THE PATIENT'S ADAPTIVE USES OF THE ANALYST *

By

Joseph Weiss, M.D.

A study of the changes that take place during analysis, in order to be complete, must consider a number of interrelated processes occuring at different levels of mental life. The most thoroughly understood of these processes are those occuring in the depths of the personality, involving changes in the patient's unconscious defenses and impulses, his transferences and resistances. Despite the tremendous development of ego psychology, the least carefully studied of the therapeutic processes, at least on the clinical level, are processes centering in the ego and having to do with the adaptive ways by which the patient uses the analyst to solve problems. This paper illustrates by means of a clinical presentation certain of the patient's adaptive uses of the analyst and shows how they are coordinated with changes that occur at the same time in the patient's unconscious drives, defenses and transferences.

The neglect on the clinical level of the patient's adaptive uses of the analyst is not due to the lack of a theoretical framework. Developments in psychoanalytic theory (2, 4, 8,) provide the basis for a systematic investigation of these processes. Nor is the neglect due to the strangeness of these processes which though complex are intuitively understandable. The neglect of the patient's adaptive activities during analysis may stem rather from a belief among analysts that these are not the essential analytic processes: that the essential analytic processes are those occuring in the depths of the personality. One reason for this belief is the recognition that an analytic treatment may not be considered a success unless certain highly significant changes do take place in the depths of

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the personality. It is not possible for example by a consideration of the patient's adaptive uses of the analyst considered in isolation from other analytic processes, to make the crucial distinction between a mere transference cure and a true analytic change. Furthermore, the patient's adaptive activities are not specific to analysis. They occur in various situations, while the analytic changes that occur in the depths of the personality during a successful treatment can occur only in analysis. Thus the idea that the adaptive activities of the patient are not essential may be correct in one sense; these activities cannot be uses as a criterion of analytic success. But this idea is false in another sense, for these activities may be necessary to bring about the fundamental changes in the depths of the personality that are necessary for a successful analysis.

A clinical example will help us to identify the patient's adaptive uses of the analyst and to show how they fit in with the other processes of analysis. For the sake of clarity and emphasis the example is first presented without any reference to the patient's adaptive uses of the analyst. It is presented in terms of the vicissitudes of the patient's drives, defenses, resistances and transferences. Then the same clinical material is reconsidered to show how a consideration of the patient's adaptive activities supplement the first account.

The patient, Mr. M., a neat, well dressed and detached looking man of thirty-five was the only son of conservative, wealthy parents. His father, a successful businessman who prided himself on his practicality, dominated the family. In his childhood, Mr. M. saw his father as a tyrant who enjoyed teasing him sadistically. The patient's mother and sister were both unhappy martyrs; the patient felt a vague sense of responsibility for their unhappiness.

At the time of beginning treatment, Mr. M., having been prodded by a solicitous professor, was on the verge of finishing a thesis toward which he had been working

ineffectively for a number of years, and thus of obtaining a PhD in theoretical physics. But this prospect frightened him in several ways. He was, as he put it "afraid of the feeling of success" that he anticipated would accompany his graduation, and in the typical manner of the obsessive compulsive character, he was afraid of the opposite feeling. He was afraid of developing a sense of failure. For Mr. M., the prospect of obtaining a degree, since it would be a real achievement, connected him with reality and hence depressed him. It interferred with his tendency to use isolation to make experiences unreal and hence tended to confront him with how little he had accomplished. Furthermore, the patient feared that obtaining his degree would interfere with his relationship to his professor so that he now needed to find a new authority to whom he could be submissive and defiant.

In his first session, Mr. M. traced his present difficulties back to an unfortunate relationship with a psychiatrist, Dr. F., who he had seen once a week for several years, ten years before. He had felt dominated by Dr. F. and seduced by him. Particularly disturbing to Mr. M. was Dr. F.'s insistance that he give up his relationship to his girl friend Phyllis, a former patient of Dr. F.'s who had begun to see Dr. F. socially, And Mr. M. had felt seduced by Dr. F.'s interest in his masturbation and by Dr. F.'s refusal to permit him to terminate. The patient's experience with Dr. F. produced the same unfortunate result as might occur from a child's relationship to an overly seductive parent; the patient's repressions were lifted in a way that was not helpful. He was left with powerful sexual and aggressive impulses close to the surface over which he had scarcely any control and which he satisfied by frequent masturbation, accompanied by fantasies of beating women. His loss of control over his sexuality made all close relationships frightening to him and it interfered with his sublimations and hence his capacity for productive work. With the failure of his repressions he had to rely on certain

unfavorable defensive attitudes; namely, retreat into fantasy, and making experiences unreal by a kind of isolation. By retreating into fantasy and avoiding close relationships the patient avoided a repetition of the traumatic experiences with Phyllis and Dr. F. and at the same time preserved them as disguised figures in his sexual fantasies.

At the beginning of his treatment Mr. M. was extremely distrustful of the analyst. He rapidly developed what may be conveniently termed a Dr. F. transference. He unconsciously expected the analyst to run his life in the manner of Dr. F.; to take responsibility for his behavior as a patient, to draw him out with questions, and to force him to talk about his sexual ideas. The patient's picture of the analyst as wishing to dominate him served his resistance by gratifying certain of his powerful and poorly controlled unconscious homosexual and sadistic fantasies, so that he did not have to become aware of them. Mr. M.'s unconscious sadism was gratified by his fantasy of power over the analyst whose presumed wish to run his life could be so easily frustrated. Even more important the patient's picture of the analyst as so interested in running his life satisfied his unconscious homosexuality, and at the same time permitted him to deny it.

When the analyst did not oblige the patient's unconscious wish to be dominated, the patient tried to provoke him into becoming dominating. He became silent for periods of time and stated that he found it impossible to say anything important to the analyst. The analyst of course remained neutral. The frustration, by the analyst's neutrality, of the patient's wish to see the analyst as dominating, made the patient more aware of the defensive value of this picture of the analyst. And the analyst's neutrality frustrated the patient's unconscious homosexual and sadistic impulses which as a result came closer to consciousness. The patient became especially threatened by his homosexuality so that he developed a new

defense against it; he attempted to avoid experiencing his homosexual attachment to the analyst by a kind of acting out in the transference. He displaced his love for the analyst onto a girl friend with whom he rapidly developed an intimate relationship, the first in a number of years. But the patient could not maintain this relationship. His sexual attachment to the analyst and to the girl, mobilized his castration anxiety and led to the repression of his sexuality. He gave up his relationship to the girl and ceased his struggle to discuss masturbation. He was not to be concerned again with sex for some time.

The intensification by Mr. M. of his sexual repressions came about because his other defenses had failed to protect him from castration anxiety. The defenses that had served him before analysis, namely, retreat into fantasy, and making experiences unreal, were rendered inoperative by his intense transference to the analyst. These defenses were not compatible with his attachment to a real person. Furthermore, once he began analysis, the patient could not maintain his picture of the analyst as dominating him in the manner of Dr. F., so that his frightening sexual and sadistic impulses were brought closer to consciousness.

The patient's re-repression of his sexuality, by the way, was not entirely unfavorable, for by it the patient repaired, to some extent, the damage that had resulted from his relationship to Phyllis and Dr. F.

Mr. M. reacted to the castration threat, mobilized in the transference, not only by intensifying his repressions but also by regressing more completely to anality. As a result of this regression the patient became a more typical obsessive compulsive character; he became more ambivalent to the analyst, he intensified his use of the unconscious defenses of undoing and isolation; he became preoccupied with time and money. And Mr. M. became in danger of ruminating obsessively as though forced to argue with himself, especially when planning how, when, or where to look

for a job which he needed to pay for the analysis. But he warded off the danger of ruminating, at first quite successfully, in two different ways. The first was to avoid thinking at all about his obtaining a job; the second was to attribute one side of his ambivalent ideas about his working to the analyst and then to argue with him. The patient, of course, became frustrated that the analyst would not express opinions about his working nor argue with him, so, as earlier, he tried to provoke the analyst to do so. The culmination of the patient's provocations came when he flatly asserted, at the beginning of one session, that he had to stop analysis immediately since he could not afford to pay for it. When this provocation also failed to elicit a reaction from the analyst, the result was a temporary break-through into Mr. M.'s awareness of his obsessive-compulsive thinking, accompanied by a feeling of confusion. He experienced a feeling of confusion when thinking about what seemed to him contrary ideas about the value of analysis. Thus he thought that having an analysis required a great sacrafice of time and money, yet a moment later it occured to him that this could not be so since he could achieve nothing without analysis. Though Mr. M. did obtain a job in less than a week he continued occasionally to feel mildly confused for brief periods of time during the next several weeks.

Mr. M.'s obtaining a job to pay for his analysis was from the adaptive point of view an important achievement. It showed that the patient had overcome his distrust of the analyst enough to commit himself to some extent to becoming a patient, and was one sign that he had formed a therapeutic alliance (1, 3, 10) with the analyst. This is a good time to pause and consider what changes in the patient's drives, defenses and transferences and also what adaptive activities of the patient made it possible for him to form a therapeutic alliance with the analyst.

Several changes, some of which have already been described, helped Mr. M. to overcome his initial intense distrust of the analyst. Thus Mr. M. became aware that his frightening picture of the analyst as dominating was motivated by an unconscious resistance. Then too, the intensification of the patient's repressions protected him for the time being from castration anxiety and thus made him less vulnerable in his relationship to the analyst. And as we shall see the patient succeeded in analyzing an aspect of his Dr. F. transference and came to recognize how it affected his image of the analyst.

But the patient's distrust of the analyst, his fear that the analyst would behave in the manner of Dr. F., could not be completely resolved by his understanding of his unconscious defenses and resistances. For the resolution of his distrust, depended to some extent on Mr. M.'s being able to discern correctly that the analyst would not behave in the manner of Dr. F. Mr. M. went about appraising the analyst by an activity that may be considered adaptive, namely, by testing the analyst. He tested the analyst by tempting him to behave like Dr. F. had behaved in order to assure himself that the analyst would not do so. Thus Mr. M. tested the analyst at first by his silences and by his assurations that he could not talk freely as a patient, later by forming an intimate relationship with a girl, and later still, by asserting that he had to quit the analysis immediately since he could not afford to pay for it.

The behavior that is here considered a kind of testing, is of course, the same behavior that was earlier described as provocative and as having a defensive function. Thus the patient was ambivalent about how he wanted the analyst to behave. While certain of his unconscious resistances were satisfied by his picture of the analyst as dominating in the manner of Dr. F., another part of the patient sought a reliable analyst and was frightened by this picture. And the analyst's neutrality affected the patient in different ways; it frustrated certain of his unconscious resistances while at the same time reassuring him that his autonomy would be respected.

It is worth noting a connection between these two distinct processes. The patient's satisfaction at finding a reliable, that is, a neutral, analyst, helped him to tolerate the frustrations, imposed by the neutrality of the analyst, on certain of his unconscious drives and defenses.

Mr. M.'s threat to stop treatment was a significant test of the analyst in view of Dr. F.'s refusal to allow him to terminate. But perhaps, the most crucial of Mr. M.'s tests of the analyst was his forming an intimate relationship with a girl, for by this behavior, the patient was by implication, asking the analyst a question of great importance to him, namely, would the analyst interfere in his relationship with a girl friend as Dr. F. had interferred in his relationship to Phyllis ten years before. That Dr. F. and Phyllis were indeed on the patient's mind was shown by a dream that occured several sessions after the patient announced his interest in a new girl friend. The dream began with Dr. F.'s threatening to operate on him, then Phyllis joined Dr. F. and they laughed together at the patient's taking seriously what was meant as a joke. This dream, of course, expressed the castration threat that had been mobilized in the patient's relationship to the analyst. It also indicated a growing awareness on the part of the patient of his Dr. F. transference.

Thus Mr. M., at the beginning of his analysis, tested the analyst by creating in rapid succession, several situations similar to precisely those situations in his previous therapy that had tempted Dr. F. to intervene in a way traumatic to the patient. Mr. M.'s testing helped him to distinguish the analyst from Dr. F. and thus to understand that his fear of the analyst stemmed in part from a Dr. F. transference. That the patient became aware to some extent of both his testing and of his Dr. F. transference, became apparent after his finding a job made him more secure. He then described his previous behavior as follows: "I was attempting to find someone trustworthy and I was also teasing. I became completely dependent on Dr. F. and it worked out badly."

Let us now reconsider the significance of Mr. M.'s becoming confused. The recognition that the patient's provocative threat to stop treatment which occurred just before he became confused, also had the purpose of testing the analyst, adds a new facet to our understanding of his confusion. Mr. M. became confused shortly after his testing of the analyst assured him of the analyst's reliability and control, and as we shall see, of the analyst's clarity of thought. He allowed himself to become confused in the analyst's presence only after developing a certain degree of trust in the analyst. Until that time the patient warded off confusion by not thinking about confusing topics, by externalizing one side of his ambivalent ideas on to the analyst, and also by making a special effort to think clearly and deliberately. Thus the patient did not permit himself to feel confused during the highly traumatic opening phase of his analysis but only after he in fact decided to commit himself to the treatment.

Mr. M. was helped to express his confusion not only by his general trust in the analyst, but specifically by his reliance on the analyst's clarity of thought. The patient could relinquish the hypercathexas of his thinking along with the defenses that protected him from confusion, knowing that he could rely on the analyst's clarity to protect him from the dangers of confusion. In other words, the patient came to use the analyst as an autonomous auxiliary ego. (5, 6, 7,) Several weeks after he first allowed himself to feel confused, Mr. M. had a dream in which he was using the analyst to protect him from an altered state of consciousness. He dreamt that the analyst was waking him from a nightmare.

Mr. M.'s confusion resulted from the failure of his defenses and indicated a deep seated obsessive compulsive disorder of thought. None the less, his permitting himself to feel confused was an accomplishment.that enlarged his capacity for new experience. Mr. M. would not have to avoid thinking about certain topics to the same

extent as before, for fear of becoming confused by them.

Let us again take up the story of Mr. M.'s analysis in terms of the vicissitudes of his drives and defenses. After the breakthrough into consciousness of his obsessive compulsive thinking, Mr. M. re-established, though incompletely, the defenses that before had held in check his tendency to obsessive rumination. As before, he avoided thinking about topics that confused him and as before he attempted to attribute one side of his contradictory ideas to the analyst. Then, over a period of several months, he again relinquished these defenses. He found it hard to avoid confusing topics and his failure to provoke the analyst made it increasingly difficult for him to attribute one side of his ambivalent ideas to the analyst.

As the patient gave up the defenses that protected him from ruminating, he became gradually more and more ruminative. But this time he did not become confused. In fact, as a result of certain isolations, the patient scarcely became aware of the gradual emergence of his obsessive compulsive thinking which to the analyst appeared increasingly prominent and pervasive. Mr. M., for example, gave no indication that he saw anything unusual in the following typical rumination about his avoiding an assignment at work. He explained that he was refusing to do the assignment because he felt stubborn: he did not like his boss telling him what to do. A short time later, apparently unaware of the contradiction, he explained that he avoided the assignment because he feared that he could not do it. Then later still, he went back to the original explanation only to contradict it again after a short while. The patient could tolerate neither his stubbornness which made him feel guilty, nor his humiliating helplessness. As soon as one affect began to threaten him, he would magically undo it by changing his ideas so as to strengthen an opposing affect which he experienced as excluding the possibility of the original affect. Thus he would undo feeling stubborn by strengthening a feeling of helplessness and vice versa.

The patient's ruminations continued in this way for many weeks becoming increasingly more obvious to the analyst yet remaining beyond the patient's awareness. However, when the analyst did show Mr. M. how he used undoing and isolation to ward off affects, Mr. M. quickly understood. As a result of the analyst's comments, Mr. M. focused his attention on his obsessive compulsive thinking. His use of undoing and isolation became a central theme in the analysis for several months. It is condensing a great deal to say that the patient's use of undoing and isolation to ward off affects was demonstrated to him numerous times and in various contexts before he became able to experience strong affects, such as rage, affection and enthusiasm.

Thus in summary, Mr. M.'s coming to experience strong affects came about in stages: first Mr. M. relinquished the defenses that protected him from his obsessive compulsive thinking, namely, avoiding thinking about certain topics and attributing one side of his ambivalent ideas to the analyst. As Mr. M. relinquished these defenses his obsessive compulsive thinking became prominent so that it could be interpreted. Then the interpretation of the patient's use of undoing and isolation to ward off affects, which was the essential element in his obsessive compulsive thinking, enabled the patient to experience strong affects.

What does a consideration of Mr. M.'s adaptive activities add to this account? Let us begin to answer this question with a new observation; that the processes under consideration are in a way circular. For the patient's obsessive compulsive thinking, which involved his magical undoing of one affect by another, could not come into prominence and hence not be analyzed until the patient could begin to experience affects with a certain degree of intensity. At the beginning of his analysis Mr. M.'s capacity to experience affects was not sufficiently developed for him to demonstrate the kind of obsessive compulsive thinking that later became so prominent. For though at the beginning Mr. M. behaved dramatically and was

motivated by powerful and poorly controlled unconscious impulses he did not for the most part experience the affects derived from these impulses.

Our account must begin with the processes that helped Mr. M. to become slightly more able to experience affects. We can explain Mr. M.'s becoming more able to experience his affects on the basis of a change in his defenses; namely, that as a result of the analyst's neutrality, Mr. M. could no longer deny certain affects in himself by attributing them to the analyst. But in addition to this, certain activities which we have termed adaptive contributed to Mr. M.'s becoming more able to have feelings. One such activity has already been discussed in a different context, that is, Mr. M.'s use of the analyst as an autonomous auxiliary ego. This helped him to experience confusion and related affects, such as helplessness, and what the patient described as feeling lost. Another activity that contributed to the patient's toleration of affects and which may be termed adaptive, involved the patient's use of the analyst as a transient model of identification. This process was in a way similar to the patient's use of the analyst as an autonomous auxiliary ego; in the one process the patient endowed the analyst with certain ego functions in order to rely on him for these functions. In the other processes the patient endowed him with certain ego functions in order to use him as a model of successful functioning.

Thus, Mr. M. would behave in a way calculated to make the analyst worry about him, in order, in a sense, to learn from the analyst, how not to worry when confronted with a helpless, complaining individual. For Mr. M., when confronted with someone helpless and upset, could not tolerate his sadistic impulse to gloat, so that he would become helpless and upset himself to placate his conscience. Thus Mr. M. would see the analyst's apparent failure to worry as indicating a kind of strength that he lacked and wished to acquire. He would identify with his picture of the analyst as having this strength. Mr. M.'s identification with the analyst would

become manifest in various ways: He would, for instance, demonstrate a greater tolerance of his sadism by recalling childhood images of his mother suffering, or he would become more conscious of his wish to tease collegues at work.

On one occasion after missing an analytic hour, Mr. M. tried to worry the analyst by describing in a helpless manner how he found it almost impossible to wake up on time to come to his sessions. When the analyst did not react, the patient became more provocative, complaining that he feared the analysis was doomed to failure because of his over-sleeping. The analyst remained neutral. The next day the patient described a dream that had occured after the last session. He dreamt that he was condescending to a helpless man. Mr. M.'s dream was partly determined by his identification with the analyst, whose neutrality in the face of his distress during the previous session he had experienced as condescending. The patient's identification with the analyst, was suggested by his first association to the dream, namely, that he behaved in the dream exactly like a certain friend often behaved toward him. He added that he often provokes this friend to become condescending. In the session following the dream the patient showed a greater awareness of his sadism. He described for the first time, his wish to tease his office partner at work. Then, about a week later the patient reported a vivid new experience. While sitting on the beach he became intensely aroused by a fantasy of watching a girl of twenty being beaten by her father.

The emergence into consciousness of derivatives of the patient's unconscious sadism, as in the above example, would ordinarily be explained as resulting from the frustration of the unconscious sadism inherent in the patient's wish to worry the analyst. Certainly, the frustration by the analyst's neutrality, of the patient's sadistic satisfactions, was a crucial factor in bringing his sadistic fantasies into consciousness, but it is worth while to recognize, too, how the patient's identification with the analyst played a part in the integration of the patient's sadistic

impulses which were left unsatisfied as a result of the analyst's neutral behavior.

Mr. M., by using the analyst as a transient model of identification, became better able to experience not only sadistic fantasies but also pride and stubbornness. As he became better able to experience one affect he gained the strength to risk experiencing a different opposite affect. Thus, as Mr. M. became capable of feeling stubborn and as he gained control of his stubbornness, so that he could be deliberately stubborn, he also became able to feel submissive. He could submit to the analyst knowing that he could stop submitting by becoming stubborn.

Mr. M.'s gaining more control of certain affects, brought his obsessive compulsive thinking into prominence and prepared the way for him to obtain insight into his obsessive cumpulsive thinking. The discussion which follows concerning the patient's use of insight into his unconscious defenses of undoing and isolation to resolve his obsessive compulsive thinking, is a very condensed summary of an article (9) on this topic. In this article the view is presented that in a successful analysis, the patient's defenses do not disappear but rather undergo the same kind of integration as his drives. At first the defenses are unconscious and act beyond the control of the conscious ego. During analysis, they are brought under the control of the conscious ego and thus come to be used adaptively; that is, in harmony with the other trends of the ego. They are thereby transformed from unconscious defense mechanisms to ego syntonic controlled mechanisms. These ego syntonic controlled mechanisms are used by the ego to regulate the impulses and affects previously warded off by the defenses.

Thus, Mr. M.'s insight into his use of undoing (and isolation) to ward off affects, which came about as a result of the analyst's interpretations, gave his conscious ego a certain degree of control over the undoing mechanism and thus partly transformed it from an unconscious primitive and magical defense to an ego syntonic control mechanism. As a result, the patient became able to use what had

been his undoing defense adaptively; that is, he could turn to affects, or away from them according to what he considered appropriate. His developing confidence that he could regulate his affects, enabled him to begin to experience strong affects.

The above conceptulization accounts for a striking clinical observation, that is not accounted for by the view that the integration of the defense leads to its gradual disappearance. Thus insight did not lead to the regular and gradual disappearance of Mr. M.'s undoing defense. Rather, after Mr. M. first became aware of his use of his undoing, there was a long intermediate phase during which the patient's use of undoing became even more prominent. Mr. M., as we have seen, had been afraid of the confusion that resulted from his obsessive compulsive thinking, so that he had suppressed it, making a special effort to think clearly and deliberately. His understanding of his undoing made him less afraid of it so that he allowed himself to experience it more and more. During the intermediate phase in which the patient's undoing defense was becoming more and more prominent, he began to experience strong affects. The intermediate phase in the analysis of the patient's undoing defense may be understood in this way; as Mr. M. became more aware of his undoing defense and hence more in control of it, that is, as he began to convert it into an ego control mechanism, he became both more able to experience undoing and also to avoid undoing. He became both more tolerant of his obsessive thinking and also more able to stop being obsessive. He could begin to experience strong affects without having to undo them.

Considered in isolation the activities of the patient that have been termed adaptive, which involved the patient's reliance on the analyst for certain ego functions and also the patient's use of the analyst as a transient model of identification, might seem to run counter to the purposes of analysis, and lead not to an analytic result, but to some variety of a transference cure. But when considered

along with the changes in the patient's drives, defenses and transference, it is apparent that this is not the case. In the case presented, the adaptive activities of the patient were inextricably bound up with the processes by which resistances were overcome and defenses analyzed.

Not that the adaptive activities may not ultimately lead to resistances. Like the positive transferences of which they are a part, they must be understood by the patient and given up before the patient can achieve complete independence.

Only the opening phase of Mr. M.'s analysis has been presented; roughly, a period of a year. Following this year, the analysis penetrated progressively into deeper layers of the patient's mental life. By the middle of the third year of treatment Mr. M. developed a transference neuroses. He became able to experience in his relationship to the analyst, the rivalry as well as homosexual longing that he had experienced in his childhood relationship to his father. He developed vivid oedipal fantasies involving his girl friend and the analyst; accompanied by rage at the analyst. As a result of castration anxiety, he developed a new symptom which interferred with his teaching, that is, a weakness of his hand that came when he tried to write on the blackboard with chalk. Mr. M.'s hysterical weakness recurred occasionally during the next two years, right up to the end of his analysis. In the terminal phase of his treatment, Mr. M. became especially aware of his homosexual love for the analyst which he connected again to his childhood love for his father. This was followed by the opposite feeling about guilt and his absorption in his work (he had become a professor of physics) and marriage. What he was especially guilty about, was that he no longer needed the analysis.

REFERENCES

1. Freud, S.: Analysis, Terminable & Interminable, Coll.Pap. V, 1950.

2. Gill, Merton: Topography and Systems in Psychoanalytic Theory PSA Is. 1962.

3. Greenson, Ralph: The Working Alliance & The Transference Neurosis, PSA Qu. XXXIV 1965.

4. Hartmann, Heinz: Essays on Ego Psychology, Univ. Pr. 1964.

5. Lowenstein, R.M.: Some Remarks on Defenses, Autonomous Ego and Psychoanalytic Technique. Int. J. PSA Vol. 35, 1964.

6. Lowenstein, R.M.: Some Remarks on the Role of Speech in Psychoanalytic Technique. Int. J. of PSA Vol. 37, 1956.

7. Lowenstein, R.M.: Some Considerations on Free Asociation, J. Amer. PSA Assoc. 1963.

8. Rapaport, David: The Structure of Psychoanalytic Theory, PSA Is. Vol. II, 1960.

9. Weiss, J.: The Integration of Defenses. To appear in The Internat. J. of PSA.

10. Zetzel, Elizabeth R.: Current Concept of Transferences. Internat. J. of PSA. XXXVII, 1956.