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Psychoanalytic Psychotherapy with Adults

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Psychoanalytic psychotherapy is a method for the treatment of mental and emotional disorders through verbal means that promote their understanding. By *mental and emotional disorders*, I mean patterns of thought, feeling, and behavior that restrict the pursuit of life's pleasures and impose objectively unnecessary suffering. By *understanding*, I refer to understanding in the conventional sense, as well as understanding in the psychoanalytic sense. In conventional usage, understanding refers to an attitude of acceptance and empathy based on the fundamental commonalities of human nature. In the psychoanalytic sense, understanding refers to a discernment of the motivations and mental processes that determine subjective experience and behavior. Understanding in the first sense, that is, in the sense of human understanding, is a basic feature of most psychotherapies, including psychoanalytic therapy, and it is a powerful agent of therapeutic change. This type of understanding engenders feelings of being a person like other persons, of being coherent, understandable, and acceptable to others (Rogers, 1957, 1961; Truax, 1963; Truax & Carkhuff, 1967). In psychoanalytic therapy, however, while human understanding is very important, it is only part of the interpersonal context within which psychoanalytic understanding is pursued. Psychoanalytic therapy is predicated on the observation that mental and emotional disorders are the expression of conflicts between unconscious contradictory motivations and that these disorders can be ameliorated when unconscious motivations are brought to light.

Psychoanalytic psychotherapy derives from the theory and technical procedures of psychoanalysis. Psychoanalysis originated with the work of Sigmund Freud (1856-1939), a Viennese physician whose pioneering efforts to help patients suffering from obscure mental disorders led him from the practice of neurology to the field of psychology. Freud discovered that when these patients speak freely about the thoughts that pass through their minds, they regularly express hitherto unconscious wishes, fears, and other painful affects, which illuminate the motivational basis of their pathologies. Moreover, he found that when these unconscious motivations were uncovered and exposed to conscious reflection, his patients acquired increased control over their pathological functioning. The investigation of a patient's mental life, Freud learned, was thus tantamount to the treatment of that patient's mental or emotional problems. The optimal therapeutic process is thus an individualized investigative procedure that produces self-knowledge, or insight. Insight may be defined as the recognition (or re-cognition) of hitherto unconscious motivations and of their influence on thought, feeling, and behavior. Psychoanalytic therapy aims to modify maladaptive patterns by enabling the client to apprehend, understand, and regulate the psychological forces responsible for their existence.

THEORETICAL FOUNDATIONS

The practice of psychoanalytic therapy requires a knowledge of psychoanalytic theory. Psychoanalytic theory has undergone many modifications since its inception. In his own lifetime, Freud repeatedly revised his views in accordance with accumulating clinical data. In the years since his death, psychoanalysts around the world have shaped and reshaped psychoanalytic theory in accordance with their own evolving views and clinical experiences. This has resulted in a proliferation of psychoanalytic schools, each championing its own points of view. Although I refer to psychoanalysis as a singular entity, the reality is that there are many psychoanalyses and therefore many versions of psychoanalytic therapy. In this chapter, I discuss psychoanalytic therapy from the vantage point of traditional Freudian thought, especially (though not exclusively) from the perspective of contemporary structural theory (Arlow & Brenner, 1964; Brenner 1976, 1982, 1994; Dowling, 1991). (For a concise review of traditional and contemporary structural theory, see Chapter 3 in this book.)

Briefly restated, psychoanalytic theory posits that mental activity is governed by a fundamental propensity to seek pleasure and avoid pain, termed the *pleasure principle*. Mental activity is motivated by instinctual drives, which acquire psychological representation in the form of specific wishes as a result of “experiences of satisfaction” during development. Since they derive from drives, these wishes are also called drive derivatives. Because the gratification of wishes is inherently pleasurable, wishes motivate mental activity. Wishful mental activity becomes complicated as a result of experiences through which the developing child comes to believe that the pursuit of specific wishes will entail calamitous consequences. As a result of such experiences, the arousal of certain wishes elicits contradictory affective signals: affects of pleasure, linked to fantasies of wish-fulfillment, and affects of unpleasure, linked to the aversive contingencies with which these are associated. These contradictory affective signals instigate an approach-avoidance dilemma characterized as *psychic conflict*.

Wishes are shaped by experiences of satisfaction with human caretakers and bear the imprint of these experiences. Wishes feature mental representations of the specific activities that have been pleasurable and of the persons with whom they were enjoyed. They may be classified as being predominantly sexual or aggressive, according to the character of their aims. In practice, most wishes contain a mixture of sexual and aggressive strivings. (The terms *sexual* and *aggressive* have a broader meaning in psychoanalytic terminology than they do in common parlance.) Affects of unpleasure are shaped by the hurtful experiences of childhood, both real and imagined. These affects are composed of two aspects: bodily sensations of unpleasure and accompanying mental representations of calamities. These representations of calamity constitute the ideational content of unpleasurable affects. The typical calamities of childhood pertain to loss, especially the loss of parental figures or the loss of their love, and to punishment, including genital mutilation, and harsh parental attitudes that induce feelings of shame or guilt. When calamities are anticipated, however unrealistically, the result is anxiety. When

calamities are experienced as having already occurred, they produce depressive affect. Most unpleasurable affects contain a mixture of anxiety and depressive affect, and they pertain to a mixture of calamities (Brenner, 1982).

In conditions of psychic conflict, mental activity naturally produces an array of alternative compromise solutions, or compromise formations, each of which permits a limited measure of gratification at a limited cost of unpleasure. Compromise formations are effected through the use of defenses. Defenses are mental activities of any kind that serve to reduce unpleasure. Defenses are deployed in complex ways to alter, disguise, or otherwise distort the experience of wishes and of the unpleasures they arouse. As a result of defenses, childhood wishes and associated affects of unpleasure are typically inaccessible to conscious apprehension as such, and can be perceived only through derivative manifestations (Brenner, 1982).

Compromises are not all equally adaptive, however, since each results in a different balance of pleasure and unpleasure. In any condition of psychic conflict, the compromise promoting the best balance of pleasure and unpleasure is naturally preferred over alternatives. This compromise will be repeated whenever the conflictual wish arises. With repetition, compromise formations become enduring programs for the organization of mental activity. Mental activity is construed as a sequence of mental events, instigated by the arousal of specific wishes that trigger associated affects of unpleasure which, in turn, mobilize the deployment of defenses to reproduce a favored compromise formation. Such sequences of wish-unpleasure-defense are repeated automatically and without conscious deliberation. We are rarely aware that our preferred patterns of living are the end products of such complex activity and often mistakenly regard them as expressions of basic unitary motives. Such programs of mental activity are called structures, because they are “processes with a slow rate of change” (Rapaport, 1960). These programs are the structures explained by contemporary structural theory and illuminated by psychoanalytic therapy.

One of the most remarkable discoveries of psychoanalytic research is that the wishes of childhood, coupled with the unpleasures and defenses with which they are associated, persist as motivations shaping the mental life of the adult. While the lives of adults differ from those of children in significant ways, adult patterns of thinking, feeling, and behaving derive from those of childhood. Adult patterns are formed as the habitual compromise formations of childhood are progressively re-shaped to fit the changing circumstances of life. New compromise formations may be conceptualized as alternative pathways in the sequence of mental events described in the preceding paragraph. All adult compromise formations are developmentally linked to their predecessors, however, and tend to reflect their continuing influence. The extraordinary continuity of psychic conflict and compromise formation in mental life, from childhood through adulthood, is responsible for the fact that we have more or less the same personalities throughout our lives (for an exceptional longitudinal study, see McDevitt, 1996).

At one time, psychoanalysts believed that psychic conflict was a feature of mental illness, while mental health was a state of freedom from psychic conflicts. Psychoanalytic research, however, has demonstrated that mental activity is always characterized by psychic conflicts and compromise formations. Mental health and mental illness are not distinguishable, then, by the absence or presence of psychic conflicts. The difference between normality and pathology lies in the character of the compromise formations to

which they give rise. Healthy compromise formations promote adaptive functioning, characterized by a favorable balance of pleasure over unpleasure, while pathological compromise formations promote maladaptive functioning, with an unfavorable balance of pleasure and unpleasure. Analysis of the healthy aspects of any individual's mental functioning, such as a happy vocational choice or the pursuit of a pleasurable hobby, regularly reveals the influence of the same desires and conflicts that determine their psychopathology. This may be illustrated by the following examples.

Mr. A is an actor who sought help with crippling bouts of stage fright that had caused him to miss several performances. Although he had always been nervous about performing, he had never before been so paralyzed that he could not go on stage. He was frustrated and furious at himself, especially since his stage fright appeared just when he was playing a leading role in a play that could make him a star. His stage fright felt like some "cosmic punishment" for a crime he could not remember committing.

Mr. A had grown up in an inner-city slum, one of many children in a marginally intact family, headed by an alcoholic father who was chronically aloof and contemptuous. As a child, Mr. A secretly nurtured fantasies of great wealth and fame. He imagined that he would use his success to inspire others. He began to act in plays at school, and studied acting at a teen center. Later, he attended a professional acting school. He experienced intense feelings of "personal triumph" whenever he performed well, and had pursued his career with intense zeal, despite the many painful "sacrifices," including years of menial work and professional insignificance.

In the course of a lengthy therapy, we discovered that Mr. A's ambitions were motivated, in part, by unconscious wishes to hurt his father, to make him burn with envy at his son's prestige and status. These vengeful wishes triggered little recognizable anxiety or guilt, because they were disguised as artistic dreams, and masked by altruistic concerns for others. If he felt any residual guilt, his "sacrifices" were ample atonement.

When Mr. A landed a leading role in a Broadway play, however, his long-simmering desire to torment his father was stimulated by the prospect of his imminent stardom. At the same time, the chronic deprivation that permitted him to atone through "sacrifices for his art" was about to be ameliorated. As a result, he became increasingly panicked and guilt ridden. Consciously, he was terrified that the audience would hate him and that the critics would ridicule him as a pompous fraud. His stage fright and his missed performances were a pathological compromise formation, fueled by vengeful wishes to hurt his father (by being a star), fear of his father's retaliation (the audience and critics despise and ridicule him), and guilt (his stage fright is a "cosmic punishment"). Mr. A kept his panic within limits by periodically missing performances, a symptom that under-mined his success (i.e., inhibited his aggression) and thereby diminished his feelings of anxiety and guilt.

Similar motivations are apparent in a healthy aspect of Mr. A's life. Mr. A volunteered to teach acting to inner-city youths at the teen center where he first took acting lessons. He took great pleasure in this work, which won him praise from other actors, as well as gratitude from community center staff, and enabled him to enjoy the admiration of the boys he taught. All of these experiences gratified unconscious

desires to supersede his father in social importance and success. The fulfillment of these wishes was highly disguised, and any guilt he may have experienced was balanced by the obvious generosity and social virtue of his efforts. These activities are clearly a successful compromise formation, forged of the same psychic conflicts which gave rise to his painfully disrupted career.

Ms. B was a twenty-nine-year-old nurse who entered therapy complaining of failed relationships, feelings of inadequacy, and a painful sexual inhibition. She was inclined to become romantically “enchanted” by sophisticated and worldly men. She enjoyed being wined and dined, and could be coaxed into bed if the man were sufficiently aggressive. Once lovemaking commenced, however, she typically became nauseated and disgusted by any further thoughts of sex. She believed that her inhibition was due to “guilt over sex,” for which she blamed her strict Catholic upbringing.

Ms. B was the first of four children. Her mother was a cold and bitter woman who offered little warmth or nurturance. Ms. B was always her father’s favorite. Her father was an “enchanted” man, who was always loving, kind, and nurturing to her. Analytic treatment revealed that her sexual problems were caused by the persistent influence of unconscious sexual desires for her father. Although she was aware of loving her father a great deal, she was not aware of her sexual desires for him, nor was she aware that she chose her sexual partners on the basis of their similarities to him. Her lovemaking with “enchanted” men thus represented the fulfillment of unconscious incestuous desires, as a result of which sex had become morally abhorrent and disgusting. Her sexual relationships were a compromise formation, in which her incestuous sexuality was partially gratified in a disguised form at the cost of anxiety, guilt, and disgust, which she minimized by attributing them to her Catholic upbringing. Her nausea was the somatic equivalent of moral disgust.

While Ms. B suffered in her love life, she derived great pleasure from her work as a nurse. She was devoted to her clients and enjoyed the feeling of intimacy she experienced from caring for their bodily needs. She was especially moved by feelings of tenderness toward her elderly male clients and felt “privileged” to care for them. These professional activities were highly pleasurable because they permitted her to gratify her wishes for greater intimacy with her father without arousing the feelings of guilt and disgust associated with sexual desires. Her professional life was a successful compromise formation.

Compromise formations are fueled by psychological forces of which we have only partial awareness. Mr. A, for example, knew that he was ambitious and fearful of the audience’s criticism, but he did not know that his theatrical ambitions were intended to achieve a triumphant revenge against his father or that he feared his father’s retaliatory attack. Ms. B knew she was “enchanted” by men of a certain type and that she felt guilty and disgusted when trying to make love to them. She did not know that she yearned for a sexual union with her father or that she felt frightened, guilty, and disgusted by this fantasy. Although Mr. A and Ms. B are intelligent and reasonable persons, neither could exercise control over the pathological aspects of their lives. Both were encouraged by their friends to “straighten up and fly right,” but neither could. Both felt they were “in the

grip of something,” something alien to themselves that they could neither understand nor control. In each case, what was experienced as alien was nothing other than disowned aspects of themselves, which had acquired the status of being “alien” as a result of defensive activities, exercised over a lifetime. Because these clients had little understanding or sense of ownership in relation to their own unconscious wishes, their ability to regulate their mental functioning was severely handicapped.

The therapist who treats clients like Mr. A or Ms. B may endeavor to change their maladaptive patterns of thought or behavior through guidance, advice, or other prescriptive measures. Psychoanalytic psychotherapy differs from other therapies, because it does not attempt to modify maladaptive patterns by any direct means. It is a “radical” (from *radex*, Latin for “root”) form of treatment because it attempts to illuminate the motivational roots of the client’s problems. While other therapists modify pathological patterns by direct means, the psychoanalytic therapist seeks only to understand his or her clients and to help them to understand themselves.

With increased understanding of the emotional forces by which they are motivated, clients are able to forge new and more adaptive solutions for their psychic conflicts, and to replace habitual pathological compromise formations with healthier and more gratifying ones. As the client becomes familiar with his or her inner conflicts, the client is able to think about them with the most mature aspects of his or her personality. This process of reflection enables the client to appreciate the childhood character of his or her wishes and unpleasures, to contemplate the circumstances in which they formed, and to weigh their present significance and importance—in brief, to reconsider them from the vantage point of mature judgment (Loewald, 1971). This process facilitates their gradual transformation. Mr. A, for instance, recognized that his wish for vengeance was a plan he had made as a child, when he had no better means to cope with the suffering he experienced on a daily basis at his father’s hands. Although his vengeful fantasies enabled him to endure the pain of his father’s contemptuous attitudes, he recognized that he was no longer subject to these indignities. Of course, he still felt the sting of these childhood injuries, such as feelings of helpless indignation and humiliation. On reflection, however, these feelings became less painful as he reviewed them from his adult perspective. His father was, after all, an unhappy and frustrated man. He should not have taken out his frustration on his son, but his nasty and denigrating attitudes carried less weight when viewed from this present vantage point. Mr. A’s feelings of helplessness and inadequacy were recontextualized as the “psychic reality” of a small boy that no longer applies to Mr. A, the man. Other significant aspects of Mr. A’s conflicts, such as his fear of punishment and his feelings of guilt, were also progressively modified as they became accessible to his mature reflection and judgment. Similar observations can be made about Ms. B, who eventually came to accept her incestuous desires as an aspect of her fantasy life, to recognize the wish-fulfilling confusion that enabled her to identify her “enchanted” lovers with her father, and finally, to differentiate consciously between her lovers and her father.

With progressive understanding, clients can alter their maladaptive patterns of living and replace them with more adaptive patterns. This process occurs spontaneously as a result of shifts in the organization of wishes, unpleasures, and defenses brought about by the client’s understanding and reflection. The new patterns are also compromise formations, and they too are subject to continuing analysis and re-organization, a process

that permits the creation of ever more adaptive compromises. Therapeutic change in psychoanalytic psychotherapy may be understood as a beneficial reorganization of compromise formations.

Mr. A began approaching his theatrical career more realistically. He felt less exalted and triumphant when the audience applauded, and his stage fright gradually dissipated. He took greater pleasure in the perfection of his craft and eventually began directing theatrical productions, activities that permitted the satisfaction of other desires he had previously ignored. As he reflected on his vengeful fantasies, Mr. A sought a more mature resolution of his problems with his father, which prompted him to initiate a "dialogue" in which he aggressively confronted his father for his myriad failings. As his persistent wish to humiliate his father was repeatedly observed and explored, Mr. A slowly adopted a more realistic attitude, which permitted him to establish a limited but happier relationship with his father.

As Ms. B came to recognize the incestuous fantasies that motivated her love life, she was able to better discriminate between reality and fantasy and began enjoying full sexual relations without nausea or other impairments. As a result, she was able to form more lasting relationships. Her behavior in these relationships, however, reflected an attitude of dependency and entitlement, which had characterized her relationship to her father. As these features of her continuing yearning for her father's love were analyzed, Ms. B slowly came to recognize both the power and the futility of her wishes to relive her child-hood relationship with her father, and through this, to compensate herself for the painful feelings of rejection she experienced in relation to her mother. Her emerging desire for a partner with whom she could feel more adult and competent gradually superseded her desire for a father figure. Her new relationships were less enchanting (she was not re-finding Daddy), but permitted her to experience new forms of intimacy, which eventually included marriage and motherhood.

As the client's compromise formations become healthier, permitting greater pleasure at less psychic cost, they cease to attract the client's attention, and the focus of the therapeutic work shifts. When the client has achieved sufficient mastery over his or her conflicts, the motivation for treatment often gradually dissipates, and therapy comes to a natural conclusion. Many clients who are excited by their emotional growth wish to continue in therapy to achieve further self-knowledge, often to pursue more ambitious therapeutic goals. Since self-knowledge is never total, every therapy is in a sense incomplete. There is no fixed point at which psychoanalytic therapy should come to an end. Termination never implies perfect health or the absence of conflicts.

THE PROCESS OF PSYCHOANALYTIC PSYCHOTHERAPY

Psychoanalytic psychotherapy is a collaborative undertaking. It cannot be administered to a passive or uninvolved client. The therapist cannot directly observe the client's inner life. Only the client has access to a knowledge of his or her inner world. The therapist

cannot reliably infer the nature of the client's psychic conflicts from a knowledge of the client's symptoms, psychiatric diagnosis, lifestyle, social relations, work history, culture, socioeconomic status, family background, or any source other than the client's most private thoughts and musings. Psychoanalytic therapy, then, must be a collaborative undertaking, or it cannot be undertaken at all.

Psychoanalytic psychotherapy is a difficult and demanding form of therapy. It requires a sustained effort over a protracted period of time, often many years. The client must be willing to expose his or her innermost thoughts and feelings to an-other person, a stranger, about whose attitudes and feelings he or she can have little knowledge. The client must be willing to tolerate the emotional discomforts this exposure evokes and to persist in the process even when it is painful. The therapist must have the skills, confidence, and emotional fortitude to accept the responsibilities this entails. The therapist presides over the entire therapeutic process. He or she is responsible for providing a safe and supportive context in which to explore buried feelings and for offering the client a coherent understanding of those feelings. The therapist is also responsible for protecting the client and the therapy from the emotional turbulence the process unleashes.

It is sometimes said that therapy begins with the first contact between the therapist and the client. While the first contact ought to be therapeutic, in a general sense, psychoanalytic therapy per se can be initiated only after both parties have met and come to a mutual understanding and agreement about the nature of the treatment and the procedures to be employed. This agreement or *therapeutic contract* (Menninger, 1958) is the rational basis of all further interactions between client and therapist. In psychoanalytic therapy, the roles of client and therapist are clearly de-fined. The client's task is to communicate his or her thoughts to the therapist. Most psychoanalytic therapists invite the client to free associate—to say aloud all the thoughts that come to mind, without censorship or conscious deliberation, thus enabling the therapist to sample the client's mental life. The therapist's primary task is to listen to the client's thoughts, understand the client's mental life and behavior, and communicate this understanding to the client in the form of interpretations, or comments that increase the client's self-knowledge.

The client will naturally talk about many things, including his or her problems, current interpersonal relationships, relationships with family members, childhood memories, and dreams. Over time, the therapist will become increasingly familiar with the client's mental life. The client's communications enable the therapist to empathize, to form a picture of the client's subjective experience. Although the client may report every aspect of his or her thoughts and conduct faithfully and without reserve, the client cannot intentionally report the unconscious aspects of mental life. This is due to the fact that self-awareness is restricted by the operation of defenses. These unconscious aspects, especially the wishes, unpleasures, and defenses that constitute the client's pathogenic psychic conflicts, can be discovered only over time, through the application of the psychoanalytic method.

Freud employed an archaeological metaphor to describe the psychoanalytic process. The archaeologist observes a particular terrain, studies it carefully, and begins to excavate at selected sites. The process of excavation is conducted in a methodical fashion, starting at the geological surface and proceeding layer by layer to an uncovering of artifacts and

objects at successively lower levels. Although psychoanalytic treatment is not archaeology, the metaphor highlights certain meaningful parallels. Like an archaeological dig, a psychoanalytic investigation proceeds from the surface to the depth—from facts and feelings that are on the surface to those aspects of mental life that are hidden and can be observed only when they are uncovered. Although analysts vary somewhat in their usage of the term, most writers use the term *surface* to characterize the observable or manifest aspects of the client's mental life (Freud, 1905a; Levy & Inderbitzen, 1990; Paniagua, 1985, 1991; Poland, 1992).

A therapy session is composed of innumerable surfaces, some of which are allowed to pass by without particular attention, while others become focal points for exploration. The surfaces selected for "excavation" may be determined by the client, whose attention is drawn to those life events and experiences that are emotionally meaningful in one way or another. Some surfaces are selected by the therapist, who notices loaded comments, pregnant pauses, incongruent gestures, or various discontinuities in the client's thought and brings them to the client's attention. Since the process of psychoanalytic therapy is a collaborative venture, the selection of any surface for exploration should be consensual (Poland, 1992). Any selected surface is progressively uncovered as the client verbalizes the thoughts that come to mind in connection with it. These associations reveal the network of feelings and thoughts within which the particular experience is embedded. They provide clues to the emotional meanings of the manifest experience. When the client follows these associated thoughts and feelings, they often link up with other trains of thought that help explain the meaning of an experience by connecting the surface to deeper and deeper motivational roots.

In an archaeological site of any size, excavation proceeds at a number of specific areas simultaneously. The process of digging begins more or less simultaneously at each of these selected surfaces, with new surfaces selected for excavation as the dig proceeds. As selected areas are unearthed and their contents identified, the archaeologist's understanding of the other areas under excavation is enhanced. Similarly, psychoanalytic exploration entails the concurrent investigation of an expanding number of surfaces. As each individual surface is explored, the therapist comes to understand the specific conflicts responsible for the manifest phenomena comprising that particular surface. As numerous surfaces are explored, the therapist will discover that similar conflicts determine multiple different surfaces. These conflicts are called *core conflicts* because they lie at the core of many different features in the client's mental life. A familiarity with the client's core conflicts can come about only when they are discovered over and over again as numerous individual surfaces are explored. The unique power of psychoanalytic therapy derives from the fact that the exposure and progressive mastery of core conflicts permit the client to alter a very wide range of problematic behaviors.

Freud's archaeological metaphor also provides a model for the therapeutic action of insight. The buried relics that archaeologists discover are often in states of remarkable preservation. As a result of being buried, these artifacts were protected from the destructive effects of exposure to the elements. Buried, they existed in a timeless universe, unaffected by the passage of the years. The tragic aspect of archaeology lies in the fact that the process of discovery is inherently destructive. When these precious artifacts are uncovered, they are once again exposed to the corrosive effects of the elements and thus returned to the realm of passing time. Freud discovered that

unconscious wishes and fears are similarly protected from the effects of time. Because they are unconscious, they do not partake in developmental processes. They are not transformed by learning or by the individual's developing capacities for judgment and reality testing. Freud characterized the unconscious sector of the mind as timeless because unconscious contents, like buried relics, are isolated from the effects of passing time. When "buried" wishes and fears are uncovered in psychoanalytic therapy, however, they are exposed to the "psychic elements"—the impact of the client's own mature mental functions (Freud, 1909; see also Loewald, 1971).

Although the archaeological metaphor is useful, it should not be taken too far. Psychoanalytic treatment does not follow a simple course of progressive uncovering as the archaeological metaphor might appear to suggest. The client is a living person, not an archaeological site. The therapist cannot simply dig through the client's psyche, shoveling through the layers of the client's mental life as though the client were an inanimate field. Unconscious wishes, thoughts, feelings, and memories are not merely buried by the psychic debris of passing time. They were intentionally buried because, when experienced, they were painful. As these contents are revealed, the client feels these old and forgotten pains anew, and the old defensive methods, by which the painful contents were buried in the first place, are once again set in motion. The client inevitably comes to see the therapy as a hazard and the therapist as a menacing figure who imperils the client's precarious stability and well-being. The therapeutic process and the collaborative relationship between the therapist and the client is thus inexorably complicated by the client's suffering and defensiveness. This inner turbulence gives rise to resistance.

Resistance may be defined as the client's paradoxical opposition to the process of psychoanalytic therapy. Resistance is a manifestation of the client's defensive functioning as it is mobilized in the context of psychoanalytic therapy. It reflects the client's feeling of being endangered by therapy and gives rise to efforts, large and small, to retard or disrupt the treatment. Resistance is evident in curious discontinuities of thought, abrupt shifts of content, odd circumlocutions, ellipses, non sequiturs, unproductive silences, and other such signs of a derailed train of thought. Sometimes the client's resistance will manifest as a feeling of resignation about the treatment, doubts about its efficacy, latenesses and missed appointments, problems in paying or scheduling, and other disruptive actions. In more extreme cases, the client may attempt to abandon treatment entirely, sometimes through a determined effort to "get it together" and a concomitant improvement in mood, which the client mistakes for a cure (the so-called *flight into health*). More destructive clients may unconsciously seek to derail the treatment by "proving" its worthlessness: by getting worse, by engaging in self-destructive activity, by adopting a combative attitude, or by trying to seduce the therapist into a sexual or criminal partnership.

Resistance is an inevitable feature of every psychoanalytic therapy, from the very beginning of treatment to the very end. The success of therapy depends in large part on the therapist's capacity to deal productively with the client's resistance. Psychoanalytic technique aims to modify the client's resistance by exposing and exploring it, so that the client may understand the unsettling feelings that motivate it. As the client recognizes and grapples with these painful feelings, they are gradually reduced, and defenses relax. As a result, previously warded-off contents can emerge and be assimilated into the client's

conscious mental life (Weiss, 1971, 1993; Weiss & Sampson, 1986). This process continues throughout the course of treatment. It is the basic method by which unconscious contents are uncovered (Brenner, 1976; Busch, 1995; Gray, 1994).

The process of psychoanalytic therapy differs from archaeology in another profound way. Archaeological artifacts do not arise from their place of burial on their own accord. The same cannot be said of buried wishes, fears, grief, or memories. When buried feelings are stirred up, they return to life, like the mummies of old horror films. Repressed contents spontaneously arise because they are buoyed up by unconscious wishes seeking gratification. This tendency to return is facilitated whenever resistance is reduced. This is why the interpretation of resistance promotes the process of uncovering. The mobilization of archaic wishes can be a source of great emotional turbulence. In some instances, for example, the client may be unable to tolerate the arousal of these wishes without also taking some actions to gratify them. In other instances, the arousal of repressed wishes is so threatening that the client is driven to take desperate defensive measures. Depending on the nature of the wishes and defenses involved and depending on the strength of the client's capacity to exercise judgment and restraint, these urges can give rise to very destructive behavior. This is sometimes loosely referred to as *acting out*.

Unconscious wishes are aroused by temptations—enticing prospects for the fulfillment of longings and desires. The therapist, who listens empathically and attentively for many hours, who provides acceptance, support, and understanding, and makes no demands for reciprocation, often comes to represent such a temptation. Because the therapist does not divulge personal information or engage the client socially, the client has no clear picture of the therapist's personality or life circumstances. As a result, the client's perception of the therapist will, to a large extent, come to reflect the influence of the client's fantasy life. This phenomenon is called *transference*. Transference is fueled by unconscious wishes and the unpleasures and defenses with which they are associated. Because these conflicts derive from childhood relationships with parents and other significant figures, the transference tends to replicate aspects of these childhood relationships.

Transference presents the psychoanalytic therapist with a major challenge as well as an unparalleled opportunity. Because transference is a distortion, the presence of transference is an inevitable source of confusion for the client. Sometimes the client will be very pleased by the appearance of transference feelings, as occurs, for example, in cases where the client feels the therapist to be very loving, nurturing, or protective. Sometimes the client will be frightened or upset by transference experiences, as when the client feels the therapist is dismissive, angry, or condemning. In both cases, the client is likely to experience the therapist as *really* loving or *really* hostile. These experiences are of potentially great value because they bring aspects of the client's emotional life to the light in a manner that both therapist and client can observe together. On the other hand, if transference feelings are too intense or too readily taken for reality, they can derail the therapy entirely. Where the client is intent on gratifying transference wishes, the demand for gratification can supplant the goal of understanding. Where the client feels endangered by the therapist, this fear may engender a total disruption of treatment. Transference presents a challenge that the psychoanalytic therapist attempts to manage interpretively. The therapist maintains a therapeutic attitude of interest toward the client's transference feelings and attempts to engage the client in a collaborative effort to explore

them. This process helps the client recognize the transference as an expression of his or her own psychology rather than as a veridical perception of reality.

Resistance and transference are closely related. Resistance is often triggered by fears that are aroused within the transference. At the same time, transference may be utilized as a means of resisting the process of treatment by changing the agenda from the understanding of conflicts to the pursuit of gratifications. At the beginning of his career, Freud saw both transference and resistance as unfortunate impediments to the exploration of the client's mental life. It is a credit to Freud's genius that he discovered a means to exploit these phenomena for therapeutic purposes, turning them from mere obstacles into unique opportunities. In a famous passage, Freud (19146) defined psychoanalysis as the therapeutic method that takes the facts of transference and resistance as its starting point. Many of the procedures of psychoanalytic therapy, in fact, may be best understood as techniques designed to protect the treatment from the disruptive effects of transference and resistance and to ensure that they will be exploited to their fullest potential.

THE TECHNIQUE OF PSYCHOANALYTIC THERAPY

The goal of psychoanalytic therapy is the promotion of the client's self-knowledge or insight. Psychoanalytic technique is the method by which this is accomplished. This technique is best understood if the practitioner has a clear appreciation of what is meant by insight or self-knowledge. The philosopher Bertrand Russell differentiated between *knowledge by description* and *knowledge by acquaintance*. Knowledge by description refers to information about phenomena that have not personally been experienced. Knowledge by description is composed of ideas without any actual experiential referents. As a result, such knowledge lacks the personal and compelling quality of knowledge that derives from actual experience. Knowledge by acquaintance, on the other hand, is information acquired by the individual through direct contact with the phenomena in question. The goal of psychoanalytic therapy is self-knowledge of this personal and authentic kind. In a classic essay, Richfield (1954), citing Russell, introduced the term *ostensive insight* to describe insights that are subjectively meaningful because they "incorporate the actual, conscious experience of their referents" (p. 404).

Ostensive insight can be achieved only through a conjoining of actual experience, on the one hand, and observation, on the other. Accordingly, a fundamental aim of psychoanalytic technique is to promote both the client's experience of mental life as well as his or her observation of this experience. To experience mental life is to encounter directly the urges, desires, emotions, images, and other events comprising mental life as specific realities with perceptible qualities and intensities. To observe mental life is to apprehend and describe the particularities of what is experienced and to reflect thoughtfully on these observed particularities from the perspective of one's mature sensibility and with the participation of one's best judgment and highest mental faculties. Without experiencing the events of mental life, the client has nothing to observe or reflect on. Without observation and reflection, nothing can be learned from experience. Accordingly, the technique of psychoanalytic psychotherapy is designed to promote an expanding experience of mental life in the context of ongoing self-observation and reflection. In a seminal essay, the psychoanalyst Richard Sterba wrote that

psychoanalytic treatment must facilitate a “therapeutic split” in the client’s mind, thus enabling the client to take his or her own experience as the object of observation. In order to acquire insight, he reasoned, the client must be able to “oscillate” between the “experiencing” and “observing” sectors of his or her mind (Sterba, 1934). These ideas are still central to contemporary psychoanalytic technique.

The technique of psychoanalytic therapy may be understood as a complex system of interdependent parts, which function in concert to promote insight by facilitating the expansion of inner experience in conjunction with self-observation and reflection. Writers differ in the way they conceptualize the elements of psychoanalytic technique. In my view, psychoanalytic technique features the creation of a *therapeutic situation* within which a *therapeutic relationship* and a *therapeutic dialogue* can be initiated. The *therapeutic situation* is the basic set-up of the treatment, which includes the working agreements and ground rules by which the treatment is conducted, and the interpersonal conditions created by the therapist’s attitude of acceptance, respect, and dedication to the goal of understanding. The *therapeutic relationship* is a unique human relationship, intentionally structured to permit the unfolding of intimate longings in an interpersonal context in which they will be studied rather than gratified. The *therapeutic dialogue* refers to the communications through which the client reveals his or her inner life to the therapist and to the therapist’s efforts to understand the client’s experience and to communicate this understanding to the client in a timely and sensitive manner. Together, the three components of technique create a safe and permissive interpersonal context for the mobilization of unconscious wishes and associated affects, while simultaneously establishing controlled conditions for these experiences to be communicated, studied, and understood.

The Therapeutic Situation

The therapeutic situation is initiated when the therapist and the client each agree to work together in a specified manner toward the achievement of specified goals, according to the terms of an explicit *therapeutic contract* (Menninger, 1958). The therapeutic contract is the indispensable basis for the formation of the therapeutic situation. It is a rational agreement between equal adults, designed to serve the needs of both parties. The terms of the contract are the basis for the working relationship between the client and the therapist. The therapeutic contract includes an explicit explanation of the roles and responsibilities of each party, the frequency and duration of therapy sessions, and the basic ground rules of the treatment, including arrangements regarding the fee, missed sessions, vacations, and so on. These structures constitute the *frame* of the therapy, a metaphor suggesting boundaries that contain the therapeutic process (Langs, 1973, 1974).

Psychoanalytic therapy can proceed only within the context of fixed and stable arrangements. These ensure the continuity of the therapeutic process and the intelligibility of the client’s responses to it. Fixed routines are a baseline from which potentially meaningful deviations are discernible. Lateness in attending sessions or paying bills, for example, cannot be observed if the scheduled times for appointments and for paying bills are overly vague. An anxious client will often feel the urge to avoid or cancel therapy sessions. If the schedule is overly flexible, the client will feel freer to act on this

impulse than if the schedule were fixed. Such “acting out” permits the client to avoid dealing with the distressing affects that have been aroused. The therapist can address such problems only if he or she can recognize them. The frame helps to ensure that the client’s emotional reactions are recognized and addressed within the context of the therapy.

The fixed arrangements of the therapy always include regular times for therapy sessions. A minimum of at least one session per week is generally required, and more frequent sessions are often preferable. Sessions should be scheduled for a fixed length of time, usually forty-five or fifty minutes. The relationship between the therapist and the client is strictly limited to verbal interactions within the context of scheduled appointments (except for emergencies, of course). Beyond attendance and payment for services, the client’s principal responsibility is to observe and express, as openly as possible, the feelings, thoughts, and ideas that pass through his or her mind during the course of the session and, at times, to reflect on the therapist’s communications. The therapist’s principal responsibilities are to listen attentively, to help the client speak freely through the investigation of resistances, to form conjectures about significant aspects of the client’s mental life, and, at appropriate times, to communicate this understanding to the client.

The therapeutic situation is also shaped by the therapist’s professional manner and attitude toward the client. The therapist should be professional and courteous in manner, empathic, reasonable, and consistent in routines and habits. (Of course, this applies to all therapists.) The psychoanalytic therapist also strives to maintain a specialized “analytic attitude” (Brenner, 1976; Schafer, 1983). The analytic attitude is a natural expression of the therapist’s basic intent to help the client by understanding his or her psychic conflicts. It is an attitude of acceptance, empathy, respect, and benevolent curiosity about all the client’s experiences. Brenner observes that the analytic therapist should behave “naturally” with the client. For the psychoanalytic therapist, “naturally” means in a manner that is in accord with the therapist’s intent to understand psychic conflicts. It is “natural” for the psychoanalytic therapist to be curious about the client’s fantasy life, to listen for latent content, or to restrict social chitchat with clients. It would be just as “natural” for therapists of another stripe to hug their clients, socialize with them, and so on. These forms of interaction would be quite unnatural for the analytic therapist, who is intent on helping through understanding (Brenner, 1976).

The analytic attitude is one of profound respect for the client’s individuality and autonomy. This respect is often conveyed by the term *neutrality*. Neutrality is manifested in many forms. The therapist’s respect for the client’s individuality manifests as neutrality in regard to the client’s life decisions. The psychoanalytic therapist imposes no private ideals on the client and refrains from the use of personal influence or authority to shape the client’s attitudes or to direct the client’s life. As Freud wrote: “We refused most emphatically to turn a client who puts himself in our hands in search of help into our private property, to decide his fate for him, to force our own ideals upon him, and with the pride of a Creator to form him in our own image and to see that it is good” (Freud, 1919, p. 164). The therapist’s neutrality is manifested in the therapy as an attitude of impartial and nonjudgmental receptivity to all the client’s communications. This is operationally reflected in the dictum that the client determines the content of the hour. In regard to the client’s psychic conflicts, the therapist’s respect for the client’s individuality is manifested by neutrality in relation to all sides of the conflict. Anna Freud (1936)

characterized this as a position of “equidistance” from each side. Neutrality should not be confused with personal indifference, unfriendliness, or disinterest with regard to the client’s welfare. Neutrality is not an attitude of uncaring. On the contrary, it is the analytic therapist’s way of caring (Dorpat, 1977; Hoffer, 1985; Gitelson, 1952; Kris, 1982; Poland, 1984; Shapiro, 1984; Wallerstein, 1965). True neutrality should be differentiated from a “pseudo-neutral” disregard for the client’s welfare, especially in the context of dangerous acting out (Poland, 1984; Dorpat, 1977; Menninger, 1958).

Abstinence and *anonymity* are principles that derive from the attitude of neutrality and serve to ensure that the therapeutic “process proceeds on the basis of what the client brings to it” (Gitelson, 1952). The *principle of anonymity* directs the therapist to refrain from self-disclosures—from expressing personal points of view, life experiences, suggestions, values, and so on. It protects the treatment from intrusions of the therapist’s personality, which may “confound the discovery process” (Shapiro, 1984). Self-disclosure may suggest to the client that cure can be achieved through intimacy, love, or “lessons” from the life of the therapist rather than through self-understanding. Equally important, self-disclosures introduce personal facts, which may complicate the transference. It should be emphasized that anonymity is appropriate only in the context of a treatment designed to promote the uncovering of unconscious fantasies and psychic conflict. It would make no sense in a therapy whose curative properties were unrelated to the therapeutic relationship, or whose therapeutic action resulted from experiences of intimacy or identification with the therapist (see Goldstein, 1994).

The *principle of abstinence* directs the therapist to conduct the treatment in a manner that does not gratify the client’s demands for emotional relief through any means that might undermine the goal of understanding. Abstinence entails “the inhibition of short-term helpfulness” to promote “substantial long-term analytic goals” (Poland, 1984), even when the client explicitly requests such help. The abstinent therapist will not try to help the client through advice, guidance, reassurance, sympathy, love, or any form of special affection that may relieve emotional pain without illuminating its meaning. The abstinent therapist also declines to gratify wishes extraneous to the treatment contract or to take on special roles that the client consciously or unconsciously strives to impose or induce. Most important, abstinence provides a vital measure of safety by assuring the client that, no matter what he or she wishes and no matter how he or she strives to induce, seduce, or provoke the therapist into gratifying those wishes, the therapist’s attitude and conduct will be predictably and routinely geared toward the expansion of understanding.

The structure of the therapeutic situation, the consistency of the frame, and the reliability of the therapist’s benign and disciplined responsiveness provide a context of safety, within which the client may express himself or herself freely without being rejected, criticized, or exploited. Of course, every client will experience the basic structures of the therapeutic situation according to his or her unique psychology. Many clients will experience the therapeutic situation as a source of security or as a “holding environment” (Modell, 1976). Sometimes the client will experience the therapeutic situation as a source of frustration, danger, or injury. However the client perceives it, the consistent and unchanging features of the therapeutic situation will provide an optimal backdrop for the exploration of the client’s mental life and psychic conflicts.

The Therapeutic Relationship

The therapeutic relationship is the interpersonal context for the activities comprising the therapeutic process. In all forms of therapy, as in all forms of social work treatment, the social worker approaches the client with an attitude of respect, acceptance, and human understanding. The affirmative qualities of this relationship facilitate the client's participation in the treatment and generally promote a sense of safety and well-being. It is generally recognized that any therapist's positive attitude toward a client engenders therapeutic effects that are independent of those produced by the therapist's specific techniques. Carl Rogers and his associates, for example, identified the therapist's empathy, genuineness, and unconditional positive regard as independent curative agents in psychotherapy (Rogers, 1957, 1961; Truax, 1963; Truax & Carkhuff, 1967). Within psychoanalytic circles, it has long been recognized that the therapist's benevolent attitudes toward the client may soften the client's harsh self-criticism (Alexander, 1925; Strachey, 1934; Kris, 1982, 1995). Alexander and French (1948) held that the therapist's conduct, if different from that of the pathogenic parent, provides a "corrective emotional experience," which disrupts the client's expectations of hurtful responsiveness. Kohut and other self-psychologically oriented therapists have cited empathy as an essential curative feature in psychotherapy (Kohut, 1984; Rowe & Maclsaac, 1993; Wolf, 1988).

Traditional psychoanalytic therapists affirm the importance of the therapeutic relationship without regarding relational factors as primary agents of therapeutic change. Most analysts distinguish between the curative effects of insight and those of relational factors (e.g., Oremland, 1991). Self-knowledge and the capacity for continuing self-inquiry, which develop in the course of psychoanalytic therapy, are qualitatively different, at least conceptually, from alterations that accrue as a result of identifications with another person or internalizations of another's positive regard for oneself. This is not to elevate the former at the expense of the latter. There is good evidence that supportive therapeutic relationships have enduring positive influence (Wallerstein, 1986). But a naive reliance on relational factors to alleviate complicated psychological problems may be superficial. Most clients, for instance, suffer from low self-esteem as a result of their psychic conflicts and maladaptive compromise formations. Recall, for example, that Mr. A was intensely self-critical in regard to his stage fright and that Ms. B always felt "inadequate." In most instances, the client's feelings of self-doubt, inadequacy, shame, or guilt will be alleviated to some degree by the therapist's positive regard (e.g., Rogers, 1957, 1961; Truax, 1963; Truax & Carkhuff, 1967). If the client internalizes the relationship with the therapist, the therapist's positive attitudes can become an inner source of positive regard that counteracts the client's self-doubts after treatment is ended. This improvement in self-esteem may enable the client to enjoy life more, establish better relationships, take new risks, and tolerate disappointments. These are very positive results, but they are not quite the same as the results attained through a psychoanalytic exploration of the client's problems. One may imaginatively compare the actual outcomes in the cases of Mr. A and Ms. B with the results that might have been achieved had they been treated by a warm and empathic therapist who did not uncover their psychic conflicts. This contrast may be observed in the following case:

Mr. C. was a twenty-eight-year-old social worker who sought therapy because he was

unable to approach women he found attractive. These women were invariably of a "classy" type, and he felt sure they would reject him. He felt painfully inadequate and inferior in relation to other men and was particularly ashamed of his penis, which he felt was too small. He had been successfully treated for this problem for three years while in college. His therapist was a "humanistic" social worker, an older man whose attitude of "support" and "friendship" had boosted his confidence sufficiently to enable him to begin dating.

Mr. C hoped I would help him, as his former therapist had, by providing him with encouragement and support. I articulated my understanding of Mr. C's wish, adding my own suggestion that we try to discover why he feels so badly about himself. Mr. C was skeptical (he had read that psychoanalytic therapy was "obsolete") but he agreed to give it a try, and we contracted for twice-weekly therapy. We soon discovered that Mr. C was reluctant to describe his romantic yearnings to me unless I explicitly assured him of my "support." Further exploration of his need for my "support" revealed that Mr. C feared I would disapprove of his sexual desires for "classy" women, that we were rivals for the love of the same woman, and that I would humiliate him for daring to poach on my turf.

Mr. C's emotional problems were the consequence of persistent oedipal conflicts. His feelings of inadequacy and low self-esteem represented, in a condensed and disguised form, his feelings of being small and inferior in relation to his father, especially regarding the size of his penis; misery about his inability to become his mother's exclusive love object; guilt over trying to displace his father in his mother's affections; and a defensively motivated stance of self-effacement and self-criticism, employed to ward off his father's punishment ("I am so inadequate and my penis is so small that I am no threat to you; I suffer so greatly already that no further punishment is needed").

Mr. C sought a nurturing, supportive therapeutic relationship in order to counteract his feelings of guilt and fear of punishment. Had I attempted to help him by providing him with "support," as his former therapist had done, he might have been sufficiently emboldened to begin dating "classy" women again, as he had after his first therapy. Such help would not, however, have enabled him to understand why he desired "classy" women or why he felt so "inadequate" when he tried to woo them. In all probability, his problems with women would have recurred, as they had after his first treatment. The use of the therapeutic relationship to reduce Mr. C's guilt and anxiety would have fostered his reliance on my support as a defense, an outcome that would promote his dependency on me and might inspire otherwise unnecessary identifications with me. While such identifications may be therapeutic in some ways, they may also complicate the client's life. Mr. C had gone to college to study journalism, a field in which he majored and in which he excelled. His decision to become a social worker was an identification, motivated by his dependence on his therapist's "support." The therapeutic relationship had enabled Mr. C to date "classy" women but saddled him with a career to which he had never aspired.

To summarize, the therapeutic relationship is central to the conduct of psychoanalytic therapy. While the therapeutic relationship may produce beneficial effects, the aim of psychoanalytic psychotherapy is the attainment of self-knowledge, not merely the

improvement of attitudes, feelings, or behavior (Eissler, 1963). Psychoanalytic therapists traditionally regard the therapeutic relationship as the interpersonal context for all therapeutic procedures. As such, it serves two essential functions. As in any other form of psychotherapy, the therapeutic relationship is a safe and supportive interpersonal context for the specialized activities comprising the therapeutic method. In psychoanalytic treatment, the therapeutic relationship also serves as an interpersonal medium for the emergence and expression of the client's psychic conflicts. This specialized use of the therapeutic relationship as a vehicle for the study of the client's mental life is unique to psychoanalytic treatment. These two dimensions of the therapeutic relationship are referred to as the helping alliance and the transference.

The Helping Alliance

Psychoanalytic therapy is a collaborative process that requires the client and therapist to cooperate, as partners in the therapeutic enterprise. This partnership is predicated on a shared understanding of the aims and methods of the treatment. The introduction and explanation of the therapeutic contract inaugurates this partnership. The therapist's conduct, including the therapist's attitude of concern and empathy, the therapist's recognizable intent to understand rather than to change or manipulate the client, the therapist's attitude of neutrality and respect for the client, and the therapist's abstinence and anonymity all contribute to the formation of a sound partnership.

If a reasonable partnership has been established, the client's cooperation will be motivated by rational considerations as well as diverse unconscious motivations, such as wishes for love, protection, nurturance, and so on. In large part, the client's cooperation will depend on the client's perception of the therapist as caring, well intentioned, and professionally competent. In a classic paper, Zetzel (1956) emphasized the importance of the client's experience of the therapist as a benevolent figure on whom he or she can safely depend for emotional nurture and support as well as therapeutic help. Zetzel characterized this aspect of the client's relationship to the therapist as the therapeutic alliance. In her view, the promotion of the therapeutic alliance is a critical priority in working with clients whose relationships are vulnerable to disruption as a result of their emotional problems. In such cases, a robust therapeutic alliance may stabilize an otherwise stormy or tenuous therapeutic relationship. Zetzel believed that the therapeutic alliance is promoted by the therapist's nurturing attitude and fueled by the revival of the client's love for the nurturing figures of childhood. Some years later, Greenson (1965) introduced the concept of the working alliance. Like Zetzel, Greenson believed that it was important to promote a productive working partnership with the client, especially where the client's capacities to co-operate were in question or prone to disruption. In contrast to Zetzel's thinking, however, Greenson envisioned the working alliance as a rational partnership, motivated by a reasonable desire to achieve realistic goals. Luborsky (1976), employing empirical research methods, discovered the existence of two kinds of alliances, which he characterized as helping alliances. Type 1 alliances are based on the client's experience of the therapist as "supportive and helpful with himself as the recipient." Type 2 alliances are based on a sense of "working together in joint struggle against what is impeding the patient" and are characterized by a feeling of shared

responsibility for the therapeutic process and a sense of “we-ness” in relation to the therapist (p. 94). Both types of alliance coexist, with a shift to the second type typically occurring as treatment progresses (Luborsky, 1984). Luborsky’s type 1 and type 2 alliances correspond closely to those described by Zetzel and Greenson, respectively.

The client’s capacity to form a helping alliance is a reliable predictor of success in psychotherapy (Luborsky et al., 1988; Luborsky, 1994). While the emergence of a helping alliance is a good prognostic sign, difficulty in establishing an alliance in the early phases of treatment is not predictive. The client who attends sessions usually has some hope of getting help, and the client’s capacity to trust the therapist or the therapeutic process often grows as a result of good treatment. Where the client’s attitude toward the therapy and the therapist is negative or stormy, the therapist has a choice of therapeutic measures. The therapist may invite the client to participate in a joint effort to examine the attitudes, feelings, or concerns that deter the client from a more productive engagement in the therapy. This invitation signals the therapist’s interest, emphasizes the importance of collaboration, and keeps the treatment on course by enabling the therapist to employ the instruments of analytic helping (i.e., listening and understanding) to the client’s problems as they show themselves in the therapy. To whatever extent the client participates in this exploration and to whatever degree this exploration reveals the cause of its disruption, the alliance and the treatment are both promoted.

Sometimes, often with more disturbed clients, the helping alliance is better promoted by noninterpretive methods. Luborsky (1984) recommends specific techniques to promote both type 1 and type 2 alliances. To encourage a type 1 alliance, he suggests the therapist “develop a liking” for the client, convey understanding and acceptance of the client as a person, communicate support for the client’s desire to achieve therapeutic goals, express a realistically hopeful attitude about attaining those goals, and provide recognition for any progress the client has achieved. He also recommends providing direct support for the client’s defenses and psychosocial functioning. To promote type 2 alliances, Luborsky suggests that the therapist encourage a “we bond,” convey respect for the client, recognize the client’s growing ability to “use the basic tools of treatment,” and refer to the experiences that the therapist and client have already been through together.

The Transference

While the helping alliance is the central and enduring basis of the client’s relationship to the therapist, the client’s attitudes toward the therapist will take on progressive complexity as therapy proceeds. In fact, the client normally develops multiple concurrent relationships with the therapist. Each reflects a different organization of motivations and mental representations of the self and of the therapist, and each is manifested by different patterns of interpersonal behavior. Mr. A, for example, began to view me as a dismissive authority whom he wished to hurt. This was manifested in the treatment situation by enthusiastic reports of his theatrical triumphs and by his occasional remarks about my ignorance about theatrical events or about my inability to help or understand him (e.g., “It’s too bad you can’t know what it’s like to receive a standing ovation so that you could understand my feelings”). Ms. B grew to fear me as a sexual predator who would use my

great powers of persuasion to seduce her. This fantasy first showed itself by expressions of anxiety about my emotional power over her. Later she expressed concern that I might suggest that we have a session over dinner, in which case she would “have” to invite me to her home for cocktails, after which she would be powerless to resist my sexual intentions. Mr. C feared that I wished to punish him for sexually approaching “classy” women and thereby “poaching” on my turf.

In these examples, the client’s view of the therapist did not fit the objective reality of the relationship actually existing between them. When asked, “What is it that gives you the feeling that I am dismissive toward you?” Mr. A angrily noted that I never attend his plays or admire his success. In response to a similar inquiry, Ms. B protested that I am too empathic, a sure sign of my sexual designs. Mr. C complained that I offer no explicit endorsement for his desires to date “classy” women, evidence of my opposition to his romantic wishes. Although these clients accurately perceived certain objective features of my behavior, they interpreted these features in a highly unrealistic way. The meanings they ascribed to my behavior reflected their own particular hopes and fears. Put simply, these clients confused me with fantasy figures, persons with whom they interact in their imaginations. This fascinating phenomenon is called *transference*.

The concept of transference was introduced by Freud when he discovered that clients often confuse the therapist with the significant figures of childhood, unconsciously attributing to the therapist various characteristics that belonged to those childhood figures. As a result of this confusion, Freud observed, the client reexperiences feelings and attitudes that originated in his or her childhood relationships as if they were aspects of the current relationship with the therapist. These feelings and attitudes are unconsciously *transferred* from the mental representations of childhood figures to the representation of the therapist. In an early paper, Freud characterized transference as a “new edition of an old object relationship,” forged under the pressure of drives seeking gratification (Freud, 1912a). Transference relationships, he observed, are highly stereotypical because each new transference relationship is modeled on the same “stereotype plate” or “template.” In a more recent contribution, Greenson (1967) defined transference as the “experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which do not befit that person but are a repetition of reactions originating in regard to significant persons of early childhood, unconsciously displaced onto figures in the present. The two outstanding characteristics of a transference reaction are: it is a repetition and it is inappropriate” (Greenson, 1967, p. 155).

These definitions correctly emphasize the confusion of past and present relationships. Transferences, however, need not reproduce the actual interpersonal relationships of childhood. These relationships, construed through the eyes of the child, are inevitably distorted as a result of the child’s immature mental functioning. An important aspect of the child’s relationship to parents and other significant caretakers are the fantasies he or she elaborates about them. These include sexual fantasies, such as Ms. B’s oedipal desires for her father, as well as aggressive fantasies, such as Mr. A’s fantasy of humiliating his father. Transference is best viewed as “a revival in current object relationships, especially to the analyst, of thought, feeling, and behavior derived from repressed fantasies originating in significant conflictual child-hood relationships” (Curtis, 1973).

Although transference was discovered in the context of the therapeutic relationship, it is actually a feature of all our interpersonal relationships (Freud, 1912a; Bird, 1972; Brenner, 1976, 1982). Whenever we encounter new people, we approach them with our own unique interpersonal agendas. Although we have realistic wishes, goals, or concerns that are appropriate to current lives, our feelings about the new person are also determined by unconscious wishes and fears of childhood origin. Even as adults we remain unconsciously attached to the love objects of childhood and unconsciously seek to relive these relationships. This is most evident in the sphere of romantic love. In romantic love, the lover's image of the beloved is formed by merging realistic perceptions of the beloved with preexisting mental representations of childhood love objects or fantasied versions of such persons. Freud (1905b) described the experience of falling in love as a process of "refinding" childhood love objects in the persons of adulthood. Transference effects this "refinding," permitting us to experience feelings of intense intimacy and familiarity with people who are actually newcomers in our lives. The exhilaration of romance is due, in part, to the unexpected joy of "refinding" these lost love objects, just as the pain of romantic disillusionment or loss is often profound grief at the "relosing" of them. This effort to refind childhood love objects explains Ms. B's love for "enchanted" men and Mr. C's fascination with "classy" women (as well as the conflicts each experienced in connection with these wishes). As illustrated in the case of Mr. A, transference may also be driven by hostile wishes, such as the wish to avenge injuries inflicted in childhood by a powerful aggressor.

Transference is sometimes conceptualized as a cognitive distortion that occurs when new persons or situations are classified according to existing categories or prototypes formed during the course of development. While this view is accurate, it does not explain the driving power of transference. Transferences are not merely automatic assumptions that are operative until proven otherwise. Transferences may have extraordinary power over the individual's mental functioning. It is often observed, for instance, that "love is blind," that lovers often idealize the objects of their romantic passion in flagrant disregard of the beloved's realistic attributes. This is not simply a result of cognitive error, but a motivated distortion, fueled by unconscious motivations, such as longings for reunion with the love objects of childhood. All transferences may be understood as attempts to gratify unconscious fantasies in the context of real life. Transference reflects the operation of the pleasure principle, which seeks to transform fantasies into actualities, to experience fantasied relationships as real interpersonal events.

Analysts have traditionally categorized transferences to the therapist as either *positive* or *negative*. Positive transferences are characterized by warm, friendly, or loving feelings. *Negative transferences* are characterized by hostile, rivalrous, or sadistic feelings. Anna Freud (1936) introduced the concept of the *transference of defense* to refer to the tendency to treat others defensively, as though they were potentially hurtful. It is also common to classify transferences according to the primary object in relation to whom the transference feelings originated (e.g., *mother transference*, *father transference*) or according to the developmental level at which the transferred feelings originated (e.g., *preoedipal transference*, *oedipal transference*). These classifications are a useful shorthand for describing the prominent features of any given transference, but they fail to convey the actual complexity of transference phenomena. No transference is purely positive or purely negative, although it may appear that way at any given moment. All

transferences, like all relationships, are ultimately ambivalent. They are constituted by complex configurations of wishes, anxieties, depressive affects, and defenses, forged in the process of development in relation to the significant figures of childhood.

Transferences, in other words, are compromise formations (Brenner, 1982).

This is also illustrated by the phenomenon of romantic love. The capacity for feelings of romance originates with the Oedipus complex. Most children develop a feeling of romantic love for one or both parents during the oedipal years (see Chapter 3 in this book). This love is normally doomed to defeat. Under normal circumstances, the child is dissuaded from his romantic quest by his inability to “win” exclusive possession of the desired parent and by feelings of guilt and fear of retaliation from the rival parent. This is a very bitter defeat for some children, leaving emotional scars such as feelings of inferiority, fear of rejection, fear of hostile or dangerous rivals, and so on. When love is aroused in adult life, it is associated with these affects of unpleasure, along with the psychological defenses habitually employed to ward them off. The adult experience of falling in love, then, cannot be described as a transference of love alone but, rather, as a transference of a whole configuration of emotional forces (Bergmann, 1987). Ms. B’s love for “enchanted” men, which represented her oedipal wish for a tryst with her father, aroused feelings of anxiety, guilt, and revulsion, which she managed in adult life, as she did in childhood, by suppressing genital feelings. Mr. C’s love of “classy” women, which represented an oedipal love of his mother, triggered guilt and fears of punishment, which he warded off in adult life, much as he did in childhood, by restricting his sexual desires, and by adopting a placating and subordinate stance to father figures in order to elicit their pity and protection.

From the clinical perspective, the most significant distinctions to be drawn in regard to the classification of transferences pertain to the subjective context in which they are experienced and understood by the client. Tarachow (1963) introduced the useful distinction between transferences that are apprehended as real and those that are experienced *as if* they were real. *As-if* transferences are relational experiences of great affective power and immediacy, but they are bounded or framed within a realistic perspective. The client recognizes the transference feelings as inappropriate to the actual character of the therapeutic relationship and thus experiences them with an attitude of reflection and curiosity. When the client experiences the transference *as if* it were real while retaining a realistic perspective, the “experiencing” and “observing” parts of the client’s personality are in a state of balance and cooperation. This is optimal for therapeutic exploration and insight.

When transference is consistently mistaken for reality, however, it may be disruptive to the therapeutic relationship, and refractory to the therapist’s efforts to interpret it. When a transference is experienced as a taken-for-granted reality, the client can experience the therapist only from within the transference frame of reference. Such a transference is called unanalyzable or, in extreme cases, a transference psychosis. If Mr. A had been convinced that I really was contemptuous of him, or if Ms. B had been certain that I really intended to seduce her, it might have been impossible for me to help them. The occurrence of an intractable and unanalyzable transference may indicate that the client requires a more supportive and reality-oriented form of therapy. Sometimes, however, an unanalyzable transference crystallizes as a consequence of subtle or unconscious aspects of the client-therapist interaction. An unanalyzable transference may

be provoked or reinforced by the therapist's eccentric, inconsistent, or irrational responsiveness to the client. This may occur when the therapist is overwhelmed by the client's transference, or when the therapist is caught up in his own transference to the client. This phenomenon is called *countertransference*. When the therapist's functioning is impaired by his or her emotional reactions to the client, an improvement in the therapist's understanding through supervision or therapy may restore the prospects for a better outcome. Sometimes, however, it is in the client's best interest to refer the client to another therapist for continued treatment.

To summarize, the helping alliance and the transference coexist as aspects of the therapeutic relationship. It is optimal for the transference to be nested within the realistic context of the helping alliance. The transference is a potentially invaluable vehicle for the communication of inner life, but it can disrupt the therapeutic enterprise if it becomes a dominant reality.

The Therapeutic Dialogue

The therapeutic dialogue is a unique form of discourse, structured to promote the exploration of the client's mental life and the discovery of the psychic conflicts that cause his or her problems. In brief, the client is invited to express, as freely as possible, all the thoughts that pass through his or her mind in the course of the session, thus giving voice to his or her stream of consciousness. This process is known as *free association*. The therapist, in turn, listens to the client's associations and forms hypotheses, or conjectures, about the psychological conflicts they reveal. When he or she has understood something that may help the client, the therapist communicates this understanding in a statement or a series of statements, sometimes referred to as interpretations. Once the therapist has spoken, the therapist returns to listening, now with a special ear for the client's response to the interpretation. The client's reactions help the therapist to judge the accuracy of the interpretation and to refine it in accordance with accumulating evidence.

Once the therapeutic situation has been initiated, the therapeutic dialogue assumes a characteristic form, determined by the aims of exploration and discovery. A basic principle is that the therapy hour "belongs" to the client. As a rule, the therapist does not open the session by selecting or suggesting a topic or in any other way influencing the client's first communications. The client begins the hour with what-ever thoughts or feelings are passing through his or her mind at that particular moment. The therapist gives the client room to settle into his or her musings, to shift from topic to topic as his or her attention is spontaneously drawn from one mental content to another. The therapist listens to the client's associations in a state of open receptivity, tuning in to the client's feelings and thoughts, as well as to his or her own reactions and intuitions.

In keeping with the goal of discovery, the therapist will not interfere with the unfolding of the client's thoughts by encouraging the client to talk about one thing at a time, or trying to "help" the client stay focused on the main point, or in any other fashion that might be natural in another context. Most therapists listen quietly for long stretches of time, intervening only when the client encounters obstacles to the free flow of his or her thoughts or when the client is attempting to clarify the feelings or reactions that have already been produced. Although the therapeutic dialogue entails multiple exchanges

between the client and the therapist, they do not occur in the same manner or rhythm as social interactions. The therapeutic interaction is not less “natural” than social dialogue. It is a “natural” expression of the unique aims of psychoanalytic therapy.

For the purpose of clear exposition, I will discuss the client’s communications first, followed by a description and explanation of the therapist’s communicative tasks. Although I discuss the communications of each party separately for the purposes of presentation, it should be recognized that I am actually describing a dialogue, albeit a most unusual one (see Kaplan, 1968).

The Client’s Communications

In psychoanalytic psychotherapy, the client is invited to participate in an unusual procedure called free association. Free association is a method for the exploration of mental life. Although psychoanalytic therapists differ in the way they introduce and explain the task of free association (Lichtenberg & Galler, 1987), most therapists instruct or, preferably, invite the client “to say whatever comes to mind, to speak freely and without regard to any purpose or agenda, to hold nothing back, to make no judgement as to what should or should not be spoken.” Free association is not merely an exhortation to extreme honesty. It is a method for promoting an altered state of mind in which the client’s attention may shift quite freely, without the organizing influence of realistic concerns or agendas. The mental activity involved in free association is characterized by the flow of thoughts from one idea to the next, and resembles the apparently aimless thought that naturally occurs when one is day-dreaming.

Free association is employed as an investigative tool because it facilitates the expression of unconscious activity. Free association reduces the organizing influence of purposeful thought and suspends the rules of normal conversation. Purposeful thought concentrates attention on a limited number of focal concerns. When purposeful thought is suspended, this concentration of attention is relaxed, and mental contents that were previously marginal or disregarded may attract notice. A second characteristic of free association is the verbalization of thoughts while they are forming. In everyday life, we think before we speak. We normally edit our thoughts for coherence, relevance, consistency, and social desirability before we communicate them. As a result, our spoken words do not readily reveal the multiple or conflicting trains of thought from which they are derived. In free association, however, the client speaks while he or she thinks. Free association thus reveals much of the raw material typically edited out in the fashioning of our normal discourse. Free association permits the client to verbalize the “inner dialogue” that occurs between the different sides of his or her personality. Citing Freud’s structural model, Bergmann (1968) characterized free association as a “trialogue” in which the voices of the id, ego, and superego may be heard.

The rationale for the technique of free association derives from the discovery that mental life is regulated by the tendency to seek pleasure and to avoid unpleasure. Unconscious wishes exert a more or less continuous pressure on all mental activity. Unconscious wishes prompt us to recall and relive past experiences of gratification and to imagine new scenes in which our wishes are satisfied. Mr. A, for instance, frequently thought about being a star, Ms. B about “enchanted” men, Mr. C about “classy” women.

If free association simply facilitated the unfettered expression of wishes, however, psychoanalysts would never have learned about psychic conflicts. The fact is that many of the client's wishes do not emerge in comfort, but in the context of unpleasurable affects. When Mr. A reported his fantasies about being a star, he was often quite anxious. When Ms. B talked about her sexual feelings toward "enchanting" men, she felt nauseated and often, for no apparent reason, also talked about women whom she felt were hostile to her. When Mr. C described his wish to date "classy" women, he felt "inadequate" and fearful of my criticism. These recurring, patterned associations between wishes and unpleasures reveal the influence of psychic conflict. Of course, the meaning of these recurring associations is rarely apparent at the outset of the treatment. Mr. A's wish to be a star was not explicitly expressed as a wish to humiliate his father, and his anxiety initially had no recognizable meaning as a fear of retribution. Ms. B's excitement about "enchanting" men, her nausea, and her concerns about the enmities of various women friends had no overtly meaningful relationship. The same may be said about Mr. C's idealized view of "classy" women, his manifest feelings of "inadequacy," and his fear of my criticism. When wishes and unpleasures repeatedly occur in the same trains of thought, however, it may be assumed that they are both aspects of an unconscious psychic conflict.

Free association, as Loewenstein, (1963), Eissler (1963), and others have emphasized, is a most difficult challenge precisely because it facilitates the experience of psychic conflict. The arousal of the client's repressed wishes inevitably triggers feelings of unpleasure, which engage the client's defenses. No client can speak without restraint or inhibition, especially at the outset of treatment. Even the prospect of free association typically stirs up feelings of embarrassment, shame, guilt, exposure, suspicion, and so on. These feelings are usually connected with the client's central conflicts. The exploration of these feelings is thus not merely preparatory to the therapeutic process; it is an essential aspect of it. It is therefore important to introduce the technique of free association in a manner that will encourage the client to discuss his or her feelings and questions about it. I generally invite the client to free-associate (rather than instruct the client). I also explain to the client that free association is naturally difficult and discomforting, and that it is just as important for us to work together to understand these discomforts as it is for us to understand anything else that free association may enable him or her to express (Loewenstein, 1963; Gray, 1986; Busch, 1994). (With clients who are unusually threatened or psychologically vulnerable, I suggest that they speak as freely as they wish. This contributes to a feeling of safety and control and enables them to cooperate with a level of openness they can handle.)

As the client expresses the various concerns and hesitations that the invitation to free-associate stirs up, the therapeutic dialogue usually gets under way. Most clients eventually try to associate as freely as they can, observing and discussing feelings of reluctance that crop up along the way. As their discomforts are reduced, their associations become freer and freer. Even when the client speaks with minimal reluctance and restraint, however, the "freedom" of the client's associations is restricted by unconscious defenses. The technique of free association is intended to suspend, or at least reduce, the client's conscious reluctance, but free association is never totally free because the expression of warded-off wishes (itself a signal of increased associative freedom) arouses associated unpleasures, which mobilize defenses that curtail or disrupt the client's

ongoing associations. This sequence of wish, unpleasure, and defense may sometimes be quite obvious, as when a client expresses a wishful fancy or musing, becomes visibly agitated or uncomfortable, and then issues another statement that undoes or modifies the meaning of the wishful communication. An obsessional client, for example, will often make a snide or hostile remark (“He’s such a pain in the neck”), express discomfort (“Please don’t get me wrong”), and then retract it (“He’s really a good guy; he’s just doing his job”). Some overt behaviors may also be recognized as serving defensive purposes. When he expressed fantasies of stardom, Mr. A not only became anxious; he also became self-critical, often severely so. For a time, Ms. B became so upset by her nausea that she had to stop speaking. Mr. C insisted on hearing expressions of support. Such sequences of mental activity are meaningful expressions of the client’s psychic conflicts.

This sequence of wish, unpleasure, and defense is not always readily recognizable. Defenses are often automatically engaged with such remarkable rapidity that no recognizable trace of the briefly aroused wish and associated unpleasure is evident in the client’s communications. Fortunately, however, free association is a sensitive instrument for the detection of such defensive functioning. When defenses have eliminated or disguised distressing contents, the associative process often betrays subtle effects of defensive tampering. This is evident as discontinuities in the flow, pauses, shifts of posture or facial expression, subtle shifts of attention to other material or environmental distractions, abrupt transitions to “more important” matters, curious non sequiturs or illogical conclusions expressed with blithe conviction, vague references or omissions in a story that may leave the therapist feeling as though he or she “missed something,” and so on. The meaning of such discontinuities can often be discerned through attention to the associative context in which it occurs. An associative context is the network of associations within which a particular thought, affect, or other event occurs. It may be defined as the thoughts that precede and follow a particular event. Discontinuities often occur regularly in the same associative contexts, that is, when the client’s associations reflect a particular theme, such as rivalry with powerful men or dependency on uncaring authorities. In such instances, the discontinuities probably reflect defensive functioning mobilized by wishes and unpleasures connected with that theme.

To summarize, unconscious wishes exert a continuous pressure on mental life. As a result, the client’s associations are shaped, in part, by the influence of his or her unconscious wishes. Unconscious wishes, however, are conflictually entangled in affects of unpleasure. This entanglement is also reflected in the client’s associations. When unconscious wishes are aroused, they emerge in association with specific affect of unpleasure. These affects habitually mobilize specific defensive operations that reduce this unpleasure. Free association reveals that specific wishes, specific unpleasures, and specific defensive operations cluster together in the same associative contexts. By systematically charting these recurring clusters of wish, pleasure, and defense in the client’s free associations, the client and therapist are able to discern the unconscious conflicts that underlie the client’s pathology.

We turn now to a discussion of the natural flow of a client’s thoughts during the course of an hour. The client’s free associations naturally begin at the surface of his or her thoughts and proceed, metaphorically, in both “vertical” and “horizontal” directions. Horizontal associations are thoughts about other surfaces that are, in one way or another,

connected with the first. Vertical associations expose progressively deeper aspects of an event or experience. This is illustrated by the following example, drawn from the treatment of Ms. D.

Ms. D was a depressed forty-four-year-old woman, a computer programmer, who was emotionally inhibited and frustrated in all her relationships. Although she had a few good women friends, her romances were all unfulfilling and painful, due to the egocentrism of the “macho” men she chose and to her own “mousiness” with them. Ms. D opened one session in the first year of her therapy by describing a dream in which she could not get a taxi in a snowstorm. With no further thoughts about the dream, she went on to describe a recurring plumbing problem that her landlord would not fix, an incident in which her boyfriend Mark arrived late for a dinner date, and finally, a childhood incident in which her father did not pick her up from school. The dream, the landlord, Mark’s lateness, and the childhood memory all evoke a similar feeling of being neglected. The data suggest that a feeling of neglect has organized the constellation of the client’s associations. Ms. D continued: “I am still bugged about the dream. It’s the same feeling. The cab drivers don’t care. I’m standing out there in the cold and no one cares. That’s the feeling: no one cares. It’s so painful, really, to feel so unimportant. I’ve felt this way so much. Other people are just so into their own things. I get so angry. You have to be a squeaky wheel to get oiled in this world ... but you can’t get too squeaky or people think you’re a crank. You always have to be nice about every damned thing. Do you know, my toilet’s been leaking for four months, and I leave a million mousy little messages on the landlord’s machine. I’m afraid to piss him off! I should have him thrown in jail! I’m also sick and tired of being so mousy around Mark. I’m sick of this Minnie Mouse and Macho Mark shit.”

In this sequence, Ms. D’s associations revealed a good deal more about her state of mind and psychic conflicts. She expressed wishes to be cared for, feelings of frustration and helplessness, aggressive wishes to fight back, anxieties about being ignored or dismissed if she does fight back, and descriptions of the “mousy” attitude with which she reduces her acute feeling of endangerment. Where the first series of associations was largely horizontal in character, these latter associations also took a vertical direction. They add to our depth of understanding. They also continued in a horizontal direction, as Ms. D linked the various episodes at deeper levels. Her anger and mousiness in relation to her landlord, for example, prompted an association with Mark. In later sessions, similar feelings emerged in connection to her father and toward the therapist. As it turned out, unspoken transference feelings were the organizing impetus behind the whole sequence of Ms. D’s thoughts in this session.

The client’s free associations often take the form of stories or “narratives” about significant relationships and situations. This reflects the centrality of interpersonal relationships in human life. Our sexual and aggressive wishes always engage us with other people. This is true even when anxieties and depressive affects disrupt relationships in extreme ways, as occurs in schizoid characters or schizophrenics. Even among those very sick individuals in whom outward relatedness is dramatically interrupted, fantasy life reflects a continuing, albeit imaginary, involvement with other people (Arlow &

Brenner, 1964). Our relationships with other people may be seen as compromise formations, formed to gratify our wishes despite our unpleasures. Of course, each of our actual interpersonal relationships is unique because each of our partners brings a different personality to the encounter. Even so, certain relatively invariant relationship patterns are usually evident in all the significant relationships of any individual (see Luborsky & Crits-Christoph, 1990). Where the individual suffers from emotional conflicts, these will generally be apparent in their relationships. It is not surprising that relationship problems are the most common complaint of clients seeking psychotherapy.

The client's stories about his or her relationships are important surfaces to be explored. They permit the therapist to identify the client's maladaptive patterns of living and to explore the psychic conflicts that shape them. In describing any one interpersonal episode, the client will typically be reminded of others in which a similar conflict or feeling is present. These associated episodes will come to include a growing number of childhood memories in which the client recalls significant experiences with parents and other childhood figures. The client's associations will also come to reflect the client's experience of the therapist. If the client is engaged in the treatment, the therapist will naturally become a person of growing importance to the client. The client may see the therapist as a person who might fulfill abandoned hopes or as one who might repeat past hurts and injuries. As the client's psychic conflicts influence his or her experience of the therapist, the transference dimension of the therapeutic relationship will become increasingly salient.

Transference typically begins to develop unconsciously and initially appears to the client as an aspect of reality. The therapist's yawn is taken as an "obvious" sign of boredom, his beard as a "self-evident" sign of religiosity, a cough as a "clear" expression of irritation. As the transference is forming, the client's free associations begin to reflect the client's emerging experience of the therapist, often in the form of indirect allusions, such as references to other figures toward whom the client harbors a similar feeling (e.g., authority figures like teachers or coaches, service providers like the taxi driver in Ms. D's dream, and so on; see Gill & Hoffman, 1982), or as expressions of interest about the therapist's life or professional activities. The client's first expressions of transference may seem trivial. On one occasion, early in his treatment Mr. A interrupted his enthusiastic description of a theatrical "triumph" to ask if I took notes. He was "just curious," he said, brushing off my inquiry about what prompted the question. He returned to his narrative, and again, as he described the audience's thunderous ovation, he paused to ask if I took notes. In a state of mounting anxiety (much like his stage fright) he expressed a fear that I might envy his "triumphs," feel humiliated to be a mere therapist while he is a "star," and that I might sell my notes about him in order to disgrace him in the eyes of his admirers. His "confession" was offered amid a flurry of self-recriminations and apologies. This intense and most revealing transference first manifested as a "simple" question—ostensibly nothing more than idle curiosity. Mr. A's deepening associations, however, provided our first glimpse of the conflict that had given rise to his stage fright: aggressive wishes to cause me (his father) to suffer from feelings of envy, coupled with fears of retribution, and a defensive attitude of self-criticism and self-denigration. Over time, the same wish, unpleasure, and defense appeared repeatedly in relation to his father, in relation to other men, in relation to the audience, as well as elsewhere.

To recapitulate, the client's associations expand horizontally and vertically. Horizontal associations link interpersonal episodes or life situations that share subjectively significant characteristics. Vertical associations expose the psychic conflicts that are significant in those situations. Most of the client's narratives will pertain to the client's current or recent relationships, to the client's childhood relationship with parents and caretakers, and to the client's ongoing relationship with the therapist. Each of these domains offers numerous surfaces for the exploration of psychic conflict.

I close this discussion with a few observations about the role of the client's non-verbal material in the therapeutic dialogue. These include *paraverbal communications*, *enactments*, and *symptoms*. Although communication in psychoanalytic therapy is predominantly verbal, the client's associations are always accompanied by paraverbal features, including the pitch, tempo, and tone of the client's voice, various facial expressions and bodily postures, and small movements of the hands or feet. These behaviors often express aspects of subjective experience of which the client is unaware or is unable to express. Paraverbal behavior often expresses un verbalized affects associated with the client's thoughts. Affects always accompany subjectively meaningful trains of thought. They can be metaphorically described as the music that accompanies the client's words. Expressions of affect are particularly notable when the words and the music do not go together. A client may announce his great joy about finally getting his divorce, while looking sad and wringing his or her hands. Another may dolefully report the same event while smiling or tapping out a tune with his fingers. When affects are incongruent with the client's manifest thoughts, they are usually appropriate to latent trains of thought. The appearance of the affect in such instances reflects the fact that affects are often harder to ward off than thoughts. These latent thoughts may be discovered by "following the affective track," that is, by asking the client to note the feeling and listening for the client's associations.

Transference is sometimes expressed through enactments. In the preceding discussion, transference has been described as an aspect of fantasy life that becomes manifest in the client's free associations. Because transference is driven by unconscious wishes, the client is motivated to confuse transference fantasy with social reality so that transference wishes may be actualized in the relationship with the therapist. As a result, transference is sometimes expressed as social behaviors, often very subtle, in-tended to induce the therapist to adopt the role he or she plays in the client's fantasy life (Boesky, 1982, 1989; Jacobs, 1991; McLaughlin, 1987, 1991; Sandler, 1976). Enactments may be regarded as expressions of the client's efforts to live out the transference with the therapist rather than to achieve insight into it (Freud, 1914a). For a period of time, Mr. A made a series of curious requests. He asked me to get him a glass of water, to pass him the tissues when he was no farther from the box of tissues than I was, to jot down a few key comments I had made so that he could refer to them later, and to save a review of his play, which he knew would appear in the particular news-paper I read. Over time, we recognized that he wished me to assume the role of a sub-ordinate assistant, a derivative of his wish to "tower over me." The following incident, taken from the case of Ms. B, is a more dramatic example of enactment.

On one occasion, Ms. B arrived at my office with her grocery shopping. While waiting for her session to begin, she put the groceries in the refrigerator of a private

kitchen, located behind a closed door in the waiting room. I learned of this when she thanked me at the end of the session for having a refrigerator handy. Having been thanked, the impulse was naturally to say, "You're welcome," a comment that would have signaled participation in the intimate arrangement Ms. B had engineered. Fortunately, I refrained from such reciprocation. In the next session, I suggested to Ms. B that we examine the thoughts that prompted her to use my refrigerator. After initially protesting that the kitchen is no more private than the bathroom, she acknowledged having viewed the kitchen as "our" kitchen, a thought that spontaneously reminded her of a recent dream in which she was living with me in the office suite. She had had no recognition of the fact that she was acting inappropriately when she blithely entered my closed-off kitchen.

These examples demonstrate that enactments have important potential communicative value. If the therapist can recognize an enactment and understand it as the behavioral expression of transference desires, he or she can help the client to verbalize and explore its emotional meaning. Enactments may thus augment the client's associations as communications of inner life.

Finally, I turn to a most fascinating phenomenon that has important communicative potential, although it is not an intentional communication. One of the most interesting events that occurs in psychotherapy is the spontaneous appearance of a symptom during a session. This is by no means rare. Mr. A often became acutely anxious during his sessions, Ms. B sometimes experienced nausea, and Ms. D frequently felt intense waves of depressive affect. Symptoms crystallize when psychic conflicts become too intense to be managed by ordinary means. The conflicts determining the symptom may be discovered by reconstructing the thoughts and feelings with which the client was struggling at the time the symptom emerged. When a symptom crystallizes during a therapy session, the therapist has an unusual opportunity to observe the thoughts that preceded and followed the onset of the symptom, that is, to study the associative context in which it has appeared. When symptoms occur frequently enough in therapy sessions, the psychic conflicts that determine them may be discerned by identifying the invariant aspects of the associative contexts in which they repeatedly occur. The study of associative contexts is a most valuable method by which a great many recurrent phenomena, including symptoms, mysterious affects, and defensive disruptions of thought (as described earlier), may be investigated (see Luborsky & Auerbach, 1969). This is illustrated by the following example:

Ms. E was a forty-one-year-old woman, a child of Holocaust survivors, who entered therapy to overcome anxieties about marrying her boyfriend of long standing. Shortly after her wedding, she developed a mysterious dermatitis, which flared up only in the company of her mother-in-law. Although prone to allergies as a child, she had never suffered from them as an adult. At first, she thought she was allergic to something in her mother-in-law's house, but she soon discovered that the worst bouts occurred when the mother-in-law visited at Ms. E's home. Neither Ms. E nor her doctor could identify the responsible allergen. Ms. E concluded that she must be allergic to something her mother-in-law wears, perhaps her perfume.

In succeeding weeks, Ms. E rarely talked about her mother-in-law and showed no

interest in doing so. The subject was raised again, however, when she suffered a particularly miserable dermatitis during an impromptu weekend visit by her mother-in-law. It seemed her mother-in-law was taking over her life, prying into her personal business, re-organizing the kitchen, and insinuating herself into private aspects of her marital life. As she spoke, Ms. E felt a mounting rage that she tried to control, saying that she did not want to hurt her mother-in-law's feelings. "But she's constantly getting under my skin," she muttered, scratching her arms and face. To my astonishment, her skin had broken out in large red splotches! The associative context of this and several later episodes revealed that the "allergen" was a state of mind in which she felt "invaded" and unable to maintain social boundaries. Although she wished to assert herself, she felt guilty about hurting a needy parent. Over time, we discovered that this dilemma recapitulated a conflict she experienced with both her parents and which had caused her anxiety about forming intimate relationships.

While psychoanalytic therapy is a method of treatment that is primarily verbal, paraverbal communications, enactments, and symptoms are important expressions of the client's inner life. Their value, however, depends on the elucidation of their meaning through the free association method. Just as the value of the transference depends on its containment within the subjective context of the therapeutic alliance, the communicative potential of nonverbal behavior is fulfilled only when its meaning is illuminated by client's verbalized associations.

Therapeutic Listening

The psychoanalytic therapist listens to the client's free associations in order to understand the client's mental life. The client's conscious thoughts are referred to as the *manifest content*, or, metaphorically, as the surface of the client's mental life. The unconscious undercurrents are referred to as *latent contents* and are metaphorically located at some depth below the surface. The therapist's goal when listening to the client's associations is to "hear" or infer the latent contents of the client's communications. The listening process by which the therapist apprehends the latent content is highly complex and differs from therapist to therapist. Freud (1912b) suggested a listening attitude of unfocused receptivity in which all conscious puzzle solving is suspended. He termed this listening stance "evenly hovering attention" and likened it to the client's free association. By suspending the therapist's inclination to conscious "figuring," evenly hovering attention diminishes the therapist's propensity to focus on contents that fit preconceived expectations or ideas about what is important. Evenly hovering attention thus enables the therapist to hear unanticipated themes and patterns in the client's associations, much as it would enable a music lover to recognize subtle themes in a complex musical composition.

Freud discovered that the client's associations elicit emotional reactions in the therapist, which provide clues to latent aspects of the client's mental state. These include resonating affects or memories from the therapist's own mental life, as well as complementary reactions to the interpersonal pressures the client is exerting in the therapeutic relationship (sometimes called the *induced countertransference*). The

therapist's own associations to the client's material will often illuminate important connections by recalling the contents of previous sessions, experiences with other patients, literary themes or figures, and so on (Freud, 1912b; Arlow, 1980). These reactions in the therapist do not reveal the client's unconscious, but they may alert the therapist to unnoticed aspects of the client's communications or enable the therapist to recognize subtle connections, patterns, or parallels between one set of observations and another.

Many analytic thinkers place special emphasis on empathy as a method for understanding the client's mental life (Fliess, 1942; Fromm-Reichmann, 1950; Green-son, 1960; Kohut, 1959; 1984; Rowe & Maclsaac, 1993; Schafer, 1959; Schwaber, 1995). Empathy is an aspect of evenly hovering attention. It may be described as an imaginative process of putting oneself in the client's shoes through "transient trial identifications" (Fleiss, 1942). The therapist imagines what it is like to be the client and then examines this empathically constructed experience to understand the client, a process characterized as "vicarious introspection" (Kohut, 1959). Through repeated empathic experiences, the therapist builds up a "working model" (Green-son, 1960) of the client's mental life, a model that is accessed and refined with each successive therapeutic encounter.

While evenly hovering attention and empathic listening prompt the therapist to form numerous impressions of the client's mental life, these processes are not sufficient to guide the therapist's interpretive activity. The therapist's impressions must be tested and refined through systematic observations of repetitive patterns in the client's thought and behavior, and they must be logically organized to form coherent conjectures about the client's mental functioning and psychic conflicts. These logical activities augment the unfocused receptivity and empathic attunement described above. In practice, then, the therapist "oscillates" between alternative states of mind, shifting back and forth between unfocused receptivity and empathy, on the one hand, and objective observation and logical analysis of the data, on the other (Arlow, 1980; Fenichel, 1941; Ferenczi, 1919; Spencer & Batter, 1990). This shifting of perspectives parallels the client's oscillation between experiencing and observing (Sterba, 1934).

Conjectures. Conjectures are the therapist's hypotheses about the client's mental life (Brenner, 1976). They are formed through the various modes of therapeutic listening and reflect the therapist's efforts to understand the client and the client's problems. The formation and refinement of conjectures is preliminary to the activity of interpretation. Conjectures vary in regard to their depth and their breadth, in accordance with the stage of the treatment and the extent of the therapist's understanding. Some conjectures pertain to the particularities of a specific moment, such as the client's reaction to a particular event, while others pertain to wider patterns of thought and behavior. Some conjectures pertain to contents that are relatively accessible to the introspection, such as a lurking feeling of sadness or a passing thought about the therapist's appearance. Others pertain to the deeper unconscious determinants of such feelings and thoughts.

Although therapists vary in the ways they arrive at conjectures, once conjectures are formed, they must be tested empirically. The therapist's formulations should correspond to the actual facts. They should accord with the contents of the client's associations, paraverbal communications, enactments, and so on. The therapist can often test the validity of a conjecture by using it to predict future behavior or associations. A school

teacher, Mr. F, described an episode in which his girlfriend acted in an obviously careless and selfish manner. After only the briefest pause, he went on to speak about her kindness and decency with unusual softness and gratitude. I conjectured that Mr. E was warding off angry feelings by adopting attitudes of a contrary character. Some moments later he became quite agitated about the selfishness of a school secretary who simply refuses to take telephone messages because “she’s too damned busy doing her nails!” This outburst provided initial confirmation, since the feelings expressed toward the secretary corresponded to those I imagined he might feel in relation to his girlfriend. I tested my conjecture further by predicting that Mr. F would again express especially loving attitudes in situations where his girlfriend behaves in a hurtful way. The repetition of the predicted pattern over a course of several months further confirmed the conjecture.

The Interpretive Process

Interpretations are statements a therapist makes to the client, by which he or she communicates an understanding of the client’s mental life. The therapist may schematically organize the interpretive task by reference to Malan’s two triangles, the triangle of conflict and the triangle of persons (Malan, 1979). Malan represents psychic conflict as an inverted triangle. The three points of the triangle represent the three components of conflict: a conflictual wish, an associated unpleasure, and a defense. The wish is represented at the bottom of the pyramid to indicate that it lies at the metaphoric root of the conflictual configuration, and the unpleasure and defense are located at the upper corners. To interpret a symptom, character trait, or any other compromise formation, the therapist must illuminate the wishes, unpleasures, and defenses that give rise to that compromise formation and elucidate the way these components are functionally connected. Such interpretations are called dynamic because they illuminate the dynamic forces (wishes, unpleasures, and defenses) that determine any given expression of mental activity.

Dynamic interpretations, or interpretations of the triangle of conflict, always link an observable surface, that is, a conscious aspect of mental life or behavior, with its unconscious roots. Dynamic interpretations can only be made, then, from a manifest point of departure. This is another way of saying that interpretation can only lead to ostensive insight when the client is in direct contact with the phenomenon being explored. It follows that psychic conflict should be interpreted when the client is struggling with some real manifestation of it, such as a problem or relationship, during the therapy session. Any important psychic conflict will be discernible in three separate spheres of the client’s life: the client’s current social relationships, the history of a client’s childhood relationships with parents and caretakers, and the client’s transference to the therapist. These three spheres may be represented by another inverted triangle, which Malan calls the triangle of persons. Childhood relationships are represented at the bottom, with current relationships and transference at the upper corners, to signify that childhood relationships influence the shape of later relationships, including the client’s current relationships and the transference. A complete interpretation of any significant psychic conflict is achieved when it has been interpreted in all three spheres. Malan describes the linking of the three corners of the triangle of conflict and the three corners

of the triangle of persons and the completion of these two triangles. The completion of the triangles enables the client to recognize madadaptive patterns of living as they occur in his life, to under-stand the psychic conflicts that fuel them, and to understand their origin in the significant relationships of childhood.

The interpretive process unfolds in a natural and systematic manner, normally proceeding in “installments” (Loewenstein, 1951) over the course of many interactions. Because interpretations are intended to connect manifest aspects of mental life with their latent determinants, effective interpretations begin with a surface that the client can directly experience. This surface, a particular state of mind, let us say, serves as a point of departure for the client’s continuing associations. As the client mulls the manifest experience, its marginal and shadowy features come into better focus. The therapist’s interventions help the client attend to these aspects or to elucidate them. As the details of experience become salient, associated contents, such as fleeting thoughts that the client had previously ignored or brushed aside, now draw the client’s attention and become new focal points of experience. These previously dismissed thoughts are themselves now manifest contents and serve as points of departure for further clarification and elucidation. The client’s deepening associations provide a continuing source of new surfaces for exploration and interpretation. The interpretive proceeds in a step-by-step advance, from one newly emergent set of contents to the next.

Of course, the associative process does not proceed in complete freedom. The client’s associations inevitably arouse feelings of unpleasure and defensiveness. As a result, resistances repeatedly impede the flow of the client’s associations. Whenever this occurs, the resistance itself becomes an important surface for interpretive work. The successful interpretation of resistance permits the resumption of the flow. Interpretations may be schematically classified as *interpretations of content*, intended to illuminate warded-off or latent contents, such as hidden feelings or impulses, or *interpretations of resistance*, intended to illuminate the interference of the client’s defenses in the associative process, as well as the unpleasures that motivate it.

Greenson (1967) described the interpretive process as a natural progression in which four different types of interventions are employed:

1. *Confrontations* (I prefer the word *observations*), comments intended to draw the client’s attention to a particular “surface.” They may be as subtle as the thoughtful repetition of a phrase the client has spoken, or they may be more explicit requests to focus on the phenomenon in question. Once a phenomenon is in focus, it must be clarified.
2. *Clarifications*, which bring out the details of a particular experience. Confrontations and clarifications help the client to apprehend experience better, but they do not expose its unconscious aspects.
3. *Interpretations*, which are communications intended to illuminate unconscious contents, such as unconscious wishes, affects, or defensive activities. Although all interventions that enhance the intelligibility of mental life may be called interpretations, some authors, like Greenson, employ this term more restrictively, to denote only interventions that “make the unconscious conscious.” (According to this convention, confrontations and clarifications are classified as interventions preparatory to interpretation.)

4. *Working through*, the continuing repetition of interpretations of a conflict as it appears over and over again in the client's history, in the client's current life outside the treatment, and in the transference (Freud, 1914; Luborsky, 1984; Menninger, 1958; Greenson, 1967; Malan, 1979).

The course of any therapy session presents the therapist with an extraordinary array of potential surfaces to explore. The therapist must decide what to interpret, when to interpret, at what level to interpret, and how to interpret. Therapists differ in their preferences for various types of surface. Some therapists prefer to interpret transference material, others prefer to begin with discontinuities in the associative process, and so on (see Levy & Inderbitzen, 1990). The choice of surface may be inconsequential since the same core conflicts lie beneath many different surfaces. What is most important, however, is the process by which the client's conflicts are explored and interpreted. The therapist's choices should be guided by a few basic principles:

1. The interpretive process always begins at the surface with a manifest content to which both the therapist and the client can attend.
2. Interpret at the point of urgency. The surface selected for interpretive work should be affectively charged, experientially immediate, and important to the client. The importance of transference interpretations derives, in part, from the affective immediacy of the transference. (Of course, transference is not always the point of urgency.)
3. Resistance should always be interpreted before warded-off contents. Any given content is warded off because it arouses intolerable unpleasures. To interpret a content that arouses intolerable unpleasures is overwhelming, perhaps even traumatizing to the client. Imagine if Ms. B were told early in treatment that her nausea is a symptom of her conflict over her desire to have sexual relations with her father. In vulnerable individuals, such "wild" or pre-mature interpretations may produce pathological states of disorganization or trigger crises in the therapeutic alliance. Even where no such crisis occurs, premature interpretations of warded-off contents usually instigate further defensiveness, which retards the therapeutic process. The timely interpretation of resistance helps the client process the unpleasure aroused by the warded-off content in manageable doses, and thus prepares the client to manage the unpleasure stimulated by the later interpretation of the warded-off content itself.
4. Interpretations should always be in the neighborhood of the client's thoughts, so that the client can readily connect the therapist's communications with his or her own immediate thoughts and feelings (Busch, 1995; Freud, 1910). Interpretations should be formulated at a depth consistent with the client's subjective experience. Interpretations of warded-off contents should be offered only when those contents are sufficiently close to the client's awareness that they may be recognized when the therapist interprets them.

In general, negative transference or other potential disruptions of the therapeutic alliance should be an interpretive priority. Many therapists, in fact, caution that the interpretation of distressing contents should be offered only in the context of a reliable

helping alliance. While this seems desirable, it is often impossible. In fact, the interpretation of distressing contents (after the interpretation of resistance, of course) often serves to enhance the alliance. On one occasion, a very disgruntled client first experienced a feeling of alliance when I, in a state of exasperation, offered a relatively “deep” interpretation that, in his words, “lanced the boil” of his confusion.

A few additional comments about the form and delivery of interpretations may be helpful. Interpretations should always be offered in the spirit of collaboration. They should always be somewhat tentative, since the therapist can never be absolutely certain of their accuracy. Incorrect interpretations are unlikely to be harmful when the client feels free to reject them. They may even prompt the client to offer a more accurate interpretation of his own. Interpretations should usually be short and simple, so that the client may hear them without losing contact with the subjective experiences being examined. If the client is drawn into protracted listening or intellectual processing, the experiential aspect of the process is disrupted. (Excellent discussions of these and other clinical rules of thumb may be found in Brenner, 1976; Greenson, 1967; Lasky, 1993; Levy, 1984; Loewenstein, 1951; and many other basic texts.)

I turn now to a more detailed discussion of interpretation of transference and resistance, the two hallmarks of the psychoanalytic approach (Freud, 1914b).

Interpretation of Transference. The interpretation of transference, like all other interpretive activity, begins at the surface with communications or behaviors that indicate transference. Transference manifestations may be subtle, fleeting, and disguised, especially when the transference is disagreeable or distressing. Transference is often expressed by paraverbal behaviors, enactments, and indirect allusions to other individuals (e.g., “My accountant is so irritating. I give him all the figures, and he gives me gobbledygook that I can’t understand!”). When transference is unacknowledged, gentle confrontations may draw the client’s attention to surface phenomena that suggest its existence. Depending on the client’s response, the therapist can comment that the client seems to be experiencing the therapist in a particular way (e.g., “I sense that you may be feeling a bit irritated with me”). The therapist might explain that feelings about other persons might come to mind during the session because they pertain to the therapist. (“Perhaps your comments about your accountant could also pertain to me. Is it possible that you might be feeling irritated at me for taking your thoughts and giving you back gobbledygook you can’t use?”) Sometimes the client will not recognize any such feeling toward the therapist or will aggressively disavow any such feeling even though the evidence for it is strong. These reactions suggest that the client is warding off the transference feelings because they are discomforting (Gill, 1979). In such cases, the therapist should address the client’s resistance.

Once the client acknowledges the transference, it can be explored. All the attitudes, perceptions, and strands of feeling that constitute the transference should be followed and carefully clarified, so that the details of the transference experience may be accurately perceived and felt. The therapist should maintain a consistent analytic attitude during this process. The therapist should be curious and empathic, without becoming reactive or overly responsive in any unusual way (e.g., to Mr. A: “It seems you are very uneasy talking about your exciting reviews with me because you worry that while I *seem* okay, I am wounded and crying inside, because I am not having as great a life as you are”). The

therapist should not “correct” the client’s transference by emphasizing how he or she *really* feels or behaves (“I understand how you feel, but let me assure you, I feel really fine. Let’s get back to the therapy now.”). Similarly, the therapist should not inform the client that his or her transference feelings really pertain to someone else (“I think this anger really belongs with your father”). Such comments prematurely dispel the transference, thus precluding its exploration. “Realistic” corrections, moreover, may strike the client as defensive, and may thus complicate the interpretive exploration of the transference.

It is often helpful to inquire about the actual experiences on which the client bases his or her transference feelings. The client may point to specific aspects of the therapist’s manner or conduct. While these perceptions are often accurate, the client’s interpretation of them will reflect the influence of his or her fantasies. Transference is always connected to current reality. The fact that the client accurately perceives certain aspects of the therapist’s personality does not mean that his or her reactions are not transferenceal. A client who feared that I might be as crazy as his psychotic mother panicked on one occasion when he saw that I was somewhat on edge. This perception of the therapist’s edginess may be accurate. The client did not know the intensity or meaning of my tension, although he was quite certain that he did. When the “missing data” were unwittingly supplied by the client’s fantasy life, he “observed” that I was “having a nervous breakdown.”

Some clients need the therapist to acknowledge the facts to which the transference is connected in order to proceed without feeling that they are “crazy” or that their therapist is “lying” to them. This acknowledgment often enables the client to relax enough to realize that the facts do not speak for themselves, and that other interpretations of the therapist’s behavior are possible. The client’s ensuing capacity to disentangle realistic perceptions from their transferenceal elaboration helps protect the client’s reality testing, and thus enables transference to be experienced and explored *as if* it were real. The client’s understanding that transference feelings may be safely communicated and jointly studied with the therapist is also promoted by the unflappable consistency of the therapist’s manner and analytic attitude.

The client’s experience and understanding of the transference may be furthered whenever transference feelings are explored. While this is often difficult for the client (and often for the therapist), the affective immediacy of the experience makes it a most productive undertaking. The intensity of the client’s transference feelings often enables them to emerge with unusual lucidity. As the client is able to describe his or her transference feelings with progressive freedom, depth, and detail, the therapist will be able to interpret specific unconscious aspects of the transference. As a result, psychic conflicts are often first illuminated in the context of transference. In Malan’s (1976) terminology, the triangle of conflict is often completed in relation to the therapist before it is completed in relation to the other spheres. As transference is understood, this knowledge helps illuminate the unconscious conflicts that have shaped the client’s other relationships, including those of childhood.

Transference interpretation, then, is central to analytic treatment. Transference is a richly textured experience, formed of multiple developmentally stratified layers of psychic conflict and compromise formation. Because transference experience is often vivid and immediate, it offers an unusually productive surface. There is another aspect of

transference, however, that makes its interpretation uniquely mutative (Strachey, 1934). Transference is a psychic reality that is subjectively immediate. It pertains to a social reality that is objectively immediate. When transference is explored in the context of the therapeutic interaction, psychic reality and social reality meet. This is uniquely mutative because it enables the client to experience the therapist as fantasied, while perceiving the therapist as he or she actually behaves. The immediacy of this contrast helps the client to appreciate the distorting effect of transference on the experience of the therapist and prompts the client to consider the possibility of distortions in other relationships. Many therapists believe that the collaborative study of the transference is the most powerful technical procedure of psychoanalytic treatment (Strachey, 1934; Gill, 1979; Malan, 1976, 1979).

Interpretation of Resistance. Psychoanalytic psychotherapy is painful because it stirs up affects of unpleasure. The arousal of these feelings mobilizes resistance. This process is largely involuntary and unconscious, and results in an infinite variety of obstacles to the progress of the treatment. Resistance is a manifestation of defenses in the context of psychoanalytic therapy. The appearance of resistance signals the client's active engagement in a psychic conflict. Resistance is thus a most promising surface for exploration. The skillful interpretation of resistance enables the client to understand and reconsider the motives for his or her defensiveness. This deepens the therapeutic process by permitting the expression of previously warded-off contents. The psychoanalytic approach to resistance is purely interpretive. The interpretation of resistance may be conceptualized as a series of steps. Schematically rendered, the therapist must demonstrate to the client *that* he or she is resisting, *how* he or she is resisting, *why* he or she is resisting, and *against what* he or she is resisting. This is a natural sequence, which begins at the the surface and proceeds, in stepwise fashion, to illuminate deeper determinants. In any given instance, this process may extend over numerous sessions or may be completed by a few terse comments.

Like all other interpretive processes, the interpretation of resistance begins with confrontations that direct the client's attention to the most recognizable manifestations of the resistance. The demonstration to the client that he or she is resisting re-orientes the client's attitude toward the manifestations of resistance. It alerts the client that these aspects of his or her functioning thwart the treatment and communicates to the client that this paradoxical functioning is meaningful and subject to exploration. A confrontation of resistance should be offered in the spirit of analytic inquiry, with the clear intent to engage the client's curiosity and self-observation. A confrontation of resistance should never be accusatory, indignant, or critical. Such attitudes communicate that the therapist thinks that the resistance is conscious, that it is willful, and that it is not allowed. Naturally such communications are utterly antithetical to psychoanalytic therapy.

The exploration of how the client resists reveals the character of the client's defenses, especially in the context of therapy. This is valuable information, because it equips the client to recognize defensive behavior and eventually to control it. A client who subjects the therapist's comments to insistent, incessant, and pointless intellectual dissection whenever the therapist's utterances strike a vulnerable nerve will be able to participate more productively when he understands that this habit is his means of disrupting the treatment. A client who gets "sleepy" whenever certain distressing thoughts arise in

therapy sessions may learn to recognize this “sleepiness” as a resistance and to bring it to the therapist’s attention so that they may work in partnership to discover the source of the client’s uneasiness.

When the client recognizes that how he or she thwarts the treatment, the therapist can invite the client to explore why he or she thwarts the treatment. If the client does not spontaneously address his or her discomforts, the therapist may note the evidence of the client’s distress. This facilitates progressive clarification of the specific affects of unpleasure that appear in the associative context of the resistance. As these unpleasures are addressed, they usually become more tolerable. This is in part due to the influence of the client’s mature judgment and reality testing, the supportive presence of the therapist, and the general ambience of safety existing in the therapeutic situation. Feelings that could not be endured in childhood, such as grief or guilt at the death of a sibling, or fears of castration by an angry parent, may be tolerated when re-experienced in adult life, especially in the context of therapy. The uncovering of these painful affects thus reduces the client’s defensiveness. As defenses are relaxed, the mental contents against which they had previously been deployed become accessible to exploration (Weiss, 1971).

When previously warded-off contents are recognizable to the therapist and believed to be sufficiently close to the client’s awareness to be recognizable, the therapist can interpret the mental content against which the client has been resisting. Although these contents will still trigger affects of unpleasure, these affects are now tolerable, and although they may still stimulate habitual defensive activity, this activity can now be inhibited because it is recognizable (the client knows how he or she resisted) and because it is no longer needed (the client knows why he or she resisted and no longer needs to). When the interpretation of resistance permits the disclosure of the contents which the client has been resisting, it becomes synonymous with interpretation of warded-off contents.

The manifestations of resistance are often rather dramatic, as in the case of clients who attempt to overturn the whole therapeutic endeavor by “proving” that the therapist is an incompetent, or by trying to engage the therapist in criminal activity (one client suggested that we sell illicit drugs together), or by attempting to seduce the therapist sexually. More common signs of resistance are latenesses or missed appointments, rigid routines, monotonous or affectless speech, repetitive material, perseveration about trivia, avoidance of particular topics, expressions of boredom with the treatment, silences, and subtle discontinuities of associative flow. The therapist’s basic approach to resistance is the same in every case. It is always interpretive, starting with a manifest surface, and proceeding in the manner described above. Let us return to Ms. D, the emotionally inhibited computer programmer.

One day during the third year of her therapy, Ms. D made an uncharacteristically affectionate comment to me. The following week, she “forgot” her therapy appointment. Recalling her unusual expression of affection, I conjectured that the “forgotten” appointment was a manifestation of resistance triggered by her affectionate feelings. In the absence of confirmatory associations by the client in her next session, I waited and tested my conjecture by predicting that future expressions of affection would be followed by similar behavior or by associations suggesting discomfort and a desire to withdraw.

Ms. D was rather cool in the weeks after the missed appointment, but gradually warmed up again after a while. Two months later, she made another affectionate comment, and again, she “forgot” the next appointment. As the resistance was now demonstrable, I drew Ms. D’s attention to the missed appointments and asked for her thoughts about it. She acknowledged that it was indeed curious. On reflection, she noted that she had felt vaguely uncomfortable after the previous session. As she mulled this experience, she recalled having been confused about the schedule. She had had a fleeting thought that I had cancelled the appointment due to vacation plans (in fact, I had cancelled a session for the following month). She’d also thought of cutting back to one session every other week.

“Well,” I said, “let’s think this over together. You felt uncomfortable in the last session. Then during the week you had the idea that I’d cancelled, and then you thought about cutting back, and then you actually did sort of cut back.” I was prepared to suggest that she might be trying to get away from therapy because something upset her, when she shook her head in bewilderment. “I don’t know how this happened. I mean, I guess I was more upset than I realize. I don’t know, but I guess I somehow avoided the session.”

“Yes, somehow,” I mulled aloud, inviting her to explore how she had arranged to “forget” the session. “I remember thinking, ‘Don’t forget your appointment, tonight’ and then . . . Actually, I called Mark—do you remember him? Macho Mark? My ‘ex.’ Any-way I called him that evening and we got into a big fight about why it never worked out, about why he was always so cold to me. It just riled me so. You know, that’s funny. The last time I forgot an appointment, it was the same thing. I’d had another fight with Mark.”

I noted that she had twice avoided the therapy session by picking a fight with Mark. “Could this all have something to do with how you were feeling after the last session? You said you were uncomfortable. Can you get back to that feeling?” Here Ms. D became irritated, and said she preferred to talk about Mark. She lambasted him for his coldness, for leading her on, for taking advantage of her sexually, and finally for humiliating her. At the end of a long tirade, she commented, “I’m so stupid. I should have seen it coming.”

In the ensuing sessions, she spoke about Mark, about how hurt she had been by him, and how she wished she had protected herself by holding herself back from loving him. Since these feelings had come up as we tried to make sense of two “forgotten” sessions, each preceded by sessions in which she expressed affection for me, and each “forgotten” by means of a telephone call and fight with Mark, it seemed reasonable to make the following interpretation: “You’ve been very agitated about Mark lately, and I’ve been wondering what brought that up. We were trying to figure out what caused you to ‘forget’ those two appointments, and since then, you’ve been thinking a lot about Mark and how much he hurt you, and how you should have pulled back. I wonder if all this might be your way of answering the question about what prompted the ‘forgotten’ appointment?”

“I don’t understand,” she said, looking a bit frightened.

“Perhaps you are afraid of being hurt by me, too?” I said softly.

As her tears began to fall, she admitted, “I’m terrified of . . . terrified of becoming attached to you.”

It is most useful to interpret resistance as it is occurring, so that the client may observe the rising affects of unpleasure and the defensive activities employed to dispel them. Paul Gray and his associates have developed a method for interpreting resistance as it manifests in the client's associations, called *close process monitoring* (Gray, 1994; Busch, 1995; Pray, 1994; Goldberger, 1996). Gray has likened close process monitoring to the work of an apple picker watching a conveyor belt for bad apples. The therapist listens to the flow of the client's material with an ear to discontinuities suggesting that the flow has been blocked by resistance. Such discontinuities may be blatant, as a massive derailment of the narrative, accompanied by paraverbal signals of distress and followed by a change of topic, or it may be quite subtle—a fleeting pause, shift of posture, and change in the affective tone with which a narrative is re-ported. Gray characterizes these moments as “breaking points” (Gray, 1986). Breaking points indicate that the client has encountered a conflict. Most important, a breaking point is an accessible manifestation of resistance that can be brought to the client's awareness.

The therapist who monitors the process with an eye to such discontinuities will listen for the moment when a resistance is evident and then draw the client's attention to it (a familiar confrontation). Gray regards as an “optimum surface for interpretive interventions a selection of those elements in the material that may successfully illustrate [for the clients] that when they were speaking, they encountered a conflict over something being revealed, which caused them involuntarily and unknowingly to react in identifiable ways” (Gray, 1986, p. 253). In Gray's view, resistance is usually prompted by feelings of guilt, which derive from the internalization of parental criticism and which the client reexternalizes onto the therapist. In his discussion of Gray's work, Busch (1995) adds that a wider range of unpleasure may stimulate resistance in the session. Busch's perspective is thus more in line with the views presented in this chapter, which in large measure derive from Brenner (1982).

Close process monitoring is a particularly useful approach to the exploration and interpretation of resistances because the breaking point is an immediate experience of conflict to which the client usually has access. Close process monitoring enables the client to participate actively in the therapeutic work. This strengthens the client's sense of ownership and responsibility for the treatment and promotes a robust helping alliance (a type II alliance). It also provides the client with the means to observe his or her own mental life independently. The client who becomes familiar with the defensive disruptions of his or her thought will be able to take note of these experiences as they occur in life. The client need not rely on the therapist's unconscious processes, or intuition, or empathy. Put simply, close process monitoring is a rational procedure, based on an empirical method, which can be practiced by any trained observer.

The Validation of Interpretations

The client's response to the therapist's communications provides an important source of data by which the therapist can assess the accuracy of his or her understanding. The therapist's interpretations may (or may not) have some impact on the client, and the client's responses may be employed to study the character of that impact. An

interpretation to the client may be viewed as an experiment whose out-come may help confirm or disconfirm the understanding on which it is based. For example, if a therapist suggests that the client may fear a particular calamity, the client's response may help the therapist determine if the interpretation is true. On one occasion, I was treating a very profoundly disturbed individual, who suffered from an itch in his perineum. The itch was particularly tormenting because he believed that scratching it would cause his legs to fall off. After listening to his thoughts for many weeks, I formed the opinion that this symptom represented a conflict over masturbation, which featured a prominent fear that his penis would be harmed. At an appropriate moment in his associations, I suggested that he might be worried about his penis falling off. "No," he said thoughtfully. "I don't worry about that at all. But I *do* worry that someone will come and chop it off."

Such a response to an interpretation is very convincing because it included the spontaneous expression of the inferred content that I had only begun to approach interpretively. The interpretation about his penis falling off was in the neighborhood of the client's fears, and this prompted a series of private thoughts that enabled the client to recognize and express his fear more accurately. Clients are often able to recognize a content about which they have been "reminded" before being able to evoke that content independently (Kris, 1956). In the case reported above, the client's capacity to experience and verbalize the warded-off fear was prepared by numerous preceding interactions that reduced the client's anxiety and heightened his feeling of safety with me, including similar episodes about other terrifying fears.

In general, the client's response to the therapist's interpretation favors the confirmation of the interpretation when it includes the expression of new material congruent with the interpretation. Other typical confirmatory responses are the spontaneous recall of forgotten events or dreams, a subjective sense that an interpretation clicks, feelings of recognition or familiarity about the contents of the interpretation, or an emotional reaction such as laughter, crying, or anger, which suggests the release of a pent-up feeling. All these reactions suggest that the interpretation has altered the balance of psychic forces, so that warded-off contents can emerge with progressive freedom from the disguises and encumbrances imposed by defenses. A single verbalization of an interpretation does not constitute a valid test of its accuracy, since no single interpretation is likely to alter this balance of forces appreciably (Brenner, 1976).

The client's assent to an interpretation is not necessarily confirmatory, since assent by itself may be motivated by numerous possible factors, such as a need to comply, or relief that the therapist is off the mark, and so on. By the same token, symptomatic improvement does not confirm an interpretation. Symptoms improve for many reasons, including the relational factors described earlier, intercurrent events in the client's life, and so on. Symptoms also improve in response to "inexact interpretations" that provide a soothing and palatable explanation for the client's anxieties or problems (Glover, 1931). However, if a particular interpretation is repeated many times and in many different contexts with no discernible impact on the client's symptoms or problems, this *does* suggest that the interpretation may be inaccurate (Brenner, 1976). (Further discussions of the "validating process" in psychoanalytic therapy—Langs, 1974—will be found in most good textbooks, including Brenner, 1976; Fenichel, 1941; Greenson, 1967; and Langs, 1974, 1977, to name but a few.)

PSYCHOANALYTIC THERAPY AND ITS MODIFICATIONS

Psychoanalytic psychotherapy is a difficult undertaking. It is intended to mobilize fantasies, feelings, and states of mind that are ordinarily painful, disruptive, and confusing. Naturally, this process is productive only if the client can tolerate these disturbing contents and turbulent emotional states and reflect on them with the most mature part of his or her personality. Psychoanalytic therapy may be damaging if the client is overwhelmed by experiences that he or she cannot psychologically digest. It follows that psychoanalytic therapy is not for everyone and that the therapist must assess the client's capacity to benefit from this form of treatment before recommending it.

In brief, psychoanalytic therapy requires that the client possess adequate ego strength to benefit from the process of uncovering without suffering severe disorganization or decompensation and without dangerous acting out. The client must be able to tolerate some measure of anxiety and depressive affect, and manage disruptive impulses safely. Moreover, since the curative process ultimately rests with the client's ability to view his or her mental life from a mature perspective, the treatment will falter unless the client has at least some capacity for mature judgment and reality testing. Participation in psychoanalytic therapy is enhanced by psychological mindedness, a capacity for sustained and cooperative interpersonal relations, and adequate motivation for this form of therapy. Psychological mindedness refers to the client's "ability to see relationships among thoughts, feelings and actions with the goal of learning the meanings and causes of his experience and behavior" (Appelbaum, 1973). To engage productively in treatment, the client must also be able to sustain a therapeutic relationship, even during periods of negative transference, frustration, or disappointment. The client will also need to be sufficiently motivated by long-term goals to tolerate the gradual character of therapeutic change.

For clients who do not possess these attributes, the technique of psychoanalytic therapy may be modified. Where the client lacks sufficient motivation for a sustained course of psychoanalytic therapy, for example, short-term treatments based on psychoanalytic theory may provide adequate relief, while in no way discouraging the client from pursuing a more open-ended therapy at a later time. I have found that "time limited dynamic psychotherapy" (Strupp and Binder, 1984) is a most serviceable, flexible, and theoretically congenial approach, which permits conversion to longer-term therapy if this is later indicated. In my experience, however, many very disturbed clients do quite well in psychoanalytic therapy if the treatment is sensitively conducted and modified to provide an adequate level of psychological support. This may include a greater degree of personal engagement with the client (Tarachow, 1963; Dewald, 1964) as well as increased attention to the therapeutic relationship, including heightened attention to subtle fluctuations in the client's experience of the therapist, more rapid interpretation of the negative transference, and the occasional use of noninterpretive means to strengthen the helping alliance (Luborsky, 1984). It should be emphasized that the therapeutic process must proceed very gingerly with more disturbed clients, whose capacity to tolerate disruptive affects is limited. In a paper that is rapidly becoming a classic, Pine (1984) introduced a series of modifications designed to improve the efficacy of interpretations by protecting the client's capacity to assimilate them without excessive

distress, loss of ego functions, or disruptions in the client's relationship to the therapist. He suggests, for example, that interpretations of disturbing contents be offered when those contents are not immediate ("strike while the iron is cold"). Sometimes the therapist may reduce anxiety by assuring the client that he or she is *not* expected to respond to an interpretation at the time it is offered. The therapist can prepare fragile clients for upsetting interpretations by alerting them that they may be upset by what the therapist is about to say. (A brief compendium of modifications for work with more disturbed clients will be found in McWilliams, 1994.)

Some clients who lack the needed ego strengths, motivation, psychological mindedness, and capacity for sustained object relations do better in suppressive or supportive therapy rather than in expressive, uncovering forms of therapy. Supportive therapies are also informed by analytic theory. These therapies, however, employ nonanalytic methods to achieve goals other than insight. Supportive therapies were created to treat clients who reacted adversely to uncovering therapies due to impaired or inadequate ego functioning. Accordingly, supportive therapy entails procedures that provide direct or indirect support to ego functioning. Supportive interventions are intended to suppress disruptive impulses and painful affects, to redirect the client's attention from the inner world to reality, to focus the client's attention on environmental challenges, and to improve adaptive functioning. The specific techniques of supportive therapy are diverse and have accumulated over the course of many years (Alexander, 1961; Bibring, 1954; Dewald, 1964; Gill, 1951, 1954; Glover, 1931; Knight, 1954; Tarachow, 1963). Standard supportive techniques include suggestion to induce adaptive attitudes; abreaction to relieve emotional tension; reassurance to relieve anxieties; advice and guidance to help foster adequate functioning and decision making; praise and encouragement for adaptive functioning; and confrontation and discouragement of maladaptive functioning. The use of these and other supportive techniques has recently been receiving more systematic attention. Two textbooks have been devoted to this form of treatment (Rockland, 1989; Werman, 1984). Rockland's volume on *psychodynamically oriented supportive therapy (POST)* provides a comprehensive exposition of the principles and practices of this form of treatment. In a promising series of papers, De Jonghe and associates (De Jonghe et al., 1991, 1992, 1994) have introduced *psychoanalytic supportive psychotherapy (PSP)*, a sophisticated supportive treatment. While PSP employs traditional supportive techniques, the emphasis is on the creation of a primary therapeutic relationship to promote emotional growth and the development of healthy psychic structures.

A CONCLUDING INVITATION

The client who consults a social worker for help with his or her problems often anticipates that the social worker will prescribe solutions in the form of things to do or ways to think. If the client has consulted a social worker who is a behavioral therapist, a cognitive therapist, or a problem-solving therapist, the client may receive a form of therapy that is more or less in keeping with those expectations. If the client has consulted a psychoanalytic therapist, however, he or she is likely to hear the most astonishing response. If the social worker has decided that a course of psychoanalytic therapy is indicated, he or she will inform the client that there is far more to be understood about the

client's problems than can be learned in a single discussion or even in a single series of discussions. The client will probably be surprised to hear from the social worker that the best way to overcome his or her problems is to understand himself or herself as a person, as an individual with a unique life story.

The psychoanalytic therapist extends to the client a remarkable invitation to explore the innermost realms of his or her private self for the sole purpose of self-understanding in the service of a freer and more authentic selfhood. It is probably unlike any other invitation the client has ever received. It is certainly unlike any-thing the client had in mind when he or she first consulted the therapist. The client who accepts this invitation may encounter many surprises about his or her own inner life. Many of these discoveries are disturbing, especially at first. Over time, other discoveries may occasion joy, often an indescribable joy, as when the client conquers a fear, recognizes a self-defeating habit and masters it, or rediscovers a capacity to love, laugh, or think independently. Psychoanalytic therapy is an extraordinary experience for many clients. But it is rarely what they expected.

The reader of this chapter may similarly discover that psychoanalytic therapy is not like any other form of treatment that he or she has studied before. To be sure, psychoanalytic therapy is not a simple form of treatment for the alteration of specific or delimited problems. It is not a method of modifying the client's behavior or social functioning in any particular direction. It is a treatment for the "psyche," a therapy for the soul. To the reader who finds these ideas intriguing, who would like to help disturbed clients in a profound and private way, this chapter is an invitation to explore the universe of psychoanalytic ideas.

REFERENCES

- Alexander, F. (1925). A metapsychological description of the process of cure. *International Journal of Psychoanalysis*, 6, 13-34.
- Alexander, F. (1954). Psychoanalysis and psychotherapy. *Journal of the American Psychoanalytic Association*, 2, 722-733.
- Alexander, F. (1961). *The scope of psychoanalysis*. New York: Basic Books.
- Alexander, F., & French, T. M. (1948). *Psychoanalytic therapy: Principles and applications*. New York: Ronald Press.
- Appelbaum, S. A. (1973). Psychological mindedness: Word, concept and essence. *International Journal of Psychoanalysis*, 54, 35-46.
- Arlow, J. (1980). The genesis of interpretation. In H. Blum (Ed.), *Psychoanalytic explorations in technique: Discourse on the theory of therapy* (pp. 193-206). New York: International Universities Press.
- Arlow, J., & Brenner, C. (1964). *Psychoanalytic concepts and the structural theory*. New

- York: International Universities Press.
- Bergmann, M. (1968). Free association and the interpretation of dreams. In J. E. Hammer Ed.), *The use of interpretation in treatment* (pp. 270-279). New York: Grune and Stratton.
- Bergmann, M. (1987).s New York: Columbia University Press.
- Bibring, E. (1954). Psychoanalysis and the dynamic therapies. *Journal of the American Psychoanalytic Association*, 2, 745–770.
- Bird, B. (1972). Notes on transference: Universal phenomenon and the hardest part of analysis. *Journal of the American Psychoanalytic Association*, 20, 267–301.
- Boesky, D. (1982). Acting out: A reconsideration of the concept. *International Journal of Psychoanalysis*, 63, 39–55.
- Boesky, D. (1989). Enactments, acting out, and considerations of reality. Paper presented on Panel on Enactments, Meeting of the American Psychoanalytic Association. Reported in Panel on Enactments in psychoanalysis, M. Johan (reporter). *Journal of the American Psychoanalytic Association*, 40, 827–841.
- Brenner, C. (1976). *Psychic conflict and psychoanalytic technique*. New York: International Universities Press.
- Brenner, C. (1982). *The mind in conflict*. New York: International Universities Press.
- Brenner, C. (1994). The mind as conflict and compromise formation. *Journal of Clinical Psychoanalysis*, 3, 473–488.
- Busch, F. (1994). Some ambiguities in the method of free association and their implications for technique. *Journal of the American Psychoanalytic Association*, 42, 363–384.
- Busch, F. (1995). *The ego at the center*. Northvale, NJ: Jason Aronson.
- Curtis, H. (1973, May). *Toward a metapsychology of transference*. Paper presented to the annual meeting of the American Psychoanalytic Association, New York.
- Dewald, P. (1964). *Psychotherapy: A dynamic approach*. New York: Basic Books.
- Dorpat, T. (1977). On neutrality. *International Journal of Psychoanalytic Psychotherapy*, 6, 39-64. Dowling, S. (Ed.). (1991). *Conflict and compromise: Therapeutic implications*. New York: International Universities Press.
- Eissler, K. (1958). Notes on problems of technique in the psychoanalytic treatment of

- adolescents with some remarks on perversions. *Psychoanalytic Study of the Child*, 113, 223–254.
- Eissler, K. (1963). Notes on the psychoanalytic concept of cure. *Psychoanalytic Study of the Child*, 18, 424-463.
- Fenichel, O. (1941). Problems of psychoanalytic technique. New York: Psychoanalytic Quarterly. Ferenczi, S. (1919). On the technique of psychoanalysis. In *Further contributions to the theory and technique of psychoanalysis*. London: Hogarth Press, 1951.
- Fliess, R. (1942). The metapsychology of the analyst. *Psychoanalytic Quarterly*, 11, 211–227.
- Franklin, G. (1990). The multiple meanings of neutrality. *Journal of the American Psychoanalytic Association*, 38, 195–220.
- Freud, A. (1936). *The ego and the mechanisms of defense*. New York: International Universities Press.
- Freud, S. (1905a). Fragment of an analysis of a case of hysteria: prefatory remarks. *Standard Edition*, 7, 3-122.
- Freud, S. (1905b). Three essays on the theory of sexuality. *Standard Edition*, 7, 125–243.
- Freud, S. (1909). Notes upon a case of obsessional neurosis. *Standard Edition*, 10, 153–318.
- Freud, S. (1910). “Wild” psycho-analysis. *Standard Edition*, 11, 219–230.
- Freud, S. (1912a). The dynamics of the transference. *Standard Edition*, 12, 97–108.
- Freud, S. (1912b). Recommendations to physicians practicing psycho-analysis. *Standard Edition*, 12, 109–120.
- Freud, S. (1914a). Remembering, repeating and working through. *Standard Edition*, 12, 145-156.
- Freud, S. (1914b). On the history of the psychoanalytic movement. *Standard Edition*, 14, 7–66
- Freud, S. (1919). Lines of advance in psycho-analytic therapy. *Standard Edition*, 17, 157–168.
- Fromm-Reichman, F. (1950). *Principles of intensive psychotherapy*. Chicago: University of Chicago Press.

- Gill, M. M. (1951). Ego psychology and psychotherapy. *Psychoanalytic Quarterly*, 20, 62-71.
- Gill, M. M. (1954). Psychoanalysis and exploratory psychotherapy. *Journal of the American Psychoanalytic Association*, 2, 771-797.
- Gill, M. M. (1979). The analysis of transference. *Journal of the American Psychoanalytic Association* (Supplement), 27, 263-289.
- Gill, M. M., & Hoffman, I. Z. (1982). A method for studying the analysis of aspects of the patient's experience of the relationship in psychotherapy and psychoanalysis. *Journal of the American Psychoanalytic Association*, 30, 137-167.
- Gitelson, M. (1952). The emotional position of the analyst in the psychoanalytic situation. *International Journal of Psychoanalysis*, 33, 1-10.
- Glover, E. (1931). The therapeutic effect of inexact interpretations: A contribution to the theory of suggestion. *International Journal of Psychoanalysis*, 12, 397-411.
- Goldberger, M. (Ed.). (1996). *Danger and defense: The technique of close process attention*. Northvale NJ: Jason Aronson.
- Goldstein, E. (1994). Self-disclosure in treatment: What therapists do and don't talk about. *Clinical Social Work Journal*, 22, 417-433.
- Gray, P. (1982). "Developmental lag" in the evolution of technique for psychoanalysis of neurotic conflict. *Journal of the American Psychoanalytic Association*, 30, 621-655.
- Gray, P. (1986). On helping analysands to observe intrapsychic activity. In A. B. Richards & M. S. Willick (Eds.). *Psychoanalysis: A science of mental conflict*. Hillsdale, NJ: Analytic Press, 1986.
- Gray, P. (1994). *The ego and the analysis of defense*. Northvale, NJ: Jason Aronson.
- Greenson, R. R. (1965). The working alliance and the transference neurosis. *PQ*, 34, 158-181.
- Greenson, R. R. (1967). *The technique of psychoanalysis*. New York: International Universities Press.
- Greenson, R. R. (1960). Empathy and its vicissitudes. *International Journal of Psychoanalysis*, 41, 418-424.
- Hoffer, A. (1985). Toward a definition of psychoanalytic neutrality. *Journal of the*

- American Psychoanalytic Association, 33, 771-796.*
- Jacobs, T. (1991). *The use of the self: Countertransference and communication in the analytic situation*. Madison, CT: International Universities Press.
- Jonghe, F. De, Rijnierse, P., & Janssen, R. (1991). Aspects of the analytic relationship. *International Journal of Psychoanalysis, 72, 693-707.*
- Jonghe, F. De, Rijnierse, P., & Janssen, R. (1992). The role of support in psychoanalysis. *Journal of the American Psychoanalytic Association, 40, 475-500.*
- Jonghe, F. De, Rijnierse, P., and Janssen, R. (1994). Psychoanalytic supportive psychotherapy. *Journal of the American Psychoanalytic Association, 42, 421-446.*
- Kaplan, D. (1968). Dialogue in classical psychoanalysis. In E. Hammer (Ed.), *Use of interpretation in treatment* (pp. 129-140). New York: Grupe and Stratton.
- Knight, R. P. (1954). Evaluation of psychotherapeutic techniques. In R. P. Knight & C. R. Friedman (Eds.), *Psychoanalytic psychiatry and psychology*. New York: International Universities Press.
- Kohut, H. (1959). Introspection, empathy, and psychoanalysis. *Journal of the American Psychoanalytic Association, 7, 459-483.*
- Kohut, H. (1984). *How does analysis cure?* Chicago: University of Chicago Press.
- Kris, A. (1982). *Free association: Method and process*. New Haven, CT: Yale University Press.
- KM, A. (1995). Support and psychic structural change. In M. J. Horowitz, O. F. Kemberg, & E. J. Weinshel (Eds.), *Psychic structure and psychic change: Essays in honor of Robert Wallerstein* (pp. 95-115). Madison, CT: International Universities Press.
- Kris, E. (1956). The recovery of childhood memories in psychoanalysis. In *The selected papers of Ernst Kris*. New Haven, CT: Yale University Press, 1975.
- Langs, R. (1973). *The technique of psychoanalytic psychotherapy (Vol. 1)*. New York: Jason Aronson.
- Longs, R. (1974). *The technique of psychoanalytic psychotherapy (Vol. 2)*. New York: Jason Aronson.
- Langs, R. (1977). *The therapeutic interaction: A synthesis*. New York: Jason Aronson.
- Lasky, R. (1993). *The development and dynamics of the psychoanalytic process*.

- Northvale, NJ: Jason Aronson.
- Levy, S. T. (1984). *Principles of interpretation*. New York: Jason Aronson.
- Levy, S. T. (1985). Empathy and psychoanalytic technique. *Journal of the American Psychoanalytic Association*, *33*, 353-378.
- Levy, S. T., & Inderbitzen, C. B. (1990). The analytic surface and the theory of technique. *Journal of the American Psychoanalytic Association*, *38*, 371-392.
- Lichtenberg, J. D., & Caller, F. (1987). The fundamental rule: A study of current usage. *Journal of the American Psychoanalytic Association*, *35*, 47-76.
- Loewald, H. (1971). Some considerations on repetition and the repetition compulsion. *International Journal of Psychoanalysis*, *52*, 59-66.
- Loewenstein, R. (1951). The problem of interpretation. *Psychoanalytic Quarterly*, *20*, 1-14.
- Loewenstein, R. (1963). Some considerations on free association. *Journal of the American Psychoanalytic Association*, *11*, 451-473.
- Luborsky, L. (1976). Helping alliances in psychotherapy: The groundwork for a study of their relationship to outcome. In J. L. Claghorn (Ed.), *Successful psychotherapy* (pp. 92-116). New York: Brunner/Mazel, 1976.
- Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment*. New York: Basic Books.
- Luborsky, L. (1994). Therapeutic alliances as predictors of psychotherapy outcomes: Factors explaining the predictive success. In A. Horvath & L. Greenberg (Eds.), *The working alliance: Therapy, research and practice* (pp. 38-50). New York: Wiley.
- Luborsky, L., & Auerbach, A. H. (1969). The symptom-context method: Quantitative studies of symptom formation in psychotherapy. *Journal of the American Psychoanalytic Association*, *17*, 68-99.
- Luborsky, L., & Crits-Christoph, P. (1990). *Understanding transference: The CCRT method*. New York: Basic Books.
- Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from psychotherapy? Predicting therapeutic outcomes*. New York: Basic Books.
- Malan, D. (1976). *Toward the validation of dynamic psychotherapy*. New York: Plenum.

- Malan, D. (1979). *Individual psychotherapy and the science of psychodynamics*. London: Butterworths.
- McDevitt, J. (1996). The continuity of conflict and compromise formation: A 25 year follow-up. *Journal of the American Psychoanalytic Association* (in press).
- McLaughlin, J. T. (1987). The play of transference: Some reflections on enactment in the psychoanalytic situation. *Journal of the American Psychoanalytic Association*, 35, 557-582.
- McLaughlin, J. T. (1991). Clinical and theoretical aspects of enactment. *Journal of the American Psychoanalytic Association*, 39, 595-614.
- McWilliams, N. (1994). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process*. New York: Guilford.
- Menninger, K. (1958). *The theory of psychoanalytic technique*. New York: Basic Books.
- Modell, A. (1976). "The holding environment" and the therapeutic action of psychoanalysis. *Journal of the American Psychoanalytic Association*, 4, 285-307.
- Oremland, J. (1991). *Interpretation and interaction: Psychoanalysis or psychotherapy*. Hillsdale, NJ: Analytic Press.
- Orr, D. (1954). Transference and countertransference. *Journal of the American Psychoanalytic Association*, 2, 621-670.
- Paniagua, C. (1985). A methodological approach to surface material. *International Review of Psychoanalysis*, 12, 311-325.
- Paniagua, C. (1991). Patient's surface, clinical surface and workable surface. *Journal of the American Psychoanalytic Association*, 39, 669-685.
- Pine, F. (1984). The interpretive moment. *Bulletin of the Menninger Clinic*, 48, 54-71.
- Poland, W. (1984). On the analyst's neutrality. *Journal of the American Psychoanalytic Association*, 32, 283-299.
- Poland, W. (1992). From analytic surface to analytic space. *Journal of the American Psychoanalytic Association*, 40, 349-380.
- Pray, M. (1994). Analyzing defenses: Two different methods. *Journal of Clinical Psychoanalysis*, 3, 87-126.
- Rapaport, D. (1960). *The structure of psychoanalytic theory: A systematizing attempt*. New York: International Universities Press.

- Richfield, J. (1954). An analysis of the concept of insight. *Psychoanalytic Quarterly*, 23, 390-408.
- Rockland, L. (1989). *Supportive therapy: A psychoanalytic approach*. New York: Basic Books.
- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-103.
- Rogers, C. (1961). *On becoming a person*. Boston: Houghton Mifflin.
- Rowe, C., & MacIsaac, D. (1993). *Empathic attunement: The technique of self-psychology*. New York: Jason Aronson.
- Sandler, J. (1976). Countertransference and role-responsiveness. *International Review of Psychoanalysis*, 3, 43-47.
- Schafer, R. (1959). Generative empathy in the treatment situation. *Psychoanalytic Quarterly*, 28, 342-373.
- Schafer, R. (1983). *The analytic attitude*. New York: Basic Books.
- Schwaber, E. A. (1995). The psychoanalyst's mind: From listening to interpretation—a clinical report. *International Journal of Psychoanalysis*, 76, 271-281.
- Shapiro, T. (1984). On neutrality. *Journal of the American Psychoanalytic Association*, 32, 269-282.
- Spencer, J. & Baiter, L. (1990). Psychoanalytic observation. *Journal of the American Psychoanalytic Association*, 38, 393-421.
- Sterba, R. (1934). The fate of the ego in psychoanalytic therapy. *International Journal of Psychoanalysis*, 15, 117-126.
- Strachey, J. (1934). The therapeutic action of psychoanalysis. *International Journal of Psychoanalysis*, 15, 127-159.
- Strupp, H., & Binder, J. (1984). *Psychotherapy in a new key: A guide to time limited dynamic psychotherapy*. New York: Basic Books.
- Sullivan, H. S. (1956). *Clinical studies in psychiatry*. New York: Norton.
- Tarachow, S. (1963). *An introduction to psychotherapy*. New York: International Universities Press.

- Truax, C. B. (1963). Effective ingredients in psychotherapy: An approach to unraveling the patient-therapist interaction. *Journal of Counseling Psychology, 19*, 256-263.
- Truax, C. B., & Carkhuff, R. (1967). *Toward effective counseling and psychotherapy: Training and practice*. Chicago: Aldine.
- Wallerstein, R. S. (1965). The goals of psychoanalysis: A survey of analytic viewpoints. *Journal of the American Psychoanalytic Association, 13*, 748-770.
- Wallerstein, R. S. (1986). *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy*. New York: Guilford.
- Weiss, J. (1971). The emergence of new themes: A contribution to the psychoanalytic theory of therapy. *International Journal of Psychoanalysis, 52*, 459-467.
- Weiss, J. (1993). Empirical studies of the psychoanalytic process. *Journal of the American Psychoanalytic Association, 41* (Supplement), 7-29.
- Weiss, J., & Sampson, H. (1986). *The psychoanalytic process: Theory, clinical observation and empirical research*. New York: Guilford.
- Werman, D. S. (1984). *The practice of supportive psychotherapy*. New York: Brunner/Mazel.
- Wolf, E. (1988). *Treating the self*. New York: Guilford.
- Zetzel, E. (1956). Current concepts of transference. *International Journal of Psychoanalysis, 37*, 369-376.