an unwelcome instinctual impulse is brought to an end with the formation of a symptom (superego). . . . But usually the outcome is different. The initial act of repression is followed by a tedious or interminable sequel in which the struggle against the instinctual impulse is prolonged into a struggle against the symptom (superego, and defense against guilt). . . . The ego is an organization. It is based on the maintenance of free intercourse and of the possibility of reciprocal influence between all its parts. Its . . . necessity to synthesize

> grows stronger in proportion as the strength of the ego increases. It is . . . natural that the ego should try to prevent symptoms (the superego) from remaining isolated . . . by using every possible method to . . . incorporate them (the superego) into its organization. . . . As we know, a tendency of this kind is already operative in the very act of forming a symptom (the superego). . . . The ego now proceeds to behave as though it recognized that the symptom (superego) had come to stay and that the only thing to do was to . . . draw as much advantage from it as possible. It makes an adaptation to the symptom (the superego)—to this piece of the internal world which is alien to it—just as it normally does to the real external world (the inhibiting function of the *perceived* parents). . . . The presence of a symptom (the superego) may entail a certain impairment of capacity, and this can be exploited. . . . In this way the symptom (superego) gradually comes to be the representative of important interests; it is found to be useful in asserting the position of the self and becomes more and more closely merged with the ego and more and more indispensable to it. . . .
>
> In obsessional neurosis (intense superego) . . . the forms which the symptoms (the superego) assume become very valuable to the ego because they obtain for it . . . a narcissistic satisfaction which it would otherwise be without. The systems which the obsessional neurotic (strongly superego possessed) constructs flatter his self-love by making him feel that he is better than other people because he is specially cleanly or specially conscientious. . . . When the analyst tries subsequently to help the ego in its struggle against the symptom (superego), he finds that these conciliatory bonds between ego and symptoms (superego) operate on the side of the resistances and that they are not easy to loosen (pp. 98-100).

Precisely this last parallel has placed the superego as a challenging but analyzable factor in approaching the work of the analysis. Understandably, before the new, 1926, view of anxiety and intrapsychic conflict, an exploitation of the influential transference was necessary to ostensibly loosen the "conciliatory

bonds" between the ego and the "ego-ideal." The newer view permits analysts to see the dynamics of superego formation as one of the ego's stratified responses (Gero, 1951) to the conflicts of the oedipal situation.

Before the ego's compromise formation involving internalization brings about the more definitive resolution of the oedipus conflicts, other compromise formations have shaped, for the child, the external perceptions of impulse inhibiting authorities. Creating or defensively enhancing those fear-evoking perceptions typically involves projection of aggressive impulses. With the dramatic process of internalization of those inhibiting images,[7] the more familiar superego formations are established. In the analytic situation, as in many other relationships, the transferential repetition of the pre-internalized superego perceptions takes place steadily and usually rapidly. Just as the pre-internalized view of the judging parental authorities was necessary for instinctual control, so the patient now needs to distort the otherwise disturbingly unauthoritarian reality of the neutrality and permissiveness (only action is restrained) the analyst provides. This is an example, *par excellence*, of transference as resistance (Freud, 1912), although that phrase is traditionally regarded as referring to *id* transferences. Again, these transferences of images of childhood authority obviously are alternatively the exploitable source for the power of suggestion.

In previous papers (Gray, 1973, 1982), I have outlined in more detail technique for the analysis of unconscious conflict within the immediate analytic process. My approach to technique led me to increasing awareness of the extent to which the phenomena observed and just described include transferential repetitions of the ego's "pre-internalization" attempts at protection from fear of instinctual impulses. It follows that the meth-

[7] The similarity between the compromise formations in this process and the symptomatic process in dramatically rapid religious "conversions" is of interest, a similarity which may be inferred from Freud's "Group Psychology and the Analysis of the Ego" (1921).

odology I have already described in those papers is applicable in analyzing superego vicissitudes. In keeping with my undertaking here as "introduction," I shall only briefly describe the process through an excerpt from a recent presentation (Gray, 1986):

> The more clearly we analysts can conceptualize for *ourselves* the detail of the analytic work of observing we may wish to have patients undertake, the greater the likelihood that we can facilitate *their* learning to do so. Let us look closer at the autonomous ego functions analysands need in order to observe the conflict-motivated defensive activities of their egos. As analysands are interrupted by the sound of the analyst's voice, they must draw back from the more spontaneous and less rational mode and must now take up objective capacities. In this new and more rational alliance . . . they may sequentially undertake the following: (1) rationally attend to what the analyst is saying; (2) recognize that the interpretive intervention implies an invitation to turn objective attention back over the reconstructed or recounted sequence of material the analyst has offered as evidence of a conflict the patient encountered during the attempted spontaneity and to which the patient's mind automatically responded with a protective, defensive solution; (3) comprehend that the motivation for the conflict solution *was due in part (and this part will be explored) to the fact that while the analysand was revealing thoughts and feelings to the other person in the room, some fantasied risk of doing so arose*; (4) analyze that irrational risk (a bit more each time) and through understanding it gradually reduce the automatic need for the patient to inhibit, by the specific means identified, those particular elements that had shortly before come into conflict; and (5) return attention to the essential task permitting a more spontaneous access to the inner self, in particular, allowing greater freedom to let emerge those conflicted elements, the inhibition of which had just been explored (pp. 250-251, italics added).

In this simplified description of technical intent, (1) and (2) show something of the process of regaining, in its original un-

compromised form,[8] the patient's observing ego that had been pre-empted by other ego functions, namely, those infantile defensive measures designated as the superego. It is, of course, (3) and (4) that hold the crucial potential for gradually making fully conscious the transference of the previously externally perceived, images of authority used by the child for restraint.

Just as in the child's early and later development, the internalization process does not eliminate the ego's "uses" of external authority for auxiliary control, so also the internalization is not so stable structurally that its reprojection cannot regularly recur in varying degrees. Transferences of external authority are as ubiquitous as the transferences of id objects (Brenner, 1976). That this occurs in the analytic situation, with its explicit aim of avowing the disavowed, is inevitable. This technical approach aims at providing an opportunity for a *maximum* of new, conscious ego solutions to conflict and a *minimum* of solutions involving new internalizations. This does not detract from the fact that internalizing forms of solution to conflict are capable of providing therapeutic action for many analytic patients. There is an inherent universal tendency toward solutions to conflict using a superego-like internalizing process as an outcome of growth experience. For some patients, it is unavoidable; their analytic process will "demand" such a therapeutic action. There are, however, avenues for mental growth through analytic experience other than those brought about through internalizations that are compromise formations and symptom-like in nature. For those patients who, I believe, have a greater capacity for non-internalizing solutions, let us return to the discussion at hand.

Usually, in the course of the analysis, a hierarchy of transferred, inhibiting fantasies is uncovered, beginning with more

[8] Dale Meers called my attention to Waelder's (1937) proposal that "the power to objectify the self and to achieve detachment from it" constituted an early acquired ego capacity which provided an "imaginary standpoint from which we confront the rest of our personality" (p. 435). Waelder (1936, p. 93) compared it with the "fixed point" of Archimedes.

recent versions of expected reactions from authority and working gradually toward earlier and more vivid defense-motivating infantile dangers—"calamities" (Brenner, 1982b, p. 55).

In the approach I am advocating, the potential for genetic and reconstructive interpretations is completely open quantitatively. The essential characteristic lies in the strong emphasis on analysis of resistance, which is the central point of superego *analysis*. Therefore, the genetic and reconstructive work points less toward establishing that there *were* infantile objects of the emerging instinctual drives. (The existence and nature of the transferred fantasy objects of id impulses becomes inexorably clear as impulse aims are freed from resistance.) Instead, the emphasis is on learning about the infantile context in which perceptions of danger opposing these impulses were so frightening that, for safety, the child cathected inhibiting, not gratifying objects (Sandler, 1983), now repeated as "armamentarium of the past," involuntarily and unnecessarily as resistance to the analytic task. The shift of genetic interest might be expressed in the following way: from "How and why, as a child, did you wish to destroy some individual?" to "What was it, as a child, that made you need to stop knowing that you could hate some individuals enough to want to destroy them, and how did you manage to stop knowing?"

Obviously, the origins of both defense and that which is defended against are inseparably interrelated, but if the analysis tilts or appears to tilt toward a search for instinctual impulses as if they "belonged to the past," rather than being alive within us all, then a sense of "closures" may evolve. Versions of "narrative persuasion" (Spence, 1983) may become operative. On the other hand, consistent attention to the persistent evidence of conflict and resistant conflict solutions, though diminishing in frequency and intensity, *keeps the process open* to further analysis of the anxiety-producing fantasies of danger from additional increments of pressing id strivings. The fantasies of danger are the bases of the conflicts and motivation for the defenses we observe as resistance.

In practice, when one observes and interprets superego activities as chronically maintained or repetitively activated ego processes, primarily mobilized for defensive purposes, one's attention is drawn, in particular, to the extent to which this process inhibits *derivatives of aggression.* The defensive meanings of the diversion of aggressive drives onto the self, a fundamental and familiar aspect of superego development, then assume a more conspicuous role in comprehending mental functioning. Conflict solutions during the analytic process that involve a version of redirecting an aggressive aim from an object to the subject, including varieties of subtle or sadistic self-accusation or self-directed aggression via projections onto the analyst, all bear the stamp of an ego activity which, in the "normal" course of events, would represent superego manifestations. In general, *superego analysis is possible only to the extent that aggressive drive derivatives are truly returnable to the ego's voluntary executive powers.* The patients who can make best use of this particular technical opportunity are largely, but by no means entirely, at the other end of the clinical spectrum from those in the "wider scope" category.

Finally, as a stimulus for further exploration of the subject, I cite one of those provocatively enigmatic observations of Freud's (1933): ". . . *we are all too ready to regard as . . . normal* [the situation] where the external restraint [parental influence, love, threatening punishments which are feared on their own account, realistic anxiety] is internalized and the super-ego takes the place of the parental agency . . ." (p. 62, italics added).

SUMMARY

In this paper, I examined the history of the ambiguity that has surrounded the concept of the superego, beginning with Freud's own vacillations down to present-day practices. After showing how some analytic thinkers have lessened that ambiguity, I presented proposals of how to approach the superego in analytic practice. I proposed that with those analysands who have sufficient potential for accessible rational attention during

the analytic process, there is significant technical advantage in approaching the transferred superego manifestations as hierarchically initiated functions of the ego. This is achieved, essentially, by recognizing the importance of the transferential repetition of those preinternalization, ego-distorted inhibiting imagoes of authority that the child used for purposes of assisting suppression of conflicted id impulses, a major, yet not always recognized form of "transference as resistance."

Two technical efforts are of particular importance: the first, a reclaiming of the uncompromised function of the observing ego from its altered role in superego formation; the second, a concurrent return of the defensively self-directed aggression to the ego's voluntary executive powers.

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DREAMS AND ACTING OUT

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Dreams can be used as containers that free patients from increased tension. This may be the principal function of certain types of dreams, called "evacuative dreams." They are dreams used for getting rid of unbearable affects and unconscious fantasies, or as a safety valve for partial discharge of instinctual drives. These dreams are observed primarily in borderline and psychotic patients, but can also be seen in the regressive states of neurotic patients during weekends and other periods of separation. Such dreams have to be differentiated from "elaborative dreams," which have a working-through function and stand in an inverse relationship to acting out: the greater the production of elaborative dreams, the less the tendency to act out, and vice versa.

In the last two decades psychoanalysis has been faced with some new problems in the conceptualization of the dream and dreaming. The same may be said of the phenomenon of acting out.

The purpose of this paper is to present my current ideas about these issues and about the technical approach to them. I will begin by proposing a clinical classification of dreams and a concept of their inverse relationship to acting out: the greater the production of dreams, the less tendency there is toward acting out, and vice versa. My presentation will further develop a hypothesis, conceived several years ago (Grinberg, et al., 1967), of the existence of evacuative, mixed, and elaborative dreams. This hypothesis originated in a study group coordinated by me and devoted to the investigation of dreams.

I believe that it is important to be able to differentiate between these various types of dreams in our clinical work, because it can enable us to learn more about a patient's level of regression, that is, what his capacity is for insight and for taking advantage of the working through function of dreams. It can also add another dimension to our procedure for interpreting dreams. I consider certain dreams to be closely linked to acting out, which can precede the dream or appear after it, even though these aspects are related to one another by a common unconscious fantasy.

Freud (1900) showed that one of the functions of a dream is to preserve sleep. According to him, the archaic psyche is reactivated in the individual who dreams, which results in the transformation of the psychic contents into visual images, condensations, displacements, symbolisms, and other singular manipulations of the circumstances of space and time. Oneiric regression makes manifest the archaic levels of the psyche and establishes continuity between past, present, and future, bringing the present back to the past and actualizing the past in the present. It is probable that the regressive process that converts day residue into objects in the dream is the same one that converts experiences and the day residue into memories selectively stored in the unconscious.

Freud also emphasized the function of wish fulfillment in dreams. A compromise is reached between the repressive and repressed forces by means of the dream work so that the forbidden wish can find a certain form of satisfaction. Freud did not revise this theory in the light of his later discoveries. Some authors, however, have raised objections to it. Hanna Segal (1981), for example, expressed her reservations about the dream's being conceived of solely as a compromise. She held that "the dream is not just an equivalent of a neurotic symptom. Dreamwork is also part of the psychic work of working through" (p. 90).

The dream, therefore, is an important and complex psychic act. Melanie Klein (1932, 1946), delving deeper into early object

relationships, basic anxieties, and defense mechanisms, has enhanced our approach to the dream by enlarging the concept to include a richly complex internal world. Thus the dream can be seen as the dramatization of a conflict and as an attempt at working it through. The dream appears within the temporal limitations of the internal world of the person, with its various structures, representations of objects, and reciprocal relationships.

Bion (1962) reformulated some of the concepts on dreaming and dreams. He believed that in order for a person to be able to dream, it is necessary for him to possess an alpha function capable of processing his sensory impressions in such a way that it transforms them into alpha elements. These elements are used in the formation of unconscious mental processes during wakefulness, oneiric thoughts, dreams, and memories. The alpha elements, upon uniting among themselves, form a "contact barrier" that isolates the conscious from the unconscious and establishes a selective passage between the two. If the alpha function is effective, the individual can distinguish between being asleep and being awake and is therefore able to dream. This "contact barrier" protects against the mental phenomena that could overwhelm consciousness and, in turn, makes it impossible for consciousness to overwhelm the fantasies. It also protects one's contact with reality, avoiding its distortion by emotions of internal origin.

This capacity to dream protects the individual from what would virtually be a psychotic state. If the alpha function fails, the patient cannot dream and therefore is not able to differentiate sleep from wakefulness. For these cases, Bion introduced another concept, the "beta-element screen," which he used to explain those mental states in which there is no differentiation between conscious and unconscious, sleep and wakefulness. This "beta-screen" is composed of beta elements, which are experienced as things-in-themselves; they are not appropriate for thinking, dreaming, remembering, but only for being evacuated through projective identification or by acting out.

In our study group we had thought about the possibility of extending to dreams Bion's (1962) concept of the existence of an "apparatus for thinking thoughts." This "apparatus for dreaming dreams" would have a double function: "to dream them" during sleep and later on "to think them" during wakefulness in such a way as to be able to recall them instead of repeating them through acting out. This apparatus is gradually formed in the infant's mind, granting it the capacity to think, through the internalization of repeated experiences of its relationship with a mother container with a capacity for "reverie," who has received the anxiety and other unbearable affects projected by the child, returning them in an attenuated form.

In the course of the analytic process, just as in infancy in the mother-child relationship, the analyst's capacity for "reverie," his ability to contain and metabolize the projections of the patient, returning them through the interpretive activity, gradually becomes assimilated by the ego of the analysand. It is then possible for the patient to continue learning to "dream" his dreams in the same way that he gradually learns to "think" his thoughts.

Thus the analyst's interpretations continue to confer on dreams meanings previously unknown to the patient. The dream itself, in its manifest and latent contents, may be considered a fairly accurate clinical indicator of the stage of elaboration or non-elaboration which the analysand is passing through.

In classic psychoanalytic theory, the latent content of a dream is considered to be where the day residue and repressed infantile wishes and memories intersect. Rallo (1982) has suggested a second meaning for latent content, when analysis of the manifest content of a dream brings to consciousness the structure and functioning of the psychic apparatus. This second concept of latent content complements and is synchronous with the earlier one. To decipher these latent contents of the manifest content of dreams would enable us to differentiate the character and nature of various dreams. Some dreams would exhibit a lack of or a deficit in processing; they would not achieve ade-

quate elaborations of internalized reality and would possess predominantly evacuative functions. Other dreams, however, in which the secondary process participates more, would have an elaborative nature and relevant functions in the adaptive integration of reality.

In accordance with the ideas put forth here, we have proposed a clinical classification of dreams during the analytic process, based either on their predominantly evacuative function (with the use of projective identification into external objects) or on an elaborative function (with a greater tendency to introjective identifications):

1. *Evacuative dreams* which primarily seek the discharge of unbearable affects, unconscious fantasies, and object relations into an external object that constitutes a container; for example, the analyst.
2. *Mixed dreams* which not only seek to discharge the unwanted affects and parts of the self and objects into a container, but also possess elements of concern and guilt.
3. *Elaborative dreams,* in which the function of discharge is not primary. They contain depressive and reparatory elements with a distinct tendency toward working through.

Evacuative dreams are those in which the function of liberating the psychic apparatus from ideational and affective contents predominates, due to the dreamer's inability to tolerate the anxiety that they awaken. They are primitive dreams, dreamed essentially in order to discharge their contents into object containers, and often appear in the initial stages of analysis when the patient has not yet built up defenses against insight into his psychotic nucleus. They become more frequent during interruptions in the treatment as a result of the separation from the analyst and the need to find a substitute onto whom the patient can project his painful affects. The condition of "evacuativity" is created by the inability of the psychic apparatus to tolerate increasing tension, by the latent content of the unconscious fantasy, and by certain characteristics of the manifest content in which elements of the primary process often ap-

pear with a primitive symbolism or with scant displacements, usually representing very regressive defense mechanisms.

Animals, machines, or apparatus from outer space, nonhuman elements, partial objects, usually appear in the manifest content of these dreams. The dreams often coincide with gross alterations of the setting, severe acting out behavior, or serious somatizations.

Evacuative dreams are predominantly observed in regressive patients, in borderline cases, or in patients with psychotic personalities. We can see this in the following dream of a seriously schizoid patient. In the first part of the dream an airplane flies over a place and drops an atomic bomb. The patient is desperate because he cannot find any place to take shelter. The bomb falls, and there is an explosion. Up to this point there is a discharge and an evacuation of explosive and annihilating anal contents with a massive destruction of a psychotic type and infinite fragmentation. There is no container capable of containing the discharge. In the second part of the dream the patient discovers that he is not dead, but he sees that he appears to have holes, and parts of his body are putrified from the effects of radiation. In other words, the attempt to search for a container in his own body has failed because of the persecutory nature of the contents, which end up by disintegrating the container.

Freud has emphasized the analogy between the dream world and the waking life of the psychotic. In his studies on the relationship of dreams to psychosis, Frosch (1976) expressed the idea that "the fear of disintegration and dissolution of the self of the psychotic patient will influence his dreams both as to form and content" (p. 48). "In several patients considered with psychotic characters, the appearance of nightmarelike dreams was a common occurrence. The manifest dream content was generally of violence, including murder, rape or fire" (p. 42). "Many analysts have observed the presence in dreams of flagrant and manifest oedipal, homosexual or more primitive material such as cannibalistic manifestations at the beginning or early in treatment. Do those dreams reflect psychosis?" (p. 43). To my mind,

these kinds of dreams are evacuative dreams which may also appear in the first stages of the analysis of a neurotic patient. Richardson and Moore (1963) submitted manifest dreams of schizophrenic and nonschizophrenic patients to a panel of analysts who were asked to differentiate between them. The ability to differentiate did not appear to be good, and the criteria used by the panel seemed as valid for one type of dream as for the other. Nevertheless, the authors found a significant difference between the two types of dreams. They found that the presence of unusual, strange, uncanny, and bizarre qualities in the manifest content was more common for the schizophrenic than for the nonschizophrenic dream.

The need to communicate the dream is especially intense in evacuatory dreams and makes up the primary goal of the dreamer who thus searches for a container into which to evacuate his dream. Kanzer (1955), insisting on the communicative function of the dream, pointed out the urgency of communicating the dream itself, which had already been described by Freud. Kanzer referred not only to the interpersonal communication with the objects of the external world, but also to the intrapersonal communication contained in the dream and which is established between different aspects of the self. Baranger (1960), who also studied dreams as a means of communication, emphasized that the patient can use oneiric regression to claim a lack of responsibility for the dream and to maintain a dissociation from certain conflicts that he refuses to acknowledge.

In our paper on "Monday's Dreams" (Grinberg and Grinberg, 1960), we called attention to the fact that these dreams were very often related to the weekend separation from the analyst. In the unconscious fantasies of their latent content we usually found oedipal situations, jealousy, feelings of exclusion, problems involving birth and death, and separation anxieties. The common element of Monday dreams was the *search for communication* or contact with an internalized analyst in order to compensate for the separation caused by the weekend.

On occasion, patients have been observed to need to write down the evacuative dream, with the apparent justification of fear of forgetting it. In reality, the paper represents, in these cases, the intermediary container prior to its projection into the therapist.

The dream itself can be turned into the persecutory part, which the patient wants to get rid of, and not merely a representation of it. It can also happen, then, that the patient will oppose the interpretation of the dream if he feels that it would entail a reintrojection, a "reverted" projective identification of what was projected. Blitzten, Eissler, and Eissler (1950) have given us a highly illustrative example. A patient who was at best a borderline case with "paranoid mechanisms," reacted with "panic and extreme rage . . . whenever her attention was drawn to her dreams and she was called upon to associate to them. The violence of her objection was so great that she even sometimes jumped up from the couch, and huddled in a corner" (p. 14).

Although with another meaning, Freud (1923) pointed out, "It is possible to distinguish between dreams *from above* and dreams *from below*. . . . Dreams from below are those which are provoked by the strength of an unconscious (repressed) wish which has found a means of being represented in some of the day's residues. . . . Dreams from above correspond to thoughts or intentions of the day before which have contrived during the night to obtain reinforcement from repressed material that is debarred from the ego" (p. 111).

In other words, as the regression deepens, the secondary process gradually loses its supremacy to the point where it gives rise to dreams termed "from below," where the primary process dominates. When the integrative command of the secondary process is maintained, we find ourselves with dreams "from above," which would be more related to the problem of wakefulness introduced by means of day residues.

Freud (1900) referred indirectly to the function of discharge in dreaming when he stated: "Dreaming has taken on the task

of bringing back under control of the preconscious the excitation in the *Ucs.* which has been left free; in so doing, it discharges the *Ucs.* excitation, serves it as a *safety valve* [italics added] . . ." (p. 579).

Segal (1981) also pointed out that "dreams may be used for purposes of evacuation. . . . A patient can use dreams for getting rid of, rather than working through, unwanted parts of the self and objects, and he can use them in analysis for projective identification. We are all familiar with patients who come and flood us, fill us with dreams in a way disruptive to the relationship and to the analysis" (p. 99).

When the patient brings this type of dream to the session, it is advisable to orient the interpretation more toward the evacuative function of the dream and its liberating objective than toward its content. On occasion, the analyst can even make clear to the patient his wish to receive and keep the patient's dream without interpreting it, in order to avoid its reintrojection.

"Mixed dreams," while they contain evacuative elements, also present depressive aspects and a beginning of working through, since feelings of guilt and responsibility arise in the manifest content, even though some of the primitive defense mechanisms, such as dissociation, still persist.

An example of this category of mixed dreams is one told by a patient who habitually passed through very regressive periods in her analysis:

> I saw a rain of fire fall as if it were a volcano in eruption destroying everything. I was terrified and tried to run away to save myself while people around me were falling down. A man took me by the hand and a voice "off stage" guided us. This way we were able to reach a house where it seemed that we were safe. Later, the police arrived to investigate something or other, but I was not frightened.

Among her associations, she referred to the cataclysm at Pompeii. She later mentioned that she had seen a film on television in the company of her husband and in-laws. She was

greatly shocked by the reaction of the protagonist who had learned unexpectedly during a visit to her doctor that she had a malignant tumor which required immediate surgery. She was moved by the protagonist's anxiety in the face of the possibility of death. On the other hand, the patient had quarreled with her in-laws, because they criticized the film, and she felt she had to control her aggression in order not to explode violently. She felt a great need to come to the session, even though she arrived a few minutes late because she thought that she had to supervise the electrician carefully who was installing some outlets in her house.

The patient feared the unexpected eruption of a violent psychotic crisis (rain of fire) that could destroy her and the others. She had identified with the character in the film and unconsciously compared her own anxiety in the face of the dreaded emergency of an uncontrolled psychotic crisis to the anxiety faced by the protagonist who had to deal with her cancer. This anxiety was evacuated in the manifest content of the dream, and she felt the need to evacuate it into the analyst along with the man (electrician-analyst) she had to control to see how he installed the outlets. In the second part of the dream the attempt at working through appears, guided by the hand and voice of the analyst to the house-analysis. She was then able to accept with less fear the need to investigate (police) what had happened to her.

In regard to elaborative dreams, they show a greater intervention of the secondary process, with the appearance of depressive elements which tend toward integration. The patient who brings elaborative dreams to the session shows his increasing capacity to introject the clarifying function of the analyst. His external attitude toward his dreams is also modified: he has diminished his anxiety in confronting them and no longer reacts with paranoid defenses that tend to hinder the reintrojection of the dream, nor does he persist in phobic avoidance mechanisms or manic mechanisms of denial to defend himself against the intolerable projected contents, which he now accepts

as his own. He therefore faces this type of dream with greater collaboration and interest, which is evident through the quality and form of his associative sequence, implying a greater connection not only with the preconscious, but also with the happenings in the world of wakefulness.

The elaborative dream constitutes for the patient a hierarchical index of the state of his internal world. In his progress, the patient acquires the capacity to recall, evoke, and work with his dreams. Ultimately, this will allow him to arrive at the possibility of analyzing his dreams himself and of taking advantage of them adequately, not only during the analytic treatment but also during the therapeutic "weaning" and post-analysis. Obviously, the attempt at working through exists in all dreams, but its intensity and context is what gives it the quality of an elaborative dream.

For Meltzer (1984), dreams must be considered as images of an oneiric life that is constantly unfolding, whether the person is asleep or awake. We could call these images "dreams" when we are sleeping and "unconscious fantasies" when we are awake. This implies that the internal world must be assigned the full significance of a place, a life-space, perhaps the place where meaning is generated, meaning that can then be deployed to life and relationships in the external world. For Meltzer, dreams told by patients are sometimes "successful" and other times "failures." The successful dream is the one which contributes to solving the problem; the failed dream does not. He added: ". . . what of the fruitful harvest of those dreams which do succeed in grasping the nettle of mental pain, resolving a conflict, relinquishing an untenable position?" (p. 94).

These reflections undoubtedly refer to elaborative dreams. By attempting to give a verbal representation to the thoughts contained in these dreams, we are also preparing them to be used in more sophisticated forms of investigation, such as the proof of reality and logical consistency. But it is the poetry of the dream which succeeds in trapping and giving formal representation to passions, which are the meaning of our experience,

so that they can be controlled by reason. Lastly, Meltzer pointed out that the oneiric process can be described metaphorically as the "theater for the Generating of Meaning." This theater, with its various participants, implies a dramatic unity, but it also allows for a greater variety of points of view about the drama. If consciousness was defined by Freud (1900) as "*a sense-organ for the perception of psychical qualities*" (p. 615), which character in this theater is, at the moment of dreaming, in possession of this organ? Is it the same as the recaller and narrator of the dream during the analytic session?

Fairbairn (1952) also viewed dreams as, "essentially, not wish-fulfillments, but dramatizations or 'shorts' (in the cinematographic sense) of situations existing in inner reality. . . . The situations depicted in dreams represent relationships existing between endopsychic structures. . . . All the figures appearing in dreams represent either parts of the dreamer's own personality (conceived in terms of ego, superego and id) or internalized objects" (p. 99).

An example of these successful dreams of an elaborative type is one that a patient told in his fourth year of analysis, after having analyzed the conflict with his wife and his problems related to his eventual future paternity. "I dreamed that I was the father of a little infant, and after looking around I found a receptacle with water so that I could bathe the baby." In this dream there arose, among other meanings, different representations of the self and object relationships, feelings of responsibility, the search for and finding of a maternal container, and attitudes of preservation and reparation.

Relationship between Dreams and Acting Out

I have observed (Grinberg, 1968) that one of the essential roots of acting out is frequently an experience of separation and object loss that precipitated mourning which has not been worked through. This mourning generated extremely painful

affects (sorrow, depression, rage, frustration, anxiety, etc.), which the patients were unable to cope with. Moreover, the experiences of separation could touch off a particular fixation in the stage of muscular discharge, creating confusion between the mental, verbalized models and the action models.

An image that eloquently reflects the reaction toward this type of loss is the one of a child who loses its mother; and before finding the father as a substitute, the child suffers marked anxiety when "in the middle of the road." The child suddenly feels alone and helpless before the "void" and has a tantrum to keep from falling into the void. This attempt at discharge in the form of a tantrum would follow the primitive model of alleviating psychic pain through the projection of parts of the self and objects in conflict into an external object.

In my opinion, acting out can be regarded as a process that calls for two participants. There must be an object relationship, even though it may generally be of a narcissistic nature. A clue to the understanding of the dynamics and vicissitudes of acting out can also be found in the model for the early and conflictual mother-child relationship. I have already pointed out that, according to Bion (1962), when the infant feels very acute anxiety (for example, fear of dying), he needs to project it into a container (his mother), capable of holding it and returning it in such a way that the anxiety is lessened. If the mother is not capable of metabolizing this anxiety, and even deprives it of its specific quality (the fear of dying), the infant will receive back in return a "nameless dread" which he cannot tolerate.

According to this model, the patient's need to find an object in the external world that could take on both his pain and his separation anxiety is a significant element in acting out. This object is, obviously, the analyst, into whom the patient evacuates his unbearable feelings. The absence of the analyst for regular intervals, such as weekends, makes him appear as a persecutory "non-object." The relationship with this object must be evacuated by means of projective identification into other objects

which are substitute containers. For this reason, separations during analysis ("voids") can often trigger episodes of acting out.

Sometimes the "container-object" can be represented by the patient's own body, giving rise to psychosomatic or hypochondriacal disturbances, or by a dream with evacuative characteristics. The somatic or hypochondriacal body symptom becomes the concrete "presence" that annuls or counteracts the unbearable affects of pain and separation anxiety, Freud (1926) clearly established the relationship between the physical pain of a body symptom and the pain of object loss. In these cases, the part of the body affected is perceived as alien and the patient maintains a kind of object relationship with it. I have termed these psychosomatic disturbances "acting out equivalents." S. H. Frazier (1965) also described psychosomatic illness as a form of acting out expressed in body language.

At other times, a dream may function as a container that tends to free the individual from increased tension. As we have seen, acting out seeks to discharge unbearable impulses and emotions, but this objective is not always entirely accomplished and must be complemented through evacuative dreams.

An interesting manifestation of behavior related to dreams was provided by Sterba (1946), who reported acting out behavior in patients which preceded the narration of a dream of the night before. Clear examples demonstrated that this acting out was closely related to the dream content. Sterba stated: "The close connection between the acting out and the dream gives the impression that the acting out functions like an association to the dream. . . . Actually, the acting out as well as the dream [report] which it precedes are both the expression of the same unconscious instinctual dynamism which succeeds in breaking through the repressing forces of the ego, particularly when the defenses are loosened up through the analytic work" (p. 179).

Acting out sometimes appears after the dream as an evacuative complement to it. In this sense, I agree with Segal (1981) in

her remarks on predictive dreams. Apparently, these dreams do predict the action, in that what has been dreamed has to be acted out. The acting out repeats almost literally the content of the dream. Possibly we are dealing here with dreams that have not been entirely successful in their evacuative function and, as a result, conflicting aspects are retained in the patient's psyche which he seeks to evacuate altogether through the acting out process.

An adolescent patient, whose case I supervised, reported the following dream at the end of a session, the day before an examination at the high school where she studied:

> I go into a bar with my sister and some friends. They sit at a table and I try to buy a pack of cigarettes from a vending machine. The machine doesn't work and I keep on putting in more coins and taking them out uselessly. I waste a lot of time. Meanwhile, the others have finished their drinks and have gone away. My sister tells me not to waste any more time and that we should go to a high-class restaurant to eat, but since it is very expensive, she suggests that we eat our own food that she brought with her.

During this period of analysis the patient felt as if she were a "robot," incapable of thinking, feeling, or living up to the expectations that she and others had for herself. She wasted her time on sterile efforts to obtain unnecessary things, while she wasted opportunities to establish positive links sitting at a table with the others. She rejected the food of the restaurant-analysis, thinking that it is more beneficial to eat her own lunch and not the one that her analyst offered her.

The dream attempted to evacuate into the analyst her feelings of anxiety and depression, because she felt that she was a machine that did not work, with a masochistic tendency toward failure, in spite of having resorted to manic and omnipotent defenses that placed higher priority on "her own food" in deprecation of the analytic meal. Thus, she told the dream at the end of the session to avoid having the analyst serve her up a

meal-interpretation. In any case, it seems that the evacuative purpose of the dream was not successful, since the following day her anxiety continued and she acted out, failing the examination, like the machine that did not work in the dream.

For Greenson (1966), acting out is similar to dreams. It would be a form of sleepwalking, a dream in pantomime. It affords the patient not only the opportunity to repeat his past, but also to modify it.

In patients with a tendency to act out, it is possible to discern, paradoxically, a fairly good perception of reality which enables them to grasp with accuracy what happens in the depository objects. We might say that they "transform" reality in elements of the primary process with elements of the secondary process. Acting out would be a dramatization of a dream through which the patient tries to modify the object alloplastically in order to transform it from something autonomous into a depository. Acting out would then be a dramatized dream acted out during wakefulness: a dream that could not be dreamed.

The term "acting out" usually suggests the pejorative connotation indicating the resistant behavior that attacks the analytic process and that is characteristic of some patients in analysis. Its communicative and adaptive nature is not always sufficiently taken into account. Acting out, like any verbal or nonverbal expression furnished by the patient, is also a source of information and should be viewed with the analytic attitude we reserve for dreams. Naturally, we cannot overlook the obvious differences between the two phenomena, particularly regarding the possible dangers of acting out and the tactical changes it may require in therapy (Grinberg and Rodríguez-Pérez, 1982).

In conclusion, we should not forget Freud's (1911) discovery that action makes thinking possible. Thought appears in the mind after motor discharge can be delayed. For this reason, all thought retains an aspect of action. In certain patients, some psychic elements can become recognizably mental only through actions that later become thoughts.

The model for discharge by means of projective identification

is the one that best expresses the essence of the psychic phenomenon of acting out. Patients who cannot bear the increase in psychic tension seek its evacuation in external objects through intense projective identifications that erupt in them, triggering, at times, "projective counteridentification" reactions that reveal themselves as acting out with the analyst himself.

In several previous articles (Grinberg, 1956, 1962, 1965, 1985) I have studied the nature and evolution of the phenomenon of projective counteridentification. I have used this term to mean the specific response of the analyst in succumbing to the effects of the patient's pathological projective identifications. In this response the analyst "sees himself carried along" passively to play out roles and to experience the affects that the patient, in an active though unconscious way, "forced" into him.

Bird (1957) pointed out a specific peculiarity common to all acting out that includes a bipersonal interaction. He stated: "An acting-out patient always tries in every possible way to get the analyst to act out with him, and in some measure will invariably succeed" (p. 635).

A Clinical Illustration of Acting Out and Evacuative and Elaborative Dreams

I shall now present clinical material of a patient who showed a strong tendency toward massive acting out. During the first period of his analysis he seemed to be identified with an idealized, omnipotent object. His ego-syntonic acting out consisted in attacking the analytic relationship in the belief that our respective roles would thus be distorted and reversed. He could not tolerate his therapeutic dependence, which he felt cruelly humiliating. He therefore denied it and projected it onto me.

During this period I had to be very careful not to fall into projective counteridentification reactions. In the course of the sessions the patient would deliberately conceal and distort the material. Later on, he himself called this behavior "attacks through omission." The "attacks through silence" were also fre-

quent. He would then keep stubbornly silent for some time, thus testing my ability to tolerate waiting and frustration. He sometimes responded to my interpretations with apparent "deep understanding." It was not, however, genuine insight but intellectual understanding or pseudo-insight of which he availed himself as another form of acting out in order not to face the truth. Acting out outside the sessions took place usually on weekends and other intervals, due to the reactivation of his separation anxiety. This consisted mainly of extra-marital sexual relationships. He sometimes spoke of his episodes of acting out as if they were dreams, with overtones of the dream-like atmosphere that prevailed in them.

He alternated his acting out with somatic illnesses, generally renal colics, feverish states, and precordial pains. As regards the latter, he said that he had been greatly disturbed to learn that the cardiovascular apparatus is the only system that is "entirely closed and does not allow evacuation." His acting out somatizations grew worse after his father's death. This, in turn, threatened him with death. To protect himself, he felt the need to resort again to acting out in search of containers (other than his own body) for his destructive impulses. But ultimately, somatizations as well as acting out would turn out to be catastrophic because they would lead him to death or to murder. If he could not resort to either of them, he found he was at a "dead end." This made him feel a claustrophobic anxiety because of his massive identification with the contents and feelings which were "under pressure" in his psychic apparatus. His acting out was then experienced as an attempt to break away from this no-exit situation.

I shall now discuss the circumstances in which this patient had one of his "evacuative dreams" in order to protect himself against his intolerable affects and fantasies.

The patient told me about this dream after a sexual acting out due to his failure to tolerate frustration when faced with the separation of a long weekend, which reawakened previous experiences of abandonment and deprivation. His reaction had

been intensely persecutory with aggressive fantasies that sprang from jealousy and envy. He had this dream during the weekend. As I had already told him I would be away for Monday's session, everything was related to the transference situation at that time. He fancied I would take a trip with my wife. He reported the following dream in Tuesday's session:

> I dreamed of a harvesting machine which, as if having suddenly gone wild, ran over two pigs. I heard the noise and horrible squeals. I saw their bodies and bellies cut open by the reaping blades. It was really ghastly. They looked like human pieces. I picked up some of the torn pieces. They looked like a child's buttocks.

The analysis of the associations to the dream showed that the harvesting machine represented an aspect of himself that had harvested the nourishment and love provided by his mother's breasts and by his parents. But driven by his frantic greed, envy, and oedipal jealousy, aroused by exclusion from the parental couple (my wife and me on a trip), he had projected his excremental fantasies onto the couple, thus turning them into a couple of pigs (as in the myth of Circe), which he degraded and tore at with his teeth. The noise and the terrifying squeals also corresponded to his fantasy of a sadomasochistic primal scene. The pigs represented, in addition, the two breasts attacked by his oral-sadistic and anal-sadistic fantasies and were transformed into buttocks in the same way the milk was transformed into excrement. Some parts of his self had also suffered the consequences of his degrading and sadistic attacks so that they too appeared as pieces of buttocks.

Unable to cope with a longer weekend separation, he had impulsively fallen into a sexual acting out before the dream. He reported that he had been struck by the way intercourse had developed, laying emphasis on how roughly he had taken hold of the woman's buttocks. He was thus reproducing a fantasy of anal coitus through which he had dramatized his fantasy of the primal scene.

As we can see, the dream shows evacuative characteristics and belongs to the primary process in which magical thinking and the pleasure principle prevail.

As his insight into the nature of his acting out episodes deepened and the effort to overcome them increased, there was an attempt to deal with his conflicts at the level of thought and emotion rather than action, as was revealed in the following elaborative dream:

> I was in your consulting room and saw my car in your waiting room. I started the engine and realized something had gone wrong with the "head" motor valves. I got out and looked to see if there was smoke coming out of the exhaust pipe. But, to my distress, I saw black oil coming out, messing up everything and burning the carpet. Then I went out and met some workers on the street who were trying to raise a car placed on a scaffold to the highest part of the building. I wanted to help the workers, and so I did.

It was clear from his associations that the car stood for himself, with his damage-illness in the head expressed by his acting out, experienced as uncontrolled anal activity. Due to his identification with the image he had of the analyst, he used his "powerful mind-motor producing flatus-exhaust interpretations." But when the omnipotence was curtailed by his being made to see the mess he made of the analysis, his adult part resumed control and was able to help in the work of lifting the "car" to the highest part, thus restoring the connection between his and the analyst's mind, and the mother's breasts, not her buttocks. In this way he offered to cooperate with his analyst so that his conflicts might be treated and finally resolved at the "higher" level of mind and thought instead of at the "lower" level of acting out.

Elaborative dreams like the one I have just described show, as Bion (1962) held, that dreaming is the equivalent of thinking. It is the ability to pour one's attention into the internal world. The creative process contained in this type of dream generates the

meaning, as Meltzer (1984) pointed out, which will later be unfolded in life and in relationships with the external world. Elaborative dreams show how problems are posed, elaborated, and solved.

In sum, this attempt to classify dreams has two primary vectors: the associative sequence of the transference-countertransference context, and the correlation between the manifest and latent contents studied comparatively throughout the analytic process.

The difference proposed by Merleau-Ponty (1957) between "spoken" words with a coagulated sense, proper to verbal actuation, and "speaking" words, alive, assumed and created by the patient in free association, is similar to the distinction we wish to establish between dreams "already dreamed" (evacuative) and "dreaming" dreams (elaborative).

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SOME NOTES ON INSIGHT AND ITS FAILURES

BY MILTON H. HOROWITZ, M.D.

Many patients who had been in a prior psychoanalysis or psychotherapy have a view that "insight" has not been useful to them. The previous treatment has often been condensed into a screen memory serving a variety of functions. An attempt is made in this paper to explore problems of the effectiveness of insight and its relation to a range of ego functions, transference issues, and related fantasy systems.

A striking number of patients who had been in one or more psychotherapies or psychoanalyses had the opinion that they knew "all about" themselves and that the knowledge had not done them any good. They were very skeptical about future psychoanalytic investigation of their continued sufferings. With some regularity, they tended to view "insight" as useless, and many of them wanted to be referred to someone who would deal with "current" problems and not with the "past." Careful investigation of such patients' knowledge of their autobiographies was disappointing to both patient and consultant. Their "insight" seemed sparse, fixed in structure and content, and tended to be limited to a few historical events early in life. Often the "insight" focused on either a single external event or a few events which were viewed as catastrophes. It was difficult to get any fullness of detail, and the "insights" often seemed two-dimensional and trivial. Full of contradictions, the narratives were told, nevertheless, with conviction. Repeated attempts at further exploration led to a stereotyping of response.

A related and similar state of affairs may be seen with certain other patients during an ongoing analysis. The patients complain that knowing about themselves is of no help. Their "insights" seem to be personal clichés (Stein, 1958). Of all the potential rich tapestry of intrapsychic experience revealed in the analysis, some patients seem to have chosen a few details of history, almost always of external and interpersonal content, and created a simple explanatory formula. It is of little heuristic advantage to view these phenomena simply as intellectualizations used for defense. Nor can we pass them over as artificial obsessional symptoms developed in response to inexact interpretation (Glover, 1931). The awareness of the complexity of intrapsychic experience, of the multiplicity of conflicts arising out of long developmental vicissitudes, all seem pushed aside. The "insights" are simplified reconstructions of personal history resembling genetic interpretations and only rarely have dynamic content. When dynamic issues are presented, they, too, tend to be formulaic, for example, "My depression is repressed rage."

These stereotyped "insights" bear a structural resemblance to screen memories, and they may be demonstrated to serve a wide variety of functions. They are rubrics or chapter headings of experience and fantasy. Like other screen memories in which a sequence of conflict, defense, and substitution involving a compromise takes place, these "constrictions" offered by the patient are built like a neurotic symptom and serve functions of both resistance and discharge in the current analytic situation. Freud's (1899) analogy between screen memory and symptom led him to question the very nature of childhood memories. He asked if we have any memories *from* childhood or only memories *relating to* childhood. Furthermore, he wondered if childhood memories *emerge* or are they *formed* retrospectively. Similar questions may be asked about the content of our patients' sparse "insights." But are these responses so different from those experiences of insight developed in the transference situation which lead to significant structural and functional

change? Are they as useless as the patients claim, or, like screen memories, do they contain a world in a grain of sand?

A series of recent papers has illuminated many aspects of the problem of insight. Abend's (1979) study of patients' fantasies of "cure," Arlow's (1981) contribution on fantasies of pathogenesis, and Stein's (1981) paper on unanalyzed aspects of positive transference have all pointed to the problems posed by insufficiently examined fantasy systems. These papers have all clearly indicated the need for increased technical refinement in the exploration of the fantasy structures of the analyst as well as of the patient. Therapeutic preconception colors technical behavior.

The role played by the analyst's interpretive interventions in establishing insight is paralleled by the study of the patient's own capacity for self-observation, discovery, and integration. Here, we may focus upon the development of the patient's analyzing and integrating functions and the consequent expansion of the autonomous ego.

The growing experience of re-analysis allows the issue of insight to be explored in the current transference situation by the analysis (and resistance to exploration) of *previous* transference situations. The problem of recovery of memory and patterns of memory touches not only on childhood but on the relatively recent past. Screen memories are not only about childhood. It is usually difficult to acquire any useful picture of what happened in a prior analysis. Sometimes largely forgotten in a manner analogous to the forgetting of a dream (Stein, 1965), the only available residue of the prior analysis may be a formulaic statement serving as a *recent* screen memory. Patients in re-analysis often tend to be dismissive of these memories and offer varying degrees of resistance to examining them, focusing instead upon the *person* of the previous analyst. Frequently, the patient tells an accusatory anecdote in which the analyst was discovered to be "imperfect" and the patient's narcissism was wounded. Another version of this problem has been repeatedly seen by me in supervisory situations where a prior psychotherapy has been

"converted" into an analysis with the same analyst. Here, difficulties are often encountered in the search for what had transpired during the psychotherapy. The prior treatment may be trivialized or dismissed, or it may be sequestered and even treasured. Access to the prior experience may be shut off by resistance on the part of both participants. The prior psychotherapy seems to become a walled-off foreign body.

Re-analysis and study of the previous treatment experience offer a special opportunity to explore the function of insight. A complex clinical experience, presented in vignette, outlines the major problems. In this example, the focus is upon the phenomenon of clichéd, reductionistic "insights."

Two years after the completion of a five-year period of psychoanalysis with another analyst, a thirty-two-year-old woman asked for a consultation. She announced at the outset that she knew all about herself and that it had not helped. She had recently interrupted a love affair with a man two years her junior. She now felt depressed and angry. She provided very few details of her recent life, and her anger soon focused upon the previous analyst. She viewed him as well-meaning but unperceptive. When asked what she had learned about herself in the analysis, she gave a few sentences of cliché formulation and capped it with a statement of closure: "That's it!" Upon reflection, she was startled that she knew and remembered so little. Her self-knowledge centered upon the birth of her younger and favored brother and, in her words, her "supposed penis envy." These sparse comments were meant to serve as an explanation for her depression, low self-esteem, career inhibitions, and difficulties in love. She found her "insights" to be of no particular use, although she believed them to be true. In the subsequent period of re-analysis, the patient found that her synoptic view of the previous treatment was indeed analogous to a précis-like fragment of a forgotten dream. In a manner resembling the dream work of condensation, a few elements came to represent the entire experience of the analysis.

This screen memory of the analysis and the recent past was

based upon screen memories of her mother's pregnancy and the brother's birth. This façade defended her against awareness of earlier experience of childhood eczema, thumb-sucking, and difficulties in bowel training, all of which contributed to elaborate fantasies in which damage at the mother's hand was a repetitive feature. The initially offered insights resembled highly condensed inexact interpretations. She became able to recall her behavior in the prior analysis where she had great difficulty in free association, rarely remembered dreams, and had long periods of silence. She now viewed herself as a poor self-observer despite an adolescent tendency toward introspection. This introspective phase became characterized by her as wallowing in self-pity. She remembered how much she had liked the first analyst during most of the treatment. However, the ending of the analysis had been an angry re-enactment of the disappointment in love experienced with her mother. This was accompanied by an unreported fantasy that she was replaced by a male patient. Her life history had been re-enacted upon the stage of the analysis, but she had not provided the analyst with sufficient data with which interpretations might be made.

The analysis of the transference in the first analysis took place in the transference situation of the second analysis. The seemingly sterile intellectualizations were in fact like "emblems" of a rich life history and an elaborate masochistic fantasy life. In the day-to-day analytic work she demonstrated what we both came to call "reductionism" as a resistance. Dreams were presented in a few words, the experience of the prior day in a few sentences. This laconic style became the subject of long exploration, and its origins seemed to be in fending off what she felt were her mother's intrusive questions. In her work, we recognized a parallel process. Though gifted as a writer and capable of inspired beginnings and story outlines she was unable to elaborate upon plot structure. Here too, she had re-enacted early conflicts and fantasies by condensation and "reductionism." Her seemingly useless "insights," demonstrated to be a product of a process analogous to the dream work of conden-

sation, could now be re-expanded into colorful detail. Her inhibition in writing seemed to melt away.

The vignette illustrates some major issues that need to be examined in future studies of insight: first, those ego functions—especially self-observation—necessary for analytic work; second, the childhood antecedents of specific defensive tendencies; and third, how fantasy and acting out shape the transference and the potential for transference interpretation. What follows are some sketches of ideas about this wide subject.

THE STRUCTURE OF INSIGHT

Kris's (1956a) paper on the vicissitudes of insight presented us with a wide spectrum of problems to be studied. He described insight acquisition and its miscarriage in both defense and in drive discharge. Moreover, he sought to link experiences of insight with infantile prototypes. A centerpiece of Kris's work was his aphoristic idealization: "the good analytic hour." This rare phenomenon where a multiplicity of elements seem to fall together into a creative entity (often seeming pre-prepared) was viewed by Kris as a triumph of the integrating and organizing functions of the ego. Thinking old thoughts in a new way and thus leading to new thoughts bears a suggestive similarity to the process of scientific theory formation.

The oscillating flow of data from present to past and back again in fused new forms reminded Kris of what Anna Freud termed the telescopic character of memory. The acquisition of insight, the processes of memory (Kris, 1956b), and the need for causality (Nunberg, 1931) are seen to be interrelated. The "good hour" is a rarity, an ideal toward which we strive. Even the "almost good hour" is not frequently experienced, and such creative bursts do not appear as often as the more usual ebb and flow of tiny bits of insight. Here, as in other aspects of analysis, we must depend more on the quiet establishment of patterns rather than blinding revelations.

At the beginning of this century, when symptom-formation

in hysteria was Freud's central model of psychoanalysis, the recovery of memories of traumatic experience was the major technical task. Insight and recovery of memory were then synonymous. Freud's initial environmentalist hypothesis was of a single-event trauma and repression of its memory, to be cured by a single-event specific memory and its attendant affect achieving consciousness. The complexity of the individual's history of drive development, of ego development, and of object relations with representations in multifold fantasies and conflicts make us aware that we cannot single out specific simple causes for the patient's current behavior (Arlow, 1981). Nevertheless, both analysts and patients are attuned to the Lorelei of "specificity" and the lure of "reductionism."

The analysis of my patient with the laconic style may offer some perspective upon the infantile roots of this problem. She was of precocious verbal ability. The earlier described model of being unwilling to answer her mother's questions led to the study of the patient's own insatiable curiosity. She asked endless questions and wanted what she called "explanations." She recalled being irritated by her father's overly detailed answers and pleased by her mother's terse responses. The question of how babies were born was "too complicated" for her, and her father's biological version was "unbelievable." However, her mother's answer: "Babies are born in the hospital" was very satisfying since it corresponded to her own fantasy that the doctor would open her mother's belly-button and the baby would emerge. As she grew older, she developed a life-long aversion to "science" and a love of fiction and poetry. Poetry was especially pleasing because of the economy of representation and the quality of ambiguity. Her development of language and cognitive functions bore a close relationship to her style of defense. She claimed that she was bored by details even about her own life. Any interpretation offered to her that was longer than a single sentence caused her to be irritated and restless. After several years of analytic work, her heightened capacity for self-observation and new interest in detail led to a process she termed

"discovery." She would find by herself issues that had in the past been the subject of the analyst's interventions. She did not want to be "told," she wanted to "find." She developed a sense of wonder at the intricacy of her mind and the complexity of her development. Her initial total focus upon events surrounding her brother's birth became viewed by her as analogous to a Japanese "haiku": deep observations stated in a few syllables. In this example, we may examine the complex interplay between a wide range of ego functions: perception, self-observation, memory, language, the need for causality, and those organizing and integrating functions which make for meaning, intelligibility, and structure.

Kris (1956a) had described the process of insight following the crumbling of resistance structures. The ability to reconstruct the past psychoanalytically as a pathway to insight involves not only the function of memory but a wide range of other ego functions. How ideas are laid down in memory will depend upon the stage of ego development in which they occur and upon the subsequent stages in which they retrospectively acquire new meanings. Memory traces primarily visual in content seem to have a different structure and fate when compared to memories after the consolidation of speech. The ability of the child to use accurate sequential ordering of perceptual data may be a variable acquisition. This capacity seems necessary for a reality-oriented sense of causality. The concepts "before" and "after" are integral to the sense of reality. Some of the telescopic aspects of memory seem to depend upon the confusion of what is "before" and what is "after." The source of the confusion may be developmentally as well as defensively determined. The use of inductive and deductive logical methods have their consolidation in late latency, but some individuals' development of cognitive functions may follow highly individual timetables. Children who have had markedly skewed development of the functions of abstract thinking and concept formation show special difficulties in the analytic process in adulthood (Kafka, 1984). Learning difficulties in childhood may be the conse-

quence of a neurobiological disorder which manifests itself later in an analysis in the inability to make sense of one's experience.

Where in the past we have examined individual differences in the functions of defense, now we are alerted to the further study of individual differences in a wider range of ego functions. Language development, auditory memory, concept formation, and logical narration are not uniformly spread among individuals, and significant maturational differences of these abilities can be noted. In analytic work, skewed aspects of development will then require the more extensive examination of intrasystemic conflicts in the ego. What we have globally designated as integrating functions of the ego may now be more profitably studied as a group of subfunctions. To create an entity from disparate data turns out to be an extremely complex task.

Kris (1956a) had placed three interrelated ego functions as central to the unfolding of insight. He referred to the "control of temporary and partial regression, to the ability of the ego to view the self and to observe its own functions with some measure of objectivity, and to the ego's control over the discharge of affects" (p. 450). Exploration of these functions may lead to therapeutically induced change or may demonstrate fixities which preclude analytic progress. Wide variations exist in these "analytic" functions, that is to say, functions which break down psychic data so that they can be reassembled in new configurations. Freud had been of the opinion that the analyst can only analyze and that the synthetic functions must be left to the patient; this view was echoed by Kris when he said, "We cannot guide patients in their 'synthesis', we can, by analytic work, only prepare them for it" (p. 453).

However, our greater knowledge of childhood development of ego functions offers us a new opportunity. We can more minutely examine the patient's modes of thought in the analysis, see characteristic patterns of narration and their relation to resistance, and explore fluctuations between free association and purposive thought. Certain specific conflicts in latency and pre-

puberty impair the development of logical thinking on the conscious level and integrating functions on the unconscious level. The study of insight is the closest that psychoanalysis has come toward developing a learning theory based on strictly *analytic* evidence. The role of the development of cognitive ego functions in latency and prepuberty has been relatively neglected in the analysis of adults. The tendency to look to earlier and earlier developmental phases in the search for pathogenic phenomena has seemed to have greater lure for analysts than has the much more accessible postoedipal period. Yet it is the ego-developmental consequence of latency and prepuberty that may make analysis possible or create such ego restrictions as to preclude analysis.

Superego development in this phase may also determine what can be seen, what must be kept secret, and what may be spoken. Even "how" something is said may have the stamp of latency superego development. It is the period in which euphemism and cliché develop and in which spontaneity may be severely inhibited by superego demand and by the need for peer approval as well. It is the developmental phase in which many children are taught "think before you speak," which one of my patients could recognize as the anlage of what Sterba (1934) described as the therapeutic split in the ego. As a child he had to learn to give thought to the consequences of his words; action was to be preceded by reflection. He had the experience of simultaneously feeling and thinking and yet observing himself long before he came to analysis. The process had high moral value for him and was related to his father's moral standards and expectations of civilized behavior. Here, the role of late latency in the processes of identification and superego formation aided the analytic work and simultaneously served as a resistance to spontaneity. We see similar results where the capacity for self-observation in certain patients is the outgrowth of identification with the analyst's observing functions, but is also immersed in libidinal and aggressive conflict and consequent fantasy formation.

Insight falters when the patient is intolerant of temporary and reversible regression. Self-observation becomes constricted and inhibited. In certain clinical states characterized by the fear of loss of control, the necessary analytic regression is warded off. A clinical example follows.

A young woman with a conspicuous phobia of crossing bridges and multiple fears of loss of control of both sexual and aggressive impulses began her second analysis with a series of facile rationalizations about her distress. Her pseudo-explanations had the tone of pronouncements or dicta. Some had antedated the first analysis, and some had come out of interpretations made to her. She was afraid to use the couch, hesitant at attempts at free association, and remarkably unobservant about herself. She could not tolerate going to plays or movies, nor could she read novels. She read only for information. She had, as a child, found stories too exciting and was more comfortable with facts. Hyperactive in early childhood, she had been aggressive and given to temper tantrums. She could not examine her own behavior in the analysis but became a condemning observer of the behavior of others. Her condemning attitude was projected in the transference, and examination of her transference fantasies led to the understanding of a pattern: she could not tolerate being in a situation whose outcome was uncertain. She could not read if she did not know how the story ended, and she was fearful of what her thoughts would expose. Her fears of loss of control and of horrid consequences had multiple meanings in a wide range of fantasies.

As the analysis of her fantasy life progressed, her symptoms receded. She was more able to associate and to observe her inner life. The clichés fell away in favor of her examination of her transference fantasies of violent sexual content and her concomitant fears of retaliation. However, this newfound ability showed frequent reversal, with the anxiety of having "gone too far." Insight was fluctuant and easily reinstinctualized. The insight would lead to self-condemnation, a phenomenon which seemed linked to negative therapeutic reaction. She would then

fall back upon intellectualization, and there remained a significant limitation in the ability to sustain insight. Though she experienced profound symptomatic relief, there were gaps in her "analyzability." Though I was tempted to fall back upon the concept of "excessive strength of the drives," I found that a non-explanation. The patient was satisfied with the therapeutic result, but significant areas of her development remained murky at the termination of the analysis. Regression "in the service of the ego" remained elusive to her.

The inability of certain borderline patients to tolerate feelings of shame may lead to special difficulties in self-observation. Such a patient came to see me shortly after ending a long analysis. She seemed unable to describe anything about the treatment and could not give a coherent account of what led her to seek the treatment in the first place. She could talk about the analyst and described her with great vividness as a motherly woman with ample breasts. She then remembered lying on the couch in silence listening to the slightest sound from this woman who was much admired. The patient was afraid that she would be silent in a new analysis. In an extended consultation lasting some weeks, she described a series of events in which shame was the central emotion. She began the analysis with trepidation, slowly discovering that her difficulty in self-observation in the previous analysis was defensive against her sexual excitement in the presence of women with large breasts. She felt humiliated by exposing this interest. As a small child she had watched her mother nurse a baby sister, and she wanted to be fed as well. She asked her mother for a suck and was rebuffed. This was the model for many diverse episodes of shameful response. Violent fantasies of revenge toward mothers and babies, analysts and patients, were hidden behind her excitement. During the subsequent analytic course, the arousal of conflicts in the transference which contained components of shame or guilt regularly switched off her self-observation, leaving her silent and feeling stupid. At such moments all the previous work of insight seemed as if "written on water" and disappeared, only

to reappear as interpretations centered upon her shame. As with many other borderline patients, her grandiose self-representations and expectations and their discrepancy with her actual personality made her specially vulnerable to shame.

In many patients, the inability to modulate affect discharge is a substantial barrier to the process of insight acquisition. In my experience, it is significantly more difficult to effect analytic change in patients' intolerance to shame or guilt than to modify their anxiety responses. This corresponds to the not infrequent clinical link between moral masochism and disorders of self-observation. In life experiences moral masochists are often oblivious to the consequences of their wishes and actions. Life is always surprising them with new pain. The unconscious nature of the need for punishment and the fantasies which stir that need present us with some of the most profound resistances to analysis. In this setting, negative therapeutic reaction can grind the work to a halt. Freud's technical suggestion that the unconscious guilt of the moral masochist must be made conscious is notoriously difficult to achieve. However, unless those pathogenic fantasies which lead to superego condemnation are made conscious, the self-observing functions necessary for insight may remain paralyzed. Here, the task is rarely accomplished by the analysis of situations outside the transference setting. Sado-masochistic fantasies with the need for punishment seem only to be accessible when the object of the fantasy is present in the form of the analyst and the impulses have a vivid immediacy. Perhaps fantasy, affect, object, and self-observation need to be sharply confluent in order to lead to understanding. Fortunately, the analytic situation provides a unique opportunity for both achieving that confluence and permitting interpretation.

THE RESPONSE TO INTERPRETATION AND THE PROCESS OF INSIGHT

The analytic procedure is a joint undertaking between patient and analyst. We ask the patient to attempt the process of free

association not because we literally expect uncensored data but because we await the inevitable conflicts to which the request gives rise (A. Freud, 1936). Those conflicts themselves become the subject of the analysis in the study of resistance. However, without the analyst's interventions, of whatever sort, the process soon comes to a halt. The analyst's interpretations (particularly those directed toward resistance) assist in modifying the patient's censorship and allow greater correspondence between associations and the primary process. The shared scrutiny of the transference situation permits the analysand more accurately to relate present to past and to see the dynamic value of fantasy and behavior in the analytic setting. Interpretation tends to heighten the self-observing functions by providing new tools for the task. But it is the patient's specific response to interpretation that will be decisive; merely to provide him with new tools does not mean that the patient will use them to build his own structure.

Interpretations, by their very nature, are merely provisional explanatory hypotheses. Whatever our own sense of conviction of the "correctness" of an interpretation, it must remain tentative as we await the patient's response. No one should be disappointed by the limitation on the part of the analyst. Accuracy is determined by the patient, not by the immediate response but by the process of conflict to which interpretation now gives rise. Therapeutic efficacy is among the least reliable of indicators. Thanks to Glover (1931), we have been aware that inexact and poorly timed interpretations may lead to considerable symptomatic relief. The inexact interpretation may function as an analyst-induced artificial symptom aiding defense or permitting drive discharge. Such a response tends to take on a fixed and stereotyped quality. The "process" stops, does not broaden or deepen. The interpretation has been swallowed whole.

By contrast, there is another realm of response. Here the issue is not merely one of acceptance or rejection, increase or decrease of resistance, or the patient's attention to the whole or to parts of the intervention. Instead, we might focus on the

events and the patterning of the process that ensues. (The very method of hearing the interpretation may depend upon the analysis of a range of ego functions.) It would seem, from certain successful analyses, that responses to interpretation leading to useful insight undergo continuous revision both during the analysis and following termination. Continuous revision allows for the patient's own discoveries and is linked to the patient's own memories and reconstructions of his or her biography. The analysis of broad structures of resistance allows the patient to become a discoverer both of personal history and of new resistances. Insight tends to grow as resistance analysis becomes a shared task and not something the patient experiences as imposed by the analyst.

The process of discovery and insight may expand after the formal termination of the analysis. Spontaneous revisions of memory may be part of this post-analytic phase. A young woman psychotherapist saw me in extended consultation several years after the successful completion of an analysis with me. She was confronted now with a series of conscious conflicts between her career and the needs of her children. In the course of several meetings she reported that about a year before the consultation she had been watching her children play "nurse and doctor" by decorating themselves with bandaids. She suddenly remembered a detail of a childhood experience that surprised her. She recalled a minor childhood injury in which she had been very frightened. Her family physician reassured her and calmed her fear. She realized that she had identified herself not with the doctor's person but with his reassuring manner. She had long been aware of the role played by the doctor game and sexual curiosity in her career choice, but the role of identification with a helpful calm adult turned out to be decisive in her career. Here, identification served not only defensive but adaptive needs. The memory was a new one and had never appeared during the analysis. Here too, the insight grew in usefulness. The process begun in the analysis continued in self-analytic response containing identifications with the analyst's analyzing

functions, *not* with his person. Review of these post-analytic issues led to a creative resolution of her career conflicts and an opportunity for greater closeness to her children.

THE VULNERABILITY OF INSIGHT TO REGRESSION

Insight is a fragile acquisition, easily subject to regression and dismantling. What is seen clearly today becomes murky tomorrow. Easily forgotten, it is often reclaimed at another time. One cannot expect a linear progression in personal hypothesis formation any more than one can believe the myth of linear development in the unfolding of scientific theory (Kuhn, 1962). What makes for this unstable vulnerability in what has been analytically learned?

Neurotic repetition of behavior as examined in the transference is not a mere automatism. Old behavior patterns are repeated because old circumstances leading to that behavior are re-created in a living form. The repetition is not exact but is modified to the new reality of the transference. The reactions to the analyst as the object of fantasies (and their drive origins) push insight forward and pull it back. Insights help expand the autonomous sphere of the ego, but newly generated fantasies toward the analyst emerge in the wake of insight. The autonomous sphere contracts with the new "re-instinctualization" of the analytic situation. Insight opens the path to fresh dangers leading to new waves of defense. The new acquisitions, instead of being reassuring, evoke new anxiety and insight is again masked.

A brief clinical example illustrates this common problem of ebb and flow of insight. A young woman with an obsessive fear of hurting her children had a series of transference fantasies in which she saw me as erratic and crazy. With much difficulty she was able to talk about her mother's severe mental disturbance and the alcoholism which was a family secret. She could see the

displacement in the transference and her own identification with her mother's instability. The new insight soon succumbed and was swept away as the patient became depressed and thought I was angry with her. She felt guilty about exposing her mother, having told me what she wanted to tell her father in childhood. Upon the analysis of this specific conflict of loyalties engendered by "telling" mother's secrets with all their oedipal-phase implications, her insight into displacement in the transference reappeared. She could again see me as helpful and not like her mother. Interpretation and partial insight may lead to new conflict and stimulate fresh waves of defense, focusing upon the transference.

The transference situation and the analysis of resistance are not only the major sources of data leading to insight, but they may also be the chief source of new resistance to the development of ongoing processes of insight. Insights are then lost, to be discovered anew by examining newly exposed resistances and new transference fantasies.

CONCLUSIONS

There is no one path toward insight. Each patient must traverse a personally unique method, and that journey will be determined by the structure of the neurosis. The same forces which govern conflict and compromise formation in symptom, dream, and screen memory will govern insight formation *if* artifacts are not introduced by the analyst by technical manipulation or role playing. Each patient has formed a developmentally idiosyncratic style of conflict resolution, and part of the analytic work is to facilitate exposure of its patterning and origins. Bibring (1954) described the analytic process as one in which the pathogenic conflicts are re-experienced on the conscious level. His comment underscores the view that psychoanalysis is a data-gathering method which utilizes the transference to inform both present and past. Part of the technical difficulty in con-

ducting an analysis is to create what Kris termed a "climate" for the transference to unfold according to the patient's own psychic structure. In the appropriate "climate" each patient's analysis is unique and different. Central to the optimal "climate" is the necessity of the analyst's not clouding the picture by therapeutic preconceptions and premature diagnostic categorizations. We come to understand the individual structure of neurosis by analysis and not by initial anamnesis. The natural corrective to global conceptualizations by either analyst or patient is the piecemeal revelation of shared analytic work. In a general way, where the transference is pushed from within and develops with relative spontaneity (depending as little as possible upon the technical behavior of the analyst), the sense of conviction about historical origins in the past and dynamic repetition in the present is strong. (Here, the "past" includes the entire longitudinal developmental history. This may include prior analysis.) Insight developed in this setting becomes part of autonomous ego functioning and is not easily destroyed. It is the consequence of shared conscious experience in the present, illuminating the past. It is characterized by a simple descriptive fact: no two cases sound alike.

In contrast, where insight hinges primarily on the analyst's behavior and interventions, deep conviction about the "present" situation may develop, and the patient often contrasts this with a picture of the distant past in which a limited and specific theory of pathogenesis predominates (Arlow, 1981). Often, this is a theory of parental mistreatment and is contrasted with analytic care. Insight in this setting may depend upon the maintenance of the transference connection and is object bound. It is unlikely to become autonomous and is likely to take on a fixed symptom-like structure. Nevertheless, it may be powerfully therapeutically effective. The structural change it may effect can often be understood as a shift in identifications. In several such cases that I was able to study in re-analysis, the patient identified with the personalities of the analysts and not

their analyzing functions, a process which leads to discipleship or enmity but not to autonomy. Discipleship gives a strange uniformity to case histories. Discipleship also poses special problems for training analysis. In this setting distortions of "insight" are not so much related to the establishment of a meaningful psychoanalytic autobiography as they are to a reverence for a meaningful therapeutic experience. The analytic process described by the patient is not about what the patient learned but what the analyst did. The story that evolves is not about autonomy but about object-bound fantasies.

Even where no manipulation of the transference has taken place, we often observe limitations upon the autonomy of insight. The most common example was described by Stein (1981) in his study of the unanalyzed residua of "acceptable positive" transference. The positive relationship to the analyst may serve as a defensive screen behind which lurk fantasies and impulses. Because one can live more easily with love of the object than with destructive impulses, it is aggressive conflict that is often behind the screen. Though the capacity for transference is never analyzed away (Pfeffer, 1963), we need to be aware that unanalyzed but re-enacted transference fantasies tug at insight and cause it to wither. The termination phase always shows us that old forces are still alive, partly changed in structure and function, but alive nevertheless. We remain the bearers of our history. Conviction and insight come with the "alive" quality of that history. Past experiences are not archaeological artifacts in a psychic museum. Sometimes that history is too unbearable and cannot be sustained in consciousness. The same psychic raw materials can generate both adaptive autonomous insight and varieties of pseudo-insight used for defense. Where the thorough attempt at the analysis of transference and of the wide range of ego functions may lead to the expansion of the ego, failure of transference analysis tends to lead to frozen restrictions of a range of ego functions. We have an opportunity to examine the very apparatus of personal learning. Re-analysis

or "better" analysis gives us a unique opportunity to question and refine our technique and its effectiveness in helping patients make sense of their lives.

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AN EGO PSYCHOLOGY-OBJECT RELATIONS THEORY APPROACH TO THE TRANSFERENCE

BY OTTO F. KERNBERG, M.D.

This paper summarizes an ego psychology-object relations theory and its application to psychoanalytic technique, particularly to the analysis of the transference. The relative importance of verbal, nonverbal, and generally relational "channels" of communication in patients with differing degrees of transference regression is examined. The use of countertransference reactions in formulating transference interpretations is reviewed. The relations between unconscious meanings in the "here-and-now" and unconscious meanings in the "there-and-then" are explored in the transferences of patients with varying degrees of severity of psychopathology. Differences with other theoretical approaches are highlighted throughout.

AN OVERVIEW OF MY APPROACH

Having spelled out my general theoretical and technical approach in earlier work (Kernberg, 1975, 1976, 1980, 1984), and having illustrated it with extended clinical material more recently (1986a, 1986b, 1986c), I will limit myself here to providing the briefest outline of that approach, to be followed by a description of its clinical aspects as applied to the management of the transference.

My ego psychology-object relations theory is anchored in the theoretical and clinical contributions of Jacobson (1964, 1967 1971) and Mahler (1971, 1972; Mahler and Furer, 1968,

Mahler, et al., 1975). I have also been influenced by Erikson (1951, 1956, 1959), Melanie Klein (1945, 1946, 1952a, 1957), Fairbairn (1954), Winnicott (1958, 1965), and Sandler (Sandler and Rosenblatt, 1962; Sandler and Sandler, 1978).

My theory of motivation adheres closely to Freud's dual drive theory, but considers drives indissolubly linked to object relations; I also consider the separation of source, pressure, aim, and object of drives, as in traditional metapsychology, artificial. I think that libidinal and aggressive drive derivatives are invested in object relations from the very onset of the symbiotic phase, that the ideational and affective representations of drives are originally undifferentiated from each other, and that affect states representing the most primitive manifestations of drives are essential links of self- and object representations from their origins on.

My theoretical formulation proposes that affects are the primary motivational system and, internalized or fixated as the frame of internalized object relations, are gradually organized into libidinal and aggressive drives as hierarchically supraordinate motivational systems. This concept distinguishes my position from the theories of motivation of the major contributors I have listed, but the emphasis on the central clinical position of affects is common to all of us. In my view, affects are constitutionally determined and developmentally activated primary motivators. I believe that after they have been integrated into the drives, they become the signals of drive activation.

Also in agreement with the authors I have mentioned, I believe that the internalizations of object relations are originally dyadic, and that self- and object representations established under the impact of various affect states are the building blocks of what eventually constitutes the id, the ego, and the superego.

In agreement with Jacobson and Mahler, I have proposed a developmental model for the conceptualization of the structural characteristics of psychotic, borderline, and neurotic psychopathology, and stressed differences in the structural characteristics of these three levels of emotional illness.

I have considered the ego, superego, and id the underlying structural organization of the classical psychoneuroses and neurotic characters and stressed that at this level the vicissitudes of impulse-defense configurations are predominantly expressed as conflicts involving the three psychic agencies and external reality. The oedipus complex is the dominant conflictual constellation that reflects the culmination of the development of sexual and aggressive drives in the context of the representational world of early childhood, and is crucially involved in the consolidation of the superego.

Patients with neurotic personality organization present well-integrated superego, ego, and id structures; within the psychoanalytic situation, the analysis of resistances brings about the activation, in the transference, first, of relatively global characteristics of these structures, and later, the internalized object relations of which they are composed. The analysis of drive derivatives occurs in the context of the analysis of the relation of the patient's infantile self to significant parental objects as projected onto the analyst.

The borderline personality organization, in contrast, shows a predominance of preoedipal conflicts and psychic representations of preoedipal conflicts condensed with representations of the oedipal phase. Conflicts are not predominantly repressed and therefore unconsciously dynamic. Rather, they are expressed in mutually dissociated ego states reflecting the defense of primitive dissociation or splitting. The activation of primitive object relations that predate the consolidation of ego, superego, and id is manifest in the transference as apparently chaotic affect states, which have to be analyzed in sequential steps (Kernberg, 1984). In summary, I wish only to stress that the approach to the interpretation of the primitive transferences of borderline patients suggested in my earlier work may bring about a transformation of part object relations into total object relations, of primitive transferences (largely reflecting stages of development that predate object constancy) into the advanced transferences of the oedipal phase.

Within my ego psychology-object relations theory framework, unconscious intrapsychic conflicts are always between (a) certain units of self- and object representations under the impact of a particular drive derivative (clinically, a certain affect disposition reflecting the instinctual side of the conflict) and (b) contradictory or opposing units of self- and object representations and their respective affect dispositions reflecting the defensive structure. Unconscious intrapsychic conflicts are never simply between impulse and defense; rather, the drive derivative finds expression through a certain internalized object relation, and the defense, too, is reflected by a certain internalized object relation.

At severe levels of psychopathology, splitting mechanisms stabilize such dynamic structures within an ego-id matrix and permit the contradictory aspects of these conflicts to remain—at least partially—conscious, in the form of primitive transferences. In contrast, patients with neurotic personality organization present impulse-defense configurations that contain specific unconscious wishes reflecting sexual and aggressive drive derivatives embedded in unconscious fantasies relating to the oedipal objects. Here, we find relatively less distortion both of the self-representations relating to these objects and of the representations of the oedipal objects themselves. Therefore the difference between past pathogenic experiences and their transformation into currently structured unconscious dispositions is not as great as is found in the primitive transferences in patients with borderline personality organization.

My emphasis is on the internalized object relation rather than on the impulse-defense configuration per se: the unconscious, wishful fantasy expresses such an object relation. The two ways in which, according to Freud (1915), unconscious wishes may become conscious (in the form of ideational representatives and as affects) are, in my view, evident in the relation between a self-representation and an object representation under the impact of a certain affect. Glover (1955), when he pointed to the need to identify both libidinal drive derivatives and ego- and

superego-derived identifications in the transference, was, I believe, pointing in the same direction. If the transference neurosis is expressed in (a) instinctual impulses expressed as affects and (b) identifications reflecting internalized object relations, then the object relations frame of reference I propose may be considered a direct clinical application of the metapsychological concept of the dynamic unconscious and the conditions under which it appears in consciousness.

The analysis of the transference is a central concern in my general technical approach. Transference analysis consists in the analysis of the reactivation in the here-and-now of past internalized object relations. The analysis of past internalized object relations in the transference constitutes, at the same time, the analysis of the constituent structures of ego, superego, and id and their intra- and interstructural conflicts. In contrast to the culturalists or interpersonal object relations theoreticians, such as Sullivan (1953, 1962) and Guntrip (1961, 1968, 1971), and to Kohut's (1971, 1977) self psychology, I conceive of internalized object relations as not reflecting actual object relations from the past. Rather, they reflect a combination of realistic and fantasied—and often highly distorted—internalizations of such past object relations and defenses against them under the effects of activation and projection of instinctual drive derivatives. In other words, there is a dynamic tension between the here-and-now, which reflects intrapsychic structure, and the there-and-then unconscious genetic determinants derived from the "actual" past, the patient's developmental history.

I assume that in all cases the transference is dynamically unconscious in the sense that, either because of repression or of splitting, the patient unconsciously distorts the current experience because of his fixation to pathogenic conflicts with a significant internalized object of the past. The major task is to bring the unconscious transference meanings in the here-and-now into full consciousness by means of interpretation. This is the first stage in analyzing the relation between the unconscious present and the unconscious past.

Rather than making a direct connection between currently conscious or preconscious experiences in relation to the therapist and the conscious past, or to an assumed unconscious past (as I believe self psychologists tend to do), I expect the patient's free associations to the uncovered unconscious transference meanings in the here-and-now to lead us into the unconscious past. I therefore suggest reconstructions to the patient in tentative and open-ended formulations that should permit him to proceed in any one of several directions.

My theoretical framework is expressed clinically in the way I listen to patients. My only expectation is that the patient's free associations will lead to the emergence in the transference of past internalized object relations superimposed on the actual interactions of patient and analyst.

I wish to stress again that I leave the question of assumed genetic origins in the process of uncovering the unconscious meaning in the here-and-now as open-ended as I can. Although it is true that the nature of the activated object relation itself points to its probable genetic and developmental origins, I think it premature to pin down this hypothetical origin before the patient's free associations and exploration of unconscious meanings of his behavior in the here-and-now have given access to new evidence. I am always acutely aware of the danger that any preconceived notions the analyst has may close this investigative field prematurely. A theoretical frame that locates dominant conflicts of the patient in a predetermined area or time seems to me to constitute an important limitation to the analyst's and the patient's freedom to explore the origins of the unconscious present in the unconscious past.

The Kleinian tendency to relate primitive defensive operations and object relations to the first year of life (Klein, 1945, 1946, 1952b, 1957), or Kohut's assumption that an ever-present fragility of the self is the primary determinant (Reed, 1986), or, for that matter, to consistently search for the oedipal determinants or for pathology of separation-individuation, etc., brings about an unwarranted narrowing of the interpretive

frame and limits the analyst's capacity for discovering and investigating the unknown.

CHANNELS OF COMMUNICATION OF THE TRANSFERENCE

The unconscious object relations that superimpose themselves on the actual one—the patient and the analyst working together within the jointly agreed upon boundaries of the psychoanalytic situation—might be either a variety of unconscious object relations in conflict with each other or a defensively functioning object relation activated against an underlying, contrasting one with impulsive functions. These unconscious object relations may emerge through various "channels." With patients presenting neurotic personality organization, and in the advanced stages of treatment of patients with more severe character pathology and borderline pathology, they emerge mostly from the patient's free associations.

Let me illustrate with a clinical vignette. Ms. A, an architect in her early thirties, consulted me because of chronic interpersonal difficulties in her work and a severe depression related to the breakup of an extramarital relationship with a senior business associate she described as being sadistic. Diagnostic evaluation revealed a hysterical personality with strong masochistic features. A happy early childhood relation with her father had turned into bitter struggles with him during her adolescence, in the context of his having severe marital difficulties. Ms. A saw her mother as an innocent victim. A sexually intolerant, suppressive atmosphere in the home had become internalized in Ms. A's own rigid repression of all sexual impulses until only a few years before starting her analysis: she was frigid with her husband and was able to achieve orgasm only in extramarital affairs.

A few weeks after beginning her analysis, her mood improved, and she now conveyed the impression of a nice, "innocent," submissive little girl who seemed eager to please the ana-

lyst. She was obviously trying hard to say whatever came into her mind, and the dominant content of her early free associations related to her work, particularly to her bosses, who seemed to her narrow-minded, biased, uninformed professionals, lacking an original, creative approach to design. She was so obviously dismissive of her bosses that she herself raised the question during a session whether she might be risking losing her job. She had, indeed, lost a job with another firm in the not so distant past because of her interpersonal difficulties.

When I said I was puzzled by the cheerful way in which she expressed her concerns over the prospect of being thrown out, she acknowledged a "dare-devil" attitude in herself, adding that this might indeed be dangerous but it was gratifyingly exciting, too. Further associations revealed her fantasies of meeting her boss, who would sternly notify her that she would have to leave, and whom she would then let know by means of subtle insinuations that she was interested in him as a man. This, in her fantasy, might lead to a sexual relation with him at the very time he was dismissing her from the business. It was exciting to be sexually involved with a man who had thrown her out.

I think this vignette illustrates the early emergence of a "nice little girl" attitude in the transference as a defense against the underlying temptation of a pseudorebellious, provocatively aggressive attitude toward a male authority aimed at bringing about an underlying, desired self-punitive sexual relation (presumably, with a sadistic father image). The fact that the apparently positive early transference relationship permitted the emergence of the underlying negative transference dispositions in the content of the patient's free associations, rather than directly in the transference relationship itself, actually gave us a lead time to elaborate this unconscious conflict before its full actualization in the transference. The focus on the contents of free association, on the communication of Ms. A's subjective experience, was the predominant communicative channel through which the unconscious pathogenic object relation emerged in the transference.

In patients with severe character pathology and borderline personality organization, the emergence of dominant unconscious object relations in the transference typically occurs by means of another channel, namely, nonverbal communication. This does not mean that what is verbally communicated through free association in these cases is not relevant or important, but rather that the nonverbal communication acquires economic (that is, affective) predominance in conveying information to the analyst.

A postgraduate college student in his late twenties, Mr. B, came for consultation because of chronic difficulties in relationships with women, uncertainty about his professional interests and future, and deep passivity in his work and daily life. Mr. B., in his early analytic sessions, dwelt on detailed descriptions of the altercations he was having with his present woman friend. My efforts to clarify further what the issues were in what appeared to me confusing descriptions of these arguments elicited ironic comments from him that I was slow and pedestrian and did not grasp the subtlety of what he was telling me. He also expected me to approve immediately the statements he had made and the actions he had taken regarding his woman friend. I asked why he felt the need for me to immediately support his actions or agree with his evaluation of her. He now angrily accused me of not being sympathetic to him and of being the traditional, poker-faced psychoanalyst.

Soon Mr. B also began to complain that I was not providing him with any new understanding that would permit him to deal more effectively with his woman friend. But when, after getting a better feeling for what was actually going on in their interactions, I did question his interpretations of her behavior and also wondered about the reasons for some of his behaviors, he accused me of taking her part, of being unfairly biased against him, and, in fact, of making his relations with her worse by undermining his own sense of security. He also offered me various psychoanalytic theories to account for his woman friend's sadistic behavior toward him. He pointed out to me that he him-

self was obviously a masochistic character and, with growing anger, that I was not doing my job—I was not relating what was happening to him now with his childhood experiences.

Although my initial diagnosis of Mr. B had been severe character pathology with paranoid, narcissistic, and infantile features—and I was prepared for stormy transference developments—I was taken aback by the intensity of his complaints and accusations, and I became increasingly cautious in making any comments to him. He immediately perceived my cautiousness and accused me angrily of treating him like a "sickie," rather than being direct with him. I then focused on his difficulty in accepting anything I said that was different from his own thinking, pointing to the internal conflict he experienced in his relationship with me: he very much wanted me to help him and to be on his side while, at the same time, he experienced everything that came from me as either hostile and damaging or absurd and worthless. Mr. B agreed (for the first time) with my assessment of the situation. He said that he found himself very much in need of help and faced with an incompetent and hostile analyst. I then asked whether he was indeed convinced that this was a reality because, if it was, it would naturally lead him to ask why he had selected me as his therapist, and he was not raising that question. He immediately accused me of trying to throw him out. I told him I was trying to understand how he felt and not necessarily confirming his views of me.

He then reviewed the circumstances that had led him to consult with me and to select me as an analyst after several unhappy experiences with other psychotherapists. In the course of this review, it emerged that Mr. B had been very pleased when I accepted him as a patient, but had also felt very unhappy about what he experienced as the enormous difference in our status. He talked about how painful it was to him to have to consult professionals he considered representative of the most conservative psychiatric and psychoanalytic establishment. Because I had been highly recommended to him, he had consulted me,

but now he was wondering whether a brief psychotherapy with a therapist from one of the "antipsychiatry" schools might help him much more. I suggested that it might be preferable for him to perceive me as incompetent and hostile if this permitted him to preserve his own self-esteem, although this perception of me was also frustrating his wish to be helped. In other words, I began to interpret the acting out of needs to devalue and disparage me that reflected dissociated envy of me.

I believe that this case illustrates how, from the beginning of the treatment, the principal channel of communication for unconscious object relations activated in the transference was reflected in the patient's attitude toward me rather than in the content of free associations per se. Certainly the content of his verbal communication was important in clarifying what went on in the relationship with me, but the nature of Mr. B's behavior was the dominant focus of communication.

On the surface, he was devaluing me as an admired yet enviously resented parental authority, with himself a grandiose and sadistic child. At a deeper level, he was enacting unconsciously the relationship of a frustrated and enraged child with a much needed parental image; but he also deeply resented that parental figure because he perceived it as controlling and devaluating. This view of the parental object triggered intense rage, expressed in the wish to devalue and destroy the object while, at a still deeper level, he unconsciously hoped that it might survive. In fact, it took many weeks to unravel these unconscious meanings in the here-and-now. Months later, we learned that this object relation reflected an unconscious relationship with Mr. B's mother and that his repeated failure in relationships with women followed a strikingly similar pattern to the one described in his relationship with me. All these women and I myself represented mother in this transference enactment.

There is still a third channel of communication, which might be considered an outgrowth of the second one, except that here

the nonverbal communication is expressed in the apparent absence of any specific object relation in the transference. Under these circumstances, over a period of many months or even years, there is minimal transference regression and an almost total absence of manifest aggression or of libidinal investment in the transference, an indication of the patient's incapacity to depend upon the analyst.

I have stressed elsewhere (Kernberg, 1984) that such patients present subtle, pervasive, and highly effective transference resistances against being dependent on the analyst and against the related regression in the transference in general, a condition that might be described as a "closure of the analytic space." To put it more concretely, an absence of emotional depth, of emotional reality, and of fantasy in the analytic encounter becomes the dominant resistance in the treatment.

I described elsewhere (Kernberg, 1986b) an artist in his late twenties who consulted because of his dissatisfaction with his bisexual style of life and his growing sexual inhibition. This man's personality had strong narcissistic features and an "as if" quality. His mother had died when he was nine years old, and an older sister had taken over her household duties while his father took over many of the mother's functions. The description of both parents was vague and contradictory. The patient conveyed a quality of unreality about his entire history. He had an adequate surface social adaptation, but there was something artificial in his appearance. He was one of those patients whose "perfect free association" effectively mimics an authentic analytic process. There was something mechanical about him, and I found it extremely difficult to link this impression to any concrete manifestations in the transference. He showed similar lack of involvement with his woman friend, toward whom, in spite of good reasons to the contrary, he showed absolutely no signs of jealousy.

By the third year of his analysis, although I was able to maintain my interest in him, I felt that I was being seduced into a

strange inactivity and tolerance of this situation, as if I were watching a theatrical display that had no depth and presented itself as from a film screen. It was as if the patient could neither acknowledge me as a person different from himself yet available to him, nor acknowledge his own presence in the room beyond that of recorder of external reality. I finally decided to focus on the nature and the symptoms of his consistent unavailability to me and my unavailability to him as he conveyed it in his attitude in the hours. I used the technique I have described elsewhere (Kernberg, 1984) of imagining how a "normal" patient might behave in a particular hour in order to sharpen my focus on the concrete manifestations of the artificiality in this man's relation with me.

The effect of my focus on this "absence" in the transference was striking: the patient began to experience anxiety in the sessions. Over a period of several weeks, his anxiety increased, and his associations changed significantly. He developed an intense fear of me, with an image of me as somebody totally unreal, who presented the façade of a friendly psychoanalyst that covered an underlying frightening empty space. He was alone in the middle of a devastating experience of himself as damaged, disintegrating, incapable of being either boy or girl. It was as if only dead objects surrounded him.

In the course of a few weeks this man changed from an almost inanimate robot to what can best be described as an abandoned, terrified child. Activated in the transference was an intense primitive object relation and, as part of my countertransference reaction, a concordant identification (Racker, 1957) with that self-representation. Following this episode, an intensely ambivalent relation to a powerful father emerged in the transference, with projection onto me of the image of a sadistic, controlling, savage father who would be disgusted by the patient's sexual fantasies and wishes. In short, for the first time it was as if elements that had previously been presented in a flat mosaic of past experiences now acquired depth in the transfer-

ence. This case, I believe, dramatically illustrates the predominance of the "third channel" of the constant yet latent "space" of the analytic encounter.

TRANSFERENCE, UNCONSCIOUS PRESENT, AND UNCONSCIOUS PAST

I have stressed that it is crucial to first uncover the unconscious meanings of the transference in the here-and-now and to make fully conscious the expression of this object relation in the transference before attempting reconstructions of the past. In the course of this process, the previously unacknowledged, denied, repressed, projected, or dissociated object relation may now be fully acknowledged and become ego-dystonic. This is where the analytic questions can be raised: what are the genetic determinants of the presently activated unconscious intrapsychic conflict, and how are these interpreted to the patient?

Our first case, Ms. A, provided dynamic information that would seem quite naturally to reflect a masochistic transformation of a positive oedipal relationship. As is characteristic of better functioning patients, the links between the consciously known history from the past and the unconscious activation of repressed object relations in the here-and-now were apparently direct. I nevertheless avoided any reference to her relationship with her father until the patient herself, wondering about her need to first transform a good relationship with a man into a bad one in order to then sexualize it, started to associate about her adolescent interactions with her father.

With Mr. B, the postgraduate college student, a very chaotic and complex acting out in the transference could not be linked directly with any known aspects of the patient's past: the information he had conveyed about his past was itself so contradictory and chaotic that it would have been difficult to accept any of its aspects at face value. It took a long time to clarify the unconscious meanings in the here-and-now; only when that

had been accomplished could I begin to raise the question of what should be explored in terms of genetic and developmental antecedents.

The dynamics of Mr. B's desperate search for dependency upon a dangerously and cruelly controlling object might lead theoreticians of different persuasions to different conclusions: (a) a Mahlerian might conclude that it related to the rapprochement subphase of separation-individuation; (b) a Kleinian might relate it to an envied good (and/or bad) breast; (c) a traditional ego psychologist might think in terms of the guilt-determined anal regression from a positive oedipal conflict. But because I had no information about what developmental stage this conflict had originated in, or regressed to, I avoided speculating about it before the unconscious here-and-now developments had become completely conscious and ego-dystonic.

In the case of the artist, the danger of premature genetic reconstructions is really highlighted. Here, even at the time of a breakthrough from a long analytic stalemate, I refrained from linking the activated primitive object relation with any aspect of the past before further evidence emerged in the transference, in the patient's free associations, in short, in the emergence of new and unexpected material.

In summary then, I attempt to carry out, first, "atemporal" constructions of the unconscious meanings in the here-and-now, and only later, when the conditions warrant it, cautiously to transform such constructions into reconstructions of the unconscious past. Similarly, I try to avoid the genetic fallacy of equating the most primitive with the earliest, as well as any mechanical linkage of certain types of psychopathology with fixed stages of development.

My three cases also illustrate another aspect of my technique: namely, the importance of carefully exploring the developments in the patient's experience both outside the analytic hours and in the analytic relationship itself. With Ms. A, I spent considerable time exploring the relationship with her colleagues

and superiors at work before attempting to link that material to the relationship with me: and that, in spite of my very early observation of her "nice little girl" attitude in the analytic hours.

My first efforts with Mr. B were genuinely focused upon the clarification of the chaotic relationship with his woman friend. Only when, in the course of the paralysis of all my efforts to help him gain further understanding, it became obvious that the transference issues had acquired highest interpretive priority, did I focus consistently on his relationship with me. I had to wait a long time before I could link the relationship with his woman friend and the relationship with me.

In the third case, of course, a long history of failure of efforts to explore both the patient's extra-analytic and his analytic relationships led to the diagnosis of what I have referred to as the closure of the analytic space with this patient. In general terms, economic criteria (that is, the search for areas of dominant affective activation, whether conscious or unconscious) should dictate whether the focus of intervention is predominantly on an interaction with the patient in the hour, or in the patient's external reality (Kernberg, 1984).

It must be apparent by now that while I strongly emphasize the analysis of the unconscious meanings of the transference in the here-and-now, I do not neglect the importance of the analysis of genetic antecedents, the there-and-then. In my emphasis on the here-and-now, I am in agreement with Gill's proposals. I do believe, however, that, by overextending the concept of the transference as "an amalgam of past and present," Gill (1982, p. 177) blurs the differentiation of what is inappropriate in the here-and-now and needs to be explained by its origin elsewhere.

I think it is an error to include the actual aspects of the analyst's behavior that trigger and/or serve to rationalize the patient's transference as part of the transference itself. For the analyst to phobically avoid acknowledging the reality of an aspect of his behavior noticed by the patient, and which triggers a certain reaction by the patient, is a technical error; even further, the analyst's failure to be aware of what in his own behavior may have unconsciously triggered aspects of the trans-

ference is also an error of technique. I think it is a distortion of the classical concept of transference to assume that the analyst's realistic contributions to the interaction with a patient should be ignored or denied; to do so is to misuse the concept of transference as a distortion of actual reality because it implies that the analyst is perfectly adjusted and one hundred percent normal. As I pointed out in earlier work (Kernberg, 1984),

> Patients rapidly become expert in detecting the analyst's personality characteristics, and transference reactions often first emerge in this context. But to conclude that all transference reactions are at bottom, at least in part, unconscious or conscious reactions to the reality of the analyst is to misunderstand the nature of the transference. The transference is the inappropriate aspect of the patient's reaction to the analyst. The analysis of the transference may begin by the analyst's "leaving open" the reality of the patient's observations and exploring why particular observations are important at any particular time.
>
> If the analyst is aware of realistic features of his personality and is able to accept them without narcissistic defensiveness or denial, his emotional attitude will permit him to convey to the patient: "So, if you are responding to something in me, how do we understand the intensity of your reaction?" But the analyst's character pathology may be such that the patient's transference reaction to him results in the erosion of technical neutrality. When the analyst is incapable of discriminating between the patient's realistic and unrealistic perceptions of him, countertransference is operating (p. 266).

In my view, what is enacted in the transference is never a simple repetition of the patient's actual past experiences. I agree with Melanie Klein's (1952b) proposal that the transference derives from a combination of real and fantasied experiences of the past, and defenses against both. This is another way of stating that the relations between psychic reality and objective reality always remain ambiguous: the more severe the patient's psychopathology and the more distorted his intrapsychic structural organization, the more indirect is the relation

between present structure, genetic reconstruction, and developmental origins. But to conclude that reconstruction of the past is impossible because it is difficult, and to use the difficulty of connecting past with present to question the possibility of uncovering the past is really an evasion and is unwarranted.

COUNTERTRANSFERENCE, EMPATHY, MEMORY, AND DESIRE

My views of countertransference have been spelled out in earlier work (Kernberg, 1975, 1984). Here, in summary, I want to stress the advantage of a "global" concept of countertransference, which includes, in addition to the analyst's unconscious reactions to the patient or to the transference (in other words, the analyst's transferences), (a) the analyst's realistic reaction to the reality of the patient's life, (b) the analyst's realistic reaction to his own life as it may become affected by the patient, and (c) the analyst's realistic reaction to the transference. For practical purposes, all these components—but not the analyst's realistic emotional reaction to the patient's transference—should remain rather subdued under ordinary psychoanalytic circumstances.

Obviously, if the analyst has retained severe nonanalyzed character pathology or if an unfortunate mutual "resonance" exists between the patient's and the analyst's character pathology, the analyst's transferences to the patient may be accentuated. The greater the patient's psychopathology and the more severely regressive the transference, the more intense the therapist's realistic emotional responses to the patient. It is this area of the realistic responses to the patient and their links with the analyst's deeper transference dispositions that presents both potential dangers for countertransference acting out and potential assets in the form of clinical material to be explored by the analyst and integrated in his understanding of the transference.

I assume that Racker's (1957) concepts of concordant and complementary identifications in the countertransference are well known by now. Their respective functions in increasing empathy with a patient's central subjective experience (in concordant identification) and in maintaining empathy with what the patient is dissociating or projecting (in complementary identification) are also well known. In my view, complementary identification in the countertransference is of particular importance in the analysis of patients with severe character pathology and regressive transference developments. By means of unconscious defensive operations, particularly projective identification, patients are able, through subtle behavioral communications, to induce emotional attitudes in the analyst that reflect aspects of the patient's own dissociated self-representations or object representations.

The psychoanalyst's introspective analysis of his complementary countertransference reaction thus permits him to diagnose projected aspects of the patient's activated internalized object relations, particularly those communicated nonverbally and by alteration in the "analytic space"—the habitual, silent relationship between patient and analyst. Under optimal circumstances, the analyst's understanding of his own affective pressure that derives from the patient's unconscious communications in the transference may lead to a fuller understanding of the object relation activated in the transference.

My attitude regarding the activation in the analyst of intense emotional dispositions toward the patient, particularly at times of transference regression, is to tolerate my own feelings and fantasies about the patient, with the clear understanding that I attempt to use them to better understand what is going on in the transference. I remain consistently alert to the need to protect the patient from any temptation I might have to act on these feelings or to communicate them to him or her. Absolute noncommunication of countertransference reactions to the patient is the counterpart of the analyst's freedom to work with them and use them in his interpretations.

A related issue is to determine the nature of what is projected onto the analyst and activated in the countertransference. In essence, patients may project a self-representation while they enact the object representation of a determined object relation activated in the transference, or, vice versa, they may project an object representation while enacting the corresponding self-representation. These projections tend to be relatively stable in patients with neurotic personality organization, but are unstable and rapidly alternating in patients with severe character pathology and borderline personality organization.

For example, the architect, Ms. A, unconsciously tried to ingratiate herself with me as an object representation of her father in order to protect herself against her own impulses to defy me as a father and to seduce me into an aggressive—and sexualized—counterattack. There was a relatively stable activation of several self-representations under the impact of different affective states in the patient, and a relatively stable projection onto me of object representations unconsciously representing father under different affective states. In other words, we did not "exchange personalities."

But Mr. B showed a rapid and almost chaotic alternation of self- and object representations in his identifications and in his projections onto me, reflecting different affective states as well. For example, at one point, he would project onto me a withholding, indifferent, and rejecting parental image, perceiving me as dominant, self-centered, unable to tolerate any view different from my own, and ready to angrily dismiss the patient (my child) who dared to think differently. Only minutes before or after such an experience, Mr. B would identify himself with the image of such a parental figure, and dismiss me (his child), declaring that he had just decided to stop his analysis because he could not tolerate such a totally misguided and obstinate analyst. His attitude implied that such a sudden termination of his relationship with me would come most naturally, and without any risk of missing me. In other words, there was a rapid ex-

change between us of the roles of the sadistic, neglecting parent and the neglected, mistreated child.

I think it is of crucial importance that the analyst tolerate the rapidly alternating, at times completely contradictory, emotional experiences that signal the activation of complementary self- and object representations of a primitive internalized object relation. The analyst's capacity to tolerate such rapid changes in his emotional responses to the patient without denial or acting out includes several preconditions.

First, the analyst must maintain strict boundaries in the analytic situation of space, time, privacy outside the treatment hours, and a sense of his own physical security during the sessions.

Second, the analyst must be able to tolerate, as part of his empathic response to the patient, the activation of primitively aggressive, sexual, and dependent affect states in himself. Thus, for example, the analyst must accept his own aggression in the countertransference (Winnicott, 1949), such as the gratifying experience of sadistic control; this experience may be much more of a problem for the analyst than tolerating, for example, developmentally more advanced levels of sexual arousal.

Third, it is important that the analyst maintain sufficient confidence in his creativity as part of his analytic work so that he may tolerate the patient's need to destroy his efforts without a reactive counterattack, devaluation of the patient, or withdrawal from him. Only if the analyst can feel comfortable with his own aggression will he be able to interpret aggression in the patient without fearing that this is an attack on the patient, or without submitting to the patient's accusation that he is being attacked (a manifestation of the patient's intolerance of his own aggression).

The impression I have gained from studying the clinical material presented by self psychologists is that they implicitly or explicitly accept the view that the analyst's interpretation of aggression in the patient corresponds to an attack on the patient,

as if all aggression were "bad." Obviously, such a view of the analyst cannot but reinforce the patient's own conviction that aggression is bad and that he must defend himself against this "accusation" by whatever means at his disposal.

As I have stressed in earlier work (Kernbeg, 1975), empathy must therefore include not only concordant identification with the patient's ego-syntonic, central subjective experience, but also complementary identification with the dissociated, repressed, or projected aspects of the patient's self-concept or his object representations.

Wilfred Bion, in a paper he called "Notes on Memory and Desires" (1967), stressed the importance of facing the patient's material in each session without preconceived notions about the patient's dynamics ("memory") and without any particular wishes regarding the patient's material, functioning, and experience, as well as any wishes not related to the patient at all ("desire"). Insofar as this contribution, in my view, marks an indirect criticism of the formulations of interpretations prevalent in the Kleinian school, and a plea for complete openness to new material with a minimum of analytic preconceptions, his point is well taken. I think, however, that Bion neglected the importance of the analyst's long-range experience with the patient's material, the understanding of an analytic process that develops over a period of weeks and months, an understanding that may become a frame of reference to be used by the analyst without his becoming enslaved by it.

My point is that the analyst needs to maintain a sense of the continuity of the analytic process and, particularly, a view of the patient, his behavior, and his reality that transcends the subjective view of the patient at any particular moment, in any particular hour, as well as the patient's own "myths" or preconceived organization of his own past. Such a frame of reference ("memory") is the counterpart to the analyst's tolerating periods of nonunderstanding, in the course of which he may expect new knowledge to emerge eventually. Similarly, regarding the analyst's "desire," the tolerance of impulses, wishes, and fears

about the patient that evolve throughout time may provide the analyst with important information that may enter his awareness in the sessions, again, without necessarily enslaving him.

While much of what I have said may apply to psychoanalytic psychotherapy with nonanalyzable borderline and narcissistic patients, my intention has been to spell out my basic approach to the transference in the context of standard psychoanalysis with a broad spectrum of patients. It has been my experience that when I apply this approach to patients with neurotic personality organization (Kernberg, 1986c), it differs little from a traditional ego psychology approach or from other object relations theories. In contrast, the differences between my approach and that of self psychology are obviously profound and global. In my work with regressed patients, however, important differences between my approach and traditional ego psychology, the British object relations schools, and the culturalists' object relations techniques in this country seem to emerge.

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A CORE PROCESS IN PSYCHOANALYTIC TREATMENT

BY LEO RANGELL, M.D.

A core mechanism of the psychoanalytic process is described. This involves the effects of treatment on an ongoing "unconscious intrapsychic process," which has specific points of vulnerability to pathology. The concept of an intrapsychic process described by the author in previous publications is an expanded formulation of the idea of thought as trial action and of the signal theory of anxiety. The psychoanalytic method alters the functioning of the ego astride this unconscious process, strengthening its control over anxiety, defense, trauma, and symptom formation. This is mutative in the psychoanalytic method.

For this special issue on developments in psychoanalytic technique in the last three quarters of a century, I will describe a mechanism of the psychoanalytic method of treatment which, in my opinion, has not been noted before. This does not negate the known elements of the psychoanalytic method: the creation of the analytic situation, the fostering, uncovering, and analysis of a transference neurosis, reconstruction to the earliest stages of neurosogenesis by analysis of the transference neurosis and all the data of free associations, the corresponding internal steps which occur in the patient, the working through of the insights gained, and the final reparative actions of the now widened autonomous ego which I have described as taking place "between insight and change" (Rangell, 1981). This paper will add an intrapsychic dynamic process which takes place continuously during the unfolding of the psychoanalytic procedure. It is a

core process underlying the entire course of treatment, which proceeds on a more macroscopic level.

My description of this dynamic process will begin with a consideration of the nature of thought, affect, and action and the relationships between these in normal mentation and during the genesis of psychopathology. It has perhaps never been sufficiently acknowledged that our accepted theory, even with the knowledge we acquire in practice, does not always reach its full potential in terms of application to our technique. Gray (1982) saw this as a "developmental lag," specifically in relation to the proper application of ego psychology to psychoanalytic technique. In similar vein, I base this presentation on an understanding of intrapsychic dynamics which is generally accepted as a baseline for understanding human behavior, but which is insufficiently developed. Insights derived from this line of thought can help in the understanding of both normal and pathological behavior and can also serve as a guide to the process of psychoanalytic therapy.

As background for the intrapsychic sequence I will describe, I will refer first to three parallel and commonly accepted formulations of intrapsychic mental life. One is the concept presented in a number of works by Freud (1900, 1911, 1933) that thought is experimental action. This concept was repeated by Rapaport (1950, 1951b) in his encyclopedic theorizing, and by Fenichel (1945) in his integrative theoretical-clinical systematization. A second formulation is Rapaport's (1953) model explanation of affect as deriving from the states of satiation and frustration, pleasure and unpleasure, of the nursing infant at the breast. And a third and most important insight, embedded at the center of this dynamic sequence, is Freud's (1926) universally accepted signal theory of anxiety, which has also failed to result in a comparably powerful and unfailing applicability to treatment.

In my effort to fuse, deepen, and extend these concepts of the intrapsychic events involving thought, affects, and action, I

have elaborated at length, in a series of publications during the last thirty years, on the etiologic dynamic process leading to anxiety, conflict, and trauma and to their behavioral derivatives (Rangell, 1955, 1963a, 1963b, 1967, 1968a, 1968b, 1969a, 1969b, 1971, 1986a). The power of explanation which I believe can stem from a microscopic consideration of this combined intrapsychic sequence can illuminate the entire spectrum of psychoanalytic interests, from the most abstract theoretical to the most practical clinical issues.

In the present paper I will focus on the fate and vicissitudes of what I have called the "intrapsychic process" as a core mechanism of the psychoanalytic process. While I have previously dealt with "the intrapsychic process and its analysis" (Rangell, 1969a), I feel, with Gray (1982), Esman (1985), Goodman (1985), and others who reconsider old papers and insufficiently developed subjects, that this nuclear concept can stand further highlighting and emphasis.

I will recapitulate in skeletal outline the linear sequence of the "intrapsychic process" which I will later develop in terms of its central role in the psychoanalytic therapeutic process. In summary, the following linear sequential series can be said to comprise a model psychodynamic process operative moment by moment in everyday life.

1. On a baseline of quietude, homeostasis, and inactive behavior, the ego permits a tentative experimental discharge of an instinctual impulse, to sample the reactions of the superego and the external world.

2. There is an automatic scanning by the ego of memories associatively connected with such intended action.

3. On the basis of this intrapsychic scanning of previous associated experiences, the ego receives a signal of safety and freedom from anxiety, or of danger accompanied by the affect of anxiety.

4. If a safety signal is received, there is little or no conflict (I include "little" because experience has shown that there must

be a certain amount of vigilance), and channels are open to the ego for further development of direct external activities in thought, affect, or action. (External here includes not only the outer world but all that is external to the ego, i.e., in the body or mind, somatic or mental, on the surface or within the psychic interior.)

5. If the signal received is that of anxiety, the ego is confronted with the presence of conflict. I have called this the first tentative or experimental phase of intrapsychic conflict, from an intention and a small experimental dose of instinctual discharge. The experimental conflict ensuing at this stage is a dilemma or choice type of conflict. The ego must now decide what to do next, in terms of id versus superego or environmental demands.

6. If the anxiety is mild and encompassable, one choice can be to proceed as in the actions following the safety signal in number 4 above. The small amount of controllable anxiety can, in such case, be bound and dealt with.

7. Anxiety of sufficient degree or of certain specific qualities leads to the decision to instigate defense. The employment of defense introduces what I have called the second phase of intrapsychic conflict. This is the more conventionally known oppositional conflict between ego and id.

8. There may now ensue a state of poised intrapsychic stability, with psychic forces deployed between ego and id in a state of sufficient balance and control.

9. If instinctual pressures continue or are too great, stability may not ensue but rather a state of increasing psychic tension. The id is stronger than the ego's capacity to contain it.

10. This state of increasing tension is associated with mounting anxiety, based on a fear of traumatic helplessness. The last two phases are the phenomenologic occurrences or equivalents of Freud's original description of "actual neurosis." The anxiety is now *following* the attempts at repression (or other defense), after having previously caused them.

11. Following these phases, which always represent what is

meant by conflict proper, the ego is again confronted with a choice or dilemma type of conflict. This is the third stage of intrapsychic conflict; the need at this point is to seek a resolution of the continuing unstable state.

12. The great variety of results which can now eventuate comprise the clinical phenomenology of psychopathology, i.e., "inhibitions, symptoms and anxiety" (Freud, 1926). Symptoms, incidentally, include the psychological and the somatic, as well as combinations of the two.

Intrapsychic conflicts are viewed as progressing from choice to oppositional to choice (or dilemma) types again; the psychic outcomes include choices and compromise formations at various stages. Psychopathology, including typically the psychoneuroses, occurs from the middle stages onward, from the time of failing defenses (phase 9 above), to the institution of neurotic symptoms to stem the tide and produce stability again, however precarious this may turn out to be. Before that point in the sequential chain, anxiety, choice, and defense occur universally in normal operational intrapsychic dynamics. These involve conflict-free and conflictual situations in normal mentation. Neurotic conflict and pathological solutions enter the picture with insufficiency of defenses or their incipient or threatened breakdown.

The ego sits astride this process, from inception to final outcome. In its functioning as an overseer of this sequential series, the ego has its own developmental history and comes to have its strengths and weaknesses in each particular phase of the process. The ego of each person has its individual stamp, its own quality of relationships to the requirements and demands of the id, the superego, and the external world which surrounds it. The ego has capacities and limitations, from deficits and insufficiencies, to capabilities, sufficiencies, and special talents and skills. These vicissitudes of ego development, building upon constitutional factors and acquiring positive and negative capabilities during the course of growth, have been studied in

various aspects by Freud (1923), Benjamin (1961), Escalona (1965), Brody (1982), Weil (1985), Rangell (1984), and others.

Derivatives of the intrapsychic process in normal, ongoing mental activity, or in the psychopathological syndromes which serve as the motivations for psychoanalytic treatment, occur from every point of this etiologic background. Conversely, each arc of this linear chain is deciphered through its surface derivatives, from the simple to the most complex. Every presenting symptom complex faced by the psychoanalytic clinician can be analyzed back to the specific intrapsychic histories which have brought them about in the individual instance. The intrapsychic process and its vicissitudes form the dynamic backgrounds for them all. Differences of outcome depend on differences in contents impinging upon the ego, the resources of the ego to cope with them, and the effects of trial solutions over time.

Between the mental activity of the etiologically operative intrapsychic process and the outward clinical manifestations is a large intermediate area of psychic products, from unconscious to conscious, from primary to secondary process oriented, from id dominated to ego controlled. All of these normal and pathological psychic products, which play a major role in every psychoanalytic procedure, face in both directions, toward the psychic interior from which they derive, and toward the external world to which they aim.

Unconscious fantasy is one such intermediate product, maintaining a suspended state of relative freedom from trauma by bridging the time between instinctual wish and action. The degree to which such fantasy is oriented toward reality and at least potential adaptedness, compared to its roots in unreality, irrationality, and unadaptability to action, determines the extent of neurotic underpinning of its etiologic base. Unconscious fantasy is not alone, however, as a formed psychic product existing in the unconscious. Unconscious affects also exist in a repressed state, either isolated and separate from thought and fantasy or connected to unconscious cognitive processes. The intrapsychic process is wider than the unconscious fantasies or affects which

result from it, containing the ingredients which go into the latter, plus other elements held in suspension and not yet disposed of or accounted for.

Besides unconscious anxiety, other affects of unpleasure, such as depression, guilt, or shame, can derive from the backward look at memories during the scanning process, or from a forward assessment of prospects which do or do not exist for meeting current and future intrapsychic situations. Repressed affects, of either a painful or a forbidden nature, exist in the unconscious either in a formed state, which can be recognized after the undoing of defenses by analysis, or in a more nascent form as potentials for affect, as pointed out by Pulver (1974), in which case they do not yet have definitive defenses deployed against them. Fenichel (1945) spoke of potential affects as causing hyperactivity or a readiness for affective discharge.

Entire symptom complexes can be held in repression, as can mini-symptoms or traits which would be ego alien if conscious, such as compulsive or obsessive trends, or restrictions which are really latent phobias. The unconscious ego, as pointed out by Freud (1923, 1926, 1927, 1940), Hartmann (1939, 1950), Nunberg (1931), Waelder (1960), Rangell (1969b, 1971, 1986a), Weiss and Sampson (1986), and others, engages in an organizing, integrating, coordinating, and planning activity akin to similar mental work at a conscious level. The difference from conscious mentation is that elements which are forbidden or threatening to the conscious ego are repressed, however sophisticated and rational they may be. Secondary process is operative in the unconscious just as primary process intrudes into preconscious and conscious mentation. Also repressed is the gulf between the self-representation and the ego ideal, a ratio which Jacobson (1953) identified as responsible for the state of self-esteem. All of these repressed contents come under the analytic eye in a psychoanalytic treatment process.

The nature of the therapeutic procedure directed against the psychoneuroses stems from one's concept of the genesis of the psychopathology. I have elaborated on this version of the etio-

logic background because of the direction to which it points with respect to technique for understanding the counterpart to the original process of neurosogenesis. Upon all of these internal processes and their derivatives, the psychoanalytic process is added and grafted. Looking outward from the experience of this inner psychic sequence by the patient combines with the looking inward toward it from the vantage point of the psychoanalytic clinician; only the common work undertaken by both can make possible the understanding of the behavior to be analyzed.

From the moment of the choice of analyst by the patient, the intrapsychic process within the patient will be different by virtue of the addition of a new and unique object relationship. The trial actions of the patient will at once be both newly tested and newly guarded. What will the new participant contribute to the intrapsychic process—additional safety or new (by increasing old) reasons for anxiety? The analyst assumes both a hoped for and feared position within the patient's interstructural mental field. The patient's intrapsychic dynamics will now revolve, in all their complexities, around the new object. What the patient expects of the new presence, even in the interval before their initial encounter, will be a composite created by his own projections. This is an immediate trial transference, later to be tested against the actual experience with the new object. What the analyst does, compared to what the patient thinks he does, or expects him to do, will be major grist for the analytic mill throughout the course of the analysis.

The relationship of the patient to the analyst is twofold from the start. From the first decision to be analyzed, the patient both utilizes the analyst (therapeutic alliance) and deflects upon him (transference neurosis). The patient's intrapsychic process is never again, at least during the analysis, without the analyst's functioning playing a part within it. Psychoanalytic treatment is through the ego. Thoughts, experimental action, assessment of memories, unconscious affects, the activities of the ego surveying all of these, now have added to them what the patient

expects the analyst to think, feel, assess, and judge, in terms of his intended and performed behavior. The patient's ego is now added to, or opposed to, or opposed by the analytic ego of the analyst, however the patient figures it to be at any particular moment.

Looking from the side of the analyst, the stream of influence from analyst to patient throughout the course of the analytic treatment proceeds from two integrated directions, one verbal, the other nonverbal, behavioral and attitudinal. The latter plays no less a part than the former in its profound analytic effect on the patient. Interpretations and other verbal interventions, including clarifications and assessments of reality, reconstructions of genetic events, or constructions of larger phases of life, add to the patient's cognitive armamentarium and aid his ego toward an altered assessment of traumatic memories of early life. These come to be seen in the light of new insights, including insights about the roles played by fantasies during or after their occurrence, which may have helped to initiate, or more often to maintain, the original traumatic events.

To the extent that the patient is seen (through reconstruction) to have been a passive victim of traumatic occurrences, subjecting the earlier experiences to the rational ego of present adult life makes for abreaction, working through, and reparative re-evaluation of such early determining traumatic events. Another dynamic is the differentiation of this from the part played by the patient himself, both in the original traumatic events and, even more significantly, in chronic prolongation of the traumata by the repetition compulsion. The ego is able to deal now, although in different ways, with what was done to the patient and what he contributed himself.

These basic consequences of reconstructive insight, which have tended to be undervalued or even lost in modern theories of the therapeutic process, remain, in my opinion and experience, the underlying mechanisms in psychoanalytic treatment and cure. The analysis of the transference neurosis is an indispensable means toward this end. But this is not the only means

or path. Free associations also reveal and refer directly to the etiologic traumata of early life. The successful exposure and reintegration of such early determinants also allows the ego to be fortified by subsequent achievements of later life, events which until now have been unable to be of balancing therapeutic effect.

As in the technical rules, resistance before content, or from the surface to the depth, the direction is from external to internal, from the macroscopic to the microscopic. I have written before that every psychoanalysis is a training analysis, or a supervised analysis, that analysis is the supervision of the patient's ego in action (Rangell, 1968a). The patient identifies with the analyst's analytic function, the patient's ego with the analytic ego of the analyst. This identification is mutative, causes change, brings about structural and dynamic alterations in the intrapsychic functioning, and therefore in the external behavior of the patient.

The method and rationale of psychoanalytic treatment are best explained by the multiple approaches of the metapsychological points of view—the dynamic, genetic, adaptive, etc., culminating in the structural view. This composite orientation of the treatment procedure was pivotal in Fenichel's (1938-1939) description of the therapeutic process. The activities of the ego that I have described as operative in the intrapsychic process, in consonance with this view, demonstrate the overseeing by this psychic system of the dynamic interplay between all psychic structures. This approach looks back genetically and forward adaptively, covering the sweep of the points of view described by Freud as encompassing a total understanding of mental processes. This is in contrast to many theoretical positions taken today which would do away with this group of approaches of Freud, Anna Freud, and others, both in understanding the neuroses and in constructing a theoretical scaffolding for treating them.

The structural view, the culmination of Freud's multidirectioned metapsychology, buttressed by its surrounding ap-

proaches (the dynamic, genetic, etc.), in my opinion, provides the most coherent and comprehensive theoretical view of both neurosogenesis and its counterpart, the therapeutic process of psychoanalysis. This substructure of understanding is like the "infrastructure" of a building, as referred to recently by an architect-engineer patient. He commented about the relationships between what he was discovering from free associations during the sessions and his feelings and attitudes toward current objects in his family and work.

"Structure" as used metaphorically by this patient, or in our own theoretical formulations, does not mean mechanical at the expense of meaning, nor does it imply any diminution in the basic hermeneutic aspects of psychoanalysis. The infrastructure I refer to is a platform of meanings, of infantile anxieties about expected dangers relating to infantile conceptions of reality and the external world, and of object relations based upon incomplete cognitive development. This includes anticipated punishments by authority figures, partly realistic in the case of punitive parents, but also due to projections by the immature subject.

Psychoanalysis aims to proceed from the observable to the explanatory. The analyst directs his analyzing instrument, containing both primary and secondary process receptors (Isakower, 1957), to the patient's ongoing psychic life at all levels, seeking to establish connections and to understand origins, developments, sequences, and outcomes. These he communicates to the patient by verbal interpretations or other interventions, and by his general nonverbal behavior as an analyst.

The behavior to be analyzed is an aggregate of elements. In the analysis of affects, I have pointed out that the analyst destratifies an agglutinated mass and attempts to establish a linear sequential order of the affects it contains (Rangell, 1978, 1986b). Jones (1929) and Glover (1939) pointed out the layering of fear, guilt, and hate, and Riviere (1932) analyzed the affect of jealousy as containing grief, anger, and fear. As is the case with the analysis of affects, so, too, the analyst, in a larger

clinical sense, is confronted with a composite behavior, coordinated and unified in an idiosyncratic way by secondary revision, much as is applied to a dream before awakening (Freud, 1900). Contained in the total presenting mental complex are symptoms, character traits, affects, and fantasies (conscious and preconscious ones before their unconscious origins can become known), cognitive and affective aspects of self-representations, and accustomed patterns of object relations.

There are not only compromise formations, as Brenner (1982) has emphasized, but choices exercised in the unconscious as well. To consider all psychic outcomes as compromises is to ignore Hartmann's contributions of ego autonomy and the conflict-free sphere. There are choices which could not be compromised or made up for at different points in the unconscious intrapsychic sequence, such as the decision to yield to impulse or to institute defense, and choices of compromise formations themselves. The same phenomena that I have described as dilemma and oppositional types of conflict have been referred to by A. Kris (1977, 1984) as divergent versus convergent conflicts, or either/or conflicts. The aggregate consists of impulses and anxieties, wishes and fears (before compromises have been made with these), instinctual derivatives of libidinal and aggressive drives, preconscious awareness of defensive behavior, and compromise formations at various stages of formation, all combined into tentative and transient, or more chronic behavioral patterns. The exercise of unconscious choice occurs not only without previous conflict but after it as well. The total results have been brought about by a combination of automaticity and relative autonomy.

As resistances always come before content, the analyst proceeds from the macroscopic surface to the microscopic interior of the psychic apparatus. The path is from the patient's "freely" associated mental products, available after censorship has been consciously relinquished, through the intermediate formations described above, then in irregular fashion back to the surface behavior, to thoughts, affects, and actions reported and ob-

served, or inward to more original sources of intrapsychic events. The course is kaleidoscopic, the speed and rhythm irregular, the order unpredictable, weblike, and seemingly unplanned. The form, contents, and style of free associations are unique for each individual. To an analyst they become as identifying of a person as a fingerprint (although not as unchangeable). The patient can be recognized from his free associations almost as easily as he can by his face. Yet along with this individual variability, we know that through the psychoanalytic organization of data and unification of theory, there can be a general understanding of longitudinal development and outcome.

The analyst makes a new kind of order out of the seeming jumble of thoughts and affects. Free associations externalize the intrapsychic process. Whether the report is of a dream, a symptom, a fleeting fantasy, or an enduring state, what is offered from patient to analyst is the evagination of an underlying ongoing process, with a combination of primary, intermediate, and more derivative products communicated outward. A patient reports a dream of being on top of a small hill or mountain, holding onto his two-year-old daughter. The gravel threatens to slip away, and there is danger of their falling. He holds onto the child tightly for them both to be safe and secure.

The associations point to many levels of attempts at control in diverse incidents at various stages of his life. These are now being repeated in the life of his child during the stage of toilet training and beginning individuation, of which he is proud. His struggles with and ambivalence toward his parents early in life that continue into the present, the relationships of his parents to their parents, and of his parents and grandparents to his child, with continuities and contrasts, are referred to in many associations. The short dream refers in its complex latent structure to past, present, and future, and exposes conflicts of parental control versus separation-individuation of the child through four generations.

Instances from simple to complex in behavioral composition are remembered, recapitulated, and reconsidered in the psy-

choanalytic process, and re-enacted in thought into the current moment, including the transference. The dangers, the anxieties, their genetic histories, the solutions, the attempts at reparation, are represented and referred to at all levels, ontogenetically and generationally. From the complex stream of associations, the analyst can understand the trial discharges of love and aggression, of self-assertion and trial object relations, the resulting anxieties, the sequence of psychic results, the accompanying affects, and the outward behavioral consequences. One result in the patient just referred to, during the associations of the analytic hour, was his expressed determination to interrupt the generational chain of parental overcontrol, to change it to what he deems rational and desirable in an area still open to him, his relationship to his daughter.

The analyst's interpretations stimulate and guide the intrapsychic process and influence its direction. By overcoming resistances, the analyst alters the field of observation, in that the patient's associations now move forward or backward or laterally in a direction from which the patient would otherwise recoil. With each such deflected movement, or rather, movement in a direction made safe and now resumed after a previous deflection has been reversed, the patient comes to speak of an element now in the preconscious-conscious which would have been avoided and maintained in the unconscious repressed. Just as Friedman (1969) and Brenner (1982) have pointed out that a patient does not seek out an analytic process per se, so is the patient not aware of structures or mechanisms, but does come to know and acknowledge wishes, anxieties, cautions (defenses), satisfactions, and disappointments.

Verbal interventions of the analyst, interpretations and others, are matched in importance by the analyst's attitudinal characteristics in the uniquely intimate and affectively sensitive relationship between patient and analyst. This includes not only the analyst's role in the complex and ever-changing relationship to the patient, but his behavior toward the realities they both face in common, e.g., relations to time, money, mutual arrange-

ments, etc., or how the analyst meets and reacts to unforeseen events. The analyst's behavior toward the wider world around the analysis—the physical, social, economic, political, cultural, aesthetic—although deliberately kept to a minimum, may also impinge, even if in a subtle way, to illustrate and test behavior on both sides.

During the course of the psychoanalytic experience, the patient's ego is subjected to the learning process of an alternative, better way, one hopes, to "conduct" his inner mental life. The patient's identification is not only with what the analyst says but with what he does, i.e., how he behaves, as a psychoanalyst, toward the patient's unfolding and increasingly revealed mental content. Central to this gestalt of an analyst is the by now well seasoned, if still difficult to attain, analytic attitude. A central spine of the analytic experience of the patient derives from his relating to the analytic attitude as practiced and lived by the analyst during the course of the analysis. From the start and as this relationship evolves, it presents to the patient a combination of challenge, opportunity, threat, and stimulus to growth.

These nonverbal aspects of the transference have been stressed recently by Stone (1981), Blum (1984), and others. In experiencing the analytic attitude, a patient, irregular and fluctuating in his traits and habits, is subjected to a sense of regularity, timing, dependability, and predictability unknown to him before (yet the regularity is not compulsive or unbending). One patient, habitually late, comes to call from his car phone when he is held up in traffic and finds he will be delayed. Another, formerly under the influence of his father's authoritarianism and braggadocio, is impressed by his relationship now with someone reasonable and fair, who treats him as an equal. "Unlike my father, you treat me with consistency, respect, objectivity, and support, not with approval but also no disapproval."

Another patient, referring to characteristics which he unconsciously is taking in toward himself, states, also indicative of his response to the analytic attitude, "You've been working with me so hard, so patiently, so consistently, so long. It's serious work"

(in spite of humor too). "I like to think of my relationship (though I hate the word) to you, it's so pure." Yet at another time, "You're so pragmatic, realistic, tough," i.e., linked to reality. This patient has come to express a special appreciation of "the truth." On a deep level, this feeling is not for reasons of morality, but because of his experience of its positive effects on anxiety, mastery, and control.

The patients' experience is of an object relationship never before known in life. While some try to equate it, erroneously, with a maternal function, the differences from this are more significant than the similarities. Without reducing its empathic quality, it is not loving, reassuring, supporting-no-matter-what, protective in the parental sense—an attitude which would interfere with effective analytic functioning. With the object of investigation avowedly one-sided, for which the patient must forgo the social, more symmetrical interpersonal exchange, the patient experiences a sustained attention and the total immersion of one person in the interests of another, which is unknown in any other human interaction.

The analytic, realistic, matter-of-fact attitude has as much empathy and affect as is necessary. The analytic attitude includes the rational affective, appropriate laughter, sadness, moods, or affects fitting to the contents and events of the moment. Just as Eissler (1953) stated that special affects to meet the patient are necessary in treating the psychotic or borderline state, so is the proper quality and quantity of affect and empathy called for with the neurotic, or even to a special degree with the pseudonormal patient. At certain times, it is the absence of empathy, i.e., in the sense of automatic reassurance, whether deserved and realistic or the opposite, which is the special challenge of the analytic relationship as compared to other object relations. Fair but not gratifying, it challenges, stimulates, and tests the anxiety mechanism. The maintenance of a reflective silence by the analyst, pausing or cautious after an ideational barrage or affective outburst, can be a therapeutic moment carrying the patient along with the analyst's thoughtful-

ness about the patient's inner life. Cumulatively, this can be as much a part of treatment as verbal communications. Although the latter are signposts on the therapeutic map, the former can be distances traveled on the journey taken silently or at least quietly.

The analyst aims to understand and convey the most sensitive issues in a truthful, kind, and objective manner, supplying data and insights which can be of use to the patient. With relentless incorruptibility, within human limits and flexibility, the analyst provides a "straight" relationship, hewing to the truth without distortion, deception, or self-serving interests, in a manner which will prove to be deserving of complete trust.

Since the analyst is a person and not a machine, his conduct toward the patient serves in itself as a model for the resolution of conflict, which is a central goal of the patient and of the analysis. Subliminally and automatically, the analyst demonstrates, with increasing appreciation by the patient if this proceeds with minimal (and allowable) complications, how to combine seeming opposites or even incompatibilities in the service of the necessary stance toward the goal. The "attitude" of the analyst, to further the analytic aims, must be able to encourage without seducing, to be neutral without being cold, to explore without intruding, to judge without being judgmental, to be moral yet not moralistic.

From experiencing how the analyst himself acts and reacts in countless delicate moments and touching interpersonal exchanges, the patient undergoes an identification in the resolution of conflict, typically unconsciously and without verbalization. This is a major experience during the analytic procedure, unconsciously applied by the patient to the overseeing of his own intrapsychic life. By it, the patient gains, or at least aims toward what I have called "intrapsychic integrity" (Rangell, 1965), minimizing, as much as he is able, the degree of distortion in intrapsychic life. I believe that this aspect of the therapeutic experience has received insufficient attention. I stressed this issue in a discussion at an international Pre-Congress on

Training as being of particular importance in the training analysis and the training of the candidate in psychoanalysis.

Psychoanalysis is directed toward an exposure and examination of the intrapsychic process and affects it in the direction of more adaptive behavior. During the unfolding of the psychoanalytic process, with its reconstructive interpretations, the production of insight, and the cognitive and affective restructuring of the ego brought about, under the guidance of the therapeutic alliance, by an understanding of the transference and the genetic past, the routine ongoing intrapsychic process of the patient is altered qualitatively and quantitatively in the nature and outcomes of its ubiquitous activity.

The analysis of resistances and transferences are not the analysis. They are means to the end, not the analytic goals in themselves. By the removing of resistances and the analysis of the transference, the contents resisted and the conflicts displaced to the transference come into central view, to be encompassed by the analytic instrument aiming toward insight. The analytic dissection of psychic outcomes to their etiologic roots results in the understanding of the underlying processes which led to the original conflicts. Unconscious fantasies and repressed affects are intermediate products which also direct and point the analysis to the same origins.

The entire etiologic, sequential chain which is revealed consists of the impulses propelling the wish, the nature of the anxiety experienced, the particular danger it foresees, the choice and extent of defense, the characteristics of the subsequent tension state, the sequelae of the latter in derivative mental and somatic phenomena, and the choice and meanings of external psychopathological outcomes, inhibitions, symptoms, character traits, and other resulting pathological phenomena. Through constructions, reconstructions, and a unified developmental organization of the events of the life under examination, as much understanding and subsequent change can come about as the particular analytic team of patient and analyst is capable of.

I can only indicate this summary statement in principle. A

microscopic view does not replace or abrogate grosser phenomena or macroscopic events, but what is going on intrapsychically determines the presence, extent, and nature of change. The elements of the internal process which are influenced to produce the changed nature of the mental activity of the analysand are many, varied, and individually idiosyncratic in content, form, rhythm, and pattern. Examples occur routinely in psychoanalytic practice. However, as in psychoanalytic formulations on the understanding of human behavior in general, although no two humans are alike, the great variability can nevertheless be organized into a cohesive whole.

I would like now to describe a number of mechanisms which I feel are common to the results of the therapeutic process. These form a linear sequential series which underlies many mechanisms previously described from other vantage points, and which I do not believe has been conceptualized in this particular successive way before. I would like to enumerate these effects, following as a theoretical framework the unconscious intrapsychic sequence of mentation, conative, cognitive, affective, and action-directed, as I have described and recapitulated it here and in previous publications.

1. The store of conscious memories is enlarged. The process of free association, even before repressions are lifted, serves to shift the balance of memories within the reservoir of the memory system first from the preconscious to the conscious, expanding the cognitive armamentarium of the conscious ego before any other effect of the analytic process is realized or appreciated. The role of the preconscious and its effects in determining the nature of psychic homeostasis, in my opinion, has not, with a few exceptions (E. Kris, 1950; Kubie, 1965), been sufficiently appreciated. I think of a patient whose associations are copious, voluble, continuous, uninhibited, and produce effects which are of interest in themselves, serving as a spur to the analytic process. Memories are made more available, a process

which itself offers data and material of use to the observing ego of the patient and for the analyzing function of the analyst.

2. From the analysis of defenses and the amelioration of anxiety, which has progressed during the entire analysis, the course of the psychoanalytic process has been to uncover repressed memories more traumatic and unassimilable than those to which free associations first led. The traumatic aspects of the repressed memories, now more readily available, are admitted into consciousness by the observing and assessing ego of the patient. These are then dealt with in conscious confrontation under the protective environment of the analytic situation and the safe aegis of the analytic relationship.

3. By undoing isolation and reconnecting the ideational and affective components of these recovered memories, the traumatic contents are exposed, understood, abreacted, mastered, and worked through. The traumatic events lose their affective impact, their capacity to produce anxiety, depression, or other unpleasure. They are not gone, forgotten, or denied, but they are stripped of their compelling power. The ego becomes freed from these demanding pulls and, to that extent, is more available for "chosen" activities.

4. As a result of this diminution of the traumatic aspects of the past, the ego, in its subsequent trial actions, subjecting impulses to experimental discharge in thought, now receives the anxiety signal less frequently. In the person coming for analytic treatment, the proportion of anxiety responses during the experimental intrapsychic process has been relatively high, the ego coping mechanisms low, and the intrapsychic balance precarious and unstable. Anxieties based originally on a child's distorted evaluation of reality are increasingly subjected to factual reality, or Erikson's (1962) "actuality," leading to a corrective evaluation of the historical distortions involved. Castration and separation anxiety change from unrealistic fantasies to realistic assessments, which leads to their disappearance or change in the "average expectable" (Hartmann, 1939) traffic of life.

5. Following these intrapsychic achievements, fewer memories now elicit caution or turn on the need for defense again. Anxiety is less necessary, the signal of safety (Sandler, 1960) occurs more often, and the ego's course is freed toward less guarded action. Affects change from peremptory and automatic to modulated and tamed, akin to the course of normal ego development (Fenichel, 1941; E. Kris, 1950; Rapaport, 1953). This is part of a wider change in the increase of secondary process over primary process functioning. With this new freedom, the ego develops an increased capacity to tolerate anxiety and frustration. This reveals itself in its new handling of the intrapsychic process.

6. Ego autonomy is expanded and the ego freed for widened choice. I have shown (Rangell, 1986a) how the concept of ego autonomy described by Hartmann (1939, 1950) and expanded by Rapaport (1951a, 1958) has been insufficiently appreciated, itself suffering from a "developmental lag" and not applied as assiduously to the clinical situation as it deserves to be. Waelder (1960) is one of the few authors who unambivalently expressed this result of analysis. The analytic process reduces compulsion, passivity, and automatic behavior, and enlarges relative freedom of activity, choice, and action. The patient now has the potential for an increased freedom of will, exercised from unconscious through preconscious to conscious mentation.

7. Not only the ego, but all psychic structures come in for ameliorative and adaptive changes. The superego is modified to an internal composition more attuned to ego- and culture-syntony. A patient who has had lifelong problems and conflicts in stormy object relationships, comes to realize how much he has been living under his father's value system, which had been incorporated as his own. "You know what my father taught me about love?," he shouted at me emotionally one day. "He said, 'love is shit,' that's what he said." The patient recognized how much this had been his own unconscious attitude as well. His superego makeup changed considerably during the analysis, partly from identification with the analyst and partly from his

own freed ego now regulating his inner life. In keeping with the requirements of a more integrated and cohesive self, this included new means of effecting id discharge and improved choices of guiding principles from an also altered superego.

8. The id also comes under the aegis of change. In addition to changes in its internal composition, with an increased dominance of libidinal over aggressive impulses, the id probably begins to exert less peremptory pressures for discharge. Neutralization of drives takes place by a reciprocal influence between ego and id (Hartmann, 1952).

9. The result of these structural and other changes is an improved self-representation within the ego. With this altered concept of the self, the person now knows his own affects—no small or unusual achievement of analysis; he has an enlarged cognitive armamentarium, better understands the connections between ideation and affect, and suffers less of a gulf between self-representation and ego ideal. A clearer feeling of the boundaries of the self is associated with an improved differentiation of self from others and more satisfactory relations between self and object. This secondarily decreases problems of projection and introjection, or what is commonly called projective identification. All of these accomplishments are what is meant by Hartmann's (1939, 1950) integrative and organizing functions and Nunberg's (1931) synthetic functions of the ego, important ingredients in the achievement of "normalcy."

10. There is still more to do, even after an increased relative autonomy is achieved. Secondary gains extracted from the external world, as an outcome and accompaniment of pathological symptoms, and "tertiary gains of symptoms," a concept I added (Rangell, 1954), referring to an altered self-representation which includes the symptom after its chronic or long-time presence, need to be analyzed and surrendered by an unconscious "willingness" of the ego. This is largely what needs to take place during the often lengthy and difficult phase of working through. The repetition compulsion, originally motivated to effect instinctual discharge, becomes admixed with

aims directed toward these subsequent gains. The repetition compulsion, during the course of the therapeutic process, becomes less id-oriented and more ego-directed toward the overcoming of anxiety and the seeking of more adaptive solutions. It can thus become a positive mechanism during the phase of working through.

Decisions—their several places in the unconscious intrapsychic arc have been indicated—remain steadfastly for the patient to exercise. In one formulation of analysis, the analyst analyzes the patient's life to him but leaves the dignity of choice to the patient. I think of this issue coming up poignantly, testily, and repeatedly with one patient about whether or not to marry, with another about whether to divorce, with another about decisions regarding his occupation and career. Freud (1916-1917) encompassed all of these in his aphorism about love and work. The warning against the abrogation of this role by the analyst was sounded by Freud (1940), the danger of analysts wishing to create others "in their own image." Although at times this dictum may be difficult to enforce, it is imperative to maintain if the patient is to achieve the individuation which is part of the goal of psychoanalysis. Decision making, at an unconscious and derivatively preconscious-conscious level, becomes less encumbered or even freed from neurotic inhibitory influences by the changes which have taken place within the intrapsychic process.

Insights into what takes place at these "microdynamic" levels are not exclusive of changes at grosser or more macroscopic levels, in symptoms, external life adjustments, and object relations. A model is a skeletal statement, an explanation of a basic mechanism which characterizes the nature of a more complex process. As such, models have been used with profit, for example, by Rapaport in understanding thoughts (1950, 1951b) and affect (1953), and by Sandler and Joffe (1969) toward explaining the wider general psychoanalytic theory of behavior. While the original direction in neurosogenesis is from micro-

scopic to grosser internal phenomena and then to external object relations, the course of analytic treatment is the reverse, from the gross to the more microscopic internal origins.

The main achievement, from the point of view of the explanatory model I have presented, is that a new analytically treated ego sits astride an altered intrapsychic process. The well-known dicta of Freud, "Where id was, there ego shall be" (1933, p. 80) and "to make [the] unconscious conscious" (1933, p. 68) are not accurate as to the goals or achievements of the psychoanalytic process. The qualitative alterations of the unconscious intrapsychic process are more explanatory. The id does not disappear, nor does the unconscious; both persist post-analytically. It is the qualitative interrelationships, and the quantitative proportions between the psychic structures which are mainly altered in treatment.

Erikson (1954) mentioned dream analysis as a major accomplishment in the post-analytic phase. I would widen this to include the achievement of an increased executive functioning of the ego over the entire scope of the patient's trial intrapsychic actions. With the improvements noted in anxiety, defense, and the need for neurotic solutions to conflict, the paths to adaptive behavior become more viable and psychic outcomes more effective and enjoyable.

Analysis, of course, does not always work that way. Besides the patient's identifying with the analyst's analytic function, the analyst must be on guard also for identification as a defense, not as an intrapsychic accomplishment. The intrapsychic process is not always altered, or not always in a favorable direction. Some patients leave analysis with no perpetuation post-analytically of the analyst's positive effect on the workings of their intrapsychic process. Some use analysis instead to extract only self-indulgent acquisitions from the analytic process. Analysis was not for the restoration but the gratification of the self. Under such circumstances, anxiety is embedded again, not released or worked through. Erikson's idea of the post-analytic analysis of dreams,

or, I add, of the intrapsychic process, is not always accomplished.

The intrapsychic process is subjected to constant assessment and supervision. Improvement in its functioning, when this occurs, is not accomplished once and for all, but progresses and regresses as do other achievements during the analytic procedure. "I find myself going back to thinking and feeling the old way as if the new way doesn't exist," a patient explains during a long working-through period; "I have been in the deepest thought/depression since I left here yesterday," reflecting on his associations about repetitive neurotic behavior, this time toward another new object. (Ego mastery is a combination of affect and cognition together, as this example shows.) The course is irregular and not always predictable. Some time later, in another, more optimistic hour, he states, "Now I am ready to start all over again, maybe for the first time the right way." Still later, he associates about his reflections during his long walks. "I was talking to myself as per Martin Luther King [on the latter's national holiday], free at last, almighty God, I'm free at last" (wishfully, first on and off, then hopefully, in a more stable way). This patient, away from the analyst on a trip, misses what he does in the analysis.

This common reaction over separation from the analyst is not always separation anxiety, but anxiety that there will be a loss of the ego gains made, of the increased mastery over inner mental processes, or a failure to maintain these, and to prevent regression. It is necessary, and would be helpful, for this distinction to be kept in mind.

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