American Handbook of Psychiatry

The Theory of Psychoanalytic Technique

Classical Psychoanalytic School

Ralph R. Greenson

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The Theory of Psychoanalytic Technique

Ralph R. Greenson

Introduction

This presentation is an attempt to outline the theoretical foundation upon which psychoanalytic practice and technique are based. There is a very special reciprocal relationship between theory and technique in psychoanalysis. Every change in psychoanalytic theory is followed by corresponding changes in technique; every technical rule can be considered valid only if it can be rooted in a specific piece of psychoanalytic theory (Anna Freud).

Psychoanalysis is the only type of psychotherapy that attempts to remove the causes of neuroses. The vast majority of psychoanalysts believe that psychoanalytic technique and theory stands or falls on the psychoanalytic theory of neurosis (Walder). In recent years a number of psychoanalysts have attempted to widen the field of application of psychoanalytic technique and have described the analytic treatment of delinquents, borderline cases, and psychotics. Aichhorn, Eiss- ler, Stone, Arieti, Searles, and Wexler, among others, have contributed to this endeavor, but all of them acknowledge the deviations in technique from classical psychoanalysis. Others, like Rosenfeld, Boyer and Giovacchini, and Arlow and Brenner, maintain it is possible to treat schizophrenics with the traditional

psychoanalytic method.

I shall limit this essay to the theoretical foundations of classical psychoanalytic technique. I shall also touch upon some unana- lytic procedures that are used regularly in psychoanalytic treatment, but that do not violate classical psychoanalytic theory. I hope it will then become clear why Freudian psychoanalysis, without basic modifications, is not generally suitable for the treatment of borderline and psychotic patients.

The Historical Development of Psychoanalytic Therapy

I believe the quickest way of ascertaining what is essential in psychoanalytic technique is to take a birds-eye view of its historical development, noting the major changes in the technical procedures and the therapeutic processes. I am using the term "technical procedure" to refer to a course of action, a tool, an instrumentality, undertaken by the patient or the therapist. Free association, suggestion, and interpretation are examples of technical procedures. A "therapeutic process" refers to an interrelated series of psychic events within the patient, a continuity of psychic reactions that have a remedial aim or effect. Therapeutic processes are usually instigated by the technical procedures; examples include the recapturing of memories, emotional catharsis, transference, and the obtaining of insight.

Psychoanalytic technique was not suddenly discovered or invented. It

evolved gradually as Freud struggled to find a way to help his neurotic patients. Although Freud disclaimed any enthusiasm for therapeutic results, it was his therapeutic intent that led to the discovery of psychoanalysis. The changes in his technique were never abrupt nor complete. There would be a shift of emphasis, a change in the order of importance assigned a given procedure or a therapeutic process, but Freud was loath to discard completely his old ideas. Nevertheless, it is possible to delineate different phases in the development and significance of different technical procedures and therapeutic processes.

The early psychoanalytic concepts were discovered by Freud in the ten years between 1888 and 1898. Stewart has written a carefully documented account of the sequence of discoveries during this period. *The Studies on Hysteria,* written by Breuer and Freud," can be regarded as the beginning of psychoanalysis. In the section of that book called *Preliminary Communication,* published originally in 1893, Breuer described the treatment of Anna O., a patient who overcame her own amnesia and in sudden spells spontaneously hypnotized herself and spoke out of her unconscious mind. Not all patients were amenable to hypnosis, and Freud described how he gradually began to circumvent this difficulty by putting his patients in a state of concentration by the use of pressure on the forehead. The aim of the treatment of hysterical patients at that time was to get the patient to remember a traumatic experience that had been cut off from consciousness and that had resulted in

a strangulated state of the accompanying affects. Freud and Breuer maintained that *“Each individual hysterical symptom immediately and permanently disappeared when tee had succeeded in bringing clearly to light the memory of the event by which it teas provoked and its accompanying affect, and when the patient had described that event in the greatest possible detail and had put the affect into words”* (p. 6).

At this point the therapeutic process was the abreacting and remembering of a traumatic event, and the therapeutic procedure was hypnosis or suggestion. The fact that certain patients, like Frau Emmy von N., fought against being hypnotized revealed to Freud the presence of *resistance.* This force, he realized, was the same force that kept the pathogenic ideas from becoming conscious. In the section on *The Psychotherapy of Hysteria,* written by Freud alone and first published in 1895, he realized that the patient’s resistance was a defense, their “not knowing” was, in fact, a “not wanting to know” (pp. 269-270).

According to Jones, Freud gradually gave up hypnosis, suggestion, and pressing between 1892 and 1896 and relied instead on *free association.* Hints of this are already mentioned in 1889 in the case of Emmy von N. and later in the treatment of Elizabeth von R. The procedure of free association became known as the fundamental rule of psychoanalysis. It has remained the basic and unique method of communication for patients in psychoanalytic

treatment. Other means of communication occur during the course of psychoanalysis but they are secondary, preparatory, and not typical for psychoanalysis. Freud described this method as follows:

> Without exerting any other kind of influence, he invites them to lie down in a comfortable attitude on a sofa, while he himself sits on a chair behind them outside their field of vision. He does not even ask them to close their eyes, and avoids touching them in any way, as well as any other procedure which might be reminiscent of hypnosis. The session thus proceeds like a conversation between two people equally awake, but one of whom is spared every muscular exertion and every distracting sensory impression which might divert his attention from his own mental activity. ... In order to secure these ideas and associations he asks the patient to "let himself go" in what he says, "as you would do in a conversation in which you were rambling on quite disconnectedly and at random." [pp. 250-251]

Freud also realized that the personal influence of the physician could be of great value and suggested that the therapist act as an elucidator, a teacher, and a father confessor. However, he also became aware that under certain conditions the patient's relation to the physician can become "disturbed," a factor that turns the patient-physician relationship into the "worst obstacle" we can come across.

Thus Freud had discovered the phenomena of resistance and transference, but they were then considered essentially obstacles to the work. His main objective was to achieve affective abreaction and to recover traumatic memories. Transference reactions and resistances were hindrances to be circumvented or overcome.

The second phase of psychoanalytic technique began with Freud's *Interpretation of Dreams* published in 1900. In the famous seventh chapter of that book Freud had described the different forms, qualities, and properties that distinguish conscious from unconscious psychic phenomena. He designated two sets of governing principles: the primary and secondary processes. By recognizing the occurrence of condensation, symbol formation, reversal, and displacement, Freud discovered the importance of a new technical procedure: interpretation. Freud now realized that the structure of a neurosis was too complex to be dealt with merely by symptom removal.

The Fragment of an Analysis of a Case of Hysteria, known in psychoanalytic circles as the Dora case, was essentially a clinical example of how dream interpretation could be used as a technical tool. It was written immediately after the *Interpretation of Dreams* in 1901 but for various reasons was delayed in publication. In it Freud stated that psychoanalytic technique had been completely revolutionized (p. 12). He no longer tried to clear up each symptom, one after the other. By allowing the patient to do free association and to choose the subject matter of the hour, the analyst would then be able to interpret the meaning of the patient's material and resistances and thus undo the repressions, leading to filling in the gaps of memory.

It was in the Dora case that Freud first stated that, "Transference, which seems ordained to be the greatest obstacle to psychoanalysis, becomes its

most powerful ally, if its presence can be detected each time and explained to the patient" (p. 117). In a postscript to that case Freud described how the patient had broken off treatment because he had failed to analyze the multiple transference elements that interfered with the treatment situation.

The major shift in the theory of the therapeutic process was the emphasis on making the unconscious conscious by means of interpreting the patient's associations, including the resistances and the transference reactions. However, the overriding importance of the transference and the transference resistances was still not fully recognized. The recovery of memories had now become the major goal, and emotional catharsis was allocated to a secondary position.

The next major changes in technique took place in the years 1911-1915 when Freud published a series of six technical papers. In *The Dynamics of the Transference* he attempted to answer why transference can be the greatest obstacle and also the greatest ally of the analyst. Psychoanalysis does not produce transference; it only provides an arena for it to appear. Our patients all suffer from frustrations in their sexual and erotic life and therefore come to psychoanalysis with a transference readiness. During treatment the patient will regress to protect and hold onto his childhood fantasies, now displaced onto the person of the analyst. The analyst's task is to permit both the loving and hateful transference reactions to occur and to resolve them by

interpretation, by making them conscious to the patient.

Part of the last paragraph of *The Dynamics of Transference* is of such importance that it deserves to be quoted:

> Just as happens in dreams, the patient regards the products of the awakening of his unconscious impulses as contemporaneous and real; he seeks to put his passions into action without taking any account of the real situation. The doctor tries to compel him to fit these emotional impulses into the nexus of the treatment and of his life-history, to submit them to intellectual consideration and to understand them in the light of their psychical value. This struggle between the doctor and the patient, between intellect and instinctual life, between understanding and seeking to act, is played out almost exclusively in the phenomena of transference. It is on that field that the victory must be won—the victory whose expression is the permanent cure of the neurosis. It cannot be disputed that controlling the phenomena of transference presents the psycho-analyst with the greatest difficulties. But it should not he forgotten that it is precisely they that do us the inestimable service of making the patient's hidden and forgotten erotic impulses immediate and manifest. For when all is said and done, it is impossible to destroy anyone in absentia or in effigie.

The next paper published later that same year described the ideal attitude of the analyst. He should listen with evenly hovering attention and should try to avoid gratifying the patient's infantile wishes by reacting like an opaque mirror to the patient, reflecting back only what the patient displaces onto him. The analyst's personal views and reactions would only interfere with the analysis of the transference reactions.

The paper "On Beginning the Treatment" is noteworthy for our

purposes because in it Freud stated that the psychoanalyst should not make important interpretations to the patient until a proper rapport had been established between patient and analyst. How this is accomplished Freud stated as follows:

> To ensure this, nothing need be done but to give him time. If one exhibits a serious interest in him, carefully clears away the resistances that crop up at the beginning and avoids making certain mistakes, he will of himself form such an attachment and link the doctor up with one of the imagos of the people by whom he was accustomed to be treated with affection. It is certainly possible to forfeit this first success if from the start one takes up any standpoint other than one of sympathetic understanding, such as a moralizing one, or if one behaves like a representative or advocate of some contending party (Pp. 139, 140).

I believe this is the first description of the origin and importance of what later came to be known as the therapeutic or working alliance (Zetzel, Stone, Greenson).

Some important additions to psychoanalytic technique were added in “Remembering, Repeating and Working Through. Interpretations are never thoroughly effective if given only once. They have to be repeated because all neurotic patients have a “compulsion to repeat.” Patients will act out in the analytic situation what they cannot remember; therefore, the transference is singularly valuable. Finally in a successful analysis the patient will replace his previous neurosis with a “transference neurosis.” This means that eventually the analyst will become the most important person in the patient’s life, and all

the patient's neurotic symptoms and attitudes will revolve around the analyst. It is the resolution of the transference neurosis that insures a successful analysis.

If we review this phase of development in the history of psychoanalytic technique, we see that the central and most important technical procedures are aimed at facilitating the development of a regressive transference neurosis. In this way the patient relives within the analytic situation what he is unable to remember. By a nonintrusive, humane attti- tude, and by repeatedly and consistently interpreting the transference and resistance, the psychoanalyst is able to resolve the transference neurosis and help the patient break away from his neurotic past.

The last major addition to the technique of Freudian psychoanalysis was the emphasis on producing alterations in the ego. This was first mentioned in the twenty-seventh lecture of *The Introductory Lectures* (p. 455), but the nature of the alteration and how it could be effected was not described. In *Inhibitions, Symptoms and Anxiety,* published in 1926, Freud returned to the concept of "defensive processes" and considered repression only one of several defensive maneuvers. The ego uses the defenses, which exert an *anticathexis,* a counterforce, in order to keep some dangerous impulse, feeling, or thought out of consciousness. As a consequence there are alterations in the ego. For example, an attitude of excessive cleanliness may

be used as a reaction formation against an unconscious tendency to enjoy dirtiness. The defenses operate through the ego, and our major therapeutic efforts are aimed directly at the ego. Anna Freud's *The Ego and the Mechanisms of Defense,* published in 1936, was the first attempt to place ego psychology in the forefront of psychoanalytic theory as well as to systematize the various mechanisms of defense.

In *The Ego and the Id* Freud stated that by analyzing the transference reactions and resistances, psychoanalysis had become "an instrument to enable the ego to achieve a progressive conquest of the id" (p. 56). Later he wrote that the therapeutic efforts of psychoanalysis are intended "to strengthen the ego, to make it more independent of the super-ego, to widen its field of perception and enlarge its organization, so that it can appropriate fresh portions of the id. Where id was, there ego shall be" (p. 80). Again in *Analysis Terminable and Interminable* Freud stated: "The business of the analysis is to secure the best possible psychological conditions for the functions of the ego; with that it has discharged its task" (p. 250).

The Psychoanalytic Theory of Neurosis

I shall only touch on some of the highlights of the theory of neuroses and psychoses as they relate to psychoanalytic therapy. This subject has been covered in detail in Part A of this chapter.

The Conflict Theory of Neurosis

Beginning in 1894 in "The Neuro-Psychoses of Defence" Freud postulated that the neuroses are the result of a conflict between an instinctual drive and a defense. This theory is mentioned at many different points in Freud's writings, but it is often obscured by the fact that in his early writings , the only instinctual drive he described clinically was the sexual drive, and he used the term "repression" for the concept of defense mechanism in general. In his *Three Essays on Sexuality* he very clearly describes his theory of the etiology of hysteria: "The character of hysterics shows a degree of sexual repression in excess of the normal quantity, an intensification of resistance against the sexual instinct (which we have already met with in the form of shame, disgust and morality), and what seems like an instinctive aversion on their part to any intellectual consideration of sexual problems. As a result of this, in especially marked cases, the patients remain in complete ignorance of sexual matters right into the period of sexual maturity" (p. 164).

Perhaps Freud's most unequivocal statement on the conflict theory can be found in *On the History of the Psycho-Analytic Movement.* His point of view will be clarified if one replaces the term "repression" with the concept of mechanisms of defense.

> The theory of repression is the corner-stone on which the whole structure of psycho-analysis rests. It is the most essential part of it; and yet it is nothing hut a theoretical formulation of a phenomenon which may be

> observed as often as one pleases if one undertakes an analysis of a neurotic without resorting to hypnosis. In such cases one comes across a resistance which opposes the work of analysis and in order to frustrate it pleads a failure of memory. The use of hypnosis was bound to hide this resistance; the history of psychoanalysis proper, therefore, only begins with the new technique that dispenses with hypnosis. The theoretical consideration of the fact that this resistance coincides with an amnesia leads inevitably to the view of unconscious mental activity which is peculiar to psycho-analysis and which, too, distinguishes it quite clearly from philosophical speculations about the unconscious. It may thus be said that the theory of psycho-analysis is an attempt to account for two striking and unexpected facts of observation which emerge whenever an attempt is made to trace the symptoms of a neurotic back to their sources in his past life: the facts of transference and of resistance. Any line of investigation which recognizes these two facts and takes them as the starting point of its work has a right to call itself psycho-analysis, even though it arrives at results other than my own. But anyone who takes up other sides of the problem while avoiding these two hypotheses will hardly escape a charge of misappropriation of property by attempted impersonation, if he persists in calling himself a psycho-analyst (p. 16).

It was only with the development of the structural point of view that it was possible to describe the psychoanalytic theory of neurosis succinctly. I believe Fenichers' approach that all psychoneuroses are relative traumatic neuroses is a valuable one for understanding the formation of psychoneuroses in general. Psychoanalysis maintains that the psychoneuroses are based on unresolved *unconscious* conflicts between id impulses (instinctual drives) seeking discharge and ego defenses that arc attempting to ward off the impulses’ direct discharge or access to consciousness. These conflicts eventually lead to a damming up of the instinctual drives. The ego, which gives rise to the mechanisms of defense,

becomes drained of its energies and is eventually overwhelmed. As a result involuntary discharges occur that manifest themselves clinically as the symptoms of the neurosis.

The superego plays a more complicated role in the neuroses. It may enter the conflict on the side of the ego and may make the ego feel guilty even for thoughts and fantasies of instinctual satisfaction. On the other hand, the superego’s self-reproaches may become regres- sively reinstinctualized so that the self- reproaches take on a drivelike quality. All parts of the psychic apparatus take part in the formation of neurotic symptoms.

The external world also plays an important role in the causation of a psychoneurosis, but it does so only when it becomes allied with the ego, id, or superego. The external world may represent and mobilize some instinctual temptation. Then all situations that are reminiscent of the instinctual temptation may trigger an eruption of symptoms. The external world may be reacted to as a superego, and people or situations will be avoided because they stir up guilt and shame. What seems to begin as a conflict with the external world turns out to have become an internal conflict between the ego, the id, and the superego.

It should be remembered that Freud believed every adult neurosis is built on an infantile neurosis and will be re-experienced in the transference

neuroses. It was once thought that all children go through some form of infantile neurosis; some overcome it, “grow out of it,” while others develop a neurosis in later life (Fenichel). Anna Freud has stated that perhaps our more modern, flexible methods of upbringing lead to other less well- defined developmental disorders in the children of today.

The key factor in understanding the pathogenic outcome of the neurotic conflicts is the ego’s need constantly to expend its energies in attempting to keep the dangerous or forbidden drives from gaining access to consciousness or motility. Ultimately this leads to a relative insufficiency of the ego, and disguised derivatives of the original neurotic conflicts will overwhelm the depleted ego and break through into consciousness and behavior. These distorted and disguised involuntary discharges manifest themselves as the symptoms of the psychoneurosis. I would like to cite a relatively simple clinical example from my book on technique (Greenson).

> Some years ago a young woman, Mrs. A., came for treatment accompanied by her husband. She complained that she was unable to leave her house alone and felt safe only with her husband. In addition, she complained of a fear of fainting, a fear of dizziness, and a fear of becoming incontinent. Mrs. A.’s symptoms had begun quite suddenly some six months earlier while she was in a beauty parlor.
>
> The analysis, which lasted several years, revealed that the actual trigger for the outbreak of the patient’s phobias was the event of having her hair combed by a male beautician. We were able eventually to uncover the fact that at that moment she was reminded of her father combing her hair when she was a little girl. The reason she had gone to the beauty parlor

> that day was her pleasurable expectation of seeing her father, who was to visit the young married couple for the first time since their marriage. He was to stay in their home and she was filled with great delight, consciously. However, unconsciously, she was full of guilt feelings for loving her father and for her predominantly unconscious hostility toward her husband.
>
> The apparently innocuous event of having her hair combed stirred up old incestuous longings, hostilities, guilt, and anxiety. To put it briefly, Mrs. A. had to be accompanied by her husband in order to be sure he had not been killed by her death wishes. Also his presence protected her from acting out sexually. The fears of fainting, of dizziness, and of incontinence were symbolic representations of losing her moral balance, losing her self-control, soiling her good character, humiliating herself, and falling from her high position. The young woman's symptoms had links to the pleasurable body sensations of childhood as well as to infantile punishment fantasies.
>
> I believe one can formulate the events as follows: the combing of her hair stirred up repressed id impulses which brought her into conflict with her ego and superego. Despite the absence of obvious neurotic symptoms prior to the outbreak of the phobias, there were indications that her ego already was relatively depleted and her id lacked adequate discharge possibilities. Mrs. A. had had difficulty in sleeping for years, nightmares, and inhibitions in her sexual life. As a consequence the fantasies mobilized by the hair combing increased the id tensions to a point where they flooded the infantile defenses of the ego and involuntary discharges took place, eventuating in acute symptom formation (Pp. 19, 20).

The Psychoanalytic Theory of Psychosis

Freud's writings on the psychoses were not consistent and were often obscure and even contradictory. Yet a careful reading of his work does reveal that he felt there were *qualitative* differences between the neuroses and the

psychoses. In *The Introductory Lectures* he distinguishes between patients who can form a *transference neurosis* during psychoanalytic treatment and those who cannot because they suffer from a *narcissistic neurosis* (pp. 420-423). Earlier in the Schreber case Freud described how Schreber's "Subjective world had come to an end since his withdrawal of love from it." In his paper on *The Unconscious* Freud stated very clearly, "In the case of schizophrenia, on the other hand, we have been driven to the assumption that after the process of repression the libido that has been withdrawn does not seek a new object, but retreats into the ego; that is to say, that here the object-cathexes are given up and a primitive objectless condition of narcissism is re-established" (pp. 196-197).

I believe that Wexler is particularly clear on the subject of the psychoses, and I would like to quote from his most recent paper. Referring to Freud's remarks above, he says:

> By this statement, Freud did not mean only the withdrawal from external reality objects. He specified repeatedly that "in schizophrenia, this flight consisted in withdrawal of instinctual cathexis from the points which represent the unconscious presentation of the object." Here was the really crucial differentiation between neurosis and psychosis. Here was the real basis for the clinical experience of inner and outer world destruction. Here was the central theoretical construct by which one could understand that if the ego was a "precipitate of abandoned object- cathexes," then the dissolution of those representations must necessarily lead to the psychic disasters of schizophrenia (p. 93).

I believe these theoretical formulations based on the clinical findings in psychoses indicate how dangerous the classical psychoanalytic procedure can be for such patients. Lying on a couch with the analyst out of sight and doing free association can mean a loss of contact with reality for the schizophrenic patient. For these patients the nontransference, real relationship is far more important. Only when there is sufficient structure building would consistent interpretation be indicated (Greenson and Wexler).

The Metapsychology of Psychoanalysis

The basic aim of psychoanalytic therapy is to undo the unresolved conflicts that are the cause of the neurosis. To understand the patient's pathology and the interactions between the patient and the analyst during therapy, we attempt to study these phenomena from five basic theoretical points of view. These are grouped together as the metapsychologv of psychoanalysis and consist of the topographical, dynamic, economic, genetic, and structural points of view. In actual practice we only analyze our patient's productions partially and fragmentarily in a given interval of time. Nevertheless, if we do succeed in working through all our insights, we realize that we have, in fact, utilized all five metapsychological approaches. Freud's metapsychological writings are scattered throughout his writings and are neither systematic nor complete. Here I shall only attempt to give a working definition of these concepts. For a more comprehensive survey the reader is

referred to Fenichel, Rapaport and Gill, and Arlow and Brenner.

The earliest point of view Freud postulated was the *topographical* one. In Chapter 7 of *The Interpretation of Dreams* he described the different modes of functioning that are characteristic for conscious and unconscious phenomena. The primary process holds sway over unconscious material, and the secondary process directs conscious phenomena. Unconscious material has only one aim—discharge. There is no sense of time, order, or logic, and contradictions may coexist without nullifying one another. Condensation and displacement are other characteristics of the primary process. Designating a psychic event as conscious or unconscious implies more than merely a difference in quality. Archaic and primitive modes of functioning are characteristic of unconscious phenomena.

The *dynamic point of view* considers all mental phenomena to be the result of the interaction of forces, some working in unison and others working concurrently in opposition to one another. An example of this is the following: A young man greets an attractive guest sitting at the family dinner table by saying: “How nice to see you, Dolores. Every time you come it is like a *breast* of fresh air. Oh, I mean it’s like a breath of *flesh* air.” The first sentence expresses the young man’s pleasure in a socially acceptable way. The slip of saying breast instead of breath indicates a breakthrough of sexual feelings toward the woman. He tries to repair this breach but succeeds only partially.

He represses the breast, but fresh gets turned into flesh. It is only a partial victory for the antisexual forces within him. The wish to expose and to hide his sexual desires is vividly demonstrated in his slips. The dynamic point of view is the basis for all hypotheses concerning instinctual drives and defenses, ego interests, neurotic conflicts, symptom formation, ambivalence, and overdetermination.

The *economic point of view* concerns the distribution, transformation, and expenditures of psychic energies. Such concepts as the ego's ability or inability to cope, sublimation, sex- ualization, aggressivization, and binding are based on this hypothesis. An example of economics can be seen in the case of Mrs. A., whom I described above. Before the outbreak of the patient's phobias she was in a state of damned up instinctual tensions, but her ego was still able to carry out its defensive functions adequately enough so that Mrs. A. could function without obvious symptoms. At the point of her father's visit the hair combing brought back sexual and romantic memories from the past. In addition, it increased her hostility to her husband. Mrs. A.'s ego could not cope with this new influx of id strivings seeking discharge. The instinctual impulses broke through in feelings of fainting, dizziness, and incontinence. This led to a phobia about leaving her house unaccompanied by her husband.

The *genetic point of view* deals with the origin and development of psychic phenomena. It deals not only with how the past lives on in the

present, but also why a specific solution was used in ccrtain conflicts. This includes the biological-constitutional factors as well as the experiential ones. An example would be a male patient who uses excessive submissiveness to avoid conflict with a strong man. This was his mother's way of dealing with his father, which he identified with.

The *structural point of view* assumes the psychic apparatus can be divided into several persisting function units. This was Freud's last major theoretical contribution. The hypothesis that the psychic apparatus is made of an ego, id, and superego is based on the concept of psychic structure. It is implied whenever we talk of interstructural conflicts like symptom formation or intrastructural processes like the ego's synthetic function.

The Psychoanalytic Situation

At this point I believe we are ready to explore the three components of the psychoanalytic situation—the patient, the psychoanalyst, and the setting—and ask ourselves what does each contribute to the process of being analyzed and how do these three essential elements interact with one another. We can now state the aim of psychoanalytic therapy more succinctly. *The analyst attempts to resolve the patient's neurotic conflicts by reuniting with the conscious ego those portions of the id, superego, and unconscious ego that had been excluded from the maturational processes of the healthy remainder of*

the total personality.

The Components of Classical Psychoanalytic Technique

The Patient’s Production of Material

Free Association

The psychoanalyst approaches the unconscious by using the derivatives of the unresolved conflicts. Derivatives are “half-breeds” that are not conscious and yet are highly organized in accordance with the secondary process; they are accessible to the conscious ego and can be put into coherent language (Freud). Psychoanalysis requires that the patient try to approximate free association, the so-called basic rule, in order to facilitate the communication of derivatives. Derivatives appear also in dreams, slips, symptoms, and acting out.

The patient is asked to try, to the best of his ability, to let things come up in his mind and to say them without regard for logic or order; he is to report things even if they seem trivial, shameful, or impolite. By letting things come to mind a regression in the service of the ego takes place, and derivatives of the unconscious ego, id, and superego tend to come to the surface. The patient moves from strict secondary-process thinking in the direction of the primary process. It is the analyst’s task to analyze these derivatives for the patient.

Usually this is attempted only after the preliminary interviews have been concluded, and we have decided the patient seems to have the capacities needed to work in the analytic situation. We want to be reasonably certain that the patient has the resilience in his ego functions to oscillate between the more regressive ego functions as they are needed in free association and the more advanced ego functions required for understanding the analyst's interventions and resuming his everyday life at the end of the hour.

The patient may report events from his daily life or past history in addition to reporting his free associations. It is characteristic for psychoanalysis to ask the patient to include his associations as he recounts any other happening in his life. Free association has priority over all other means of producing material in the analytic situation.

However, free association, like any other tool of psychoanalysis, may be misused by the patient or the psychoanalyst (A. Freud). This does not mean such tools are outdated and should be replaced or downgraded as suggested by Lacan, Alexander and French, or Marmor. I agree with Anna Freud who said that the tools of any trade should be periodically inspected, revised, and sharpened. Every psychoanalyst should be familiar with the most common misuses of our technical rules. Some schizophrenic patients cannot stop free associating. The error in such an instance would be in asking such a patient to enter into an analytic situation.

The Transference Reactions

Psychoanalysis is distinguished from all other therapies by the way it promotes the development of the transference reactions and by how it attempts systematically to analyze transference phenomena. By transference we refer to a special kind of relationship toward a person; it is a distinctive type of object relationship. The main characteristic is the experience of feelings for a person that do not befit that person and that actually apply to another. Essentially a person in the present is reacted to as though he were a person in the past. Transference is a repetition, a new edition of an old object relationship (Freud). A displacement has taken place; impulses, feelings, and defenses pertaining to a person in the past have been shifted onto a person in the present. It is primarily an unconscious phenomenon, and the person reacting with transference feelings is in the main unaware of the distortion.

Transference may consist of any of the components of an object relationship; that is, it may be experienced as feelings, drives, wishes, fears, fantasies, attitudes, and ideas or defenses against them. The people who are the original sources of transference reactions are the meaningful and significant people of early childhood (S. Freud, A. Freud). Transference occurs in analysis and outside of analysis, in neurotics, in psychotics, and in healthy people. All human relations contain a mixture of realistic and transference reactions (Fenichel).

Transference reactions are always inappropriate. They may be so in the quality, quantity, or duration of the reaction. One may overreact or underreact, or one may have a bizarre reaction to the transference object. The transference reaction is unsuitable in its current context; but it was once an appropriate reaction to a past situation. Just as ill-fitting as transference reactions are to a person in the present, they fit snugly to someone in the past.

> For example, a young woman patient reacts to my keeping her waiting for two or three minutes by becoming tearful and angry, fantasying that I must be giving extra time to my favorite woman patient. This is an inappropriate reaction in a thirty-five-year-old intelligent and cultured woman, but her associations lead to a past situation where this set of feelings and fantasies fit. She recalls her reactions as a child of five waiting for her father to come to her room to kiss her good night. She always had to wait a few minutes because he made it a rule to kiss her younger sister good night first. Then she reacted by tears, anger, and jealousy fantasies—precisely what she is now experiencing with me. Her reactions are appropriate for a five-year-old girl, but obviously not fitting for a thirty-five-year-old woman. The key to understanding this behavior is recognizing that it is a repetition of the past, i.e., a transference reaction. [Greenson, pp. 151-153]

It is important to recognize that in transference reactions the patient tends to repeat instead of to remember; and in this sense transference is always a resistance in regard to the function of memory. However, by repeating, by re-enacting the past, the patient does make it possible for the past to enter into the treatment situation. Transference repetitions bring into the analysis material that might otherwise be inaccessible. It properly

handled the analysis of transference will lead to memories, reconstructions, and insight, and an eventual cessation of the repetition.

There are many ways of classifying the various clinical forms of transference reactions. The most commonly used designations are the positive and the negative transference. The positive transference refers to the different forms of loving and the negative transference implies some variety of hatred toward the analyst. It should be borne in mind that all transference reactions are essentially ambivalent. What appears clinically is only the surface.

For transference reactions to take place in the analytic situation, the patient must be willing and able to risk some temporary regression in terms of ego functions and object relations. The patient must have an ego capable of temporarily regressing to transference reactions, but this regression must be partial and reversible so that the patient can be treated analytically and still live in the real world. People who do not dare regress from reality and those who cannot return readily to reality, like the psychotics, are poor risks for psychoanalysis. Freud" divided the neuroses into two groups on the basis of whether a patient could develop and maintain a relatively cohesive set of transference reactions and still function in the analysis and in the external world. Patients with a "transference neurosis" could do this, while patients suffering from a "narcissistic neurosis" could not.

Freud also used the term “transference neurosis” to describe that intensity and extent of transference reactions in which the analyst and the analysis have become the central interest in the patient’s emotional life, and the patient’s major neurotic conflicts are relived in the analytic situation. All the important features of the patient’s neurosis will be relived or re-enacted in the analytic situation (Freud).

Psychoanalytic technique is geared to insure the maximal development of the transference neurosis. The relative anonymity of the analyst, his nonintrusiveness, the so-called rule of abstinence, and the “mirrorlike” behavior of the analyst all have the purpose of preserving a relatively uncontaminated field for the budding transference neurosis (Fenichel, Greenacre, Gill). The transference neurosis is an artifact of the analytic situation; it can be undone only by the analytic work. It serves as a transition from illness to health.

On the one hand, the transference neurosis is the most important vehicle for success in psychoanalysis; on the other, it is the most frequent cause of therapeutic failure (Freud, Glover). The transference neurosis can be resolved only by analysis; other procedures may change its form, but will only perpetuate it (Gill).

Psychoanalysis is the only form of psychotherapy that attempts to

resolve the transference reactions by systematically and thoroughly analyzing them. In some briefer or diluted versions of psychoanalysis one does so only partially and selectively. Thus one might analyze only the hostile transference when it threatens to disrupt the treatment, or one analyzes only as deeply as required for the patient to be able to work in the therapeutic situation. In such cases there is always a residual of unresolved transference reactions after the treatment is completed. This implies that there is some unanalyzed neurosis left unchanged.

In the *antianalytic* forms of psychotherapy the transference reactions are not analyzed but gratified and manipulated. The therapist assumes the role of some past figure, real or fantasied, and gratifies some infantile wish of the patient's. The therapist might act like a loving or encouraging parent, or like a punishing moralist, and the patient might feel some temporary improvement or even be "cured." But these "transference cures" are fleeting and last only as long as the idealized transference to the therapist is untouched (Fenichel, Greenson).

The Working Alliance and the Real Relationship

As important as the unfolding and interpreting of the transference reactions are, they are not sufficient for producing lasting changes in the patients. In order for a neurotic patient to work effectively in the analytic

situation he must establish and maintain a working or therapeutic alliance with the analyst. Zetzel and Stone were among the first to stress this aspect of the psychoanalytic situation. The core from which the working alliance is derived is the real, nontransference relationship between the analyst and patient (Greenson and Wexler).

Ever since Freud's Dora case of 1905, psychoanalysts have made the analysis of transference the major focus of psychoanalytic technique. This development has reached such proportions that Kleinian psychoanalysts consider all interactions between the patient and his analyst as transference or countertransference and would make interpretation the only correct intervention. "Orthodox" Freudians often recognize that personal interactions other than transference may occur but tend to treat them as irrelevant or trivial, at least in their writings. They even acknowledge that interventions other than strictly defined interpretations may at times be necessary, but these are mainly considered "parameters" and are to be used sparingly and then eliminated (Eissler). On the whole both groups ignore the subject.

Over the years, however, a number of psychoanalysts, too heterogeneous to be classified, have taken a growing interest in what may be broadly termed the working alliance and the nontransference interactions that take place in the course of psychoanalytic treatment. As stated previously, transference is the experiencing of impulses, feelings, fantasies,

attitudes, and defenses with respect to a person in the present that do not appropriately fit that person but are a repetition of responses originating in regard to significant persons of early childhood, unconsciously displaced onto persons in the present. Transference is an indiscriminate, nonselective repetition of the past that ignores or distorts reality and is inappropriate (Greenson).

The very fact that the concept of transference has, over the years, come to have this rather precise meaning implies that it was technically and theoretically necessary to differentiate it from other reactions that are relatively transference-free. Anna Freud, in a recent personal communication on the subject of differentiating between transference and nontransference relationships, had the following to say: ‘I have always learned to consider transference in the light of a distortion of the real relationship of the patient to the analyst, and, of course, that the type and manner of distortion showed up the contributions from the past. If there were no real relationship this idea of the distorting influences would make no sense.”

All object relations consist of some elements of repetition from the past, but the so-called real, the nontransference, relationship differs from transference in the degree of relevance, appropriateness, accuracy, and immediacy of what is expressed. Furthermore, nontransference responses are basically readily modifiable by both internal and external reality; they are

adaptive and realistic.

The terms “transference,” “nontransference,” “transference-free,” and “real relationships” must be considered as relative and overlapping. All transference contains some germs of reality, and all real relationships have some transference elements. All object relationships consist of different admixtures and blendings of transference and nontransference components. Nevertheless, I feel it is important to draw some clear-cut distinction between them. For this purpose a clinical example may serve better than abstract definitions.

A young man, Kevin, in the fifth year of analysis, told me hesitantly after I had made an interpretation that he had something to say that was very difficult for him. He had been about to skip over it when he realized he had been doing just that for years. Taking a deep breath, he said: “You always talk a bit too much. You tend to exaggerate. It would be much easier for me to get mad at you and say you’re cockeyed or wrong or off the point or just not answer. It’s terribly hard to say what I mean because I know it will hurt your feelings.”

I believe the patient had correctly perceived some traits of mine, and it was indeed somewhat painful for me to have them pointed out. I told him he was right on both counts, but I wanted to know why it was harder for him to

tell it to me simply and directly as he had just done than to act in an angry fashion. He answered that he knew from experience that I would not get upset by an exhibition of temper since that was obviously his neurosis and I wouldn't be moved by it. Telling me so clearly about my talking too much and exaggerating was a personal criticism and that would be hurtful. In the past he would have been worried that I might retaliate in some way, but he now knew it was not likely. Besides, he no longer felt my anger would kill him.

Here the difference between transference and nontransference reactions becomes clear. The patient had correctly perceived some characteristics of his analyst's way of working and had also quite realistically predicted that it would be painful for the analyst to have them pointed out. These are nontransference phenomena; they are contemporaneous, appropriate, and realistic. His earlier fantasies about a potentially retaliatory anger that might kill him were historically rooted carryovers from his childhood anxieties, inappropriate exaggerations, and therefore transference distortions. The patient had developed a good working alliance in relation to his temper outbursts at the analyst, but this alliance could not maintain itself when it came to more realistic criticism. This only developed in his fifth year of analysis (Greenson and Wexler).

It might be well at this point to clarify the relationship between the working alliance, transference, and the real relationship. The working alliance

is the nonneurotic, rational, reasonable rapport that the patient has with his analyst and that enables him to work purposefully in the analytic situation despite his transference impulses (Zetzel, Stone, Greenson). The patient and the psychoanalyst contribute to the formation of the working alliance. The patient's awareness of his neurotic suffering and the possibility of help from the analyst impel him to seek out, and work in, the analytic situation. The positive transference, the overestimation and overevaluation of the psychoanalyst, may also be a powerful ally, but it is treacherous. Above all, the reliable core of the working alliance is to be found in the real or nontransference relationship between the patient and the analyst. Transference reactions, whether loving or hateful, from the most infantile to the most mature, eventually lead to idealization, sexualization, or aggressivization and become important sources of resistance in the end. The analyst's participation will be discussed in the section on the analyst's contributions to the analytic situation.

The Resistances

Resistance means opposition. All those forces within the patient that oppose the procedures and processes of analysis—that is, that hinder the patient's free association, that interfere with the patient's attempts to remember and to gain and assimilate insight, that operate against the patient's reasonable ego and his wish to change-—-all of these forces are to

be considered resistance (Freud). Resistance may be conscious, preconscious, or unconscious, and may be expressed by means of emotions, attitudes, ideas, impulses, thoughts, fantasies, or actions. Resistance is in essence a counterforce in the patient, operating against the progress of the analysis, the analyst, and the analytic procedures and processes. Freud' had already recognized the importance of resistance in 1912 when he stated: “The resistance accompanies the treatment step by step. Every single association, every act of the person under treatment must reckon with the resistance and represents a compromise between the forces that are striving towards recovery and the opposing ones” (p. 103).

Resistance opposes the patient’s reasonable ego, defending the neurosis, the old, the familiar, and the infantile from exposure and change. It may be adaptive. The term “resistance” can be equated with all the defensive operations of the mental apparatus as they are evoked in the analytic situation. The defenses are processes that safeguard against danger and pain and are to be contrasted to the instinctual activities, which seek pleasure and discharge. In the psychoanalytic situation the defenses manifest themselves as resistances. Freud used the terms synonymously throughout most of his writings. The function of defense is originally and basically an ego function, although every kind of psychic phenomenon may be used for defensive purposes.

Freud distinguished among several types of resistances, but I believe it is safe to state that no matter what its origin may be, for a psychic phenomenon to be used for defensive purposes, it must operate through the ego. This is the rationale for the technical rule that the analysis of resistance should begin with the ego. Resistance is an operational concept; it is nothing new that is created by the analysis; the analytic situation only becomes the arena for these forces of resistance to show themselves.

The Analyst’s Contribution

In classical psychoanalysis a great number of therapeutic procedures are employed in varying degrees. It is characteristic of all techniques that are considered analytic that their major aim is to increase the patient’s insight about himself. Some procedures do not add insight per se, but strengthen those ego functions that are required for gaining understanding. For example, abreaction may permit a sufficient discharge of instinctual tension so that a beleaguered ego will no longer feel imminently endangered. The more secure ego is now able to observe, think, remember, and judge, functions it had lost in the acute anxiety state. Insight now becomes possible. Abreaction is one of the *nonanalijtic* procedures that is frequently used in psychoanalytic treatment; it is often an indispensable prerequisite for insight.

The *antianalytic* procedures are those that block or lessen the capacity

for insight and understanding. The use of any measure or course of action that diminishes the ego functions of observing, thinking, remembering, and judging belongs in this category. Some obvious examples are the administering of certain drugs and intoxicants, quick and easy reassurances, infantile transference gratifications, diversions, and so forth.

The most important analytic procedure is interpretation; all others are subordinated to it both theoretically and practically. All analytic procedures are steps that lead to an interpretation or make an interpretation effective (E. Bibring, Gill, Menninger).

The term "analyzing" is a shorthand expression that refers to typical insight-furthering techniques. It usually includes four distinct procedures: confrontation, clarification, interpretation, and working through. Before discussing these procedures I believe it would be helpful to consider the dynamics of the treatment situation in general and also explore the question of how an analyst listens.

The Dynamics of the Treatment Situation

The treatment situation mobilizes conflicting tendencies within the patient. It would be valuable to survey the alignment of the forces within the patient in the analytic situation (see Freud, pp. 142-144). I shall begin by enumerating those forces that are on the side of the psychoanalyst and the

psychoanalytic processes and procedures:

1. The patient’s neurotic misery, which impels him to work in the analysis, no matter how painful.

2. The patient’s conscious rational ego, which keeps the long-range goals in view and comprehends the rationale of the therapy.

3. The id, the repressed, and their derivatives; all those forces within the patient seeking discharge and tending to appear in the patient’s productions.

4. The working alliance, which enables the patient to cooperate with the psychoanalyst despite the coexistence of opposing transference feelings.

5. The deinstinctualized positive transference, which permits the patient to overvalue the competence of the analyst. On the basis of little evidence the patient will accept the analyst as an expert. The erotic positive transference may also induce the patient to work temporarily, but that is far more unreliable and prone to turn into its opposite.

6. The rationale superego, which impels the patient to fulfill his therapeutic duties and obligations. Menninger’s “contract” and Gitelson’s “compact” express similar ideas.

7. Curiosity and the desire for self-knowledge, which motivate the patient to explore and reveal himself.

8. The wish for professional advancement and other varieties of

ambition.

9. Irrational factors, such as competitive feelings toward other patients, getting one's money's worth, the need for atonement and confession, all of which are temporary and unreliable allies of the psychoanalyst.

All the forces listed above influence the patient to work in the analytic situation. They differ in value and effectiveness and change during the course of treatment.

The forces within the patient opposing the analytic processes and procedures may be broken down as follows:

1. The unconscious ego's defensive maneuvers, which provide the models for the resistance operations.

2. The fear of change and the search for security, which impel the infantile ego to cling to the familiar neurotic patterns.

3. The irrational superego, which demands suffering in order to atone for unconscious guilt.

4. The hostile transference, which motivates the patient to defeat the psychoanalyst.

5. The sexual and romantic transference, which leads to jealousy and frustration and ultimately to a hostile transference.

6. Masochistic and sadistic impulses, which drive the patient to provoke a variety of painful pleasures.

7. Impulsivity and acting-out tendencies, which impel the patient in the direction of quick gratifications and against insight.

8. The secondary gains from the neurotic illness, which tempt the patient to cling to his neurosis.

These are the forces that the analytic situation mobilizes in the patient. As one listens to the patient, it is helpful to have this rather simplified division of forces in the back of one's mind (Greenson).

How the Analyst Listens

It might seem unnecessarily pedantic to set down in writing how a psychoanalyst should listen. Yet clinical experience has taught us that the way a psychoanalyst listens is just as unique and complex a procedure as doing free association is for the patient. Here only an outline will be sketched as a preliminary briefing.

The analyst listens with three aims in mind:

1. To translate the productions of the patient into their unconscious antecedents. The patient's thoughts, fantasies, feelings, behavior, and impulses have to be traced to their unconscious predecessors.

2. The unconscious elements must be synthesized into meaningful insights. Fragments of past and present history, conscious and unconscious, must be connected so as to give a sense of continuity and coherence in terms of the patient's life.

3. The insights so obtained must be communicable to the patient. As one listens one must ascertain what uncovered material will be constructively utilizable by the patient.

Clinical experience has suggested a few basic guidelines in order to accomplish these divergent aims (Freud, pp. 111-117). One listens with evenly suspended, evenly hovering, free-floating attention. One does not make a conscious attempt to remember. The analyst will remember the significant data if he pays attention and if the patient is not stirring up the analyst's own transference reactions. Non-selective, nondirected attention will tend to rule out one's own special biases and will allow the analyst to follow the patient's lead. From the evenly suspended, free-floating position the analyst can oscillate and make blendings from among his free associations, empathy, intuition, introspection, problem-solving thinking, theoretical knowledge, and so forth (Ferenczi, Sharpe).

All activities that interfere with the capacity to make the oscillations described above are to be avoided. An analyst should not take any notes if this interferes with his free-floating listening. Word-for-word notes are obviously contraindicated since that would distort his main purpose. The analyst is

primarily an understander and a conveyer of insight. He is not essentially a recorder or a collector of research data (Berezin). In order to listen effectively one must also pay attention to one's own emotional responses since these responses often lead to important clues. Above all, the analyst must be alert to his own transference and resistance reactions since they can impede or help his understanding of the patient's productions.

The analytic situation is essentially a therapeutic one. The analyst is to administer insight and understanding for therapeutic purposes. He listens to gain insight, and he listens from a position of free-floating attention, with restrained emotional responses, with compassion, and with patience. All other scientific pursuits have to be put aside if he is to perform his complicated tasks effectively.

Analyzing the Patient's Material

Confrontation

The first step in analyzing a psychic phenomenon is confrontation. The phenomenon in question has to be made evident to the patient's *conscious* ego. For example, before I can interpret the reason a patient may have for avoiding something, I first have to get him to acknowledge that he is avoiding something. Eventually the patient himself will recognize this, and it will be unnecessary for me to do so. However, before any further analytic steps are

taken it must be certain that the patient recognizes the psychic phenomenon within himself that we are attempting to analyze.

Clarification

Confrontation leads to the next step, clarification. Usually these two procedures blend together, but I find it valuable to separate them because there are instances where each of them cause distinct problems. Clarification refers to those activities that aim at placing the psychic phenomenon being analyzed in sharp focus. The significant details have to be dug out and carefully separated from extraneous matter. The particular variety or pattern of the phenomenon in question has to be singled out and isolated.

> Let us take a simple example. I confront a patient, Mr. N., with the fact that he is resisting and he recognizes that it is indeed so, he does seem to be running away from something. The patient's further associations may then lead in the direction of revealing why he is resisting or what he is resisting. Let us take the former instance. The resistant patient's associations lead him to talk of various events of the past weekend. Mr. N. went to a P.T.A. meeting at his daughter's school and felt abashed by the presence of so many wealthy-appearing parents. This reminds him of his childhood and how he hated to see his father attempt to ingratiate himself with his wealthy clients. His father was a tyrant in his dealings with his employees and an "ass-kisser" with the rich. He was afraid of his father until he left home to go to college. Then he developed a contempt for him. He still has a feeling of contempt for him, but he doesn't show it. After all, it would serve no purpose, his father is too old to change. His father must be getting close to sixty, his hair is almost all white, "whatever is left of it." The patient becomes silent.

I had the impression that Mr. N.’s associations were pointing to certain feelings he had about me and it was those feelings which had caused him to be resistant in the early part of the hour. I also felt that this probably had to do with contempt and, more precisely, the patient’s fear of expressing his contempt for me directly. When the patient became silent, I said that I wondered if he didn’t feel some contempt for another white-haired man. The patient’s face flushed and his first response was to say: “I suppose you think I was talking about you. Well, it’s just not true. I don’t feel any contempt for you—why should I? You treat me very well—most of the time. I have no idea how you treat your family or your friends. But, that’s none of my business. Who knows, maybe you are one of those men who steps on the little guy and makes up to the ‘big shots.’ I don’t know and I don’t care.”

At that moment I pursued the point. I replied that I felt he was relieved not to know how I really behaved outside the hour. If he knew he might feel contempt and he would be afraid to express it to me directly. Mr. N. was silent for a few seconds and answered that if he imagined me doing something contemptible, he wouldn’t know what to do with the information. This reminded him of an occasion a few weeks back. He had been in a restaurant and heard a man’s angry voice belaboring a waiter. For a fleeting instant the voice sounded like mine and the back of the man’s head resembled mine. He was relieved a few moments later to see that it wasn’t true.

It was now possible to point out to the patient that he was trying to avoid feeling contempt for me because if he were to do so, he would be afraid of expressing it, just as he had with his father. It was this specific complex pattern of emotional responses that had to be singled out for clarification before one could go on with the further analysis of his resistances. [Greenson, pp. 38-39]

Interpretation

The third step in analyzing is interpretation. This is the procedure that

distinguishes psychoanalysis from all other psychotherapies because in psychoanalysis interpretation is the ultimate and decisive instrument. Every other procedure prepares for interpretation or amplifies an interpretation and may itself have to be interpreted. To interpret means to make an unconscious phenomenon conscious. More precisely it means to make conscious the unconscious meaning, source, history, mode, or cause of a given psychic event. This usually requires more than a single intervention. The analyst uses his own unconscious, his empathy and intuition, as well as his theoretical knowledge, for arriving at an interpretation. By interpreting we go beyond what is readily observable and we assign meaning and causality to a psychological phenomenon. We need the patient's responses to determine the validity of our interpretation (E. Bibring, Fenichel).

The procedures of clarification and interpretation are intimately interwoven. Very often clarification leads to an interpretation that leads to a further interpretation (Kris).

Let me return to the clinical excerpt from the treatment of Mr. N. to illustrate these points. The patient is aware that he is resisting facing something, but he is unaware of the feelings and toward whom they are directed. His associations to his contempt for his father impel me to clarify this further, and I point out that he is *afraid* of feeling contempt and having to express it to another white-haired man. The fear of expressing contempt is a

clarification; the introduction of “another white-haired man” is an indirect transference interpretation. Mr. N.’s immediate response is a vehement denial: “I suppose you think I was talking about you. Well, it’s just not true. ... I have no idea how you treat your family or your friends. But, that’s none of my business. ... I don’t know and I don’t care.” This response is so intense that I feel I have touched something inside him that is on the verge of becoming conscious.

I then interpret that he is relieved not to know how I treat people in the outside world because if he were to feel contempt he would be afraid to express it to me directly. Mr. N. then recalls an experience in a restaurant when he heard an angry voice belaboring a waiter and for a flash he thought of me. His relief that it was not me indicates that he would have felt contempt for such a man. Mr. N. thus validated the correctness of my clarification and interpretation. I was then able to connect his feelings in the hour to me to the same specific pattern he had felt to his father —a deepening of the interpretation.

Working Through

The fourth step in analyzing is working through. Working through refers to a complex set of procedures and processes that occur after an insight has been given. Working through makes it possible for an insight to lead to

change (Greenson). It refers in the main to the repetitive, progressive, and elaborate explorations of the resistances that prevent an insight from leading to change. In addition to the broadening and deepening of the analysis of resistances, reconstructions are also of particular importance. A variety of circular processes are set in motion by working through in which insight, memory, and behavior change influence each other (Kris).

> In an hour, some two weeks after the session reported above, Mr. N. reports a fragment of a dream. All he can remember is that he is waiting for a red traffic light to change when he feels that someone has bumped into him from behind. He rushes out in fury and finds out, with relief, it was only a boy on a bicycle. There was no damage to his car. The associations led to Mr. N.'s love of cars, especially sport cars. He loved the sensation, in particular, of whizzing by those fat old expensive cars. The expensive cars seem so sturdy, but they fall apart in a few years. The little sports car of his can outrun, outclimb, outlast the Cadillacs, the Lincolns, and the Rolls Royces. He knows this is an exaggeration, but he likes to think so. It tickles him. This must be a carry-over from his athletic days when he loved to be the underdog who defeated the favorite. His father was a sports fan who always belittled my patient's achievements. His father always hinted that he had been a great athlete, but he never substantiated it. He was an exhibitionist, but Mr. X. doubted whether his father really could perform. His father would flirt with a waitress in a cafe or make sexual remarks about women passing by, but he seemed to be showing off. If he were really sexual, he wouldn't resort to that. [Greenson, p. 40]

It seemed clear to me that the patient's material concerns comparing himself with his father in terms of sexual competence. It also deals with people who pretend to be what they are not. Up until this point in the analysis the patient had no memories concerning the sexual activities of his parents. In

the hour just described Mr. N. stated that he felt sure his mother disliked sex and his father made use of prostitutes. When I pointed out that this could be a wish-fulfilling fantasy, Mr. N. fell into a long silence.

In the following hour Mr. N. admitted he was furious with my interpretation, but toward the end of the session he acknowledged that his sex life with his wife was “all screwed up.” He was unable to look at his wife the day after they had sexual relations because he felt she must abhor his sexual behavior.

In the course of the next several weeks Mr. N. became aware of the fact that alongside of his wish that his wife become sexually free, he had contempt for her when she was sexually excited. This was connected to a childhood screen memory of seeing his mother wink slyly at his father when they saw two dogs copulating in the street. This material was followed by memories of childhood concerning his mother being repulsive to him when he detected her menstruating. This insight was followed by several weeks of complete sexual avoidance of his wife.

During the next several months Mr. N. raged at the hypocrisy of most married adults, “You and your wife included.” It was more honest to pay cash for sex than to buy sex with marriage and expensive homes. I interpreted this as contempt covering over an unconscious envy of adults who had a good sex

life. Mr. N. reacted with sullen anger for several days. Only gradually was he able to realize that he was reacting like a little boy who begrudged his parents a good sex life. Finally he was able to accept the notion that he could let his parents have their own sex life, and he was perfectly free to enjoy the sex in his own bedroom.

All of this work took a period of six months beginning with the dream of being bumped in his sports car at a red light by a boy on a bicycle. This was not the end of Mr. N.'s sexual problems, there were many back-and-forth movements, but progress continued. Eventually the theme of homosexuality and aggression entered the picture, and there were varieties of regression and progression. I also want to stress that Mr. N. himself did a good deal of the analytic work of working through outside the analytic hour (Stewart).

Working through is the most time-consuming element in psychoanalytic therapy. Only rarely does insight lead very quickly to a change in behavior; and then it is usually transitory or remains isolated and unintegrated. Ordinarily it requires a great deal of time to overcome the powerful forces that resist change and to establish lasting structural changes. The interesting relationship between the work of mourning and working through, the importance of the repetition compulsion and the death instinct, may be pursued in greater detail in the writings of Freud, Fenichel, Greenacre, Kris, Novey, and Greenson.

The four steps outlined above represent a schematized version of what is implied by the concept of analyzing a psychic event. All these steps are necessary, but some may be done spontaneously by the patient, particularly the confrontation or part of the clarification. These steps do not follow in the exact order described, since each procedure can produce new resistances that will have to be taken up first. Or an interpretation can precede a clarification and can facilitate a clarification of a given phenomenon. An additional variable is the fact that the imponderables of everyday life can intrude into the patient's life and take precedence for psychoeconomic reasons over everything else that is going on in the analysis. Nevertheless, confrontation, clarification, interpretation, and working through are the four basic procedures that the analyst performs when he analyzes.

There are two further important processes that play a role in the analyst's contribution to the psychoanalytic situation. I am referring here to the countertransference and the real relationship.

Countertransference

We call it *countertransference* when a psychoanalyst reacts to a patient as if the *patient* were a significant person in the *analyst's* past. Countertransference is a transference reaction of an analyst to a patient, a parallel, a counterpart, to transference as it occurs in patients. The counter in

countertransference means analogue, duplicate of, like the counter in counterpart. I stress this point because some authors use the term as though the only countertransference reactions are the psychoanalyst's reactions to the patient's transference reactions. This is not the ease. The psychoanalyst may develop countertransference reactions based on the patient's physical or emotional qualities, the patient's psychological history and experiences, and so forth. What is of importance is that countertransference reactions in the analyst, if unrecognized by him, can lead to persistent misunderstanding or mistreatment of the patient.

I can give a simple and brief example. After several years of treatment I suddenly realized to my dismay that I had been giving a young woman patient 55 to 65 minutes each session. I had been completely oblivious of this until I wondered why the patient had so few hostile reactions to me. I then realized this was due to a countertransference reaction. I did some free association about it and was able to trace it back to my feelings toward a certain member of my family. I then started giving the patient the regular 50 to 55 minutes, which she eventually recognized. She questioned me if it were not true that I was giving her less time than I had previously. I admitted that I had realized I had been giving her extra time and I was now correcting my error. She was very curious about the cause of my error. I replied that giving her extra time had not been deliberate, but that I believed my personal unconscious reasons did not belong in her analysis. Then we analyzed her many fantasies to my

previous behavior as well as to my asserting a right to privacy and the inequality of the analytic situation. It was not long before the pent-up hostility came out and the analysis proceeded to greater depths.

Countertransference reactions, particularly if they are mild, controllable, and recognizable by the analyst, may be valuable clues to the goings on in the patient that are escaping the notice of the analyst. For example, the first sign you may have of a patient's wish to annoy you is a sense of feeling annoyed for no apparent reason. Finally these few remarks should not be concluded without stating that all psychotic patients and all primitive reactions in our patients will stir up countertransference reactions in ourselves. Winnicott's brief paper on *Hate in the Countertransference* and Searles's textbook are excellent reference sources.

The Real Relationship

Just as the patient reacts to his analyst with other than transference distortions, so does the analyst react to the patient as a real person. Our basic technical tool is interpretation, and the analyst's relative incognito and muted personal responses facilitate the maximal development of the transference reactions that we analyze. Nevertheless, I, along with a growing number of analysts, contend that the technique of "only interpreting" will stifle and distort the development of the patient's transference neurosis and block his

capacity to develop realistic object relationships.

The analyst can contribute to the patient's working alliance and nontransference relationship by his consistent and unwavering pursuit of insight, plus his concern, respect, and care for the totality of the patient's personality, sick and healthy. The analyst must help the patient's beleaguered ego distinguish between what is appropriate and distorted, correct and false, realistic and fantastic in regard to his reactions to people, above all, toward his psychoanalyst. He must not fall prey to the vocational hazard of one-upsmanship.

The transference reactions are the vehicle that enables the patient to bring the warded off, inaccessible material into the analytic situation. The working alliance makes it possible for the patient to understand the analyst's insights, review and organize interpretations and reconstructions, and finally integrate and assimilate the material of the analysis. The basis for the working alliance is the capacity for relatively conflict-free ego functioning and the ability, to some degree, to form a real, nontransference relationship to the analyst.

In the clinical instance of Kevin, given above, confirmation by the analyst of the patient's judgments put the analyst for the moment on the side of the patient's observing, realistic ego. In this the analyst supports the

working alliance in its efforts to overcome the experiencing ego, previously flooded by neurotic transference. Acknowledging that the patient was right in his criticism was certainly unanalytical. What is more important, however, is that the procedure is not antianalytie. It does advance the analysis, it helps reality testing.

I would like to quote from a paper on this subject:

> All patients, whether neurotic, borderline, or psychotic, have transference reactions in and out of the therapeutic situation. It is our belief that only those patients are analysable who have the capacity for transference-free relationships as well. This is necessary to "get into" analysis. Patients who lack this capacity for transference-free relating require preparatory psychotherapy. This means they need to be helped to build an object relationship based on reliable and predictable perceptions, judgments, and responses. They require more than interpretation and insights. Even most of our neurotic patients, at different periods of the analysis (for example, at the height of the transference neurosis), may require such additional measures. While exact prescriptions for building or strengthening a "real" object relationship in the analytic situation cannot be given, some general guidelines may prove helpful.
>
> The most important and most difficult ingredient to describe is the creation of a productive analytic atmosphere. This should consist of a sense of serious purpose, of dedicated work, of discipline and restraint on the part of the psychoanalyst. Yet this atmosphere must also contain indications of the analyst's humanitarian concern and respect for the patient's predicament. . . . The analyst has to explore and probe into sensitive and intimate areas, and insights should be given with precision, directness and frankness, yet with full awareness of the patient's vulnerability and exposure. The analyst is a physicianly person who must be able to administer painful insights without unnecessary sugar-coating or damaging delays (see Greenson,, Chapter 4.2).

> We have found it beneficial to explain every new or strange procedure or measure to the patient so that he understands why we work in a certain way. An important rule of thumb we have found useful in promoting the non-transference reactions is the frank admission of any and all errors of technique, whether they be due to countertransference reactions, faulty interpretations, or shortcomings in the analyst's personality or character. The timing of the admission of error and the issue whether one expresses regret verbally or by tone are too complex to be discussed in this limited presentation.
>
> All our patients, to varying degrees, doubt their judgment perceptions, and worthiness. If we "only interpret" or "only analyze" we unintentionally leave them with the impression that their reactions were '"merely" repetitions of their infantile past, and that their behaviour was immature, wrong or crazy. If part of our therapeutic aim is to increase the patient's healthy ego functions and capacity for object relations, it is important that we confirm those aspects of his behaviour which indicate healthy functioning. Ry ignoring those undistorted aspects of the patient's productions we unwittingly imply that his realistic reactions are unimportant, hardly worthy of comment, and that all that matters is understanding the unconscious meaning of his behaviour. . . . Beyond that, many of our patients need the experience of feeling in ways that "they are right." They need the experience of having their appropriate ego functions and object relationships acknowledged and respected by the analyst's proper "handling" of both the transference and nontransference phenomena. Structure building occurs not only as a result of dissolution through interpretation but by positive recognition and dealing with the patient's most effective levels of performance. [Greenson and Wexler, pp. 36-37]

To conclude this summary on the importance of the working alliance and the real relationship:

> With this in mind, we want to state our basic propositions: To facilitate the full flowering and ultimate resolution of the patient's transference reactions, it is essential in all cases to recognize, acknowledge, clarify,

> differentiate, and even nurture the non-transference or relatively transference-free reactions between patient and analyst. The technique of "only analysing" or "only interpreting" transference phenomena may stifle the development and clarification of the transference neurosis and act as an obstacle to the maturation of the transference-free or "real" reactions of the patient. Central as the interpretation of transference is to psychoanalytic therapy, and about this there can be no question, it is also important to deal with the non-transference interactions between patient and analyst. This may require non- interpretive or non-analytic interventions but these approaches are vastly different from anti-analytic procedures. [Greenson and Wexler, pp. 27-28]

The Analytic Setting

The term "analytic setting" refers to the physical framework and the routines of psychoanalytic practice that form an integral part of the process of being psychoanalyzed. Although it is true that one or another of these elements may be altered without making psychoanalysis impossible, it is also true that the analytic "atmosphere" does influence the various processes that do occur in psychoanalytic treatment. We also know that transference reactions take place spontaneously in neurotic human beings who are not in psychoanalytic therapy. Yet experience has shown that the classical analytic setting does facilitate and maximize the appearance of all the different transference reactions.

Until relatively recently most psychoanalysts stressed the overwhelming importance of the patient's past history and of the analyst's attitude of relative neutrality, incognito, and passivity as the factors

determining the course of the transference reactions. Although this is still essentially valid, we do recognize today that certain elements in the analytic setting and procedures may promote or hinder these developments. The papers of Macal- pine, Greenacre, Lewin, Spitz, and Stone have been of particular value in illuminating the significance of the analytic setting for the evolution of the various transference reactions.

Greenacre stressed that the circumstance of two people meeting together repeatedly and alone for a long period of time makes for an intensity of emotional involvement. The fact that one is troubled and relatively helpless and the other expert and offering help facilitates an uneven, “tilted” relationship, with the troubled one tending to regress to some form of infantile dependency. The routine of having the patient lie on the couch also contributes to the regression in a variety of ways. The reclining position is a carry-over from the days of hypnosis and a modification of the attempt to put the patient to sleep (Lewin, Khan). The diminution of the external stimuli, the fact that the patient does not see the analyst, that the analyst is relatively silent, and that there is no physical or visual contact between them, also furthers a sleeplike state (Macalpine, Spitz).

Spitz emphasized other elements that push the patient in the direction of objectlessness. The patient is lying down and therefore is lower than the analyst sitting upright behind him, the patient’s locomotion and bodily

movements are restricted, and he speaks but he cannot see to whom. It is Greenacres contention that this combination of elements recapitulates the matrix of the mother-child relationship of the first months of life. Free association itself is an invitation to regress toward the primary process and the dream (Macalpine, Lewin). It resembles as well the prattling of a child in that we ask the patient to say everything without discrimination and without responsibility (Spitz).

The analyst’s routine behavior also contributes to the regressive pull of the analytic setting. His muted emotional responses, relative incognito, and generally nongratifying attitude regarding the patient’s neurotic wishes all expedite the transference neurosis (Macalpine, Spitz). The circumstance that the analyst is a treater of the sick, a therapist, also activates the many infantile antecedents of the doctor in the patient’s fantasy life.

Many components of the setting described above that further the regression toward the infantile neurosis also contribute to the formation and maintenance of the working alliance. All procedures that become predictable make for a relative sense of security; and if they are perceived as having a therapeutic intent, they will create a feeling of trust, which is the core of the working alliance. Security and trust make it possible for the patient to allow himself to regress just as they give him the courage to risk discarding a neurotic defense and trying a new form of adaptation. The analyst’s

unflagging pursuit of insight and understanding, his respect and protection of the rights, potentials, and dignity of the patient, his concern and compassion, and his frank and thoughtful commitment to relieving the patient's neurotic misery should be part of the analytic atmosphere.

It is characteristic for many of the processes of psychoanalysis eventually to mobilize ambivalence. The insatiable instinctual hunger of the neurotic patient can turn even the analyst's gratificatory attitudes into a frustration; the patient's mistrust may twist the analyst's therapeutic concern into a form of rejection and the analyst's patience into indifference. The crux of the matter is the relative strength of the patient's reasonable ego in regard to his id, to his superego, and to the external world at a given moment. The patient's working relationship to the analyst is dependent upon these factors.

The imponderables of everyday life can play a decisive role. Despite the fact that the analytic setting is of importance in the therapeutic equation, it cannot replace psychoanalytic technique; the art of interpretation and the skill in relating to a human being. It must also be remembered with all humility that even with the best technique it requires a goodly amount of time to overcome the formidable tyranny of the neurotic patient's past and his compulsion to repeat (Greenson).

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[1] A definition of a classical psychoanalyst along organizational lines was considered but did not prove to be satisfactory. The majority of the members of the American Psychoanalytic Association may be classified as classical psychoanalysts, but a substantial minority appear not to be of this persuasion. A significant minority of the members of the American Academy of Psychoanalysis subscribe to classical theory as do a large number of classically trained, nonmedical psychoanalysts who are associated with local and national nonmedical psychoanalytic organizations and training institutions.

[2] In the United States classical psychoanalysts generally use the term “instinctual drive” to translate Freud’s word “triebe.” British psychoanalysts, including James Strachey, translator and editor of the *Standard Edition* of Freud’s works, translate “triebe” as instinct. In this essay the American usage will be followed.