In 1987 Brenner noted that the psychoanalytic meaning of *working through* was theory-dependent. As an example, Kohut (1969) placed *working through* primarily within the context of narcissistic transferences.

“The principal end of the *working through* processes in the idealizing transference is the internalization of the idealized object……; the principal end of the *working through* processes in the mirror transference is the transformation of the grandiose self (p.100).

Perusing the literature since 1987 one finds little has changed. For example, Aron, (1991), summarizing the interpersonalist position, presents their own idiosyncratic view.

“For interpersonalists *working through* entails the accumulation of detail about a person's interpersonal relations with a focus on how anxiety leads to selective inattention and to a constriction of the individual's self-perceptions. Gradually the many interlocking facets
of a person's character become clearer and subject to change (COOPER, 1989).

In short, each theorist who posits a theory on working through has his unique perspective. Surprisingly, the Modern Kleinians use the term working through, but don’t define it.

I would like to suggest that in our wish to discover the true, new theory of psychoanalysis we sometimes discard the past, and in this way lose valuable findings. Thus, let’s briefly go back to Freud’s original definition of working through to see what has happened with it.

Freud referred to working through in 2 papers. In “Remembering, Repeating, and Working through” Freud (1914) and in “Inhibitions, Symptoms, and Anxiety” Freud (1926). In both he clearly tied working through to the newly discovered ego resistances. In 1914 he states,

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

And again in 1914,
This *working through* of the resistances may in practice turn out to be an arduous task for the subject of the analysis and a trial of patience for the analyst. **Nevertheless it is a part of the work which effects the greatest changes in the patient and which distinguishes analytic treatment from any kind of treatment by suggestion.**

(Freud, 1914, bold type added)

It is my contention that the ego resistances, especially the unconscious ego resistances, are **still** central to *working through*. If one looks at how the mind is formed, it is hard to see how resistance analysis could be ignored as a central factor in *working through*. There is little doubt across theories (Busch, 2000) that in response to terrifying thoughts, feelings or experiences, certain defenses are erected as an adaptation. A child who continually approached his depressed mother with age appropriate needs, only to be criticized, will show up in an analyst’s office terrified of his own longings, because it is associated with loss of love. The kindly, empathic analyst will be surprised by the patient’s response to these humane qualities. **Remember, that in our patients, the resistance guard against the most primitive, fears and anxieties known to man. How can these catastrophic dangers to the human psyche be ignored in the process of *working through*?** Yet in my reading of the literature
there is a general rejection of resistance analysis throughout the world. One hears it referred to far too rarely in clinical discussions, while published papers dealing with the topic most often fluctuate between its pre- and poststructural meanings and the technical implications inherent in these positions. As Schafer (1983) states, "Certain things about resisting which ought to be well known, and are said to be well known and sufficiently appreciated and applied, are in fact not known well enough and not consistently attended to in practice" (p. 66). Gray (1994) charitably calls this muddled understanding of one of our basic concepts a "developmental lag," while reminding us that our understanding of theory informs our clinical stance.

A number of writers (Busch, 1992, 1993; Gray, 1994; Paniagua, 2007) fruitfully attempted to understand the reasons for the psychoanalytic community’s rejection of resistance analysis as central to working through. High on my list is Freud’s own ambivalence toward the clinical method dictated by his move to the Structural Theory, and also toward his second theory of anxiety (Busch, 1993). In these discoveries, the ego was seen as the seat of anxiety due to (often) unconsciously perceived dangers. From this perspective the dangers to the ego would have to be analyzed before getting to other dynamic factors. However Freud still
clung to his first theory of anxiety, which saw anxiety as the result of
dammed feelings and fantasies. This led to a technique where getting to
the unconscious affects and fantasies seemed to be the primary curative
factor (Busch, 1992). It is my impression this remains the primary goal of
many analytic interpretations, resulting in a bypassing of the unconscious
resistance throughout the world (Gray, 1994, Busch, 1992).

Even within the group that championed resistance analysis most
ardently, the American Ego Psychologist of the 1950’s and 60’s, it has
become clear that there was no coherent theory of resistance analysis
(Busch, 1992, 1999; Gray, 1982). What is consistently confused is the
analysis of the fears and dangers that keep the unconscious resistances in
place, and the analysis of the fantasies and feelings the resistances
protect. Grenson (1967), a champion of American Ego Psychology,
provides an example where these two levels of analysis become
confused. That is, while Grenson attempts to get at the feelings the
patient is attempting to protect against, he ignores the dangers that keep
the resistances in place. Thus from my perspective the patient is guarding
against a perceived catastrophe, Grenson is viewing this as irrelevant.
Here is what Grenson presents:

A physician in analysis with me for several years begins to speak
medical jargon in the middle of an analytic hour. In stilted tones he reports that his wife developed a "painful protruding hemorrhoid" just prior to a mountain trip they were planning. He said the news caused him "unmixed displeasure" and he wondered whether the hemorrhoid could be "surgically excised" or whether they would have to postpone their holiday. I could sense the latent anger he was withholding and could not refrain from saying: "I think you really mean that your wife's hemorrhoids are giving you a pain in the ass…… (p.66).

By confronting the patient with his latent anger (i.e., the supposed painful feeling he is avoiding), Greenson gives up the opportunity to explore his use of "medical terminology" which, at this time, is the most obvious resistance. If resistances guard against catastrophic dangers, we simply cannot bypass them. The answer to the question of why this patient is fearful of his anger, except in generic terms, is not answerable in Greenson's approach. He is interested more in getting out the strangulated affect than in understanding the reasons for it being kept in.

As Schafer (1983) notes:

There are many moments in the course of an analysis when analysands seem to dangle unexpressed content before the analyst. These are moments when
the analyst is tempted to say, for example, "You are angry," "You are excited," or "You are shamed." But if it is so obvious, why isn't the analysand simply saying so or showing unmistakably that it is so? To begin with, it is the hesitation, the obstructing, the resisting that counts. If the analyst bypasses this difficulty with a direct question or confrontation, the analysand is too likely to feel seduced, violated, or otherwise coerced by the analyst who has in fact, even if unwittingly, taken sides unemphatically [p. 75].

In this regard the patient’s response to Greenson’s bypassing of the resistance is telling, "That's right, you son of a bitch, I wish they would cut it out of her...". We see the patient’s fury for Greenson’s bypassing of the resistance, which is understandable if we fully grasp their importance as guardians against extreme dangers. I hope this brief example gives you an idea of why the analysis of ego resistances is so important to working through, and why the specificity of technique in resistance analysis is so crucial.

I have likened the approach to core unconscious conflicts and cumulative traumas and their sequeli, and the resistances that protect against them, as like trying to get through invisible laser beams connected to an alarm system protecting what seems to be a valuable piece of antiquity in a museum.
Another problem is that the patient doesn’t even know about this elaborate alarm system, as it is occurring unconsciously.

Let me now present a clinical vignette, which demonstrates one component of an evolving technique of resistance analysis developed by a group of American Ego Psychologists, along with Cecilio Paniagua from Spain. These are some of the basic principles guiding technique:

1. We rely on higher-level ego functions to explore the more regressed levels of ego functioning.

2. Exploring the dangers of specific resistances is a primary method of opening up pathways to deeper regions of the unconscious. It is only when a patient finally feels safe enough will they openly explore these areas. By the time we interpret a patient’s polymorphous perverse sexual fantasies, it shouldn’t come as a shock to the patient.

3. Our understanding of Ego in the midst of conflict is that it functions at a concrete level, and thus we must work concretely for longer periods of time. Symbolic interpretations work better, later in an analysis.

4. It is easiest for a patient to understand the workings of a resistance when it is identified in the present moment.
Clinical Example

I had to change an appointment time and asked the patient (a 35 year old woman named Emma who came to analysis because of depression and multiple inhibitions, and in her second year of analysis), about an alternate time. Emma agreed to the change in appointment time, and after a brief pause, started to cry. She then began to berate herself for crying, saying "it was really stupid". In a dry, unemotional voice, Emma elaborated how she was momentarily feeling badly that she would have to miss an aerobics class to come to the appointment, and this is what led to her self reproaches. (Her enrollment in aerobics was a recent occurrence, after never having exercised.)

Emma thought it was stupid to think about an aerobics class being more important than therapy. It reminded Emma of her previous therapist, who when exhorting her to come more frequently to therapy, suggested she should do anything she could for her mental health.

This led to a thought about how badly she felt over the weekend. She had come home from work on Saturday, and started eating. [She is a petite woman.] She had pop-corn, then some cocoa with buttered toast. It reminded her of her childhood, and how much she liked this combination as a child, especially when she dipped the bread in the cocoa. Emma
spontaneously explained the reasons why she had used butter rather than margarine, citing a recent newspaper article regarding use of corn oil based margarine and its negative effects rivaling butter. In this, it seemed she was warding off an anticipated criticism from me. Her thoughts then turned to going out for dinner the previous evening, where she ended up not getting what she wanted, but what she thought would be healthiest. The meal was not to her liking.

FB: When I asked you about changing our appointment time, you started to feel badly about missing the aerobics class, and then chastised yourself for this feeling. Your thoughts then went to situations where you seemed to feel what you wanted was excessive, followed by attempts to curb your appetites. I think we can see how you inhibit yourself because you feel what you want is too much, too excessive, too indulgent.

*There are a number of components in this clarification of a resistance that are central to working through resistances. First, we try to raise to awareness the existence of the resistance and the uneasiness that leads to the resistance. With Emma, it is the uneasiness over wanting that leads to the inhibition. Until the patient can grasp these factors there is no point in going further with interpretations. It would be like asking someone to understand a story that was written in a language she didn’t understand.*
It is important to repeat the sequence that leads to the clarification, as the patient cannot recapture this when working at a concrete level. Further, I am pointing out something that happened right before us as a way of helping the patient feel the emotional impact, as well as having the best chance to grasp a heretofore-unnoticed central psychological event.

These are the beginning steps necessary to **analyze** the resistances as part of the working through process. **Our purpose is to bring them to awareness so that associations to them will emerge to further clarify their meaning.** It is in contrast to how Freud originally saw the analyst’s task in working through resistances:

“to overcome it, by continuing in defiance of it” (Freud, 1914). “we bring forward logical arguments against it; we promise the ego rewards and advantages if it will give up its resistances (Freud, 1926).

**In short, there was no analysis, only suggestion and exhortation.**

Emma then associated to having sex with her husband the previous evening. In an unusual display of assertiveness, she suggested to her husband that she would be interested in intercourse. This was also unusual in that the patient rarely wanted or obtained pleasure from intercourse. According to Emma her husband gave various reasons why this wasn't a good idea...i.e., she doesn't enjoy it, by the time she put in her diaphragm she
wouldn't feel like it, and several others. He was right. By the time he was finished talking she had very little interest in sex.

Her thoughts then turned to a time when she was 3 or 4, when her mother came into her room when she was rubbing the nap of her flannel sheet and sucking her thumb. Mother changed her sheets to a different material the next day. These had a whole different feel. She had difficulty sleeping after that, and has had continued problems (This was new material).

FB: You feel your sensual and sexual pleasures have a long history of being disapproved of.

After the clarification of the resistance, Emma is now freer to specify one fear of wanting too much...i.e., the emergence of sensual and sexual feelings and their anticipated disapproval. It is the specificity of the resistance we are attempting to identify. In fact, Emma grew up in a strict Catholic household where religion trumped every need. I don’t mean to suggest that the elaboration of the resistance is so simple as it appears here. Rather what happened here was the result of a long process. My intervention is an empathic response, again focusing on her inhibition.

Emma’s thoughts then turned to the mess she has at home, and the constant dilemma she has about cleaning up. Has she ever told me about this touching phobia? (She hadn't.) There are certain textures that she just doesn't like to
touch. Crisco came to mind. She hasn't used that in years. Recently she surprised herself when using something with a similar texture, and she liked it. As she's thinking about this she's aware that she's feeling anxious.

In the first part of the session just reported the patient interrupts her crying, berates herself, and then has a series of association where she felt badly for indulging her needs resulting in an inhibition (i.e., eating what she thought she should rather than what she wanted). My interpretation is based upon this sequence.

In hearing this material, colleagues frequently respond by asking, "Isn't she really crying about the change in appointment time?", or "Isn't she really angry, and turning her anger against herself?" While these considerations are important to keep in mind, they speak to core issues regarding how we as analysts understand clinical material.

With Emma the focus of my interpretations was the inhibition which occurs in the session, while it is the feelings which trigger the inhibition rather than what is behind these feelings which seems most important at this point. It is the fact that she wants, and the disapproval she expects
because of it, that triggers the inhibition. Thus, it is the moment the patient needs to inhibit her crying, rather than what caused her to cry, which is my immediate focus. These two levels of inquiry often get mixed up in our clinical thinking. If it is correct that what she is really crying about is the analyst's request for a time change, and some feeling this stirs up in her (sensual pleasure), analyzing the conflict over wanting is a crucial component of this process. How can the patient and analyst know that she really wants to go to aerobics for its sensual pleasures, while the conflict over wanting remains unanalyzed? While we as analysts believe we are interpreting more deeply by first getting behind a feeling, from the perspective of the patient it will frequently end up being more of an intellectual exercise. For this patient what is deeper, an assumed feeling she is defending against, or the recognition of an inhibition in action (both in the session and her associations) with life long consequences that brought her into treatment in the first place?

After my initial interpretation the patient's associations lead to current and genetic components of her inhibition, as well as dynamic-genetic suggestive content. It is the deepening of the associative content, as well as its internal consistencies, which lend weight to the correctness of the initial formulations.
In summary, it is my impression Freud discovered something essential to working through when he identified resistances as the key ingredient. Yet resistance analysis, if it is discussed at all, is often equated with blaming the patient and unempathic technique. One of the earliest psychoanalysts to champion resistance analysis, Wilhelm Reich, demonstrates some of the technical problems that plagued analyzing unconscious resistances from the very beginning. Reich's work reflects his understanding of the resistances as the ego's response to danger, and he offers the first technical suggestions based on this premise, which reflect a true psychoanalytic working through of the resistances and not simply overcoming them.

The better way, then, is to approach first the defense of the ego which is more closely related to the conscious ego. One will tell the patient at first only that he is keeping silent because—"For one reason or another," that is, without touching upon the id-impulse—he is defending himself against the analysis, presumably because it has become somehow dangerous to him [p. 65].

Working on the premise of the resistance as a danger to the ego, Reich elaborates on the procedure for analyzing the resistances. In current terminology, he suggests the necessity of first identifying, and then clarifying the resistance, before the unconscious wishes can be interpreted.
We recognize in this the beginnings of ego analysis, of which analysis of the resistance is a major component. However, Reich is not consistent in applying this perspective. As Schafer (1983) notes:

*Reich himself shows in his militaristic metaphors of armor and attack how much one may fall into an adversarial view of the analytic relationship.*

*Despite his rich understanding of the analysand's needing to resist and the complex meaning of function of this policy, he, like so many others, lapses into speaking of it as though it were a motiveless form of stubbornness or belligerence [p. 73].*

It is as if Reich approached the resistances *simultaneously* from two different perspectives—as an ego under threat and as a blockade that must be overcome.

Paniagua (2007) has recently noted the Sirens call of the Id for many analysts. I remember what at the time seemed like the penultimate moment of my analytic training. After a clinical case presentation at a Scientific Meeting, one of the senior analysts rose and asked the presenter if the patient had an undescended testicle. There was a gasp from the audience as the presenter confirmed this fact. There was no discussion of what this fact had to do with the case, rather the important issue was the brilliance of the analyst for his intuitive grasp of the unconscious. The global admiration for
skill in reading the unconscious id has detracted, I believe, from the less glamorous work understanding the **unconscious ego resistances**, and their crucial role in *working through*.
REFERENCES


