tual gratification possible without guilt. The entire relationship among the psychic structures was changed, and with that a new and more gratifying and effective relationship to the outside world emerged.

1.3 The Components of Classical Psychoanalytic Technique

Now that the reader has an overall view of psychoanalytic therapy from the historical development and the theoretical framework, the present section will outline a general introduction to technique as it is currently practiced. It will consist of working definitions or descriptions of the therapeutic procedures and processes which are utilized in classical psychoanalysis. The purpose is to provide a glossary of technical terms and concepts and to demonstrate how some of them are used in the partial and diluted analytic therapies as compared to psychoanalytic therapy (E. Bibring, 1954; Greenacre, 1954; Gill, 1954; and the Additional Reading List).

1.31 The Production of Material

1.311 Free Association

In classical psychoanalysis the predominant means of communicating clinical material is for the patient to attempt free association. Usually this is begun after the preliminary interviews have been concluded. In the preliminary interviews the analyst had arrived at an assessment of the patient's capacity to work in the psychoanalytic situation. Part of that evaluation consisted of determining whether the patient had 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 analytic interventions, answering direct questions, and resuming everyday life at the end of the hour.

The patient usually associates freely most of the hour but he may also report dreams and other events of his daily life or past history. It is characteristic for psychoanalysis that the patient is asked to include his associations as he recounts his dreams or other experiences. *Free association has priority over all other means of producing material in the analytic situation.*

However, free association may be misused in the service of resistance. It is then the task of the analyst to analyze such resistances in order to re-establish the proper use of free association. It may also occur that a patient cannot stop free-associating because of a breakdown of ego functions. This is an example of an emergency situation arising in the course of an analysis. The analyst's task then would be to attempt to re-establish the ego's logical, secondary-process thinking. He may have to employ suggestion and direct commands in order to do so. This is an unanalytic maneuver, but it is indicated in the above instance because we may be dealing with an incipient psychotic reaction.

Free association is the major method of producing material in psychoanalysis. It is used on selective occasions in those forms of psychotherapy which attempt some amount of uncovering, the so-called "psychoanalytically oriented psychotherapies." It is not used in the anti-analytic therapies, the covering-up or supportive therapies.

There will be a further discussion of free association in the chapter dealing with what psychoanalysis demands of the patient (Section 4.12). The introduction of free association in connection with the transition to the couch will be described in Volume II.

1.312 The Transference Reactions

Ever since treating Dora, Freud recognized that the patient's transference reactions and resistances produced the essential material for the analytic work (1905a, pp. 112-122). From then on the analytic situation was arranged so that it would facilitate the maximal development of the patient's transference reactions. The resistances are aimed at preventing this development or at obstructing the analysis of the transference. Both resistance and transference are the bearers of vital information about the patient's past, repressed history. Chapters 2 and 3 of this volume are devoted to a systematic and thorough discussion of these topics. Here I shall attempt only a preliminary orientation.

Transference is the experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which are inappropriate to that person and are a repetition, a displacement of reactions originating in regard to significant persons of early childhood. A patient's susceptibility to transference reactions stems from

his state of instinctual dissatisfaction and his resultant need for discharge opportunities (Freud, 1912a).

It is important to focus on the fact that the patient tends to repeat *instead* of to remember; the repetition 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 which is otherwise inaccessible. If 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 sexual longing as well as liking, loving, and respecting the analyst. The negative transference implies some variety of aggression in the shape of anger, dislike, hate or contempt 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 are poor risks for psychoanalysis. Freud divided the neuroses into two groups on the basis of whether or not 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, 1916-17, pp. 341, 414-415, 420-423).

Freud also used the term *transference neurosis* to describe that constellation of transference reactions in which the analyst and the analysis have become the center of the patient's emotional life and the patient's neurotic conflicts are relived in the analytic situation (Freud, 1914c, p. 154). All the important features of the patient's illness will be relived or re-enacted in the analytic situation (Freud,

1905a, pp. 118-119; 1914c, pp. 150-154; 1916-17, Chapter XXVII).

Psychoanalytic technique is so geared as 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, 1941, p. 72; Greenacre, 1954; Gill, 1954). 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, 1912a, 1914c; Glover, 1955, Chapt. VII, VIII). The transference neurosis can be resolved only by analysis; other procedures may change its form, but will only perpetuate it (Gill, 1954).

Psychoanalysis is the only form of psychotherapy which 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 negative 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 anti-analytic 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 "cured." But these "transference cures" are fleeting and last only as long as the idealized transference to the therapist is untouched (Fenichel, 1945a, pp. 559-561; Nunberg, 1932, pp. 335-340).

1.313 The Resistances

Resistance refers to all the forces within the patient which oppose the procedures and processes of psychoanalytic work. To a

greater or lesser degree it is present from the beginning to the end of treatment (Freud, 1912a). The resistances defend the *status quo* of the patient's neurosis. The resistances oppose the analyst, the analytic work, and the patient's reasonable ego. Resistance is an operational concept, it is not newly created by the analysis. The analytic situation becomes the arena where the resistances reveal themselves.

The resistances are repetitions of all the defensive operations that the patient has used in his past life. All varieties of psychic phenomena may be used for the purpose of resistance, but no matter what its source, the resistance operates through the patient's ego. Although some aspects of a resistance may be conscious, an essential part is carried out by the unconscious ego.

Psychoanalytic therapy is characterized by the thorough and systematic analysis of resistances. It is the task of the psychoanalyst to uncover how the patient resists, what he is resisting, and why he does so. The immediate cause of a resistance is always the avoidance of some painful affect like anxiety, guilt or shame. Behind this motive will be found an instinctual impulse which has triggered the painful affect. Ultimately one will find that it is the fear of a traumatic state which the resistance is attempting to ward off (A. Freud, 1936, pp. 45-70; Fenichel, 1945a, pp. 128-167).

There are many ways of classifying resistances. The most important practical distinction is to differentiate the *ego-syntonic* resistances from the *ego-alien* ones. If a patient feels a resistance is alien to him, he is ready to work on it analytically. If it is ego syntonic, he may deny its existence, belittle its importance, or rationalize it away. One of the crucial early steps in analyzing a resistance is to convert it into an ego-alien resistance for the patient. Once this has been accomplished, the patient will form a working alliance with the analyst. He will have temporarily and partially identified himself with the analyst in his willingness to work analytically on his resistances.

Other forms of psychotherapy attempt to evade or overcome resistances by means of suggestions or by using drugs or exploiting the transference relationship. In the covering-up or supportive therapies the therapist attempts to strengthen the resistances. This may well be necessary in patients who may be slipping into a psychotic state. It is only in psychoanalysis that the therapist seeks to uncover

the cause, purpose, mode, and history of the resistances (Knight, 1952).

1.32 Analyzing the Patient's Material

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 they have the direct aim of increasing the patient's insight about himself. Some procedures do not add insight per se, but strengthen those ego functions which 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 then enabled to observe, think, remember, and judge, functions it had lost in the acute anxiety state. Insight now becomes possible. Abreaction is one of the *nonanalytic* procedures that is frequently used in psychoanalytic treatment. It is often an indispensable prerequisite for insight.

The *anti-analytic* procedures are those which block or lessen the capacity for insight and understanding. The use of any measure or course of action which 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, certain kinds of transference gratifications, diversions, etc.

The most important analytic procedure is *interpretation*; all others are subordinated to it both theoretically and practically. All analytic procedures are either steps which lead to an interpretation or make an interpretation effective (E. Bibring, 1954; Gill, 1954; Menninger, 1958).

The term "analyzing" is a shorthand expression which refers to those insight-furthering techniques. It usually includes four distinct procedures: *confrontation*, *clarification*, *interpretation*, and *working through*. In the ensuing chapters there will be ample discussion and clinical examples of how each of these procedures are employed. Here I shall limit myself to working definitions and simple illustrations.

The first step in analyzing a psychic phenomenon is *confrontation*. The phenomenon in question has to be made evident, has to

be made explicit to the patient's conscious ego. For example, before I can interpret the reason a patient may have for avoiding a certain subject in the hour, I first have to get him to face that he is avoiding something. Sometimes the patient himself will recognize this fact 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 discerns within himself the psychic phenomenon we are attempting to analyze.

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.

The third step in analyzing is *interpretation*. This is the procedure which 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, 1954; Fenichel, 1945a; and Additional Reading List).

The procedures of clarification and interpretation are intimately interwoven. Very often clarification leads to an interpretation which leads back to a further clarification (Kris, 1951). The clinical case

cited above indicates this. Let me illustrate an example of interpretation and validation from the same patient.

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. N. doubted whether his father really could perform. His father would flirt with a waitress in a café 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.

It is clear that the patient's material concerns comparing himself with his father in terms of sexual ability. It also deals with people who pretend to be what they are not. The strongest affect in his associations was the moment when he said he was "tickled" by the fantasy of beating out the big cars. He knew this was a distortion, but he liked imagining it. In the dream his fury changes to relief when he discovers he has been bumped by "only a boy on a bicycle." It seemed to me that these two affect-laden elements must contain the key to the meaning of the dream and the analytic hour.

I interpreted to *myself* that the boy on the bicycle means a boy masturbating. The red light probably refers to prostitution since "red-light district" is a common term for those areas where prostitutes congregate. I knew my patient claimed to love his wife but preferred sex with prostitutes. Up until this point in the analysis the patient had no memories concerning the sexual life of his parents. However, he often mentioned his father's flirtations with waitresses, which I took to be screen memories. I therefore felt that I would point my interpretation in the direction of his adult attitude of superiority versus his childhood concern with the sexual life of his father. (I deliberately neglected, for the time being, all the references to bumping, behind, anger, etc.)

I said to Mr. N. toward the end of the hour that I felt he was struggling with his feelings about his father's sexual life. He seemed to be saying his father was sexually not a very potent man, but I wondered if he had always thought so. The patient responded rather quickly, in fact, a bit too quickly. In essence he was in haste to agree that his father always seemed to him to be arrogant, boastful, and pretentious. He didn't know what his sex life was like with his mother, but he is quite sure it couldn't have been very satisfactory. His mother was sickly and unhappy. She spent most of her life complaining to him about his father. Mr. N. was quite sure his mother disliked sex, although he couldn't prove it.

I intervened at this point and said that I supposed the idea that his mother rejected sex with his father tickled him. The patient said that it didn't tickle him, but he had to admit it gave him a sense of satisfaction, a sense of triumph over the "old boy." In fact, he now recalls finding some "girlie magazines" (magazines with photos of nude women) hidden in his father's bedroom. He also recalls that he once found a packet of condoms under his father's pillow when he was an adolescent and he thought, "My father must be going to prostitutes."

I then intervened and pointed out that the condoms under the father's pillow seemed to indicate more obviously that his father used the condoms with his mother, who slept in the same bed. However, Mr. N. *wanted* to believe his wish-fulfilling fantasy: mother doesn't want sex with father and father is not very potent. The patient was silent and the hour ended.

The next day he began by telling me that he was furious with me as he left my office. As he drove away he drove wildly, trying to pass all the cars on the freeway, especially the expensive ones. Then he got the sudden impulse to race against a Rolls Royce if he could only find one. A fleeting thought crossed his mind. On the front of the Rolls Royce are the initials R. R. Those are Dr. Greenson's initials, he suddenly realized. With that he began to laugh, all by himself in the car. "The old boy is probably right," he thought, "it does tickle me to imagine that my mother preferred me and I could beat out my father. Later I wondered whether this had something to do with my own screwed-up sex life with my wife."

I suggest that this clinical vignette illustrates the complicated steps that are involved in making even a simple interpretation and also how one has to wait for the patient's clinical responses to determine whether one is on the right track. The patient's affective response to my first intervention, his haste in responding, indicated I had touched something quite alive. The new memories of the

"girlie magazines" and the condoms confirmed that I was essentially correct. His reactions after the hour, the anger, the association to Rolls Royce, the laughter and connecting it up to his own sex life seemed to indicate that the dosage and timing were in order. (In Volume II more will be said about interpretation.)

The fourth step in "analyzing" is *working through*. Working through refers to a complex set of procedures and processes which occur after an insight has been given. The analytic work which makes it possible for an insight to lead to change is the work of working through (Greenson, 1965b). It refers in the main to the repetitive, progressive and elaborate explorations of the resistances which 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, 1956a, 1956b.)

In order to illustrate the concept of working through let us return to the case of Mr. N. In the first hour I reported how I had interpreted his wishful fantasy that his mother didn't like sex, and rejected his father sexually, and his father was sexually impotent. He did not like this interpretation, but later that day realized it seemed to be correct. By the time he came for his next hour he had amplified this insight and connected it to the fact that his own sex life with his wife was disturbed. What was most difficult for him was to look at his wife the day after sexual relations. He felt she must abhor him for having behaved sensually. When I questioned this, he connected his reactions to a childhood memory of his mother humiliating him for masturbating.

In the course of the next several weeks, however, Mr. N. became increasingly aware of the fact that alongside of his wish that his wife enjoy herself sensually with him, *he* had contempt for *her* when she became sexually excited. The feeling that she abhorred him after intercourse was a projection of his own feelings. Shortly thereafter Mr. N. recalled a memory of his mother winking slyly at his father when they saw two dogs copulating on the street. At first there was little affect connected to this memory. However, the patient behaved strangely toward his wife at this time. He found her utterly unappealing, avoided her altogether sexually, and sought out prostitutes. I interpreted to him that he seemed to be acting as he imagined his father had.

The patient replied to this that he didn't blame his father for avoiding

his mother sexually. Although his mother had been an attractive woman, he recalled some memories when she was in bed and she was "not exactly a sex pot." Her face seemed flushed and sweaty, her hair was matted down, and there was a repulsive odor. These memories were associated to sickness and to menstruation. I interpreted that menstruating was related to bitches being in heat. Later, I reconstructed for Mr. N. the likelihood that the picture of his mother with the flushed, sweaty face, and the repulsive odor was connected to seeing his mother in sexual intercourse with his father. I suggested the possibility that the notion of his mother not liking sex and the many memories of his father's flirtations with other women were attempts to contradict the unconscious memory of having seen his mother sexually excited by his father. I pointed out that the memory of his mother winking at his father while watching two dogs mating was also a screen memory of this kind.

Mr. N. agreed that my reconstruction seemed plausible, but "it left him cold." In a following hour I told him that his neglect of his wife sexually and his pursuit of prostitutes were further attempts "to prove" that good women, married women, women who are the mothers of children, don't care for sex and husbands of such women don't have sex with them. The weekend following this interpretation the patient reported having the most satisfying sexual experience of his life thus far, with his wife. This was followed by several weeks of resistance to analysis and to sex based on the idea all grownups are hypocrites and liars except for a few rebels and mavericks.

Once again Mr. N. was struggling with his childhood conflicts about the sexual life of his parents. If he had to give up the denial of the existence of their sexuality, he hated them and despised them for their hypocrisy. His mother winking at his father epitomized this. His wife was also a "phoney" and so was I and my wife. The only honest people were those who shunned society and convention. It was more honest to pay for sex in cash than to buy it with expensive homes, clothes, furs, cars, etc. I interpreted to him that this seemed to be an attempt to degrade his mother and father and other married people because of his rage and envy of his mother's winking. Underneath his contempt was envy. He would have reacted quite differently if his mother had winked at him and not his father.

Mr. N. reacted to this interpretation and further reconstruction with sullen anger and resistance. Then slowly over a period of weeks, he began to mull over the relationship between contempt and envy. He realized there might be some merit to my formulation. He begrudingly admitted I was right and he hated to give up the idea that mother didn't want sex with father and preferred no sex at all. If she had sex, she did

it submissively and then he made his father impotent in his fantasy. The picture of his mother sexually excited by father enraged him or made him indignant. He felt like a little boy or like a superior adult. Maybe he ought to let them have their own sex life and he ought to concentrate on his own bedroom.

I believe this clinical material illustrates some of the work that goes on in working through. What I have described covers a period of some six months. It begins with the dream of the patient in his sports car at a red light being bumped by a boy on a bicycle. On and off since then we worked on the problem of his emotional reactions to the sex life of his parents and how that determined his own sexual difficulties. On the surface there was superiority toward the father and sympathy toward the mother. Father was an impotent braggart and mother a reluctant nonvirgin. Then, against great resistances we found flashes of anger toward mother and father. Then mother became repulsive and he had contempt for both parents. Toward the end of this period we uncovered envy of the parental sex life. Finally, Mr. N. got the notion that perhaps they are entitled to the privacy of their bedroom and he ought to do likewise.

This was not the end of Mr. N.'s sexual problem, but it does demonstrate the achievement of a significant amount of valuable insight. There were many back-and-forth movements, but progress continued. For instance, the theme of homosexuality was not pursued during this period, but was taken up at later times. There were intrusions of other problems, and for shorter or longer periods of time sexual problems receded into the background or were complicated by admixtures of aggression. There were also regressive phases when the libido was involved on other levels. My aim, however, was to offer an example of working through as it occurs in psychoanalysis.

It should be noted that some of the work of working through is done by the patient outside of the analytic hour. 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 which 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 will be discussed in Volume II (see also Freud, 1914c, 1926a, 1937a; Fenichel, 1941, Chapt. VI; Greenacre, 1956; Kris, 1956a, 1956b; Greenson, 1965b).

The four steps that I have outlined 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 which 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.

1.33 The Working Alliance

The psychoanalytic patient enters analysis because his neurotic suffering impels him to embark on this difficult therapeutic journey. His problem is severe enough to induce him to undertake this long-term, painful, costly program. His ego functions and his capacity for object relations[2] are, despite his neurosis, considered healthy enough to endure the rigors of psychoanalytic therapy. Only a relatively healthy neurotic can be psychoanalyzed, without major modifications or deviations.

The psychoanalytic patient produces the material for the treatment via free association, transference reactions, and resistances. The analyst uses the procedures of confrontation, clarification, interpretation, and working through. But all of this does not fully explain

[2] I find the term "object relations" and similar terms, such as "love objects" and "lost objects," unsatisfactory. They seem to cast an impersonal and detached quality upon concepts which are fraught with intense personal meaning. Nevertheless, I have continued to use them throughout because they have gained wide acceptance in psychoanalytic circles and I find no better replacement that would meet all the requirements implied by these terms. The term "object" goes back to the notion that the id needs objects to satisfy the drives. In this sense, the original need-satisfying objects had little distinction or uniqueness other than they were need-satisfying.

what happens or fails to happen in the course of therapy. There is one other major therapeutic ingredient which is vital for the success or failure of psychoanalytic treatment. I am referring to the "working alliance," which is not precisely a technical procedure or a therapeutic process but is necessary for both (Greenson, 1965a). Here I shall only present an outline of the subject. For a full discussion of the working alliance see Section 3.5.

The working alliance is the relatively nonneurotic, rational relationship between patient and analyst which makes it possible for the patient to work purposefully in the analytic situation. Freud (1913b, p. 139) wrote of an "effective transference," a rapport, which must be established before an interpretation should be given to the patient. Fenichel (1941, p. 27) described a "rational" transference, Stone (1961, p. 104) a "mature" transference, Zetzel (1956) a "therapeutic alliance," and Nacht (1958a), the analyst's "presence," all of which refer to a similar concept.

The clinical manifestations of this working alliance are the patient's willingness to carry out the various procedures of psychoanalysis and his ability to work analytically with the regressive and painful insights which arise. The alliance is formed between the patient's reasonable ego and the analyst's analyzing ego (Sterba, 1934). The significant occurrence is a partial and temporary identification that the patient makes with the analyst's attitude and method of work which the patient experiences firsthand in the regular analytic sessions.

The patient, the analyst, and the analytic setting contribute to the formation of the working alliance. The awareness of neurotic suffering and of the possibility of help from the analyst impels the patient to seek out and work in the analytic situation. The patient's ability to form a relatively rational, desexualized, and de-aggressified relationship to the analyst stems from his capacity to have formed such neutralized relationships in his past life. The patient's ego functions play a decisive role, since the capacity to establish a multiple relationship with the analyst is possible only with a resilient ego.

The analyst contributes to the working alliance by his consistent emphasis on understanding and insight, by his continual analysis of the resistances, and by his compassionate, empathic, straightforward, and nonjudgmental attitudes (Freud, 1912a, p. 105; 1913b, p. 123; Fenichel, 1941, p. 85; Sterba, 1929, pp. 371-372). The analytic setting facilitates the development of the working alliance by the frequency of the visits, long duration of the treatment, use of the couch, silence, etc. This promotes not only regression and neurotic transference reactions but also the working alliance (Greenacre, 1954).

The analyst's way of working, his therapeutic style, and the analytic setting produce an "analytic atmosphere," which is an important means of inducing the patient to accept on trial something hitherto repelled. This atmosphere promotes the working alliance and entices the patient temporarily and partially to identify with the analyst's analytic point of view. The analytic atmosphere can also become a resistance when it casts an aura of make-believe and "not real life" over the analytic work.

The working alliance is that part of the relationship to the analyst which makes it possible for the patient to cooperate in the analytic hour. Under this benign influence the patient tries to understand the analyst's instructions and insights, reviews and mulls over the interpretations and reconstructions, which aids in the integration and assimilation of the insights. The working alliance along with the neurotic suffering provide the incentive for doing the analytic work; the bulk of the raw material is provided by the patient's neurotic transference reactions.

In order to analyze the transference neurosis successfully, it is necessary for the patient to have developed a reliable working alliance with the analyst. The transference neurosis is the vehicle that enables the patient to bring the warded-off, inaccessible material into the analytic situation. The patient's ability to oscillate between the working alliance and the neurotic transference reactions is a prerequisite for doing the psychoanalytic work. This ability is parallel to the split in the patient's ego between a reasonable, observing, analyzing ego, and an experiencing, subjective, irrational ego.

This split can be seen in free association. When the patient permits himself to be carried away by a painful memory or fantasy, the experiencing ego is in the foreground, and there is no awareness of the meaning or appropriateness of the emotions at the time. If the analyst were to intervene at this point, the patient's reasonable ego would come back into the fore and the patient would now be able to recognize that the affects in question came from the past;

be understood in terms of topography, like the shift from secondary process to primary process. Gill (1963, p. 93) believes this also implies a structural regression, a regression in the ego's perceptual function, expressed in transforming thoughts into visual images. Winnicott (1955, pp. 283, 286) maintains that the most important aspect of regression is the regression of ego functions and object relations, particularly in the direction of primary narcissism.

Anna Freud's (1965, pp. 93-107) discussion of regression is the most thorough and systematic. She states that regression can occur in all three psychic structures; it can concern psychic content as well as functioning; and it may influence the instinctual aim, the object representations, and the fantasy content. (I would add the erogenous zone and the self-image to this list). Id regressions are more stubborn and adhesive, while regressions in terms of ego functions are often more transitory. Temporary regression in ego functions is part of the normal development of the child. In the process of maturation, regression and progression alternate and interact with each other.

Regression occupies a special position among the defenses, and there seems to be some doubt whether it really belongs among them (A. Freud, 1936; Fenichel, 1945a; Gill, 1963). However, there is no doubt that the ego does use regression in a variety of forms for purposes of defense and resistance. The role of the ego is somewhat different in regard to regression. In general it seems that the ego is more passive than it is in other defensive operations. Very often regression is set in motion by an instinctual frustration on a given level which impels the drives to seek outlets in a backward direction (Fenichel, 1945a, p. 160). Yet under certain conditions the ego does have the ability to regulate regression as it does in sleep, wit, and in some creative activities (Kris, 1950, pp. 312-313). Actually, for mental health and above all for psychological-mindedness, primitive functions are needed to supplement the more highly differentiated ones (Hartmann, 1947; Khan, 1960; Greenson, 1960). As with all defenses, it is important to discriminate between the relatively more pathogenic and adaptive regressions.

It is also important to keep in mind that regression is not a total, all-encompassing phenomenon. Usually we see selective regressions. A patient may regress in certain ego functions and not in others. Or there may be a great deal of regression in terms of instinctual aims and relatively little regression in terms of object relations. The "unevenness" of regression is a very important concept in clinical practice (A. Freud, 1965).

This discussion has important implications in terms of therapeutic processes. For psychoanalytic therapy, regression is needed—indeed our setting and attitude facilitate this development (see Chapter 4; also Menninger, 1958, p. 52). However, most analysts have in mind an *optimal* amount of regression. We select patients who, for the most part, can regress only temporarily and partially. Yet there is some difference of opinion on this matter. For example, Wexler (1960, pp. 41-42) cautions against using procedures like free association, which will lead certain borderline patients to object detachment, whereas Winnicott (1955, p. 287) feels it is the analyst's task to encourage a full regression even in a psychotic patient.

2.5 Classification of Resistances

2.51 According to the Source of Resistance

During the course of his many writings on problems of defense and resistance, Freud at various times attempted to distinguish between different types of resistance. In *Inhibitions, Symptoms and Anxiety* he distinguished five kinds of resistance and classified them according to their source (1926a, p. 160). (1) The resistance of repression, by which he meant the resistance of the ego's defenses. (2) Resistance of the transference. Since transference is a substitute for memory and is based on a displacement from past objects onto present objects, Freud classified this resistance too as derived from the ego. (3) The gain from illness, or secondary gain, he also placed under the ego resistances. (4) The fourth variety he considered those which required working through, namely, the repetition compulsion and the adhesiveness of the libido, which he considered to be resistances from the id. (5) The last resistances Freud designated were those which arose from unconscious guilt and the need for punishment. He believed that these resistances originated in the superego.

Glover (1955), in the two chapters devoted to defense resistance in his book on technique, classifies resistances in many different

ways, but goes along with Freud's classification according to sources of resistance. Fenichel (1941) considered this method of differentiation unsystematic, and pointed out that Freud himself had the same impression (pp. 33-34).

Before pursuing our discussion of the sources of resistance, I believe it would be wise to state the truism that all psychic structures participate in all psychic events, although to varying degrees. If this is kept in mind, we will be less prone to oversimplify or overgeneralize our formulations. In accordance with our discussion of resistance and defense, I believe that the function of defense, the activity of avoiding pain, no matter what the evocative stimulus is, is initiated by the ego. The ego is that psychic structure which mobilizes warding-off, avoidance functions. It may do so by employing the unconscious primary mechanisms of defense, such as repression, projection, introjection, etc. However, it may also do so by utilizing any other conscious and unconscious psychic function. For example, heterosexual activity may be used as a defense, and, in the analysis, as a resistance against facing homosexual impulses. Pregenital sexual pleasures may not only be expressing infantile id components, but, if they become a source of resistance, they may also be serving a defensive, resistive function against the oedipal situation (Friedman, 1953). Freud, Glover, and Anna Freud described id resistances as those resistances which require working through and which stem from the repetition compulsion and the adhesiveness of the libido. In my opinion, these resistances too operate via the ego. A particular instinctual activity is repeated and remains intractable to insight only if it has enlisted the aid of the ego's defensive functions. Working through operates not directly upon the id but only upon the ego. For working through to succeed, the ego has to be induced to give up its pathological defensive function. Thus the id may participate in the resistance maneuvers, but it seems to me only by allowing itself to be used by the ego for defensive purposes. It should be stressed that this formulation holds true for the transference neuroses; the problem may be a different one in the psychoses (Winnicott, 1955; Freeman, 1959; Wexler, 1960).

A similar situation exists in terms of the superego. Guilt feelings may prompt the ego to institute various mechanisms of defense. But we can also see situations where the sense of guilt demands satisfaction, demands punishment, and takes on an idlike quality. The ego may defend itself against this by utilizing a variety of reaction formations which have a supermoral quality. We see this quite typically in the obsessional neurosis, for example. However, in severe masochistic characters, we can see a situation when the need for suffering is pleasurable, and where the patient gives vent to his superego demands, indulging in behavior which openly brings him pain. When this happens we have a resistance in the analysis because this sought-for pain is relatively pleasurable and simultaneously is warding off some other anxiety (Fenichel, 1945a, p. 166). It is serving both a gratifying and defensive, resistive function. Our therapeutic task will be to get the patient's reasonable ego to recognize the resistance function and to persuade it to dare to face the greater, underlying painful anxiety so that it can be analyzed.

Thus I have the impression that no matter what the original source of an activity may be, its resistance function is always derived from the ego. The other psychic structures have to be understood as operating through the ego. The motive for defense and resistance always is to avoid pain. The mode or measures of resistance can be any type of psychic activity, from the defense mechanisms to instinctual activities. The evocative stimulus which triggers the resistance maneuver may *originate* in any of the psychic structures—ego, id, or superego. But the *perception* of danger is an ego function.

Freud's ideas on signal anxiety are of basic importance in approaching these complicated interrelationships. I would like to use the ego's role in anxiety to exemplify some of the vital issues. In *Inhibitions, Symptoms and Anxiety* he described (a) the ego as the seat of anxiety, (b) anxiety as a response of the ego, and (c) the ego's role in *producing* anxiety and its role in defense and symptom formation (1926a, pp. 132-142, pp. 157-168). These problems were meticulously reviewed and clarified by Max Schur (1953) in his paper on "The Ego in Anxiety." He modifies Freud's concept that the ego produces anxiety to signal danger and to induce defenses and formulates instead: ". . . the ego evaluates the danger and experiences some shade of anxiety. Both evaluation and experience act as a signal to induce defenses. Not only in anticipation of danger, but also in its very presence, and even if the situation has some elements of a traumatic situation, and if the anxiety reaction

of the ego is a regressive one, with resomatization, this experience may still serve as signal for the rest of the ego to call for the reserves to take necessary measures. This formulation in no way alters the concept of the function of an anxiety as stimulus of adaptation, defense and symptom formation. . . . The ego is able to *produce danger* and not anxiety. It can do so by manipulating situations and by engaging in fantasies. . . . The concept of 'automatic' anxiety originating in the id (e.g., in sexual frustration) is substituted by the concept of the ego evaluating certain changes in the id as danger and reacting with anxiety. This formulation stresses the fact that anxiety is always an ego response" (pp. 92-93).

2.52 According to Fixation Points

All attempts to classify resistances will necessarily overlap. Nevertheless, it is of help to the psychoanalyst to have ready at his fingertips various kinds of classifications since it can alert him to the typical id material, ego functions, object relations, or superego reaction he may be dealing with. Let me give the following example of an anal resistance which came up during the third year of analysis of a young man, Mr. Z., who was essentially an oral-depressive neurotic character. The recognition of the anal quality of a particular resistance was helpful in eliciting and understanding the underlying unconscious material.

The patient lies on the couch, tense and taut. His fists are clenched, his jaw is tight, one can see the muscles in his cheeks taut, his ankles are crossed tightly, his face is somewhat flushed, his eyes stare straight ahead, he is silent. After a few moments he says, "I'm depressed. Even more than before. I hate myself. I beat myself unmercifully last night . . . [pause]. But it is justifiable. I just don't produce . . . [pause]. I'm not getting anywhere . . . [pause]. I'm stuck. I don't want to work. I refuse to work when I feel like this . . . [silence]. I don't want to talk . . . [long silence]."

The words are spoken in short, clipped phrases and syllables. They are spat out. I can feel in the tone, in the manner, in the posture, that he is angry, but more than that: he is spitefully and defiantly angry. Even though he talks only about hating himself, I feel he is angry and spiteful toward me. Moreover, I am alerted by the kinds of things he says: "I can't produce, I'm stuck." All of this, the content and the attitude, bespeak a kind of anal spite reaction. I keep quiet and then after a considerable silence say to him, "You not only seem to hate yourself but you also seem angry and spiteful toward me." The patient answers, "I'm angry with myself. I woke up at 12:15 and I couldn't sleep after that. I just dozed on and off [silence]. I don't want to work. I would rather give up analysis than work on this. And you know I could almost do it. It's a strange thing to say, but I could almost do it. I could quit right now and go on this way the rest of my life. I don't want to understand it. I don't want to work."

Again I wait and then after a while say, "But this kind of anger is telling us something. It is more than just hating yourself." The patient answered, "I don't want to dissipate the anger. I can sense I am angry, but I don't want to let go of it, I want to hold on to it. I go on all day, all day like this. All of this hatred and anger. I loathe myself. I know you are going to say that loathing is tied up with the toilet, but I don't mean loathing, I mean I hate myself, although I used the word loathing. I keep thinking of murder, of being hanged, or being hanged on a gallows, and I can see myself with a rope around my neck over a trapdoor and it opens and I fall, and I wait for the trapdoor to open and wait for the fall and for my neck to be broken. I can feel myself, I imagine myself dying. Or else I imagine myself being shot by a firing squad. I'm always being executed by some kind of authority, by the state, by some kind of agency. I seem to have a morbid curiosity about hanging and being hanged, and I am always involved with the trapdoors. I am much more involved with hanging than with the firing squad. There is much more variation in the hanging, it is much more frequent, and all through it I hate myself."

Again there follows a period of silence and then I say, "It's not just hate and it's not just myself." To this the patient answers, "I won't give in to it. I'm not going to give in to you. You are trying to push something off on me. I don't want to acknowledge there is any pleasure in it. I have a feeling you hate the idea of my pleasure, and I hate it. I'm just furious about this whole thing. I think you really hate my having pleasures of any kind. You're accusing me, you're a vicious, evil-minded person, you're attacking me. I have to sustain myself, I have to fight you. You seem to be alert to my dirty-mindedness and I have to deny it and have to say it is not there. I have to agree it is terrible if it were there."

At this point I say, "Yes, and you seem to beat yourself in order to prevent me from saying anything." To this the patient answers, "Yes, and I wonder why hanging and why this trapdoor, there's something about the trapdoor and a toilet flushing. I just don't want you to say it. I still resent you, and I feel that the self-flagellation is a protection . . . [pause]. You know, it's a funny thing, I now have the feeling that I'm just beginning my analysis, that I am essentially unanalyzed, and I wonder how long it will take—but it doesn't matter."

I use this case to illustrate that the way the patient was angry, the mode of the resistance, the spiteful, anal anger, was the starting point for a very important piece of analysis. We went from the spiteful anger to the hanging fantasy, which then led to the toilet fantasies and back to the projection of anal hostility onto me. Subsequent months of analysis revealed many important historical determinants. The key to it all, however, was the anal quality of his resistance, the way in which he was angry in that particular hour. Recognizing that spite and defiance are typical of the anal phase of libidinal development, the feeling stuck, the not wanting to produce, the tightness of the jaws, the sadistic and masochistic beating fantasies, the shame, are also all understandable as elements of the anal phase. This was crucial in working with the resistance of that particular hour.

Just as it was possible to classify the above resistance as pertaining to the anal phase, it is similarly possible to decribe oral, phallic, latency, and adolescent resistances. The clue may be given in the instinctual quality of a resistance, or the object relations, or the character trait which is in the foreground, or by a particular form of anxiety or attitude, or by the intrusion of a certain symptom. Thus in the case cited above, we can list the spite, defiance, stubbornness, shame, sadomasochism, retentiveness, and withholding, the marked ambivalence and the obsessive recriminations, all of which are typical of the anal phase. This statement is not intended to deny the existence of "uneven" or heterogenous resistances.

It should be stressed that the form and type of resistance change in a patient during the course of the analysis. There are regressions and progressions which occur, so that every patient manifests a plethora of resistances. In the case cited above, for example, there were long periods of analysis devoted to a working through of phallic drives and anxieties, where masturbation guilt, incestuous fantasies, and castration anxiety were in the foreground. There was a prolonged period of depression and oral resistances manifested by passivity, introjection and identifications, suicidal fantasies, fleeting addictions, anorexia and bulemia, tearfulness, fantasies of being rescued, etc.

2.53 According to Types of Defense

Another fruitful approach to the resistances is to ascertain the type of defense the resistance makes use of. For example, we might

distinguish the nine types of defense mechanisms which Anna Freud (1936) described, and note how the resistances employ them in opposing the analytic procedure. *Repression* enters the analytic situation when the patient "forgets" his dream, or his time for the hour, or his mind is blank about crucial experiences, or key people in his past are blotted out, etc.

The resistance of *isolation* enters the clinical picture when patients split off the affects stirred up by an experience from its ideational content. They may describe an event in great verbal detail, but they are prone neither to mention nor to show any emotion. Such patients often isolate the analytic work from the rest of their life. Insights gained in the analysis do not carry over into their everyday lives. Patients who use the mechanism of isolation in their resistance to analysis, often retain the memory of traumatic events, but the emotional connection is lost or displaced. In analysis they will misuse their thinking processes in order to avoid their emotions.

One could go on and list all the various mechanisms of defense against instinctual impulses and affects and describe how the forces of resistance seize upon one or another and utilize them against the analytic procedure. The reader is referred to the basic works on this subject (A. Freud, 1936, pp. 45-58; Fenichel, 1945a, Chapt. IX). For our present purpose it is sufficient to point out that all the ego's mechanisms of defense can be used for purposes of resistance.

However, not only do we see the simple and basic defenses utilized as resistance, but we also see more complex phenomena made use of by the forces of resistance. By far the most important types of resistance met with in analysis are the *transference resistances*. Transference resistances, which are very complex phenomena, will be dealt with in detail in the next chapter. Here I only want to point out that transference resistance refers to two different sets of resistances: (1) those developed by patients because they have transference reactions; (2) those developed by patients to avoid transference reactions. The entire concept of transference is related to resistance, and yet transference reactions are not to be understood only as resistances. I shall therefore postpone a discussion of transference resistance until we have clarified our understanding of the nature of transference.

Acting out is another special resistance maneuver which deserves separate consideration. Here again we are dealing with a phenome-

non which always serves a resistance function in the analysis and is quite complicated in its meaning. Acting out contains important id and superego elements as well as ego functions. We define acting out as the enactment of a past event in the present, which is a slightly distorted version of the past, but which seems cohesive, rational, and ego syntonic to the patient. All patients engage in some acting out during analysis, and in inhibited patients this may be a welcome sign. Some patients, however, are prone to repeated and protracted acting out, which makes them difficult if not impossible to analyze. Analyzability depends, in part, on the ego's capacity to bind stimuli sufficiently so that the patient can express his impulses in words and feelings. Patients who tend to discharge their neurotic impulses in action pose a special problem for analysis. The problem of recognizing and handling acting out will be discussed in Section 3.84 and again in Volume II. The reader may familiarize himself with the subject by referring to some of the basic work on the subject (Freud, 1905c, 1914c; Fenichel, 1945b; Greenacre, 1950).

Character resistances are another complex and extremely important type of defense which deserve special mention (W. Reich, 1928, 1929). The question of what is meant by character is not easy to answer. For our present purposes I would simplify the answer and state that by character we refer to the organism's habitual mode of dealing with the internal and external world. It is the ego's constant organized and integrated position and posture in regard to the demands made upon it. The character consists essentially of habits and attitudes. Some of them are predominantly defensive, others are essentially instinctual. Some are compromises. The character trait of cleanliness may well be understood as a defense, a reaction formation, against pleasurable soiling. But we can also see sloppiness as a character trait which is not a reaction formation but an expression of pleasurable soiling.

The character resistances are derived from the character defenses. They pose a special problem in analytic technique because they are habitual, rigidly fixed, and usually ego syntonic. Glover (1955) calls them the silent resistances. By and large the patient is at peace and even approves of his character defenses, since they often appear to conventional society as virtues. The special technical measures which character resistances require will be described later in Section 3.8. W. Reich (1928, 1929), A. Freud (1936), and Fenichel (1941) should be referred to for a more complete discussion of the nature of character and character resistances.

Screen defenses have also been described which can be used by patients for purposes of resistance. Some patients tend to make extensive use of screen memories, screen affects, and screen identity to ward off an underlying more painful memory, affect, or identity. This defensive formation is also a complicated psychic event and contains important gratifications as well as defenses (Greenson, 1958a).

2.54 According to Diagnostic Category

Clinical experience has taught us that certain diagnostic entities make use of special types of defense and therefore that particular resistances will predominate during the course of the analysis. However, many different forms of resistance come to light in all analyses. The clinical entities we describe are rarely seen in pure form; most patients have some admixture of different pathology along with the central diagnosis we give them. Further, during the course of analysis, we see temporary regressions and progressions which complicate the clinical picture and the type of resistances.

An example of this is Mr. Z., the case illustration I used to demonstrate and anal resistance (Section 2.52). The patient had an oral-depressive, neurotic character disorder. However, he had gone through some anal traumata in childhood and he therefore did relive a period of anal spite, hatred, and rage in the particular phase of analysis I described. Just prior to that period his hatred was carefully isolated and confined to special female love objects in his outside life. During the peak of his anal spite he displaced and projected his rage and hatred onto me.

If we briefly survey the typical transference neuroses we treat analytically, I believe we will find the following resistances predominant:

The hysterias: Repression and isolated reaction formations. Regression to phallic characteristics. Emotionality, somatizations, conversions, and genitalizations. Identifications with lost love objects and guilt-producing objects.

The obsessional neuroses: Isolation, undoing, projections, and massive reaction formations. Regression to anality with reaction

in to it because he dreaded the possibility of meeting me there, "face to face." In fact, the thought occurs to him now that he comes early so that he might use the toilet without the risk of an "encounter" with me. He would rather be dead than "caught with his pants down."

The patient becomes silent after this outburst. I say nothing. He resumes in a sad tone of voice: "I suddenly realize I have a new phobia, a fear of meeting you in a toilet." I add gently that the discovery was new, the fear had been there all the time, hidden by his punctuality.

I believe this clinical vignette illustrates the special problems of analyzing ego-syntonic resistances. They require additional work compared to the ego-alien resistances. Actually they have to be made ego alien for the patient before effective analysis can be accomplished. In other words, our task will be first to help the patient establish a reasonable ego in regard to the particular resistance. Only if this is accomplished will the resistance emerge as an ego-alien resistance. Then one can hope to obtain a history of the particular resistance and to analyze it. When the patient can understand the historical reasons for the origin of the resistance defense, he will be able to differentiate his past needs for that defense and the present inappropriateness of that defense.

Ordinarily in the beginning of analysis one works with the ego-alien resistances. Only after the patient has been able to form a reliable working alliance is it possible to start looking for and working on the ego-syntonic resistances. These latter resistances are present from the beginning, but it is pointless to attack them since the patient will either deny their significance or will only give lip service to analyzing them. One must have accomplished some previous work with ego-alien resistance *and* also achieved a reliable working alliance before one can effectively analyze the ego-syntonic resistances.

This subject will be brought up again in Section 2.6. The reader is advised to compare W. Reich (1928, 1929), A. Freud (1936), Fenichel (1941), and Sterba (1951) on this matter.

2.6 Technique of Analyzing Resistances

2.61 Preliminary Considerations

Before launching into a detailed discussion of technical problems it is well to review some fundamental points. Psychoanalysis as a technique came into existence only when resistances were analyzed and not avoided or overcome by other means. One cannot define psychoanalytic technique without including the concept of the consistent and thorough analysis of resistance. It is important to remind ourselves again of the intimate relationship between resistance, defense, ego functions, and object relations.

Resistance is not only to be understood as opposition to the course of analysis, although that is its most direct and obvious clinical manifestation. The study of a patient's resistances will shed light on many basic ego functions as well as on his problems in relating to objects. For example, the absence of resistances may indicate that we are dealing with a psychotic process. A sudden burst of obscene and abusive language and behavior in a hitherto prim and proper housewife may be such a manifestation. Furthermore, resistance analysis also illuminates the way the various ego functions are influenced intrastructurally by the id, the superego, and the external world. In addition, resistances to the therapeutic procedures repeat the neurotic conflicts among the different psychic structures. As a result the analytic situation gives the analyst an opportunity to observe firsthand, on his analytic couch, compromise formations which are analogous to symptom formations. The ever-changing relationship between the forces of the resistances on the one hand, and the urge to communicate on the other, may be seen at its clearest in the patient's attempts at free association. This is one of the reasons free association is considered the primary instrument of communication in psychoanalytic procedure.

The term "analyzing" is a condensed expression for many technical procedures all of which further the patient's insight (see Section 1.32). At least four distinct procedures are included or subsumed under the heading of "analyzing": *confrontation, clarification, interpretation,* and *working through.*

Interpretation is the single most important instrument of psychoanalytic technique. Every other analytic procedure prepares for an interpretation, amplifies an interpretation, or makes an interpretation effective. To interpret means to make an unconscious or preconscious psychic event conscious. It means making the reasonable and conscious ego aware of something it had been oblivious to. We assign meaning and causality to a psychological phenomenon. By interpretation, we make the patient conscious of the history, source, mode, cause or meaning of a given psychic event. This usually

requires more than a single intervention. The analyst uses his own conscious mind, his empathy, intuition, and fantasy life, as well as his intellect and theoretical knowledge, in arriving at an interpretation. By interpreting we go beyond what is readily understandable and observable by ordinary conscious, logical thinking. The patient's responses are necessary in order to determine whether the interpretation is valid or not (E. Bibring, 1954; Fenichel, 1941; Kris, 1951).

In order to engage the patient's ego effectively in this psychological work, it is a prerequisite that what is to be interpreted must first be demonstrated and clarified. In order to analyze a resistance, for example, the patient must first be cognizant that a resistance is at work. The resistance must be demonstrable and the patient must be confronted with it. Then the particular variety or precise detail of the resistance has to be placed into sharp focus. *Confrontation* and *clarification* are necessary adjuncts to interpretation and have been recognized as such ever since our knowledge of ego functions has increased (E. Bibring, 1954, p. 763). Sometimes the patient requires no confrontation, clarification or interpretation by the analyst because the patient is able to do this on his own. Sometimes the three procedures occur almost simultaneously or a flash of insight may precede confrontation and clarification.

Working through refers essentially to the repetition and elaboration of interpretations which lead the patient from an initial insight into a particular phenomenon to a lasting change in reaction or behavior (Greenson, 1965b).

Working through makes an interpretation effective. Thus, confrontation and clarification prepare for an interpretation and working through completes the analytic task. But it is interpretation that is the central and major therapeutic instrument in psychoanalysis.

2.611 Dynamics of the Treatment Situation

The treatment situation mobilizes conflicting tendencies within the patient. Before we attempt to analyze the patient's resistances, it would be helpful to survey the alignment of the forces within the patient (see Freud, 1913b, pp. 142-144). I shall begin by enumerating those *forces which are on the side of the psychoanalyst*, 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 instinctual 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 rational superego, which impels the patient to fulfill his duties and obligations. Menninger's "contract" and Gitelson's "compact" express similar ideas (Menninger, 1958, p. 14). (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. This will become clearer as we discuss different clinical problems in subsequent chapters.

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 which 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. Many of the items listed above will be discussed in greater detail in the later sections of this book.

2.612 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. This matter will be pursued in greater depth in Sections 4.211, 4.212, 4.221, and 4.222. 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, 1912b, pp. 111-117). (1) 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. Nonselective, 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, etc. (Ferenczi, 1928b; Sharpe, 1930, Chapt. II).

All activities which 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 conveyor of insight. He is not essentially a recorder or a collector of research data (Berezin, 1957). 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.

2.62 The Recognition of Resistance

The analyst's first task is to recognize that a resistance is present. This may be simple when the resistance is obvious, as they are in the clinical examples cited in Section 2.2. It is more difficult when the resistance is subtle, complex, vague, or ego syntonic to the patient. In the latter instances, the patient may complicate our task by attempting to cover up the fact that he is running away from something. Or the situation may be difficult to ascertain because the patient's material contains a mixture of some meaningful unconscious id content as well as resistance. Observing the patient intellectually may have to be supplemented by the analyst's empathy in order to detect these subtle resistances. Clinical experience and psychoanalytic work under the supervision of an experienced analyst are the best ways of learning to recognize these complex manifestations of resistance. Nevertheless, I would like to illustrate the problem of detecting resistances with a clinical example in order to make some technical points.

A thirty-two-year-old professional man who has been in analysis some six months begins his Monday hour by telling me he is tired, has a headache, and feels somewhat irritable, but he can't pin it down. The weekend had been boring and even a bit depressing. His daughter had wet her bed for the first time in months and his son had a recurrence of an ear

infection. The patient, too, had been a bed wetter as a boy and he recalls how his mother had humiliated him for this. His daughter would not suffer what he had had to suffer. His wife is a far more considerate nurse than his mother had been. Of course, this kind of responsibility is a drag and he can't blame his wife for being tired. Nevertheless, she was quite willing to have sex and even went out of her way to do the things he liked. She volunteered to suck his penis and she did, but she is not very good at it. Maybe his preference for being sucked is a sign of homosexuality. That had come up in the Friday hour, he believes. Yes, we had talked about his interest in comparing penis sizes with other men. This idea had tormented him when he had dated other women. Did they prefer men whose penes were larger than his? His son seems to be "well hung," maybe he won't have the sexual problems the patient had to endure. Somebody once said, "Anatomy is fate." But he had never been a believer in axioms and he had always despised religion.

The above is an excerpt of the highlights of about forty minutes of the hour. As I listened I heard a depressive and angry undertone and the material seemed to be in accord with this mood. The weekend was boring, the daughter had wet, the son was ill, the wife was only passably pleasing sexually, other men had larger penises, and fate had been unkind to him. As I went along with him in his associations I expected a breakthrough of some underlying angry or depressive impulse at different points in the hour and I did not intervene. But this failed to materialize. It seemed to me that the patient was struggling with some latent strong emotions, but his material seemed to point to too many different significant possibilities.

Was he angry at his mother, fate, his wife, or was all of this related to me? Did he feel more angry than aggrieved or depressed? I was not certain what was the most important underlying content seeking discharge, and whether it would eventually emerge on its own or whether the resistances would be sustained. I therefore allowed him to go on until almost the end of the hour. At this point I decided to intervene because despite the presence of some unconscious derivatives, there seemed to be a goodly amount of resistance and yet his reasonable ego seemed accessible to an interpretation.

I said to him: "You feel you have been mistreated by your mother, your wife, your kids, and by fate. You sound slightly depressed and angry, but you seem to be holding back your feelings." The patient could hardly wait for me to finish and blurted out: "Yes, there is more. As you were talking, I felt disgusted and enraged at your saccharine tone. Then I remembered that before Friday's hour I was furious with you for keeping me waiting while you gave that pretty woman patient some of my time. I guess I didn't mention it in that hour, but I know I thought of it after I left. As I was driving home I made a wrong turn and almost drove into another car. That night as I was falling asleep I had a peculiar sensation in my hands, they felt paralyzed. I had the thought that maybe I will have to kill someone if I want to get well. Maybe I'll have to have a temper tantrum right in your presence. Sometimes I get the feeling I'd love to wring the necks of all you good, kind people. You're even more hypocritical than I am. At least I have the honesty to have symptoms."

I believe the patient's response indicates that I was correct in recognizing the presence of resistance and in pointing it out. I might have intervened at earlier points in the hour and tried to pursue one or another of the themes he presented. For example, I could have tried to get him to explore how his mother had humiliated him or his fear of homosexuality that had already been present in Friday's hour, or his resentment at having been cheated by fate. But it was my feeling that he was hovering over some emotions and impulses that were struggling to break through; I therefore decided to focus on the struggle, i.e., the battle between the unconscious impulses seeking discharge and the resistances opposing them. This struggle is what came most clearly to the surface in his free association. Our task is a simpler one when one or the other prevails in a clear-cut fashion as they do in the clinical examples in Section 2.2 or in those so-called "good hours" when derivatives become less and less distorted. In listening to a patient our first duty is to determine whether unconscious derivatives, i.e., "content," predominate or forces of resistance, or whether we are dealing with a stalemate.

This leads to the next question: how does one recognize resistance when the material is not obvious. The answer is based on our understanding of free association and the opportunity it affords the patient in analysis. By asking the patient to let things come to mind and to report them without the usual social censorship, we try to rule out the conscious resistances. The result exposes the struggle between the more unconscious resistances and the unconscious id derivatives trying to gain discharge. Fenichel (1941, p. 34) used the analogy of releasing a compass needle and watching it swing back and forth. There are two signs of possible disturbance: the needle does not come to rest but it keeps on swinging, or else it comes to rest too quickly, too directly. In the first instance of the needle swinging constantly the patient is talking about heterogene-

ous material which does not localize around some unconscious impulse or some common denominator seeking expression. Localization would take place if there were no significant resistances at work. When the needle sets itself too exactly and directly, then we can assume that the patient has a conscious program and is omitting the stray thoughts that must arise if his associating is done relatively freely.

I have found it useful to ask myself as I listen to the patient: is he going toward or away from something unconsciously meaningful? Is the material deepening or flattening out? Is the patient adding something significant or is he padding the hour? If he seems to be going toward something, I remain quiet until that something becomes clear. If he seems to be going away from something, I wait until that is sufficiently clear, then I recognize this as resistance and proceed to work with it. Sometimes I remain uncertain. I usually say to the patient at the end of such an hour that I am not clear about what is going on.

2.63 Confrontation: The Demonstration of Resistance

The first step of the general procedure in analyzing resistance was devoted to a description of what the analyst must perform by himself before he can work with his patient on resistances. The succeeding points are all steps the analyst attempts to carry out conjointly with his patient. To put it briefly, our task is to get the patient to understand *that* he is resisting, *why* he is resisting, *what* he is resisting, and *how* he is resisting.

Demonstrating the resistance may be relatively simple or even an unnecessary step if the resistance is obvious to the patient. If this is not the case, if the patient is unaware of the resistance, then it is essential to confront the patient with the fact that a resistance is present before we attempt anything further. The patient's ability to recognize a resistance will depend on two things: the state of his reasonable ego and the vividness of the resistance. A highly reasonable ego will take cognizance of the slightest resistance and a barely reasonable one will demand overwhelming evidence of resistance. Our task is to assess, via observation and empathy, the status of the patient's reasonable ego in order to determine how clear must the evidence of the resistance be in order for the patient to recognize

it as such. Confronting the patient ought to be undertaken only when there is a likelihood that the confrontation will be meaningful to him, and when he will not succeed in his attempt to deny or minimize its validity. Premature demonstration of resistance is not only a waste of time but it dissipates material that might be effective at some later point. No matter how clear the evidence of resistance may seem to be, the decisive factor is—will this confrontation have meaning for the patient? Let me illustrate with a simple example:

A patient, early in analysis, comes a few minutes late and breathlessly explains that she had difficulty finding a parking place for her car. To point this out to the patient right then and there as a resistance would be an error. First of all, you might be wrong and your intervention would have distracted the patient from the real content she was ready to communicate. But furthermore, you will have wasted a potentially valuable opportunity by using a questionable instance that the patient might successfully deny. If you had waited silently, and if your idea were correct, this little resistance would be followed by others. The patient I am describing fell silent at different intervals of the session. She then reported that she had forgotten her dream of the preceding night. Again silence. My silence had permitted her resistance to grow which increased the likelihood that she would not be able to deny my later confrontation.

In order to increase the demonstrability of a resistance, it is advisable to let the resistance develop. For this your silence is the best method of approach. But at times one can use another technique to increase the resistance and the demonstrability. Again I can illustrate this best with a clinical example:

A young man, Mr. S., early in his analysis, comes to his hour and begins by saying: "Well, I had a rather successful marital experience last night with my wife. It was very satisfactory for both parties concerned." He then goes on to talk in a very restrained way about how he enjoys "making love" to his wife, and then proceeds to talk about rather innocuous goings-on. I intervene at this point and say, "You mentioned earlier that you enjoyed a 'marital experience' last night. Please explain to me what you mean by a 'marital experience.'" The patient hesitates, flushes, and then haltingly begins to explain, pauses, and says, "I guess you want me to be more specific . . ." and pauses again. Now I answer: "You seem bashful when it comes to talking about sexual matters." The patient then spends the rest of the hour describing his difficulties in talking about sex. He has now begun to work on his resistances.

It was obvious to me that the patient had considerable reluctance to talk about his "marital experience" and yet he was attempting to glide over it by going on to speak of trivia. I highlighted his reluctance by asking for elaboration of precisely that part of his material. Then the existence of resistance was inescapable. We then proceeded to work on his resistance about talking of sex, which was the vital subject matter of that hour.

The two illustrations exemplify two methods of facilitating the demonstration of resistances by increasing the resistance: the analyst's silence and asking for elaboration about a resistant point. These methods will vivify the resistance and make it recognizable by the patient's reluctant reasonable ego. By asking the patient to notice that he seems reluctant to talk about sexual matters the analyst has shifted the conflict situation for the patient by saying in effect: "Don't talk about sex but tell me about your trouble in talking about sex." We first have to analyze his resistance to talking on sexual matters before we can effectively analyze his sexual problems. Furthermore, he will not be able to present a clear picture of his sexual problems until he is able to communicate effectively on this subject.

Another technique for helping the patient recognize the presence of resistance forces is to point out all the clinical evidence. In the case of the lady who came a few minutes late to her hour because she could find no parking place, I waited until there were at least two other signs of resistance. Then I intervened by saying, "You seem to be avoiding something. You came a bit late, then you became silent, and now you tell me you forgot your dream." The patient herself is now persuaded that she is running away. If I had intervened at the first small sign, she might have dismissed it with a rationalization. It should be noted that I merely point out what brought me to the conclusion she was resisting. I did not insist she was resisting. I suggested this as a possibility to her. If she were to deny this, I would not try to convince her on the basis of the clinical evidence. I would become silent and observe whether she now tries to cover up the resistances or if they intrude even more pronouncedly. One can only prove something to a reasonable ego—one will have to wait until a reasonable ego appears or until the evidence is so overwhelming that even the puniest reasonable ego will have to acknowledge it.

2.64 The Clarification of Resistance

Let us continue with the procedure for analyzing a resistance. We have made the patient aware that he has a resistance. What do we do next? There are three possibilities that we may now pursue: (1) Why is the patient avoiding? (2) What is the patient avoiding? (3) How is the patient avoiding? The first two questions: why and what is the patient avoiding; can be considered together as the motive for the resistance. The question how is the patient avoiding, refers to the mode or means of resistance. It does not matter which of the two we pursue, the motive or the mode of resistance. In either case, the analysis would proceed by *clarifying* the matter under scrutiny. We would attempt to sharpen our focus on the psychic process we are trying to analyze. We would carefully single out and isolate the particular motive or mode of resistance we are attempting to explore. The significant details would have to be dug out and carefully separated from the extraneous matter.

I shall start with the clarification of the motive for resistance because, all things being equal, it takes precedence over the mode of resistance, since it is more productive. Only when we feel that the means of resistance is striking or unusual would we pursue that question first. Or if we have already guessed from the material why and what the patient is running from, would we explore the method the patient is using.

The question, "Why is the patient resisting?" can be reduced to: what painful affect is he trying to avoid. The answer to this question is closer to consciousness usually than the answer to the question "What instinctual impulses or traumatic memories make for the painful affect." As stated earlier, the immediate motive for defense and resistance is to avoid pain, i.e., painful affects. The resistant patient is trying to ward off some painful emotion like anxiety, guilt, shame, or depression, or some combination of them. Sometimes, despite the resistance, the painful affect is obvious because the patient behaves in a way which is characteristic of that specific affect. For example, a patient talking hesitantly or in clichés or rambling around in trivia may betray his sense of shame by blushing or by covering his face with his hands, turning his head away so that one cannot see any part of his face, covering his genital area with his hands or suddenly crossing his thighs tightly together,

etc. Hiding behavior indicates shame. Tremor, sweating, dryness of tongue and mouth, muscular tension, quivering or rigidity may be signs of fear. In a patient who has been talking in a slow, mournful tone, the clenched jaw, sighing, silence, painful swallowing, and tight fists may indicate the struggle against tears and depression.

In all these instances, I am trying to detect the nonverbal, bodily reactions that are taking place. They may offer us clues as to what particular painful affect the patient is struggling with. If I think I can detect the specific affect, I confront the patient with, "You seem to be embarrassed, or afraid, or sad, or afraid of crying." I say "You seem," not "You are." Why? Because, first of all, I might be wrong, and secondly I want to give him a chance to run if he needs to. Later on, I may become more assertive if I am more certain of my correctness or if his running from working with the resistances ought to become the subject of discussion.

If I cannot detect the particular painful affect, then I would simply ask, "What feelings are you trying to push away?" or "How did you feel when you were trying to describe to me your sexual experience of last night?" or "What are you feeling as you lie there silently?"

Some technical points of importance have to be mentioned here. My language is simple, clear, concrete, and direct. I use words that cannot be misunderstood, that are not vague or evasive. When I am trying to pin down the particular affect the patient might be struggling with, I try to be as specific and as exact as possible. I select the word which seems to portray what is going on in the patient, the word which reflects the patient's situation of the moment. If the patient seems to be experiencing an affect as though he were a child, for example, if the patient seems anxious like a child, I would say: "You seem scared," because that is the childhood word. I would never say, "You seem apprehensive" because that would not fit, that is a grown-up word. Furthermore, "scared" is evocative, it stirs up pictures and associations, while "apprehensive" is drab. I will use words like bashful, shy, or ashamed, if the patient seems to be struggling with feelings of shame from the past. I would not say humiliation or abasement or meekness.

In addition, I also try to gauge the intensity of the affect as accurately as possible. If the patient is very angry, I don't say, "You seem annoyed," but I would say, "You seem furious." I use the ordinary and vivid word to express the quantity and quality of affect I think is going on. I will say things like: You seem irritable, or edgy, or grouchy, or sulky, or grim, or quarrelsome, or furious, to describe different kinds of hostility. How different are the associations to "grouchy" as compared to "hostile." In trying to uncover and clarify the painful affect and the memories associated to that specific affect, the word one uses should be right in time, quality, quantity, and tone. More will be said about this when I discuss transference interpretations and tact in Section 3.943 and Volume II.

Just as we attempt to clarify the affect causing the resistance, so would we try to clarify the impulse causing the affect, if that were to present itself in the analysis.

Let me illustrate. A patient who has been in analysis for over three years and who ordinarily has little difficulty talking about sexual matters suddenly sounds evasive when he describes sexual intercourse with his wife that occurred early that morning. He is obviously embarrassed about something that happened. I decide to give him a chance to clarify this himself. He finally says: "I guess it's hard to tell you that we had some anal play this morning." Pause, silence. Since I had a good working alliance with him in general, I pursued the point directly. I merely repeat: "Anal play?" but I add the question mark. The patient gulps and sighs and replies: "Yes, I somehow wanted to poke my finger into her anus, her ass hole, I guess I mean, and I'll be damned if I understand that since she seemed to dislike it, but I persisted. I wanted to force something into her against her will, I wanted to burst into her, tear her in some way. Maybe I was angry with her unbeknownst to myself or maybe it wasn't my wife at all. I just know I wanted to hurt her down there."

This is an example of partially clarifying an instinctual impulse, in particular, clarifying the instinctual aim. In this instance the aim was to inflict intrusive, tearing pain on a woman "down there." During the rest of the hour and in the next hour we were able to clarify this further. The woman he was hurting in his fantasy was his mother and he was trying to tear into her "cloaca," where he imagined his baby brother had been born from, when he was age three. The other meanings of this activity, particularly those connected to me, his "anal-ist," would lead us too far afield.

Just as we have clarified the painful affect or forbidden impulse which motivates a resistance, so might it become necessary to clarify

the mode of a resistance, *how* a patient is resisting. Before we can explore the unconscious history of the means the patient uses to resist, we first have to be sure that the issue under discussion is sharply defined for the patient and extraneous or ambiguous material is dissected away.

For example, one of my patients, Professor X., who is an extremely intelligent and articulate biologist, has a strange way of reporting a dream. He begins the hour by stating he had an interesting dream last night and "you were in it and there was something sexual going on." Then he reflects a moment silently and says, "I'm not sure it was last night, it may have been this morning. I went into a large schoolroom and there was no seat for me. I felt embarrassed at being late just as I often do now when I come late to a meeting. The last time this happened I had to go to a small office nearby and drag in a small chair and I felt very foolish. That's the way I used to feel when I would visit one of my father's classes when he taught summer school. He had large classes and the students were a good deal older than I was. He was an excellent teacher, but I think he himself was awed by the students or maybe I was projecting. Now I get the thought that maybe he also had homosexual tendencies that made him ill at ease, or is that also one of my projections? Anyway I was in this large classroom which turned into a moving picture theater. Something went wrong with the film and I was furious with the movie operator. As I went to scold him I saw he was tearful. He had soft big eyes like a Greek, that's where you come in. At least that's what occurred to me when I awoke this morning. Those big droopy eyelids overflowing with tears remind me of you and if I think of a man crying, it makes me feel soft and loving and I suppose that's connected to homosexuality and my father, although I can't recall my father crying. He was always so absorbed in his work or his hobbies, and the only emotions he showed were toward my sister and older brother. My sister was in the dream, that part when I was in the movie theater. When the movie got dark and there was nothing on the screen she said to me that we shouldn't have come. That's when I got angry with you. My sister wanted to be an actress at one time; in fact, we often acted in plays together and she would play the boy's role and I the girl's. Now that I think of it, there were all boys in the classroom and in the movie there were mostly girls, etc., etc."

This is a sample of a particular mode of resistance this patient demonstrated when he reported dreams or told of an incident from his present or past life. He never told the incident precisely as it occurred but often started in the middle, jumped to the beginning, then to the end, interspersed his report with associations and some interpretations, and then filled in some details from the beginning, middle, or end that he had omitted. I was loath to interrupt him because I did not want to disturb the flow of his associations. However, I was never sure of the manifest content of what he was reporting and what his associations were. I was never certain if I had heard the complete dream or incident he was recounting and if I inquired, his responses also contained mixtures of fact, fantasy, and associations.

I finally asked him whether he was aware of the fact that he could not simply tell a dream or incident from his life from beginning to end, but would start in the middle and I described in detail how he communicated. At first he protested weakly that he thought he was supposed to say things as they came into his mind, but he smiled and sighed after a bit and said that he knew he had this tendency to "scramble" his assignments or duties. He then spontaneously reported that he never read a book from the beginning but usually started from the middle and read piecemeal toward the end and then toward the beginning. In school, and he had many years of postgraduate study in which he excelled, he never started homework assignments from the beginning but either from the middle or the end. He did the same in other spheres as well. While he was in elementary school he started writing a book on advanced mathematics, and while he was a beginner in his profession he started teaching men many years his senior.

I shall describe some of the unconscious determinants and meanings of this mode of resistance in Section 2.652 on the interpretation of the mode of resistance. Here let me state that the crux of the matter had to do with the fact that his father was a well-known teacher and academician, and his entire family were renowned for their studiousness. At the moment, the point I want to stress is how the clarification of the mode of resistance was the starting point for many important insights into the unconscious factors.

2.65 The Interpretation of Resistance

2.651 Interpreting the Motive for Resistance

Here I must interpolate that sometimes it is not necessary for the analyst to demonstrate and clarify the resistance because the patient does this for himself spontaneously. These steps do not necessarily go in the sequence described since both events may occur more or less simultaneously. After the resistance is demon-

strable and clear, we are ready to attempt to interpret the unconscious determinants. That means we try to uncover the hidden instinctual impulses, fantasies or memories which are responsible for the resistance. (It is customary in psychoanalytic discussions to designate as "content" the repressed or warded-off unconscious impulses, fantasies or memories which determine a given psychic event.) In analyzing the motive for a resistance we would attempt to explore the content which caused the painful affect that brought about the resistance.

Let us return to the patient, Mr. S., in Section 2.63, who became bashful when he tried to talk of his "marital experience." In order to understand his embarrassment we would now try to uncover what impulses, fantasies, or historical events were associated to his talking about sexual matters. The exploration of the content might lead us to feelings, impulses, and fantasies that occurred as he was speaking in the hour, to transference reactions, or to his past history, or from one to the other. Ordinarily we let the patient decide which avenue to pursue and ask an open-ended question such as: "What occurs to you when you imagine talking about sex?"

The shy Mr. S., with the "marital experience," responded to my question and began to recount that sex was considered a dirty and forbidden subject at home, that he was scolded for asking about how babies are born and told this was not a fit subject for a decent boy, etc. He later overcame this shyness with his school companions, but he still reacts with embarrassment when sexual matters come up with a stranger or authority. This then led to his feelings about me as a stranger and authority. Though he intellectually knew I must be familiar with all kinds of sexual experiences, nevertheless he found himself reacting as though I would be very prudish and would reprimand him. I interpreted to him that the moment he mentioned sex I had become a father figure and he became a little boy. If the patient had not spontaneously let his thoughts drift back to me and had only talked about his embarrassment at home, I would have said to him before the end of the hour: "And now you react to me as though I were your parent and you become embarrassed." The analysis of resistances must always include the analysis of the transference resistance, a subject that will be elucidated in Chapter 3.

The further analysis of Mr. S.'s embarrassment in talking about sex took place over a period of several years. In the process of working through we discovered that he felt he had to hide his sexual interest because he was afraid of being considered oversexed. This was connected

to childhood memories of sexual games with his sisters and sexual fantasies concerning his mother. His masturbation fantasies concerned watching "grownups" in intercourse and then watching them being beaten. He also had deeply repressed masochistic wishes of being beaten as well as a tendency to identify with the woman's role. Mr. S. had great anxiety in his relationship with men since it was still full of instinctual impulses, both hostile and sexual. He was also uncertain about his gender identity, his feeling of being male. This is a condensed report on the analysis of the motives for his resistance to talking about sex.

But let us return to our analysis of the motive for resistance. The patient avoids because he wants to escape some painful feeling. But *what* content, what material is evoking the painful affect? The man with the "marital experience" revealed the content by trying to talk about sex despite his timidity. In this instance, it was clear that sexual material was the immediate cause of the embarrassment and the resistance. But there are instances when it is not clear either why or what the patient is resisting. A patient may keep silent more or less for an entire hour and not betray any clue of what is going on by his bodily reactions or facial expressions. In my experience this is a rare occurrence. The absolute silence and the lack of body and facial expression would seem to be clues to fantasies about death, coma or deep sleep. On the two occasions it has happened in my practice it means a combination of murderous rage and suicide (Greenson, 1961).

Let us assume that we have first worked on the why, and we have ascertained the specific painful affect, but still have no clue as to what evoked it.

Again an example: a young woman patient, Mrs. K., who was mentioned earlier (Section 1.24), in her third year of analysis, has been working quite productively of late and then has an hour in which she shows considerable resistance. She begins the hour by saying she didn't feel like coming to the session, she has nothing on her mind, why don't I give her a hint as to what to talk about, her life is going along quite smoothly, her baby is wonderful, her new apartment is comfortable, maybe she ought to let well enough alone, she has improved, and does she really need to go on in her analysis, she went to an interesting art gallery and didn't buy anything, she had a date with an "egghead," the men she meets are either "slobs" or "eggheads"—and on and on, interspersed by short silences. I was aware her tone had a quality of irritability

and annoyance. So after some ten minutes of this, I intervene and say: "You seem annoyed." She answers: "I guess I am, but I don't know about what." I say: "Something is irritating you. Lets try to find it. Just let your thoughts drift with the idea, 'something is annoying me.'"

The patient is silent for a moment and then says suddenly: "Oh, I forgot to tell you my mother phoned me last night from New York." The patient then goes on to recount the phone conversation and her reactions to it in a steely, cold tone, in a stilted, jerky rhythm. The mother had reproached her for not writing, and the patient was furious but controlled herself and acted only aloof and disdainful. Bitterly, she says that she would send her mother her regular check, but she'd be damned if she would write. Pause, silence. "I don't intend to get involved with her again . . . even though I know you want me to. . . . You say it will help my analysis and maybe you're right, but I can't, and I won't, and I don't want to get involved with you either."

I keep silent. I recollect that in the hour before she had told me of a date she had had with an artistic young man. She had felt he was interesting, even fascinating, but there was something about him which had repelled her. In that hour we did not discover what that repulsive feeling was due to. The patient then goes on to tell me about her two-year-old daughter, how she loves to play with her, and how beautiful the baby's body is, not ugly like a grown woman's, and how she loves to bathe her. She stops and suddenly recalls a dream: She was a member of the frog women—she was supposed to go into the harbor of Moscow and to memorize what she saw under water. The water was cold and dark but she was protected by her rubber suit. There was the danger that something would explode and she had to hurry and get out. There was some idea that she had to finish by 4 o'clock.

The patient's associations lead to a story she had heard that people who die in their sleep die at 4 A.M. Maybe she is afraid I might die; she had heard I had some heart condition. When she awoke, the roof of her mouth was sore, she must have been rubbing it with her tongue in her sleep. That's a problem we have never gotten to the bottom of. Her stomach aches. She feels tight. She ought to work on this, but she feels weary and depressed. Silence. I say at this point: "You are afraid of what you are going to find under water, in your unconscious mind. You are scared, so you put on your rubber suit, so you won't feel things, so you won't get involved—in what?"

The patient thinks a moment and says: "I'm tempted to run, to go back to how I was before analysis, being bored and empty. I'm tired of fighting and searching, I want to relax and take it easy. You're pushing me and I want you to do the work. I had a fantasy yesterday that I developed cancer of the larynx and couldn't talk and then you'd have to do all the work." Pause.

I reply: "You're annoyed at me because I won't feed you; I won't be your good mommy." The patient literally shouts at me. "Don't say that word, I can't stand it. I hate it and you, too. Yes, I want you to help me but not just work for me; I want you to be warm and kind. All you do is work, work, work [pause]. . . . I guess you're right. I want you to take care of me like I take care of my baby. You know, yesterday when I was bathing her, I looked at her genitals, her vulva, and it looked so beautiful, like a flower, like a luscious piece of fruit, an apricot. I could have kissed it, only I know it wouldn't be good for her." I say simply: "For her?" The patient goes on: "Well, not just for her, I suppose, but also for me. Which reminds me, you know that artist I dated a few days ago. We went to the beach and I noticed his thighs were very fleshy, and his behind, too, like a woman's. Maybe that is what repulsed me." I answer: "And fascinated you, too. That's the dangerous harbor you are afraid to find under water. That's what you're running from." The patient: "I bought a bikini bathing suit for my daughter, she looks just adorable in it—its bright red—I could eat her up in it—and I mean literally—eat her up."

This is an unusually productive hour for one that began with considerable resistance. However, the patient was a hard worker in her analysis and had established a good working alliance. I think it is a clear example of how I like to pursue the question what are the motives for defense. If we review the hour, one can see the patient was aware of her resistance, she didn't feel like coming, she didn't want to get involved. The early material of the hour gave no definitive clue, only some hostility to men, but not enough to go on. Then I confronted her with her resistance and asked her to associate to feeling annoyed. This led to her recalling her angry, cold talk with her mother, and her anger with me. Then she remembered her dream, a sign that the resistance interpretation was on the right track. The manifest content of the anxiety dreams shows beautifully her fear of discovering some unconscious impulses. The harbor symbolizes mother as does the water. The frog-woman idea hints at homosexuality. Then, too, she recalled the dream while she was talking of bathing her baby. Her first associations led to her fear and wish I would die. She needs me and fears me. She rubbed the roof of her mouth, a repetition of infantile sucking impulses. Then

more resistance and not wanting to work and her fury at my interpretation that she wants me to be her "mommy."

Thus, in the resistance we see the repressed impulses returning —the dread of her infantile longings for her mother. Then her associations to her baby and the frank oral-incorporative and sexual desires toward the baby's vulva. Again an attempt to displace her anxiety onto her baby and again getting her to see she is running from her own fears. Then the confirmation by her association to the thighs and behind of her artist friend. And the final confirmation going back to her baby's red (red=Moscow) bathing suit and the urge to eat her up.

The answer to the question, what is the patient avoiding, what caused the painful affect which made her angry at me and the analysis, is: She was trying to avoid her oral active and passive homosexual, sadistic strivings toward her mother, her child, and me. These were the motives for her resistance.

I stated earlier that in attempting to analyze the motive for resistance, one ordinarily begins with trying to uncover the painful affect because the painful affect is usually more accessible to the conscious ego than the content evoking the painful affect. That is not always true and sometimes the content may reveal itself in the analytic hour before we are clear about the affect. Our task then is to pursue the content of the resistance which will, if we are successful, illuminate the affect. We start with the material on hand and then proceed to search for what is missing—we go from the known to the unknown. The following example illustrates how the content of a resistance became known before the affect:

A male patient comes to an hour after I had been out of town for a week. He reports that he had a wonderful vacation while I was gone. He speaks glowingly of how he had gone on a short trip to the country, how very rested he felt, how well he got along with his wife and children, how he was able to do a lot of physical exercise and reading. And then, after five minutes of describing how he enjoyed himself while I was on vacation, he suddenly runs out of things to say and becomes silent. I keep silent. He wonders what we had been talking about before I had gone on vacation. Pause. He wonders if *I* remembered what he had been talking about before I had gone. Do analysts remember what their patients tell them? Another pause. He wonders where I had gone and what I had done. He wonders, did I go alone or did I go with my wife. He thought that I seemed somewhat drawn and pale the last hour before my absence. He recalls now having some concern about my health. He even recalls a thought that maybe I would die. He wonders, had I left somebody's name for him to go to in case I should become sick or die.

All this he says with much hesitation and much pausing. It is obvious that he is resisting. It is also quite obvious that what he is avoiding is talking in greater detail and with more feeling about his reactions to my absence. I therefore confront him by saying, "You seem reluctant to really talk about the different feelings you had about me when I went away, when I left you behind." To this he promptly brings up how he resented being left behind, and how often this happened to him in his past. His father often went away alone on vacations, leaving him and his mother home alone. Then he goes on to other memories when he and his mother went away alone, leaving his father behind, which then led to all kinds of death wishes about his father. At the end of the hour, it is clear that the painful feelings he was trying to avoid were his angry death wishes and disappointment in me for having left him behind.

I submit this illustration as an example of how the event that is the motive for the resistance becomes clear despite the resistance and thus becomes the starting point for the analysis of the resistance. This then leads to the affects, impulses, fantasies, and memories.

Again it should be stressed that by uncovering the specific event or affect which triggered the resistance, in this case the event, one goes from the resistance to the history of that particular event or affect or fantasy in the patient's life. Whether one begins with the affect or the event, or the fantasy, one eventually arrives at the history of the affects or events or fantasy. If this succeeds, the analyst can then come back to the current resistance in the analysis and point out to the patient: "Yes . . . and my going away seems to have stirred up a similar reaction in you which you are afraid to tell me." Once more the patient becomes aware that the resistances which occur in the analysis are a repetition of events that happened before in the patient's life. To repeat: resistances are not an artifact of analysis, they are not new creations, but repetitions, new editions of past events.

A clinical note of importance that should be reiterated at this point is that the most frequent source of resistance is the transference situation. Every clinical example I have cited bears this out,

although I have not always stressed it. All other things being equal or being obscure or unknown, one has to look for the transference reactions as the source of resistance. I shall go into this in detail in Chapter 3.

2.652 *Interpreting the Mode of Resistance*

Sometimes, in attempting to analyze a resistance, it is not the affect, the impulse, or the causative event which is the most promising avenue for exploration. It may be that the mode of resistance, the method or means of resistance, offers the most fruitful avenue for investigation. This is apt to be the case if the mode of resistance is often repeated, in which case we are probably dealing with a trait of character. Although the analysis of the mode may not often be the first approach to the analysis of resistance, the typical and habitual methods of resistance eventually have to become the subject of analysis, since this procedure is the gateway to analyzing the so-called character defenses. If the mode of resistance is bizarre and "out of character" for the patient, it is usually a symptomatic act and usually more easily accessible to the patient's reasonable ego.

The steps in analyzing the mode of resistance are the same as outlined for other aspects of resistance. First of all we have to get the patient to recognize that a given piece of behavior is a resistance. This may be simple or quite difficult, depending on whether the activity is ego syntonic or ego alien. If the resistance behavior is an ego-syntonic character trait, the question then is, how difficult is it to make the behavior ego dystonic; in other words, can one enlist the aid of the patient's reasonable ego and get it to join with the analyst in regarding this activity as resistance (Fenichel, 1941, pp. 66-68). Can one succeed in splitting off a reasonable ego from the patient's experiencing ego, and so get the patient to explore the activity in question?

The demonstrability will depend on two factors: first, on the ego's relationship to the activity, i.e., how ego syntonic it is; and second, on the working alliance, i.e., how willing the patient is to take an analytic attitude. The more coherent, adaptive, and successful an activity appears to the patient, the more difficult it will be to persuade him this activity is a resistance. In our society, for example, it is not easy to get a woman patient to regard her habitual

neatness in her free associations and in her outside life as something to be analyzed. Neatness is a virtue in American society, one is praised and highly esteemed for this trait in the family. The bombardment of the advertising community helps make neatness an ego ideal for many people even in later life.

How different this is from attempting to analyze a more ego-alien activity. For example, a patient in a very strong hostile transference falls asleep momentarily during an hour. Despite the aggressive attitude toward me the patient could recognize that falling asleep during the hour was a resistance.

The situation is more difficult when reality factors are intermingled with the patient's unconscious resistances.

For example, a patient spends a good portion of her hour talking about the dangers of a nuclear bomb attack and the advisability of moving away to the Midwest where she would be safer. When I suggest that perhaps she would feel safer moving away from me and psychoanalysis, she is obviously angry and falls silent. Then she truculently reminds me that people are building bomb shelters. After a pause I acknowledge that there is some possibility of a nuclear attack, but I believe her reactions are inappropriately intense. Most experts are of the opinion that shelters are not sufficient protection and moving away also would not guarantee her safety. Then the patient begins to talk. She admits her fears might be out of proportion, but the merest thought of an atomic explosion terrifies her. I tell her that every reasonable person fears an atomic war, but there must be something else going on in her that makes her fear so strong that she would contemplate uprooting her life. Slowly the patient begins to associate, her thoughts leading to her unhappy marriage, her years of frustration and inhibition, and her desire to get it "out of her system," to start a new life. I am now able to show her that it is the accumulated rage inside her which threatens to explode. That is what makes the nuclear bomb explosion seem so imminent. This is why her fear intensifies to terror. The patient seems to understand and the next several hours we work productively on this theme.

I want to pause at this point to underscore a small but important technical point. Whenever reality factors compound a resistance, the reality factors have to be adequately acknowledged (Marmor, 1958). If one does not do so, the patient will cling all the more vociferously to the reality element of the resistance and will spend his time trying to convince the analyst of the logic of his argument.

Note how my patient brought up bomb shelters when I tried to interpret her flight to the Midwest as a flight from the analysis. Only after I admitted there was some reality to her fear could she begin to work with me, could she form a working alliance. Until then her anxiety about the nuclear bomb was ego syntonic. My acknowledgment of the reality factor promoted the establishment of a working alliance and then the fear of the nuclear explosion, at least in its intensity, became ego alien to her. She was able to work on this as an internal problem and eventually did recognize the flight to the Midwest as a transference resistance.

Once the patient has recognized the resistance aspect of his behavior, our next task is *clarification*. We now seek out the pattern of behavior outside of analysis and then pursue the history and purpose of this activity. What happened in the patient's life to cause him to adopt this way of resisting? Let me return to Professor X., the man who reported his dreams in a "scrambled" fashion (see Section 2.64).

Professor X. recounted how he read books in this "scrambled" manner and did his homework in this way. He could not study sitting at a desk but only lying down or walking! This became understandable when I realized his father had been a well-known teacher and had groomed his son to follow in his footsteps. The boy wanted to rebel because he had deep-seated hostile, jealous, rivalrous feelings toward his father, and his way of working was an expression of spite and defiance. But there was also a deep love for his father, which had a strong pregenital anal and oral cast. He was afraid to get too close to his father since that would mean anal and oral penetration and swallowing up. His history revealed that his father loved to assume the role of doctor when the patient was ill. There was much rectal temperature taking by the father, enemata, throat swabbings, etc. The "scrambled" behavior was also a manifestation of his struggle against identification with the father since identification was tantamount to being devoured and annihilated. It represented the return of the repressed longings for fusion and loss of ego boundaries (see Greenson, 1954, 1958a; Khan, 1960).

Another scientist patient used to describe all his experiences in a very matter-of-fact tone and in technical terms. He would even go into great detail about intimate sexual events, but he never betrayed any emotion. He was never hesitant or eager, but mechanical and thorough in his reporting. I tried to get him to see that he was omitting all his

emotional reactions by using technical terms, by describing these events as though he were reporting an impersonal experiment. He was a cold, detached observer reporting to a fellow scientist instead of a patient recounting an intimate experience to his therapist.

For a long time the patient justified himself by stating that the facts were the important thing, not the emotions. Then I was able to show him that emotions are also "facts" but that he had an aversion to acknowledge those "facts" about himself. The patient then realized he left out emotions in reporting to me because he felt it was shameful for an adult scientist to have feelings. Furthermore, he also recognized he hid his emotions from others as well, even from his wife in his sexual relations. This behavior he then traced to his childhood, when his engineer father showed contempt for emotional people, considering them weak and unreliable. Eventually, the patient recognized that he considered showing emotions as equivalent to becoming incontinent and uncontrolled. He equated coldness with cleanliness, and emotional warmth with dirtiness and loss of control.

The analysis of the mode of resistance, in cases such as this, became possible only when the patient was no longer able to justify his use of the method in question. It had to become ego dystonic before he would willingly pursue the analysis of this old, habitual way of behavior. It took over a year for the last patient described above to change his attitude about his detached way of speaking. Even when we were able to trace this mode of behavior back to his childhood conflicts concerning toilet training and anal-sadistic impulses, he was not able to sustain a reliable working alliance. His underlying anxieties eventually took on a paranoid quality and robbed him of genuine motivation to continue the analysis. He was willing to be analyzed only if he could remain essentially unchanged and unmoved emotionally. We finally agreed to discontinue the analysis.

2.653 *Recapitulation*

If we now recapitulate the general procedures in the analysis of resistance, they can be outlined as follows:

(1) Recognize the resistance.
(2) Demonstrate the resistance to the patient.
    (a) Allow the resistance to become demonstrable by waiting for several instances.
    (b) Intervene in such a way so as to increase the resistance; help it become demonstrable.

(3) Clarify the motives and modes of resistance.
  (a) What specific painful affect is making this patient resistant?
  (b) What particular instinctual impulse is causing the painful affect at this moment?
  (c) What precise mode and method does the patient use to express his resistance?
(4) Interpret the resistance.
  (a) What fantasies or memories are causing the affects and impulses behind the resistance?
  (b) Pursue the history and unconscious purposes of these affects, impulses, or events in and outside the analysis, and in the past.
(5) Interpret the mode of resistance.
  (a) Pursue this and similar modes of activity in and outside of the analysis.
  (b) Trace the history and unconscious purposes of this activity in the patient's present and past.
(6) Working through.
  Repetitions and elaborations of steps (4) (a) (b) and (5) (a) (b).

It is important to realize that only a small fragment of the work can be accomplished in a given hour. Many hours end up with only the dim awareness that there is some resistance at work, and all one can do toward the end of such an hour is to point out to the patient that he seems to be avoiding something. Sometimes one can clarify only the affect, and even that incompletely; sometimes only the historical antecedent, sometimes only the mode. Whenever possible and as much as possible one tries to explore avoidances with the patient, assaying how much of this probing the patient can meaningfully and usefully do in a given hour. The analyst's own zeal for exploration and uncovering of unconscious phenomena must play a secondary role to how much the patient is able to endure and to utilize. The patient should be neither traumatized nor allowed to enter into some playful, gamelike exploration of resistance.

It is important not to make interpretations of resistance prematurely, since that only leads the patient to rationalize or intellectualize, or it makes an intellectual contest of the interpretation

of resistance. In either case it deprives the experience of emotional impact. Thus it adds to the resistances instead of diminishing them. The patient must be given the opportunity to feel his resistances, to become aware of their strength and tenacity. It is important to know when to be passive and when to be active in the analytic work. Too much patience can permit the patient to waste valuable time when he might be working effectively. Too much activity may either interfere with the patient's ability for being active and gratify his passive wishes; or it may remobilize events for which the patient is not ready and thereby stir up a traumatic situation. Above all, too much activity can serve to evade the emotional impact and turn the analysis of resistance into a guessing game (see Freud, 1914c, p. 155; Fenichel, 1941, pp. 36-43).

It is important, furthermore, not to play into the resistance of the patient by using the same kind of resistance he does. If he is silent, you must be alert that your silence is not a counterresistance. Or if he uses stilted language, obscenities, or clichés, you must avoid going along with this resistance or doing the opposite. It is important to be direct and to the point without being crude, playfully provocative, or reproachful.

The steps and the order of the various steps vary from hour to hour and from patient to patient. One can pursue only what seems to be the most promising avenue of exploration at a given time. One has to keep an open and alert mind and be willing to alter one's approach or be willing to stick to it if it seems correct.

The analyst's indispensable ally in this work is the patient's reasonable ego. It must be present or it must be evoked by the analyst's interventions; otherwise one has to wait for the emotional storms to subside and for the reasonable ego to return. This can be expressed in terms of the relationship to the analyst. A working alliance must be present or evocable before one embarks on the deep analysis of resistance. It is a prerequisite for interpretation (Greenson, 1965a). This will be illustrated in detail in Chapter 3.

Finally, it is important to realize that no matter how skillfully and how correctly one works with resistances, the resistances will return. One should remember Freud's remark that resistance will be present at every step, in every aspect, in every hour of the analysis, until the analysis has been completed. Working through is necessary for a given resistance to lose its pathogenesis. Resistance analysis is

not a detour of the analysis but a necessary and vital part of every analysis.

2.66 Special Problems in Analyzing Resistance

2.661 Resistances in the First Hours

Early in analysis, in the first hours, when a resistance has been recognized by the analyst and has been demonstrated to the patient, before one proceeds to the exploration of the motive or mode of resistance, one should consider interpolating the following steps.

1. The patient should be told that resistance is an activity of the patient. It is an action he is bringing about either unconsciously, preconsciously, or consciously (Fenichel, 1941, p. 35). It is not something which is happening to the patient passively, although he may feel it as such. This is important because many patients feel resistance just happens to them, it befalls them, and they tend to feel helpless or resigned. I have found it helpful to educate them on this point.

For example, a patient will tell me that his mind is a blank. After waiting a suitable length of time, I have found it useful to inform my patients that the mind seems to be blank only when one is trying to avoid something. I ask them then to let their thoughts drift with the notion, "I am avoiding something," and to report what comes up. Inevitably some associations will come into focus. I may accentuate this point by reminding them that their minds are not blank if they are lying undisturbed on a couch at home, or if they are just letting their thoughts wander while driving a car. It must be so here, unless something is interfering and either keeping things from going on in their minds or keeping them from detecting what is going on.

2. The patient should be told at an appropriate time that the detection of resistance and the analysis of resistance are important, worthy, and respectable parts of psychoanalysis. Resistance is not an error or a fault or a weakness of the patient. He is not to feel criticized or rejected for having resistances. Here of course it is of crucial importance to be aware of one's tone of voice in demonstrating resistance to the patient. The analyst's words may say to the patient that it is perfectly all right to have resistances, but if his tone is reproachful, the words are meaningless. The patient should

be made aware that the analysis of resistance is a necessary, inevitable, and productive part of the psychoanalytic procedure.

After I have succeeded in analyzing some aspect of a resistance early in the analysis, I try to demonstrate the validity of the point that the analysis of resistance is fruitful and worthwhile.

I think these interventions are important early in analysis because they help to establish a certain atmosphere in the analytic situation. I want my patient to feel that he is entitled to know certain things about what goes on in analysis, in order to feel that he is my co-worker in the analytic situation. I want to facilitate the development of a working alliance. I don't want him to feel that he is a child, to be kept in the dark, or that I am the expert far beyond and above him. I do not want to create an authoritarian atmosphere, a mysterious atmosphere, or a parental atmosphere. I want this to be a situation between two hardworking, serious adults, one in need of help, and one an expert, but both equally serious and responsible in their work together. And I want to give him whatever educational means he needs in order to help him become an analytic patient; to help him work in the analysis. I do not want to make him an analyst, but I want him to be familiar with certain aspects of the process of being analyzed after he has experienced them, so that he can cooperate with me to the best of his conscious ability. This point will be amplified in Section 3.5 and in Volume II.

When a patient detects on his own not only that he is resisting, but why he might be resisting, or what he might be resisting, then I feel he has made an important step in the analysis. One often hears the expression that a patient is "in analysis." I think this refers to the above situation. It means that a part of the patient's ego, the observing, reasonable ego, has the capacity, now on its own, from time to time to look at the experiencing part of his ego and to work as an ally of the analyst, i.e., in temporary identification with the analyst's way of working. A working alliance has been temporarily and partially established. By no means does this mean he can completely analyze his own resistances, but at least he is aware of the importance of analyzing resistances and has an analytic attitude toward resistances, instead of trying to avoid, hide or cover up his resistances.

Very early in the analysis I am careful not to use the term resistance but to use such phrases as, you are avoiding, you are running

All these situations are potentially dangerous for the patient and should be handled somehow in the hour. The least satisfactory method is to use force of any kind to stop the patient from acting in a particular way. Yet sometimes it is the only possible method of preventing something worse. Then the firm, but compassionate tone, the plea to "let's work," while grasping the patient's arms, is the last resort. To put it succinctly, one behaves like a strong and concerned parent with a child who has lost his controls. Related problems of acting out will be covered in Volume II.

3.10.2 The Monday Hour

Actually, the heading of this section should be the Friday and the Monday hour, or better still, the analytic patient's reactions to the weekend separation from the analyst. For the sake of brevity, and also because Freud spoke of the "Monday crust" as early as 1913, I have condensed the heading to the Monday Hour. We know that our patients will react emotionally to all separations from the analyst. Some respond as though the weekend is a holiday, a carnival, others as though it were an abandonment or a desertion. Ferenczi (1919c) described the "Sunday neuroses" which occurred when his patients lost the distractions and diversions of their everyday work. Freud, in *Totem and Taboo* (1913a) and later in "Mourning and Melancholia" (1917b), described some of the dynamics and structural changes which occurred in festivals. He pursued some of these ideas further in various writings. A good summary of them was published in 1955 by Grinstein. However, none of the authors stressed the central importance of the transference situation as the determinant for the patient's reaction to the weekend. I propose to explore some of the typical ways in which patients in analysis react to the weekend interruption in the analytic work.

3.10.21 The Weekend Is a Holiday

For some patients the weekend separation is an occasion for celebration, it is an intermission, a respite, a rest; it offers the possibility for recuperation from the rigors and demands of the psychoanalytic treatment. Obviously when this occurs it is a sign that the everyday psychoanalytic work is being carried out under a constant resistance. It is very striking how often it can happen that the

patient does not indicate openly the presence of this resistance until the Friday hour or the hour before the vacation occurs. Then, to one's surprise, the patient reacts as to an impending celebration and festivity; in this case one must infer the presence of a latent resentment toward the psychoanalytic treatment that has been occurring silently throughout the working interval. This indicates that the analyst must be some kind of critical superego agency for the patient. The patient has been working in the analysis under the stress of feeling obliged, of being under duress, and has submitted to the situation without articulating this submission. The patient may or may not be consciously aware of this, but his reaction to the impending holiday clearly indicates it. Patients who feel this way on Friday hours before weekends and patients who have a sense of relief and pleasure at the end of every psychoanalytic hour belong in this category.

When the analyst represents a critical superego figure for the patient, then the patient's behavior during the weekend will consist of all sorts of instinctual liberties. There will be a plethora of libidinal and aggressive activities, usually with a regressive, infantile cast. It is striking to note how patients will behave with a certain restraint during the week in regard to their sexual life and then indulge in a variety of pregenital activities on weekends. There is often a great increase in forepleasure activities, masturbation, and promiscuity on weekends. There is a parallel upsurge in aggressive actions. Some patients act out on weekends what they free-associate to during the week. These patients behave as though the analyst is the bearer of their superegos. The Monday hour then becomes an hour for confession and atonement. For them, the Monday hour has become the Sunday confessional. On Monday they very often begin the hour with a recital of all their sins, with much guilt and shame, fear of punishment, and much self-abasement. It is striking that when such patients accidentally meet their analyst during a weekend, they are shocked because they had the fantasy the analyst does not exist in the outside world. Or else they fantasy he is locked in the office and has no life outside of the office. There are patients who are staggered when they meet their analyst at a concert, or at a theater. Some will fail to recognize him, will become hysterically blind, and develop a scotoma for him. It is important to recognize

this projection of id and superego, as well as the subtle resistances which must be silently at work during the weekday sessions.

3.10.22 The Weekend Is a Desertion

For many patients the weekends or the interval between analytic hours denotes the loss of a love object. To them, the intermission means separation, detachment, disengagement, disconnection, or termination. In some form or other the patient behaves as though he feels he is losing a love object. He often reacts to the weekend as though it meant a rejection by the analyst. The Friday hour is often spent in nonproductive anger, for the weekend means the analyst is taking a holiday and is abandoning and deserting the patient. For such a patient the Monday hour means a confrontation between him, the excluded one, the wronged one, and the analyst who is the rejector and the aggressor. For neurotically depressed patients the Monday hour can also represent a reunion with a lost love object and be felt as a kind of bliss. Some patients feel relieved to discover the analyst has survived their death wishes. It is important to recognize the level on which this is being experienced, or at least the level on which the predominant reactions are occurring. Furthermore, do we see drives or defenses in the foreground? Do we see aggressive behavior or reparation and restitution attempts?

For many patients the weekend revives the oedipal situation. For such a patient the weekend is a primal scene from which he has been excluded. He struggles with his incestuous feelings, or develops guilt, anxiety, or depression, or perhaps he acts out in some form or other some aspect of the oedipal situation. Some patients struggle with unconscious death wishes and are anxious and guilt-laden every Monday upon meeting their analyst. Some feel sad and depressed at the exclusion. Others feel hostile with jealous envy. Some patients feel this as such, and come to the hour with depressed feelings or hostility. Others deny such feelings by their behavior or by indicating: "I couldn't care less" or "Who needs you." Some patients work very hard in the Monday hour to atone for their guilty wishes or guilty behavior and in this way try to make reparation to the analyst. Some become silent on Monday out of their hostility and resentment at having been rejected. Some patients develop somatic reactions on weekends as an attempt to discharge otherwise inaccessible emotions or drives. It is typical for patients to be habitually early or habitually late on Mondays. I had one patient who sang in the waiting room every Monday hour and whistled joyously, which was his attempt to deny the hostility and guilt he felt upon coming back to the analytic situation.

The loss of a love object on weekends can be experienced on an oral or anal level as well. I have seen patients who felt they had nothing to produce on Monday, and others who came with a big pile of material which they had stored up and retained in order to express a huge mass before me for my approval. For some patients the weekend was an oral deprivation and they came back on Monday hungry to be fed by me, to drink in my voice rather than to hear what I had to say. One such patient, Mrs. K., often spent the entire weekend sunbathing as an attempt to replace the warm, loving sun-father, as Ferenczi (1914d) described.

From a technical point of view, the task is to recognize how the weekend reactions relate to the transference situation and to make the patient aware of this. It is striking how patients can resist accepting the transference meaning of their weekend behavior. The Friday hour and the Monday hour are of particular importance in revealing and demonstrating important transference reactions. A depressed patient of mine became constipated every Friday, holding on to her fecal mass as a substitute for me, and could only move her bowels on resuming her analysis on Mondays. This was the first breakthrough in our understanding of her oral-anal relationship to me.

3.10.23 The Weekend and Ego Functions

For some patients who are in a relatively severe regressed state, the absence of the analyst can be perceived as a loss of ego functions. This is apt to occur in a neurotic patient who is in the throes of an intense infantile transference neurosis, or it may occur at any time in borderline patients. Then the analyst has been functioning as an auxiliary ego and separation from him can bring about a loss of reality testing, disorientation, depersonalization, loss of identity, etc. It may be necessary to see such patients during a weekend or to have telephone contact with them. Sometimes just knowing the analyst's whereabouts makes it unnecessary to arrange for some substitute to replace him.

There are other ways in which the patient may be using the

analyst as an ego function in the transference which may come to light during a separation. The analyst may be used by the patient to temper the critical demands of his superego. Then on weekends such patients may return to their hypercritical anti-instinctual state. Such patients cannot bear to waste time during weekends or holidays and have to pursue some gainful task, either a cultural pursuit or a health measure. For some such patients the id temptations of the weekends can mobilize severe guilt and shame reactions. For them, the Friday hour is embarking on a dangerous journey and the Monday hour is a return to safety.

3.10.24 Other Clinical Findings

There are patients who will stop working on Fridays according to the formula, "I will leave you before you leave me." This question of who is leaving whom can be an important technical point with very sick patients. In order to spare such a patient the feeling of acute abandonment I have often found it advisable to allow him to leave for a brief holiday a day or so earlier than I do. It is not rare for such patients to cancel the last hour before the analyst's vacation. I have seen patients who were silent or otherwise unproductive on Fridays in order to display the attitude: "Who needs you?" They waste the last hour to show their contempt for the analytic work.

When the analyst is felt predominantly as a figure of hatred, the Friday hour can mean the gateway to freedom from misery and one can detect a certain euphoria in the patient. However, under such circumstances the patient can become depressed during the weekend from the turning inward of such hostility, or anxiety can arise from the unconscious expectation of some disaster befalling the analyst.

Reactions to the Monday hour will depend on what has transpired during the weekend and, above all, on what transference meaning the analyst has at that time. Is one returning to a critical superego, a lost love object, a rejecting love object, a needed ego, or a tempting id. Is the figure of the analyst loving or hating, benevolent or harsh, supportive or critical?

No matter what else may be going on in the analysis, the Friday hour heralds the weekend, and the impending separation from the analyst has to be taken into account. Similarly, no matter what else transpires during the weekend, the fact that an event occurred during a separation from the analyst will influence the other findings. It is not rare to find patients reacting on Monday with the feeling: "I am worse and it is your fault because you deserted me over the weekend."

Patients' reactions to the Friday and Monday hours will change during the course of analysis.

A male patient of mine, Mr. Z., who hated Monday hours because he could not admit he missed me, since that would imply homosexuality, used to be spitefully unproductive on Mondays. Eventually, he was able to express his regret when the Friday hour approached and became a hard worker on Mondays.

A depressed woman patient, Mrs. K., felt she stopped living when Fridays arrived and became a "Zombie" on weekends because she felt she was no longer "plugged into" me. After she was able to fall in love outside of the analysis, she looked forward impatiently to the Friday hours and her own weekend vacations.

It should not be forgotten that the weekend offers a valuable replica in miniature of what one can expect at termination.

3.10.25 The Technical Problems

One of the technical problems is to re-establish a working alliance so that one can analyze the patient's reaction to the separation. I believe that the "Monday crust" Freud spoke of referred to the day residues, the experiential events of the separation plus the resistances evoked by the separation which interfere with the resumption of the therapeutic alliance. Once these residues and resistances are expressed and clarified, one can proceed with the analytic work.

Another technical problem deals with the timing and dosage of an interpretation. One must take into account that an interpretation given in a Friday hour or preceding a vacation will have to be handled by the patient himself for a period of time. Therefore, the dosage of new and painful insights should be less than if that same interpretation were given on a regular working day. The analyst has to weigh the question of: can the patient bear this insight alone for such and such a period? I recall an error in this regard when I was still a young analyst.

A young woman patient brought in a dream on a Friday which for the first time had clear-cut homosexual imagery. Her associations also touched on this theme. I made what I thought was a careful interpretation of her homosexual feelings toward a schoolteacher friend. The patient's response in the hour seemed appropriate. When she returned on Monday she was completely silent and remained so for over two weeks. Later I discovered that she had become depersonalized during the weekend as she ruminated about my interpretation. This matter of dosage will be discussed in greater detail in Volume II.

Another problem in technique is the complicating circumstance of what the weekend may mean for the analyst. Although this is mainly a problem of countertransference, and will be discussed in Volume II, it merits a few lines at the moment. Some analysts will react to the Friday hour as though they are leaving their children, with a feeling of heavy-heartedness, or concern, or worry, and for others it is an experience of relief and joy. For some analysts the Monday hour is returning with a sense of relief to those about whom one was worried. Other analysts meet Monday with tired resignation, as a chore. There are analysts who cannot wait for Friday hours or who cannot wait for Monday hours. There are some who even seem compelled to work on Sunday; and there are others who are exhausted and depleted by Tuesday. I must say that although analysis is work, it ought to be enjoyable work and not torturesome and exhausting. It is striking how frequently analysts complain about their fatigue. However, I suspect that at times this complaint is not accurate, that it has become a manner of speech; it has become the acceptable mode to talk about one's exhaustion. It is as though some analysts are embarrassed to admit they enjoy their work, as though enjoyment might imply lack of seriousness (Szasz, 1957).

At this point, I would like to add that many psychoanalysts do suffer from overwork; it seems to be an occupational hazard. Some work far more hours than they can handle effectively. I am impressed by the number of analysts who engage in strenuous extracurricular activities in the evenings like committee meetings, scientific meetings, lecturing, seminars, etc., after a full day's work with patients. They have little time or energy left for their families and are depleted when they begin the day's work with their patients. Psychoanalytic therapy is a demanding profession and overwork makes it an impossible one (Greenson, 1966).

To summarize: There are special clinical and technical problems of the Monday hour. There are innumerable ways for patients to react to the weekend separation from their analyst: it depends on what childhood figure the analyst represents. But patients do react, and this reaction has to be detected and interpreted. It is necessary to re-establish the working alliance which has become interfered with by the separation and the accumulation of external experiences. All of this is complicated by the countertransference meaning of the weekend separation.

3.10.3 Intractable Transference Reactions

I have already stated that the most frequent cause of stalemated psychoanalyses is the intractable transference reaction. By this term I am referring to a special variety of transference resistance which is characterized by being fixed, unyielding, and uninfluenceable despite what seems to be correct handling. Strangely enough, patients with this problem seem willing and even eager to continue their unproductive analyses for years on end. They seem to find some subtle combination of satisfaction and security in the analytic situation which makes them prefer to cling to treatment rather than to seek some other solution for their problems. Although intractable transference reactions may occur in widely diverse diagnostic groups of patients, for the purpose of focusing primarily on the technical problems, I will divide them into two categories. It is possible to single out a large group of patients whose superficial clinical appearance and behavior would make them appear suitable for classical psychoanalysis and who become recognizable as unsuitable only after a period of analysis. The other group of intractable cases are those which have become so because of some subtle but important errors in technique. Most cases of stalemate will turn out to contain a mixture of both errors.

3.10.31 Errors in Appraisal of Transference Capacity

Ordinarily we expect patients who seem to be suffering from psychoneurotic symptoms and who evidence no sign of psychosis or any marked impoverishment of their object relations, and who