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ROBERT WAELDER ON PSYCHOANALYTIC TECHNIQUE: FIVE LECTURES

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Biographical information regarding Robert Waelder is readily available (Guttman, 1986),[1] and this is not the place for it. The following is a rare and direct example of his "old-fashioned" teaching. "Old-fashioned" and "conservative" are criticisms often leveled at Waelder these days. Yet, "Old-fashioned is not precisely the word for Waelder. . . . He was a conservative in the best sense, as his later writings continued to prove, one who would not relinquish what is good for the sake of the supposed 'ideal' situation imagined by those restless for change. This was his ethic, and his conservatism was entirely humanitarian. He refused to idealize 'human nature' and tried to preserve the realism of his clinical sense in matters beyond the clinic" (Lewin, 1968, p. 9).

PREFACE

These lectures constitute a seminar presented by Robert Waelder to candidates at the Washington Psychoanalytic Institute in 1941-1942. They came into my possession upon his death, as part of his literary estate, of which I am executor. They were unsorted, undated notes. It took me a while to establish their origin, and then to fuss with them before deciding they should be published.

Although his English was far from perfect—he had emigrated to the United States only some three years before, in the

[1] See also *Bulletin of the Philadelphia Association for Psychoanalysis*, 1968, Vol. 18, No. 1.

spring of 1938—Waelder had acquired a well-deserved reputation as an excellent lecturer: he had an elegant way of discussing character types and psychopathology in the simplest jargon-free language, and he was able to master clinical and theoretical material and make it come alive. In Vienna, he was reputed to be the brightest student in Freud's circle; Anna Freud said of him, "He understood my father better than anyone else."

Waelder knew where he stood psychoanalytically, and he made his position very clear and plausible. He disliked and had little patience for the bewildered, confused psychoanalyst. He liked the clear, the brief, and the bold. He had a great distaste for ignorance, and an even greater one for attempts to compound it.

I resolved not to update or elaborate on this material in any way. The value here is to take these lessons from Waelder as a starting point for seminars, discussions, clinical and theoretical psychoanalytic work, and instruction. Of course, Waelder himself did elaborate on all these topics. A bibliography of his other work may be found elsewhere (Waelder, 1976). I shall cite but two examples. I chose them because they contain the final efforts of his years of clinical practice and theoretical excursions based on work with his patients in the psychoanalytic situation. He always concentrated on fundamentals, the essence of the matter, and basic concepts.

In his *Basic Theory of Psychoanalysis*, Waelder (1960) set down the psychoanalytic approach as focusing essentially on the unconscious (mental processes), the sexual (and aggressive) drives, and the lasting importance of seemingly trifling childhood experiences. He stated, "An alertness for the unconscious, the sexual, and the infantile may be called the *psychoanalytic point of view*" (p. 51). Later, in "Psychoanalysis, Scientific Method, and Philosophy," Waelder (1962) stated, "In speaking of psychoanalysis . . . one can distinguish between different parts which have different degrees of relevance." He cited levels of "observation," "clinical interpretation," "clinical generalizations," "clinical theory," "metapsychology," and "Freud's philosophy" (pp. 250-251). These basic tenets are as true today as they were a generation ago.

I take this opportunity to acknowledge my indebtedness to Robert Waelder for permitting me to learn so much first-hand. It took me a long time to become accustomed to the fact that by making me his literary executor, Waelder turned over everything, lock, stock, and barrel, for my discretionary use. I am very grateful to his widow, Mrs. Elsie Waelder, and especially to their children, Catherine Waelder Weiss and David Waelder, for giving me their complete trust, their confidence, and a free hand, with never a hard time.

SAMUEL A. GUTTMAN, M.D., PH.D.

I

THE START OF A PSYCHOANALYSIS

There have been quite a number of books and papers, of lectures and seminars, attempting to teach psychoanalytic technique. Yet, if the teacher is honest and knows what he is trying to teach, he will admit that actually only a very small part of psychoanalytic technique is teachable. Freud himself declared that, as in chess, it is merely the opening moves and some typical concluding situations that lend themselves to teaching. Everything else is practically unteachable.

I begin with some preliminary remarks. As you know, we may look at every science from a theoretical as well as a practical viewpoint. I want to emphasize that you will learn no theory at all in this course. There are excellent books and papers about the theoretical aspects. I will name two authors who are a "must" for every analyst not only to read, but to study very thoroughly. I want all of you to read very carefully the papers Freud (1911-1915) wrote about psychoanalytic technique, and I also want you to study very carefully Otto Fenichel's (1938-1939)

II

TRANSFERENCE

Let us examine closely the peculiar phenomenon which is apt to help the psychoanalysis or to make it impossible, which may be an extremely useful tool or a stumbling block, and which may be instrumental in bringing an analysis to a successful end or in ruining it completely. One must attempt to teach the skillful handling of this highly compound structure. I say "attempt," because, again, it is something that lends itself very little to real teaching. All we can do is to discuss it theoretically, to warn of the most frequent mistakes, and to give examples which the less experienced analyst may compare with his own cases. Now, as I said before, the theoretical side of this was taken care of in an excellent way in the writings of Freud (1911-1915) and in Fenichel's (1938-1939) book on technique.

If you study these theoretical considerations carefully you will recognize that transference is nothing but a special case of the much-discussed compulsion to repeat. Such repetitions, such transferences, accompany and complicate the life of every one of us, create and destroy friendships, and often make us do things we never would have done without those transferences. If and when the repetition compulsion concerns the patient's relation to his analyst, as it is bound to, it becomes the most important issue of the whole treatment. It is only with this transference proper (which we see germinate and grow during an analysis) that we shall concern ourselves. The patient responds to what his analyst does or says not according to reality, but according to old infantile automatic patterns, which were formed—out of necessity—in his relations with the persons of his environment during his early childhood. One of the most important aims of analytic treatment is to break those patterns and to replace them with the ability to respond to stimuli from the outside with reactions warranted by reality.

You may say that this is very different from what most people believe transference to be. It is. There is no part of psychoanalytic technique that lends itself to more misunderstandings. And, unfortunately, there is no psychoanalytic concept that is more discussed by uninformed people who may have read a few books or have seen a so-called "psychoanalytic movie" and are now convinced that the very core of analytic treatment is that the patient falls in love with his analyst or hates him so much that he wants to kill him. True, love and hate are among the feelings patients transfer to their analysts. But there are many more feelings, and among them are some that cannot easily be classified as loving or hating. How will you do that with a patient whose relation to his analyst consists of the belief that the analyst need only wave his magic wand and the patient recovers? There are others who consider their analysts as sort of personal servants. They have a maid and a cook and a laundress and a gardener and a chauffeur and an analyst, pay them well, and expect good service. Now is that love? Or hate? I do not mean that in such instances love and hate are merely mixed, that is, that the situation can be covered by the term ambivalence. These transference feelings are something quite different from love or hate; the only trait they have in common with transference love and transference hate is that they were transferred from the patient's childhood. What I mean will become clear perhaps when you realize that there are patients—rare specimens, however—who never were able to really develop any love. From such a patient you certainly cannot expect any love transference. If you succeed in analyzing him, he certainly will learn to love. But the love he will develop will not be transference, and it will very soon no longer be directed toward the analyst, but toward an outside object. Of course, I do not deny that in a great number of cases there is real love and real hate transferred to the analyst. But that is just the point; never forget that transference means the repetition of the feeling involved, not the first edition. In doing control work, I often hear of interpretations given to a patient, with the meaning: "You

speak of your mother (or father), but what you really mean is your analyst." Very seldom do I hear the interpretation in reverse, which is needed much more often: "You show me your feelings about me, but what you really mean is your father (or mother)."

It has been recommended by people who certainly do not understand what transference is to "encourage" the patient in developing his transference—as if the analyst should act in a way that will make the patient react emotionally. The idea is, for instance, to be unfriendly or ironical in order to "bring his anger to the surface."

I cannot warn you enough against this method. In the first place, the patient's reaction would certainly not be real transference (that is, a neurotic, automatic repetition of infantile attitudes), but justified, plain anger. And if you interpret this as transference, the patient will most probably feel that you are wrong (which you are) and not come back. I am decidedly against everything used as a "trick," and consider such advice as sheer nonsense. I have heard patients at the beginning of the analysis tell me that a relative, or sometimes a physician, had predicted they would have to fall in love with their analyst, and they ask me whether this is absolutely necessary. I always answer truthfully that patients react to the analyst according to their personalities and their neuroses and that such predictions show only that those relatives or that doctor did not know what they were talking about.

Now, what are the signs that show you the patient has formed a transference? They vary. They vary so much, in form as well as in intensity, that it is very difficult to mention all possibilities. It depends entirely on the personality, or rather on the history, of the patient. There are some whose transference (both positive and negative) is expressed merely in the fact that they come on time to their hours and pay punctually. Others act out scenes of melodramatic passion, send presents to the analyst, or break his windows. Still others use their symptoms: in getting worse, they may express their wish to be pitied or to make the analyst

feel guilty; in getting well (without the symptoms having been really understood), they may try to justify an early end of the treatment or may intend to please the analyst. In short, everything that can happen between two persons may become the expression of transference. Let us, however, examine the more typical manifestations that may indicate the beginning of transference.

At first, the patient will react to the analyst exactly as he reacts to anybody who has declared his willingness to help the patient. From submissiveness, to gratitude, to stubbornness, every shade of reaction is possible. But soon you will notice, either in his words or his behavior, that a change is taking place. While you realized in the beginning, "this is the way he behaves toward his dentist, lawyer, teacher . . . ," you will no longer be able to say so. You will realize that, in his mental life, you have been assigned a special role, which would be incompatible with his behavior toward his teacher, lawyer, or dentist. Needless to say, this is only true for patients who do not react to their teachers, lawyers, or dentists in a specific neurotic way.

The change may be that the patient pauses in his speech longer than usual, or that, having associated freely up to then, he starts talking along preformed lines, or more systematically. Or he comes in with downcast eyes, avoids looking at you when he greets you, is embarrassed and self-conscious. Or he starts to poke fun at you, at analysis, at "the whole procedure." Or he announces he has talked enough and now you should tell him about your own childhood. Or he describes new feelings, which he never had experienced. Or he tells you how he would handle a patient like himself if he were the analyst. Or he tries to "educate" you in some subject which is dear to him, be it politics or astronomy, woodwork or religion. All these and many other possible reactions have in common that they concern you personally, whether this is expressed in so many words or not. The long pauses for instance, which many patients make after the first few weeks of apparently uninhibited speaking, mostly cover up thoughts they do not dare utter. Patients sometimes

suddenly notice something in your office, which they never noticed before—the wallpaper or the ticking of a clock—something that belongs to you and that they can mention instead of mentioning you. Such reactions are signs of change in the relationship with the analyst, sometimes positive, sometimes negative. As soon as you notice it, watch out—but not too much. Do not forget to listen to everything else because you are on the alert. But do not pass over it, do not be satisfied with merely stating that something has changed. If the change is very conspicuous, that is, if you can be quite sure the patient is aware of it, you may ask him, not why he does or says this or that, but, for example, "Do you often feel [or act] this way?" With questions such as this you may accomplish two things: (1) you may make him realize that something has changed, that is, something in his attitude toward you, and (2) you may be able to confront the realistic part of his ego with the unrealistic, the infantile. Maybe it is too early, and he says, "What do you mean? What's wrong?"—showing you that he does not understand. But maybe he responds: "Yes, very often; but I do not know why. Only last week I said the same things to so-and-so." If he can see that, the first little step has been achieved.

I recommend this approach only "if the change is very conspicuous." Mostly it is not. As I said before, let the transference develop. Transference is not at all a simple structure, and it can be really understood only after careful study. In a certain sense, transference is always resistance insofar as an infantile mode of behavior has overruled the realistic one. In other words, the patient reacts to you as if you were not his doctor, but his father or whoever it is to whom his feelings belong.

Now, you have learned that transference has to be interpreted when it becomes a resistance, and you may ask, if it always is, why wait with interpreting?

Transference is always a resistance as far as it serves to support the neurosis. As long as it does not do more, do not interpret it. As soon as it turns against analysis, it has to be interpreted, and as soon as possible. Transference always turns

against the analysis when the patient does not only talk, but acts out. By then you probably will have enough material to interpret it, collected during the time the patient limited himself to talking. Let us look more closely at what happens when you do that.

I told you about the patient who, after a few weeks of continuous talking, suddenly grew silent and stayed silent for over three months, and I told you also how this very strange and peculiar behavior revealed itself, after these three months, as a magnificent example of acting out. I could not interpret it, as you will remember, because it was shortly after the beginning of the treatment and neither he nor I knew then what he was repeating. To recapitulate, during the first few weeks, the patient talked uninterruptedly, very fast, and in a low voice. I pointed out that he talked differently from the way he talked in the first interviews (when I had him sitting up), but he did answer, and he continued the way he had begun. Suddenly he stopped and just did not speak again, despite my attempts to induce him to do so. What had happened? He had, for the first time, mentioned that he liked his brother, with whom he used to sleep when he was a little boy. Afterward, the analysis revealed a very strong homosexual attachment between the two. You will remember that his mother prevented, by a strict prohibition, any further talk between them when they were in bed. The prohibition was: never to speak once they were lying down. When mention of his brother revived his feelings in that situation, he re-experienced the anxiety he had felt initially in relation to his mother. This time he felt anxiety in relation to me (whom he experienced as being his mother). He could not talk anymore because there was not only anxiety, there was also resentment and the wish for revenge. This was the moment when the transference resistance set in. Instead of remembering, he acted out, blocking the analysis completely.

Of course, the next question was why he had not told me before that he could not talk when he was lying down. First he said he did not know. Then he chuckled a little and said: "I know that this doesn't belong to it [by the way, always watch out when a patient says that], but suddenly it occurred to me that sometimes I wished that something might happen, a burglar might come in, or the house might be on fire—and I would not call mother. Had she not said we should not open our mouths when we were lying down? It would serve her right, I thought, to be punished for this silly prohibition."

Now I could interpret the whole thing. Now it was clear that in not telling me earlier about his inhibition, he acted out not only his feelings in the childhood situation, but also his resentment in the analytic situation. What he wanted to express was: "What a silly procedure to have me lying down. What good can it do me? I'll show her [mother] how ridiculous it is. She soon will become bored. Let's see which one of us can stand it longer."

The patient was much relieved when I told him all this. He himself found the most concise and exact formulation of his resistance when he replied: "Oh, that's how it works! But then I must have done it in order to disrupt the treatment. How silly of me!"

This example also provides a lesson in interpretation. There are many ways of interpreting. The best is to take the interpretation just short of the last step and let the patient complete it. The patient experiences a narcissistic satisfaction which is a valuable counterweight to the equally narcissistic satisfaction of his resistance. The interpretation is much more convincing when the patient himself takes the last step. In the above example, I told the patient he wanted to annoy me, to see which of us could stand the silence longer. It was he who completed the interpretation by stating he must have wanted to disrupt the treatment, followed by some insight: "How silly of me!" From then on the analysis could move forward.

Finally, why could he tell me, at the very end of the three-month term, that he could not speak when lying down? The answer is very simple. He was convinced that this was his last day with me. He expected me to say: "Well, if you cannot speak

lying down, then you cannot be analyzed, good-bye." And he wanted me to know how silly I had acted; he wanted to put the blame on me, because I had asked the impossible. On the other hand, he was relieved that he could stop the analysis because he felt the tremendous aggression against his analyst (in this mother transference). He was afraid of his own aggression, which had risen to considerable intensity during those three silent months.

I consider this example very instructive. It would have been easy to tell this patient that he was silent because he wanted to keep back something, that there were facts he did not want to reveal, and so on. All this would not have accomplished anything. The thing to interpret was his attitude, his behavior, that which was done by his conscious ego. And the most conspicuous feature of this attitude was his transference, which had become a resistance. This transference had to be interpreted, not the contents. In general, whenever you are in doubt what to interpret first, contents or transference resistance, the latter should take precedence. You will see that frequently the interpretation of the resistance enables the patient to interpret the contents himself. Let me give you another brief example.

A young woman, very eager to be rid of her multiple phobias and trying hard to do exactly what she was supposed to, gradually developed a peculiar way of associating. She would emphasize that she had to make everything she said quite clear, and for this purpose she made numerous preliminary remarks about what she was going to say. It went something like this: "Something occurred to me just now, but I don't know how to say it so that you will understand. It is so difficult to understand. But after all, you will, undoubtedly, I know that you will. When I think of what I am going to tell you, a peculiar feeling comes up as if I just had to say it, and I know of course I will. Isn't it strange how such things work? I feel now I just have to say it and I feel the power, the tremendous power of this urge to say it, as if someone much stronger than I am were threatening to kill me if I didn't. But of course I will because you want me to say everything, and after all I always say what I am thinking, and this is what will help me to get rid of my fears . . ."—and so on, for the rest of the hour, without really saying what started all this. It was not always fear (as it was, obviously, in this example) that prevented her from saying what was on her mind, because sometimes it went like this: "I had a peculiar thought this morning and right away I knew this was what I was going to tell you today. Each time I feel that way I am full of admiration for you because you always make me say such things finally, and I really don't know how you do it. It reminds me of a friend of mine who always says that she knows in the morning what she is going to do during the day. But this is different, because I don't know what I am going to do, I only know what I am going to tell you. . . ."

If I now tell you that the contents, around which all these conflicts revolved, repeatedly concerned minor matters such as she had told me about without any conflict before, you will understand at once that not these contents, but the talking around them must be interpreted. But the contents, irrelevant as they seemed to be, had a common denominator. They always concerned something she did not want her mother to know—small things, like a recipe that enabled her to bake a better cake than her mother, or that she had exchanged a dress her mother had given her as a present for a nicer one. As this became evident, these contents could have been interpreted. But that would not have eliminated this special type of resistance, consisting in "talking around." So I asked her simply: "Have you ever noticed what children do when they want to avoid admitting they have done something they were not supposed to?" "Of course," she said, "they talk about something else. I observed it the other day when my friend's little girl came home. I had never seen her so loquacious. She told stories, and she made fun of her friends and made cute little jokes, until her mother, my friend, said: "And what about the report card?" And I remember I did exactly the same thing. I really prepared myself and had a lot of stories and jokes ready for just such an occasion." Now I could

show her what she did—that she did not resort to stories any more, but that all those introductory and preliminary remarks served the same purpose. I give this example to emphasize that on such occasions it would be not only useless, but wrong to stress the content the patient wishes to hide. You have to interpret solely the means used for this purpose. Only in this way can you eliminate the resistance which is a result of the developed transference. Then, and no earlier, can you interpret the transference to the patient. In the case of my patient, I was able to show her that she reacted to her analyst in exactly the same way she once reacted to her mother. She herself had said: "I did exactly the same thing. I really prepared myself and had a lot of stories . . . ready." The transference character of her relation to me was so close to the surface that she could and did understand.

It is not always so easy. Sometimes patients do not reveal anything of their transference in their behavior or their associations, but their dreams show it very clearly, much to the embarrassment of the patient. A girl once brought me a dream, very early in her analysis, in which she was in bed with me and enjoyed it to such a degree that she was glad she awoke. She said: "It would have been terrible to go on dreaming. I don't understand how I can have such a dream. I never dreamed that way, not even something like that about my own mother."

If you do not want to jeopardize the entire treatment, never interpret such dreams at the beginning of an analysis. Merely say it is much too early to understand that dream; it will become understandable later on. With some patients, you may perhaps add that the dream must mean something the patient refuses to think about in the daytime. There are other patients who, after quite a stretch of analysis, still show no sign of transference, but keep dreaming about the analyst. If the associations to such dreams make it possible to interpret them, the patient most likely will admit having had thoughts or feelings or impulses like those expressed in the dreams, but they had not occurred to him in that hour. If you cannot interpret the dream, ask the patient why he thinks he repeatedly dreams about something that has no place in his daytime thinking. While you cannot expect a rational answer, the question may serve as a stimulus for further associations closer to the subject he is avoiding.

The most important thing in handling the transference is not to play along with the patient, not to participate in the game he is trying to play. He gives you a part in this play. Do not accept it. But do not refuse it either. Analyze it, exactly as if he had assigned the role to some other person. By the way, I prefer to speak in the interpretation of transference in terms of "your analyst," not in terms of "me"; I reserve this "me" or "I" for situations that are highly emotionally charged for the patient or for when he tries to minimize his positive or negative feelings toward me personally.

Some young analysts find the transference the patient has formed unacceptable because it results in being cast in the role of villain. As a consequence, they do not recognize expressions of transference and will never be able to interpret them, in other words, to help the patient.

The counterpart of this attitude is the narcissistic satisfaction of the inexperienced analyst when the patient develops a transference with the meaning, "You are the most wonderful person. I love you and admire you, and you are the only one who understands me and can help me." This is in most cases a repetition of the child's attitude toward one of his parents. Do not forget that a positive transference also has to be dissolved, just like a negative one. The ultimate aim of handling the transference is to let the patient change it into an identification with the analyst. Of course, the patient can do this only after a long stretch of analysis, but the process can be prepared much earlier.

On the other hand, the analyst has to watch out for an early identification as a resistance. The real, healthy identification can only be the end result of the patient's transference, not a substitute for it. If, for instance, a woman patient makes an early identification with her male analyst, it mostly means just

another expression of her penis envy, which will soon develop into a stubborn resistance, meaning: "I know just as much as you do; you cannot help me; I alone can help myself." You can frequently notice an early identification in the attempts of the patient to analyze the persons of his environment. I said that the ultimate aim of handling the transference is to let the patient change it into an identification with his analyst. The patient does this by introjecting the analyst and letting the analyst become part of his superego. Perhaps it is unnecessary to say so, but I want at least to mention that this new part of the patient's superego finally has to be dissolved, too.

I mentioned only a few typical forms of transference. Innumerable other forms are possible. Among them is one I want to warn you about especially, because it may lead to critical and even dangerous situations (dangerous for the patient) if you do not handle it correctly. Some patients try to get their satisfaction in provoking the analyst; they, so to say, test whether he will react objectively. Whenever you notice this, say so, that is, interpret it. It usually represents something like this: "No wonder my analyst is nice and helpful to me. I always did what he wanted me to do, so he likes me. Let's see whether he really loves me, whether he remains nice and helpful also when I behave nastily." You see how double-edged this type of resistance is: if you do not interpret this but remain nice and helpful, then the patient is convinced you love him and probably will turn to transference demands which may prove to be very difficult to handle; if you react emotionally and reprimand him or start to argue, he will enjoy his triumph over your analytic attitude and make his analysis still more difficult for you. The only right way to handle such transference resistance is to interpret it. If you have enough material to trace it back to earlier attitudes, do it. If not, make a statement that he certainly may have tried to provoke his parents by similar behavior. You will always find that such patients had displayed the same behavior toward their parents and that these parents failed, that is, they reacted with too quick punishment, with unjust scolding, perhaps with

temper tantrums. Under the influence of the transference, the patient now wants to test whether you, too, can be fooled, or whether you maintain the same analytic attitude you kept until then. Be careful not to let yourself be provoked to do or to say anything unanalytic, to get angry, to respond with emotions. Hold the analytic mirror before the patient's eyes, showing him what he does, and why.

Maintaining the necessary objectivity in such situations may appear a hard task to the beginning analyst. Whether he will master it or not is dependent entirely on the degree to which he himself was analyzed. One can depend on the sensitivity of highly neurotic patients to spot every diversion from the true analytic attitude, much as they try to seduce the analyst to display emotional reactions. On the other hand, do not try always to watch yourself and to avoid natural attitudes. Adherence to the rules soon becomes automatic. The need to watch yourself suggests that there are vestiges of emotional problems which should have been resolved by your own analysis. If you have been sufficiently analyzed, you will not always think: "Do I follow all the rules?" "Was it really the surface I interpreted?" and so on. I remember how I felt when I learned how to drive: "What, all these gadgets—accelerator, clutch, brake, steering wheel, rear view mirror—I should think of them all the time? And at the same time watch for other cars and pedestrians, and for the white line, and for the speedometer, and for street signs —and give signals?" No really good driver ever thinks of all that any more, as all of you know.

Be on the alert for small lies. I do not mean those contradictions that turn up in every analysis as a result of repression. In every analysis you will find discrepancies or incongruities concerning dates, places, and so on. The patient may tell you of games he played at the age of three, games you know he could not possibly have played until very much later; or he may claim to have heard or seen things which you recognize as fantasies. This is not what I mean. And I do not mean a real *pseudologia phantastica* either. But many patients are fully aware of a ten-

dency to distort the truth in small measure. They say "a dozen" when they mean seven, they say they were furious when they were slightly annoyed, they falsify unimportant things, not because they are unimportant, but because they want to deviate from the truth just in small, unimportant matters. The analysis of these small lies inevitably leads to earlier big lies, which are represented and thus externalized by those petty ones.

If you suspect a patient is lying, do not hesitate to tell him so. Of course, you will be tactful in this, but never leave anything unsaid because of the risk that the patient might feel hurt or because you want to spare him unnecessary suffering. You cannot tell that it is really unnecessary. Furthermore, the ability to stand suffering is a part of analytic success. True, that there are exceptions. You certainly will not give a moral masochist the great satisfaction of making him suffer before his masochism has given way at least partially. But then you do not spare him the suffering—which you cannot entirely spare any analytic patient—but you withhold the pathological satisfaction from him. I mentioned the tendency of some patients to lie because it is one of the most frequent manifestations of a certain type of transference. There is scarcely anything else that children are punished for more frequently. Therefore it comes in handy when a patient in transference wants to provoke the analyst. Needless to say, you must not reproach him for lying. Merely point it out and watch for associations.

Another advice, particularly important for the beginner: when you are quite sure of an interpretation (of transference or anything else), never omit it because it might drive the patient away. A correct interpretation, given at the right time, will never do that. A correct interpretation must "click"; and usually the patient reacts with relief and a feeling of gratitude. If this does not happen, you may be sure the interpretation was either wrong or given at the wrong time. If you realize that an interpretation was wrong, try to learn from it for the next time, and do not be discouraged. With many patients, however, an interpretation has to be repeated, sometimes again and again.[2] With others, you get no reaction at all, but the next day the patient comes, quite excited, and reports that after the hour or during the night he suddenly realized what you had said, and now he reacts to the interpretation the way he should have the day before. This latter behavior is a transference resistance, too, and mostly means that he begrudges you the satisfaction of having been successful. This "delayed reaction" must be interpreted at once.

Now, you may ask: "How can we be 'quite sure' of the correct transference interpretation, so that we feel justified in giving it?"

I guess you all are familiar with the technique of crossword puzzles. You know that when you have found some of the words in one direction, there are other words (in the other direction) that require no effort on your part. Perhaps there is one letter you have to add, perhaps two. But on the whole, the word is "given" by those previous ones which came to you in quite a different way: you had to guess those, trying out whether they fit or not. The feeling that accompanies the recognition of the correct word is the same "clicking" I mentioned as accompanying the correct interpretation—for the analyst as well as for the patient.

If the material given by the patient suggests a certain interpretation, but you are not quite sure of its correctness—which sometimes happens—make the interpretation in the form of a suggestion, a proposal, an assumption, a question. Never forget that our knowledge is limited and that not every denial on the part of the patient is a resistance. He may be right, after all. I say in such a situation: "I may be wrong, but it seems to me that. . . ." Or: "Do you think it possible that . . . ?" Or something on that order.

What is true for a transference interpretation is true for any

[2] For more about working through, see Lecture V.

other interpretation as well. Transference interpretation is only one specific application of our interpretative technique in general. I conclude with an example that, once again, demonstrates something that cannot really be taught.

Transference interpretation by no means always consists of telling the patient, "What you mean is. . . ." or "This indicates that. . . ." Sometimes you can achieve much more by reminding the patient, with your response to something he says, of something he said several hours or even weeks ago, and by making him accept this as an interpretation. Once I said to a patient: "If I did not know that you were an only child, what you said would indicate that you once were desperate because your mother had another baby." He said: "This time I'm sure you are wrong. Because the only other child my mother ever had was stillborn." He stopped and began to laugh. "I have no idea why I said that. Because, of course, there never was any other child." Well, later we learned that there really had been this stillborn baby, whose birth he remembered for a moment, only to repress it again immediately. I am quite sure that the so-called slip (which was really a momentary lift of his repression) made it easier for him later to remember this incident which took place when he was eight. I did not insist when he took back what he said. I kept it in mind and counted on the dynamic power of the loosening of analytic interpretations. Several weeks after he had said that, he met a young woman socially who mentioned that she knew me. He guessed immediately that she was my patient, and he became jealous. He told me about meeting her and added sneeringly: "So you have a daughter, too, eh?" This was exactly the moment for an interpretation of his acting out (instead of remembering), and I said only one word: "Stillborn?" This was enough at this moment to revive the old repressed memory. All his unhappiness about his mother's pregnancy came back to him, and with an enormous amount of emotion he could now recall all the details of this totally forgotten event.

From this example you can learn something which has been called the principle of minimum dosage. The one word "stillborn" brought the undoing of a repression which had held for many years. Had I made the same interpretation using many words, telling the patient that he acted toward the fact of my having other patients as he had acted when he was eight, had I added that he was not jealous of me but of his mother, perhaps his resistance would have prompted a renewal of his repression. He felt, at the moment, only jealousy against me, not against his mother. We also have to interpret the surface in transference interpretation. But the word "stillborn" implied the prototype for his jealousy. This was enough to make him ready to accept the truth.

I shall come back to this example later (Lecture IV). Here I want only to demonstrate that it is not always necessary to say: "What you really mean is not your analyst but your mother." Sometimes it is much better to interpret the transference by using elements from the original situation. The element "stillborn" did not all belong to the present transference situation. Using it interpreted the transference, without long explanation, as a repetition of the childhood situation, and left it to the patient to draw the necessary (and obvious) conclusions.

I want to add a few words about what we call countertransference, and some misconceptions about it.

You know that an analyst does not respond emotionally to the words and actions of the patient. He does not argue with him, is not offended by his insults, and is not flattered by admiration. I mean this literally; I do not mean that he merely does not show his feelings. Now, it frequently happens that the patient, in the course of his associations, speaks of his achievements and of things that happen to him outside his analysis. Does the analyst respond to them? Of course he does. If, for instance, the patient's young and much loved wife suddenly is killed in an automobile accident, it would be impossible and inhuman not to respond with pity and sympathy. The analyst should express this to the patient and not ask, "What occurs to you about this?" It would be wrong and unnecessarily cruel, and probably detrimental for his analysis. The right thing to do is to let him cry

and to listen sympathetically, even if it means that an hour or two are wasted. But this is not countertransference. Countertransference is not a first edition, but a repetition, based not on reality, but on a compulsion to repeat. The patient's tragedy is reality.

The reverse mistake is to react to tragic or lucky events in the patient's life by behaving as if that tragedy or that lucky event had happened to you or to a person very close to you. If you react this way, try to realize what makes you identify with your patient. Probably, you will find out that you really are repeating something, which obviously was not sufficiently analyzed. This is real countertransference.

Besides such extraordinary events, of course, countertransference may occur in analyses conducted by inexperienced analysts. Ask yourself whether you treat all your patients with the same amount of interest, of attention, and as a result, with the same amount of success. Examine your attitude carefully and do not tolerate "star patients" or "pets." It does not contribute to your quality as an analyst, and it is decidedly against the interests of your patients.

III

DREAMS

Taking up our next subject, we come to the handling of dreams. In general, there is very little to be said about dreams that would not have to be said about any other material the patient brings. Specifically, there is much to be said about the way to interpret them and about the way the patient uses them as resistance.

The resistance is expressed mostly in either having no dreams at all (or very few) or in having too many. That sounds very simple, but the analyst has to determine whether the extent to which the patient dreams is different from what it was before the analysis. As a matter of fact, there are people who almost