The Emergence of Warded-Off Contents

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The research reported here was designed to investigate a process that psychoanalytic theory assumes to be central to therapy: that by which the patient becomes conscious of previously repressed mental contents, including ideas, memories, impulses, defenses, transferences, and resistances. In our research we tested two different psychoanalytic theories about this process.

The first was Freud's early theory, in which repressed mental contents are regulated automatically in accordance with the

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pleasure principle; that is, mental contents, once repressed, are subject to automatic regulation by indications of pleasure and pain. A person has no control over these contents, and cannot ordinarily lift his[1] defenses against them. Therefore, the analyst's interpretations play a central role in making them conscious. If a repressed mental content is not interpreted, it ordinarily remains unconscious, unless the content is intensified. An intensified content pushes toward consciousness, and evokes intensified defensive efforts. If the repressed content is powerful enough, it may emerge into consciousness in a relatively undisguised form, in which case the patient will continue to feel conflict about it, will feel anxious about it, and will attempt to re-repress it. If, however, the repressed content becomes conscious in a sufficiently disguised compromise formation, the patient may not experience further conflict with it. But since its true import is disguised, the patient cannot understand its significance either and cannot use insight into it to advance the therapy.

In his later work, Freud introduced a different theory about how unconscious contents may become conscious. In *Inhibitions, Symptoms and Anxiety* (1926), Freud proposed that a person may think unconsciously about the consequences of satisfying an emerging unconscious impulse, and, if he anticipates that satisfaction of the impulse would bring about a "situation of danger," cause the impulse to be repressed. Freud developed this idea further in *An Outline of Psychoanalysis* (1940) in which he wrote that the ego's constructive function

> consists in interpolating, between the demand made by an instinct and the action that satisfies it, the activity of thought which, after taking its bearings in the present and assessing earlier experiences, endeavours by means of experimental actions to calculate the consequence of the course of action proposed. In this way the ego comes to a decision on whether the attempt to obtain satisfaction is to be carried out or postponed or whether it may not be necessary for the demand by the instinct to be suppressed altogether as being dangerous [p. 199].

[1] For the sake of brevity the male pronoun is used throughout this paper in the generic sense. The reader should always keep in mind the missing female pronoun.

Freud's later theory has been used and elaborated by other analysts, such as Kris (1956), Loewenstein (1956), Sandler (1960), Rangell (1969), and Weiss (1971). Sandler, Rangell, and Weiss have suggested that a person not only has the capacity to repress a content which he judges would endanger him, but also to lift his defenses and to bring forth such a content if he decides that he can experience it safely. Weiss has proposed that a patient in analysis may keep a content warded off until he has overcome his anxiety about it, and then bring it to consciousness without anxiety (p. 460). If so, then we may expect repressed mental contents to emerge into consciousness frequently in analysis—even if these contents have not been interpreted—and to emerge without anxiety or conflict. Moreover, the patient may be able to understand the import of these new contents, and to use them to advance the therapy.

Let us summarize the two theories. Freud's early theory assumes that repressed mental contents are regulated automatically, and that this regulation takes place in accordance with the criterion of pleasure-unpleasure. Freud's later theory (and its elaborations by other analysts) assumes that repressed mental contents may be regulated by unconscious thoughts and decisions, and that this regulation is based on appraisals of danger and safety.[2]

The research reported here examines, over the first 100 sessions of a single psychoanalysis, which theory better explains how warded-off mental contents became conscious in therapy.

[2] The distinction between early and later theories is made largely for heuristic purposes. Some of Freud's later ideas can be found in his earlier writings, and his later theories retain many of his earlier ideas.

A Method For Identifying Previously Warded-off Contents

We identified the warded-off contents of the patient we studied by the usual clinical method, but added two stringent requirements which clinicians ordinarily do not have to meet. We established the reliability of our clinical judgments by demonstrating agreement among a group of judges. And we avoided basing the judgment about whether a particular content had been warded off by considering how the patient felt as it emerged. We did not, for example, assume what the early theory predicts, that an uninterpreted content which emerges without anxiety could not have been warded off. Were we to have made such an assumption, we would have been arguing for one of the theories we were testing.[3]

The method used in this study was in most respects a replication of the method devised by Horowitz, Sampson, Siegelman, Wolfson, and Weiss (1975). Horowitz et al., studying the first 100 hours of a patient's analysis, identified all statements containing contents which this patient had not expressed in the first 40 hours. They then randomly selected 50 of these new statements for study. Twenty psychoanalytic clinicians were asked to judge independently which of these 50 statements contained contents that had previously been warded off. After reading the process notes of the first ten treatment hours, the 20 judges agreed about which statements contained contents that were previously warded off, and their judgments corresponded to those made by the patient's analyst. Control judges, given the same statements to rate, but not provided with the information contained in the process notes, did not agree with the judgments made by the patient's analyst or the informed judges. This research demonstrates that high interrater reliability can be achieved when experienced therapists make clinical judgments from case-specific material, and that such judgments are based on complex clinical evaluations rather than on preconceptions of the kinds of mental contents that are likely to be warded off.

[3] If a patient calmly discusses new contents which might have been expected to have been repressed earlier, the traditional perspective could lead the clinician to the *post hoc* assessment that the content had never been repressed.

The Replication Study

Our replication study was based on the case of Mrs. C., who was successfully analyzed during the 1960's. Mrs. C. was a professional woman in her late twenties who had been married for several years at the time she entered analysis. She was a middle child with an older and a younger sister, and an older and a younger brother. Her mother was a housewife, her father a businessman.

Mrs. C. had been diagnosed, by the psychiatrist who referred her for analysis, as a neurotic woman suffering from obsessive-compulsive difficulties. Her symptoms included sexual frigidity and complaints of self-dissatisfaction, joylessness, and constriction.

The analysis was conducted by an analyst who was not a member of our research group and who had no knowledge of our research group's hypotheses at the time he conducted the analysis. He was highly experienced. With the consent of the patient, the entire analysis was tape-recorded for research purposes. In addition, the analyst wrote detailed summaries of the contents of each session. The first 100 hours of the analysis have been transcribed, and the study here reported made use both of the verbatim transcripts and of the process notes of these 100 sessions.

In carrying out a replication of the Horowitz et al. study, we believe we improved on the earlier method in five ways[4]:

[4] It should also be noted that for purposes of this research we sought a case, such as that of Mrs. C., in which (1) the therapist made relatively few interpretations, and (2) the therapy proceeded successfully and relatively smoothly.

(1) We used portions of the verbatim transcripts of the first 100 hours in order to verify the accuracy of the process notes. All the statements we selected to be rated as to whether they had been warded off were demonstrated to be highly similar to the corresponding statements in the transcripts. The demonstration of similarity between process notes and transcripts was a separate step which required judges to rate similarity on a five-point scale. (2) We also verified that the statements used in this study, which were taken from hours 41–100, were actually new. We determined that they were new by showing that they were not similar to anything which appeared in the verbatim transcripts of the patient's first ten treatment hours. (3) We sampled statements systematically from a wide range of thematic contents. These included ideas which the patient expressed about each of the key objects in her life, and ideas about all of the thematic concerns to which she referred. We assumed that the more comprehensive the range of warded-off ideas that the judges could identify, the greater the power of this method for identifying warded-off contents. (4) Seven of the 100 statements used in this study contained acknowledgments made by the patient that the ideas which she was expressing had earlier been difficult for her to experience and face. In presenting such statements to judges, we deleted those portions of the patient's speech which would have suggested to the judges that the patient viewed the ideas expressed in them as previously warded off. (5) We were careful to provide the judges with statements

The case of Mr. B., used in the Horowitz et al. study, was not suitable on either count. The analyst's technique was highly active, interpretive, and confrontational. This made it a difficult case in which to observe the emergence of previously warded-off contents without interpretation. Further, because the analyst pressured the patient to focus on certain topics, it is likely that the patient brought forth contents related to these topics mainly out of compliance with the analyst's wishes and that he did so despite considerable anxiety. Indeed, Horowitz et al. found that, in the case of Mr. B., anxiety *did* accompany the emergence of previously warded-off contents. Additional evidence that Mr. B. was anxious during the treatment period studied is that shortly after this period of work, he abruptly interrupted the analysis. Although he returned to his analysis later and completed it successfully, the first 100 hours do not illustrate a typical progressive therapeutic process.

that were sufficiently complete, and to check that the idea expressed was sufficiently explicit, so that it could be rated without reference to additional material.

The method for identifying previously warded-off contents, described below, involves two steps. The first step identified *new* contents; that is, contents which had not been present earlier. The second step required psychoanalytic clinicians to judge which among these new contents had consciously been unacceptable to the patient at an earlier time and so, had been warded off by defenses.

We proceeded as follows: All statements containing ideas which emerged in hours 41–100, but which were not present during hours 1–40, were identified. Two judges studied the process notes of the first 100 hours in order to identify them. These statements were grouped by thematic content. One hundred statements were randomly selected from these groups in direct proportion to the total number of statements found in each group.

The 100 statements selected were presented to 19 experimental judges and 16 control judges. Both groups of judges were highly experienced. All were trained in psychoanalytic psychotherapy and one-third of the judges were practicing psychoanalysts.

The experimental judges were presented with the process notes of the first 10 treatment hours and the 100 new statements from hours 41–100. They were asked to use the process notes to make their own case formulation, then to apply this formulation to decide which of the previously unreported statements contained contents which, during the first 10 sessions, were warded off by defenses. In keeping with the method devised by Horowitz et al., the judges were told:

> These 100 statements come from hours 41–100; they appeared for the first time during these hours. Please read each statement. We want to know whether you think that the content had been warded off earlier. Use your clinical intuition to make this judgment, applying whatever criteria

would lead you to call a content warded-off. As one possible criterion, you might want to ask whether that content would have been acceptable to the patient during the first ten hours of treatment. Other criteria may also occur to you. Feel free to apply whatever criteria seem pertinent.

The control judges were asked to rate the same 100 statements, but were not provided with the process notes from the first 10 treatment hours.

All judges were given limited background information about the patient, such as the patient's age and sex. Neither group of judges received any special training for doing this task.

Both groups of judges were asked to rate the 100 statements on a five-point scale that indicated the degree of confidence they had that a content had previously been warded off. A rating of "1" indicated a strong belief that the content had *not* previously been warded off; a rating of "5" indicated a strong belief that the content *had* previously been warded off. Varying degrees of uncertainty were indicated by the intermediate values.

In addition, the treating analyst was asked to make the same ratings as to which of the 100 unreported statements had previously been warded off. He was asked, in making this judgment, to use all that he had learned about the patient in the course of the entire analysis.

Results And Discussion

An average of the ratings made by the 19 experimental judges, and the standard deviations, were obtained for each statement. The resulting mean was designated as the scale value for the statement. The overall mean of the ratings for the statements was 2.89, and the standard deviation .74. Thirteen statements received a scale value of "4" or higher, 20 a scale value of "2" or less. Table 1 presents the 13 statements with a scale value of "4" or higher—those which the experimental judges strongly believed represented previously warded-off contents—alongside the mean of the experimental judges' ratings and the treating analyst's ratings.

We found that the judges' ratings were highly reliable. A split-half reliability coefficient was calculated by correlating the mean values of one randomly selected group of nine experimental judges' ratings with the remaining group of ten experimental judges. The resulting split-half reliability coefficient was .90. This analysis demonstrates that most raters asked to make a clinical judgment about whether an idea had earlier been repressed were able to reach a consensus that 13 of the 100 previously unreported statements had been previously warded off.

A split-half reliability coefficient of .89 was obtained for the 16 control judges who were given the same statements to rate, but who had not been provided with any other information about the patient. When the ratings of the experimental and control groups were correlated, a .70 product-moment correlation was obtained, significant at $p < .001$. This finding indicates that, to some extent, the particular patient whom we were studying had earlier defended herself against experiencing certain mental contents that are conventionally assumed to be difficult to face.[5]

Our procedure identified 13 statements which clinicians could agree had previously been warded off. It produced a set of contents judged previously warded off which conform to what psychoanalytically informed clinicians mean when they refer to unconscious contents or warded-off contents.

[5] We do not think this correlation means that the experimental judges were just rating as warded-off those ideas which most people are conventionally thought to ward off—i.e., sexual and aggressive themes. From talking with the judges it was clear that they had applied their own case formulations to the rating task. And, after all, Mrs. C. did ward off sexual and aggressive themes. In the earlier study of Mr. B., Horowitz et al. (1975) found that the experimental and control judges' ratings did not correlate significantly. When, in that case, the patient tried to shock the analyst, the experimental judges did not view the shocking sexual and aggressive statements as previously warded off.

TABLE 1
RESULTS FOR ITEMS RATED HIGHLY WARDED-OFF

Statement	Mean of experimental judges' ratings	Treating analyst's ratings
She recalls wanting to kill her older brother.	4.56	5
She thought how she and Henry had had intercourse and she had wanted it and enjoyed it.	4.45	5
After she was very angry with me yesterday, she went home and felt very, very happy.	4.39	5
When she had to knock on her parents' bedroom door, she must have felt angry at being left out.	4.34	4
She had some kind of sexual attraction for her brother.	4.33	5
When she imagines her parents having intercourse, she thinks of her father being on the bottom because he just accepts it.	4.22	5
She looked at her bowel movements with the urge to see what she had done.	4.22	5
She knew how to work her parents, their guilt, and their need to be absolutely fair.	4.22	2
It is as though her control while having intercourse is somehow disciplining Henry.	4.17	5
She feels some satisfaction seeing that she reacts just as her mother does.	4.17	5
The drawing she made turned out to be an elephant and when she went back and looked at it, the nose was a penis.	4.12	5

(Table 1 continued on p. 65)

She couldn't have me raise a question without having to say that she had already thought of it.	4.07	2
She controls when Henry has an orgasm by whether she moves or not.	4.06	4

Nevertheless, the question remained as to whether our procedures had in fact yielded clinically meaningful warded-off contents. We were aware that our measurement procedures could result in a distortion of the phenomenon under investigation. Therefore, we sought evidence by other means that would enable us to assess whether the contents which the judges identified as previously warded-off were indeed of clinical significance or if our procedure had yielded contents that were relatively trivial or irrelevant from a broader clinical perspective.

WERE THE CONTENTS WHICH THE JUDGES IDENTIFIED AS WARDED-OFF OF CENTRAL CLINICAL SIGNIFICANCE?

As we shall show below, the patient herself, the treating analyst, and finally a research group working independently from the judges all thought that the statements judged as warded-off had been previously warded off, and were of central significance.

Our evidence in regard to the patient's judgment was this: There were seven statements which the patient made which contained temporal or affective phrases that directly acknowledged the difficulty the patient experienced in facing the expressed content. These were statements which we designated "cued as previously warded off." Examples of such phrases are: "Suddenly I realize . . ."; "I've never let myself think or feel . . ."; "I can't believe I'm saying that. . . ," etc.

In order to avoid providing judges with such cues, all phrases which betrayed the patient's judgment that the idea

had previously been warded off were omitted. For example, had the patient said, "I never could allow myself to face that my brother is really condescending," the opening phrase, "I never could allow myself to face that," was eliminated from the information which the judges received.

We compared the mean ratings which the judges gave to the seven statements which had originally been cued by the patient as previously warded off with the ratings they gave to seven other statements randomly selected from the remaining 93 items. The means of the cued as previously warded off statements was 3.96, whereas the means of the non-cued statements was 2.86. This difference in the scale values between the "cues deleted statements" and the non-cued statements is statistically significant at the .05 level, evidence that the experimental judges were fairly well able to identify the "cues deleted statements" to be previously warded off.

The treating analyst also thought that the statements which were judged previously warded off had been warded off earlier. As can be seen from Table 1, the treating analyst rated 11 of the 13 statements as previously warded off. We should also mention that the treating analyst considered the statements to which our judges gave the highest ratings as so revealing and powerful that he asked us to disguise their contents for purposes of this publication!

Finally, our research group, working independently of the judges, made its own case formulation. This formulation anticipated what kinds of ideas, feelings, and memories the patient would have to allow into consciousness in order for her analysis to progress well. Our group felt that the statements judged as previously warded off did involve significant powerful impulses, or painful childhood memories and ideas, and that these contents were directly connected to our formulation.

Thus, three converging lines of evidence suggest that our method identified as warded-off, contents that were clinically meaningful. Now we will turn to the important theoretical questions that we posed at the outset of our discussion.

Emergence Of Warded-Off Contents Without Interpretation

Let us first give an overall picture of the analyst's activity during these 100 sessions. During this phase of the treatment, the analyst made 846 interventions.[6] Two members of our research group[7] studied these interventions to identify all instances in which suggestions, clarifications, or interpretations were made. They found that 78 percent of the interventions were intended as clarifications, as, for example, questions like, "When did that happen?"

We looked at each of the analyst's interventions to determine whether the content of anything he had said prior to the emergence of the ideas judged previously warded off related *in any way* to these ideas. One judge read through all 846 statements to identify any analytic interventions which might pertain to the 13 statements judged previously warded off. This judge was instructed to identify interventions even if they were only vaguely related to the judged warded-off contents. Although we had anticipated using additional judges for this task, it turned out that the findings were so clear-cut that additional judges were unnecessary. The judge was able to find only one interpretation which the analyst had made which related in any way to an idea judged previously warded off. The one interpretation occurred 14 sessions prior to the patient's stating that whenever the analyst raised a question she felt compelled to say that she had already thought of it. The analyst had said: "If I say anything you did not already know or did know but didn't think of, you feel it reveals some inferiority on your part."

Thus it was found that 12 of the 13 statements had emerged without any previous interpretation which pertained directly or indirectly to the ideas expressed in the contents judged pre-

[6] Two members of our research group, Carol Drucker and Marla Isaacs, catalogued all the interventions which the analyst made during the first 100 hours.

[7] Saul Rosenberg and Lynn Campbell.

viously warded off. Perhaps the reason that the analyst's interpretations were unrelated to all but one of the contents judged previously warded off was that, in this early part of the treatment, the analyst's interpretations did not focus on the contents themselves, but, in a general way, on the patient's reluctance to talk. For example, the analyst would say, "I notice you find it hard to begin."

Conflict Over Emergence: Presence Of Anxiety

Having located 12 contents which emerged without interpretation, we next attempted to determine how the patient felt about them as they were emerging. Was she anxious or calm? We used three techniques to assess the patient's anxiety at any given moment in the treatment: the Speech Disturbance Ratio (Mahl, 1956), the Gottschalk-Gleser content analysis scale (Gottschalk and Gleser, 1969), and clinical ratings.

Mahl's Speech Disturbance Ratio investigates momentary anxiety in patients by quantifying aspects of how they speak. Such disturbances in speech as sentence changes, stutters, slips of the tongue, intruding incoherent sounds, repetitions, omissions, and sentence incompletions are identified. A Speech Disturbance Ratio can be obtained for any segment of speech by compiling the ratio of speech disturbances to the total number of words spoken. Numerous studies have been conducted using the Mahl measure to assess anxiety and its correlates in psychiatric patients (Mahl, 1956, 1959a, 1959b, 1961). It has been found to be an objective approach to the quantification of anxiety, and a reliably discriminating measure.

The Gottschalk-Gleser content analysis scale is designed to assess immediate anxiety by measuring manifest anxiety-related verbal content. Phrases that focus on any of the following six contents are viewed as evidence of the presence of anxiety in the speaker: mutilation, death, shame, guilt, separation, and diffuse or non-specific anxiety. Since each of the six sources of anxiety are considered of equal importance, their manifestations are added together to obtain a measure of the magnitude of a person's anxiety.

Any direct expression of the six types of anxiety is considered evidence that an internal state of anxiety has been activated. In addition, defensive and adaptive manifestations of anxiety are inferred when the speaker (1) imputes anxiety or anxiety-motivated behavior to other people, to animals, or to inanimate objects; (2) repudiates or denies the affect; or (3) reports the affect in an attenuated form. There have been numerous studies demonstrating the reliability and the predictive validity of this measure, and there is some evidence for its construct validity (Gottschalk and Gleser, 1969; Gottschalk, 1974a, 1974b).

The third method we used involved clinical judgments of anxiety. Judges were given the following instructions:

> You will be listening to and reading the typescripts of sequences of patient talk on a variety of themes. I would like you to rate each episode along the following five-point scale of anxiety (with "1" designated as "relaxed, not anxious"; "5" designated as "very anxious"). This is a rating of manifest anxiety; that is, anxiety which either the patient is experiencing or potentially would experience if asked whether she were anxious. As you listen, consider the patient's general mood during the episode; try to get a feel for her emotional state at the time she is saying these words. Content may or may not be important. Rely on your clinical impressions, using whatever cues make sense to you. Try to use the entire scale with "3" as the center point representing the average anxiety level for the patient. In order to obtain a sense of what the patient sounds like, listen to the first five episodes without rating them, and then start rating with episode six.

Interrater reliability was high for all three anxiety measures. A .91 reliability coefficient was obtained by the two judges who applied Mahl's Speech Disturbance measure to 103 epi-

sodes in which the 12 warded-off statements and 91 randomly selected statements appeared.[8] Four judges applied the Gottschalk-Gleser technique to the same 103 episodes, with an interrater reliability coefficient of .80. An intraclass correlation coefficient of .74 was obtained for the average intercorrelation between pairs of six raters who made clinical judgments about the amount of anxiety the patient was expressing in episodes containing the 12 warded-off contents and episodes containing the 20 statements which the judges did not believe were strongly warded off. (Graduate students served as judges for the Mahl and Gottschalk-Gleser ratings. The clinical ratings of anxiety were made by clinicians who had between two and ten years of clinical experience.)

For all three methods used, it was found that there was *no* evidence that the patient was any more anxious when previously warded off contents were emerging than at other times during the analysis (see Tables 2 and 3). And in the data produced by Mahl's Speech Disturbance technique, randomly selected statements were accompanied by considerably *more* anxiety than were previously warded off statements. This difference was statistically significant at the .025 level.

Use Of the Emerging Contents to Advance the Therapy

According to Freud's early formulations, a patient may calmly express (without prior interpretation) a previously warded off content only if the repressed content becomes conscious in a sufficiently disguised compromise formation. The patient remains calm—without anxiety—because he does not experience the content's true import. Compromise formations reflect continuing and indeed intensified defensive efforts to keep the true meaning of the content unconscious. Thus we should not expect the patient to reflect on—try to understand and experience emotionally—even that content expressed in the compromise formation, since it is but a disguised version of the actual content. This is why the condensations and displacements that typically evidence compromise formations are precisely the subject of the analyst's interpretive efforts.

In the case that we studied, for example, one of the previously warded off contents which emerged in the psychoanalysis was the patient's statement that she recalled wanting to kill her brother. Is it possible that this statement represented a compromise formation? And that we should not expect to find the patient reflecting on and attempting to understand and experience emotionally the true significance of the statement?

[8] One hundred statements were selected by a random stratified procedure from the first 100 hours of the analysis. Nine of these were found to be too brief to score on the Gottschalk-Gleser scale. The remaining 91 statements constituted the sample of random items that were used as a comparison group.

Table 2
Means and Standard Deviations of Anxiety Ratings on Episodes Containing 12 Warded-Off Statements and 91 Randomly Selected Statements

	Speech Disturbance*		Gottschalk-Gleser**	
Statements	Mean	S.D.	Mean	S.D.
Warded-off	.247	.102	2.58	.318
Random	.319	.159	2.48	.663

*t = 2.25, alpha < .025
**t: N.S.

Table 3
Means and Standard Deviations of Clinical Judges' Ratings of Anxiety During Episodes Containing 12 Warded-Off Statements and 20 Statements Judged Not Highly Warded-Off

Statements	Mean*	S.D.
Warded-off	2.62	.624
Judged not highly warded-off	2.58	.448

*t: N.S.

In order to find out whether this was the case, we applied the Experiencing Scale to the 12 previously warded off statements and to 91 randomly selected statements.

The Experiencing Scale assesses the degree to which a patient focuses on his changing feelings as they occur during psychotherapy, how he reflects about these feelings, and how he puts such observations to use for problem-solving purposes. The scale has been found "to be sensitive in shifts in patient involvement: this makes it useful for microscopic process studies" (Klein, Mathieu, Gendlin, and Kiesler, 1970, p. 1). The Experiencing Scale has been widely acclaimed as one of the most accurate objective means for the study of how a patient is progressing in psychotherapy.

There are two kinds of scores which can be obtained from the Experiencing Scale. One is the modal score, which characterizes the overall experiencing level of the therapy segment being studied. The other is the peak score which describes the highest scale level reached in the segment being studied. In our research, we calculated both the modal and peak scores for segments in which previously warded off contents emerged, and segments in which the randomly selected statements emerged.

Four trained judges, all graduate students, applied the Experiencing Scale to these segments. Their interrater reliability was found to be .75.

From Table 4 it can be seen that previously warded off contents were rated significantly higher on the Experiencing Scale than were randomly selected statements. This means that the patient was actually *more* involved in reflecting on the feelings she had associated with the warded-off contents than with the randomly selected contents chosen from her psychoanalysis. When the modal measure was used, the difference was significant at the .05 level; when the peak measure was applied, the difference approached significance at the .10 level. This data suggests that as previously warded off contents became conscious, the patient was particularly involved in the analytic process and was doing progressive therapeutic work with these contents.

TABLE 4
MEANS AND STANDARD DEVIATIONS OF EXPERIENCING SCORES ON EPISODES CONTAINING 12 WARDED-OFF STATEMENTS AND RANDOMLY SELECTED STATEMENTS

	Modal Score*		Peak Score**	
Statements	Mean	S.D.	Mean	S.D.
Warded-off	3.40	.632	3.96	.554
Random	3.00	.791	3.61	.749

*t = 1.70, alpha < .05
**t = 1.61, alpha < .10

CONCLUSIONS

According to Freud's early formulations, warded-off contents become conscious either as a result of the analyst's interpretations or as a consequence of some increase in their strength relative to the strength of the defenses directed against them. If an uninterpreted warded-off content emerges into consciousness, the patient will continue to feel conflict about it and become anxious. If, however, the repressed content becomes conscious in a sufficiently disguised compromise formation, the patient may not experience further conflict with it. But since its true import is disguised, the patient cannot use insight into it to advance his therapy. Thus, according to Freud's early formulations, a patient would not be expected to be able to bring forth a previously warded off content which had not been interpreted, maintain it in consciousness without anxiety, and use it to advance his therapy.

In the first 100 psychoanalytic hours of the case we studied, we found that warded-off contents typically emerged without the patient manifesting anxiety about the contents, without her attempting to re-repress them, and without the analyst having

made any prior interpretations which were relevant to the warded-off contents. Moreover, the patient worked with these contents to advance her analytic understanding. These findings are clearly incompatible with Freud's early theory.

The results of the present study *are* compatible with Freud's later theory and its elaboration by other analysts. According to this theory, repressed mental contents are regulated by unconscious thoughts and decisions based on appraisals of danger and safety. Therefore, a patient may keep unconscious ideas warded off until he has overcome his anxiety about them, then lift his defenses against them and allow them to become conscious. Hence, repressed contents may become conscious in analysis without interpretation, yet without anxiety, and the patient may recognize the meaning of these contents and work with them therapeutically.

These findings must necessarily be viewed with caution until replicated in other investigations.

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