El estudio clínico de Etienne, un adolescente de 17 años, nos permite ilustrar la función positiva y progresiva del masoquismo moral durante la adolescencia; éste mantiene un conflicto suficientemente importante por medio de la contracatexis de masoquismo erotogénico y de una de sus formas más importantes, el masoquismo femenino. La re-sexualización del funcionamiento mental que se ve en la inhibición intelectual de Etienne y su fracaso académico, así como en sus quejas masoquistas al respecto, atestiguan la existencia de un conflicto activo, el cual evita la neurosis y se opone a la desexualización de la sexualidad tal como se manifestaba en las prácticas homosexuales y heterosexuales denigradas de Etienne. El trabajo analítico con este chico nos permitió confirmar la importancia de la fantasía de haber sido golpeado por el padre, fantasía reprimida por el sufrimiento inherente en el masoquismo moral. Hay mucho en juego en este conflicto de la adolescencia, correspondiente a la necesidad de resolver el complejo negativo de Edipo a fin de hallar de nuevo las funciones del superyó, desafiadas al recurrir al yo ideal narcisista.

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Int. Rev. Psycho-Anal. (1988) **15**, 207

TECHNICAL ASPECTS OF THE ANALYSIS OF AN ADOLESCENT BOY

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> 'In analysis one asks: how *much* can one be allowed to do? And, by contrast, in my clinic the motto is: how *little* need be done?' Winnicott (1962).

Introduction

One of the most discussed points in the theory of psychoanalytic technique concerns the relative participation of the patient and the analyst in the analytical work. When we ask what and how much each participant in the analytical relationship contributes to the work being done, this is not a sterile theoretical question with no practical relevance. On the contrary, the answer given to this question by each analyst (or psychoanalytic school) will give rise to radically different techniques concerning the content, timing, amount and manner of interpretation.

My highly personal interest in this aspect of psychoanalytic theory and practice has its origins in my own professional development as an analyst and in an important change of direction which occurred during this development, involving a shift of emphasis from interpretation by the analyst to active participation by the patient. It was precisely at this point in my development that I began the treatment of an adolescent boy aged 12½. This was the patient who contributed so much to the crystallization of the change in my technique whose gestation dated from some time further back.

The parents of this boy, whom I shall call Héctor, sought a consultation because their son had been seduced homosexually by a maternal uncle. This relationship had begun when the boy was 10 years old and came to an end a few months before the consultation when Héctor, just before his twelfth birthday, told his mother what had been going on. The parents' main concern was that the boy 'should not end up like that character', but the factor that had triggered the request for treatment was that Héctor was suffering from terrible nightmares, from which he awoke crying. He had obsessive ideas of wanting to kill his father, which caused him intense anxiety and made him ask the father for help. The attitude of the parents towards their son was decidedly ambivalent: they wanted to help him, but they also distrusted him and constantly kept watch over him in case he should seduce his younger brother. A final important point is that it was the patient himself who asked to come for treatment.

When I met Héctor, I found myself with a very serious and obsessional pre-adolescent, who kept on repeating his doubts about whether he would not 'turn out to be like that character'. At the beginning of the treatment, the boy refused to play or to draw and confined himself to talking repetitively and without affect. Again and again, his thoughts returned to the episodes of the relationship with the uncle, but he could not talk openly about it, so that he had to use all kinds of circumlocutions. He proved to be very worried about the physical and mental changes

Abridged and updated version of the paper which won the Sigmund Freud Prize awarded by FEPAL, Mexico City, July 1986.

of puberty and by the fear that they would turn him into a homosexual, but, since his linguistic inhibition also embraced any reference to bodily organs and functions, his talking about the subject displayed a poverty which was inconsistent with his obvious intelligence.

Up to this point, Héctor appeared as an obsessional neurotic whose fixation on the sexual trauma of the seduction was reactivated by the instinctual intensification of puberty, thus triggering neurotic defence mechanisms with the aim of gaining better control over instincts and avoiding signal anxiety. However, it was not long before indications of a more severe disturbance of personality started to appear. As the analysis progressed, he would report experiences of alienation and unreality, corresponding to a depersonalization-derealization syndrome (Fast & Chetnik, 1976). He looked in the mirror and failed to recognize himself; he felt as if there was a strange being inside him, a kind of demon who might possess him, as in the story of Dr Jekyll and Mr Hyde. He had odd sensations in his body, in particular in his right hand, which he associated with a sexual act demanded of him by his uncle. The feelings of alienation and unreality were particularly intense in his dreams, which were usually set in unknown places or in places that were known but subtly transformed, places that were bathed in a climate of danger that reminded him of horror films. This appeared to be one of those cases, which are by no means infrequent in child analysis, which, having presented themselves as a traditional neurosis, reveal a grave concealed pathology of the personality during the course of treatment.

What is the relevance of Héctor's case to the problem I have been discussing? Here I was with a very intelligent boy with serious obsessional pathology, who had considerable inhibitions in verbal communication and totally rejected the other forms of communication characteristic of child analysis, such as play and drawing. It was also clear that the fear of relating to me stemmed from profound homosexual anxieties in the transference. However, I chose not to interpret any of this, as I was convinced that early interpretations of this kind would increase his anxiety instead of reducing it. Instead, I decided to allow time to do its work, i.e. to provide an opportunity for a relationship to develop between Héctor and myself, without trying to perform any analytic work until this relationship had been more firmly cemented. This approach corresponded to what Anna Freud (1927) called the 'period of introduction' to the treatment and what Anthony (1981) described as the phase of 'taking in the landscape'. This last concept proved to be particularly useful for me: I was taking in the landscape of Héctor's internal and external world, while he was taking in the landscape of my person, the consulting room and the treatment.

Throughout the first months of the analysis, I therefore avoided any deep interpretation or strictly transference-related interpretation, confining myself to pointing out to him that there were many things about which he did not dare to speak, owing to the intense pain and shame they caused him. Regarding the transference, I did not omit to tell him that I was an unknown to him and that he no doubt felt that he needed to get to know me much better before he would know whether he could trust me or not. As Héctor gradually began to establish a slightly more explicit form of communication with me, I was able to discover that his refusal to play or draw during the sessions was an expression of his fear of possible loss of control of his instincts in the context of his relationship with me. (In particular, the fear of drawing was connected with a memory in which the uncle made him draw the sexual acts he was performing with him.) The analysis of this defence succeeded in liberating the patient's fantasy, although he continued to communicate with me on an exclusively verbal level. I respected his choice of the channel of communication he preferred, as I consider that in child analysis play must always be taken as a means of access to verbalization and not as an end in itself (Aiza & Tubert-Oklander, 1983).

From then on, Héctor began to express an extremely rich fantasy life, usually projected on to the films he saw in the cinema or on television. The consulting room thus came to be peopled with snakepits, fires, dead bodies, demons and piranhas. There is no doubt that this development of his analysis was expressing various primitive fantasies and mechanisms (Jacobson, 1957; Klein, 1946); should I interpret these contents in detail by references to the earliest stages of development, or, conversely, should I stay within the limits of the impulse/defence conflict active at the time? To resolve this dilemma, I resorted to observation of the concrete events that were taking place in the analytical situation. Although the *content* of the patient's discourse referred to primitive anxieties and mechanisms and to part-object relations, his *behaviour* during the sessions and his nascent *transference relationship* with me remained within the limits of neurotic anxieties and defence mechanisms and of the oedipal conflictual situation. By keeping constantly in mind the fundamental difference between the *content* and the *function* of my patient's communications (Rodrigué, 1967; Zetzel, 1970), I had a reliable indicator as to what I should interpret. I therefore continued to interpret the material on the neurotic level, i.e. in terms of whole-object relations and the Oedipus complex and castration anxiety.

In the ensuing months, I was present as a fascinated observer while Héctor began to 'rediscover' psychoanalytic theory. I at all times abided by the principle of remaining a step behind my patient, without ever going on ahead of his own discoveries, and I was able to see how he gradually discovered the unconscious, repression, sexuality, aggression, castration anxiety and the meaning of his dreams and symptoms. My main task during this period was to reformulate his discoveries in clearer terms, at a time that confirmed them implicitly or explicitly. My attitude during the sessions was therefore substantially passive, taking the form of an attentive silence, while the patient continued to work on his own account. This silence, broken only by the odd question or brief comment, was interrupted at the end of the session when I summarized what he had been working on. I also, of course, intervened with an interpretation whenever his spontaneous work was impeded by a resistance.

Throughout this period, it was obvious to me that Héctor's effort of exploration and working through was taking place largely *outside the sessions*. As a result of this observation, I again put to myself the question of the active, conscious collaboration of the analysand in the analytic process.

At this point in my argument, I can clearly see the central theoretical point which I wish to discuss. This could be summarized in a question: how far is it possible to regard the work of analysis as an activity of the analyst or as a task of the patient? The obvious answer that it involves the work of both simply avoids the problem, as there is no doubt that the disagreement between the various technical schools largely depends on their relative emphasis on the activity of the patient or of the analyst during the analytic process. Nor is this a question of detail, as *the choice of one approach or the other will give rise to therapeutic processes of very different kinds*.

A problem I do not intend to discuss here is that of 'technical variants' aimed at applying psychoanalysis to cases of serious (non-neurotic) psychopathology. What I am trying to determine is *the correct standard psychoanalytic technique to be applied under ideal conditions* (a traditionally analysable, intelligent patient motivated for the treatment). There are important differences of view on this point.

Technique used

Héctor began his treatment in August 1982, so that he has now (October 1987) been in analysis for just over five years. For the first year and a half he came twice a week, but we increased his sessions to three a week from January 1984, and this is the frequency at which he is still coming. During the last year he has been working on the couch, instead of face to face as he did for the first four years of treatment.

I shall present here some fragments of Héctor's analysis, with the aim of discussing the following aspects of technique which are used in his treatment: (i) the introductory period; (ii) the first interpretations; (iii) the working alliance; and (iv) interpretation, working through and construction.

(i) *Introductory period*

Once the reverberations of the Freud–Klein polemic on the introductory period in child analysis had died down, this period became a

technical device to be used in certain selected cases (A. Freud, 1965, p. 36). This was also the view taken by Winnicott (1958), who characterized the difference between the techniques of Anna Freud and Melanie Klein as 'largely a matter of *conscious or unconcious co-operation*' (p. 119). To this he added that, in the case of very intelligent children, he felt it would be a pity to waste the resources that the patient's intellectual understanding could contribute to the analysis. This was basically my position before Héctor's analysis, in which I consciously chose to begin the treatment with an introductory period in the most traditional sense, i.e. *to postpone any analytic work until my patient had established a relationship of trust with me*.

The reasons for my choice of this approach were based directly on the psychodynamics of the case. I found myself with a highly intelligent and sensitive adolescent boy, whose intellectual functions, however, were subject to serious inhibitions owing to the neurotic conflict that was active at the time. I also knew that the boy had sustained sexual overstimulation by his uncle and that he was experiencing an intense conflict, which was at least partly conscious, with his father. Considering this entire background and also the effect of the instinctual reactivation of puberty, it was to be expected that my patient would live out all these conflicts very intensely in the transference and that he would experience any interpretation of repressed instinctual contents as a seduction or aggression on my part. I therefore chose not to interpret anything at the beginning and to seek ways of establishing a positive real relationship with the boy, to serve as a foundation for the subsequent work of interpretation.

The first difficulty in Héctor's treatment was to find a channel of communication with him. As stated earlier, the patient's discourse was seriously inhibited, and at the same time he rejected the use of drawing or play material. At the beginning of his treatment, Héctor would sit in an armchair without looking at me and alternate between his repetitive questions about whether 'he would turn out like that character' and long silences.

In view of this difficulty in establishing any useful communication with him, I chose to search for a subject about which we could talk, whatever it might be, as my sole aim was to create a relationship which could subsequently be put in the service of the analysis. For instance, Héctor once told me that when he was grown up he would like to be a physicist-mathematician, like Einstein. I asked him what he knew about Einstein and he enthusiastically replied that 'he was the greatest of the physicist-mathematicians and the inventor of the atomic bomb'. I gave no interpretation at this point, but confined myself to talking to him about Einstein. However, this material, like other material emerging during the introductory period, did not remain a mere 'cyst', unconnected with the subsequent analytical work, as it became possible much later for us to analyse the unconscious meaning of these intellectual interests of Héctor, as we shall see further on.

(ii) *The first interpretations*

As the relationship between my patient and myself gradually grew stronger, I began to formulate my first interpretations. However, these were not interpretations of unconscious contents but related to the most superficial and conscious (or at most preconscious) level of his defences. For instance, I was able to tell him that a particular subject made him anxious and that he was therefore avoiding it, or presenting it so ambiguously as to make it almost incomprehensible. I also mentioned his fear and distrust of me, but always deriving them from conscious, ego-syntonic reality factors, such as the fact that he did not yet know me well, or the novelty of the therapeutic situation itself.

As this work of interpretation developed, I was able gradually to broaden my interventions, but always adhering to the classical principle of 'interpreting what is immediately below the psychical surface'. In other words, my interpretation was limited to going forward a small step beyond the patient's conscious statements; I left for the future the analysis of the unconscious contents which I could guess at in his discourse, on the basis of my knowledge of psychoanalytic theory. The material to be presented below belongs to this period.

Summary of session 23 (end of third month of analysis)

Héctor came in and asked me about a closed room he had seen next to mine. The other day he had seen a gentleman sitting there. Was it another consulting room? I answered that it was. His attention then turned to my books. He asked me if they were psychiatry books. I remarked that he seemed to be very interested in me today. He agreed. I asked him which books he had particularly noticed. He said the fattest ones. There was a silence and he looked one way and then the other. Then he told me that he had not had his (obsessive) 'ideas'. 'It is funny how they go away and then come back again.' I asked him where those ideas might be when they disappeared. He answered that they were in the brain; he had seen a programme on TV about the brain, and there, memory was represented like a library or file, full of books and papers. I suggested that the library of his brain might contain rooms that were never opened, because inside them there were memories or ideas that he was afraid to know about. Héctor agreed. 'They say there are things that human beings ought not to know, like in the Bible.' He had not read the Bible, but he knew that it told of the origin of the world. But he had a doubt: who wrote the Bible? I told him that he had come along very curious today, wanting to know about all sorts of things—the closed room, my books, the Bible—but perhaps his curiosity was really about things that had happened when he was very small, when he was not yet able to remember them, and these things made him afraid.

He returned to the subject of the brain. It and the body were like a machine, like a car, full of circuits and sparking plugs, the nerves being like cables. I told him that, unlike a car, if the brain was damaged, it could not be replaced. He said no, but the heart could, or an arm, like that of the bionic man on TV. He told me about a boy he had seen on TV, who had lost an arm and had it replaced by a mechanical one. But it was not as strong as the bionic man's, but was more like an ordinary arm. I interpreted that perhaps he was afraid of being mutilated, of some part of him being damaged and it not being possible to repair it, unlike the bionic man, who was afterwards better than he had been before and much stronger. He told me that the bionic man had short-circuits, and then explained at length how his circuits were exposed and repaired. I told him that what he was asking was whether he was seriously damaged in the circuits of his brain and whether I could mend him. Héctor nodded agreement and told me that he was wondering what would happen if someone put a lighted match to all those old papers and books . . . The whole lot would go up in flames. I interpreted that, in the library of the brain, that would be equivalent to going mad. He nodded and I went on to say that that was why he preferred not to try and light up the darkest corners of his mind, which contained the memories he would prefer to forget.

Héctor thought for a while and then embarked on a long account of a film he had seen. It was *Raiders of the Lost Ark*. He said there was a model of a buried city, in which a ray of light showed the exact position where the ark was hidden; he also emphasized the episode where the archaeologist and the girl were shut in a pit full of snakes; the scene in which the opening of the ark released a ray which killed all the evil Nazis but spared the couple because they had closed their eyes; and the end, in which the ark was put away and forgotten in a kind of museum. 'It was something sacred', he said. I told him that he was again telling me that there were old things stored away that were only for God, and that men must not tamper with, because they were very dangerous and might destroy them. I pointed out that in his story the ones who were destroyed were the evil ones, while nothing happened to the good ones. He replied emphatically that this was because they had closed their eyes; had they opened them, the same would have happened to them. I accepted his correction and told him that, in that case, there were things it was better not to see—that is, to know—because otherwise one might die or go mad. This time he agreed, so I summed up the work we had done. I told him that he was very curious, like the archaeologist, and that he wanted to discover old things and know what had happened a long time ago. But he was afraid that he might be punished for his curiosity or mutilated, like the boy on TV. That is why he often preferred to forget things, as if he were storing them away in a museum. He seemed to

be afraid of investigating these things by himself and would prefer to have a map or guide who knew all about these things and accompanied or protected him so that nothing bad could happen to him. Perhaps that was why he was interested in my books, to know what knowledge I had in my head, and whether it would be enough to help him in this search. I then ended the session.

Commentary on the material: I believe that this material is sufficiently explicit concerning the technique I was using at that time. It shows that I was maintaining a fairly active dialogue with Héctor, in which I gradually included interpretations formulated in the same language as he was using when speaking to me. At no point did I include symbolic interpretations of deep contents. This is obvious, for example, in my interpretation of his obvious castration anxiety, manifested in the reference to the boy who 'had lost an arm'. However, the symbolic interpretations which I could not avoid formulating for myself enabled me to achieve a growing knowledge of the psychodynamics of the case, which I would need in effect as a 'road map' for the subsequent course of the analysis. For instance, this session clearly revealed the intense conflict taking place in Héctor between his desire to know (see) and the prohibition of knowledge. Just like Adam and Eve, whom God had forbidden to partake of the fruit of the tree of knowledge of Good and Evil, Héctor was struggling between his desire to know about sexuality and the prohibition on accession to this knowledge. The prohibited and annihilating vision here is, as in Freud's paper 'Medusa's head' (1922), that of the feared female genital. However, none of this was interpreted at that time but was transformed into a subject for analysis for the ensuing years of treatment.

(iii) *Working alliance*

One of my initial objectives in the treatment of Héctor was to establish a solid *working alliance* with him. Although this concept is not accepted by those analysts who prefer to see the entire therapeutic relationship in terms of transference and countertransference (Racker, 1960), since the work of Zetzel (1956) and Greenson (1967), more and more analysts have come to accept the need to distinguish between the transference proper and another, non-repetitive, aspect of the analytic relationship which is usually called the 'therapeutic alliance' (Sandler et al., 1973). It is particularly interesting that a Kleinian analyst such as Etchegoyen (1986) has included the therapeutic alliance in his excellent treatise on psychoanalytic technique. I personally also prefer to distinguish, in accordance with Greenson (1967), two additional components within the therapeutic alliance: the 'working alliance' and the 'real relationship'. The *real relationship* is the new, non-repetitive component comprising the human relationship that arises between patient and analyst. A good real relationship corresponds to what used traditionally to be called 'sublimated positive transference', i.e. the affectionate libidinal aspect, accessible to consciousness, of the relationship between the patient and the analyst (Freud, 1912). In this sense, my work with Héctor during the introductory period consisted basically of encouraging the development of a good real relationship between him and myself. Conversely, the *working alliance* refers to the artificial, conventional aspect of the analytical relationship, governed by the contract. In other words, the working alliance is an artificial relationship (as are all professional relationships) in which both parties play predetermined parts in accordance with conventionally established rules, based on the requirements of the task to be performed. Consequently, *these parts have to be learned.* The therapist must perform his function as a psychoanalyst, which he has acquired during his training, while the patient has to learn his 'function as analysand'. Since most patients do not come to us knowing 'how to be analysed', they must obviously learn what is expected of them, what their contribution to the analytical process must be, *during the course of the analysis itself.*

The views of different analysts diverge on this last point. Some begin to interpret immediately, trusting that the coherence of the analyst's professional behaviour will allow the patient gradually to discover what an analyst is, what analysis is and what it means 'to be in analysis'. Others, however, prefer to explain carefully to the patient what is expected of him, what he can expect from the analyst, what they are trying to do and what are the reasons for each of the unusual procedures used by the analyst. In other words, we are once again confronted with the problem of 'conscious co-operation versus unconscious co-operation'.

In my work, I always try to secure the conscious co-operation of my patient, whether child or adult, and I never underrate the contribution of his intelligence. Although I avoid overwhelming the patient with extensive theoretical explanations, I never fail to explain to him the nature and objectives of the technical procedures of psychoanalysis. Many of these explanations are not given at the beginning of the treatment but only when I see that the patient himself is beginning to approach the question as to the nature of the process on which he has embarked. In this field, as in the case of the sexual enlightenment of children, the information must arrive just at the moment when the subject begins to look for it, as information given prematurely will not be assimilated but incorporated as a veritable 'foreign body'. We shall see later how I apply a similar principle to the timing of interpretations.

The patient's spontaneous attempts to understand and theorize about the analytical process are a fundamental aspect of the working alliance. Although these cognitive efforts may often be used in the service of defence, this does not mean that they are not useful, as the better the patient understands the structure of psychoanalytic thought, the better he will be able to understand the interpretations. We sometimes tend to forget that, for an interpretation to have any effect, *it must first be understood.*

In the case of Héctor, a few months into the treatment he began to show interest in what his contribution to the analysis might be. He asked me what he should talk about. I in turn answered by asking him what he thought might be suitable subjects for discussion in his treatment. He told me that for example he sometimes had dreams. Would it be of any use for him to tell them? I suggested that he do so and that we see what happened. He thus told me a dream, which I did not interpret symbolically, instead asking him for associations. By the end of the session, we had not gone very far in understanding the dream, but Héctor had recieved the message that he could do something with his dreams and that there was a method of giving meaning to them and using them as a means of communication between us.

From now on, my patient gradually developed an understanding of the nature of the analytical process and of the theory underlying the interpretations. This understanding did not depend on my explanations but on his spontaneous investigation. My main contribution to this process was not to impede it and occasionally to confirm his discoveries. The material to be presented below is from a series of sessions in the sixteenth month of the analysis, in which, among other things, we can see the patient's attempts to theorize about his illness and the analytical process.

Summary of sessions 139 and 140

Arriving at his session, Héctor, after a short pause, told me that something was going on in his mind which made him forget things as if they had never happened. He gave me a number of examples of how he forgot things in school which he already knew. The same thing happened when his schoolfellows told dirty jokes: he would laugh without knowing why.

The other day he had seen a film on television about some earthlings who went by spaceship to a planet to rescue a professor and his daughter who lived there. On this planet there had long ago been a very advanced civilization which had disappeared, leaving its cities deserted. In one of these there was a machine which measured intelligence through the subconscious (as he called it). This machine caused the doctor's subconscious to change and he lost control over it. Afterwards a strange force appeared, a kind of invisible monster, which destroyed everything and killed people; it was the doctor's subconscious acting through the machine. Héctor wondered whether something like that could actually happen. Eventually the doctor died and the machine was destroyed, and that was the end of the monster. That old civilization had disappeared, destroyed by the monsters released by the machine.

I told him that it seemed that he felt that delving into the subconscious was something

dangerous. He agreed, saying that he knew nothing about all this, but it seemed to him that the subconscious was something like his other self. He had read in a book on 'self-hypnosis' given to him by his father that the subconscious punished people or acted on the body to make them do bad things. He went on talking about the Ouija board and how it made it possible to communicate with spirits. The subconscious was like a spirit: it was not destroyed. He continued to talk about the monster and told me that in the film the subconscious punished the doctor, causing him to kill his loved ones. That was how his wife had died. But the ancient civilization had built big doors of a very strong material . . . It seemed that they already knew about this force that was attacking them . . . Everything they had made was of very high quality, because, although two hundred thousand years had elapsed since their civilization had disappeared, everything had been preserved intact.

I interpreted that he was telling me that he felt he had within himself a very dangerous force and that he had therefore built a strong barrier to contain it. This was why it was both his wish and his fear that we might delve into what was behind the barrier. He agreed that this was so, that it seemed as if something like this—not the same but similar—happened in his dreams. It was as if he had built a very strong and invisible barrier, as in the film. Perhaps this was why his dreams were steeped in an atmosphere of danger, as in a horror film. But this was affecting his daily life: since he had dreamt about a danger situation in the Underground, he had begun to be afraid of travelling on the Underground in reality . . . If there were a monster or something behind his dreams, or behind him, something would happen to him like when he came to the treatment and had horrible thoughts which frightened him. It seemed that afterwards he had put up a barrier that would not let them through, but perhaps the thoughts remained the same, stronger, and if he were to drop his guard, the thoughts might come out, catch him unawares and cause a reaction that might perhaps be worse . . . But maybe it would not be so dangerous for him, with the help of something else, to get to see what was behind the barrier . . .

I told him that this was the case, particularly as, as he had told me in the previous session, there might be behind the barrier not only the things he was most afraid of but also valuable things, such as his good memories, or even his lost mental faculties, such as memory, He agreed, saying that this was bothering him and that he thought that perhaps he needed to renew himself with the things that were behind the barrier again. So the session ended.

In the next session, he began to say that this barrier was as if a part of his brain had stopped working. He wondered what the thoughts behind the wall would be like, whether they would be very different from the others. He had read that the brain was divided into two parts and that each controlled the other half of the body, and he assumed that all his 'resentful parts' had gone to the left-hand side of the brain. It was as if there were two parts to this person, one light and the other dark, and he was afraid that the bad thoughts in the dark part might use the mental faculties trapped on the other side of the barrier to invade and darken the light part.

I again interpreted his fear of exploring the bad part of his mind and of not being able to cope with it. Yes, he said, what he was afraid of was that the part that was not dark, as it did not remember, had learned less things and might therefore be weaker, and that would prevent it from controlling everything that came from the dark part. That is why he was afraid.

I again interpreted that this was precisely why he needed help, my help, to make him feel safer in opening the door to his memories and thoughts. He replied that there was something else: his parents. If his parents had not behaved as they had, he would have learned to have confidence. He had no confidence, he was afraid of doing things and that is why they turned out badly. He was often even afraid to speak.

I pointed out to him that it had been almost impossible to understand his words at the beginning of the session, as if he had been trying to speak with his mouth closed. Now, however, he was uttering his words with great clarity, as if he had been gaining confidence as the session progressed, This was how he could acquire the confidence necessary to explore the dark part of his mind. As time was up, I ended the session.

Commentary on the material: These sessions show Héctor spontaneously theorizing about his illness, his treatment and his possible cure. These theories, based on thinking by analogy, at times took on mythical dimensions. ('And so those thoughts, that were stronger, predominated. And then a wall was formed to control them, but afterwards my mind was divided . . . Lots of mental capacities stayed on the other side . . .') My argument here is that these 'mythical theories', although having a defensive function (to reduce his confusion and anxiety), must also be seen as involving adaptive mechanisms in the service of the analytical work, as they brought him closer and closer to a full understanding of what was happening to him.

(iv) *Interpretation, working through and construction*

It is clear from the material presented here that I now have a different conception of *interpretation* from those authors who regard the analyst's interpretive interventions as the main (and sometimes even the only) vehicle of the therapeutic process. In embracing a view of the analytical process which attributes insight to the perception of new relations and meanings by the patient's 'observing ego', I can conceive *that the patient interprets for himself and that this interpretation can be correct and effective.* On the other hand, although our present knowledge of psychopathology, developmental theory and symbolic processes often allows us quickly to understand the unconscious meaning of the patient's communications, *this understanding is useful for us but not necessarily for the patient* (A. Freud, 1965). If we intend our interpretations to be of any use for the therapeutic process, we must wait, before communicating them to the patient, until his ego is capable of assimilating and taking advantage of them. This happens only when the material shows us that he is on the point of verbalizing them for himself, but does not do so. At this time, the interpretation gives him the 'push' he needs to complete the idea which is implicit (but almost explicit) in what he has been saying.

These considerations about the interpretation of contents do not prevent me from analysing whenever necessary the phenomena of resistance and transference, as can be seen from the records I have presented. However, I believe that this interpretation of the transference and of resistances must not be constant and systematic, at least in the analysis of the neuroses (or, as Bion (1957) would say, of the 'non-psychotic personality'). On the contrary, in my view, it must be used only when the associative process is interrupted or when it is necessary to strengthen or restore the working alliance, analysing the negative or idealizing transference or pointing out the latent positive aspects of the relationship.

In view of all the foregoing, I regard *working through* as *a task which is basically the responsibility of the patient* and which, to a substantial extent, *is performed outside the sessions* (Greenson, 1967). We all know that the correct interpretation and insight do not suffice to produce a genuine therapeutic change. Such a change calls for a long and difficult process of working through, which consists in the exhaustive exploration of the multiplicity of manifestations and ramifications of a conflict which has already been analysed and understood, until the establishment of new connexions weakens this conflict, thus permitting emotional and behavioural change. The analyst can certainly contribute to this process, by pointing out again and again how the same conflict is expressed in different contexts and forms, but the actual process of working through only begins when the patient himself comes to perform this task actively and spontaneously upon each new manifestation of the conflict, establishing new connexions, without the mediation of an invitation by the analyst. It is only by this constant exercise that this ego function which Bion (1962) called the 'psychoanalytic function of the personality' can become established and develop. It is precisely this function which, alone, can sustain lasting therapeutic change, by way of self-analysis (Tubert-Oklander, 1987).

In Héctor's analysis, it was gradually becoming clearer how he used the discoveries made during the sessions for the purposes of constant investigation of his own mental processes. The impression was that, once he had acquired the instrument for analysis of these, my patient was continuing to apply it in his own search for a better understanding of what was happening to him.

Of course, this emphasis on the process of *conscious working through* does not imply any underestimation of the importance of *unconscious working through*, which took place in Héctor's analysis as in any other. A clear example of this latter process was evident in a series of dreams expressing the many alternative forms of his conflict between the wish to see the female genital and panic at doing so. In the first of his dreams, he was looking at his naked sister and found a penis with testicles. In the next dream, when he was looking underneath the skirt of a schoolmistress, there was a kind of 'cut like in the cinema' and the image of a penis appeared, but it did not belong to the woman and was instead a clear instrument of censorship; in another dream, looking for a girl's genitals, he 'saw absolutely nothing'; in yet another dream, he was looking at his mother in the nude but her pubic hair concealed everything; finally, he succeeded in seeing a girl's genitals in another dream, but 'there was something funny about them, it looked more like the anus'. As can be seen from these vignettes, Héctor tried every kind of defence to avoid this dreaded vision, which became increasingly imminent. On the other hand, the analysis of these dreams brought up an infantile memory in which he was discovered looking up the skirts of the mistresses from below a staircase, which gave rise to a strong telling off by the head of the kindergarten and his mother. This memory in turn conceals deeper aspects of the relationship with his mother whereby he experienced her as a witch who forbade him sexuality.

With regard to *constructions*, Freud (1937) distinguished between 'interpretation' and 'construction'. The former related to the search for the meaning of component parts of the material while the latter endeavoured to explain the patient's neurosis to him on the basis of what the analyst thought had happened to him in the forgotten years of his childhood past. Although this distinction between interpretation as partial understanding and construction as an attempt at comprehensive, integrating understanding has not been upheld in contemporary psychoanalytic literature (Sandler et al., 1973), I believe it is still useful. This difference between 'interpretations' and 'constructions' is not limited to the fact that the latter refer to the past.

Although many interpretations are based on *dynamic* considerations and omit *genetic* considerations (Hartmann & Kris, 1945), there is a type of interpretation, called 'genetic interpretation', which does refer to the past. This is really an *explanation* of a current mode of behaviour, experience, thought or emotion of the patient, in terms of a supposed causal relationship with its origins. The question which these interpretations claim to answer is how, where, when, why and with whom this current mode was established. In this sense, an interpretation (whether genetic or otherwise) is an *hypothesis*. A construction, on the other hand, is a *theory*. On the basis of these definitions, a construction is an attempt to explain the totality of the patient's neurosis and personality and of the events and observations corresponding to a longer or shorter period of analysis by a theory concerning the origins, establishment, maintenance and subsequent evolution of the observed patterns. Clearly, a symbolic structure of this kind has a complexity and logical type (Bateson, 1972) superior to those of any interpretation or set of interpretations. Although the interpretations pave the way for the construction, and although the latter must include and give meaning to all the successful interpretations formulated during the analysis, once the construction is formulated, all the interpretations remain subordinated to it.

These considerations on the nature of constructions have a number of corollaries. Firstly, a construction can only be formulated at an advanced stage of the analysis. Secondly, in contrast to the case of interpretations, which are very numerous, it is only possible to formulate a small number of constructions during the course of an analysis (in fact, there are not usually more than one or two constructions in any given analysis). Thirdly, owing to the complexity of the work involved in formulating a construction, the latter is in most cases the exclusive province of the analyst. It is difficult (although not necessarily impossible) for a patient to formulate for himself a comprehensive and integrating construction (although he frequently makes a contribution with highly pertinent genetic interpretations). However, once a construction has been made, the patient often contributes to its subsequent development, correction and adjustment, by new memories, interpretations, observations and reflections.

In Héctor's analysis, the period of constructions began in the third year of his treatment, when it became possible for us to move on from the dynamic analysis of his conflicts to that of an overall historical view of his life. Since the comprehensive nature of a construction makes it difficult to illustrate the formulation of a construction by the record of a session, I have reserved a part of the section on results and prospects for the presentation of the current state of the construction that takes account of Héctor's pathology. Note that he participated actively in the discussion of the details and validation of this explanatory theory, many aspects of which he amplified and amended.

Results and prospects

In clinical psychoanalytic papers, the section on results usually refers to the therapeutic achievements. However, it must be acknowledged that in a case like Héctor's, where treatment is still continuing, the therapeutic results are necessarily partial and uncertain. Only the presentation of a completed treatment (and preferably a follow-up after the termination) can provide a more or less reliable validation of the therapeutic achievement. For this reason, in discussing the discoveries and achievements of this analysis so far, I have preferred to approach them from a number of different aspects, namely: (i) the evolution of the case, (ii) the explanatory construction so far reached, and (iii) the partial therapeutic results achieved.

(i) *Evolution of the case*

Héctor's treatment was characterized by a sequence of phases which in my view represent a stratification of the psychopathological material, although I cannot justify this assertion because of the necessarily fragmentary nature of the material presented. The *first phase* corresponded to the *introductiory period*, already described in the previous section. The *second phase* was that of *the first interpretations and the establishment of the working alliance*. The *third phase*, which partially overlaps its predecessor, comprised the *analysis of the conflict with sexual instincts, masturbation and the memories of seduction*. Here, the central theme of the *denial of the difference between the sexes* also arose. The *fourth phase* concerned the *analysis of the conflict with aggression and primitive sadism*. This phase began during the second year of analysis in a way which subsequently proved to be characteristic of Héctor's treatment: the achievements and discoveries of the previous phase were transformed into resistances with the aim of avoiding the emergence of new conflicts, not so far dealt with. In this case, in view of the continued references, unaccompanied by the corresponding affect, to conflicts with sexuality already worked through, I interpreted to him that he was using these as a 'smoke screen' to avoid the emergence of something that frightened him much more. As a result, we were able to begin investigating Héctor's conflict with his aggressive impulses and recover the most elaborate sadistic fantasies, some of which stemmed from his earliest childhood. A by-product of this was that we were able to go back to certain material that had emerged in the introductory period, which was not analysed at the time. For instance, his wish 'to be like Einstein' took on the meaning of 'inventing an atomic bomb', as an expression of his repressed primitive hatred. The *fifth phase*, which began half-way through the third year of analysis, when the aggressive material came to be used in the service of resistance, was that of *analysis of the depression* underlying the aggression. Here the central theme was his feelings of pain and sadness at the rejection by his father, who always despised him as 'clumsy' and 'foolish', and at the violent sado-masochistic relationship that had always existed between his parents. He now had to experience and partially work through the mourning for the ideal parents they never were. Finally, the *sixth phase*, still continuing, is that of *analysis of the basic schizoid fault*. This phase commenced with an intense period of resistance in which he regressed for several months to the obsessive repetition of his initial doubts about homosexuality, until we were able to understand these as an expression of his *fear of feeling*. It was this rejection of his own feelings that prevented us from completing the

analysis of the depression in the previous phase. When this resistance was resolved, Héctor agreed to move on to the couch, and since then we have been analysing his experiences of emptiness and unreality and his fear of acknowledging his own feelings and wishes as real, instead of adapting them to what he thinks are other people's wishes and expectations.

My present hypothesis is that, to the extent that we can resolve his schizoid defence by analysing it, Héctor will be able to enter into a new phase of *therapeutic regression* (Winnicott, 1954), which will enable him, through his real relationship with me, to establish new mental structures which never developed in his early infancy (Palacios, 1965) because of the shortcomings of his mother's capacity for empathy (the 'capacity for reverie' (Bion, 1962)). It is clear that this treatment evolved from analysis of neurotic conflicts to the point of tackling what Balint (1968) called the 'basic fault'. However, the technical considerations I have presented must be confined to the analysis of the neurosis.

(ii) *Explanatory construction*

As Héctor's analysis progressed, it became possible to formulate a construction about the origins of his illness which took account of most of the aspects of the case. Although the explanatory construction of the clinical picture is not completed in any analysis (as regards the analyst, since the patient can continue to complete it by self-analysis), until the treatment is at an end, I should like here to describe the level of understanding that Héctor and I reached about the genesis of his illness.

Héctor's parents are two highly disturbed people and their relationship has always been violently conflictual. His mother is a typical borderline case who, although she loves her son and has protected him whenever she could, has also terrified him since he was very small, owing to her unpredictable outbursts of violence, in which she insults him and threatens him with abandonment, the police, prison or the lunatic asylum if he does not mend his 'bad behaviour'. During his analysis, Héctor recovered a terrifying image of his mother 'looking at him with the eyes of a madwoman'. The father is a case of pathological narcissism who, as he got older (he is 25 years older than the mother), gave up all pretence at taking an interest in his wife and children. A few years ago he ceased to contribute economically to the household, in spite of a substantial income, and had completely washed his hands of Héctor's treatment, which is paid for by the mother. It is perfectly clear that, for some reason that we do not know, he has always rejected and despised his son. However, we have reason to believe that the origin of this rejection may lie in the narcissistic wound represented by having had a sick child.

Héctor was born with a cephalomyohaematoma due to a prolonged period of labour, and subsequently suffered from neonatal haemolytic jaundice which required an exchange transfusion. The doctor in charge of the case told the parents that 'the boy might turn out to be an idiot'. From early infancy, Héctor showed a considerable lag and awkwardness in motor development, possibly due to his neonatal jaundice, as a result of which his learning to walk was delayed. Once again a doctor intervened, asserting that 'this child will never learn to walk' (a prediction which turned out to be just as unfounded as the previous one). At this time the father became furious with Héctor, hitting him and insulting him whenever he tottered, broke something or bumped into doors. The mother looked after him, spoiled him and soothed his bruises, but my patient does not recall her ever having done anything to protect him from the father's ill-treatment. Héctor's reaction to this ill-treatment seems to have been one of terror and submission, and at the same time he took refuge in omnipotent sadistic fantasies, which were to crystallize later in his wish to 'be a physicist-mathematician and build an atomic bomb'.

He was taken at an early age to nursery school, where he was also severely punished by the mistresses for his awkwardness. He had had a phobia of doctors, hospitals, injections and, in particular, blood since he was very small. In his analysis, we were able to relate this phobia to the projection of his sadistic fantasies. These, of course, had their counterpart in the masochistic fantasies, in which he wanted his father to hit him; these fantasies subsequently extended to other objects. Héctor apparently thus transformed the beatings he got from his father, which he had previously experienced passively, into active ones: the father continued to hit him, but now it was because he himself wanted it (Freud, 1920).

Another very important factor in the subsequent development of my patient was that the father had been married before and had grown-up children from this marriage whom the boy did not know. Faced with what the father considered to be Héctor's 'clumsiness' and 'imbecility', he used to blame him for not being like his other son, whom he portrayed as if he were a genius. This son had studied mathematics, and so we could understand that the fantasy of 'being like Einstein' was the simultaneous expression of a libidinal wish and an aggressive wish. On the one hand, as we have seen, the manifestation of his wish to be omnipotently destructive ('to build an atomic bomb') was in effect a compensation for his feelings of impotent hatred at his father's attacks and his own difficulty in co-ordinating his movements. On the other hand, it was an expression of his wish to be like his half-brother, or rather, to be able in this way to be loved and admired by his father. In reality, Héctor was compelled to repress his aggression and submit in a passive, feminine way to his father. He often still feels incapable of acting aggressively, and this prevents him from defending himself or assuming an active attitude in many situations, although he has begun to overcome this inhibition in the last few months.

As stated above, Héctor's mother is a borderline case with profound melancholic and masochistic traits, and this contributed through identification with her to the patient's passivity and masochism. Her relationship with her son is exceedingly ambivalent: no sooner does she reject him than she looks for him lovingly, and then complains that he is a bad boy who hates and ill-treats his mother. She has often called on him to 'declare once and for all whose side he is on: his father's or hers'. Since he was very small, she has threatened to throw him out of the house, to call the police to take him to prison or to have him locked up in an asylum, whenever he does something that annoys her. Héctor attributes a prophetic value to his mother's words which means that they are bound to come true. He therefore feels that he must become a madman, a murderer or a homosexual, as 'she is always right'. At some times, since he revealed to his mother what had happened with the uncle, she has kept a close watch on him, to make sure that 'he was not becoming a homosexual' and assured him that 'if you turn out like that character, I will throw you out of the house'.

Among the children of this marriage, Héctor occupies the same position in the sequence as his uncle, his mother's elder brother, who performed the seduction. This uncle, whose personality is highly psychopathic, was the preferred child of the grandparents, and Héctor's mother has an ambivalent relationship with him which swings between attraction and deep resentment. During the period of the seduction, it was the mother who encouraged Héctor to get close to his uncle, with the conscious aim of 'providing him with a positive father figure'. The patient noticed this attitude of his mother's and, after the discovery of the seduction, accused her in a frankly paranoid way of having been 'in cahoots with this character to hand him over to him'. Although this accusation obviously contains a fragment of unconscious truth, we were, on the other hand, able to analyse it as a projection on to the mother of the personal responsibility which the boy wanted to disavow. In a highly emotive session, Héctor was finally able to tell me, between tears, how much he loved his uncle and how cheated he felt when he began to suspect that the uncle did not really love him but was only using him as the object of his perverse desires.

My patient's profound identity disturbance becomes more comprehensible in the light of these considerations. He cannot be like his father, whom his mother despises, presenting him as a madman and a monster. Nor can he be like his mother, who terrifies him with her outbursts of fury which he feels to be homicidal. All that remains to him is to be like his uncle, but this involves expulsion from his family and home as well as the renunciation of his masculinity. Faced with this accumulation of impossible situations, he chooses to withdraw and to hide his capacity to feel (Winnicott's 'true self' (1960b)). This also prevents him from relating fully to me—his main resistance to the treatment

during the present phase. However, behind all this lies the symbiotic relationship with an omnipotent and intrusive mother, which he does not dare to give up, as it was the only thing that enabled him to survive the early attacks by the father.

All the above was worked on with Héctor during his analysis. At present, I believe that the main gaps still remaining in this reconstruction are precisely those connected with the early relationship with the mother, and it will only be possible to fill these after a period of regressive transference allows Héctor to complete the formation of his psychical structure, which was left unfinished by this disturbed relationship.

(iii) *The therapeutic achievement*

As already stated, I believe that the therapeutic achievement has been only partial, as the crucial phase of the analysis which we are now beginning is still lacking. However, although achievement of *modifications to the nuclear structures* must wait upon the development of a regressive transference neurosis (Dewald, 1972), I can point to a number of *progressive changes in the secondary psychical functions* (resolution of inhibitions and symptoms) which must be attributed to the analytical work performed. Héctor long ago resolved the anxiety and insomnia which were the reasons for his original consultation. He has overcome the verbal inhibitions which prevented him from referring to sexuality and bodily functions. He has also lost his fear of masturbation. His social relations away from home have improved considerably. He now has a group of friends and his fears at the first contacts with the opposite sex are those of a normal adolescent, although quite a shy one. In the last few months he has been able to cope with the very painful process of his parents' divorce, towards which he had to adopt an extremely definite and personal position. He has also taken responsibility for the care of his own health, attending hospital alone, thereby truly overcoming his phobic symptoms. On one occasion he complained to the hospital authorities that a doctor had failed to keep to the time of his appointment. This and other episodes in which he has dared to defend his rights actively represent the beginning of the resolution of his conflicts with aggression, which can now be used for adaptive purposes.

But apart from these very positive developments, there is a part of his personality which has not yet been touched by the treatment, which is his true self, lying concealed behind his 'schizoid compromise' (Guntrip, 1963). This is a point at which the treatment could be deemed to be at an end, if we were to accept that the partial achievements represent the most that can be hoped for. But Héctor does not feel satisfied with what has been achieved so far. Although he acknowledges the changes that have taken place, he has an agonizingly painful perception of the experiential void underlying these partial developments and he knows that unless he manages to repair the basic fault in his personality everything else will pale into insignificance. This is his motivation for continuing with the treatment despite his resistances and fear.

Discussion

I have travelled a long way since my initial statement. I believe I have shown that my work with Héctor has been consistent with my theoretical position and that it has enabled us to work through a number of conflicts in the neurotic area. But I have also come up against the limits of this type of analytic work. In my opinion, my patient perhaps does not ideally satisfy the conditions required for systematic and exclusive application of the so-called 'classical technique' of psychoanalysis. The fact that Héctor is not only an obsessional neurotic but also presents an underlying schizoid pathology has made it necessary for me to consider him within a wider frame of reference, including the process of therapeutic regression and regrowth (Balint, 1968; Guntrip, 1963; Winnicott, 1954).

However, even if we accept the theory (which not all analysts accept) that defects in psychical structure can only be resolved by a therapeutic regression and internalization of the real relationship with the analyst, is it possible to justify the technique applied by me during the initial years of Héctor's treatment? Will I have not simply encouraged intellectualization and resistance? If these criticisms are accepted as valid, one is in effect asserting the existence of a more direct route for the treatment than my own: a route that would succeed in encouraging regression and restructuring of the psychical apparatus without running the risk of intensifying intellectualization and defence. This route could be no other than that of direct, deep interpretation of unconscious contents, as proposed by Melanie Klein (1932). I myself have laid myself open to this criticism in showing that with a material that could be interpreted either oedipally or regressively, I chose the former basis, disregarding the latter for the time being.

Yet this argument fails to convince me. In my view, the extreme fragility of Héctor's ego would not have tolerated the brutal onslaught of deep symbolic interpretations, which would have made him run away from the treatment. As I see it, the prolonged work in the oedipal area was the factor which encouraged the strengthening of his ego and is now enabling him to contemplate a new stage of 'descent into hell'. However, what I have just said is basically no more than a reaffirmation of my previous theoretical conviction. A psychoanalyst with a different orientation might insist that early, deep and exact interpretation does not increase anxiety but, on the contrary, alleviates it, thus laying the foundations for the unconscious co-operation of the patient (Klein, 1932). What makes me think that my technical option was correct is the fact that Héctor's mother is an intrusive borderline personality, who, from the beginning of his life, tended to establish with him a pathological symbiotic relationship in which she treated him as an extension of herself. If there is any validity in my hypothesis that it was this intrusive relationship that caused the withdrawal of the boy's true self, which afterwards remained hidden and protected by a false self that achieved a passive adaptation to conditions of life far below the 'average expectable environment' (Hartmann, 1939), what reaction might be expected in Héctor to an analyst who intrusively interpreted to him contents which he was not yet able to assimilate?

If we accept Winnicott's (1952) idea that the breast must arrive precisely at the moment when the baby hallucinates it, so that the baby can nurture the illusion that it was he who created it by his wish, it is possible to suppose that something similar happens with interpretation. From this point of view, the interpretation should arrive precisely at the moment when the patient is waiting for it and is ready to incorporate it, so that he can feel that it is a product of his own, instead of experiencing it as something alien which the analyst forces on to him and to which he must adapt passively. If, as I believe, this theory is correct, the conditions for expression of the true self can be created only by an attitude of patient waiting and great respect for the analysand's own rate of progress, his ego capacities and his spontaneous actions and movements. In this case, as Winnicott (1960a) says, the analyst will not have waited in vain.

Conclusions

I have presented the case of a boy who entered upon adolescence with an obsessional neurosis and underlying ego damage. On the basis of my evaluation of the case and my own theoretical convictions, I adopted a particularly cautious technique in which I allowed the patient to make the running, while I always remained a step behind him and gave him as much space as possible for the unfolding of his ego capacities. I thus took advantage of his intelligence, motivation and conscious co-operation for the purposes of the analytic process. The results obtained conformed to my aims and theoretical expectations: the treatment was brought to a point at which, after certain partial therapeutic achievements, my patient and I have to choose whether to terminate or to proceed to a new and deeper level. According to my view of the analytic process in patients of this kind with early structural damage, this level can only be that of a phase of therapeutic regression to allow the formation of new, normal psychical structures through internalization of the real relationship with the analyst. However, my presentation has centred on the first phase of the treatment, prior to the regression.

With regard to my initial question as to how far the work of analysis is to be seen as an activity of the analyst or a task of the patient, I believe that each analyst's (and each analytical

school's) answer will depend on certain basic theoretical presuppositions. Two fundamental polemical points are relevant to this discussion. The first relates to the importance attached to the patient's ego functions in the analytical process. If the view is taken that every psychoanalytical interpretation is directed towards the ego, that its main function is strengthening of this psychical structure and that insight and working through are the result of the active exercise of certain ego capacities of the patient, interpretations will be given extremely sparingly and the analyst will always be waiting for the appropriate time to make them, thus allowing the greatest possible space for spontaneous analytical work on the part of the patient. Conversely, if an analyst believes that the interpretations are directed towards the unconscious and that the latter is always prepared to receive them, provided that their content coincides with that of the anxieties and fantasies active at the time, he will tend to be much more active in the treatment and stress the analyst's interpretive activity as the fundamental factor in its progress.

The second point concerns the importance assigned to internalization of the baby's early interactions with the environment for the establishment of the psychical structures. If the analyst regards the baby's original state as one of non-differentiation, out of which the psychical structures will differentiate and become established by way of a complex interaction between innate maturational factors and internalization of stimuli from the facilitating environment, he will tend to base his role in the treatment (at least, with patients in whom he has diagnosed early damage) on his evaluation of the type of experiences he considers the patient to have lacked during his development. This approach is based on the assumption that the interpretation cannot by itself modify the lesions resulting from experiences during a pre-representational period, and that these can be resolved only by way of new experiences lived in the real relationship with the analyst. On the other hand, if the analyst supposes that the ego is active from the first moment of life, creating fantasy representations of itself, of the object and of the self-object relationship, and that subsequent development is the result of successive processes of projection and introjection determined basically by the nature of the instinctual impulses involved, he is bound to believe that the totality of the experiences of early infancy are accessible to interpretation, and this will again lead to an emphasis on the interpretive activity of the analyst.

It is obvious that my technical choice for the conduct of Héctor's treatment was the result of a theoretical framework of reference which emphasizes the participation of the ego functions in the analytical process and early environmental influences in the process of the establishment and differentiation of the psychical structures. My results appear to confirm my theoretical assumptions, but there is no doubt that a theoretical and technical question of this import can be answered definitively only by painstaking comparison of records of treatments of comparable patients conducted by one or the other technique.

Summary

The author asks to what extent the work of analysis can be regarded as an activity of the analyst or a task of the patient. While the work of analysis obviously involves both, very different therapeutic techniques and processes result according to whether stress is laid on the analyst's or the patient's activity. The choice of one or other of these positions appears to depend on the analyst's assumptions about the importance of participation of the ego in the analytical process and of interaction with the environment for the formation of psychical structure. An attempt is made to answer the question by presentation of the case of a boy entering upon adolescence with an obsessional neurosis and underlying ego damage. The therapist's technical approach, based on maximum respect for the patient's spontaneous activity, is analysed in detail. The therapeutic and analytical results obtained appear to confirm the validity of this passive and cautious technique on the part of the analyst in the case presented. However, final resolution of the question would require a comparative study of treatments performed by analysts representing both schools.

Translations of summary

L'auteur pose la question de savoir dans quelle mesure il faut considérer le travail de l'analyse comme une activité de l'analyste ou comme une tâche du patient. Alors que ce travail implique manifestement les deux activités, les techniques et les processus thérapeutiques mis en jeu sont très différents selon que l'on met l'accent sur l'activité de l'analyste ou sur celle du patient. Le choix de l'une ou de l'autre de ces positions semble dépendre des hypothèses de l'analyste sur l'importance de la participation du moi dans le processus analytique, et de l'interaction avec l'environnement dans la formation de la structure psychique. L'auteur tente de répondre à la question en présentant le cas d'un garçon entré dans l'adolescence avec une névrose obsessionnelle et une altération sous-jacente du moi. Il analyse en détail l'approche technique du thérapeute, qui s'appuie sur un respect maximum de l'activité spontanée du patient. Les résultats thérapeutiques et analytiques obtenus semblent confirmer la validité de cette technique passive et prudente de la part de l'analyste au cours du cas présenté. Toutefois, une réponse définitive à cette question nécessiterait une étude comparative de traitements effectués par des analystes representant ces deux écoles.

Der Autor stellt die Frage, bis zu welchem Ausmaße die analytische Arbeit als Aktivität des Analytikers oder als Aufgabe für den Patienten betrachtet werden kann. Obwohl die analytische Arbeit offensichtlich beides beinhaltet, ergeben sich sehr verschiedene therapeutische Techniken und Prozesse entsprechend der Betonung auf die Aktivität des Analytikers oder des Patienten. Die Wahl zwischen der einen oder anderen Position hängt von den Annahmen des Analytikers hinsichtlich der Wichtigkeit der Teilnahme des Ichs am analytischen Prozess und von Interaktion mit der Welt zwecks Bildung der psychischen Struktur ab. Es wurde versucht, diese Frage durch die Präsentation des Falles eines Jungen, der seine Adoleszenz mit einer obsessiven Neurose und darunterliegendem Ich-Schaden antrat. Die technische Methode des Therapeuten, die auf einem großtmöglichen Respekt vor der spontanen Aktivität des Patienten beruhte, wird im Detail analysiert. Die erreichten therapeutischen und analytischen Resultate scheinen die Angemessenheit der passiven und vorsichtigen Methode, die der Analytiker in diesem Fall anwendete, zu unterstreichen. Die endgültige Lösung der Frage würde jedoch eine Vergleichsstudie von Behandlungen von Analytikern von beiderlei Schulen erfordern.

El autor plantea la pregunta de en qué medida es posible concebir el trabajo del análisis como una actividad del analista o como una tarea del paciente. Si bien el análisis es evidentemente una labor de ambos, el poner el énfasis en la actividad del analista o en la del paciente determina técnicas y procesos terapéuticos bien diferentes. La elección de uno u otro punto de vista parece depender de las presuposiciones teóricas del analista acerca de la importancia de la participación del yo en el proceso analítico y de la transcendencia de la interacción con el ambiente para la constitución de la estructura psíquica. Se intenta resolver la pregunta planteada por medio de la presentación del caso de un niño que ingresa a la adolescencia con una neurosis obsesiva y con un daño yoico subyacente. Se analiza en detalle la conducta técnica del terapeuta, basada en el mayor respeto por la actividad espontánea del paciente. Los resultados terapéuticos y analíticos obtenidos parecen avalar la pertinencia de esta técnica pasiva y cauta por parte del analista para el caso presentado. La resolución definitiva del interrogante planteado requiere, sin embargo, de un estudio comparativo de tratamientos efectuados por analistas representantes de ambas posturas.

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THE CHILD AND ADOLESCENT ANALYST'S EMOTIONAL REACTIONS TO HIS PATIENTS AND THEIR PARENTS

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Analysts have long known that their emotional reactions comprise a most important tool and a potential insidious hazard. They can help the analyst understand his patients through delicate empathy or perception of his own responses to the patient's intentions, or they can produce perilous blindspots and evoke anti-therapeutic behaviour. It is unfortunate that many gather the complex array of such emotions under the single umbrella of countertransference and thus blur the distinctions between them. Indeed, the term has become a cliché which enables the user to label his behaviour without examining its exact nature. He can thus justify neglect of an essential ingredient of psychoanalysis—self-analysis. The blurring of boundaries also interferes with scientific discourse. Dialogue suffers when each person uses the same term differently or when the participants fail to understand what their own usage comprises.

In this paper, we will attempt to differentiate various emotional reactions while recognizing that an overlap of categories necessarily exists. We will discuss the analyst's reactions to both his child patients and their parents. We will also sort out responses to children and adolescents at different developmental levels. Finally, we will discuss reactions to termination.

DEFINITIONS

First we will define and cast light on the following emotional reactions of the analyst (Bernstein, 1975; Bernstein & Glenn, 1978; Glenn et al., 1978):

1. Countertransference.
2. Transference to patients or their parents.
3. Relating to patients or parents based on character traits.
4. Identification.
5. Narcissistic attachments to the patient.
6. Responses to the patient or parents as real people. This includes empathy or failures of empathy, signal reactions or more intense responses to the behaviour of the patients and their parents, and failures to understand the patient due to differences in the developmental level of the patient and analyst.

Countertransference then is but one type of emotional reaction to patients. There are other types of counter-reactions as well, and all require discussion. In addition, we must differentiate responses to children from reactions to parents.

Laplanche & Pontalis (1973) define countertransference broadly as 'the whole of the analyst's unconscious reactions to the individual analysand—especially to the analysand's own transference' (p. 92). Freud (1910) never defined countertransference completely. He stated that it 'arises in him [the analyst] as a result of the patient's influence on his unconscious feelings' (p. 144) and requires self-analysis to 'overcome' it. Freud (1915), in 'Observations on transference love', provided a series of insights that enable us to sketch his thoughts on transference and countertransference further. He gave as an example of countertransference the analyst's feeling proud of a 'conquest' when a patient falls in love with him. We may assume that Freud believed that the analyst's 'returning the