# 3. Psychoanalytic Therapy

S. NACHT

IT WAS BREUER IN VIENNA in 1881 and Janet at Le Havre who made practically simultaneous observations which eventuated in the discovery of psychoanalysis. Janet published *Mental Automatism* in 1889, whereas Breuer's *Studies on Hysteria* in 1893 awaited the collaboration and the impetus of Freud.

The discovery consisted of this: hysteric symptoms appeared related to emotionally painful events which were buried by the patient under forgotten material. The recall of these events by the patient brought about the loss of hysteric symptoms. This recall was accomplished under hypnosis and was accompanied by considerable emotional reaction. Janet wrote: "We would have to go over all of physical pathology to show the disorders that are produced by the exclusion from personal consciousness of one thought. An idea, like a virus, develops in a part of the person that the subject cannot reach, troubles his conscience and provokes all the accidents of hysteria and madness." (*Mental Automatism,* 1889.)

Freud* (1895), speaking about the theory according to which symptoms arise from forgotten events, said, "This theory throws light on the genesis of symptoms. In so doing it underscores the significance of emotional life and the importance of distinguishing between conscious and unconscious action. The theory introduces a dynamic factor in showing the symptom as a result of accumulated affect, and an economic factor in considering the same symptom as a result of the displacement of a mass of energy ordinarily engaged in a different channel. Breuer called our method cathartic. We had, as the therapeutic goal, bringing the affective charge into

* See also Breuer and Freud, *Studies on Hysteria,* 1893.

normal channels, so that it could flow instead of remaining blocked in false paths."

In these few words are contained the master ideas around which Freud was to build his work. The theoretic explanation of the therapeutic effect was inspired by the "principle of constancy" of Helmholz-Fechner that was accepted at that time in physics and in physiology. Perhaps the prestige of the principle explains why Freud for twenty years concentrated his therapeutic efforts on the recall of forgotten events before realizing the vainness of these efforts. For about ten years, Freud used hypnosis on his patients in an effort to uncover memories that could have had a traumatizing effect. The evocation of these memories was accompanied by emotional discharge and was helpful. Symptoms disappeared, at least temporarily.

This was the period of hypnotic catharsis. But Freud gradually discovered the disadvantages of hypnosis: all patients could not be hypnotized, the therapeutic effects were not certain, and, above all, the state of dependency of the patient on the physician was undesirable. (Here we see the prefiguration of the fundamental discovery of transference.) For these reasons Freud discarded hypnosis.

Next came the period of waking catharsis where the patients, under pressure from the doctor, were encouraged to remember forgotten events. Freud rapidly gave up this method but it enabled him to discover the strength of certain resistances operating against the patient's recall.

He then devised the "free association" technique in order to bypass this obstacle. The patient was asked to relinquish control over his thoughts and to express them in the way they came to his mind (*Psychoanalysis,* Freud, 1904). This period of technical research continued until 1914. The material given in "free association" was interpreted with the object of reconstructing the past and also in order to overcome the resistances that opposed themselves to the unfolding of the pathogenic and traumatizing memory. The objective was the same: to look for and find lost memories, but the method of operation had changed. It was no longer necessary to force the unconscious to deliver the material. It was then possible to get at the material through the interpretation of varied manifestations of the unconscious functioning.

This work of interpretation was of considerable value in gaining knowledge of the unconscious, but it was not without certain draw-

backs as far as therapy was concerned. The analyst and the analysand ran the risk of becoming engrossed in the intellectual pursuit of reconstructing the past to the detriment of the therapeutic action. This risk cannot be completely avoided even today. The knowledge of the unconscious, instead of being a means to an end, becomes an end in itself, both to the patient and to the therapist.

At the same time as Freud noted this intellectual aspect of his work, he discovered and evaluated more and more clearly the emotional quality of the analytic situation. This aspect emerged as the most vital one of the psychoanalytic process. This alone enables the patient to relive situations that he has suppressed, but it may also become the root of resistances that prove to be an obstacle to the rethinking of the traumatic situations and may obstruct the rational consideration of the problem (*Dynamics of Transference,* 1912). Freud clearly defined the role of the analyst: He must be neutral. He functions as a mirror that must reflect everything the patient wishes to project on it. He must adopt as a fundamental rule the quality of "floating attention."

It is easy to imagine what psychoanalytic treatment was like at that time. The patient was encouraged to submit to the "fundamental rule" that consisted of saying everything that came to his mind. The doctor had to listen to him with "floating attention," allowing himself to follow the suggestions that the patient's material brought up within the analyst. The material gathered under these conditions and the emotional reactions of the patient in regard to his analyst (transference) were interpreted by the doctor with the view of recalling the past. The dispelling of the infantile amnesia responsible for the neurosis was the essential goal of treatment, for at that time such recall constituted the whole cure.

This ceased to be true after the publication of Freud's article *Recall, Repetition and Elaboration* (1914). This study is a landmark in the development of analytic therapy and theory. The article states that the therapist must pursue the goal of dispelling the infantile amnesia "even if he knows that this goal is unattainable." Freud had understood that the recall of traumatic memories was made difficult, or even impossible, because of the unconscious resistances of the patient. He grasped an essential fact: Instead of simply remembering, the patient repeats and repeats a past that is charged with fear. The interpretation of unconscious material that

stands in the way of recall has as its goal the conquering or destroying of the resistances. This is a long and arduous piece of work, but essential, because it is by this process that ego modification may be effected. The cure is not obtained by removing amnesia but comes from personality changes that analytic therapy is able to effect. The theoretic concepts formulated by Freud regarding psychic organization (*The Ego, the Id and the Superego,* 1921) accentuated this orientation of analytic therapy.

Freud and his group, after having concentrated specifically on the new world of the unconscious, started in 1920 to concentrate their work on that which was operative in repression. From this point on the function of the ego and its reaction with the id take a growing place in the preoccupations of the analyst. At the same time, the neurosis appears to be the result of a disturbance in the total personality. This concept affected analytic technique. Therapy no longer proposed to cure by reconstructing the past life of the patient with materials that had been repressed and buried in the unconscious and laboriously excavated by the analyst. Therapy now proceeded to reconstruct the personality in its entirety by modifications that it effected in the functions of the ego. Analysis ceased to be an interesting study of the unconscious and became the reorganization of an ego disturbed by the pressures of impulses and by the demands of the environment. One was, in this way, brought to understand that the dispelling of the amnesia was not the cause of the progress toward recovery but the consequence of the modification of the ego. "One does not recover by remembering, but one remembers as one recovers."*

Parallel with the influence of these new concepts, psychoanalytic technique was undergoing another change. S. Ferenczi and O. Rank pointed out the important therapeutic value of the emotional experiences lived by the patient during the course of his analysis (*Development of Psychoanalysis,* 1924). This phenomenon remains the essential preoccupation of psychoanalytic technique today. Intellectual reconstructions through interpretation have no therapeutic value unless they are confirmed by what the patient experiences affectively. This resume was necessary in order to appreciate the present concepts of analytic therapy.

* Alexander: *Genesis of the Castration Complex,* 1930.

## Principles and Techniques of Analytic Therapy Today

The "psychic apparatus" is made up of three parts: the id, the ego and the superego. Psychic activity is the result of the interaction of these three forces. Therefore, all psychic disturbance reflects a disturbance in the total personality. Analytic theory and experience demonstrate that the id, or elementary unconscious, is not accessible to direct action. Essentially, instinctual forces are not modifiable. Only the ego and the superego are altered by therapy. That which was forbidden by the superego and repressed by the ego may become permissible, integrated, differentiated, and then finally acted upon by the ego with the end-result of the obtaining of realistic gratification.

This is the outline of the psychoanalytic cure. It is produced by the double effect of the climate created by the analytic situation and by the activity of the analyst. When the patient perceives the climate of the analysis as a permissive and a reassuring one, his superego has a tendency to become more lenient and more tolerant. In such an atmosphere, the ego also more willingly faces the demands of the id and learns to use some of its energy to compromise with the demands of reality.

When things stop at this point (and sometimes they do), we witness apparent recoveries with ephemeral loss of symptoms. The improvements are not consolidated because they are obtained without the necessary dynamic and economic modifications that are indispensable for definite recovery. Deeper modifications are obtained by the double participation of the analyst and the patient, a form of relationship that creates the second element of therapy. By evoking responses from the patient, the analyst forces the patient to participate in the climate of the analysis. This explicit participation of the patient, lived by him on the conscious level, enables the ego to modify itself, and this is the necessary condition of a durable recovery. This dialogue, initiated by the analyst, will also be the root of the obstacles that will stand in the way of the patient's recovery.

Briefly, the "climate" of the analytic situation is favorable to improvement on the superficial level (just as one sees a child's behavior improve when he is in presence of improved parents), but recovery on a deeper level can only be achieved through the conscious par-

ticipation of the patient, his explicit and experienced role in the dialogue, so that his insights become integrated into his ego.

The active role of the analyst is therefore a double one. By his interventions he provokes emotional responses that give the analysis its affective content, and, at the same time, by his interpretations he must make these reactions available to the conscious thinking of the patient. These progressive awarenesses are, in the long run, the elements of a durable recovery.

However, these emotional reactions, whether they come about spontaneously or whether they are brought about by the intervention of the analyst, provoke resistances that impede insight. The analyst then is in the paradoxic situation of bringing about situations that oppose recovery. The emotional reactions of the patient will stand in the way of insight so long as the resistances are not handled by the treatment. Psychoanalytic treatment attempts to maintain the emotional climate that will lead to new insights, at the same time as it labors to destroy the resistances arising from these reactions. All of this makes transference the pivot of the analytic technique.

Freud saw in the transference a one-way movement, from the analyst to the patient. The role of the "mirror" that Freud assigned to the analyst indicates that he saw the analyst as being the receiver of whatever was projected on to him, rather than being an active participant in the dialogue. For Freud, as for all the early analysts, the analytic situation was not conceived of as a relationship between two persons with a mode of exchange. The existence of countertransference was noted by Freud, but he put aside this aspect. Nowadays, psychoanalysts are convinced of the prime importance of the relationship between analyst and patient, and countertransference is at least as important as transference in the analytic technique.

The analyst now faces a dual role: He must grasp, understand and explain all the movements that occur in the transference of the patient to his analyst and, at the same time, grasp, understand and overcome all the movements that sway him, the analyst, toward or away from his patient. This second task became feasible for the analyst when his inner freedom became assured through didactic analysis.

One of the major difficulties faced by the analyst is that of having constantly to draw on his own personality reserves. The necessity

to be present without unduly imposing himself and to feel and act as if he was not affected can only be done by the analyst who has acquired a great deal of freedom in direct communication with his own unconscious and the unconscious life of others. Primarily, he must have the capacity of facing and handling the patient's demands for love and his explosions of hatred.

Thus, we are often brought to say that what counts in an analysis is not so much what the analyst "does" or "says" as what he "is." What the analyst does and says he has learned, but the use he makes of what he learns depends upon his own personality. This is what makes a didactic analysis so essential. Whatever the value of a didactic analysis, however, it will not make a good analyst out of all those who submit to one; certain innate gifts are necessary.

**Technical Rules of Analysis**

The rules which underlie the analytic situation apply in part to the patient, in part to the therapist, and some apply to both.

The first rule is what Freud called *the fundamental rule,* that of free association. The patient must, during the hour, do his best to express all that he thinks and all that he feels just as he thinks and feels it. This means that he should verbalize each picture, each thought, each sensation in the order of their appearance in the conscious field without exercising any control or choice. Freud first attempted to recapture forgotten or repressed memories by abolition of censorship. Later on, the method of "free association" appeared to be the best condition for the patient to express psychic content that, when interpreted, would allow fruitful gains in awareness ("What is unconscious must become conscious, or more exactly, what is id must become ego." Freud). In this respect the suggestion given to the patient to obey the fundamental rule remains valid. However, experience has taught us that we must keep in mind that this rule is an ideal rather than an attainable reality. From many standpoints this is preferable. A patient who gave us the full measure of all his free associations would create such a gap between his ego and what emerges from his unconscious that all integration and strengthening of the ego would be seriously threatened if not made completely impossible. As a matter of fact, when this happens the rapid flow of associations represents a form of resistance.

When the patient endeavors to conform to the fundamental rule, he allows us to reconstruct his unconscious processes. This is classic procedure, long recognized as basic to the analytic technique. The analyst not only uses what the patient expresses in his free associations but he is particularly attentive to the reaction of the patient when the patient makes a deliberate effort to obey the fundamental rule. Such reactions are typical manifestations of the resistance of the ego when it is faced with the elementary unconscious, the id. Obedience to this rule creates an experimental situation that permits us to observe in which way the ego handles the forces of the id. When the ego opposes a resistance we are able to observe the form and the manner of the defense mechanisms that are in operation. And when the climate of the analysis is favorable the patient feels sufficiently secure so that he, too, learns to recognize conscious resistance blocking his associations. He then tries to overcome this resistance either directly or by self-analysis. In any event the result is the same—maladaptive ego defenses are recognized, then destroyed, modified, or replaced. A step has been made toward the essential goal of the analysis: the maturation of the ego through its strengthening.

The rule of "floating attention" concerns the therapist. This rule parallels the "fundamental rule" and its application places the analyst in a position analogous to that of the patient following the rule of "free association." The therapist must be capable of hearing everything without fixing his attention and must suspend all critical judgment that would lead him to be particularly interested in this or that aspect of the patient's productions. He must register everything, just as the patient must express everything. In this first operational phase he attempts to communicate with the unconscious of the patient and his own unconscious. Thus, the analyst must be able to associate freely in regard to the material given him by the patient. It is only in the second phase that this seemingly irrational work of the analyst becomes conceptualized and takes on a rational form that will enable him to engage in useful action. This attitude of the therapist is most difficult to communicate to anyone who has not experienced it. It presupposes a great flexibility on the part of the analyst and makes his own unconscious the best and most reliable technical tool.

At the conscious level, the second rule for the therapist is the rule of *benevolent neutrality*. This rule implies that the analyst must avoid all emotional response to his patient in his manifest behavior and in his own perceptions. He must remain neutral and keep from all value judgment on what the patient is exhibiting. He must further abstain from all sentimental participation in the patient's drama and must refrain from any personal reaction to what the patient feels for him. If applied to the limit, this rule results (as Freud intended it to) in making a "mirror" of the analyst that purely and simply reflects the projections of the patient. Such an attitude is sometimes necessary, even indispensable, in treatment, and may be useful throughout the entire treatment. But to apply it with rigidity to all patients and at all points in the treatment may hinder treatment, as we shall endeavor to show.

The attitude of complete neutrality is quite necessary for the development of authentic transference. It sets the very condition of the analytic situation wherein the patient may live and relive his own emotional patterns with a minimum of interference from the outside. In the analyst-patient relationship, the vacuum created by the neutrality of the analyst constitutes the most favorable milieu for emotional resonance compared to what the patient has experienced in the past. In this way, the repressed drama may be relived in a fully conscious manner. Then it may be put away in a healthy manner if the transference relationship has been accepted by the patient.

Unfortunately, the transference relationship is not always accepted. This is even likelier if the analyst has committed any infraction of the rule of "neutrality," thereby altering the spontaneity and the purity of the transference. The attitude of neutrality is furthermore destined to maintain the patient in a state of technically calculated frustration. This is one of the ways at our disposal to provoke and then analyze the reactions to frustrating traumas in the patient's past experience.

It is easy to understand that the work of analysis becomes impossible if the patient can, or thinks he can, find a source of real or apparent satisfaction in the attitude of the analyst. The patient would then hang on to the analysis and develop a transference neurosis that would endanger therapy or make it impossible. The

analyst becomes part of a myth that permits the patient to live outside of reality. Excessive respect for the "rule of neutrality" may result in the same difficulty. Such neutrality, if not favoring the existence of the myth, would at least put no opposition in its path, which ends up by being the same thing. In order that the analyst be able to follow this rule with the maximum adaptability, he must be free to face his own reactions of countertransference and adjust his behavior accordingly.

It is in relation to the reactions of countertransference that we must consider the last rule, which applies to both the analyst and the patient: that is the *rule forbidding all relationship between patient and analyst outside of the treatment situation.* Such a relationship would be impossible to analyze and would be detrimental to the evolution of the treatment.

However, it is wise not to apply this rule too rigidly. Occasionally a meeting of the analyst and the patient outside of the treatment situation may be useful to "demythify" the analyst by confronting myth and reality. These meetings should probably not be deliberately arranged or encouraged, but when circumstances lend themselves to such meetings, they may prove beneficial to the course of treatment.

The forces that determine the analytic interaction can be defined as follows:: rapidly and progressively the impulse needs of the patient are oriented toward the analyst. The patient expects from him the satisfactions that he cannot or does not dare obtain elsewhere. The forces that the analyst frees are then employed by the patient in reaching his goal, which is more set in fantasy than in reality. The therapist strives constantly with firmness and tact to redirect these demands away from his own person toward reality. From this angle, analysis appears like a battle between patient and therapist in which the analyst is unconsciously considered as the enemy.

### Interventions (Analytic Interpretations)

The therapeutic effects of analysis can be classified in two categories: the acquiring of insights and the corrective readjustment of emotional attitudes. For many years, psychoanalysis proceeded exclusively through the acquisition of insight obtained either through

interpretations made regarding material brought by the patient or relative to his manifest behavior. In this second therapeutic phase, the manner of emotional exchange between patient and therapist is the main factor. The deeper attitudes of the analyst (that the patient's behavior unconsciously corresponds with) play an essential role in this corrective, or desensitizing, phase. The living of this experience contains in itself a therapeutic value that is enriched and reinforced by the fact that it is realized not only unconsciously but consciously.

Here one can see that interpretation is the intervention *par excellence*. Other means of intervention are available, but interpretation is used more than any other form. Whatever teaching the analyst received, he will always maintain his personal manner of applying the art of interpretation in terms of his endowment, intuition, imagination, and personal experience. As in all discussions concerning technique, it is wise to limit oneself to indicating general lines of procedure. One can ask certain questions and attempt to outline an answer.

First of all, what should one interpret? At what time during the treatment? Can one establish a chronologic, quantitative, or qualitative order in this matter? Some analysts believe that this last question can be answered affirmatively. For them a systematic classification of interpretations is not only possible but desirable. Others only interpret resistances, while still others interpret transference manifestations. Some would like to analyze character and neglect symptoms. When one considers the complexity of the problems at hand it is hardly possible to adopt such certitude, tempting though it may appear.

The respective position of various analysts in this matter can be separated into two schools of thought: one wishes to systemize and rationalize the work of the analyst; the other prefers to make personal intuition the best guide of the therapist. It appears, however, that both attitudes do not exclude each other and that, actually, they should complement one another in a flexible structure where intuition, experience and reason blend together to become active thought.

The main objective of analysis is to strengthen the ego. The chief efforts of the analyst should be directed against the resistances in order to modify the defense mechanism. Therefore, we are tempted first and foremost to interpret each resistance as soon as it is mani-

tested. But resistances are closely linked with the movements of the transference; they may also be linked with symptoms that are manifested by character traits and behavior. Such interdependence and intricacy of factors forces us to consider them in relation to one another at any given moment. If interpretation were to be focused simultaneously on all these elements, it would tend to take the form of a veritable lecture. The interpretation then loses all efficacy. The analyst is obliged to limit and choose the sector at which his interpretations are aimed. This choice is generally dictated by unconscious rather than by systematic reasons. Intuition, after all, is perhaps the totality of the efforts we have enumerated, integrated by the unconscious. In point of fact the analyst does not have the time to delay over each interpretation he gives. This does not mean of course that the analyst never thinks over what he has heard or what he is about to say to the patient, but his thoughts in general occur at other times and accumulate unconsciously.

The shorter the interpretation and the closer it comes to what the patient has just felt or thought, the more chance it has of being accepted. One may interpret a group of associations at once or wait for the end of the hour to give a global interpretation. However, an interpretation given at the end of the analytic hour presents the danger of being lengthy, necessitates a considerable concentration of attention on the part of the patient, and leads to intellectualization rather than emotional acceptance. Such interpretation, given at some distance in time from the moment when the material was produced, can only be useful at certain points, namely, when the analysis is near its conclusion. Another danger is that such interpretation leaves the patient time to mobilize resistances.

For many reasons it seems to us more helpful to interpret during the course of the analytic hour. First of all, when the analyst offers his interpretation at the time the patient is expression an emotion, the patient "feels" the interpretation rather than "thinks" it and he accepts it with less resistance. If the interpretation does provoke some resistance, it can be handled immediately before it has had time to consolidate. Immediate interpretations have the added advantage of taking up less time because they can be formulated much more briefly. When the interpretation is brief, the patient does not feel obliged to answer. It will be heard by the patient without his having to listen to it. Such procedure lends flexibility to the analysis and

spontaneity to the analyst, which is an aid in maintaining "floating attention."

Interrupting the associations of the patient presents certain risks. It may close off the flow of associations, may remind the patient of the presence of the therapist, or may change the direction of the patient's associations. All these are real disadvantages that have to be considered, but the main difficulty remains of choosing associations that the patient will receive and interpret. Here the analyst has to rely heavily on his own unconscious perception of what is going on in his patient.

This perception, at first only vague, becomes clearer by degrees and conscious when it triggers associations relating to the patient's history. What the analyst heard without attaching his attention to it suddenly presents itself to his conscious attention. The associations of the patient are literally "rethought" by the analyst. Fixing the limits of the associations is not easy. First the content of the patient's productions are considered as a homogenous story, which is not the case during an analytic hour. Then groups of associations form around certain dominant affects of the patient. Certain clues tell us of the approach of one of these "knots." A change in the tone of the recital, a slip of the tongue, a silence that interrupts the associations, an effort to evade a theme that had been pursued up to that point, a gesture that underlines an association, or an emotional manifestation that betrays the underlying affect. The best indications for interpretation are the associations that are charged with affect or those that are accompanied by resistance.

The most judicious interpretation may have regrettable results if it is not administered in an appropriate manner. Knowledge is ineffectual if tact and "know how" do not accompany it to make it acceptable. The interpretation must first and foremost take into account the degree of fear that the patient can tolerate. Do not forget that the defense mechanisms constituting the basis of a neurosis have no other *raison dêtre* than fear. Destruction of these mechanisms should follow the strengthening of the ego, failing which the fear that has been covered up by these defenses will create new resistances or symptoms more serious than the original ones.

Dream interpretations undoubtedly allow the therapist to learn a great deal about his patient but it often becomes for him and the

present an easy solution. Surely it is good to analyze dreams when they arise, but soliciting them can be a technical error. If this error is made, patients begin to dream abundantly and fill the hour with the stories of their dreams. After all, a dream is nothing but a dream. The psychic reality that it holds, even correctly analyzed, always has the quality of second-degree reality and is not felt by the patient as a directly lived experience. Furthermore, resistances use dreams to escape direct analysis. It often happens that the therapist, embarrassed by the silence of a patient, asks, "Have you no dreams to tell me?" He then feels that he has found a way out of an impasse, but he has entered another blind alley. It also appears preferable to discard the classic technique of asking the patient to give associations relative to each fragment of each dream. The spontaneity of the associations that leads to the latent content of the dream is smothered by this technique. The best therapeutic use of a dream is made when the memory of the dream comes up spontaneously in the course of association like any other material.

The tone used in formulating an interpretation must correspond to the general attitude of the analyst. It should be natural and normally colored with kindness. Any other tone turns the attention of the patient from the content of the interpretation to the form of expression of the therapist. Transference reactions are reinforced and made more difficult to analyze because they have an objective starting point. One must avoid any character of certainty because actually the therapist is not always certain. Even if he were certain, it would be in the interest of the treatment to allow the patient to explore the soundness of what is proposed to him. The terms used must be adapted to the intellectual level of the patient, and must never be technical. These precautions should be used to reduce to a minimum the patient's intellectual activity at the time of interpretation. The best results are obtained when the interpretation comes rapidly enough to precipitate a shock which surprises the patient emotionally. However, the necessity of precipitating such shocks is only true in the early phases of analysis. Later, the conscious thinking of the patient plays an important part, because it does the work of integrating the instinctual forces of the ego.

The analyst must be cautious. It is important to interpret resistances, but it is not always easy to distinguish those to be interpreted.

The defense mechanisms of which resistances are the manifestation can only be modified as the ego becomes strong and capable of handling fear. This is the goal of "working through." One constantly must pick up and reinterpret what has already been interpreted often, without being dismayed. Interpretation is a work of slow wearing down of the defense mechanisms and progress is manifested by certain secondary benefits for the patient. Sometimes, when the patient has strong oral fixations, he may see nothing else in the interpretation other than the fact that the analyst has spoken to him. The patient may then cherish the words as a gift, without attaching any sense whatsoever to the meaning of the words. It is useful to know of such a possibility in order to gauge the best "dosage" of interventions. The amount of interpretation varies at different times in the analysis. Occasionally, interpretations may be used to ease the extreme frustration of the patient when it is felt that he may not be able to tolerate his anxiety, and particularly in the beginning of the treatment it may also be useful to increase interpretation in order to demonstrate to the patient the method of analysis.

Although interpretations are the main part of the analyst's interventions, there are other ways of bringing insight to the patient: a sudden question asked by the analyst; the interruption of associations by underscoring one word used by the patient; the recalling of another version of a story that the patient has told differently at some point, and the repetition of a sentence that he has spoken before are all interventions that may bring about insight more rapidly than the most classically formulated interpretations, especially in patients given to rationalization.

## Evolution of Treatment

The treatment may be divided into three main periods: (a) the beginning of treatment and establishment of the analytic situation; (b) the transference neurosis; (c) the end of treatment. Such division is useful in teaching the procedure even though the periods overlap.

In most cases, the *opening period* is like a "honeymoon." The patient gets exhibitionistic, narcissistic, and particularly masochistic rewards in discussing his symptoms. He perceives the analyst's neu-

reality as permissive and his superego begins to loosen up. Symptoms moderate and the patient stops talking about them. The latent fear, basic to all forms of neuroses, tends to diminish. The ego becomes more responsive to impulses, and the patient becomes more demanding of instinctual satisfactions that he expects the analyst to fulfill. In this way he transfers to the analyst the attitudes similar to those of a child who expects all satisfactions from his parents. Disappointment rapidly ensues, giving way to painful and growing discontent. The patient's demands meet two types of obstacles: some come from himself, for he is not yet free of his inhibitions and cannot accept the satisfactions he requires. The remaining obstacles come from the analytic situation, which is frustrating in itself. The neutrality of the analyst becomes the source of ambivalent transference reactions that create discomfort. At this point the analyst must be cautious in seeing that the situation does not become overpoweringly hostile. He must avoid in himself, consciously and unconsciously, all deeper movement of feeling in wishing to retain or relinquish the patient. Either of these attitudes are perceived by the patient and determine aggressive defenses that would end treatment.

As treatment is continued, the patient-analyst relationship becomes stronger but keeps ambivalent coloring. Eventually this relationship entirely fills the analytic situation. It even extends beyond the analytic situation and fills the whole life of the patient. The initial neurosis for which the patient sought treatment gives way to the *transference neurosis* ("The new sickness will replace the old one." Freud). The bonds that the patient makes with his analyst reproduce the cycle that had chained the patient to his neurosis: unsatisfied needs, frustration, aggressivity, fear, masochism, and, finally, partial and vicarious rewards of symptoms. The analysis of these movements within the transference produce, with patient repetition, a type of freedom-creating insight that strengthens the ego. These insights also liberate a great amount of energy hitherto blocked by repression and manifested in defense mechanisms or in symptoms. The verbal aggression against the analyst becomes more apparent as the patient's fear lessens, serving to strengthen the ego. The patient does not turn as much aggression against himself as he did in the past. A greater potential of energy is available for constructive activity. This can be biologically explained by positing a double

set of neurophysiologic processes: the deconditioning of neurotic behavior and the neurovegetative phenomena which one perceives when the analytic hour has had an intensely emotional content; flushing, pallor, trembling, etc. Such a hypothesis would explain the fact that only analytic treatments that have been accompanied by intense emotional reaction are successful. The changes in the ego at the conclusion of the transference neurosis are in the direction of maturation. The love impulses hitherto inhibited come to light and seek expansion. The adult ego relinquishes the fantasies it had sought in the transference neurosis. The patient liquidates the neurosis, giving up infantile satisfactions.

At this point, the patient enters the *end phase of treatment.* The first sign of this is the progressive loss of interest of the patient in the analyst and the analysis. New interests and new investments form: work, study, profession, home, children, a shared love. The patient is virtually well. Unfortunately, the transference neurosis does not always follow this ideal course.

The study of the transference neurosis shows the great importance of the patient's transference to the analyst and the equal importance of the countertransference of the therapist to the patient. Transference is essentially characterized by the extreme amplitude of the patient's reactions. He is unable to look at it with any perspective or to establish any distance between the analytic situation and himself. The analogy (always underscored in the interpretations) between what has been lived in childhood and what is perceived during analysis ceases to make sense to the patient. Analysis may become an end in itself and not just a means to an end (recovery). This regrettable development is seen in individuals who do not fulfill the proper indications for analysis, although sometimes we must look elsewhere for the sources of this form of transference neurosis. When it cannot be reduced it becomes a global resistance and impedes the recovery from the infantile neurosis. One then is faced with an interminable analysis. The unconscious bonds between patient and therapist continue to feed this neurosis.

Technical rules may have been properly observed, but in analyses that are called "interminable," the patient finds satisfaction for his unconscious needs in the analytic situation: whether the therapist's reactions are positive or negative, they exert the same regrettable

effect on the patient. This is noted when certain conscious and unconscious aggressive needs of the analyst are expressed in the tone, the content of interpretations, or the time chosen to give interpretations. The sadomasochistic tendencies of the patient are strengthened and he seeks revenge against his loved analyst. What would have remained a projection of fantasy in the transference becomes real to the patient. The attitude of kindly neutrality serves to avoid this difficulty.

At the other extreme, the therapist's neutrality may be regarded as hostile indifference or even as aggressivity. When this is the case, the patient's masochistic tendencies become stronger. The patient lives a more and more painful life and assumes the role of the victim of the analyst who becomes a beloved tyrant. If the analyst is unconsciously sadistic, both patient and therapist are soon linked in a sadomasochistic relationship in the transference neurosis. For these reasons, the classic attitude of neutrality is indispensable in management of a transference neurosis. If one does not sense the impending detachment of the patient from the analyst and does not see the signs of new investments in reality, then it may be concluded that the analyst's attitude has not been as it should have been.

The analyst intuitively perceives when his patient's "cure" is realized, when the patient is ready to go forth unaided, but often the patient is still too frightened to do so. This constitutes a decisive moment of the treatment at which a change in the therapist's attitude is mandatory. The attitude of neutrality must be replaced by a response that will help the patient in regrouping his newly liberated forces and in re-employing them. This new attitude of the therapist affirms that his own reality will reward the patient's relinquishing his fantasy world and acquiring authentic interests necessary to adult adjustment. The therapist puts more emphasis on current behavior, using the healthy drives that have been made available through the treatment. The analyst becomes a human being of the real world, and must disengage himself from the fantasy world from which the patient is emerging. He is no longer a "mirror" for the patient's fantasies. This change in attitude enables the patient to work through the myth that he has created around the personality of the analyst and the analytic situation and favors the beginning of an adult-to-adult relationship. Freud did not emphasize the necessity of ending

an analysis by synthesis, because he felt that the healthy forces of the patient would naturally tend to a harmonious regrouping. This is often true where classic analysis remains uncomplicated. However, when the transference neurosis threatens the possibility of a recovery, this "presence" of the therapist may facilitate harmonious unification of the patient's drives.

The deeper attitudes of the analyst are at least as important as techniques. Authentic interest in the patient finds its basis in love and respect for human beings. The patient perceives it as kindness. In some patients the need for "reparation" is so intense that nothing can be done unless they feel loved by the analyst. It is only under this condition that their defenses weaken and that a reconstruction of their personality is effected. The true inner attitude of the analyst, rather than words or gestures, colors his behavior and makes of him a "good object" in the eyes of his patient.

Some patients have an infinite need for love, a need that nothing can satisfy and that they cannot give up, the need for an unfailing, limitless kindness entirely and always directed toward them whatever happens and whatever they may do. This is for them the only "gift of reparation" that can make up for what has been suffered in the course of devastating, pre-oedipal relationships. The analyst gives them this in terms of a maternal figure. One may object that the attitude of the analyst then tends toward gratification of infantile needs and encourages transference neurosis. But this attitude is deliberately adopted by the analyst in a small number of cases after adequate preparation. This deeper part of the analyst's attitude is more important than all the questions of technique or theory of analytic treatment. A very precious and tenuous part of the patient's psyche is not accessible to classic interpretations because it seems placed at a level that bears no formulation but may, on that account, be even more active. This most sensitive part of the individual is constantly solicited and influenced by the innermost attitude of the analyst.

After the liquidation of the transference neurosis, the patient is virtually ready to terminate analysis. He may, in ideal situations, feel that he is able to do without his analyst and take the initiative of suggesting this, whereupon if the doctor shares the point of view, he merely gives his agreement. The patient frequently decides

which day will be the last appointment. Occasionally, certain symptoms of "weaning" may still appear and create short delays between the desire for terminating and the last appointment.

When the initiative is not taken by the patient, the therapist must make the first move. Where the work is really well done, the patient readily agrees. However, both patient and analyst may be hesitant about terminating the analysis so some criteria of recovery are useful in determining termination. Disappearance of symptoms does not constitute a proof of recovery for they may appear, disappear, and reappear episodically. The deeper modifications of personality are shown partly by the ability of the patient to be at peace with himself and partly in his ability to show a healthy resistance to the realistic frustrations of life. The triple goal of the analytic treatment has been achieved: the relaxation of the superego, the strengthening of the ego, the integration of the ego impulses in the fullest possible measure.

Rickman suggests these criteria as valid:

a. Reduction of infantile amnesia permitting easy communication between past, present, and the elements of the oedipus complex.

b. Ability to get satisfaction from genital heterosexual activity.

c. Ability to endure libidinal frustration without the use of regressive defenses or anxiety.

d. Ability to work, as well as the ability to enjoy leisure.

e. Ability to endure aggressive impulses against self or others without guilt and without acting in such a way as to lose the loved object.

f. Ability to endure mourning.

Rickman underscores two particular points: the first concerns the irreversibility of the factors gained in an analysis, even after termination. The second is that new factors added to the personality during treatment should be capable of quantitative change and should not lead to a rigid and ideal personality.

Treatment is terminated when the patient has acquired the ability to satisfy his instinctual needs without compulsive restraints, within the limits of his own constitutional possibilities within his environment. He must be able to maintain stable object relationships. He

should be able to tolerate frustration without regression or self-punishment. Each patient has different possibilities of adjustment. Psychoanalysis gives the patient new and stronger possibilities for action and protection, but one must avoid expecting of analysis more than nature herself can give. There is no absolute immunity against neurotic accidents nor can armor be devised that is invulnerable. No man, however healthy, has ever been assured of these gifts.

# PSYCHOANALYSIS OF TODAY

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# Contents