



Research Article

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How Psychoanalytic Process's Work: Considering the Relation between Traditional Theory and Contemporary Scientific Theory and Techniques

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Abstract

The main aim of this article is to try and demonstrate the difficulties and obstacles involved during the process of psychoanalytical therapy, mainly a case conceptualization by taking both traditional Psychoanalytical theory and contemporary scientific findings into consideration. By looking at the traditional theory of psychoanalysis, it is palpable that interpretation and the study of the human mind will eventually deem the issue of subjectivity undeniable, as you will see from the reference section, of those used; essential materials from the International Journal of psychoanalysis, introductory lectures of Freud, and studies of hysteria and also for the contemporary reference, lecture notes of Wilma Bucci (2009). This article will focus mainly on resistance, and what then is the cure? Freud described the notion of an analytic cure in 'Introductory Lectures on Psycho-Analysis'. Through this method, psychoanalysis sets itself up as the 'talking cure' and communication, its weapon. Any process of communication which does not have the aim of providing a cure isn't in the strict sense of the word, psychoanalysis. According to Freud, the ego is the source for three types of resistance while the super-ego and the Id is responsible for each other. This article has no methodology since all the information used is based on theoretical information obtained from reliable sources and all references have been included accordingly. According to Wilma, the contemporary psychoanalytic process differs. Due to the nature of this article, the conclusion is the fact that further research is required to observe how exactly theory relates to technique and therapy becomes more effective.

Keywords: Psychoanalytic Process, Traditional, Contemporary, Scientific, Theory, Technique

1. Introduction

The difficulties inherent in the relation between theory and technique are a fact of life. Although psychoanalysis appears to end up with more than its fair share of difficulties, it is by no means the only one affected. One has only to bring up the example of how passing one's driving test does not make one a good driver to see how issues of subjectivity, experience, personal limitations act come into play in practice.

That which has anything to do with the study of the human mind will inevitably have to come face-to-face with the issue of 'subjectivity'. And unless the human mind is reduced to no more than a machine run by artificial intelligence, it will not possible for subjectivity to be removed from the relation between theory and technique.

Unlike physical sciences, establishing psychoanalytic facts is immeasurably more difficult.

Psychological activity is not empirical science. Psychoanalytic theory is not something which can be repeated and proven at will in an experiment. Even if it is so, there is still the question of the audience.

Given that all analytic work is carried out in a 'closed' and 'secluded' environment, between the analyst and the analysand, with no independent third party, the question of whether an observation, an intervention or an interpretation is the 'correct' one or not, must inevitably arise. In her paper, 'what is a clinical fact?'. Accordingly, O'Shaughnessy (1994) argued that:

"Subjectivity is a word with many meanings. For a start, psychoanalysis studies psychic reality, which in one sense is subjective reality. And then, all human studies depend more on the knowing mind than the study of physical nature; in psychoanalysis, the analyst's mind is the instrument investigating the mind of the patient. This raises the alarming idea of psychoanalysis being doubly subjective, from the analyst's as well as the patient's side".

She made an interesting point in the same paper about the age we live in, an age where the "objective achievements of machines dazzle" and "make us see them as everywhere superior- even in questionable areas... In the same vein, a tape-recording is presumed to be a more objective record of a session than an analyst's written and mental notes" (O'Shaughnessy, 1994).

So what then is a clinical fact? Is it verifiable? How will one know that it is a claim to truth and not a mere observation by the analyst? Freud (1917) debated this in his 'Introductory Lectures' as follows:

"But you will now tell me that, no matter whether we call the motive force of our analysis transference or suggestion, there is a risk that the influencing of our patient may make the objective certainty of our findings doubtful... That is what our opponents believe; and in especial they think that we have 'talked' the patients into everything relating to the importance of sexual experiences..." (Freud, 1917).

Here comes his reply:

"Anyone who has himself carried out psycho-analyses will have been able to convince himself on countless occasions that it is impossible to make suggestions to a patient in that way... After all, his conflicts will only be successfully solved and his resistances overcome if the anticipatory ideas he is given tally with what is real in him" (Freud, 1917).

In addition to the issue of 'subjectivity', there is perhaps another which brings many difficulties to analytic work- the issue of different psychoanalytic schools and how their orientations define the analytic cure.

Differing views such as, what constitutes the analytic setting, variable sessions versus fixed sessions, interpretation of the transference versus interpretation in the transference, integration of lost objects versus re-experiencing psychical conflicts – these are all options open to the direction of treatment.

It is not my intention here to debate the merits or demerits of each school. Suffice to say that, however adequately or inadequately theory measures up in the stark reality of the analytic setting and whichever psychoanalytic school one chooses to adopt, a theory is something central to analytic work. Without an organised body of knowledge, there can be no organised practice called psychoanalysis. Theory guides the analyst. It provides the foundation and the framework within which analytic work can be carried out. Despite discernible differences, let us not forget also that the existence of commonly held beliefs, for example, the recognition of an unconscious, the ego's need for defences and the repetition of ideas formerly repressed in the form of transference onto the analyst, from the common ground for psychoanalysts.

2. The Notion of an Analytic Cure

Through its method, psychoanalysis sets itself up as the ‘talking cure’ and communication, its weapon. Any process of communication which does not have the aim of providing a cure isn’t in the strict sense of the word, psychoanalysis.

What then is the cure? Freud described the notion of an analytic cure in ‘Introductory Lectures on Psycho-Analysis’ as follows:

In order to maintain a successful analytic treatment which results in overcoming resistances, the doctor and the patients needs to go through an efficient work. When the existing resistances are lifted successfully, the patient's state of mind will go through some permanent changes that enhance their development and enable them to protect themselves against any possible mental issues (Freud, 1917).

Lifting such resistances is one of the most important functions of any successful analytic treatment which “the patient has to accomplish it and the doctor makes it possible for him with the help of suggestion operative in an educative sense. For that reason, psychoanalytic treatment has justly been described as a kind of after-education” (Freud, 1917).

For Freud, overcoming resistances and the working through of resistances are central to the notion of an analytic cure. This makes for a fascinating academic study but in practice, probably terribly frustrating for both the analysand and analyst. As such, are the perfect candidates for a discussion on the relation between theory and technique!

This article will focus mainly on resistance followed by a brief discussion on working through towards the end. It will draw upon Freud’s work beginning from ‘studies on Hysteria’ in 1895 until his ‘Analysis Terminable and Interminable’ which was published in 1937. References to papers published in the Internal Journal of Psychoanalysis as well as the writings of Joseph Sandler and Darian Leader will also be made along the way.

3. The Historical Development of Resistance

Freud never wrote a book or a paper titled ‘Resistance’, yet, ‘resistance’ is used frequently by Freud in his writings. His reference to resistance goes as far back as the early days of ‘Studies on Hysteria’ (Freud, Breuer, & Strachey, 1895).

Resistance as a clinical concept emerged in Freud’s initial work with his patients while he was still using hypnosis and the ‘Pressure technique’. At the time, Freud regarded resistance as anything which prevented his patients from recalling to memory, material analysis. For example, he noted in his work with Fraulein Elisabeth von R that there existed a force which was opposed to remembering.

Later on, in the same book, Freud described ‘resistance’ like this:

I had to overcome a resistance, the situation led me at once to the theory that by means of my physical work I had to overcome a physical force in the patients which was opposed to the pathogenic ideas becoming conscious (been remembered) ... a physical force, aversion on the part of the ego, had originally driven the pathogenic idea out of association and was now opposing its return to memory. The hysterical patient's ‘not knowing’ was in fact a ‘not wanting to know’ – a not wanting to know which might be to a greater or less extent conscious. The task of the therapist, therefore, lies in overcoming by his physical work this resistance to association. (Freud, 1955)

In many ways, we can credit resistance with the discovery of ‘Free association’ in psychoanalysis. Instead of insisting on ‘remembering’ which Freud found to be a great resistance on the part of his patients, he asked his patients to ‘Speak freely’ and this succeeded finally in breaking the impasse so that the treatment could move on.

Interestingly, Freud believed that this ‘not wanting to know’ was to a greater or lesser extent conscious. This is in contrast to his later views which placed the emphasis squarely on the role of him

unconscious in putting up defences.

In his book 'Interpretation of Dreams' in 1900, Freud argued that "whatever interrupts the progress analytic work is a resistance" (p. 517).

He compared resistance to 'censorship' in dreams and attributed the repulsion of unacceptable ideas, impulses and memories to these to mechanisms. Hence, resistance was no longer directed exclusively to fighting back repressed memories, but it was also believed to be responsible for the holding back of unacceptable impulses.

Freud believed that resistance always presents, he argued that as the treatment goes by, the patients' resistance will follow up throughout each treatment steps. Therefore, the therapist should be aware of such resistance and consider such resistance in every associations and actions of the patient. This way, the therapist will be able to achieve a balance between the recovery process and patient's strike throughout the therapy (Freud, 1912).

Resistance, though sometimes concealed, is always present and intensity changes during analytic treatment. The closer the analyst gets to the core of the repressed material, the greater will be the resistance to cover. This, I suppose what one would call the 'ups and downs' of analysis:

"For resistance is constantly altering its intensity during the course of a treatment; it always increases when we are approaching a new topic, it is at its most intense while we are at the climax of dealing with that topic" (Freud, 1917).

4. Five Classifications of Resistance According to Freud

Freud laid down the distinction between five different types of resistance 'Inhabitations, symptoms and anxieties' (Freud & Breuer, 2001). By this time he had already developed his 'structural model' of the mental apparatus, a three-fold division of the psyche into what he referred to as the ego, super-ego and id. According to Freud, the ego is the source for three types of resistance while the super ego and Id are responsible for each other. The five classes of resistance proposed by Freud are elaborated in the following few pages:

Resistance due to the ego

In his work 'Analysis Terminable and Interminable', Freud argued that "the ego treats recovery itself as a new danger" (1937, p. 238).

Repression resistance:

Apart from transference resistance, repression resistance would be among the earliest forms of resistance identified by Freud. It is a resistance put up by the ego to prevent repressed material from becoming conscious. In other words, the ego defends by directing its attention away from the unacceptable idea and impulses. This ongoing expenditure of energy to avoid unacceptable ideas and impulses, Freud called anticathexis.

An example of repression resistance is the absence of free association or the 'inability' by the analysed to think of anything to say.

Transference resistance:

Transference resistance takes place through a false connection or a displacement of repressed impulses or ideas. During analysis, the efforts of the analyst to bring to consciousness this repressed material is met with a transfer of such repressed ideas onto the person of the analyst.

Instead of remembering and recognizing the material as belonging to the past, the analysand repeats this material by acting out in the present. This form of resistance whereby the analysand reproduces repressed material not as a memory, but as an action is transference resistance. For the analysand, repeating under resistance is a form of remembering. An example of transference resistance is transference love.

Gain from illness:

Freud believed that there is a third kind of resistance caused by the ego and he called it 'gain from illness' transference. He explained the formation of this form of resistance by a process of

assimilation by the ego. Sometimes, the ego refuses to give up some forms of obtained through the manifestation of a symptom or illness. When this happens, the ego treats these symptoms as part of itself and proceeds to assimilate the symptom.

Any attempt at recovering is met with strong resistance from the ego as it seeks to protect what it perceives to be the many advantages to be derived from a continuation with the symptom. In a way, this form of resistance goes beyond the pleasure principle.

An example of this would be patients suffering from anorexia nervosa. Further investigation may reveal that the patient has just discovered his or her partner has been having an affair. The symptom of anorexia nervosa gratifies the ego's demand for revenge by including others in the patient's suffering. Also, by falling ill and refusing to get well, the patient obtains pity and attention and may even succeed preventing the partner from leaving the relationship. In other words, the patient stands to gain in other important ways, through his or her suffering.

Resistance due to the id:

Id resistance is a form of resistance which entails 'working through'. Freud explained that; "Even of the ego has decided to relinquish its resistance, it still finds difficulty in undoing the repressions; and we have called 'this period of strenuous effort which follows after its (the ego's) praiseworthy decision, the phase of 'working through' (Freud & Breuer, 2001).

Freud described such resistance as one which is due to "adhesiveness of the libido". He also called such behaviours as 'resistance from the id'. However, he discussed that "But with the patients I hear have in mind, all the mental process, relationships and distributions of force are unchangeable, fixed and rigid. One finds the same thing in very old people..." (Freud, 1937).

'Repetitive running away' behaviour is an example of id resistance. Whenever a situation is perceived to be no longer acceptable or pleasurable, the person suffering from Id resistance 'runs away'-moving from job to job or from relationship to relationship without ever coming any closer to finding out what the problem is.

Any attempt in curing such a person may have to result in working through that is, many more so-call at (mistakes) in the handling of love relationships before he or she is finally able to break free of this vicious circle.

Resistance due to the super-ego:

Super-ego resistance in the form of resistance brought about by the analysand's sense of guilt and the need for self-punishment. Freud regarded this form of resistance as the most difficult to detect and to deal with. Super-ego resistance results in a paradoxical reaction by the analysand. Any distinct relief or improvement results in a shrinking back by the analysand from the prospect of recovery. The old illness reinstates itself and the analysand ends up believing that treatment by psychoanalysis is not the answer to his or her problems.

"I am so happy I could die!" is probably not that far off from the truth for someone suffering from super-ego resistance. Having one's wish fulfilled makes one so full of guilt that it becomes an unbearable load.

Whether there is a relapse, a denial of the therapeutic effects of analysis, or a running away from the treatment, Freud, in his work 'The ego and the Id', would argue that these are all manifestations of a negative therapeutic reaction:

"Every partial solution that ought to result, and in other people does result, in an improvement or a temporary suspension of symptoms produced in them for the time being an exacerbation of their illness; They get worse during treatment instead of getting better. They exhibit what is known as 'negative therapeutic reaction' (Freud, 1961).

"In the end, we come to see that we are dealing with what may be called a 'moral' factor, a sense of guilt, which is finding its satisfaction in the illness and refuses to give up punishment" (Freud, 1923, pp. 49-50).

Why does the super-ego behave in this way? Freud believed that the reprisal of an extremely

severe super-ego may be due to that death drive: "The great significance which the sense of guilt has in neuroses makes it conceivable that common neurotic anxiety is reinforced in severe cases by the generation of anxiety between the ego and the super-ego (fear of castration, fear conscience, of death)" (Freud, 1961).

Examples of super-ego resistance would be the destructive behaviour of those who are wrecked by success or who become severely depressed upon attainment of a long-cherished goal.

Kurt Cobain, the lead singer of the very successful 90's band Nirvana, committed suicide at the height of the band's success. He found success unbearable. In his suicide note to his wife, Courtney Love, he described the pain hopelessness and depression which haunted him. He found no relief in being alive and so he chose the only alternative he thought was open to him – death.

5. Working Through

Freud understood perfectly well the problems of self-doubt and frustration faced by analysts who see no improvement in their analysands, even when they believe the right interpretations have been pointed out to them. Freud (1958) observed that:

"The analyst had merely forgotten that giving the resistance a name could not result in its immediate cessation. One must allow the patient time to become acquainted, to work through it, to overcome it by continuing, in defiance of it, the analytic work according to the fundamental rule of analysis."

The analyst has nothing to do but to wait. The repressed materials have been made conscious and pointed out to the ego but the tendency of id to repeat past defensive behaviour has to be overcome one by one. It follows from the basic law of simultaneity that every single one of the id's attachment to the complex of representations associated a particular conflict, has to be severed before a person can be considered 'cured'.

Even everyday language has a way of describing working through. 'Old habits die hard' and 'You can't teach an old dog new tricks' imply stubborn resistance to change. An interesting clinical fact is the re-appearance of symptoms after years of analytic work. What was there at the start comes back. Does this mean then, that the analysis is right back where it started? By no means. Darian Leader explained this strange clinical phenomenon using a musical analogy:

"In a fine piece of music, as the initial motive is broken down, recombined and rearranged, it's meaning and its effects on the listener change. When it returns at the end, resonances may be profoundly different from what they were at the start. The idea one entertains consciously at the start will be adjusted and corrected through the symbolic work of the analytic process, to produce something new, a secure sequence that may be found in many other fields of research." (Leader, 2000).

Working through is a trial of patience for both analyst and analysand. Although there are technical differences, I would argue that working through is, in many ways similar to mourning. In mourning, one continues to feel an acute sense of loss – long after it no longer makes sense for one to feel that way. There seems to be lagging behind the sense of reality in mourning. Similarly in working through, the id lags behind the ego in letting go of the past.

Frustrating as it may seem, it is this process of learning and unlearning called working through which Freud describes as that part of the analytic work which "distinguishes psychoanalysis from all other forms of treatment by suggestion" (S.E. Vol. XII, Papers on Technique, 1914, page 155).

Interpretation, acting out, transference etc., guide the voyage of analysis to its penultimate point... working through stands as its final frontier.

6. Conclusion

The relation between theory and technique is an interesting one. It leads us down the 'familiar road

of same nagging questions' – 'What is a clinical fact?', 'Is it verifiable?', "How does language affect the way a clinical fact is described?" "How should an analyst respond when clinical facts upset theory?" and finally, 'What will progress in theory and technique depend on?'

As an example of how language and theory impact clinical work, let us consider for a moment how analysts with different psychoanalytic orientation treat resistance. Without ignoring the importance of external influences, a Freudian would treat by looking for the source of the psychological conflict i.e. by getting closer to the unconscious while a Kleinian would seek to accomplish the mission by examining the role of projective identification in the creation of pathological object relations.

Also, on what basis should an analyst choose his or her analyst? How will choosing one psychoanalytic school over another alter the direction of the treatment? Can more research be done on 'the alternate view', or is this a brief that can't be filled anyway? Given that discovery is protected by the four walls of a consulting room and unrepeatability by another analyst whatever his or her orientation, how is another point of view, and indeed a comparison possible for psychoanalysis?

As a body of science, psychoanalysis more closely resembles Thomas Kuhn's shared paradigm model than Karl Popper's 'deductive' model. This means that a fact may be described in many different ways so long as the 'shared paradigm' is adhered to. There are arguably too many theories in psychoanalysis... and half-jokingly, some would say 'Blame Freud!'

Similarity can be found between Freud's classical theory of psychoanalysis and the 'Big Bang' theory. Freud created an impact so great and far-reaching that expansion of the psychoanalytic universe goes on till today...

In general, finding a new perspective on existing theories is a healthy development for any discipline which wants to be taken seriously as a science. As long as any expansion in old theories enlighten it in a useful and unique way, why not? But one should be wary of analysts who invent a new language to explain old ideas. Are they motivated by an ulterior motive of wanting to lay claims to originality?

On the other hand, according to Wilma Bucci, Adelphi University, looking at it from the new perspectives from Cognitive Science and Affective Neuroscience, major contributions of Psychoanalysis are;

- Theoretical: To open the scientific Study of Psyche-Soma (mind, brain, emotion, body) interactions.
- Methodological: The Psychoanalytical method of free association in the context of the therapeutic relationship is being used in order to maintain a more naturalistic setting.
- Clinical: It enables psychotherapists in developing an efficient approach in treating emotional disorders.

Psychoanalysis is inherently a multi-system theory and emotional disorders caused by an idea that is split from this organizing network. It divides influential behaviour and emotion, cause physical symptoms. Cure (Change) occurs through talking in the context of a relationship (Bucci, 2009).

According to Wilma Psychoanalysis is inherently a multi-system theory. The divisions of psychic apparatus have been formulated in different versions stages of the psychoanalytical theory in the terms such as conscious/preconscious/unconscious; ego/id; the primary and secondary processes of the thought and others; through all these versions, the concept of multiple systems of formats of thought remain.

Adaptive functioning involves the integration of ideas in a network of associations that regulate and organize life (Bucci, 2009). The human organism is multi-code, multi-format emotional information processor with partial and limited interaction among systems. Dissociation is inherent in the human information processing system and may be adaptive as well as maladaptive. As it is cited in Solano (2010), Bucci (2009) believed that avoidant dissociation happens "when integration of new information is actively blocked." (p. 1455).

7. A Final Thought on the Future Technique

Ending with a quote by Greenson, which sums up very nicely, the relation between theory and technique as well as the pitfalls that hinder the future of psychoanalysis?

“When Freud discovered the crucial importance of systematically analyzing the resistances of his patients, he was some twenty years ahead of discovering the ego implications of this procedure. Today we seem to know a great deal more about ego functions than we are able to use directly in our technique (Hartmann, 1951). “But I believe that our greatest hope for progress in technique lies in a better integration of clinical, technical, and theoretical knowledge.” (Greenson, 1974)

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