THE TECHNIQUE AND PRACTICE OF PSYCHOANALYSIS

Volume I

Ralph R. Greenson

ROUTLEDGE

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DEDICATED

TO

MY TEACHERS

MY STUDENTS

AND

MY PATIENTS

Acknowledgments

It is impossible to thank individually all those who have contributed to this book. I consider all the authors listed in the bibliography among my official teachers; here I only want to express my gratitude more personally.

My father, Joel O. Greenschpoon, M.D., a general practitioner, is responsible for transmitting to me his concern and devotion to his patients and the profession of medicine. Otto Fenichel, my training analyst, inspired me by his unwavering dedication to the teaching of psychoanalysis and by his incorruptible honesty.

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Introduction

It is my opinion that despite the many difficulties involved, it is time for a textbook on psychoanalytic technique. I have the impression that there is a great danger in allowing ambiguities, divergencies, and deviations to be transmitted by word of mouth from training analyst to analysand, from supervising analyst to candidate, and from colleague to colleague, in private discussions without their being duly noted and recognized for what they are.

The standard works on technique written by Freud, Glover (1955), Sharpe (1930), and Fenichel (1941), excellent as they are, are only outlines. They do not describe in sufficient detail what the psychoanalyst actually does when he analyzes a patient. As a result, for example, analyzing a resistance can mean one thing to one analyst and something astonishingly different to another, yet each may believe he is analyzing a resistance according to classical psychoanalytic principles.

The panel on "Variations in Classical Psycho-Analytic Technique" held at the 20th Congress of the International Psycho-Analytical Association in Paris in 1957 illustrated the diversity of the points of view (see Greenson, et al., 1958). Glover's questionnaire on common technical practices, which he distributed to the members of the British Psycho-Analytical Society in 1938, revealed an unexpected amount of disagreement among the members as well as a high degree of hesitancy, timidity, and indecision in revealing their techniques (Glover, 1955, p. 348). Helen Tartakoff's excellent

review (1956) of recent books on psychoanalytic technique stressed the finding that the term "psychoanalysis" in the titles of each of the new publications was loosely applied to very different therapeutic methods based on the author's personal and special theoretical postulates.

This confusion and uncertainty is borne out by the startling fact that the Committee on Evaluation of Psychoanalytic Therapy of the American Psychoanalytic Association disbanded in 1953 after six and a half years of fruitless debate attempting to find an acceptable definition of psychoanalytic therapy (Rangell, 1954). See Fromm-Reichmann (1954), and Eissler (1956) as examples of widely divergent views of the meaning of dynamic psychiatry and psychoanalysis. A textbook on psychoanalytic technique would not eliminate differences of opinion or controversies about technical matters, but it might serve usefully as a common reference point by setting forth in detail and systematically how one psychoanalyst works when he claims to be analyzing certain psychic phenomena in a patient.

It should be pointed out that although there is little public communication about details of technique, there is a great deal of private talk between analysts within small closed groups. As a consequence there exist numerous isolated factions—a fact which makes for esoteric aloofness and retards scientific progress (Glover, 1955, p. 261).

Those who wish to suggest innovations or modifications of technique do not usually confer with others who are more traditional in their viewpoint. They tend to form cliques and to work underground, or at least segregated from the mainstream of analytic thought. As a consequence the innovators are apt to lose contact with those groups in psychoanalysis that might help validate, clarify, or amend their new ideas. The secluded innovators are prone to become "wild analysts," while the conservatives, due to their own insularity, tend to become rigid with orthodoxy. Instead of influencing one another constructively they each go their separate ways as adversaries, blind to whatever benefits each might have gained from an open and continuing discussion.

The single most important reason for maintaining an open forum on psychoanalytic technique is the need to expose the serious student to other techniques besides those of his personal analyst and

his supervisory analysts. A big disadvantage in learning technique from only a handful of sources is that it increases the likelihood that the candidate in training will retain certain neurotic transference feelings and attitudes toward his teachers which will block his opportunity to discover the technique best suited to his own personality and theoretical orientation. It is not rare to find young psychoanalysts who bear the unmistakable stamp of their personal analyst to a degree that resembles the slavish imitation seen in adolescents. On the other hand, the recent graduate who conspicuously opposes his training analyst may be equally enmeshed in an unresolved transference neurosis. Glover (1955, p. 262) called such reactions "training transferences" and emphasized their stultifying effects in the inexperienced psychoanalyst.

It is an impressive fact that the fundamentals of psychoanalytic technique that Freud laid down in five short papers some fifty years ago still serve as the basis of psychoanalytic practice (Freud, 1912a, 1912b, 1913b, 1914c, 1915a). No acknowledged major changes or advances have taken hold in standard psychoanalytic technique.

In part this is a tribute to Freud's genius for having recognized so early and clearly what is essential in psychoanalytic therapy. There are other reasons, however, for the lack of progress. One decisive factor seems to be the complicated emotional relationship between the student of psychoanalysis and his teachers, a relationship which is an inevitable consequence of the methods used for teaching psychoanalysis (Kairys, 1964; Greenacre, 1966a).

The training analysis carried out as part of a professional training program usually leaves a considerable residue of unresolved transference reactions which restrict and warp the student's development in the field of psychoanalysis. When an analyst attempts to carry out psychoanalytic therapy for the purpose of training, he complicates his relationship to his patient by inadvertently assuming responsibility for the student's professional progress. He inevitably loses some of his customary incognito, splits the patient's motivations, and increases the candidate's tendencies to dependency, identifications, submissiveness, and pseudonormal behavior. In addition, the analyst himself becomes a partisan, usually unknowingly and unwillingly, in a triangle situation, consisting of the student, the psychoanalytic training institute, and the training analyst.

One of the secondary consequences of the unresolved transfer-

ence-countertransference problems is the reluctance psychoanalysts display in revealing openly to one another how they actually work. This state of affairs may have influenced Freud himself who, according to Jones (1955, pp. 230-231), often spoke of his intention to write a systematic exposition of psychoanalytic technique but never did. Strachey (1958) suggests that the absence of any full discussion of countertransference in Freud's writings may confirm this supposition.

The reluctance of psychoanalysts to expose their methods of practice stems partly from another but related source. The work of the psychoanalyst depends on many intimate and personal processes within himself (Greenson, 1966). As a result there is a feeling of exposure and vulnerability in revealing how one analyzes. Since much of the patient's material is highly instinctualized and evocative, and since the analytic understanding of a patient depends on a special empathic intimacy with him, shame, hostility, or fear reactions may arise when exposure of this situation is called for. As a consequence it is not rare to find among psychoanalysts some variety of stage fright, exhibitionism, or combinations of both. The fact that so many analysts are inhibited in discussing openly what they do in their practice makes the psychoanalyst particularly prone to slip into one of two extreme positions: orthodoxy or sectarianism.

Psychoanalysis is a lonely profession and one feels comfort in belonging to a group, but this blocks and impedes scientific progress by encouraging conformity. There is an additional vocational hazard in the loneliness of psychoanalytic practice—the absence, as a rule, of another analytically trained observer of the analytic situation as it progresses.

The analyst's own view of what he does is unreliable and apt to be distorted in some idealized direction. I am not suggesting that it would be preferable to have observers or auditors, because I believe that their presence, even if unobserved, would distort the analytic situation. (Other writers, particularly Merton M. Gill, have expressed different views.) What I do suggest is that the psychoanalyst, working alone with his patient and thus shielded from the scrutiny of his peers, is predisposed to a biased and uncritical attitude toward his own technique.

When one describes in any detail what one does in psychoana-

lytic work, one reveals not only a great deal of one's intimate involvement with the patient, but also a great deal of one's personal life in general. The psychoanalyst's unique and most important working tool is the workings of his own preconscious and unconscious mind. It is inevitable that if he is going to recount how and why he approached a situation in the analysis, he will be forced to reveal much of his fantasy life, ideas, traits of character, etc. Ordinary humility and self-protection will make him tend to avoid any undue exposure of his intimate self.

Perhaps a book which depicts the practice of classical psychoanalytic therapy will help stimulate a full, open, and continuing discussion of psychoanalytic technique. In this way, variations, innovations, modifications, and deviations might be clarified and tested, thus establishing their scientific value for psychoanalysis and giving impetus to the progress of psychoanalytic technique.

I had intended to write these volumes by approaching the technical problems in chronological order as they arise in the course of psychoanalytic therapy. I had planned to begin with the Initial Interviews, Transition to the Couch, the First Analytic Hours, etc. I soon discovered that it was impossible to talk intelligibly in depth and in detail about any technical problem without a thorough understanding of Resistance and Transference. I also realized that the student would benefit from a concise outline of some basic concepts of psychoanalytic theory and technique to serve as a preliminary orientation. Therefore, these volumes are organized so that after an introductory survey the first volume begins with the chapters on Resistance and Transference, which are the foundations of psychoanalytic technique. The last chapter of Volume I is devoted to The Psychoanalytic Situation. It is included at that point because it offers an overall view of the complex interrelationship between the different procedures and processes which go on in the patient and in the psychoanalyst. (See the table of contents for details.) The second volume will be organized along more chronological lines.

The text is arranged so that each technical chapter begins with a preliminary definition which is illustrated by simple clinical examples. This is followed by a brief survey of the literature and theory before going on to the practical and technical considerations. Throughout the volumes there are bibliographical references to the major works on the subject matter under discussion. Whenever there

are numerous bibliographic references to a selected topic, I have noted them at the end of the given chapter under the specific heading in an Additional Reading List. I have done so in order to avoid interfering with the flow of reading the material which long bibliographical lists cause. At the end of the book there is a comprehensive bibliography.

1

Survey of Basic Concepts

1.1 The Historical Development of Psychoanalytic Therapy

One way of ascertaining what is essential in psychoanalytic therapy is to take a bird's-eye view of its historical development and to note the major changes in the technical procedures and in the therapeutic processes. What follows is a selective summary of the highlights of Freud's writings on these matters. A more detailed investigation of each subject, including the contributions of others, will be found in the appropriate place in the text that follows.

Let me clarify the terminology. I am using the term *technical procedure* to refer to a measure, a tool, a course of action, an instrumentality, undertaken by the therapist or the patient, with the purpose of furthering the therapeutic processes. Hypnosis, suggestion, free association, 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 forces and acts which have a remedial aim or effect. They are usually instigated by the technical procedures. Abreaction, recapturing memories, and insight are therapeutic processes. (See E. Bibring [1954] for a similar but more comprehensive methodological approach.)

Psychoanalytic technique was not suddenly discovered or

invented. It evolved gradually as Freud struggled to find a way of effectively helping his neurotic patients. Although he later disclaimed any enthusiasm for therapy, it was his therapeutic intent which led to the discovery of psychoanalysis.

Freud was an astute clinician and could discern what was meaningful in the complicated sequences of clinical events that followed the various technical procedures he employed. He also had a gift for theoretical and imaginative thinking which he blended together to construct hypotheses relating technique to clinical findings and to therapeutic processes. Fortunately, Freud possessed that complex combination of temperament and character traits that enabled him to be a conquistador, an "adventurer" of the mind and a careful scientific investigator (Jones, 1953, p. 348; 1955, Chapt. 16). He had the boldness and inventiveness to explore new regions of thought vigorously and creatively. When proved wrong, he had the humility to change his technique and theory.

A careful reading of Freud's technical and clinical papers reveals that the changes in technique were neither abrupt nor complete. One can observe a shift in emphasis or a change in the order of importance assigned to a given procedure or a therapeutic process. Nevertheless, it is possible to delineate different phases in the development of technical procedures and in the theory of the therapeutic process. Freud himself briefly described three phases, but that was before he had arrived at a structural point of view (1914c).

1.11 Changes in Technical Procedures

Although Freud had heard the case of Anna O. from Breuer in 1882 and had studied hypnosis with Charcot from October, 1885 to February, 1886, he confined himself to using the conventional therapeutic methods of the time when he first began to practice. For some twenty months he employed electrical stimulation, hydrotherapy, massage, etc. (Jones, 1953, Chapt. 12). Dissatisfied with the results, he began to use hypnosis in December of 1887, apparently attempting to suppress the patient's symptoms.

The case of Emmy von N., treated in 1889, is significant because here for the first time Freud used hypnosis for the purpose of catharsis. His therapeutic approach consisted of hypnotizing the patient and commanding her to talk about the origin of each of her symp-

toms. He would ask what had frightened her, made her vomit, or upset her, when the event had occurred, etc. The patient responded by producing a series of memories, accompanied often by great affect. At the end of certain sessions Freud would suggest that the patient forget the disturbing memories which had arisen.

By 1892 Freud realized that his ability to hypnotize patients was severely limited, and he had to face the choice of abandoning the cathartic treatment or of attempting it without achieving a somnambulistic state (Breuer and Freud, 1893-95, p. 108). To justify this approach, he recalled that Bernheim had demonstrated that patients could be made to recall forgotten events by waking suggestion (p. 109). Freud therefore went on the assumption that his patients knew everything that was of pathogenic significance and that it was only a question of obliging them to communicate it. He ordered his patients to lie down, shut their eyes, and concentrate. He would apply pressure to the forehead at given moments and insist that memories would appear (p. 270).

Elisabeth von R. (1892) was the first patient Freud treated completely with waking suggestion. By 1896 he had abandoned hypnosis altogether.[1] It is less certain when he gave up using suggestion as his primary therapeutic tool. However, by 1896 Freud had already completed the essential work on *The Interpretation of Dreams,* although it was not published until 1900. It seems plausible to assume that the ability to comprehend the structure and meaning of the dream had increased his skill in interpretation. As a consequence Freud was enabled to rely more and more on the patient's spontaneous production of material. He could use interpretations and constructions to arrive at the repressed memories.

There is no exact date for the discovery of the procedure of free association. Apparently it gradually developed between 1892 and 1896, becoming steadily refined from the hypnosis, suggestion, pressing and questioning that accompanied it at its inception (Jones, 1953, pp. 242-244). Hints of it are already mentioned in 1889 in the case of Emmy von N. (Breuer and Freud, 1893-95, p. 56). Jones describes a historic occasion when Freud was pressing and questioning Elisabeth von R. and she reproached him for interrupting her flow of thoughts. Freud had the humility to accept this sug-

[1] See Strachey's note, *Standard Edition,* 2:111.

gestion and the method of free association had taken a giant step forward.

Freud explained that by giving up hypnosis and suggestion, the widening of consciousness, which had supplied the analyst with the pathogenic memories and fantasies, was now missing. Free association was a completely satisfactory substitute in that it permitted the involuntary thoughts of the patient to enter the treatment situation. This is Freud's description of this method: "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" (1904, pp. 250-251). The procedure of free association became known as the fundamental or basic rule of psychoanalysis (Freud, 1912a, p. 107).

Free association has remained the basic and unique method of communication for patients in psychoanalytic treatment. Interpretation is still the decisive and ultimate instrument of the psychoanalyst. These two technical procedures give psychoanalytic therapy its distinctive stamp. Other means of communication occur during the course of psychoanalytic therapy, but they are affiliated, preparatory, or secondary, and not typical of psychoanalysis. This point will be discussed in Section 1.34.

1.12 Changes in the Theory of the Therapeutic Process

The *Studies on Hysteria* (1893-95) can be regarded as the beginning of psychoanalysis. In it one can discern how Freud struggled to discover what is essential in the therapeutic process in the treatment of hysterics. It is impressive to note that some of the phenomena that Freud described at that time have become the foundation of the psychoanalytic theory of therapy. It is characteristic of

Freud that he began by struggling to overcome certain obstacles to his therapeutic approach only to realize later that these obstacles were crucial for understanding the patient's neurosis and the therapeutic process. It was Freud's perseverance and flexibility that enabled him to cope successfully with a variety of obstacles that led to the discovery of psychoanalysis.

In the Preliminary Communication [1893] Breuer and Freud (1893-95) maintained that "*each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing 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). They believed that only by abreacting could a patient achieve a completely "cathartic" effect and thus be freed from the hysterical symptom. These experiences, they claimed, were absent from the patient's memory under normal conditions and could be reached only by hypnosis.

The pathogenic ideas had persisted with such freshness and affective strength because they had been denied the normal wearing-away process. Thus they were dealing with affects in a "strangulated" state (p. 17). The discharge of strangulated affects would deprive the pathogenic memory of its force and the symptoms would disappear.

At this point in the history of psychoanalysis, the therapeutic processes were considered to be abreaction and remembering, with the emphasis on the abreaction. One hypnotized the patient and tried to get him to remember the traumatic event because he would then have a curative cathartic experience. Anna O., whom Breuer treated in 1882, had spontaneous hypnotic trances in which she spontaneously relived traumatic past events. After she recovered from a somnambulistic state she felt relieved. The experiences of Anna O. thus paved the way for the method of cathartic therapy. She herself called it a "talking cure" or "chimney-sweeping" (p. 30).

Freud became increasingly aware of a force within the patient opposing the treatment. It crystallized in the case of Elisabeth von R., whom he could not hypnotize and who refused to communicate certain of her thoughts despite his urgings (p. 154). He came to the conclusion that this force, which was a resistance to the treatment, was the same force which kept the pathogenic ideas from

becoming conscious (p. 268). The purpose was one of defense. "The hysterical patient's 'not knowing' was in fact a 'not wanting to know'" (p. 269-270). The task of the therapist, Freud believed, was to overcome this resistance, and he did this by "insisting," pressing, pressure on the forehead, questioning, etc.

Freud recognized 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 (p. 282). However, he also became aware that under certain conditions the patient's relation to the physician can become "disturbed," a factor which turns the patient-physician relationship into the "worst obstacle we can come across" (p. 301). This may occur if the patient feels neglected, if the patient becomes sexually dependent, or if the patient transfers onto the figure of the physician the distressing ideas from the content of the analysis (p. 302). One dealt with this by making it conscious and tracing it back to the moment in treatment when it had arisen. Then one attempted to persuade the patient to communicate despite these feelings (p. 304).

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

In the *Studies on Hysteria*, Freud attempted to focus his therapeutic efforts on the patient's individual symptoms. He realized that this form of therapy was a symptomatic one and not causal (p. 262). In the Dora case, which was published in 1905 but written in 1901, Freud stated that psychoanalytic technique had been completely revolutionized (1905a, p. 12). He no longer tried to clear up each symptom, one after the other. He found this method totally inadequate for dealing with the complex structure of a neurosis. He now allowed the patient to choose the subject matter of the hour and he started his work on whatever surface of the unconscious the patient presented at the moment.

Apparently Freud realized that a therapeutic process could not be effected in a single operation because neurotic symptoms had multiple causes. Although he already had recognized the principle of overdetermination in the *Studies on Hysteria* (pp. 173-174), he made this point explicit only in his paper on "Freud's Psycho-Ana-

lytic Procedure" published in 1904. In that essay he stated that the change in technique from hypnosis and suggestion to free association led to new findings and "finally necessitated a different though not contradictory conception of the therapeutic process" (p. 250). Hypnosis and suggestion conceal the resistances and obstruct the physician's view of the psychic forces. By evading resistances one can only get incomplete information and transitory therapeutic success. The therapeutic task is to overcome resistances, to undo repressions—then the gaps in the memory will be filled in.

I believe we see here a shift in the theory of the therapeutic process from the dominant importance of abreaction of affects to the overcoming of amnesia. This does not contradict the fact that abreaction has a therapeutic effect. By permitting the discharge of emotional tensions, the patient usually experiences a temporary sense of relief. Furthermore, catharsis is valuable because the emotional discharge reduces the quantity of affect and smaller quantities of affect are easier to handle. More important is the fact that the verbalization which accompanies the discharge of emotions and impulses makes it possible to study them more clearly. But catharsis is no longer an ultimate aim of therapy. I believe this is what Freud alluded to in his "different though not contradictory" statement above.

The new emphasis was now on making the unconscious conscious, the removal of amnesia, the recovery of repressed memories. Resistance became a cornerstone of psychoanalytic theory and was related to those forces which had brought about the repression. The analyst used the art of interpretation to overcome the resistances.

In the Dora case (1905a) Freud first emphasized the crucial role of the transference. "Transference, which seems ordained to be the greatest obstacle to psycho-analysis, becomes its most powerful ally, if its presence can be detected each time and explained to the patient" (p. 117). In the postscript to that case, Freud described how the patient had broken off treatment because he had failed to analyze the multiple transference elements which interfered with the treatment situation.

In the paper on "The Dynamics of Transference" (1912a), he described the relationship between transference and resistance, the positive and the negative transference and the ambivalence of transference reactions. Part of one paragraph deserves to be quoted be-

cause it states Freud's new therapeutic orientation very distinctly. "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 be forgotten that it is precisely they that do us the inestimable service of making the patient's hidden and forgotten erotic impulses immediate and manifest. For when all is said and done, it is impossible to destroy anyone *in absentia* or *in effigie*" (p. 108).

From 1912 on, the consistent analysis of transference and resistance became the central element of the therapeutic processes. Later that same year Freud warned against transference gratifications and suggested that the psychoanalyst be opaque as a mirror to his patients and maintain his anonymity (1912b, p. 118). In his paper on "Remembering, Repeating and Working-Through (1914c), Freud described the special problem of acting out in relation to transference and resistance and connected it to a compulsion to repeat. He also used the term "transference neurosis" to signify that during psychoanalysis the patient replaces his ordinary neurosis by his involvement with his analyst. This is amplified in Chapter XXVIII in the *Introductory Lectures* (1916-17, pp. 454-455).

Something new was added to the discussion of therapeutic processes in that chapter when Freud mentioned that an alteration of the ego is made possible by analyzing the transference (p. 455). He stated that the work of interpretation, which transforms what is unconscious into what is conscious, enlarges the ego at the cost of the unconscious. In *The Ego and the Id* (1923b), Freud expressed this idea quite succinctly: "Psycho-analysis is an instrument to enable the ego to achieve a progressive conquest of the id" (p. 56). In 1933 Freud 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" (1937a) 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).

If one reviews the historical developments in the major procedures and processes of psychoanalytic therapy, one can observe that hypnosis has been abandoned, but all the other elements have been retained, albeit with a very different role in the therapeutic hierarchy (Loewald, 1955). Suggestion is not used for obtaining memories and is no longer a major therapeutic device in psychoanalysis. It may be utilized as a temporary supportive measure, the need for which will ultimately have to be analyzed. (This will be discussed in Section 1.34.)

Abreaction is no longer considered a therapeutic goal but is valuable in other ways. The analyst still attempts to get beyond the barrier of consciousness, but he uses free association, dream analysis, and interpretation. The major field for analytic work is the area of transference and resistance. We hope to make the unconscious conscious, recover warded-off memories, and overcome the infantile amnesia. But even this is no longer conceptualized as an ultimate aim. The ultimate aim of psychoanalysis is to increase the relative strength of the ego in relation to the superego, the id, and the external world.

1.2 Theoretical Concepts Essential for Technique

1.21. The Relation between Theory and Practice

Before we can proceed to a more thorough and systematic examination of therapeutic procedures and processes, it would be well to review briefly some of the basic theoretical concepts of the psychoanalytic point of view. There is a reciprocal relationship between theory and practice. Clinical findings can lead to new theoretical formulations, which in turn can sharpen one's perceptiveness and technique so that new clinical insights may be obtained. The reverse is also true. Faulty technique can lead to distortions in the clinical findings, which in turn can lead to faulty theoretical concepts. Whenever there is a lack of integration between theory and technique, both aspects are likely to suffer (Hartmann, 1951, p. 143). For example, one can deal with a resistance more effectively if one is aware of the multiple functions of resistance, its relation-

ship to defenses in general, as well as its purpose in a particular instance.

There are analysts who tend to isolate their practical from their theoretical knowledge. Some do it by drifting along with the patient until some fragment of the patient's material becomes understandable and is then unselectively communicated to the patient. They misuse the notion that it is the analyst's unconscious mind and empathy which are his most important tools for therapy, and they ignore the need to do some intellectual work with the data they may have obtained. As a consequence there is no overall view of the patient, no reconstructions of larger segments of the patient's life, there are just collections of insights. Errors in the other direction are equally serious; there are analysts who too quickly formulate theories on the basis of skimpy clinical data. For them, the experience of analysis becomes a thinking contest or an intellectual exercise. Such analysts avoid instinctual or emotional involvement with their patients, they forego intuition and empathy and become data collectors or interpretation dispensers.

Psychoanalytic therapy makes strenuous contradictory demands on the analyst. He must listen to the material of his patient, permitting his own associative fantasies and memories to have free play as he does so; yet he must scrutinize and expose to his intellectual capacities the insights so obtained before they can be safely transmitted to the patient (Ferenczi, 1919a, p. 189). The ability to let oneself associate freely is acquired from the analyst's experience of having been successfully analyzed. To use one's theoretical knowledge effectively in practice, it must have been mastered intellectually; it must also be accessible when needed without dominating one's clinical skills. If the psychoanalyst's work is to remain a scientific discipline, it is imperative that he maintain the capacity to oscillate between the use of empathy and intuition on the one hand and his theoretical knowledge on the other (Fenichel, 1941, pp. 1-5; Kohut, 1959).

In the early years of psychoanalysis most of the advances came from clinical discoveries. In recent years, however, there seems to be a lag on the side of technique. When Freud discovered the crucial importance of systematically analyzing the resistances of his patients, he was some twenty years ahead of discovering the ego implications of this procedure. Today we seem to know a great deal

more about ego functions than we are able to use directly in our technique (Hartmann, 1951). But I believe that our greatest hope for progress in technique lies in a better integration of clinical, technical, and theoretical knowledge.

1.22 The Psychoanalytic Theory of Neurosis

The theory and technique of psychoanalysis are based essentially on clinical data derived from the study of neuroses. Although in recent years there has been a tendency to enlarge the scope of psychoanalytic investigation to include normal psychology, the psychoses, sociological and historical problems, our knowledge of these areas has not progressed as far as our comprehension of the psychoneuroses (A. Freud, 1954a; Stone, 1954b). The clinical findings of the neuroses still provide us with the most reliable source material for formulating psychoanalytic theory. To grasp the theory of psychoanalytic technique it is necessary for the reader to have a working knowledge of the psychoanalytic theory of neurosis. Freud's *Introductory Lectures* (1916-17) and the texts of Nunberg (1932), Fenichel (1945a), and Waelder (1960) are excellent condensed source books. Here I can only outline what I have found to be the most important theoretical concepts required for the understanding of technique.

Psychoanalysis maintains that psychoneuroses are based on the neurotic conflict. The conflict leads to an obstruction in the discharge of instinctual drives eventuating in a state of being dammed up. The ego becomes progressively less able to cope with the mounting tensions and is ultimately overwhelmed. The involuntary discharges manifest themselves clinically as the symptoms of psychoneurosis. The term "neurotic conflict" is used in the singular, although there is always more than one important conflict. Custom and convenience make us refer to the single conflict (Colby, 1951, p. 6).

A neurotic conflict is an *unconscious* conflict between an id impulse seeking discharge and an ego defense warding off the impulse's direct discharge or access to consciousness. At times clinical material may reveal a conflict between two instinctual demands, for example, heterosexual activity may be used to ward off homosexual desires. Analysis will reveal that in such an instance the heterosexual activity

is being used for purposes of defense to avoid the painful feelings of guilt and shame. Heterosexuality, in this example, is fulfilling an ego demand and opposing a more forbidden instinctual impulse, homosexuality. Therefore, the formulation that a neurotic conflict is a conflict between the id and the ego is still valid.

The external world also plays an important role in the formation of neuroses, but here too the conflict must be experienced as an internal conflict between the ego and the id for a neurotic conflict to arise. The external world may mobilize instinctual temptations, and situations may have to be avoided because they bring the danger of some type of punishment. We will then be dealing with a neurotic conflict if the instinctual temptation or the danger has to be blocked off from consciousness. A conflict with external reality has become a conflict between the id and the ego.

The superego plays a more complicated role in the neurotic conflict. It may enter the conflict on the side of the ego or the side of the id or both. The superego is the agency that makes the instinctual impulse seem forbidden to the ego. It is the superego that makes the ego feel guilty even for the symbolic and distorted discharges, so that they are felt consciously as essentially painful. The superego may also enter the neurotic conflict by becoming regressively reinstinctualized, so that the self-reproaches take on a drivelike quality. The guilt-laden patient may then be driven into situations which again and again result in pain. All parts of the psychic apparatus participate in neurotic symptom formation (see Fenichel, 1941, Chapt. II; 1945a, Chapt. VII, VIII; Waelder, 1960, pp. 35-47; and Additional Reading List).

The id never stops seeking discharge, and its impulses will attempt to gain some partial satisfaction by utilizing some derivative and regressive outlets. The ego in order to appease the demands of the superego has to distort even these instinctual derivatives so that they appear in some disguised form, hardly recognizable as instinctual. The superego causes the ego to feel guilty nevertheless, and the distorted instinctual activity causes pain in a variety of ways. It is felt as a punishment and not as a satisfaction.

The key factor in understanding the pathogenic outcome of the neurotic conflict is the ego's need constantly to expend its energies in attempting to keep the dangerous drives from gaining access to consciousness and motility. Ultimately this leads to a relative insuf-

ficiency of the ego, and derivatives of the original neurotic conflict will overwhelm the depleted ego and break through into consciousness and behavior. From this point of view the psychoneuroses can be understood as relative traumatic neuroses (Fenichel, 1945a; Chapt. VII, VIII). A relatively innocuous stimulus may stir up some id impulse, which may be linked to the dammed-up instinctual reservoir. The impoverished ego is unable to keep up its defensive work and is flooded to the extent that it has to allow some instinctual discharge, although even this is disguised and distorted. These disguised and distorted involuntary discharges manifest themselves clinically as the symptoms of the psychoneurosis.

Let me illustrate this with a relatively simple clinical example. 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.

Two additional points should be noted, although further clarification will have to be postponed at this time. The ego attempts to cope with the forbidden or dangerous id impulses by resorting to the various defense mechanisms it has at its disposal. The defenses may be successful if they provide for periodic discharge of instinctual tensions. They become pathogenic when many varieties of libidinal and aggressive impulses are excluded from contact with the rest of the total personality (A. Freud, 1965, Chapt. V). Eventually the repressed returns in the form of symptoms.

An adult neurosis is always built around a nucleus from childhood. The case of Mrs. A. demonstrates that her sexual feelings were still fixated to her childhood image of her father, and sexuality was just as forbidden as it had been in her childhood years. Although she had overcome her childhood neurosis sufficiently so that she could function effectively in many areas of her life, Mrs. A. remained neurotically regressed in regard to all matters concerning genital sexuality. The childhood phobias and body anxieties returned with her adult neurosis. (The only neuroses without a childhood basis are the pure traumatic neuroses, which are extremely rare and rarely pure. They often become linked up to the psychoneuroses [Fenichel, 1945a; Chapt. VII].)

1.23 The Metapsychology of Psychoanalysis

Psychoanalytic metapsychology refers to the minimum number of assumptions upon which the system of psychoanalytic theory is based (Rapaport and Gill, 1959). Freud's metapsychological writings are neither complete nor systematic and are scattered throughout his writings. The seventh chapter of *The Interpretation of Dreams* (1900), the "Papers on Metapsychology" (Freud, 1915b,

1915c, 1915d, 1917b), and the addenda to *Inhibitions, Symptoms and Anxiety* (1926a) are the main reference sources. Actually, Freud formulated only three metapsychological points of view explicitly —the topographic, the dynamic, and the economic. The genetic point of view he seemed to take for granted. Although he did not define the structural point of view, Freud did suggest that it might replace the topographic (1923b, p. 17). (See Rapaport and Gill [1959] and Arlow and Brenner [1964] on this point.) The adaptive point of view is also implicit and essential to psychoanalytic thinking (Hartmann, 1939).

The clinical implications of metapsychology intimate that in order to comprehend a psychic event thoroughly, it is necessary to analyze it from six different points of view—the topographic, dynamic, economic, genetic, structural, and adaptive. In clinical practice we analyze our patients' productions only partially and in fragments, in a given interval of time. Nevertheless, experience teaches us that we do use all these points of view when we try to work through our initial insights. I shall attempt to sketch an outline of these concepts. For a more comprehensive survey the reader is referred to Fenichel (1945a, Chapt. II), Rapaport and Gill (1959), and Arlow and Brenner (1964).

The earliest point of view Freud postulated was the *topographical* one. In the seventh chapter of *The Interpretation of Dreams* (1900) he described the different modes of functioning that govern 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.

Let me illustrate. A male patient tells me the following dream: "I am building an addition to the front of my house. I am suddenly interrupted by my son's crying. I look for him full of fearful expectation and I see him in the distance, but he keeps running away from me. I begin to get angry and I finally catch up with him. I start to reprimand him for running away when I notice that he has a triangular cut in the corner

of his mouth. I tell him not to talk because the cut will become bigger. I can see the pink flesh underneath the skin and I feel queasy. Then I realize it isn't my son at all but my older brother. He smiles at me condescendingly as though he had made a fool of me. I turn away from him but am embarrassed because I feel that now I am sweaty and hot and he might notice that I smell bad."

The patient's associations may be condensed to the following: My older brother used to bully me when I was younger, but he had a nervous breakdown and then I became the stronger of the two. My brother copies me in everything. When I bought a stationwagon, he bought one. "When my wife and I got pregnant, he became pregnant." My brother seems to have a problem with his masculinity. His son is still in curls at four and doesn't speak. I tried to tell him that it was wrong to keep a boy in curls.

At this point I intervened and indicated that the patient had said: "When my wife and I got pregnant, he became pregnant." The patient replied defensively that this was merely a manner of speech. Then he laughed and said that perhaps he had thought he could have a baby when he was a child. His mother had regretted that he was born a boy, had curled his hair and kept him in dresses. In fact he remembers playing with dolls until he was six years old. The triangular wound reminds him of a bad gash he saw on a playmate as a child. Gash makes him think of vagina. His wife had an operation on her vagina once and it makes him sick to think of it.

Again I intervene and point out to the patient that the dream contains the idea it is better to keep quiet if you want to hide your gash; if you talk, your gash will become more exposed. The patient is pensive and then says that he guesses he is afraid to uncover some of his own worries about being masculine. Maybe some activity of a homosexual nature did occur with his brother as we had previously hypothesized.

The dream and the associations clearly demonstrate some characteristics of the primary and secondary processes. "I am building an addition to the front of my house" seems to symbolize a pregnancy fantasy in my male patient's unconscious. This also comes out later in the patient's associations when he said, "My wife and I got pregnant and my brother became pregnant." The triangular gash symbolizes the patient's view of a vagina. It also hints at his castration anxiety as indicated by feeling queasy in the dream and feeling sick at the idea of an operation on the vagina which came up in his associations. The son changes into his brother, but this does not cause any amazement in the dream since logic and time are of no consequence. However, this change expresses in a condensed form that on the surface the patient may seem to be in com-

mand, but in the past and in the analytic situation the patient had and still has some passive, anal, and feminine attitudes and fantasies. The triangular gash is a displacement from below to above as well as a condensation. The little boy who runs away is also a condensation of the patient's son about whom he has homosexual desires and anxieties, the patient's older brother, and the patient himself. The analysis is represented by the building of an addition, by the fearful expectations, by the running away, and by the admonition to keep quiet. The analyst is represented as running after the little boy, as getting angry at him for running away, as smiling condescendingly, and as being the embarrasser who might notice the bad smell.

I believe this dream and the associations demonstrate many qualities of the primary and secondary processes as they occur in a fragment of clinical work.

The *dynamic point of view* assumes that mental phenomena are the result of the interaction of forces. Freud (1916-17, p. 67) used the analysis of errors to demonstrate dynamics: "I would ask you to bear in mind as a model the manner in which we have treated these phenomena. From this example you can learn the aims of our psychology. We seek not merely to describe and to classify phenomena, but to understand them as signs of an interplay of forces in the mind, as a manifestation of purposeful intentions working concurrently or in mutual opposition. We are concerned with a *dynamic view* of mental phenomena." This assumption is the basis for all hypotheses concerning instinctual drives, defenses, ego interests, and conflicts. Symptom formation, ambivalence, and overdetermination are examples of dynamics.

A patient who suffered from premature ejaculation had an unconscious fear of and hatred for the vagina. It represented to him a dreadful, gigantic cavity which would devour him. It was a dirty, slimy, sickness-spreading sewer. At the same time the vagina was a luscious, juicy, milk-giving breast which he longed to take into his mouth. During intercourse he would oscillate between fantasies that the huge vagina would engulf him and that his erect penis might tear and rip those delicate and fragile walls until they bled. His premature ejaculation was a means of expressing impulses to soil and degrade that hateful organ and also to run away from that dangerous and fragile genital. It was also a symbolic plea to the bearer of the vagina: "I am only a little boy who just urinates in a vagina, be nice to me." The premature ejaculation

was a compromise between varieties of destructive sensuality and oral supplication. As his analysis progressed and his wife remained his wife during intercourse, he could express aggressive sensuality in forceful phallic activity and his orality in the foreplay.

The *economic point of view* concerns the distribution, transformations, and expenditures of psychic energy. Such concepts as binding, neutralization, sexualization, aggressivization, and sublimation are based on this hypothesis.

An example of economics may be seen in the case of Mrs. A. whom I described in Section 1.22. Before the outbreak of the patient's phobias, she was in a state of dammed-up instinctual tensions, but her ego functions were still able to carry out their defensive functions adequately enough so that Mrs. A. could function without obvious symptoms. She was able to maintain her mental equilibrium by avoiding sexual relations with her husband, and if she had to participate, she would not allow herself to become sexually aroused. This required a great deal of her ego's defensive energies, but she was able to keep matters under control until the hair-combing incident. At that point the father's visit and 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. In order fully to understand the breakdown of Mrs. A.'s defensive capacities, it must be approached in terms of changes in the distribution of her psychic energies.

The *genetic point of view* concerns the origin and development of psychic phenomena. It deals not only with how the past is contained in the present, but with why, in certain conflicts, a specific solution was adopted. It brings into focus the biological-constitutional factors as well as the experiential.

Example: A patient of mine, Mr. N., claimed he was the favorite child of both his mother and father. For proof he cited how he was allowed to go to summer camp as a boy and later to college. His two younger brothers received neither of these benefits. He also claimed to be happily married, although he rarely had sexual relations with his wife and was often unfaithful to her. He felt he was basically a fortunate

person, although he suffered from periodic depressions and from impulsive bouts of gambling.

One of this patient's major defensive maneuvers was to collect screen memories. The memories he recalled were true, but they were retained to ward off the memory of unhappy experiences. At times he actually had been treated as the favorite child, but that was rare and not typical. His parents were inconsistent and hypocritical, which was a decisive factor in shaping his particular symptomatology. The parents would often reject and deprive him and when he complained, they would point out some special pleasure they had given him some time in the past. What his parents did to him consciously, my patient did unconsciously by using screen memories. He denied the past and present unhappiness by screen formations which proclaimed the opposite. His periods of depression revealed the underlying sadness. The gambling was an attempt to prove he was lucky, the favorite child of "Lady Luck."

The *structural point of view* assumes that the psychic apparatus can be divided into several persisting functional units. This was Freud's last major theoretical contribution (1923b). The concept of the psychic apparatus as consisting of an ego, id and superego is derived from the structural hypothesis. It is implied whenever we talk of interstructural conflicts like symptom formation or intrastructural processes like the synthetic function of the ego.

A clinical illustration is the patient described earlier with the premature ejaculation. When he began treatment he would lose the ego function of discrimination in sexual situations. All women became his mother, all vaginas were charged with oral-sadistic and anal-sadistic fantasies. As he progressed he no longer regressed in that way in sexual situations. His ego could differentiate between his mother and his wife; his id strivings were then able to progress from oral and anal to phallic.

Finally, today we also formulate an *adaptive point of view* although Freud only implied this. "The concept of *adaptedness* is implicit, for instance, in Freud's propositions concerning the coordination between drive and object, and in Hartmann's and Erikson's propositions concerning inborn preparedness for an evolving series of average expectable environments" (Rapaport and Gill, 1959, pp. 159-160).

All propositions concerning the relationship to the environment, objects of love and hate, relations to society, etc., are based on this

hypothesis. Every clinical example I have used previously is also an example of attempts at adaptation.

1.24 The Theory of Psychoanalytic Technique

Psychoanalytic therapy is a causal therapy; it attempts to undo the causes of neurosis. Its aim is to resolve the patient's neurotic conflicts, including the infantile neurosis which serves as the core of the adult neurosis. Resolving the neurotic conflicts means reuniting with the conscious ego those portions of the id, superego, and unconscious ego which had been excluded from the maturational processes of the healthy remainder of the total personality.

The psychoanalyst approaches the unconscious elements through their derivatives. All warded-off components of the id and ego produce derivatives—"half-breeds," which are not conscious and are yet highly organized in accordance with the secondary process and accessible to the conscious ego (Freud, 1915b, pp. 190-192; Fenichel, 1941, p. 18).

The procedure that psychoanalysis requires the patient to use to facilitate the communication of derivatives is free association, the fundamental method of psychoanalysis, the so-called "basic rule" (Freud, 1913b, pp. 134-136; 1915b, pp. 149-150). These derivatives appear in the patient's free associations, dreams, symptoms, slips, and acting out.

The patient is asked to try, to the best of his ability, to let things come up and to say them without regard for logic or order; he is to report things even if they seem trivial, shameful, or impolite, etc. 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. (The meaning of the term "to analyze" and other technical and clinical terms will be discussed in Section 1.3.)

Although the patient suffering from a neurosis enters psychoanalytic treatment with the conscious motive of wanting to change, there are unconscious forces within him which oppose change, which defend the neurosis and the *status quo*. These forces oppose the procedures and processes of treatment and are called the *resist-*

ances. Resistances stem from those same defensive forces of the ego which form part of the neurotic conflict. In the course of treatment the patient will repeat all the different forms and varieties of defensive maneuvers that he used in his past life. The analysis of the resistances is one of the cornerstones of psychoanalytic technique. Since resistance is a manifestation of the defensive and distorting function of the ego, it is resistance which psychoanalytic technique attempts to analyze first. Insight can be effective only if the patient is able to establish and maintain a reasonable ego. Resistances interfere with the reasonable ego and have to be analyzed before any other analytic work can be done with success.

For example, a young man seems to be hesitant to tell me anything derogatory about his wife. Whenever he finds fault with her he is quick to excuse her or justify her shortcomings. When I point out this defensive attitude to him, the patient at first denies it and then tearfully admits that I am right. He acknowledges that he tries to cover up his wife's deficiencies because he is sure I would expect him to get a divorce if I "really" knew how inadequate she is. When I pursue this point about divorce, the patient recalls that in his childhood his father repeatedly threatened to divorce his mother whenever he found fault with her. Thus, it seemed clear that the patient's hesitancy indicated that he was afraid I would act like his father. He tried to protect his wife from me as he had wanted to protect his mother from his father.

Only after the patient recognized this source of resistance could he go on to realize that it was he, not I, who had such a strong, "fatherly" resentment against his wife. It took a great deal more analysis for him to become aware that although he wanted to defend his mother against his father, he himself had had an enormous resentment against his mother. Unconsciously he wanted me to urge him to divorce his wife as he once had wanted his father to do to his mother.

In this clinical example, it was necessary to analyze each aspect of the resistance step by step to enable the patient to face the reality of the situation. First, he had to recognize that he feared I would want him to divorce his wife and consequently he was hiding certain things about her from me. Then he had to realize that he had confused me with his father and his wife with his mother. Finally, the patient was able to detect that underlying his protective feelings toward his mother, there was also great hostility. Each step in the analysis of resistances implies that the reasonable ego of the patient

has to be enabled to face some irrational, distorted aspect of its own activity.

This clinical example leads to another basic concept in the theory of psychoanalytic technique. Neurotic patients are prone to *transference reactions*. The transference is one of the most valuable sources of material for the analysis, one of the most important motivations, and also the greatest obstacle to success. The instinctual frustration of the neurotic tends to make him unconsciously seek objects upon whom he displaces his libidinal and aggressive impulses. The patient tends to repeat his past, in terms of human relations, in order to obtain satisfactions he had not experienced or belatedly to master some anxiety or guilt. Transference is a reliving of the past, a misunderstanding of the present in terms of the past. The central importance of the transference reactions in the theory of technique stems from the fact that, if the transference reactions are properly handled, the patient will experience, in the treatment situation and in regard to the psychoanalyst, all the significant human relations of his past which are not consciously accessible to him (Freud, 1912a).

The psychoanalytic situation is so structured as to facilitate the maximal development of the transference reactions. The psychoanalyst's deprivational attitude and his relative incognito help bring out the full range of transference feelings and fantasies. However, it is the consistent analysis of the transference, both in and outside the analytic situation, which enables the patient to endure the different varieties and intensities of transference.

Transference is also the source of the greatest resistances during the analysis. A patient may work hard in the beginning of an analysis in order to gain favor with the analyst. It is inevitable that the patient will feel some form of rejection because all our patients have experienced rejection in their past lives and the analyst's attitude is essentially nongratifying. The hostile feelings of the repressed past or the forbidden sexual longings of childhood or adolescence will evoke strong tendencies in the patient to fight against the analytic work unconsciously. The quality and quantity of the "transference resistances" will be determined by the patient's past history. The duration of these reactions will also be influenced by how effectively the psychoanalyst analyzes the transference problems which stirred up the resistances.

A word should be added at this point about the relatively nonneurotic, rational, and realistic attitudes of the patient toward the analyst: the *working alliance* (Greenson, 1965a). It is this part of the patient-analyst relationship that enables the patient to identify with the analyst's point of view and to work with the analyst despite the neurotic transference reactions.

Psychoanalytic technique is aimed directly at the ego since only the ego has direct access to the id, to the superego, and to the outside world. Our aim is to get the ego to renounce its pathogenic defenses or find more suitable ones (A. Freud, 1936, pp. 45-70). The old defensive maneuvers proved to be inadequate; new, different, or no defense might permit some instinctual outlet without guilt or anxiety. The id discharge would lessen the instinctual pressure, and the ego would then be in a relatively stronger position.

The psychoanalyst hopes to induce the relatively mature aspects of the patient's ego to contend with what it once banished from consciousness as too dangerous. It is the analyst's expectation that under the protection of the working alliance and nonsexual positive transference the patient will look afresh at what he once considered too threatening, will be able to re-evaluate the situation, and eventually will dare to attempt new ways of dealing with the old danger. Slowly the patient will realize that the instinctual impulses of childhood which were overwhelming for a child's ego resources and were distorted by a child's superego can be looked at differently in adult life.

The psychological work which occurs after an insight has been given and which leads to a stable change in behavior or attitude is called *working through* (Greenson, 1965b). It consists of such processes as the utilization and the assimilation of insight and reorientation (E. Bibring, 1954). It will be discussed in the next section.

Psychoanalysis tries in this way to reverse, to roll back, the process of neurosis and symptom formation (Waelder, 1960, p. 46). The only reliable solution is to achieve structural changes in the ego which will allow it to renounce its defense or to find one which permits adequate instinctual discharge (Fenichel, 1941, p. 16).

Let me try to illustrate a typical sequence of events with a clinical example. A twenty-seven-year-old woman, Mrs. K., seeks analysis for

a variety of reasons. For several years she has had episodes of feeling out of things, numb, "gone," "like a zombie." In addition, she has periods of depression, an inability to have an orgasm in sexual relations, and most recently, an impulsive-obsessive idea to have a sexual affair with a Negro. This last symptom was most torturous for her and impelled her to come for treatment. I shall use this single symptom as the focal point to illustrate the theoretical description I have given of the aims and goals of psychoanalytic technique. (See Altman's [1964] report of a panel on this subject, particularly Ross's contribution.)

All psychotherapies would attempt to relieve the patient from her symptoms, but only psychoanalysis attempts to do this by resolving the neurotic conflicts which are at the bottom of the symptoms. Other therapies might try to help the patient by strengthening her defenses, or by using the transference and suggestion to subdue or displace her sexual impulses for Negro men. Or they might try to help the defense-instinct conflict by suggesting some instinctual outlet that might be possible under the protection of a superegolike transference to the psychotherapist. Some therapists might use drugs to tranquilize the libidinal drives and in that way help out the patient's beleaguered ego. Some others might suggest drugs like alcohol or phenobarbital, which might temporarily dull the demands of the patient's superego. All these methods can be helpful, but they are temporary since they do not effect a permanent change in the psychic structures involved in the causative unconscious conflicts.

Psychoanalytic therapy would try to make the patient aware of all the different unconscious impulses, fantasies, desires, fears, guilts, and punishments that are expressed in a condensed way in her symptom. The patient I am using as an example was slowly given insight into the fact that the Negro was a disguise for her powerful, sexually attractive, and frightening red-headed stepfather from her puberty years. The impulsive-obsessive idea of having sexual relations with Negroes was demonstrated as being partly derived from disguised incestuous desires for the stepfather. It was also a screen for sadistic-masochistic impulses and concealed a "toiletization" of sexuality. The Negro also represented a condensation of an anal-phallic man from age three. The painful quality of the symptom was uncovered as a self-punishment out of guilt for the forbidden impulses.

As the patient was able gradually to face these insights her ego no longer had to expend so much of its energies in attempting to repress the forbidden impulses and fantasies. Her reasonable ego could now accept the notion that incestuous fantasies are not the same as actions and are part of growing up in our society. Mrs. K. could now recognize