Edrita Fried

On "Working Through" as a Form of Self-Innovation

Curative Factors in Dynamic Psychotherapy

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Contributors

Edrita Fried, Ph.D., Training Analyst and Senior Supervisor, Training Department, Postgraduate Center for Mental Health, New York, New York; formerly Associate Professor of Psychiatry, Albert Einstein College of Medicine.

On "Working Through" as a Form of Self-Innovation

Edrita Fried

It is a remarkable fact that ever since Freud introduced the term "working through," it has remained a vaguely and variously defined therapeutic activity. If one were to ask therapists what they mean by working through, one would receive many different versions of the concept and the therapeutic processes involved. Working through is central to the achievement of change. But, whereas other aspects of psychodynamic treatment have been defined with precision (e.g., "insight," "the transference neurosis," "transference," "countertransference"), the essence of working through has remained relatively obscure. The kind of therapeutic efforts that working through calls for are described in hazy and unintegrated terms (Blanck and Blanck, 1979).

To this author, working through has as its primary objective the *accomplishment of change*, not only in cognitive but also in structural, emotional, and behavioral terms. Working through is largely the achievement of *self-innovation* (Fried, 1980). New structures are gradually built that allow for the flow of fresh and varied emotions and thoughts. This means that new bridges (Spitz, 1965) are established between mind and body; that the self

becomes more authentic; that self-esteem derives from the inner condition of the self and depends less and less on external praise; that the range of ego functions is extended; that the superego is modified and the id-ego-superego balance is changed.

Working through calls for a broad assemblage of processes related to insight, some preceding and promoting insight, and others following in its wake. Insights are essential to working through, though they are looked on and treated primarily as forerunners of subsequent psychological experimentation and the active search for new directions. What counts, after experiential insight, is: learning a new outlook on the self and the world; modulating the superego; trying out new structural balances; acquiring the capacity for object love; and the like.

The objectives and processes of working through are always undertaken jointly, by the therapist and patient together. As a rule, the therapist moves first, showing the patient how experiential insight alone is not enough. The emphasis in the working-through phase is on new modes of feeling and thinking, especially within the transference situation. The need for innovations following interpretations is highlighted. Patients learn not just to tuck away insights but to find and try out new ways of living. Eventually, the patient assumes the lead in the search for self-innovation and no longer settles for insights alone. I often prefer to call experiential insights "active

insights," because they create an urge to try out new forms of psychological activeness, which is not identical with action, but constitutes an emotional-cognitive state. Working through, as I conceive of it, provides the fuel for change and leads to an emphasis on doing something about one's pathological inclinations and structures. I believe that working through is the most time-consuming aspect of dynamic psychotherapy, and indispensable to the achievement of change.

The vagueness about what constitutes working through seems to me due to the continuing belief that one central reparatory approach—rather than an assembly of approaches—can accomplish the therapeutic objective. The task of working through is often seen as limited to the removal of resistance to insight: rendering the resistances conscious, circumventing them, or puncturing them. This definition is too narrow if we accept the proposition that working through has as its main objective the building of new psychic structures and comprehensive personality changes. At the least, we have to aim not only at the removal of resistance to *insight* but at the removal of resistance to change. Anyone who collects insights step by step but does not do anything with them—that is, does *not* use them by casting around for and adopting behavioral change—is not engaged in the serious labor of working through.

In order to effect structural and subsequent behavioral changes, does

the patient need new parameters, which have to be added to the established techniques of dynamic psychotherapy? As Eissler (1955) saw it—and he concerned himself in detail with the problem of parameters, particularly in the treatment of borderline cases—parameters are special, temporary alterations of the psychoanalytic process, and their use is not always totally legitimate. My own position is that the use of parameters to accomplish the objectives of working through is legitimate. To be sure, this approach calls for some restraint, since we cannot simply assume that any deviation from established therapeutic process is commendable because it has worked in certain other cases. But such caution should not lead to rigidity.

To help us discern the essence of working through, and to decide whether we need new parameters to pursue its primary objective, namely, structural and behavioral change, let us describe in greater detail the different purposes of working through.

The Objectives of Working Through

(1) Working through, as already stated, consists of a wide variety of processes. Some of them cannot be described directly. It is possible to gain access to their nature, however, by focusing on their *function*.

(2) To work through has come to mean that the therapist makes

interpretations, now from one angle, now from another. For instance, at one point the therapist highlights the secondary gains accruing from the existence of the pathology; at another time, the anxiety resulting from existing conflicts and ego deficits; or the therapist may focus on the still obscure past that is responsible for the patient's disturbances. In this sense, working through calls not for a purely sequential approach but for a multipolar one.

(3) To work through means to further both *reflective* and *experiential* insight (Kris, 1956b).

When you have an "experiential" insight, you do not just say to yourself, "this is interesting," but often—perhaps invariably—you wish to express new feelings in some concrete way. These changes need not be spectacular: some patients walk more determinedly or hold themselves more erect; others sit down right after the session and write that important letter they have put off for so long, or have that first frank talk with the spouse.

A different way of putting it is to speak of "spectator" (reflective) and "active" (experiential) insight. By itself, spectator insight adds as little to a person's emotional well-being as spectator sports add to a person's physical musculature. Active insight, just like active sport, brings concrete improvement. Via active insight, patients go about the chores and

gratifications of life in a different way. They now have some *novelties* at their disposal—not only cognitive but also emotional and concrete, practical novelties. Since the production of psychological novelties has much to do with creativity, dynamic psychotherapy emphasizes creativity as an essential contribution to, or indeed precondition for, emotional well-being (Kubie, 1958). We unlock the patient's creativity as we work through.

Artists have no monopoly on creativity. People who consider themselves "ordinary" employ creativity when they are at their happiest. The other day a businessman told me that he had hit on a plan for solving a promotion problem by joining together three previously unrelated groups of employees. When I remarked that this plan was creative, he replied in his self-depreciating way, "I think of myself as quite ordinary." Although he was proud of his plan, he did not realize that he had taken a leap, that he had moved beyond his customary tight, static, hostile passivity. He had accomplished a piece of characterological working through, at least for the time being. Working through proceeds bit by bit, leading up to some seemingly sudden innovations.

The "experiential" or "active" insights that lead to solid self-innovation and an active state of mind are rarely the result of logical reasoning. Genuinely creative and integrative insights are likely to surface in loose states of consciousness, related to but not identical with Freud's state of free

association. They are not "willed" but "found." It is therefore not the neat pigeonholing of facts that produces the genuine understanding which, in turn, leads to an activist, creative state of mind. Instead, receptiveness and the temporary relinquishment of established order are the prime prerequisites. To assemble the preliminaries for certain forms of working through, the patient needs to realize that the issue of being "right" or "wrong" is beside the point. What matters is that he become increasingly open in the psychotherapeutic interchange; that he stop trying to please the therapist; that he allow repressions and self-imposed restraints gradually to lessen; in short that he loosen the "brakes" or, to use another metaphor, that he lean less and less on, and finally throw away, encumbering neurotic crutches.

(4) Working through means correcting the ego malformations and distortions that have accumulated as result of hampered psychic development. The patient must gradually give up counterproductive efforts to control outside events and forces. An example of such efforts is found in clinging behavior. These distorted efforts may be accompanied by magic thoughts, avoidance patterns, obsessive repetitions, and eventually, domination through power and money. Such *archaic* ways aim at installing the person as dictator over the environment, but they backfire in the end. Working through means gradually replacing such cumbersome and intrusive power methods with *genuine*

strength. Genuine strength consists of a rich flow of emotions, realistic perceptions, careful anticipation and organization, and other life skills. As therapists, we work from the inside out, and from the outside in. Some ego distortions correct themselves spontaneously as conflicts are resolved. Others are gradually corrected in deliberate ways that we will explore later.

(5) Working through means that in addition to the *correction of ego malfunctions*, we aim at *ego completion*. Psychological faculties that have been missing in the existing ego structures can be built up. Genuine self-love. authentic identity formation, the energy derived from taming destructive aggression, the ability to anticipate, and the integration of opposites are some of the ego functions that can be shaped to a considerable extent through specific measures of working through.

(6) Working through invariably presupposes the staking out of a *time continuum*. Past, present, and future become connected in new and meaningful ways. Thus far, dynamic psychotherapy has too frequently neglected the future dimension. The purposes of establishing a time continuum are manifold: the patient is gradually weaned away from outdated mental and emotional processes of the past, many of which are too magical, simplistic,

> and rigid to be of service in the present and future. Establishing the time continuum helps patients give up faulty connections between causes and effects. It alerts them to the realization that many existing behavior patterns, established to cope with events of the past, are both senseless and changeable. Above all, the time continuum makes it clear that we must grope for an existence in the future.

To envisage, prepare for, and move toward the future must, I believe, be a part of all working through. We need to keep in mind that through this process the patient realizes his threefold existence in time. Until now, working through has *not conjured up references to the dimension of the future*. Rather, the term has come to suggest an excessive preoccupation with psychological leftovers from the past.

Freud discovered that the past can have a strong adverse effect on the present, especially for disturbed persons who are victims of the repetition compulsion. This discovery shifted attention to the inhibiting, unconscious connections between past and present. Therefore, the working-through phase used to deal preponderantly with the past, especially the recapture of repressed impulses. Ego psychology has, in some measure, shifted attention to present-day functioning. It is certainly true that the here-and-now transference phenomena reveal the twisted, distorted, or fractional

functioning that has to be repaired.

We know that disturbed personalities repeatedly reestablish relationships with persons whom they do not fully accept. What they search for and eventually resent are alliances through which they can borrow the powers they themselves do not possess. The only real solution, however, is to evolve their own strength. Working through in the present means to dispense with the reliance on complementary figures that permits the neurosis to continue.

Establishing the future part of the time continuum by means of working through proves to be highly productive. Few aspects of therapy are as likely to pull disturbed persons out of their old ruts as the trying out and practice of experiences that are perceived as just emerging on the horizon.

The working-through theme is likely to become a major focus of future psychoanalytic debates and conceptualizations. This prospect does not mean that dynamic psychotherapists must abandon established basic principles, but rather, that they *expand* such principles. We will continue to rely on insight into and interpretation of patients' unconscious desires in order to help them recognize the inner pulls that cause anxiety and other symptoms—this is the first step. But, *in addition*, we will explore the structural defects and developmental deficits that handicap patients in settling their conflicts even

when these have come out into the open. For working through, in the true sense, depends on insight *accompanied* by self-enrichment. The ego and self innovations that are gradually acquired enable the person to take the second step. To put it simply, the first step is to *discover what is wrong*. The second step is to acquire the psychic wherewithal—as a patient said, the new plumbing—to *set right what has been wrong*.

That second step poses its own tasks. Among other things, we discuss with the person which external (and, as the case may be, internal) circumstances are unalterable and hence call merely for a rearrangement of defenses, and which call for much more.

Altogether, we see as a primary goal of working through a gradually widening achievement of activity, spontaneity, and creativity, which means flexible and renewable forms of relating, loving, working, and living. Fundamental changes in the external conditions of life call for new forms of educating and modifying people. Dynamic psychotherapy gives consideration not only to basic currents in human nature but also to the possibilities existing in a world that is, in this period of history, constantly and visibly in a process of fundamental change.

The Role of the Transference Object in Working Through

The individual is not a closed system but a product of interchanges

between self and environment (H. E. Durkin, 1975; J. E. Durkin et al., in press) that take place from birth until the end of life. This reciprocity between self and environment is one foundation of our belief in change. Distortions, arrests in ego development, and gaps in the range of ego skills are correctable. So are limitations in the capacity for object relations. As we shall see, even the condition of the passions and of energy (the id), as well as imbalances between the id and the rest of the psyche, can be altered by weaving experiential insights and other therapeutic experiences into actual and immediate functioning. Fresh objects, new situations, and unexpected challenges—I call them the "therapeutic startlers"—set off processes of interaction and kinds of functioning that spur the psyche on to reach out for, discover, and practice new emotions and ego capacities. A significantly expanded range of object-relations skills, a fresh self-image, and other new structures surface in the patient-therapist setting. The patient enriched by the resumption of ego development in the experience of the transference delves into the world instead of pulling away from it.

When a new central object, the therapist (in group therapy, the other group members), behaves differently from what the patient expects, the rug is pulled out from under his set reaction patterns. Eventually these new realities, in conjunction with the interpretations offered, convince him that better "fits" have to be found and used. The treatment situation becomes a laboratory where psychological experimentation is necessary. Old reactions

are rendered bizarre by new stimuli, such as therapeutic interpretations combined with respect and care (Loewald, 1960). Even the basic roster of old stock emotions and ideas finally becomes unusable. This is especially true of the transference expressions, which are among the most noxious imprints of the past and must gradually be shed.

If the formulations I have just used appear simple, it is because I have merely outlined the skeleton of rather complex efforts. In order to produce the patient's first signs of improvement, overcome relapses, and increase the improvement, much encouragement and many interpretations are necessary.

When patients venture to reveal their mistrust, depreciation, and anger toward the therapist, they fear that they will be deserted. The airing of such feelings within the treatment situation accomplishes a good deal of reparation. The therapist's reaction gives the patient the opportunity to ascertain whether his basic fear that he will be abandoned if he is critical and angry is justified.

As a man told me after he had shouted at me in the therapy hour, "It's good to be angry with you in your presence. Having you listen makes the anger less threatening. I'm coming to believe that you can take it, that my anger won't break or kill you. Holding my anger in gives me self-sufficiency and power. But it is also very painful."

Direct exchanges in the transference situation create experiential insight and fresh beginnings. They go beyond cognition into the world of affect and psychological action (which is not identical with acting out). To illustrate, let me discuss a specific case.

Karen, a twenty-five-year-old woman who had just broken up with the man who had been her lover and companion for three years, remarked: "I feel I really did not deserve him. I never went along with him, though I never opposed him cither. I was as anxious with him as I am with everyone. The minute I try to speak truthfully to a person, my thoughts elude me. I stammer and then go under. I am never sure what I really feel or think; maybe it's one thing, maybe it's the opposite."

In subsequent sessions, we clarified some important aspects of her relationship with her mother, which had been central in her life. The hard-working, depressed mother had taken every expression of disagreement by Karen, who was her only child, as a sign of ingratitude and lack of love. Karen never felt free to exercise that degree of self-assertion that is necessary to become a person in one's own right—to individuate. She rebelled in muted ways whenever she felt squelched, for example, by going off to a girlfriend's house, where she would sit with a book in a little spare room. She was usually silent, with an air of mild truculence. Not daring to think her own thoughts and pursue her own interests, she more or less ceased to go in any direction

at all. It was a case of pervasive passive hostility. Karen's anxiety-producing loss of thoughts and words when she was about to engage in a dialogue was one expression of her hostile passivity: hardly had she thought something, hardly had she started to formulate it, when her oppositional spirit took over and eradicated what she was about to put forth. As words failed her, the ideas behind them also vanished. The anxiety was largely the result of a certain ego disintegration. The patient experienced a gradually growing vacuum of object connections and ego processes. Her unconscious rage was born of the feeling that she was *compelled* to act the way she did. She lost herself in vague fantasies.

The exploration of her passive-hostile condition and of the many processes resulting from it in relation to her mother and girlfriends was merely a prelude. It was when Karen began to weep bitterly over the parallel aspects in the transference situation that she discovered and practiced a form of self-help. Her insights became meaningful and eventually enabled her to resume her ego development through identity formation and individuation.

When she lost her thoughts and words with me, as she did with others, I interpreted this sudden cessation of interchange as a way of expressing her reluctance to comply with the requirements of communicating, since, after all, this meant giving in and suffering a form of self-extinction. After some such remark, Karen became furious with herself. "I know," she said, "that you are

different and not really forcing anything on me. So why should I get antagonistic?" I suggested that she find a special way of speaking designed to fit our relationship. Karen then proposed being deliberately silent as often as she wished. "Maybe that way I will sense that it is *me* who determines what I say and when," she remarked. Her design worked. She felt free to pause at crucial moments and to speak when she chose. My acceptance of her self-determined silences helped her to individuate in a less guilty, more constructive way.

By the fifth month of treatment, the patient was smiling, teasing me, and showing in various ways, both within therapy and outside of it, that her anxiety was significantly reduced. What I have called the three-dimensional time orientation began to develop, a sign of growth and development. Karen said, for example, "I now think about the future. It has become a bright spot, and the past is getting less important. I have more energy. I am experiencing considerable changes. Tell me, how did this come about?"

It is not enough to identify patients' problems and to help them comprehend their uses of destructive behavior; or to show them how the symptoms originated and where they pop up and interfere with truth, superior functioning, and creativity; or to point out that patients are fighting to maintain their resistance to behavioral change, and to pinpoint how they are waging that battle. To tell patients that they are narcissistic, that they

withdraw, and readily fill up with guilt—either in outside life or in the patient-therapist relationship—is tantamount to a static F type of labeling and is often experienced as a scientific, polite form of name-calling.

Over and above insight into the existence of resistance and the major forms it takes, patients need to recognize and to alter—preferably within the transference—the minutiae of the strategies they use to escape truth, to avoid awareness of a conflict, and to perpetuate an ego arrest. It is true that such strategies must first be perceived by the patient, through insight, as destructive. But simultaneously, new visions of reparatory experimentation and of a better way to pursue life must be constructed. These reparatory experiments will at first consist of very small steps—what I call *ministeps*. But they are, in the true sense of the word, stepping stones; and they are highly important.

There are transitions that lead one from insight into what is wrong toward the discovery of ultimate alternatives of feeling and acting. The therapist listens to the description of the problem, points out the patient's invariably transferred fears, and—most important—highlights precedents or possibilities of alternative, more constructive behavior that have been tentatively emerging in treatment. Alternatives, creative solutions, fresh perspectives, and neglected affects are among the chief concerns of the new human team, patient and therapist.

The usually impatient patients often ask on the heels of an insight, "And what should I do now?" Such questions—usually asked to get immediate, "big" solutions—need to give way to satisfaction with constructive ministeps. But the questions should also be understood as a reaching-out for delineations of new behavior; thus they do not necessarily indicate a regression toward renewed dependency. Many patients ask them because they are steeped in ignorance, rather than because of resistance or regression.

Gaining insight into a conflict and taking an inventory of ego deficits do not by themselves constitute working through. The ego does not unfold spontaneously when conflicts are understood and removed. Often new structure-building must be mobilized in patients through fresh images of themselves. These fresh images are obtained from the therapist, who is holding them in safekeeping for the patient (Loewald, 1960) and who supplies them by evoking fresh responses. The potentialities of new structures—and thus new object relations—are kept alive in the transference. I do not mean role playing, as Alexander (Alexander and French, 1946) is accused of having proposed, but mobilization of higher structures because of the patient's wish to communicate and deal with a person of more mature self-organization.

I shall describe an episode from a group session to illustrate how

ministeps help, and how the demand for higher-level behavior—which groups articulate vividly and individual therapists make by implication—mobilized a patient.

The most striking symptoms of a highly intelligent man, whose career was in politics, were his arrogance and his immediate withdrawal whenever a small demand of his was not met. In three consecutive fruitful meetings, the groups members helped Rick to confront his strategies of evasion, to abstain from using them, and to discover new ways of coping, at least during the sessions. Having been told many times that he was as quick to withdraw as a mouse, group members traced his strategies of resistance step by step. When asked to come out of his shell, Rick's first reply was that, after all, he had avoided personal issues for the better part of his life. Group members told him that that was no reason to continue extricating himself by withdrawal.

Rick's next stance was to tell us that he was not able to use the group's confrontations because he lost interest in the pressures exerted on him and could not remember what was said. Again this evasive strategy was repudiated; he was asked to refrain from using it and instead to call on his extraordinarily fine memory, which never let him down when he dealt with abstractions. Thereupon the patient said that he wished a group member from the previous year was present to protect him. Everyone smiled at Rick and teased him. "Now you are trying to get away by taking on the role of the

poor little boy. You should stop this. Don't you see how lucky you are to have us confront you and insist that you give up your hiding maneuvers, which drive you and your teenage son crazy?"

Such well-meant miniexaminations and miniattempts to dislodge resistance make transformation of behavior possible in the transference. For a profound cognitive-emotional reorientation to occur, the impatient patient has to come around to the idea that "slow is beautiful." Although sudden flashlike "aha!" experiences do sometimes occur, they are not the events that herald and bring about change. Working through the minutiae of resistance strategies—the pinpoint work—is much more important.

Ego Repair and Ego Completion

Every society in every period of history has made heavy demands on the psychic apparatus of its members. In the fluid society of today, for example, manners and courtesy no longer suffice to carry a person along, and rigid work habits, while they bring their own rewards, do not equip the person to cope with work demands that, in this era of constantly growing automation, call for greater creativity even in relatively simple work performances. There is a growing and often uncomfortable awareness that the ego and the self have to be put on the line. The twisted or incomplete ego and synthetic self cannot do the job of relating to others, finding a sense of identity within the

existing loose social structure, and coping with ever shifting economic conditions. Real capacities and genuine authenticity are needed. In many instances it is just those structures that psychotherapy helps to build (Winnicott, 1965).

The ego psychologist who is psychoanalytically anchored assumes that many problems in the present are the unfortunate result of interference and neglect by the prime parental caretaker of the past; because the required developmental sequence was neither encouraged nor facilitated, deficits became woven into the fabric of the personality. As a result, the psyche had to use make-believe, psychological bypaths, and clumsy, primitive modes of conduct. In turn, this makeshift existence made storms of anger and rage an ever more frequent occurrence, interfering with the currents of energy and love.

The unfortunate connection with the past, then, consists of severe cripplings and deficits. One objective of working through is to bring development up to date. To accomplish this, therapy has to be corrective and reconstructive. It has to invent ways of raising the level of functioning from primitive to more skillful performances. All people, not just borderline cases and schizophrenics, suffer from ego deficiencies that have to be repaired through belated growth experiences.

Reparatory experiences are comprehensive and numerous, and by no means limited to the kind of overprotection that is not unjustly described as "chicken soup therapy." There are many other positive experiences that are more likely to help build good ego functioning. Contact with the therapist mediates these experiences and helps the patient make his way out of the shadows. Often, when the immediate reactions preceding, within, and following the therapeutic session are examined, it becomes possible to devise technical ways and means to alter the ego (Kris, 1956a). I consider such alteration an absolutely essential part of working through.

An example of ego repair is the following. A narcissistic young woman suffered guilt and depression because of the open jealousy and antagonism with which she treated her stepchild. Sondra was fearful, erratic, and impatient, as evidenced by her constant demand for a quick and magical personality change. She also lacked proper ego boundaries, often confusing her own daughter with the stepdaughter, and her own self with that of other women. To improve her self-image, Sondra would sacrifice her boundaries. When she felt inadequate, she frequently sought some form of nearness with a competent female—often a certain cousin who was two years older and had a solid personality.

The patient used a method of "coupling up": she would have long telephone talks with her cousin; she would ask the cousin to spend part of the

day with her; the two women went to fine restaurants and ordered identical meals. The "coupling up" also occurred, of course, in the transference. Sondra would call up with some frequency to ask for an extra session. On such occasions I regularly inquired what she wanted to accomplish through the extra appointment, and, whenever she seemed able to tolerate refusal, I recommended that we not schedule an additional meeting. Instead, I encouraged her to stick out an anxious day or weekend without resorting to the magical union with me.

In subsequent sessions I expressed interest in any behavior that showed Sondra was beginning to draw on her own strength. I explained that borrowing strength from the therapist or close friends through her "coupling up" strategies actually delayed her growth. After all, did she not have to forfeit her own selfhood (ego boundaries)? As a result, Sondra's ego expanded as she began to call on her own resources for sustenance.

A ground rule of the analytic process, namely, not gratifying the patient, essentially aims at exactly the kind of ego strengthening mentioned above. Not to answer patients' questions is one aspect of nongratification. I believe the quoted example also has some other reparatory aspects. Nongratification was used specifically to add solidity to Sondra's inadequate ego boundaries, which she tried to bolster through identification. Furthermore, frustrations were combined with a technique of positively cathecting the self by

emphasizing the patient's own strength in demarking her own boundaries. It is my conviction that when it comes to ego repair and ego enrichment, frustration must be combined with acknowledgment of strength and progress. Both are part and parcel of working through.

The individual's self-representation (or self-image, to use an older term) is put together gradually. It has to be reaffirmed and continually revised from infancy on. The self-representation starts out as the body image (Freud, 1923). What is called "mirroring" (Mahler, 1968; Kohut, 1977) is one of the early foundations for the body image and hence for self-representation. As the mother affectionately follows her child's movements with her eyes and exclaims at his or her body, the first layers of self-representation are laid down. When later the family or friends applaud the teenager who builds a fence or repairs a faucet, the growing youngster is encouraged to perceive himself or herself as a functioning person who can *accomplish things*. The beginnings of self-representation have been firmly laid down.

Because the self-representation, which is an intrapsychic phenomenon, develops largely through interaction with others, we are dependent on *the ways in which others react to us*. If an important system that we depend on for our self-representation and the affirmation of our own reality is unresponsive or highly idiosyncratic, then our self-representation becomes fuzzy and bizarre. The self-representation bounces off others, so to speak. Their

responses round out and correct the first skeletal representation of the self. The therapist (in group psychotherapy, the group members) becomes the open and active system from which a patient with a fragile self-representation can expect strengthening and enrichment. Thus, responsiveness is an essential ingredient of working through.

Samuel was a middle-aged patient who found it very difficult to be alone because his fragile and sketchy self-representation dissolved easily; he lacked both a picture of who he was and the necessary certainty that he existed at all. As a result, he never came home to his bachelor quarters before late in the evening, just in time to make eight or nine frantic phone calls to friends in order to get reassurance of who he was. One day Samuel remarked in the treatment session: "My existence becomes nebulous when I am by myself, but I have discovered that disagreement helps me to discover who I am. When I get to your door I sense my anger rising because I want to fight with you. I'll start right away and say that you are responsible for my troubles during the last two years."

Clashes with others and outbursts of aggression against persons to whom the patient normally submits assist not only in forming the previously mentioned ego boundaries but also in delineating and emphasizing the processes that form the self-representation (Fried, 1956). Aggression prepares the way for individuation and, in Samuel's case, for the building of a

solid self-representation. It is in clashes with the therapist that patients discover who they are. While therapeutic soothing is a necessary reparatory experience for patients who are restless and irritable because they have never had their fill of symbiotic gratification (Modell, 1976; Winnicott, 1965), there are other cases in which the formation of solid self-representations is greatly facilitated by the therapist's acceptance of the patient's hostile stances.

On the other hand, absolute neutrality is easily construed by patients as indifference (Dewald, 1976). A continuously neutral attitude in the therapist fails to repair and complete the ego. I hasten to add that, in my opinion, appropriate expressions of acknowledgment, close attention, and warmth from the therapist are just as important as acceptance of the patient's hostility. Indeed, the willingness to share the patient's outbursts of hostility, even with occasional humor, is an important form of acceptance.

The number of ego functions that need to be enriched and anchored in dynamic psychotherapy is unlimited. For instance, patients with strong dependency leanings tend to engage in relatively little anticipatory thinking, which is one reason changes in the status quo are likely to arouse anxiety. Anxiety is a reaction to situations in which the helplessness engendered by ego deficiencies threatens to take over. Expanding the range of anticipatory thinking is one goal of working through in order to accomplish self-

innovation. The following incident will illustrate the point.

A borderline patient, who had never gone beyond the symbiotic stage of development, moved far away from home to avoid the mother's continuous attempts to envelop him. Despite the patient's move, the mother called her son long distance almost nightly. Conversely, the patient was drawn daily to the telephone, that lifeline of the dependent person. He meant to call some acquaintance in town to help him with even slight frustrations. But more often than not he found himself dialing his mother's long-distance number to obtain consolation from the customary source. By the afternoon, he rarely knew how he was going to spend the evening.

One day he had a chance to sign a lease for a low-rent apartment, and quite against his habit he committed himself. As the date for moving came closer, he grew anxious. The therapist asked questions about the layout, the lighting, the arrangement the patient foresaw for his bookcases and furniture. The young man exclaimed in surprise: "Those are interesting questions you are asking. I'll remember them. I suppose some people ask such questions of themselves, and this would help them to plan. I need someone else to do the asking." The young man had hit upon a central problem. At an age when healthier people have internalized and integrated both question asking and question answering, he still needed a partner if this dual activity was to be performed. He was able to anticipate problems and come up with answers

only if another person supplemented his ego.

A low degree of anticipatory thinking is a source of anxiety and weakness. We have to help dependent people to ask pertinent questions of themselves and to cast about for answers. In this last case, the expansion of anticipatory thinking began with questions asked by the therapist. Did this patient hesitate to ask questions because question asking was frowned on in his parental home? Did he hesitate to ask questions because of their aggressive, devouring nature? Were questions associated with once-forbidden sexual curiosity? Did he hesitate to ask questions because as long as they remained dormant, he could stay passive? Such queries, along with the therapist's expectation that anticipatory thinking would be used in the sessions, enhanced the patient's ego. Working through was begun and the inventory of ego skills was enlarged in such rather direct ways.

Mobilizing, Expressing, and Processing Aggression

In many ways, dynamic therapists are the allies of aggression. With the proviso that aggression should be expressed but not acted out, they look on it as a potentially constructive force that reestablishes contact following extreme withdrawal, that fortifies boundaries, that promotes individuation, and that supplies energy, provided the aggression is worked through and processed. In dynamic psychotherapy, the patient is helped to become aware

of his aggression. Inklings of aggressive thoughts, feelings, and impulses ready to break through defensive barriers are heeded and welcomed. The direct expression of aggression is encouraged in the therapeutic setting. I consider dynamic group therapy an ideal medium in which to work through aggression. This is due partly to the existence of certain forms of splitting that the group situation allows. The patient can express anger without having to be afraid that he will lose all support and love. He attacks the therapist more readily if he feels assured of some goodwill from one or several group members (Fried, 1977).

The emergence of somatic defenses—for instance, in the form of muscular tensions—helps to make the person aware of anger. Areas of the human body where nervous excitations to strike or kick are located, such as certain spots between the shoulder blades, are subject to muscle contractions which are meant to inhibit the contemplated motions. Patients can become aware of such muscle tensions and retroactively, as it were, get hold of their aggressive impulses. A thorough working through includes the following steps: (1) awareness of aggression; (2) expression of aggression, preferably in the patient-therapist relationship; and (3) receiving and processing, or refining, aggression. The term refining alludes to the processes that convert the crude oil that spurts from the well into the products that produce energy. It has been mentioned that aggression shores up ego boundaries and promotes individuation, two developmental accomplishments that the

disturbed person urgently needs. Moreover, the patient who finally ventures to express aggression resuscitates primitive forms of energy that have been closed off because of past taboos.

By working through their aggressive feelings in the three-step way described, although not necessarily always in that rigid order, patients gradually become ready to allow their loving feelings to surface. More and more clearly the listening and observing self, as well as the world, hears "those titanic melodies," as the Freudian school calls them, "that play on the power of the drives."

When previously repressed aggressive drives venture forth, they are accompanied by the need for nurture and reassurance that their expression will not be punished by abandonment. Unless we recognize these needs, great waves of anger, desires for revenge, and attempts to withdraw will again arise. But if these needs are understood, then the aggressive drives can emerge from their hideouts. The person becomes more animated and energized because aggressive drives are more effective "uppers" than amphetamine pills.

The expression and processing of aggression must take place together. Otherwise, the working through is dangerously incomplete. A woman I treated erroneously believed, as many patients do, that expressions of anger

were all that was called for in therapy. Bettina slammed my door and attempted to humiliate me. After one such confrontation she dreamed that she was about to set fire to her (actually my) apartment and was going to drop a new type of green bomb over Germany (that was the land from which her autocratic father had come, but was located near Austria, my country of origin). She felt both guilty and proud of her gradually acquired ability to show rage; this previously timid patient considered such an ability the essence of therapy. It took two years to complete the processing of her rage—in other words, the working through of it—which was not too long considering her deep-seated problems. The first result was that Bettina stopped drinking. Then she stopped wasting weekends in bed to prevent her rages from exploding against others. Eventually she became a rather caring, firm, and effective person.

Freud (1914) remarked that working through is a trial of patience for the analyst and that it is related to the patient's "psychic inertia." This remark is very true, of course, but it is equally true that it is working through which brings in its wake the changes in personality and life which patients so desperately need. And these changes, after all is said and done, are the purpose of any psychotherapy.

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