

## CERTAIN FACETS OF THE THERAPEUTIC PROCESS<sup>1</sup>

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The course of an analysis may be followed in terms of how the patient works on his difficulties and what he accomplishes. Followed in this way it may be schematically organized into a continuous story, or rather group of stories. Ordinarily, certain parts of the analytic story or stories are especially clear and sharp. When the patient, for instance, overcomes an important piece of resistance or gains a new understanding of an aspect of the transference, it is relatively apparent what the patient is accomplishing and how he is accomplishing it. The sharpness of the analytic story in such instances is due not only to the dramatic nature of the events in the analysis but also to the fact that our concepts prepare us to see these types of events with clarity. In other parts of the analysis the patient's progress may be silent;(1) then, both what the patient is accomplishing and how he is accomplishing it take place outside the focus of analytic attention. In these instances the patient's changes are not so dramatic, or our concepts have not fully prepared us to take seriously what changes are discernible.

The purpose of this paper is to describe clearly and in some detail certain ways that the patient uses the analyst to work on his difficulties,

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<sup>1</sup> This paper has to a large extent been inspired by discussions that have taken place in the last several years in a study group on the therapeutic process conducted by Dr. Emanuel Windholz. Other members of the group are Drs. Ralph Potter, Haskell Norman, Edward Weinshel and the author. Comments from all the members of this group, and especially Dr. Windholz, have been most helpful and stimulating. The ideas in Section II are directly inspired by comments of Dr. Windholz.

ways that are ordinarily either overlooked or are referred to only casually. These methods of working are best illustrated in the synopsis of a segment of an analysis. In this synopsis three interrelated therapeutic processes contribute to the patient's accomplishments. These processes are: 1. The patient's use of the analyst as an auxiliary ego. 2. The patient's attributing capacities to the analyst and subsequently identifying with the analyst as having these capacities. (2) 3. The patient's use of insight into his unconscious defenses in order to employ these defenses more effectively. Since the purpose of the synopsis is to illustrate therapeutic processes and to indicate the part each plays in an analytic story, the synopsis is presented in a schematic, even diagramatic, way. No information extraneous to the one "story line" under consideration is included, so that the skeleton of the story may be laid bare and the contribution of each process readily followed.<sup>2</sup> Later each of the processes is discussed in more detail, both in connection with the patient referred to in the synopsis and also in general terms.

In the synopsis, the analysis of a compulsive character is followed along the story line of his acquiring a capacity to experience strong affects, the major achievement of his first year of analysis. At the beginning of his analysis the patient is at his low point as regards a capacity to experience strong affects since these are effectively warded off by his unconscious obsessive-compulsive defenses. His initial progress brings these obsessive-compulsive defenses closer to consciousness so that they may be interpreted. Finally the patient's insight into his use of these defenses to ward off affects enables the patient to experience strong affects.

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<sup>2</sup> Thus, the synopsis contains no explicit reference to changes in the patient's transference in the sense of his revival in his relationship to the analyst of specific impulses once directed to important objects in his childhood.

As stated above, the patient at the beginning of his analysis, is at his low point as regards a capacity to experience strong affects. For though he is threatened by powerful affects derived from unconscious sadism and homosexuality, he experiences consciously only a mild feeling of confusion. The patient's situation may be accounted for in terms of two conflicts: An intersystemic conflict and an intrasystemic conflict.

The patient's major conflict is intersystemic, between powerful affects derived from his unconscious sadism and homosexuality on the one side, and his obsessive-compulsive defenses of ambivalence and undoing that are part of his unconscious ego on the other. (As shown later, a necessary condition for the undoing defense to function is the presence of ambivalence. Ambivalence and undoing work together in the process of defense.) These defenses are largely successful in protecting the patient from affective experience.

The lesser conflict is intrasystemic between the patient's conscious ego and his unconscious obsessive-compulsive defenses. For the patient experiences the automatic operation of these defenses outside of the control of his conscious ego as a threat to his clarity of thought; that is, these defenses threaten him with confusion. (The patient's confusion results not only from his unconscious defenses but also from the unconscious drives themselves, or rather from affects derived from these drives; in other words, from a failure of defense. However, this consideration does not affect the relationships that this schematic presentation attempts to clarify.) The patient attempts to deal with this threat by making a special effort to think clearly.

The patient's initial progress beyond the low point described above may be understood in terms of two closely related accomplishments, both of which contribute to his becoming more aware of his obsessive-compulsive defenses. These accomplishments both depend on changes in the patient's picture of the analyst, changes that the patient brings about by testing the analyst.<sup>3</sup> These accomplishments are: 1. The patient becomes less afraid of the confusion resulting from his unconscious defenses so that he becomes able to relax the special effort he makes to think clearly, and thus to expose to a greater extent the defenses that underlie the confusion. 2. The patient becomes more aware of his ambivalence by becoming more aware of and hence more in control of his opposing attitudes of stubbornness and submissiveness.

The first accomplishment concerns mainly the intrasystemic conflict. The patient by testing the analyst comes to see him as an ally who by his own control and clarity of thought protects the patient from the confusion resulting from his (the patient's) unconscious ambivalence and undoing. The patient's coming in this way to rely on the analyst as an "auxiliary ego" (and super-ego), permits him to relax the special effort he makes to cover up the confusion resulting from his unconscious defenses and thus to expose these defenses to a greater extent.

The second accomplishment concerns the patient's becoming more aware of his ambivalence. The patient

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<sup>3</sup> Since the patient's initial improvements depend on changes in his picture of the analyst they are to a large extent (but not completely) reversible. They may be reversed by whatever prevents the patient from maintaining his more favorable picture of the analyst. Though these initial improvements are to a large extent reversible they pave the way for more permanent accomplishments.

The patient achieves this by becoming first more aware of and hence more in control of, his stubbornness, then of his submissiveness. The processes by which the patient brings these changes about may be summarized as follows: The patient tests the analyst in a way that facilitates his attributing to the analyst a capacity that he needs to acquire... a capacity to be deliberately stubborn. He then identifies with his picture of the analyst as capable of being stubborn and thereby acquires, if only to a slight extent, both more awareness of his own stubbornness and a greater capacity to be deliberately stubborn himself. As the patient gains more control over his stubbornness, he also gains more control over his submissiveness. He can submit more readily knowing that he can become stubborn and thereby stop submitting. Having become able to be both more deliberately stubborn and more deliberately submissive the patient can begin to express these attitudes alternately (originally both attitudes found expression simultaneously beyond the patient's awareness and control). The patient's capacity to express stubbornness and submissiveness alternately and deliberately rather than simultaneously and unconsciously permits him to be more aware of his ambivalence.

As stated above then, both of the patient's accomplishments bring his obsessive-compulsive defenses (or perhaps more accurately his obsessive-compulsive thinking) more into the open and closer to consciousness so that these may be interpreted.

The analyst's interpretations of the patient's obsessive-compulsive thinking are organized around the patient's use of ambivalence and undoing to ward off strong affects. As

will be recalled these unconscious defenses play a role in two conflicts: These defenses oppose powerful affects derived from unconscious drives (intersystemic conflict) and also, since their automatic operation is out of the control of the conscious ego, threaten the patient with a feeling of confusion (intrasystemic conflict).

Each of these conflicts is affected by the patient's insight into his use of these defenses. As regards the intrasystemic conflict, the patient's insight into these defenses ultimately enables his conscious ego to gain control of them. The patient's undoing becomes to a large extent divested of its primitive magical nature and the patient acquires the capacity to "undo" deliberately. As regards the intersystemic conflict, the integration of the defenses into the conscious ego as described above greatly strengthens the patient's ego in its struggle with the affects derived from the unconscious drives. Now that the patient can consciously and deliberately turn away from his affects ("undoing" them) he can tolerate experiencing his affects. He can tolerate experiencing them knowing that he can control the experience. Now for the first time he does, in fact, experience strong affects of enthusiasm, pride, anger and affection.

## I

The use of the analyst as an auxiliary ego by the patient referred to in the above synopsis is now considered in greater detail. The patient, as the reader will recall, pays a price for his use of the unconscious defenses of ambivalence and undoing. For the automatic operation of these defenses beyond the control of the patient's conscious ego creates an intrasystemic conflict; that is, these defenses while a part of the patient's unconscious ego threaten other of his ego functions, specifically those that regulate his thinking. He deals with this threat by a hypercathexis of the threatened functions. In other words, he tries to avoid a feeling of confusion by making a special effort to think clearly. The patient in this situation wishes to be able to rely on the analyst's clarity of thought to protect him from the dangers of confusion. After testing the analyst he becomes able to use the analyst to protect him in this way, that is as an "auxiliary ego." The patient's reliance on the analyst as an auxiliary ego enables him to relax the special effort that he makes to think clearly. He now permits himself to feel confused and by so doing to expose to a greater extent the unconscious defenses that contribute to his confusion.

Now for some brief clinical vignettes that illustrate these processes. The patient's awareness of his reliance on the analyst as an auxiliary ego to protect him specifically from a feeling of confusion is apparent from his associations to a dream, that the analyst is waking him from a nightmare. According to the patient the nightmare symbolizes his confusion, and the dream as a whole means to him that he is tempted to trust the analyst.

The patient is also aware of the role of testing in his coming to use the analyst as an auxiliary ego. The day after he demonstrates his increased reliance on the analyst by getting a job to pay for his treatment he tells the analyst, "If I need someone and they respond favorably then I act worse. I want to be helped in spite of myself. This is partly to find someone trustworthy and is partly teasing." A few sessions later the patient reports teasing a colleague at work. The colleague does not become confused or upset and the patient "overcomes" a confused feeling in himself.

That the patient's reliance on the analyst as an auxiliary ego makes it easier for him to experience confusion is suggested by the following: During the period in which the patient is least secure in his relationship to the analyst, that is, up to the time when he is able to submit to the analyst to the extent of getting a job to pay for the treatment, he is scarcely able to acknowledge any feelings of confusion. In the next several weeks after he becomes more able to rely on the analyst as an auxiliary ego the patient repeatedly describes both feeling more secure and more confused than in a long time.

Now for an example from a different patient. In this example the patient's use of the analyst as an auxiliary ego is particularly striking; in fact, various of the therapeutic processes in this patient have a clarity of structure that gives this example the quality of a paradigm. The analysis of this patient is described in a fascinating unpublished paper by a colleague. The paper is concerned mainly with states of consciousness, not with the therapeutic process. Nonetheless I believe that this colleague would agree with the following account, which, of course, is presented in such a way as to make clear the story line of the therapeutic process.

The patient, a woman in her mid-thirties, suffered severe and repeated painful traumata in her early childhood in the form of treatment administered by a doctor for a chronic illness. As a result of this very painful treatment the patient, according to her analyst, developed a primitive ego defense, a capacity to shift ego cathexis that altered her state of consciousness in the direction of a dreamlike state. In later life she continued to use this defense, now no longer against pain, but to ward off disturbing sado-masochistic fantasies.

Neither the patient nor her analyst became aware of her use of this primitive defense until after she had been in analysis for several years. The patient apparently was afraid to experience the altered state of consciousness that resulted from her use of this defense. For this primitive defense, though a successful protection against sado-masochistic fantasies, was itself a danger to the patient, threatening her sense of the continuity of her experience.



The patient compensated for her use of this defense by attempting to be alert and also by maintaining some permanent external record of important experiences. This she did in a disguised form in her writing and art, with which she was most reluctant to part.

After her marriage this patient's relationship with her husband took the place of her art and writing. Her reliance on him to maintain an external record of events enabled her to have successful sexual relations. That is she was able to avoid her disturbing sado-masochistic fantasies during intercourse by using (though not consciously or deliberately) her primitive defense to create a dreamlike state, all the while relying on her husband to protect her from the threat to her feeling of continuity resulting from this state. Certain behavior on the part of her husband which interfered with her maintaining a picture of her husband as reliable resulted in her failure to have satisfactory sexual relations and ultimately precipitated her coming to analysis.

In her analysis the patient came to use her analyst as an auxiliary ego only after repeated testing of his reliability as someone who would keep for her a permanent external record of the events of the analysis. To quote from the unpublished paper describing this case -- "She (the patient) had a maddening habit of quoting out of context something I had put into words a week or two earlier and with apparent sincerity would claim that I had said something quite degrading to her. . . it required the most painstaking recall of interpretations to make it clear to her that she had indeed distorted the meaning of my remarks."

After a period of such testing the patient for the first time did permit herself to experience a wish to sleep during her analytic sessions. She now felt safe in experiencing the altered state of consciousness in the analysis, knowing that her analyst would keep a permanent record of events, and thus protect her from the dangers connected with experiencing the dreamlike state.

The subsequent course of the analysis may be schematically presented as follows: The patient's experience of the altered state of consciousness is a step in the direction of her gaining insight into her use of the primitive ego defense and thus of eventually gaining control over it. The patient becomes able to use the primitive defense deliberately, initially because she feels that her analyst protects her from the dangers resulting from its use, later because insight gives her control over it. With a new capacity to bring on deliberately the dreamlike state the patient can experiment with staying awake; that is, with experiencing her sado-masochistic fantasies. She can experience these fantasies knowing that she can deliberately turn them off so that she ultimately is able to face these fantasies and to succeed in analyzing them.

## II

In this section another therapeutic process illustrated in the synoptic account is considered; that is, the patient's attributing capacities to the analyst and subsequently identifying with the analyst as having these capacities. As the reader will recall, the patient referred to in the synopsis tests the analyst in order to experience the analyst as having a capacity to be deliberately stubborn; his subsequent identification with the analyst as capable of being stubborn enables him to become more aware of and also more in control of his own stubbornness. This process of testing and identifying is now discussed in general terms and later illustrated by a vignette from the analysis of the compulsive patient referred to in the synopsis.

The process of testing and identifying is closely related to patient's use of the analyst as an auxiliary ego. In each instance the patient, by testing the analyst, comes to attribute to him a certain capacity; in the one instance, in order to rely on this capacity, in the other, in order to acquire it himself by identification. These processes inevitably occur

together. Thus, the patient who needs to assure herself that her analyst maintains a permanent record of the events in the analysis, not only wishes to be able to rely on her analyst's memory but also to acquire a reliable memory herself by identification. As this patient experiences it, her analyst's behavior demonstrates a way of reacting to painful traumata that differs from the way she reacted to the painful medical treatment in her childhood and also from the way she still reacts to her painful sado-masochistic fantasies. Her analyst retains the use of his memory despite the patient's torture (testing); the patient's subsequent identification with this capacity in her analyst contributes to her eventually being able to stay awake and face her own torturing fantasies. Similarly, the compulsive patient who attributes to the analyst a capacity for stubbornness not only does so in order to identify with this capacity but also be able to rely on the strength that it implies.

Both the patient's use of the analyst as an auxiliary ego and the patient's attributing capacities to the analyst and subsequently identifying with the analyst as having these capacities, play a role in bringing warded off mental contents closer to consciousness but not in the same far reaching way as through the assimilation of insight. The use of the analyst as an auxiliary ego as already described allows the patient to relax compensatory measures that cover up underlying contents, and the process of testing and identifying helps the patient to become more aware of forbidden contents by allowing him to experience these contents first in the analyst.

To consider this latter point in greater detail: What the patient attributes to the analyst is a mental content that he can not accept in himself. Thus the compulsive patient who attributes to the analyst a capacity to be deliberately stubborn does so at a time when he is unaware of his own stubbornness. He can experience stubbornness in the analyst more readily than he can experience it as part of himself, and by experiencing it in the analyst he brings it a step closer to consciousness. The

patient's subsequent identification with the analyst who apparently can tolerate being stubborn contributes to the patient's being able to tolerate experiencing it. He comes to be able to see himself as stubborn in the same way that he originally saw the analyst as stubborn.

The patient's attributing to the analyst a content that he can not accept in himself may be aptly compared with what sometimes happens in a child's "play therapy" with dolls. The child attributes to his doll (transitional object) some content that he can not accept in himself. He can thus become familiar with this content, think about it, and connect it with other contents. In this way he may acquire greater control over it--possibly enough so that later he may be able to acknowledge it as part of himself.

Now for a short vignette to illustrate the process of testing and identifying discussed above. This vignette is from the analysis of the compulsive patient already referred to and concerns the patient's acquiring greater awareness of and control over his sadism. The patient's testing the analyst facilitates his attributing to the analyst a capacity to be deliberately sadistic. He subsequently identifies with his picture of the analyst as sadistic and thereby becomes a little more aware of his own sadism.

The vignette begins with the patient's missing one of his analytic sessions after a period of irregular attendance. The patient's not coming to the session is quite over-determined. Two meanings of his missing his session relevant to the vignette are: 1. The patient by missing the session expresses his unconscious sadism about which he is intensely guilty. 2. The patient by missing the session tests whether or not the analyst will show some concern about his missing by coaxing him to come or by insisting that he come.<sup>4</sup> Though to a slight extent he

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<sup>4</sup> The patient's wish for the analyst to take responsibility for his coming to his session expresses among other things a father transference. Often during his childhood he would sleep until his father would force him out of bed.

hopes that the analyst will coax him to come or insist that he come, he mainly hopes that the analyst will not interfere with his autonomy. In other words, he hopes that the analyst by not worrying about him will demonstrate what he experiences as a capacity to be deliberately sadistic.

The next session after he misses the patient is very guilty and apologetic, apparently afraid that he is worrying the analyst. He describes how "petty and mean" he feels for missing his session. "But why do you feel so petty and mean?", the analyst asks. The patient hesitates for a minute and answers, "Well, the analysis won't work if I miss." The analyst continues, "That may be true, but it does not explain your feeling so petty and mean."

A dream reported in the next session shows that the patient experiences the analyst's comments as expressing an attitude of friendly condescension that is, as the patient experiences it, a capacity on the part of the analyst to be deliberately sadistic. In this dream the patient expresses an attitude of "friendly condescension" to another man. The patient comments that his (the patient's) attitude in the dream is exactly like the real attitude of his best friend, S, to him (the patient). The patient continues, "S is not really condescending but I provoke him to be that way." The patient's associations to the dream show that he is becoming aware of the processes of testing (provoking) and identifying.

The patient's identification with his picture of the analyst as capable of being sadistic leads to an important breakthrough a few sessions later. The patient for the first time describes in vivid detail a sadistic sexual fantasy in which he imagines a father beating his daughter on the buttocks.

## III

This section describes how the patient referred to in the synopsis uses insight into his obsessive-compulsive thought processes to acquire a capacity to tolerate strong affects. The patient's earlier achievements in the analysis make his obsessive-compulsive thinking more conscious. Now he is able to gain insight (conveyed by interpretations) into his use of undoing and ambivalence as a defense against affects. An account of his use of these obsessive-compulsive defenses will prepare us for a discussion of how insight into the workings of these defenses helps the patient.

Undoing and ambivalence work together to form a primitive defense used by the patient to ward off powerful affects such as pride, enthusiasm and love derived from his unconscious sadism and homosexuality. As one affect develops that threatens the patient's sense of control (or threatens the patient with a sense of guilt) his ego deploys certain of its energies to strengthen an opposing affect. The patient experiences the strengthened affect as magically wiping out or undoing the affect that it opposes. Thus the patient may oppose stubbornness by submissiveness, or affection by anger. But the new affect soon becomes a threat to the patient and must itself be undone. A necessary condition for the undoing defense to operate is an inability on the part of the patient to experience his ambivalence. For if he were able to accept feeling, say, both angry and affectionate at the same time, he could not feel that one affect magically undoes the other.

While the undoing defense<sup>5</sup> protects the patient by warding off affects derived from his unconscious drives, its automatic operation outside

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<sup>5</sup> Since undoing and ambivalence work together and since undoing implies ambivalence I shall speak of "undoing" to mean both of these defenses working together.

the control of his conscious ego is itself a threat to the patient. Its automatic operation threatens the patient's sense of control over his thinking. The patient's undoing is initially kept from his conscious awareness, and hence from his conscious control, not only by the special effort that he makes to avoid confusion but also by isolation and externalization (an example of defense against defense. (3) When the patient does become aware of his undoing as a result of the analyst's interpretations he at first feels all the more helpless and confused, for at first he can only notice this defense--he can not control it. At this point undoing is something that happens to him, not that he does.

To summarize: The patient's unconscious defense of undoing plays a role in two conflicts: The major conflict is the intersystemic conflict between the ego and the drives. In this conflict the undoing defense functions to protect the patient from powerful affects derived from unconscious drives. The lesser conflict is the intrasystemic, between the patient's conscious ego and unconscious defenses. In this conflict the patient's undoing threatens his clarity of thought. The patient's insight into his use of undoing to regulate affects alters both of these conflicts.

The patient's insight into his undoing eventually enables him to get control of it. He becomes able in a sense to "undo" deliberately. In other words, the defense of undoing is integrated into the conscious ego. This integration resolves the intrasystemic conflict and transforms the undoing from an unconscious defense that operates automatically into a conscious ego control mechanism.

The integration of the undoing defense into the conscious ego greatly strengthens the ego as a whole in its struggle with the affects derived from the drives. With the patient's being able to undo deliberately he can also tolerate experiencing strong affects. He can experience strong affects knowing that he can consciously turn away from them ("undo" them).

As may be seen from the above the resolution of the intrasystemic conflict and the intersystemic conflict occur together as part of one process.

The integration of warded off elements transforms them. The undoing defense loses to a considerable extent its original primitive and magical nature. As the patient becomes able to experience his ambivalence he can no longer experience one affect as undoing an opposing one. Thus the capacity to "undo deliberately" may ideally mean no more than the capacity to turn from one affect or interest to another. In this sense the analysis of the undoing defense "abolishes" it by transforming it into an ego control mechanism. But as with other mental elements complete "integration" or "abolishment" does not occur. The patient with an obsessive-compulsive character after analysis is still an obsessive-compulsive character and his improved methods of affect control continue to bear some relationship to the primitive undoing defense.

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The story of the obsessive-compulsive patient's acquiring greater toleration of strong affects is only one chapter in an analysis that lasts five years. This chapter is of course related to the whole story in a number of ways. Only one important connection along a central story line of the analysis will be indicated here. This connection is that the patient's greater toleration of strong affects contributes to his ability to form more intense transferences. It is of interest that this patient who is initially so unable to tolerate affects is eventually able to revive in his relationship to the analyst both sides of his father transference; that is, intense jealousy based on oedipal fantasies as well as homosexual longing.

The consideration of an entire analysis, however, is beyond the scope of this paper. The purpose of the paper as stated at the beginning has been to describe clearly certain therapeutic processes that are ordinarily outside the focus of analytic attention. These processes occur in every analysis--in some more "silently" than in others and in patients with different clinical syndromes in different ways.



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