maternal environment we can also find the means within the classical analytic setting to release the 'harmonizing function of the ego' (Hartmann, 1956*a*) through enabling them to achieve primary affective integration in terms of their experience in the analytic situation.

M. Masud Khan

2

Dream Psychology and the Evolution of the Psycho-Analytic Situation

I. Freud's Self-Analysis and the Discovery of the Analytic Situation

JONES (1953) in his biography of Freud tells us: 'Two important parts of Freud's researches are intimately connected with his self-analysis: the interpretation of dreams, and his growing appreciation of infantile sexuality' (p. 320). Kris also stressed this in his introduction to the Fliess Letters (Freud, 1950*a*, p. 33). What has not been sufficiently pointed out is that the unique gain to the science of psycho-analysis from Freud's self-analysis, which he undertook in the summer of 1897 and kept up for a lifetime, was the invention of the analytic situation as the therapeutic and research instrument towards the understanding and resolution of another person's intra-psychic unconscious conflicts, which are symbolized and epitomized in his symptoms and illness. Freud's self-analysis was conducted on two parallel lines: (*a*) through interpretation of his dreams, and (*b*) through empathy and insight into his clinical experience with patients. This latter was an old bias of Freud's temperament. As early as 29 October 1882 he had written to his fiancée: 'I always find it uncanny when I can't understand someone in terms of myself' (Jones, *op. cit.*, p. 320).

Freud's self-analysis not only gave us his monumental work on dreams and the theories of infantile sexuality as well as hypotheses on the aetiology of neuroses in infantile psychic life, but it essentially and irreversibly changed the aim of therapeutic endeavours. The invention of the analytic situation changed the goal of analytic process. As Szasz (1957) pertinently states: 'The goal of helping the patient became subsidiary to the goal of scientific understanding'. It was this shift in the direction and intention of Freud's therapeutic

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procedure that was in time going to earn him as much hostility and criticism from his own disciples as earlier on his theories of dream mechanisms and infantile sexuality had laid him open to from society at large. Most, if not all, of the later defections amongst his disciples (Jung, Adler, Rank, Reich, Reik, etc.) in one way or another centred round the therapist's eagerness to help the patient at the cost of sponsoring insight and understanding. Freud himself was most acutely aware of this resistance among his followers, and with this in view, in his address to the Fifth International Psycho-Analytic Congress at Budapest in 1919, he explicitly formulated the basic task of the analytic situation as being

> to bring to the patient's knowledge the unconscious, repressed impulses existing in him, and for that purpose to uncover the resistances that oppose this extension of his knowledge about himself . . . our hope is to achieve this by exploiting the patient's transference to the person of the physician, so as to induce him to adopt our conviction of the inexpediency of the repressive process established in childhood and of the impossibility of conducting life on the pleasure principle . . . Analytic process should be carried through, as far as is possible, under privation –in a state of abstinence. . . . As far as his relations with the physicians are concerned, the patient must be left with unfulfilled wishes in abundance. It is expedient to deny him precisely those satisfactions which he desires most intensely and expresses most importunately (1919*a*).

For a comparison of the therapeutic aims one has only to glance at the concluding paragraph of *Studies on Hysteria* (1895*d*) where Freud promises the patient 'help or improvement by means of a cathartic treatment' towards transforming 'hysterical misery into common unhappiness' (p. 305).

If it is true that it was Freud's self-analysis that led him to the invention of the analytic situation, then we should look more carefully for clues in that direction for a clearer understanding of the analytic situation. I hasten to add that I am not proposing a re-analysis of Freud's subjective data. That would be not only impertinent but utterly futile. Freud has done that for us, and in Jones's apt phrase 'once done it is done forever'.

How hard Freud had to struggle to maintain the determination to understand the mysterious workings of his own psyche has been most vividly described by Eissler (1951):

> Freud was able to lift his own repressions solely by his own efforts. . . . It is therefore true of Freud's self-analysis that as a type of psychological and historical event it can never be duplicated; it is a type of event which is represented only by a single occurrence unique in its kind, and incapable of being repeated by any other person. . . . The process of self-analysis, at the point of human history when Freud conducted it, was, so to speak, against human nature . . .

What enabled Freud to transform this heroic subjective experience of self-analysis ('this analysis is harder than any other' (1950*a*) into a therapeutic procedure was his genius for abstraction, which led him to re-create all the vital elements of the dreamer's situation in the analytic setting, so that in a wakeful conscious state the person in analysis can psychically *re-experience* through transference-neurosis the unconscious psychic disturbances and states of arrest that are distorting his ego-functioning and affective freedom.

Furthermore, it was Freud's most fateful discovery from his own experience of self-analysis, and from his insight into the use he had made of his relation with Fliess during this period, that this re-experience through transference-neurosis is only possible if there is another person available who by lending himself as an object and his ego-support can help the patient to express and work through personal conflicts to a therapeutic point of self-integration. One could almost put it that Freud's self-analysis revealed to him the impossibility of such a self-analysis for most human beings and compelled him to create a setting and the means of a relationship where this could be achieved.

The hypothesis that I am offering towards the genetic sources of the analytic setting in terms of Freud's self-analysis is that through the analysis of his own dreams and empathy with the clinical experiences of his patients in the hypnotic and cathartic situations of treatment Freud intuitively re-created a physical and psychic ambience in the analytic setting which corresponds significantly to that intra-psychic state in the dreamer which is conducive to a 'good dream'. I shall later detail the ego-aspects of this intra-psychic state.

II. Hypnotic Situation, Dream Psychology and the Analytic Situation

The regressive incentive of the analytic situation and its relation to the hypnotic situation and sleep states has been discussed often

(cf. Lewin, Fisher, Gill and Brenman, Macalpine, Fliess, etc.). Lewin, in particular, in a series of stimulating and provocative papers has discussed the bearing of the derivation of the analytic situation from the hypnotic one. He has attempted (1955) 'to project upon the couch and the analytic situation the idea that the patient is as if somewhat asleep' and elaborated:

> genetically, the analytic situation is an altered hypnotic situation . . . sleep, excluded by agreement from the analytic situation, gained access to it in another form–the method of free associations . . . the wish to be put to sleep, which the patient brought to the hypnotic situation, has been supplanted by the wish to associate freely in the analytic situation. The patient lies down, not to sleep, but to associate . . . The narcissism of sleep . . . coincides with narcissism on the couch. The manifest dream text coincides with the manifest analytic material. . . . Dream-formation is to be compared with 'analytic-situation' formation. . . .

Lewin, following Rank (but judiciously) sees in this regressive repetition 'the direct experience of the baby in the nursing situation'. Lewin pointed out, however (as had Kris), that 'attention to the interpretation of contents and the dream world has distracted us, here too, from the problem of sleep and from a consideration of the analytic subject as a fractional dreamer or sleeper. . . . The patient on the couch was *prima facie* a neurotic person and only incidentally a dreamer.'

In psycho-analytic literature three aspects of sleep have been often discussed:

(i) Sleep as a biological need (Freud, 1900*a*, 1917*d*) and the dream's function of maintaining sleep.

(ii) Sleep as a regressive defence reaction in the analytic situation against aggressive, masochistic and passive impulses which threaten the ego's equilibrium of defences (cf. Bird, 1954; Ferenczi, 1914; Stone, 1947, etc.).

(iii) Regression in sleep as recapturing the ontological phases of infancy development and the infant's primary relation to the breast (Isakower, 1938; Lewin, 1955; Spitz, 1955, etc.).

The relation of the sleep-wish and its regressive defence derivatives to the wish for cure and ego's cathexis of consciousness (self-awareness) have been relatively neglected. Lewin (1955), discussing

the evolution of the analytic situation from the hypnotic treatment, pertinently states:

> It was during the transition from hypnotic treatment to catharsis and analysis that the neurotic patient changed from being a hypnotic subject to being a confider, and the therapist *pari passu* became a psycho-analyst . . . The magical sleep-maker became a confidant, and the analytic situation arrived in history. . . . The inference is that the analyst is a waker.

It is my impression that we have not, as yet, done full justice to the implications of this most significant change in the therapist's role, from hypnotizer to 'the arouser' (Lewin, 1955). When Freud respected the patient's resistances, rather than magically getting them out of the way through hypnotic sleep, he was starting a new process in the development of human consciousness, a process which bridged the split between the conscious and the unconscious. By crediting that in the patient's ego there was more co-operativeness available for cure besides the wish to be hypnotized, and guided by his observations in self-analysis, he created the analytic situation where the patient through the analyst's help could become just as receptive as in his sleep to dreams or as in the hypnotic state to the repressed content. To express it cryptically, whereas the rationale of the hypnotic therapy had been to induce 'dream-states' which the patient could then be confronted with, i.e. where the patient was put to sleep in order to 'dream' and in the final stages to be woken up and be enabled to recall and remember 'the dream' of the hypnotic state, in the altered and new analytic situation the analyst helped the patient's conscious ego in its task of reclaiming the repressed and the unconscious. Once Freud had changed the basic tool of the therapeutic process from hypnotic sleep to conscious recall, with all the attendant resistances in the ego against relaxing its repressions, the very nature of the therapeutic situation and the analyst's role changed. New areas of psychic activity became available to the therapeutic process. For example, what had so far been seen only as the restricting influence of the censor in dream formation (Freud, 1900*a*) now became clinically accessible as the resistance in the patient to the analytic process. In due course this was to yield us profound insight into the pathogenic functions of the archaic and sadistic superego in severely disturbed character-neuroses (see pp. 129-135 below).

III. Wakefulness, Sleep and the Analytic Situation

Dream psychology, which has taught us so much about the unconscious processes and primitive id contents of the human psyche, has, however, left us relatively in the dark about the nature of sleep itself and its psychological meaning for the human being. The wish to go to sleep and the wish to wake up have been somewhat taken for granted as man's natural necessities, both by the psycho-analysts and by the biologists. Here I can only briefly refer to the valuable researches of a few analysts who have given this complex and mysterious problem their attention, namely those of Jekels (1945), Federn (1934), Grotjahn (1942) and Scott (1956). For us what is significant to point out here is the clinical fact that observations of the oscillations of sleep and wakefulness in the analytic situation have thrown some valuable light on the wish for cure and the willingness to keep awake and free-associate in the analytic situation. Clifford Scott's contributions (1952*a*, 1960) towards the understanding of this problem are particularly valuable, since he has extended the hypotheses of Jekels, Isakower, and Federn to the direct examination of rhythms of sleep and wakefulness in the analytic situation. Scott's hypothesis is: 'The total satisfaction of sleep is waking or the act of waking up' (1952*a*). He further postulates the existence of a 'wake-wish' in the psyche which operates as the motivation for the act of waking-up.

It is interesting to compare Scott's researches with those of Lewin (1954) and Jekels (1945). Jekels has postulated: 'I assume that the awakening function is inherent in all dreams and that it constitutes their quintessence, their fundamental task'. Lewin has ascribed the role of 'a waker' to the analyst. From this it would follow that one function of the dream has been taken over by the analyst in the analytic situation, that of an awakener. Jekels, in his most interesting discussion of schizophrenic states, ego-activity in dreams and processes of falling asleep arrived at the conclusion: 'The restitution of the ego, identical with awakening, is started by the mental ego; it is carried out just as in schizophrenia by means of hallucinosis, that is, by means of the dream'. If my inference is correct, then the analyst's ego takes on this 'restitutive' role in relation to the more regressive states of severely ill patients (cf. Winnicott, 1954*b* and *c*; Bion, 1958, 1959). Only in the analytic situation the analyst does not work through hallucinosis but with interpretations. His capacity to interpret relies very much on his

ego-strength which involves controlled experimental preconscious activity in the service of the patient. This is what we normally describe as empathy and intuition. Therefore if the narcissism of sleep is replaced by the narcissism of the couch (Lewin, 1955), then the awaking function of the dream is apportioned to the analyst. It is he who keeps awake and guides the regressive drift of the patient's affective processes and gives them meaning and shape through his interpretations. It is our frequent clinical experience that during the acute regressive states of severely disturbed cases, it is the analyst's wakefulness and ego-activity, expressed through his body-aliveness and interpretations, that keeps the patient going and stops irreversible surrender to primary process activity.

I would like briefly to draw attention here to the more severe and profound disturbances of the quality and subjective experience of both sleep and consciousness in a certain type of schizoid regressive patient. With these patients, who present in their overt behaviour manic over-elated hyperactivity or extreme forms of inertia and apathy, it often transpires that only when they can gradually begin to rely and depend on the analyst's wakeful and embodied presence and functioning in the analytic setting are they able to get to sleep without anxiety. And only then can they wake up in an affective state that does not compel primitive splitting mechanisms in the ego. In these patients it is only when this very primitive rhythm of sleep and wakefulness has been re-established that one can see the capacity for a good dream and free association coming into operation.

I have made this long digression to show how the analytic situation, once it was established, has made it possible to observe the very processes from which it has derived: namely the wish to sleep and the wish to wake up and the capacity to dream.

By rejecting hypnotic sleep as the therapeutic agent and redistributing the total psychic forces operating in the dreamer in the analytic situation, Freud made it possible to evaluate the role and function of sleep and wakefulness both in the therapeutic situation and in ontological development (cf. Fliess, 1953; Isakower, 1938; Lewin, 1954; Federn, 1934; Gifford, 1960; Hoffer, 1952; Spitz, 1955; Scott, 1950; Winnicott, 1954*b* and *c*).

IV. Hypothesis of 'The Good Dream'

A vast amount of our literature, myths, social customs, rituals, and intellectual discoveries are either based on or derived from the

capacity to dream (cf. Sharpe, 1937; Lewin, 1958; Roheim, 1952). In this sense dreaming is prototypic of all psychic creativity in the human adult. I am here proposing the concept of a 'good dream' on the lines of Kris's (1956*a*) concept of the 'good analytic hour'. I shall now schematically state some salient features of the sleeper's intra-pyschic situation which enables a 'good dream' to materialize.

(i) A secure and restful physical ambience where the ego can withdraw safely its cathexes of the external world and reinforce the sleep-wish.

(ii) A state of trust in the ego that this external world will be there to return to after the satisfaction of sleep-wish.

(iii) Ego's capacity to be in touch with the wish to sleep.

(iv) An unconscious internal source of disturbance which is the motive force of the dream and is articulated through the dream-work.

(v) Availability to the ego of the day-residues for formal structuring of the latent 'dream wish'.

(vi) Capacity to tolerate the regressive process in the psychic apparatus: away from motility to hallucination (Kris, 1952).

(vii) Reliability of the integrative processes in the ego. This reliability presupposes that the earliest stages of psyche-soma integration in the nascent ego (Winnicott, 1949*b*) have been established firmly.

(viii) Ego's narcissistic capacity for gratification from dream-world in lieu of either the pure narcissism of sleep or the concrete satisfaction of reality. This implies a capacity in the ego to tolerate frustration and accept symbolic satisfactions.

(ix) A capacity in the ego for symbolization and dream-work, in which sufficient counter-cathexis against primary process is sustained for the dream to become an experience of intra-psychic communication.

(x) A capacity for benign distancing from primitive and sadistic superego elements so as to allow for relaxing of the repression-barrier.

(xi) A capacity in the ego for receptiveness and surrender to the id-wishes with a corresponding confidence in being able to 'resist' their chaotic and excessive influx.

(xii) A reliable time-space unit of experience in which all this can be undertaken and repeated at fairly predictable intervals.

(xiii) Availability to the ego of enough neutralized energy to be able to harness and harmonize the intruding id-impulses: both libidinal and aggressive (Hartmann, 1954).

(xiv) The capacity to retain an 'after-image' of the dream in waking state should this be felt necessary.

Given some such intra-psychic state a person can have a 'good dream'. By a 'good dream' I mean a dream which incorporates through successful dream-work an unconscious wish and can thus enable sleep to be sustained on the one hand and can be available for psychic experience to the ego when the person wakes up. In this context it is interesting to compare the ego-activity of the sleeper in relation to the 'good dream' with what Winnicott (1951) has described as the primitive psychic functions utilized by the infant in relation to transitional object (also cf. Milner, 1952, 1957).

The capacity for a 'good dream', though a prerequisite for psychic health, is, however, not a guarantee of it. It is a measure of a psychic capacity in an individual; it is the dream increment of ego-strength.

V. The Classical Analytic Situation and its Functions

Let us now examine briefly the concept: 'the analytic situation'. The total analytic situation can be somewhat arbitrarily divided into three component parts: (*a*) the patient; (*b*) the analyst; (*c*) the analytic setting. The interplay between these three constitutes the analytic process and procedure.

The patient brings to it a wish for cure, which forms the basis of therapeutic alliance. In terms of dream psychology, his capacity to surrender to the couch-situation is a derivative of the narcissistic sleep-wish (Lewin, 1955). His symptom is the expression of the 'latent dream-wish', i.e. the unconscious repressed conflicts and wishes. He also brings a capacity for analytic work which is intimately dependent on his capacity for dream-work in sleep (cf. Kris, 1956*a*). Where a patient's 'dream-work' capacities are grossly disturbed by ego-distortions, primitive defence mechanisms, or psychotic anxieties (cf. Bion, 1958, 1959), we invariably find they cannot comply with the fundamental rule and free-associate. In such cases acute defensive or regressive use of sleep and silence is a characteristic feature of their behaviour in the analytic situation. Conversely, hypomanic states of elation and acting out can disrupt the transference working through (cf. Klein, 1946 and Winnicott, 1935, on manic defence).

The analyst in his person provides a receptiveness towards the material of the patient, i.e. his free associations. In this way he

reinforces both the 'wake-wish' ('analyst is a waker'–Lewin), and also occupies the role of the sleeper's ego that articulates the dream-work. He helps to release and organize the unconscious wishes through his interpretation of the resistances in the patient and alleviation of primitive guilt feelings. He operates as an 'auxiliary ego' (Heimann, 1950) in the analytic situation. He also lends his freer capacity for symbolic associations to the patient. He holds the patient's material 'alive' and in focus over time. He sees to it that there are no false and precipitate defensive closures of the psychic and affective process. Thus he establishes a movement in the analytic situation (Glover, 1928).

The analyst, like the dreaming ego, does not gratify concretely any of the unconscious wishes of the patient as they find expression in the transference-neurosis, but restricts his role to that of sympathy, support, and understanding. These are the symbolic satisfactions he offers.

In order to facilitate the expression of the patient's wishes and behaviour as well as to operate creatively and freely himself, he establishes a physical ambience: *the analytic setting*. By analytic setting I mean the physical ambience in which an analyst undertakes to initiate and carry out the analytic process with a patient. In our vast literature exhaustive discussions of the patient and the analyst are readily available. It is only in the post-war years that the setting as such has come in for closer scrutiny and examination (cf. Stone, 1961). How and why Freud established the physical attributes of the analytic setting are generally taken for granted. I would like to reiterate here that I am not concerned with the subjective reasons for Freud's choice of certain elements in this setting, such as his personal dislike for being stared at and hence choosing to sit behind a patient (1913*c*). It was Freud's genius that, starting from subjective data, he invariably succeeded in abstracting a general and valid therapeutic procedure (cf. Eissler, 1951). The analytic setting consists of a room, with privacy and guaranteed protection against intrusions and infringements from the outside world. Also a comfortably warm temperature, light, and air, and a couch to lie on in a relaxed way. The analyst provides a predictably repetitive span of time with a beginning and an end. He also undertakes to keep awake, receptively alert and capable of action, and remains unintrusive (Rycroft, 1956*a*; Winnicott, 1954*b*).

Even a casual comparison shows how ingeniously Freud redistributed the intra-psychic state of the sleeper between three

elements in the analytic situation, namely the patient, the analyst, and the analytic setting. How well these three constituents of the total analytic situation lend themselves for the displacement and projection of the tripartite structuring of the human personality, e.g. in terms of id, ego, and superego, has been detailed exhaustively and ingeniously by various analysts.

One very significant and crucial difference from the state of the sleeper is that the analyst through his person makes available a relationship (the transference) which is at the extreme opposite of the isolation of the dreaming ego. And it is precisely this transference relationship which makes the analysis, in contradistinction to dreaming, therapeutic. One further distinguishing feature of the analyst's activity (interpretations) as compared with the ego's dream-work is that he deals with the unconscious impulses not through regressive mechanisms which the sleeper's ego uses, e.g. displacement, condensation, hallucination, etc. but through dealing with both the resistances and the pathogenic use of primitive defence mechanisms. He does not obviate the resistances, as in hypnosis, but works with them and at them, thus gradually enabling the patient's ego to have access to new sources of energy and more effective psychic processes. Through the transference relationship Freud enabled the human ego to achieve its maximum conquests of the unconscious into conscious and reclaimed to self-awareness, insight, and communication vast areas of affectivity and psychic inner life (fantasy) which had been so far available only metaphorically through the products of poets, artists, and gifted dreamers. In a century which was to devote itself almost exclusively to the exploration and conquest of the physical environment, Freud established the techniques for the exploration of the inner life and what man has done to man. He made it possible creatively and patiently to enquire into the forces and factors that make us human, i.e. our emotions, instincts, psyche, and consciousness. In him the human ego found its first true ally and not yet another inspired prophet or an intellectual or therapeutic tyrant. It is now conceded even by the opponents of Freud that he enabled us to make therapeutic inroads into the unconscious; what is not so clearly seen is that after him and through his work the very function and scope of human consciousness have changed and widened, inwards and outwards (Trilling, 1955).

What Freud (1941*b*) has attributed to Michelangelo in his creation of Moses, in spirit, is even more aptly true of Freud's

struggle with himself which led to his creation of the analytic situation:

> But Michelangelo has placed a different Moses on the tomb of the Pope, one superior to the historical or traditional Moses. He has modified the theme of the broken Tables; he does not let Moses break them in his wrath, *but makes him be influenced by the danger that they will be broken and makes him calm that wrath, or at any rate prevent it from becoming an act.* In this way he has added something new and more than human to the figure of Moses; so that the giant frame with its tremendous physical power becomes only a concrete expression of the highest mental achievement that is possible in a man, that *of struggling successfully against an inward passion for the sake of a cause to which he has devoted himself.* . . . thus, *in self-criticism, rising superior to his own nature*' (pp. 233-234). (Italics mine.)

To shift our attention to the clinical aspects of the analytic situation. This situation, during the first two decades of psychoanalysis, was intended to meet the needs and requirements of hysterics (Freud, 1919*a*). In other words, the patient who was considered suitable for analysis was supposed to have reached a fair degree of ego-integration and libidinal development. The conflicts were in the nature of unresolved tensions between the ego, the superego, and pregenital impulses and object-relationships. The ego-functions of these patients were more or less intact and their symptoms were the result of involvement of these intact ego-functions with primitive id-impulses and guilt feelings. The conflicts had not sapped or distorted in any acute degree the ego-functions themselves. Because of this these patients could be relied upon to use the transference function of the analytic setting. In 'the good dream' neither does the disturbing id-impulse break through the ego's regressive control of the dream-work into motility (otherwise the sleeper would wake up), nor has the ego to use primitive total defences to deal with the dream (as in psychosis, cf. Nunberg, 1920 and Bion, 1958). Similarly, for these patients the analytic situation's transference-potential for carrying regressive thought and wish cathexes and their expression through words is sufficient for the therapeutic process. They do not 'act out' in analysis or their social life in any harmful or intense way. Conversely, it is my clinical experience that patients who cannot have a 'good dream' also cannot creatively use the analytic situation.

VI. Borderline Cases, Regression, and the New Demands from the Analytic Situation

In the past three decades a variety of patients have come for treatment who, because of the very nature of their illness, have not been able to use the classical analytic situation constructively. They are compelled by their personality-disorders to fail to fulfil the 'expectancy' and rules of the analytic situation. They come to treatment without specifically identifiable symptoms or even a well-organized wish for cure. Though intellectually they can all too easily grasp the requirements of the analytic situation, affectively and in terms of ego-process they fail to make any use of it. They freeze up, instead of free-associate; regressively cling to various elements of the setting and the person of the analyst (Fliess, 1953), and can establish neither a therapeutic alliance (Zetzel, 1956) nor transference-neurosis (Sterba, 1957; Stone, 1947) that is workable. In their experience of the analytic situation a regressive confusion and blurring of the boundaries of self, analyst, and setting continuously takes place. These patients have been variously defined as borderline cases (Greenacre, 1954*a*, Stone, 1954), schizoid personalities (Fairbairn, 1940; Khan, Chapter 12 below), narcissistic neuroses (Reich, 1950), 'as if' personalities (Deutsch, 1942), identity disorders (Erikson, 1959; Greenson, 1958), suffering from 'ego-specific defect' (Gitelson, 1958), 'false personality' (Winnicott, 1956; Laing, 1960) and 'basic fault' (Balint, 1960), etc., etc. The primitive ego-distortions in these patients do not lend themselves to the establishment of that 'benign split' which is a prerequisite for the success of the clinical process in the classic analytic situation. In these cases confusions of self and object, urgent wishes to control regressive psychic affective experiences through motility and intellectual defence (A. Freud, 1952*a*), delusional transference (Little, 1960; Stone, 1954) and symbiotic dependency states precipitately take hold of the analytic situation (Sterba, 1957). And they try desperately with all varieties of bizarre and primitive defence mechanisms to bring this charged analytic situation within the range of their omnipotence (Winnicott, 1960*a*).

The various new technical procedures, amendments, and innovations that have been offered during the past three decades by analysts, with varying degrees of certainty and assurance, have all resulted from an honest clinical attempt to meet these clinical states.

And yet even a casual examination convinces us that they

contradict each other (cf. Balint, 1950). Some analysts are inclined to exploit the regressive processes in the patient and the analytic situations towards a re-creation of the patient's personality (cf. Little, 1960). Others distrust the regressive potential of the transference and the analytic situation and impose upon it and the patient wisely selected restrictions and obligations and with these hope to guide the patient through 'corrective emotional experiences' to a new freedom and vitality of ego-functions and psychic health (cf. Alexander, 1950, Macalpine, 1950, etc.). By and large most of us are agreed today that for the aetiology of these disorders we have to look much further back than the the oedipal situation and pre-genital id-conflicts and object-relationships. In the words of Gitelson in the consideration of these cases 'our thinking is channelled in a direction which assumes an ego-specific defect'. We are more and more inclined to account for these disorders in terms of the disturbance of the primitive stage of ego-differentiation and its emergence from the ambience of infant care into a self-unit. With this, by definition, the very nature of our therapeutic task, and the function of the analytic setting changes. No longer can we exclusively devote our skill towards the evolution of a transference-neurosis in the analytic setting which will express the latent conflicts of the patient and through interpretation and working through resolve it. I shall not discuss them separately in detail (cf. Eissler, 1950), but merely indicate here that once the clinical process goes beyond the 'transference limits' of the analytic situation and the patient compulsively acts out in a concrete way his *needs* (as against wishes, for which the symbolic speech idiom was sufficient) and primitive ego-distortions, then the analogy of the sleep and dream-situation with the analytic situation is no longer feasible. In chapter 7 of *The Interpretation of Dreams*, Freud makes it quite explicit that wish-fulfilment in dreams is only possible if the mnemic images of the previous satisfaction of needs are available for cathexis. He succinctly sums it up on page 598: 'The first wishing seems to have been a hallucinatory cathecting of the memory of satisfaction'. We can elaborate on this to say where in a person's experience of infant care such *satisfactions* have not been either reliable and consistent or have been too inadequate, the capacity to use these 'mnemic images of satisfaction' for mobilization of dream-wish must by definition be lacking or distorted (cf. Winnicott, 1945*a*). In these circumstances later ego-development can be used as a magical way of making good the deficiency of early satisfaction experiences. Intra-psychically this can mean an *abuse*

of dreaming to create a magical omnipotent dream-world which aims at creating the illusion of satisfying actual needs with an omnipotent denial of the necessity of external objects for satisfaction and the dependence on them. We see this most vividly in certain psychotic illnesses. My experience clinically is that patients who have very primitive ego-distortions cannot work with the symbolic transference value of the analytic situation. They either deny their *dependence* on it altogether or try to compel it into a magical omnipotence of thought or regress to making actual need-demands that are totally beyond the scope of the analyst or his setting. The clinical crises of these patients demand a different capacity from the analytic situation, and if we are not to get lost in this situation, we must keep clearly in mind that it is not the analytic situation that has created this state of affairs, as Macalpine, Alexander, and Fairbairn suggest, but the *need* in the patient. The one saving grace of these clinical crises is that Freud's instrument of the analytic situation is resilient and pliable enough to meet these 'needs' and can withstand all the primitive 'delusions' (Little) and distortions to which the patient subjects it. As Winnicott, Spitz, Milner, Scott and others have reported, in these circumstances the 'transference' idiom of the analytic situation changes into a more primitive and primary mode of experience, very much in the nature of the infant-care situation. And once this comes to pass clinically, how metapsychologically valid a specific therapeutic procedure would be depends upon the 'theory' with which the analyst is working. And the more we can openly discuss the theories, expectancies, and anticipatory attitudes with which we approach these clinical crises, the greater will be our benefit from each other and the more shall we correct our procedures into true analytic focus (see pp. 306-15 below).

Meantime, it is best for us to heed Freud's cautionary words to his audience at the 5th International Congress at Budapest in 1919:

> We refused most emphatically to turn a patient who puts himself into our hands in search of help into our private property, to decide his fate for him, to force our own ideals upon him, and with the pride of a Creator to form him in our own image and see that it is good.