PSYCHOANALYTIC PSYCHOLOGY

(1998). Psychoanal. Psychol., (15)(4):451-479

Intrapsychic and Interactive Dimensions of Resistance

A Contemporary Perspective

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An integration of contemporary perspectives on resistance analysis is presented that emphasizes the salience of both intrapsychic and interactive dimensions of this phenomenon. Viewed as embodying desperate psychological imperatives imbued with unconscious infantile misconceptions, resistance is presented as serving multiple functions and encompassing aspects of all mental action within the psychoanalytic situation. Finding the analytic resources to exploit its relevant meanings is described as a central and indispensable aspect of working in depth. Several basic strategies for working with these phenomena are delineated in this article and the continued usefulness of understanding the role of resistance as guardian of psychic equilibrium is highlighted. Emphasis is given to safeguarding an analytic relationship that both sustains the patient and provides a vehicle for the exploration and modification of resistant activity.

The observation that all patients devote considerable time and energy to activities that impede their analytic progress has impressed psychoanalysts

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of every persuasion. Freud's trenchant definition of resistance—elegant in its simplicity—as “whatever interrupts the progress of analytic work” (Freud, 1900/

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1953a, p. 517) focused exclusively on the psychoanalytic situation. Early analysts, in keeping with an as yet rudimentary conception of psychic structure, tended to locate this resistance in the rebellious willfulness of a difficult patient—a rebellion directed against the analyst's authority to structure the psychoanalytic situation. Technical discussion was limited to specific behaviors and attitudes that avoided or obstructed the scheduling of appointments, use of the couch, payment of fees, or more problematically, the fundamental pillars of the psychoanalytic process itself: free association and analytic neutrality. This circumscribed and inadequate understanding of resistance bolstered a deteriorating, largely antagonistic view of the relationship between patient and therapist, wherein the patient's passivity and the analyst's uncontested authority became defining elements of a productive working alliance.

The first and probably most significant breakthrough in this adversarial understanding of resistance came about through a clarification and classification of the modes of defense. Freud (1893-1895/1955b) had noted early on that patients typically struggle to maintain the defenses they have developed, viewing the treatment—and the analyst—in the context of an attack on their established ways of feeling safe. However, with the growing recognition that defense was itself a phenomenon shaped by complex unconscious processes, clinicians were finally in a conceptual position to begin to extricate themselves from an increasingly frustrating technical impasse. Resistance could now be addressed analytically through exploration and understanding rather than through force of personal persuasiveness. This new understanding of defense emphasized two divergent yet overlapping concepts: character style, primarily articulated by Wilhelm Reich (1949), and the mechanisms of defense elaborated by Sigmund (1893-1895/1995b, 1915/1957, 1925-1926/1959, 1896/1962a, 1894/1962b) and Anna Freud (1936). Each of these ideas opened somewhat different technical and theoretical paths that subsequently proved invaluable in the evolution of psychoanalysis. Character as defense was elaborated as the primary conceptual framework for a neo-Freudian or culturalist approach to resistive phenomena. Their work with resistance was rooted in the recognition that the patient rebelled against the analytic situation because it presented a fundamental challenge to a basic pathological orientation to life. Confronting and undermining these fundamental premises so that the patient might approach the therapy with emotional authenticity became central to this technical approach. Developments

within mainstream ego psychology took another direction, emphasizing the analytic clarification and working through of intrapsychic defense mechanisms.

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Working individually or in concert, these defense mechanisms were seen as generating the foundation for a host of elusive obstacles to the uncovering of unconscious contents.

In time, other major theoretical advances in psychodynamic understanding eventually translated into more sophisticated appreciations of the complexities of resistance analysis. As the role of aggression in intrapsychic conflict received expanded theoretical emphasis (Freud, 1919/1955a, 1923/1961a; Strachey, 1934), psychoanalysts came to appreciate that reorienting a patient's values with regard to previously unacceptable desires was a naive formulation of their task. The largely unconscious contribution to resistance of systematically structured self-punitive and self-sabotaging action and attitude had been thrown into sharp relief. The pivotal role of guilt, both as an obstacle to self-awareness, and as a motivation for clinging to constricted and compromised forms of relating came to the fore in this heyday of superego analysis. Similarly, as theoretical explications of guilt began to identify the dynamic role of internalized object representations embedded in psychodynamic structure Klein, 1957, an unforseen malleability in the structure of analytic experience came into view. From this perspective, projectively externalized representations and stimulated re-enactments could subvert the analyst's liberating intentions. Analysts became sensitized to the way their benign interpretive activity could be perniciously corrupted by projected and introjected imagoes of a menacing or overstimulating nature. Correspondingly, advances in the understanding of narcissism, both in its grossly pathological and normative vicissitudes (Kernberg, 1975; Kohut, 1971, 1977, 1984), led to renewed interest in shame and self-shaming attitudes as a motivational force underlying many obstinate forms of resistance in the clinical encounter. An empathic grasp of this crucial vulnerability with regard to an experience of cohesive selfhood dictated a more refined timing and articulation of interventions. Calling a spade a spade might not always be the best approach. Interpretation, it became evident, had to be finely tuned with an ear for the subjective echo in the patient's mind or its reverberation would drown out every other awareness.

Informed by these multiple perspectives, contemporary psychoanalysts have come to feel increasingly uneasy about considering resistance exclusively within any one of the traditional theoretical frameworks. Formulations that emphasize characterological defense seem to be too broadly pathologizing large areas of adaptive and healthy personal functioning.

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On the other hand, formulations that isolate discrete “mechanisms” of defense within an ego “apparatus” organized to integrate drive derivatives and environmental demands seem too narrow and mechanistically conceived. A reluctance to be hemmed in by traditional analytic conventions has played a significant role in shaping the contemporary handling of resistance in the clinical encounter. In this context, a growing appreciation of Waelder's (1930/1936) principle that mental processes serve multiple functions has emerged as a specific conceptual pivot, propelling theoretical integrations that encourage greater technical flexibility in many areas of analytic practice. Accordingly, the conception of resistance, like the concepts of transference Sandler, 1983 and defense Brenner, 1982, has evolved from a rather discrete process that points to limited and particular mental activity toward one that encompasses aspects of all mental activities (Levy, 1984, White, 1996).

Today, psychoanalysts recognize more clearly that resistance is a dimension of every analytic experience (Gray, 1986, 1987) and that as one gains an increasingly synoptic perspective on the complex unity of any patient's inner world, neat conceptual distinctions between resistance, defense, transference, or character lose their clear boundaries.[1] Although contemporary thinking about resistance analysis is marked by evolving complexity, at its core is the hard-won appreciation that whatever one comes to identify as the resistant attitudes and behaviors of a given clinical encounter are never simply resistant. “To some extent, we no longer speak of resistances *per se*, but rather attempt to identify the resistance inherent in all the patient's activities” (Levy, 1984, p. 71). Resistances serve multiple purposes—as do all of the psychological phenomena that are observed—only one of which is to subvert the analyst's goals and procedures. Resistant attitudes and behaviors simultaneously defend against the painful affects of anxiety and depression, express or enact unconscious fantasies, and repeat or protect genetically significant relational patterns, as well as preserve psychically vital states of autonomy, identity, and self-cohesion from potentially destabilizing impingements. As such, resistances embody desperate psychological imperatives imbued with unconscious infantile misconceptions. From a clinical perspective, an important implication of this understanding is that any behavior or attitude can serve the purposes of resistance only until an analyst finds the technical resources to exploit its other relevant meanings. If this occurs, rather than impede the analyst's

[1] *Such hybrid technical terms as transference-resistance and defense-transference are conceptual condensations that attest to this ambiguity.*

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efforts, resistive phenomena further the analyst's intentions by announcing and defining crucial areas of meaning that must receive specific elaboration.

The basic technical strategy is to establish a context of meaning in which the attitudes, fantasies, and/or behaviors that have been identified and described as resistant will be recognized as having an imperative emotional investment for that person in that place. The analyst's goal is to fully appreciate this contingent meaning, rather than to change the patient's behavior. This can be realized only by carefully detailing the psychodynamic structure of the patient's subjective perspective within the analytic situation. What painful affect is the person warding off? What threat to psychic equilibrium is anticipated? What wishful or reparative fantasy is being advanced? What relational pattern is being conserved? Equally important, how are the analyst's behavior, attitudes, and expectations being construed in regard to these intentions? Do they articulate with these anticipations in ways that intensify or ameliorate them? In principle, therefore, whether it takes an hour or an entire analysis, one approaches all varieties of resistance with the same patient and persistently inquisitive attitude. Analysts try to observe with precision and describe in detail the attitudes, behaviors, or fantasies in question, to identify the immanent concerns within the context of the analytic relationship, and to explore the manifest and latent fantasy structure of the motivations involved, including their genetic foundation.

Resistance and Defense as Guardians of Psychic Equilibrium

An early, and still fundamental orienting perspective on the problem of resistance is anchored in the concept of psychodynamic equilibrium. Rangell (1983), following Freud (1937/1964), Fenichel (1941), and Greenson (1967), is the contemporary analyst who most clearly articulated the view of resistance as a universal motivational force mobilized against the undoing of a defensive system that maintains intrapsychic equilibrium. Children, adapting to internal and external pressures within a familial environment, develop stable modes of functioning that ameliorate the inevitable conflicts of early childhood. The evolution of this unique organization, represented by an unfolding of unconscious fantasy in response to a predictable sequence of maturational challenge, can be counted one of the most significant achievements of childhood. Satisfying multiple considerations, these early “solutions” endow the analyst with powerful protective functions that persevere into adulthood. In this sense,

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the force of resistance can be said to be concentrated upon, but not created in, the psychoanalytic situation. Bypassing resistance, either through ill-considered maturational initiatives in life or by premature interpretation in analysis, overloads the adaptive and interactive capacities of an individual, evoking a desperation born of helplessness. This, in turn, becomes the impetus for an immediate counterpressure toward establishing a new, or reestablishing the old, homeostatic balance. Resistance, therefore, is an inevitable and even healthy phenomenon. It guards psychic equilibrium in dangerous—though archaically conceived—circumstance, until an improved solution can be substituted. It is only from an external vantage point that it will seem unnecessary, contrary or constrictive. The motivational force of resistance, mobilized by any anticipated change, will express itself in the variety and persistence of a person's actions, thoughts and attitudes that ward off emotional novelty. In Greenson's (1967) words, resistance “defends the status quo of the patient's neurosis” (p. 36).

In this context, it is relevant to draw a distinction between defense (or more narrowly, defense mechanism) as a discrete attribute of mental functioning and resistance as a ubiquitous dimension of the psychoanalytic situation. From the perspective of psychoanalysis as a clinical process, resistance is by far the more embracing concept. When psychoanalysts refer to defense analysis, they are thinking of a treatment conducted within a conceptual framework that appreciates the role of certain habitual patterns of mental and emotional action closely allied with homeostatic adaptation. Broadly speaking, this refers to the balance of pleasurable and painful affects that are tolerable to a person in a particular psychodynamic context, as well as the automatic strategies or habits of mind that are initiated to avoid traumatic overstimulation. Analysts do not, strictly speaking, observe defenses in action Fenichel, 1941; rather, they observe the mental and affective consequences of a defensive process. Indeed, when defenses work effectively analysts can only infer their existence by the absence of something expected or the presence of something unexpected. Like a default setting on a word processing program, though its effects appear at the surface of awareness, its ordinary operation takes place in some hidden recess of the mind. Defensive action basically attempts to reestablish homeostatic equilibrium in response to disruptive tensions clinically identifiable as anxiety, depression, shame, and guilt, the emotional states that give warning of potentially traumatic psychic threat. Just what this ultimate traumatic danger consists of is hard to grasp phenomenologically, as patients who approach such states often have

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difficulty articulating their experience coherently.[2] It seems to be rooted in the losses, real and fantasized, that evolve in earliest childhood experience of self and others. Intense dread and helplessness are its most accessible psychic contents.

Important as this understanding may be theoretically, within the analytic situation one rarely draws attention to defensive patterns of mental action without reference to their impact on the immediate psychoanalytic process or transference configuration. An analyst does not tell patients that they have forgetten important feelings and thoughts, (i.e., used repression) without anchoring such advice in a specific context that suggests motivated action (i.e., a resistant action or a transferentially meaningful action). Though it may be conceptually cogent, it has limited technical impact to simply point out defense mechanisms as such. To do so is to shift the analyst's interpretive perspective from the motivations of a person who is living a life, to the operations and patterns of that person's mind as an instrument of psychobiological adaptation. Clinical effectiveness generally resides in the meaning of the defensive action in the context of the psychic processes that have been or are about to be mobilized within the psychoanalytic situation: “You didn't want to remember that you had an erotic fantasy about me in our last session, perhaps because it would suggest I was becoming too important in your life.” Psychoanalysis undermines habitual defensive modes of thought and action by identifying and ameliorating the essential dangers that make them imperative.

Sustaining the Work With Resistance

The psychoanalytic situation is specifically designed to set in motion processes that challenge existing psychic equilibria while clarifying the preconditions of safety immanent in a person's ongoing adaptation. Its open-ended structure thwarts comfortable consolidations, as each new equilibrium is progressively examined and undermined in turn. This confronts a person with the inescapable dilemma inherent in radical change—it doesn't feel good. Indeed, analysts often hear patients complain, “I feel like I've left myself behind. I'm profoundly alienated… as if I'm stepping out into a terrifying void.” This lament is to be expected, as

[2] *Each theorist tends to infer some underlying content of traumatic states that accords with his or her own premises. Thus, object relations theorists tend to emphasize a state of isolation or abandonment, whereas self psychologists*

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characterize the traumatic state as dissolution of the self, and ego psychologists define trauma in terms of unmanageable excitation.

patients confront their apprehension of surrendering familiar ways. Not infrequently, a central aspect of this distress revolves around the way in which early defenses and compromises have become imbued with parental functions, representing sustained contact with parental care in the present Schafer, 1960. Patients speak poignantly of the way in which growth involves separating from the experience of “appealing to” or “connecting with” a parental figure, a fantasy most clearly expressed in the transference. As one patient said, in describing her struggle to stay with new ways of relating to herself and others, “It just doesn't sit easily. It doesn't do something for me. Maybe because there's nothing, no one to appeal to.” Inevitably, the process will be painful. For some people, it will be psychologically unacceptable.

This understanding puts the analyst in a better position to respect the enormous personal courage patients must find to challenge, struggle against, and renounce resistive tendencies. It is important for the analyst to be reminded of this frequently, for awareness of resistance in the clinical encounter is often something that frustrates the analyst's intentions or wishes. Resistance quite literally “puts one off,” creating emotional distance and intellectual confusion. It disrupts the satisfying rhythms of analytic engagement that provide assurance that things are going well. The friction of resistant attitudes, behaviors, and constructions strains the analyst's resources of patience and hopefulness. Yet the analyst's availability as a sustaining source of emotional connectedness, containment, and support to patients during their efforts to change is often crucial. This availability, ultimately an expression of the analyst's own capacity for love and commitment over time, is communicated in countless ways: It is palpable in the analyst's attention to developing a partnership with the patient, a joint process that is continually informed by the goal of fostering the patient's autonomy (Busch, 1995; Gray, 1982; Greenson, 1967; Greenberg, 1991; Renik, 1995). It is evident in the analyst's persistent effort to stay in touch with the intersubjective underpinnings of analytic process (Odgen, 1986, 1989) so that when the analyst approaches the patient's conflicts, the patient can stand with the analyst and accept a truly self-reflective perspective. It is represented in the recognition the analyst extends to emergent maturational initiatives, the acknowledgment of genuine advances, and in the ability to mediate a more integrated and articulate vision of the patient's core process Loewald, 1960. As Schafer (1960) has made clear, “normal courage, endurance, and ability to withstand intense

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stimulation or deprivation, all depend on the feeling of being recognized and attended to by the superego” (p. 175). That the analyst

serves in the psychoanalytic situation as auxiliary—and hopefully more benign—superego Strachey, 1934 underscores his or her importance in the analysis of resistance. Resistance is most likely to become a truly pernicious obstacle to progress when the analyst does not fully accept the necessity of analyzing and empathizing with the patient's unconscious sense of danger. Wishing to make the resistant attitudes and behavior stop or disappear so that something the analyst considers more productive can take place is human and understandable, but it is not a helpful analytic attitude (Brenner, 1976; Friedman, 1997; Schafer, 1983). Inevitably, it intensifies the very behavior or motivation one wishes to resolve.

An impetus to slow down or flee the momentum of psychoanalytic processes points emphatically to the enduring dynamic relevance of a more fundamental psychic framework that preserves a person's earliest relational configurations while containing the conflicts and unconscious fantasies that mediate an archaic apprehension of the experiential world.[3] The establishment of such a stable psychic framework serves powerful adaptive functions that are essential to psychic survival. Early structuralization eliminates the need to sort through infinite decision-making possibilities by pre-ordering a complex array of mental imagery Damasio, 1994. This aids immeasurably in the difficult task of negotiating the risks and opportunities of an uncertain world, enabling the person to increase his or her predictive abilities in space and time. No parent, however nurturing and competent, can adequately prepare a child for the emotionally intense, frequently overwhelming dilemmas of childhood. Here the child is inevitably alone in a landscape ambiguously defined by internal and external desire, intention, and fantasy. It is important to remember, however, that the resulting resolutions, however limiting in the life of the adult, are true testament to Eros; they express an enduring determination to nurture the self. Though constructed around compromise formations arrived at by a cognitively immature and psychically vulnerable child, the effort to preserve this framework is a force with which every true analysis must contend. Modification of fundamental structure is the highest aspiration of the psychoanalytic enterprise.

Freud's (1905/1953b) initial formulation of the self-preservative drive, Kohut's (1971, 1977, 1984) focus on the development of the self (including his principle of the primacy of preserving the self), and

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[3] *Resistance can be observed clearly when a person endeavors to engage in self-analysis outside the orbit of the psychoanalytic situation. Because Freud encountered violent resistance in his self-analytic efforts, he was understandably reluctant to see resistance exclusively as a creation of the analytic situation.*

Winnicott's (1960) description of the protective function of the false self, each represents an important contribution to the analyst's understanding of the ways in which the individual actively strives to preserve the cohesive dynamic and representational structures that anchor a sense of secure identity. An appreciation of this profound psychic investment must always inform the analytic effort to articulate, explore, and analyze resistances. When encountering frustrating and recalcitrant defensive efforts to protect the self from pain, one is mindful that these "solutions" embody a dedication to caring for oneself, a self-concern that must be validated, nurtured, and won over as an ally of any thorough-going therapeutic process. Nowhere is it more consequential to align oneself with a patient's potential for growth and integration than when dealing with resistance and the emotions that generate it. Working to strengthen these areas of vulnerability, what might be described as the growth plates of therapeutic engagement, inevitably intensifies resistance. Patients re-institute automatic modes of dealing with anticipated injury (Arlow & Brenner, 1990; Busch, 1995; Gray, 1994) as the analytic process threatens adaptations structured during childhood. Emphasizing the adaptive functions of resistant behaviors and attitudes is crucial. It mitigates the person's dread of being helplessly exposed to overwhelming danger. Without a strategy for mastering the depression, guilt, shame and anxiety that accompany a serious challenge to old ways, few persons would find the courage to change. As patients come to appreciate how and why particular self-protective ways of perceiving and organizing the world developed, their insight serves to guide them through turbulent currents of emotional distress that surge upon each new tide of change. By being aligned with the patient's yearning to escape confinement, the analyst supports maturational risks that, in turn, place them once again in harm's way. Added to the terror of functioning in an uncertain world without familiar defensive structures is a confounding sense of loss as one surrenders key elements of early organization, elements that may feel like the foundation of personal identity.

The analyst begins to better appreciate the tenacity of resistance; at bottom it speaks of the desperate effort to hold onto a fundamental orientation that makes sense of and stabilizes one's experience of the world. This orientation feels both desperately needed and painful to discard. When the patient

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identifies and begins to reorganize these earlier configurations of meaning, desire, and avoidance, the relationship with the analyst in both its adaptive and archaic dimensions becomes pivotal to the process of working through. Analysis of resistance immerses the analyst in

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powerful issues of attachment and separation, loss and integration, and safety and avoidance. The need for the analyst as a supportive ally during this process is palpable, even though patients may struggle to ward the analyst off as an unwelcome disturber of their peace.

Case Illustration

Harriet came to her session wrestling with what she called "crazy thoughts." Her adult daughter had called to inform her that she was meeting her cousin for lunch later that day. Though Harriet could identify no rational grounds for her apprehension, she could not rid herself of the disturbing idea that the true purpose of this get together was only to give the two of them an opportunity to unite in criticism of herself. With considerable reluctance and shame, she haltingly acknowledged the details of the scene she envisioned, a scenario essentially constructed around a derisive, conspiratorial accounting of her inadequacies as mother, aunt, and human being. Although Harriet "knew" that all this was "paranoid and neurotic", vivid images of an imagined alliance plagued her relentlessly, accompanied by familiar feelings of being, once again, ostracized and alone.

Harriet went on to express surprise that she was "torturing herself" this way, because until she had spoken with her daughter she had been having a particularly fine morning. She had accomplished a lot of what she had set out to do, and was feeling a sense of contentment about her productivity that she hadn't experienced for some time.

Following the "logic" of these associations, her analyst asked if there might be a connection between her experience of contentment and the "crazy" fantasies she had described:

Harriet: "I think there may be. I've come to see how compelling the fantasy of being the outsider is for me… I mean, I know that Jennie and Sally aren't getting together to make fun of me… I see how I undermine my sense of well being so much of the time. It's almost as if

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the fantasy serves to justify an impulse to take something away from myself."

Therapist: "To take something away from yourself? What occurs to you about that?"

Harriet: (reflective pause) "Actually, I'm thinking about my favorite doll, in childhood, Eloise. When my mother was in the hospital having Carole, I was farmed out to my Aunt Flora. My cousin Nina—Sally's mother—was a year younger than I and during the time we were together, and my memory tells me that it was a very long time, she grew attached to my Eloise. For some reason, when my father came to bring me home to meet my baby sister, I gave Eloise to Nina as a present. I don't know what possessed me! Everyone thought it was so sweet of me, but as soon as I left, I began to feel horrible regret. I knew that I had done something terrible and irrevocable. I remember that for a long time

afterwards ... every night... I would cry myself to sleep thinking miserably how much I missed Eloise."

Therapist: "You gave your baby away just when your mother was bringing her new baby home. Perhaps this was not coincidence. We've come to appreciate just how traumatic your sister's birth was for you ... How profoundly abandoned you must have felt."

Harriet: "What are you getting at? That I abandoned Eloise? But I suffered terribly..."

Therapist: "As you do in your fantasy about Jennie and Sally. But at least you are in control, not waiting helplessly for the worst to happen again."

Harriet: "It's hard to believe I could do something like that to myself ... I'm remembering something else about that week. Nina and I had an elaborate fantasy game that we played out around Eloise. Eloise was a sick child... a baby ... and we ... I mean, I had to take her to the hospital and Nina was the nurse who took care of her. I think that must have been how she got so attached to her. Taking care of her in our imaginary hospital."

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Therapist: "You mean Nina got attached to Eloise as your mother got attached to your sister—in the hospital."

Harriet: "And I gave them both up."

In Harriet's treatment, abundant analytic evidence supported the idea that she had experienced the birth of her first sibling as a catastrophic abandonment. Abandonment, in one form or another, had emerged as a central theme of her adult living and was a ubiquitous stimulus to transference reactivity in the analysis. However, as the above piece of analysis suggests, already in place at a very early age was a tendency to turn passive into active by making happen what she feared most. This was apparent in the remembered struggle to master a sense of impending loss, and to redirect destructive wishes away from her anticipated new rival. She exercised control through fantasy (the play with Nina) and enactment (giving her doll/baby away) over the tensions (the fear, guilt, and depressive anxiety) of passive waiting. Through this proactive step, she succeeded in mitigating the traumatic helplessness of unexpected loss, experienced at the birth of her first sibling. She became the agent of loss and anguish (vis-à-vis Eloise) in her own life. As this memory also suggests, derivatives of oedipal and sibling rivalry were already implicated in this complex "solution" to a profound childhood dilemma.

As an adult, undermining herself by taking away any contentment that she might enjoy at her own capacity to *produce*, both as a parent and as

an artist (i.e., the children of her creativity), was a ubiquitous strategy for gaining control of potential threat. Analytically observed, this undermining action could be seen as a repetitive effort to re-establish psychic equilibrium in the face of threatened abandonment or loss. Feeling left out or not good enough was a price she willingly paid to manage a dread so overwhelming that she could articulate only the edges of it. Predictably, throughout a period of years, Harriet had desperately resisted the terror of surrendering herself to the uncertainties of spontaneous expression in the presence of her analyst, unless she was articulating a punishing state of loss or worthlessness. This circumscribed range of transference affect, which was initially represented as a reworking of early traumatic experiences of dissappointment with her mother, was eventually revealed as an unconsciously initiated resistant strategy. Its purpose was to forestall a risky transferential encounter that might put her analyst's capacity for devotion and reliability to a more searching test. Treating her analyst like her once beloved Eloise, Harriet repeatedly "gave her away" to

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avoid discovering that she was not the real thing, but only an inadequate surrogate.

Understanding resistance as a fundamental aspect of how the mind works has value for both analyst and analysand. It provides a context within which the inevitable vacillations that characterize analytic work become comprehensible. This can be immeasurably helpful in assessing the feelings, thoughts, and actions that emerge in the course of treatment. In Harriet's case, for example, a growing understanding of the complex reasons for her dread of uncertainty enabled her to gradually stay with this feeling long enought to allow a deeper exploration of its triggers in the psychoanalytic situation. This understanding also provided her with a tool with which she began to assess the endless repetitions of self-initiated loss in her daily life, gradually empowering her to establish, bit by bit, a new relationship to her fears. Working primarily in the transference, her analyst's attention to the flow of her associations stimulated a developing capacity to observe her own mind at work. This sustained collaboration enabled analyst and patient to identify multiple meanings of her transference dynamics. These included, but were not limited to the following: positioning herself as a child needing adult help and validation; containing, denying, and expressing rage at usurping rivals; punishing herself for the greedy and rivalrous wishes that she believed had caused her early abandonments; and enacting a relationship with the analyst in which she would be passively penetrated and impregnated by a powerful analyst-father. As she understood more fully this unconscious transferential context within which her dread of uncertainty had taken root, she began to strive to

establish new foundational principles of psychic equilibrium based on adult productivity and well-being rather than on the avoidance or acting out of sibling and oedipal rivalries. Though Harriet still confronted wishes that were frightening in their intensity, her experience of these urges underwent change. She began to be able to differentiate aspects of experience originally fused in an overwhelming explosion of terror. Yet even after she had come to recognize and integrate many of the essential elements of this dynamic configuration, the resistive pull of her childhood solution—here expressed once again as the impulse to give away her (now adult) baby and to restore a fantasy of abandonment—was easily evoked.

Resistance, as a manifestation of the patient's need to control the pace and extent of progress, is a dimension of the analytic situation that can never be fully resolved. Analysts no longer expect, as the psychoanalytic pioneers

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apparently did, that resistant behaviors and attitudes will disappear when they are observed and described. Analysts ask no more of the patient's willpower than a temporary brake on impulsive or compulsive dispositions. Analysts hope to render them less consuming so that exploration of the traumatic fantasies, overstimulating wishes, and unbearable conflicts that make these adaptive strategies seem imperative, can proceed. Analysis of the resistance provides the analyst with a map of the boundaries of the archaic psychic organization, identifying the territories that need to be explored.

The Clinical Encounter With Resistance

A problem with some early clinical theorizing was that intrapsychic and interactional dimensions of resistance had been dichotomized. Analysts were asked to ally themselves with either one understanding or the other. Yet to focus solely on the intrapsychic dimension of psychic organizing neglects the human hallmark of experiential adaptation, a special flexibility that allows people to assimilate and accommodate novel experience. Counterbalancing the rigidities of a relatively fixed psychic framework in human functioning, one also must recognize a genetically programmed *adaptive flexibility* that enables human beings to continually construct ongoing experience (Damasio, 1994; Langs, 1996; Kriegman & Slavin, 1989; Odgen, 1986, 1989). Adult living continues to influence those elements of prestructured psychic activity as long as a vital connection with the experiential dimension of adaptive functioning is maintained. Clinically, this directs analysts to stress the importance of the personal meanings, feelings, and thinking that mediate the actions and interactions

that comprise a therapeutic process. It is here that the descriptive understanding of resistance takes center stage as analyst and analysand work together to explicate the entrenched obstacles to increased awareness that arise in any working relationship. Both the fundamental psychic organization, the framework, and the capacity to fully engage the physical and social environment, the flexibility, influence the constructions of all experience. The checks and balances delineated by these two contributors has significant implications for the analysis of resistance. Specifically, the tenacity with which people cling to early psychic organization directs the analyst to consider that working with resistance may require both analysis (Busch, 1995; Freud, 1914/1958; Gray, 1994) and active efforts to overcome it (Freud, 1916-1917/1963).

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Though the foundation of persistent resistive structures will always be firmly anchored in the emotional, conceptual, behavioral, and even physiological bedrock of very early childhood experience, the analyst's immediate awareness of the ongoing dynamic interplay of intrapsychic and extrapsychic expressions of resistance informs technique in the clinical encounter. In this arena, depth of interpretive focus is not easily equated with impact; one needs to address salient points of disjunction if forward momentum is to be maintained. Boesky (1990) contended that disjunctions are integral and informative aspects of any analytic encounter. Starting with the observation that patient and analyst inevitably fail in their respective goals of free associating and maintaining analytic neutrality, he maintained that the relationship between these failures is a potent source of information. The mutual construction of resistance becomes an essential focus for analytic interaction.

Every resistance, no matter how trifling, is a resistance to something, and its exploration—in the moment—provides the analyst with a bridge to dissociated experience. Inevitably, an expression of the patient's most problematic love relations shades and shapes these resistant surfaces. Engaging a patient's interest in exploring precise moments of interaction is a critical aspect of working with resistance that has been incisively elaborated by Boesky (1990), Busch (1993, 1994, 1995, 1997), Gray (1982, 1986, 1994), Schwaber (1983, 1986, 1994) and others. Central to this endeavor is the importance of addressing experience that is consciously available to both parties, what Renik (1995) has described as “facts of observation that are available [to] and have been agreed upon by both analyst and analysand” (p. 88). Technically, this may involve helping the patient oscillate between spontaneously verbalized thoughts and feelings regarding the analyst and taking this subjective mental content as a

point of departure for further analytic inquiry. Early in treatment, patients often have difficulty sustaining this open-ended, associative momentum. Typically they regard their thoughts and feelings exclusively as reflections of external reality, demonstrating an intolerance of inferential ambiguity largely shaped by the categorical pressures of archaic conscience and calamity. As analysis deepens, thinking about thinking, being able to observe the process of creating meaning itself (Busch, 1995, 1997; Gray, 1973, 1994) enables the patient to construct “definitive realities” from the potential realm of plausible possibilities. In this sense, transference, defense, and resistance analysis are synergistic dimensions in the process of expanding the subjective perspectives that can be tolerated within the analytic encounter. As patients come to understand that they are acting, fantasizing or thinking in order to protect themselves, the

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analyst can, with appropriate tact and timing, use these targeted resistances to uncover buried or disowned wishes and fears, as well as to define the ideas, emotions, and unconscious fantasies that give rise to signals of danger. Giving specific form to these dissociated elements plays a crucial role in developing the therapeutic relationship.

It is important to emphasize that it isn't a behavior or attitude in itself, but only its functional or motivational role in thwarting analytic goals that identifies something as resistance (see Brenner, 1982, for a functional understanding of defense). Potentially fruitful analytic efforts turn barren when dimensions of resistance are neglected. Virtually any aspect of the analytic situation, even essential analytic processes intimately associated with progressive momentum can become infused with resistant purpose. When patients relentlessly elaborate insights or fearlessly undertake daring maturational initiatives, the analyst may legitimately begin to wonder whether avoidant intention is in ascendence: *"Until I fully and finally understand this, I never have to give this up or change my behavior"* or *"If I change my behavior, control this feeling, or adjust my attitude, I'll never have to come to terms with what it means to me"* form the core of familiar strategies to curtail the most profound reach of psychoanalytic therapy.

In the psychoanalytic situation, resistance is what patients do to curtail the momentum of analytic change. The analyst's attention is alternately drawn toward disruptions of intrapsychic equilibrium and to disguised meanings in the patient's relatedness to the analyst, those intraand extrapsychic poles that define the elusive field of resistant activity. In the course of a treatment, the phenomena embraced may be more or less circumscribed, strategically significant, and/or recalcitrant. Entire areas of psychoanalytic exploration may be blocked, as is the case when a patient

avoids all fantasy expression, hides erotic impulse, or chronically forgets dreams and affectively loaded memories in the analyst's presence. Yet, it is a commonplace of clinical wisdom that patients who fill multiple sessions with obscure and thematically disorganized dreams overwhelm the analysis with an embarrassment of riches that are intended, in actuality, to impoverish the process. Although flooding the analysis with undigestible fantasy is not an impediment of the same magnitude as the inability to recall any fantasy derivatives or affectively loaded memories in the analyst's presence, its resistive meanings must be addressed on multiple levels and various locales.[4]

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Psychodynamically successful solutions that satisfy archaic needs and fears are, as we have seen, among the most significant sources of resistance—cherished like the tattered “blankee” of childhood. Yet like the child's need for his transitional object, the manifestations of resistance point the analyst directly to the underlying object of desire. Resistance occurs at the cutting edge of the patient's development; it points the analyst unfailingly to the place where crucial analytic work awaits his or her attention, to the specific attitude and/or behavior that is blocking a more profound evocation, exploration, or integration of psychic life. Exploring these junctures offers patient and analyst a first hand opportunity to approach dissociated experience. Understanding the essence of these split-off, unconscious desires and fears is a crucial aspect of deepening the therapeutic process, for an expression of the patient's archaic love relations lies hidden beneath its surface.

Jonathan, an attractive, articulate 42-year-old man came into treatment because his marriage of 12 years was in trouble. He wondered whether he should continue to work on it or “call it a day.” As his relationship with his wife was explored, it became evident that behind Jonathan's marital difficulties was an even more disturbing set of internal experiences: Jonathan lived with almost constant suicidal thoughts and feelings. For as long as he could remember, these thoughts were present soon after he woke up and stayed with him unless he intentionally distracted himself. This preoccupation was an ever powerful undercurrent of daily experience, always threatening to drag him down. As this dramatic internal reality was brought into focus and clarified, he could easily

[4] The copious and unproductive dreamer, may, upon further analysis, be seen to be expressing wish(es) with regard to the analyst; to go on sleeping in his protective presence, to be his incontinent infant, to confront him with menstrual outpourings of her pubescent body. She may, as well, be enacting a scenario of defiance and rebellion: “You asked for my uncensored, uncontrolled self, here, take it, make something of it!” She may, on the other hand, be warding off the anxiety aroused by the phallic thrust of the analyst's incisive understanding, flooding him with images, words, and meanings so that he will remain passive and silent.

recognize that years of heroin addiction (he described himself as “an addict in recovery”) and endless struggles with sexual compulsions

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had essentially been his attempt to deal with the perpetual torment of these suicidal thoughts and feelings.

Analysis gradually revealed that Jonathan's suicidal preoccupation embodied a powerful compromise formation, a mode of relating to himself that satisfied many internal and external demands. These included, most prominently, a need to punish himself for childhood transgressions as well as a desire to ward off involvements with potentially rejecting others. But suicidal feelings also embodied the disguised object of Jonathan's dissociated desire, for it maintained a conflictual relationship to a disapproving maternal imago who relentlessly offered the same damning judgement of his worth—Jonathan's "life was not worth living."

Although he had struggled valiantly to manage these impulses, there was an intractable quality to this tormenting obsession; it had become pivotal to an intrapsychic balance that contained his despair, rage, and thwarted longing toward the primary objects of his love. In this sense, the tormenting idea of suicide had become a trusted companion as well as an object of allure, and he strenuously resisted giving it up. It had accompanied him for years, despite attempts to banish, suppress, or narcotize its painful aspects. This struggle now came to the fore in his transferential constructions within the analysis. Jonathan ingeniously developed endless scenarios in which his analyst would have to say no to him, in fact as well as in fantasy.[5]

A crucial insight was emerging: Jonathan was very comfortable with rejection, whether it was rejection of his own desire or rejection at the hands of someone else. He rejected both his desire to be loved as well as any gratification in being loved. Jonathan's violent impulse to cut off any desire to love or be loved was concretized in the fantasy of cutting off his life, even as this desire preserved a punitive attachment to a cruelly ungiving maternal imago—the grave beckoned to him with its cold eternal embrace. Working with Jonathan's resistance to moving away from suicidal thoughts and feelings pointed directly to this archaic desire. A more deeply buried longing to elicit a loving response only became evident through the analysis of unconscious transference fantasies carefully disguised in his self-destructive and provocative acting out. Not surprisingly, as the resistant elements of his obsession with self rejection were worked through, profound feelings of sadness, loneliness, and longing began to emerge and take center stage in his conscious experience.

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As this case material illustrates, analyzing resistance steers the analyst to the wishful longings and fears that are most problematic for the patient. Working through these obstacles unveils an elaborate unconscious organization of fantasy and motive Arlow, 1985 that introduces a conflicted and consequently tendentious bias to the construction of current

[5] *By confusing the time of his appointment, he would arrive an hour or a day ahead of schedule so that she would have to turn him away.*

experience. The analyst observes this influence most clearly in a reductive filtering of potential meaning in the analytic interaction through which the therapeutic scope of the analyst's intentions, words, and deeds are severely circumscribed. Jonathan seemed insistent on finding in his analyst a cold, ungiving, rejecting maternal presence: his actions and his attitudes, as well as his constructions of her expressive action, all conspired toward the same end. Only as Jonathan's resistance to seeking new forms of relatedness with his analyst was confronted and worked through did these archaic dimensions of experience lose their pre-emptive authority (Busch, 1995; Gray, 1994; Loewald, 1960).

To make it possible for a patient to begin to encounter life in its fullness, the analyst must nurture an alliance in the present that bridges the losses that occur as patients relinquish the past. Awareness that this transition is a perilous one can help the analyst to approach the analysis of resistance with both tact and tenderness. One must bear in mind, of course, that the nature of this bridge is not exempt from analytic investigation. Inevitably, there are inducements to confusing the caretaking functions of the analytic process with the fantasy of being the patient's caretaker. The analyst must be wary of what Levine (1993) has formulated as conceptual drift, a tendency to imbue one's concepts, interactions, and the analytic process itself with unconscious fantasies that carry parental representations often experienced as soothing and permissive. Unanalyzed, these fantasies can distort technique by impeding efforts to recognize and understand unconscious conflict. Understanding the patient's experience requires that the analyst maintain the analytic attitude even when a more facile explanation is at hand.

Surrendering the safety of childhood solutions is never easy, even when the analyst meets these emotional and technical challenges. The patient faces an ever-present temptation to strive for the excitement and/or constriction that psychoanalytic exploration has revealed to be one more variant of the familiar

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excitement or constriction of the past. Often enough, excitements of this sort are mistaken for the genuine passion of life, and the constrictions are viewed as its necessary conditions of safety. As in a fairy tale, the allure of living out ancient fantasies of blissful engagement calls with siren serenade, promising the fulfillment of the heart's desire. But surrendering to these illusions condemns one to imprisonment in the past, imposing upon a more innocent and welcoming reality a sentence of blind repetition. Thus drugs, perverse erotic scenarios, and the endless pursuit of exquisitely desirable, but unavailable women lured Jonathan endlessly on, only to leave him empty and forlorn as these excitements repeatedly

betrayed their exotic promise. Working through resistance, however, opened the gate to complex and sustainable passions. It facilitated an opportunity to find and preserve the love of a real person in the real world. It unveiled the illusory ties that bound him to an archaic past with its fantastical pleasures and dangers. Through work with the resistance, especially its manifestations in the transference, patients can come to learn, in Winnicott's (1974) words, that the trauma they anticipate is, in part, a trauma that has already happened.

The Interactive Rhythms of Resistance

Interactive elements of the analytic relationship have become a primary focus of contemporary advances in resistance analysis. Until recently, the analyst's contributions to the creation of therapeutic impasses have been conceptualized mainly within a framework of countertransference. It was seen as an expression of unconscious conflictual responses to the patient or to the patient's material, a problem of the analyst's transferences or defensive organization. This recognition had been the inspiration for Freud's prescription that every psychoanalyst should have an analysis before doing analysis to eliminate “blind spots” that might lead to collusive avoidance and to master irrational intensities that might be expressed through surreptitious reenactments. The contemporary approach acknowledges that entrenched resistances may also form around the *appropriate and nonconflictual* exercise of the analyst's particular mode of analyzing. The way the analyst embodies neutrality, establishes boundaries, interprets symbolism, or is guided in his or her formulations by particular theoretical models or educational influence, are unavoidable expressions of a unique *professional subjectivity*—a subjectivity that has numerous edges to snag the momentum of an analytic process. Eliminating these blind spots is difficult, if not impossible, because they are built into the

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lens of an “analyzing instrument” that the clinician is not prepared to abandon. The analogy is apt, however. To scrutinize an object through an instrument such as a microscope reveals detailed phenomena that escape the attention of the naked eye, making things seem—in some sense—“larger than life.” The analyzing instrument through which a vision of clinical phenomena is brought into focus—by observing precisely the associative linkages in a person's narrative, clarifying the transference-countertransference interaction, discerning the symbolic allusions in denotative language, or empathizing with an unspoken affective posture—reveals unconscious concerns and motives that otherwise elude attention. It

is one way of making the unconscious conscious. Yet it also renders these phenomena disproportionate to the person who is living that life. When patients accuse analysts of “making a big deal out of nothing” they may be objecting not so much to the content of the analyst's observation as to the focal length of the lens through which it is clarified:[6]

> *Whenever her analyst made an interpretation that touched upon any aspect of Leslie's envious animosity toward a rival, she would be thrown into a state of enormous turmoil and despair. Regardless of how inconsequential the thought, feeling, or act in question appeared to be to her analyst, Leslie would protest vehemently.*
>
> *Leslie: (crying bitterly and with great vehemence) “How could you think such a thing of me? I feel completely misunderstood by you! You accuse me of being such a destructive and hateful person. I can't stand it!”*
>
> *An extended silence would ensue. Initially Leslie's analyst had read these reactions of distress followed by silence as both indicative of the magnitude of her resistance as well as confirmatory of the interpretive content. She considered it an instance of severe intrapsychic disequilibrium induced by a challenge to the defensive isolation warding off the destructiveness of her envy. Her interventions, following this understanding, emphasized the defensive projection of Leslie's accusatory conscience onto herself. However, as her patient's recalcitrance and despondency persisted with inexhaustible fury—expressed in virtually the same form and wording whenever or whereever it was triggered—she gradually came to doubt the adequacy of this understanding. It seemed that any approach to the*

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subject was completely taboo, no matter how incrementally or tactfully broached.

Her analyst's doubts did not concern the accuracy of the interpretation, as far as it went. These eruptions of despair occurred in contexts that left little question as to the nature of Leslie's underlying impulses or the caste of her feelings. Rather, she focused instead on the meaning of Leslie's disproportionate despair and resentment at having the interpretation made to her. She was particularly impressed by the vehemence of Leslie's attribution that she had completely misunderstood her. It seemed unfair on a number of grounds. She could, upon serious introspection, detect nothing accusatory in her attitude toward Leslie. What she had attempted to point out wasn't something that she personally considered hateful. Indeed, she had gone to lengths to try to convey through wording, tone, and intonation her belief that such feelings were simply a part—albeit a rather disagreeable part—of everyone's human nature.

[6] *We are not suggesting that there is one appropriate distance or perspective for observing an analytic patient. Many perspectives are useful in developing the depth of vision that analysts strive for. Rather, we are saying that the analyst will be more effective in addressing certain resistances when prepared to observe the impact of the multiple observational perspectives brought to bear, as well as shifts between convergent perspectives. In effect, part of analyzing resistance involves attending to these various facets of the analytic instrument.*

Internally occupied with reflections such as these, she chose to interrupt Leslie's aggrieved silence: "Why do you say 'completely?' That I completely misunderstand you?" she wondered out loud.

Leslie: (Appearing to be slightly mollified by her analyst's query and with a note of beseeching appeal softening the accusatory pointedness of her anger): "You only tell me when I'm bad, you never say anything positive about me. It's as if you are listening to prove that I am in the wrong and that I'm unworthy!"

Analyst: "I think I understand what you're getting at. You feel that my listening is biased towards the unsavory things you think and feel."

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Leslie: “Isn't it?”

Analyst: “I would have said that I'm simply listening carefully to what you leave out of your account, what is implicit but not stated directly.”

Leslie: “That may be how you view it, but it doesn't feel like that. Yeah, I might have been a little jealous of Nancy's engagement, maybe you're right, but I love her—she's my best friend in the world! I need to feel that you are on my side.”

The way each partner organized this analytic exchange can be charted along a mutually determined continuum. One can describe this process as moving from an unproductively integrated adaptation characterized by pathological relatedness (dominated by archaic fears and fantasies), to an accommodation of enhanced communication. Leslie was embroiled in a struggle to both ward off and re-enact an anticipated traumatic repetition while her analyst was understanding her as engaged in a specific defensive effort to deny a set of wishes, impulses and fantasies. Each found in the other's behavior sufficient evidence to support their construction of events. Their mutual understanding within this context, however frustrating and disturbing, was more incomplete than distorted. Contemporary approaches to the analysis of resistance have increasingly focused on mapping the specific, subtle, intersubjective elements of such dynamic interplay. The analyst follows elements—which might best be described as recurrent rhythmic patterns of interrelatedness—and attends to the stylistic nuances that characterize each individual's participation. By carefully coordinating these observations, tracing the elaborate interface of resistance intensifying interactions, shifts from productive to disjunctive momentum can be isolated. Though the elements of this vignette are undoubtedly interpretable within a broader framework of transference—the patient believed that her mother had favored her younger sister throughout childhood and that “the little angel” could do no wrong—resistance became most salient as Leslie distended those dimensions of the

analyst's vision that could serve to close off an encounter with this more ambiguous reality. It could be said that Leslie's despair was not so much triggered by a confrontation with her own destructive envy, as by the belief that once again she would have no hope of fulfilling a long deferred wish to be seen as “the most worthy one.” Resistance permeates this belief. To allow herself to openly acknowledge her wish for something different in the present involves moving away from the defenses and ideas that protected her from anguish in

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the past. Leslie anticipates that she will be seen as bad, organizing her interaction with her analyst along familiar lines, rather than confronting the uncertainty of wanting something she fears she cannot have.

Resistance at this descriptive level is a manifestation of the patient's adaptation to the psychoanalytic relationship; in this instance, to the analyst's function of exploring manifestations of the patient's unconscious. Although subject to a number of relevant interpretive contexts, this patient's despair could be most productively worked with when recognized as a reaction to structured aspects of the analytic situation embodied in the person of the analyst, that is, the analyst as interpreter of the patient's disowned desires. This dimension of the analyst's role could plausibly be construed in terms of specific interpersonal configurations of childhood Gill, 1994: “My analyst will never love me. She will always magnify my faults and find my rivals blameless!” These aspects may be inaccessible within the analyst's immediate field of attention, not because they are subject to defensive distortion, as in countertransference, but because they are the structuring elements that determine the analyst's field of vision. If analysts view their patients' experience through a particular lens, they must catch their reflected image in the mirroring eye in order to properly observe the impact of their analyzing instrument.

From a contemporary perspective, it isn't only professional subjectivity that may snag the momentum of analytic progress. There are incalculable ways in which the analyst's personal subjectivity contributes to the development of resistance as well. The analyst inescapably views the analysand through tinted lenses that are colored by certain preferences influenced by deeply rooted conflicts, childhood solutions, and fantasies. This perspective is communicated in every decision the analyst makes, from how to intervene and when to be silent, as well as in the tone, tension, and timbre of every utterance. Inevitably, the interaction between the participants plays a significant role in the choice of what will become the focus of the analytic process and what will be resisted. As Kupferstein (1997) has phrased it, “resistance is an avoidance or interference in the

here and now by the there and then” (p. 6), expressed concretely in the analytic interaction. This view, incorporating the necessity to understand both past and present, has led some contemporary thinkers to propose that it is resistance, not transference that is co-constructed.

According to this perspective, the analyst inadvertently but decisively contributes to the formation of resistance through an emotional interaction

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with the patient Boesky, 1990. Engagement at this level is essential if analysis is to reach the deepest levels of experience and avoid becoming an intellectual exercise. However, although the depth of this emotional involvement is mandated, it comes at a price. Not infrequently, it triggers a potential in the analyst corresponding to that of the patient: to act out rather than to analyze the resistant activity they have jointly created. As with many of the processes the analyst uses in analysis, this potential can either bolster resistance or be turned into a powerful therapeutic incentive for working it through (Boesky, 1982; Chused, 1991; Jacobs, 1986; McLaughlin, 1987). On occasion, the lure to resist analyzing jointly created enactments that further resistance can be compelling enough to derail an entire treatment. If, however, engagement is framed through an oscillating perspective that moves between participatory immersion and participant observation Arlow, 1963, the analyst can bring an observing ego to bear on the analytic interaction that is often inaccessible to the patient and crucial to working through resistance.

Does the idea of co-construction of the resistance imply that a patient's analysis will be different depending on the analyst? Yes and no. Certainly we recognize that because every analyst makes a unique contribution to the interaction, no two analyses can be alike. Inescapably, some issues or conflicts will be more salient dependent on the analyst's personality, and unavoidably, some will be given short shrift. Yet if the analyst maintains a focus on the patient and is able to structure a psychoanalytic situation around neutrality and free association (Adler & Bachant, 1996; Busch, 1997), the patient's core conflicts and the resistances that accompany them will inevitably emerge. Balancing an ability to exploit the interaction for those manifestations of resistance triggered by the distinctive analytic couple, while simultaneously maintaining a focus on the patient in an analytic situation gives access to the broadest array of analytic possibilities.

The Limits of Resistance Analysis

Operating on all levels of development and serving multiple functions, resistance is never completely resolved in analyst or analysand. In this

sense, resistance analysis is truly “interminable” (Freud, 1937/1964). The wishing, fantasizing, and compromising that are manifest in resistant activity serve vital and varied functions that will be obscured by a conceptualization of the process that emphasizes only its detrimental effects. Finding the aspect of

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resistance that faciliates development and understanding is an indispensable aspect of deepening analytic experience. Resistance asserts a fundamental framework that organizes experience. How then, does one know what the limits are of resistance analysis? How does one know where to stop?

Recent clarification of the centrality of the early mother—child interaction in organizing psychological functioning places life-long, fundamental struggles around attachment and separation, dependence and independence, and the losses associated with the calamities of childhood at the heart of analyzing resistance. A regressive pull to the “golden fantasy” Smith, 1977 of early bliss seduces analyst and analysand alike, with its illusions of protection actualized through omnipotent ideas of perfection. Archaic modes of functioning will continue to trigger impulses to organize experience in habitual ways even after they have been essentially analyzed. In these instances, one can rely on changes in patients' more integrated understanding of these experiences to alter their meaning. In this way their relationship to the original “solution” is fundamentally transformed.

Although the ideal of neutrality directs the analyst not to impose a particular way of being upon a patient, it does not follow that the analyst has no ideas or even “wishes” about the sort of changes a patient should make, particularly with regard to their resistant attitudes and behavior in the analytic situation. The analyst's wishes for patients are inevitably colored by the analyst's own history and transferences, but within broad and flexible guidelines psychoanalysts are committed to certain normative values of psychological health that that cannot be disowned. Analysts seek to help patients identify and resolve pathological resistances: Those that cause pain (Brenner, 1982; Freud, 1893-1895/1955b) stand in the way of higher integrations (Bachant & Adler, 1997; Freedman, 1985; Loewald, 1960) and, necessarily, those that undermine the analytic process itself. By clarifying the resistances to change, analysts help patients understand more fully and direct more successfully the forces continually converging in their construction of experience. An ability to acknowledge one's own limitations is essential here, because even the most intense or empathic treatment cannot ever fully comprehend the complexities of another's unique experience. Ultimately, the choice of what to accept and what to struggle against must reside with the patient.

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