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A CRITIQUE OF CERTAIN TRADITIONAL CONCEPTS IN THE PSYCHOANALYTIC THEORY OF THERAPY*

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Built on Freud's basic discoveries, this critique of psychoanalytic concepts is within the mainstream of psychoanalytic theory and carries forward a main line of development within psychoanalytic ego psychology. Yet, I propose fundamental changes in certain traditional psychoanalytic concepts about how therapy works and how it fails to work. My critique is based on a new psychoanalytic theory of therapy and technique which Weiss (1971, 1975) and I (Sampson *et al.* 1972) have been developing which we call the "control-mastery theory." Our ideas are based on certain observations we have made in our clinical work which are difficult to explain with the traditional theory and can be accounted for only by a theory such as the one we propose.‡

I shall begin this paper with a brief outline of some important differences between the control-mastery theory and its antecedents within psychoanalysis. The traditional psychoanalytic theory of therapy, as set forth by Freud in his papers on technique (1911–1915), assumes that a person can exert little or no control over his unconscious mental life, for unconscious processes are regulated auto-

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‡ A group of psychoanalysts and research psychologists at Mt. Zion Hospital and Medical Center, San Francisco, California, and at the San Francisco Psychoanalytic Institute are carrying out systematic research studies to verify these observations in a more formal, reliable, and objective way.

matically by the pleasure principle. Therefore, all processes which take place unconsciously during therapy, such as the development of the transference neurosis take place outside of the patient's control, determined by the dynamic interaction of his impulses and defenses. The traditional theory also assumes that a patient's most powerful unconscious motivations are to seek pleasure by trying to gratify repressed infantile wishes and to avoid unpleasure by resisting the analysis of his unconscious motives.

The traditional theory was gradually modified by the inclusion of a number of concepts from ego psychology. But certain concepts from ego psychology differ substantially from the traditional theory of therapy and are not readily assimilated into it. For example, the concept of regression in the service of the ego implies two ideas that do not fit readily into the traditional theory: (1) A person may either express an unconscious mental content in his behavior or bring it to consciousness under his own control, rather than it simply being a result of the dynamic interaction of his impulses and defenses that are beyond his control. (2) A person may either express the unconscious mental content or make it conscious for an adaptive purpose, such as to solve a problem rather than to gratify an impulse or to serve as a resistance.

Contemporary psychoanalytic theories of therapy contain both traditional concepts and concepts from ego psychology. However, concepts from ego psychology, such as regression in the service of the ego, are unsystematic and peripheral in contemporary psychoanalytic theories of therapy. They are used mainly in abstract, inexplicit formulations which apply in only limited and isolated ways to therapy and which conceal the contradictions between the traditional theory and modern ego psychology. In these contemporary theories the traditional concepts have remained basic and central. They are used to explain major therapeutic processes and to justify therapeutic techniques. For example, the formation of the transference neurosis is explained primarily as a mobilization of conflict brought about by an intensification of the patient's transferences and resistances outside his control.* And the therapist's neutrality when a patient makes a transference demand continues to be justi-

* See Weinshel's (1971) survey of recent psychoanalytic literature on the transference neurosis.

fied by the rule of abstinence, i.e., by a principle based on the traditional concepts of frustration and drive intensification.

In the control-mastery theory, the concept that a person may exert considerable control over his unconscious mental life is explicit and central, as is the assumption that a patient's most powerful unconscious motivation is to solve his problems. These concepts are used systematically in explaining therapeutic processes. For example, according to the control-mastery theory, the patient controls both the formation and the resolution of the transference neurosis. During the stage of formation he makes his transferences prominent as a step toward bringing them to consciousness; during the stage of resolution he makes them conscious and masters them.

According to the control-mastery theory, a patient makes and carries out plans to solve his problems. The patient's plans, which are unconscious, require him to bring warded-off mental contents to expression and to consciousness in order to increase his mastery over them. The patient must do a great deal of work to overcome the internal danger he would face were he to experience a mental content he had warded off by defense. He does this work by attempting to create with the analyst a relationship that would protect him from this danger. An important part of this work is the patient's testing the analyst to assure himself that were he to bring the warded-off mental content to prominence or to consciousness, the analyst could be relied upon to respond in a way that would afford protection against the danger.

Let us examine how each of the theories I have mentioned explains a central event in a successful psychoanalytic therapy, namely, the analysis of an unconscious conflict. Each theory agrees that the analysis of conflict takes place in two distinguishable stages; the first stage takes place unconsciously, the second consciously. In the first stage, which I shall designate the "stage of prominence," an unconscious conflict comes to be expressed prominently in a patient's behavior. The patient expresses an unconscious impulse as well as defenses against that impulse. For example, a patient may express submission to the therapist without awareness that he is doing so, while at the same time defending himself against submission by being extremely stubborn, also without awareness. In the second stage, the patient becomes conscious of his defenses and of

the impulse being warded off. He may recall childhood instances of his conflict and gradually resolve it. How does each theory account for the conflict becoming prominent and for its becoming conscious and resolved?

The traditional theory explains the stage of prominence as a mobilization of conflict which is brought about outside of the patient's control. His repressed impulses are intensified, which leads to the intensification of defensive efforts. The mobilization hypothesis was stated cogently by Fenichel (1943) in his explanation of typical transference repetitions: "What happens is that a repressed impulse tries to find its gratification in spite of its repression; but whenever the repressed wish comes to the surface, the anxiety that first brought about the repression is mobilized again and creates, together with the repetition of the impulse, a repetition of the anti-instinctual measures" (p. 542). In traditional theory, the analysts's neutrality contributes to the mobilization of conflict by frustrating the patient's unconscious transference wishes, thereby intensifying them and causing them to thrust toward expression.

According to the traditional theory, therapy takes place in two stages which work in opposite directions. In the first stage the conflict is mobilized outside of the patient's control. In the second stage the patient gains control over it through the assimilation of insight. The transition between the two stages invariably requires interpretive work by the analyst, for the patient in the first stage has little or no control over the conflict and is seeking only to gratify his impulses and to resist analyzing them. The central role of the therapist's interpretations in converting the unconscious conflict into a conscious one which the patient can resolve was vividly depicted by Freud (1912): The patient ". . . is flung out of his real relation to the doctor . . . . he seeks to put his passions into action without taking any account of the real situation. The doctor tries to compel him to fit these emotional impulses into the nexus of the treatment and of his life-history, to submit them to intellectual consideration and to understand them in the light of their psychical value" (pp. 107–08).

Contemporary psychoanalytic theories of therapy, as I have already indicated, generally use the concepts of the traditional theory to explain how an unconscious conflict becomes prominent during treatment and how a patient becomes conscious of it and resolves it.

In contrast, the control-mastery theory assumes that the patient unconsciously decides to make the conflict prominent in his behavior as a step toward bringing it to consciousness and mastering it. An important factor in his decision to do so is an unconscious judgment that he can express the conflict safely in the therapy. He does not do so because the conflict has been intensified outside of his control. According to the control-mastery theory, the neutrality of the therapist helps to make the conflict prominent because it reassures the patient that the therapist will not react to his expression of unconscious mental contents in any way that would endanger the patient. For example, a patient who defended against expressing his unconscious sexual feelings toward the analyst for fear the analyst might reciprocate them, thus endangering the patient's tenuous control over them, unconsciously tested the analyst by behaving seductively. When the analyst remained neutral, the patient was reassured and could then express his sexual feelings more prominently in the transference as a step toward becoming conscious of them.

In the control-mastery theory, the stage of prominence and the stage of insight both work in the same direction. The patient regulates both stages, and each stage is a step in the patient's own effort to resolve his conflict. He has considerable control over the conflict in the first stage, which is what enables him to make it prominent without experiencing the danger of trauma. He gains additional and more modulated control in the second stage as he acquires conscious knowledge about his conflict and its background. The transition between the two stages, therefore, does not necessarily depend upon the interpretive help of the therapist, for the patient himself is attempting to make the conflict conscious and to resolve it. The patient may in fact have sufficient control over it to make it conscious even without interpretation. If in this situation the therapist does interpret what the patient is warding off, the patient is likely to make use of the interpretation, for it helps him to accomplish what he is already trying to do. There are, of course, many instances in which a patient may be unable to experience a warded-off mental content without the help of an interpretation.

Most instances of successful conflict analysis take place under the patient's control. Sometimes, however, a patient loses control over a powerful unconscious mental content and has to accede to its disguised expression in his behavior—mobilization of conflict, as

described in the traditional theory. It may prove therapeutic if the patient discovers with the therapist's help that the mental content is not as dangerous as he had feared. In many instances, however, the mobilization of conflict will not lead to a therapeutic outcome. The patient may be too frightened to use interpretive help, and he may either reestablish his repressions or experience a trauma that is disruptive to the treatment.

The control-mastery theory explains certain observations about the analysis of conflict that cannot readily be explained by the traditional theory. These observations are unlikely to be made by a therapist whose ideas and intuitions are shaped by the traditional theory, for he would not expect unconscious mental contents to become prominent and then conscious in the following way: First, a patient expresses prominently powerful unconscious impulses toward the therapist as well as defenses against these impulses. He does so relatively calmly and smoothly without increased anxiety which would be predicted by the traditional theory. The traditional theory could, however, explain the patient's calmness as based on the patient's successful defenses against awareness of the mental content he is expressing. Second, the patient becomes conscious of his impulses and defenses without interpretation by the therapist, remaining calm as he does so. His calmness cannot be due to defenses against the awareness of the mental content he is expressing, for he is now conscious of them. The traditional theory could only explain this observation by the idea that the patient was isolating the emerging mental content in consciousness and thus warding off his anxiety. Third, the patient links the emerging mental content to other past and present contents and integrates them within his personality without interpretive help from the analyst and without much anxiety. Thus, the patient's lack of anxiety in the second part of the observation cannot be explained as due to isolation; if the patient were isolating these mental contents, he could not be working on them therapeutically.

This three-part observation* can only be explained by a theory that assumes the patient brings his impulses and defenses to prom-

* Joseph Weiss and I have made this three-part observation frequently in our clinical work and are conducting a research study which we believe will demonstrate this observation objectively with highly reliable measures in the analysis of one patient.

inence under his own control and, therefore, is not made anxious by their expression. It also requires a theory which assumes that the patient makes his impulses and defenses prominent in order to master them rather than simply to gratify them or to resist the treatment, for if the patient gains insight into these mental contents and masters them by his own work without interpretive help from the therapist, then it must be because he wishes to do so.

I should like to conclude this presentation with two additional comments on psychoanalytic therapy. The first, implicit in what I have already presented, is that the task of the therapist is to help the patient carry out his unconscious plans for solving his problems. The therapist's interventions are likely to be useful only inasmuch as they are compatible with these plans. For example, a young woman avoided closeness to other people because she felt obliged, out of unconscious guilt, to accept all of their criticisms of her. She therefore felt exposed in any relationship to the risk of feeling helpless and vulnerable. Early in her analysis she developed an unconscious plan to solve her problem of being unable to be intimate with others by first reducing her sense of vulnerability through developing a capacity to fight back and to blame other people for difficulties which arose. When the analyst made interpretations of her hesitance to criticize other people, including himself, the patient pressed ahead actively with the work, bringing forth new ideas and feelings and making new connections. When the analyst made interpretations that were also true but which were in opposition to her plan—such as her feeling dependent on or wanting to be close to others—the patient became constricted in her therapeutic work and was unable for a time to bring forth new material or to make new connections.

My final comment is based on a topic I have not mentioned earlier and shall take up only briefly here, namely, the role of unconscious guilt in human life and in therapy. In our view, a crucial factor in a patient's continuing attachment to infantile objects and to infantile gratifications is unconscious guilt about wanting to turn away from early objects, to exercise self-control, and to run his own life. Thus, therapy is not a process in which a patient gradually and reluctantly renounces infantile satisfactions. Rather, in the course of therapy a patient gradually comes to feel reassured that he may relinquish infantile object ties and pleasures without harming the analyst and

without becoming overwhelmed by guilt toward earlier objects. For example, a young man behaved impulsively and irresponsibly in his everyday life, in part as an unconscious submission to the analyst based on guilt in the maternal transference. When the analyst remained neutral, neither scolding him for his irresponsibility nor offering guidance as to how he should conduct himself, the patient was unconsciously reassured that the analyst, unlike his mother, did not derive satisfaction from his weakness and immaturity. Thus reassured, he began to act more responsibly and was able to recall his fear that doing so would hurt his mother.

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