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Basic Psychoanalytic Concepts: V. Resistance

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While the *treatment alliance* (Sandler, Holder and Dare, 1970a) and some aspects of *transference* (Sandler, Dare and Holder, 1970b) relate to tendencies within the patient which act to maintain the treatment relationship, the concept of *resistance* is concerned with elements and forces in the patient which oppose the treatment process. Although resistance is a clinical rather than a psychological concept (Sandler, Dare and Holder, 1970a), originally described in connection with psychoanalytic treatment, it is one which can readily be extended, without substantial revision, to other clinical situations.

Resistance as a clinical concept emerged in Freud's discussion of his early attempts to elicit 'forgotten' memories from his hysterical patients. Before the development of the psychoanalytic technique of free association, when Freud was still employing hypnosis and the 'pressure' technique*, resistance was regarded as anything in the patient which opposed the physician's attempts to 'manipulate' him. He saw these opposing tendencies as being the reflection, in the treatment situation, of the same forces which brought about and maintained the dissociation (repression) of painful memories from consciousness. He commented (1895): 'Thus a psychical force . . . had originally driven the pathogenic idea out of association and was now opposing its return to memory. The hysterical patient's "not knowing" was in fact a "not wanting to know"—a not wanting which might be to a greater or less extent conscious. The task of the therapist, therefore, lies in overcoming . . . this resistance to association.' Resistance was regarded by Freud as being present in pathological states other than hysteria or obsessional neurosis (the 'defence neuroses'), e.g. in psychotic conditions. In describing his case of a chronic paranoia (1896) he remarked that 'in this case of paranoia, just as in the two other defence neuroses with which I was familiar, there must be unconscious thoughts and repressed memories which could be brought into consciousness in the same way as they were in those neuroses, by overcoming a certain resistance. . . . The only peculiarity was that the thoughts which arose . . . were for the most part heard inwardly or hallucinated by the patient, in the same way as her voices.'

The motives for resistance were seen to be the threat of arousal of unpleasant ideas and affects. The ideas which had been repressed (and which resisted recollection) were regarded as characterized by being 'all of a distressing nature, calculated to arouse the affects of shame, of self-reproach and of psychical pain, and the feeling of being harmed' (1895). The entry of psychoanalysis into its second phase (Rapaport, 1959) and the recognition of the importance of inner impulses and wishes (in contrast to painful real experiences) in causing conflict and motivating defence did not bring about any fundamental change in the concept of resistance, although resistance was now seen as being directed not only against the recall of distressing memories but also against the awareness of unacceptable impulses. In a paper on 'Freud's psychoanalytic procedure' (1904), written by Freud himself, he states: 'The factor of resistance has become one of the corner-stones of his theory. The ideas which are normally pushed aside on every sort of excuse . . . are regarded by him as derivatives of the repressed psychical phenomena (thoughts and impulses), distorted owing to the resistance against their reproduction . . . The greater the resistance, the greater is the distortion.'

In this formulation a new element can be seen. Resistance was no longer regarded as a

* Instead of hypnosis, Freud used for a time a variety of methods in order to evoke associations in the patient. One of these was to apply pressure to the patient's forehead with the suggestion that this would bring thoughts to mind (e.g. as described in the case of Frau P. J. in the Fliess papers of 1892–99).

complete suppression of unacceptable mental content, but as being responsible for the *distortion* of unconscious impulses and memories so that they appear *in disguise* in the free associations of the patient. In this context, resistance was seen to operate in exactly the same way as the 'censor' in dreaming (Freud, 1900).

The link between the clinical phenomenon of resistance and such 'distorting' or 'censoring' processes led naturally to the formulation that resistance is not something which appears from time to time during analysis, but is constantly present during that treatment. The patient 'must never lose sight of the fact that a treatment like ours proceeded to the accompaniment of a *constant resistance*' (1909). In this paper Freud also commented on the satisfaction which patients receive from their sufferings, a point which he amplified elsewhere, and to which we will return later.

In a previous paper in this series (Sandler, Dare and Holder, 1970b), we commented on the importance which Freud attached to the relation between transference and resistance. The so-called 'transference-resistances' were regarded as the most powerful obstacles in the path of psychoanalytic treatment (1912, 1940). Thoughts and feelings involving the person of the therapist may arise as a consequence of the patient's tendency to re-experience repressed earlier important attitudes, feelings and experiences instead of recalling them, and these will tend to arise anew in the here-and-now of the analytic situation. The development of such transferences from past figures to the analyst may cause the most intense resistances to free association, for the patient's new feelings about the analyst may be felt to be extremely threatening. The patient who becomes dominated by a strong transference-resistance 'is flung out of his real relation to the doctor . . . feels at liberty then to disregard the fundamental rule of psycho-analysis which lays it down that whatever comes into one's head must be reported without criticizing it . . . forgets the intentions with which he started the treatment, and . . . regards with indifference logical arguments and conclusions which only a short time before had made a great impression on him' (1912).

By this time, the major distinction made by Freud in regard to the sources of resistance in patients undergoing psychoanalysis was between *transference-resistance* and *repression-resistance*, the latter being the resistance, inherent in the psychological structure of the patient, to the awareness of painful or dangerous impulses and memories. While transference-resistances may disappear, and even be replaced by transference attachments which reinforce the treatment alliance, repression-resistances can be conceived of as an ever-present (though fluctuating) force which acts in opposition to the aims of treatment.

By 1926 Freud was in a position to distinguish between five major types and sources of resistance.

(1) *Repression-resistance*, which could be regarded as the clinical manifestation of the individual's need to defend himself against impulses, memories and feelings which, were they to emerge into consciousness, would bring about a painful state, or would threaten to cause such a state. The repression-resistance can also be seen as a reflection of the so-called 'primary gain' from the neurotic illness, inasmuch as neurotic symptoms can be regarded as being last-resort formations aimed at protecting the individual from conscious awareness of distressing and painful mental content. The process of free association during psychoanalysis creates a constant potential danger-situation for the patient, and this promotes the repression-resistance. The closer the repressed material comes to consciousness, the greater the resistance, and it is the analyst's task to facilitate, through his interpretations, the emergence of such content into consciousness in a form which can be tolerated by the patient (cf. Sandler, Dare and Holder, 1970c).

(2) *Transference-resistance* which, although essentially similar to the repression-resistance, has the special quality that it both expresses and reflects the struggle against infantile impulses which have emerged, in direct or modified form, in relation to the person of the analyst. The analytic situation has reanimated, in the form of a current distortion of reality, material which had been repressed or had been dealt with in some other way (e.g. by its

canalization into the neurotic symptom itself), and this revival of the past leads to the transference-resistance.

(3) Resistance deriving from the *gain from illness* (secondary gain). Although in the first instance the symptom may be felt as a 'foreign body' and undesirable, a process of 'assimilation' of the symptom into the individual's psychological organization may and often does occur. Freud puts it thus: 'The ego now proceeds to behave as though it recognized that the symptom had come to stay and that the only thing to do was to accept the situation in good part and draw as much advantage from it as possible' (1926). Such secondary gains from symptoms are familiar in the form of the advantages and gratifications obtained from being ill and cared for or pitied by others, or in the gratification of aggressive and revengeful impulses towards those who are forced to share in the patient's suffering. Secondary gain may also accrue through the satisfaction of a patient's need for punishment, or of concealed masochistic trends. The grossest examples of gain from illness may be seen in patients with 'compensation neuroses'. The patient's reluctance to abandon these secondary advantages of illness during the course of treatment constitutes this particular form of resistance.

(4) '*Id-resistance*', due to the resistance of instinctual impulses to any change in their mode and form of expression. As Freud put it (1926): 'And . . . as you can imagine, there are likely to be difficulties if an instinctual process which has been going along a particular path for whole decades is suddenly expected to take a new path that has just been made open for it.' This form of resistance necessitates what Freud called 'working through' for its elimination.*

(5) '*Superego-resistance*', or the resistance stemming from the patient's sense of guilt or his need for punishment. Freud regarded the superego-resistance as being the most difficult for the analyst to discern and to deal with. It reflects the operation of an 'unconscious sense of guilt' (1923), and accounts for the apparently paradoxical reaction of the patient to any step in the analytic work which represents the fulfilment of one or other impulse which he has defended against because of the promptings of his own conscience. Thus a patient who has strong guilt feelings related, for example, to the wish to be the most-loved son and to triumph over his siblings, may react with resistance to any change which threatens to bring about a situation in which he can become more successful than his rivals. Or a patient who has intense unconscious feelings of guilt about his particular sexual wishes may react with intense resistance following the freeing of such wishes through the analytic process. The special element in this form of resistance is that the normal analytic work would, were it not for the sense of guilt, lead to a lessening of tension and a greater feeling of freedom and satisfaction in the patient. Instead of feeling better, the patient feels worse because of an internal threat of punishment, and may show an extreme resistance to the analytic procedure. The most intense form of such superego-resistance can be seen in the so-called 'negative therapeutic reaction', to be discussed in a later paper in this series (Sandler, Holder and Dare, 1970b).

Freud saw the clinical phenomena of resistance as being intimately (though not exclusively) related to the whole range of the patient's mechanisms of defence, not only to the mechanism of repression, although he often used the term 'repression' as a synonym for defence in general. These mechanisms are developed and utilized to deal with situations of danger (in particular the dangers which would arise if unconscious sexual and aggressive wishes were to be allowed free and direct expression in consciousness or in behaviour). '. . . the defensive mechanisms directed against former danger recur in the treatment as *resistances* against recovery. It follows from this that the ego

* This type of resistance in treatment can be regarded as a consequence of the natural psychological resistance to giving up acquired habits—a resistance to 'unlearning'. An aspect of the concept of 'working through' would be the process of learning new patterns of functioning and learning to inhibit the older, firmly established patterns, a process which is regarded as constituting an important part of the analytic work. The concept of working through will be discussed in a later paper in this series (Sandler, Dare and Holder, 1970d).

treats recovery itself as a new danger' (Freud, 1937).

Freud had made a number of references to the relation between the form of the resistance shown by the patient and the nature of the underlying defensive organization. For example, he had described particular types of distortion of free association which were thought to be characteristic of obsessional neurotics (1909). But while the type of resistance was felt to be indicative of aspects of the patient's psychopathology (1926) they were, in the main, regarded by Freud as obstacles to the work of analysis.

In 1936 Anna Freud, in her book *The Ego and the Mechanisms of Defence*, emphasized the extent to which the resistances can provide information on the patient's mental functioning. Resistances, in so far as they reflect the type of conflict and the defences used, were an object of analytic study in themselves. Analysis of resistances could be seen as essentially the analysis of those aspects of the patient's defences which entered into and contributed to the pathological outcome of his conflicts. 'Defence-analysis', via the analysis of resistances, has come to play in increasingly important part in psychoanalytic technique (Hartmann, 1951; Glover, 1955; A. Freud, 1965).

In a number of important publications, Wilhelm Reich (1928, 1929, 1933) had demonstrated that certain patients had developed fixed character traits which were the outcome of past defensive processes, and which showed themselves both in the personality and in the psychoanalytic process as characteristic 'fixed' attitudes. Reich referred to these as the 'armour-plating of character' (*Charakterpanzerung*), but while he maintained that resistances due to such 'fixed' personality characteristics should initially be the primary focus of the psychoanalytic work, Anna Freud maintained that they should be placed in the foreground only when no trace of a current conflict could be detected.

In 1939, Helene Deutsch proposed a threefold classification of forms of resistance into (i) the intellectual or 'intellectualizing' resistances, (ii) the transference resistances and (iii) those resistances which emerge as a consequence of the patient's need to defend himself against the recollecting of childhood material. She discussed the first group *in extenso*, commenting that patients who show the intellectual resistances attempt to replace analytic *experiencing* with intellectual *understanding*. Such resistances may be found in highly intellectual individuals, in obsessional neurotics and in patients 'with blocked or disturbed affects, who, having repressed the affective side of their life, have retained the intellectual side as the sole means of expressing their . . . personality.'

In spite of the close link between resistance and defence, it has been repeatedly emphasized that resistance is not synonymous with defence (Gerö, 1951; Loewenstein, 1954; Lorand, 1958). Whereas the patient's defences are an integral part of his psychological structure, resistance represents the patient's attempts to protect himself against the threats to his psychological equilibrium posed by the analytic procedure. As Greenson (1967) puts it: 'The resistances defend the *status quo* of the patient's neurosis. The resistances oppose the analyst, the analytic work, and the patient's reasonable ego.'

An examination of the psychoanalytic literature since Freud indicates that the *concept* of resistance in psychoanalysis has remained essentially unchanged. However, the *forms* which resistance can take have been described in detail, and there is little doubt that the sensitivity to subtle signs of resistance has come to be felt as an increasingly important part of the psychoanalyst's repertoire of technical skills. It would appear to be useful to follow the descriptive differentiation made by Glover (1955) between the 'obvious' or 'crass' resistances on the one hand, and the 'unobtrusive' resistances on the other. The 'crass' resistances include breaking-off treatment, lateness, missing appointments, silences, circumlocution, automatic rejection or misinterpretation of everything the analyst says, assumed stupidity, a persistent mood of abstraction, and falling asleep*. The less obtrusive resistances are hidden

* Some forms of resistance, e.g. falling asleep and silence, may, at certain points in the analysis, be regarded not as resistance but as non-verbal forms of expression of repressed wishes, fantasies or memories (Ferenczi, 1914; Khan, 1963).

beneath an apparent compliance with the requirements of the analytic situation. They may show themselves in the form of agreement with everything the analyst says, in the bringing of material (e.g. dreams) in which the patient believes the analyst to have a special interest, and in many other forms. As Glover remarks: 'On the whole, the characteristic of these unobtrusive resistances is just that they are not explosive, do not break through or disrupt the superficies of the analytic situation, but rather infiltrate the situation, exude through it, or, to vary the expression, move with the stream rather than against it, snagwise.' Fenichel (1945) has distinguished between 'acute' resistances as opposed to the more hidden forms, the latter showing themselves mainly in the lack of change in the patient, even though the psychoanalytic work appears to be proceeding without hindrance.

All authors now tend to agree that it is an important part of the psychoanalytic process for the analyst to make the patient aware of his resistances, to attempt to get the patient to view them as obstacles which have to be understood and overcome; they also agree that this can be a far from easy task, for the patient will often make every attempt to justify or rationalize his resistance, to view it as appropriate in the circumstances. The threat which the analytic work may constitute to the particular equilibrium which the patient has established may be so great that he may even manifest his resistance through a 'flight into health', and justify the cessation of treatment by the fact that his symptoms have, for the time being at least, disappeared. Here the fear of what might occur as a consequence of the analysis would appear to be so great as to outweigh the primary and secondary gains from his symptoms. The mechanisms whereby the 'flight into health' can be accomplished are, in our view, insufficiently understood, but it seems more likely that this process can take place when the secondary gains from illness have played an important part in maintaining the patient's symptoms. The 'flight into health' should be distinguished from the denial of symptoms, which may be part of the patient's justification for stopping treatment when the resistances aroused outweigh the treatment alliance.

As far as the sources of resistance are concerned, those outlined by Freud (1926) remain central in the theory of psychoanalytic technique. However, the list may be extended and modified in the light of later contributions.

(1) Resistances due to the threat posed by the analytic procedure and its aims to the particular adaptations made by the patient. In this context the concept of adaptation is used as referring to the individual's adaptation to forces arising both from the external world and from within himself (Sandler and Joffe, 1969). The repression-resistance can be included here, being a specific case of what might be termed 'defence-resistance', for defences other than repression can give rise to resistance. The mechanisms of defence can, in turn, be regarded as mechanisms of adaptation, and are essential for normal functioning as well as being involved in pathogenic processes (A. Freud, 1936).

(2) Transference-resistances, essentially as described by Freud (1926).

(3) Resistance deriving from secondary gains, as described by Freud (1926).

(4) 'Superego-resistance', as described by Freud (1923, 1926).

(5) Resistance arising from faulty procedures and inappropriate technical measures adopted by the psychoanalyst. Such resistances may be dealt with during the normal course of the analysis, if their source is realized and acknowledged by both analyst and patient, or they may lead to a breakdown of treatment (Glover, 1955; Greenson, 1967).

(6) Resistances due to the fact that changes in the patient brought about by the analysis may lead to real difficulties in the patient's relationships with important persons in his environment. Thus a masochistic and subservient spouse may offer a resistance to insight and change because such a change would threaten the marriage.

(7) Resistances prompted by the danger of cure and the subsequent loss of the analyst. Many patients remain in analysis because of

concealed gratifications obtained from the procedure and the analytic relationship, particularly where the patient has come to depend on the person of the analyst as an important figure in his life. Thus a patient may unconsciously re-experience the analyst as a protecting or nurturing parent, and the resistance to cure may reflect a fear of giving up the relationship. Such patients may get worse when termination of treatment is considered, but this is not the same as the negative therapeutic reaction which is a form of 'superego-resistance'.

(8) Resistances due to the threat of the analytic work to the patient's self-esteem (Abraham, 1919). This is particularly important in those patients in whom *shame* is a major motive for defensive activity. Such patients may have difficulty in tolerating the infantile aspects of themselves which emerge during the course of treatment.

(9) Resistance to the giving up of past adaptive solutions (including neurotic symptoms) due to the need for 'unlearning' or extinction. While this includes the so-called 'id-resistance', it also encompasses sources of resistance to change in modes of functioning of the more organized and controlling aspects of the personality (i.e. of the ego).

(10) Character resistances, of the sort described by Reich (1928, 1929, 1933) due to the 'fixed' nature of character traits which may persist after the original conflicts which brought them into being have diminished or disappeared, and show great resistance to change.

While the last two forms of resistance are obviously related, and may even be considered to be forms of 'secondary gain', the basis for the resistance is different from what is usually conceived of as 'secondary gain'. It has been suggested that an adaptive solution, be it a neurotic symptom, a character trait, or some other method of functioning, can be reinforced (and thus offer a resistance to change once the original 'primary gain' has disappeared) by the fact that its predictability and availability as a pattern of functioning creates an increment in the individual's feeling of safety (Sandler, 1960). This has been described by Sandler and Joffe (1968) in relation to the persistence of the psychological 'structures' which are regarded as patterning aspects of behaviour. They remark: 'Some structures may evolve in order to solve ongoing conflict. But they may persist and be utilized in order to maintain safety feeling even though the original impulses which entered into their formation are no longer operative in the same way. It is likely that the latter structures are [those] most amenable to change through behaviour therapy. Thus, a neurotic symptom (and the structures which subserve it) may be directed towards solving, for example, an ongoing conflict between an instinctual wish and internal (super-ego) standards of the individual. But it may equally function at a later date as a method of producing safety feeling, and if other methods of providing safety feeling are available then a different and more comfortable solution may be created and utilized, and the employment of the older symptom-structure inhibited. . . . All systems and techniques of psychotherapy (including behaviour therapy) abound with potential alternative safety-giving solutions which can be adopted by the patient.'

While resistance was originally conceived of in terms of the patient's resistances to recollection and to free association, it is clear that the concept was soon extended to include all the obstacles to the aims and procedures of treatment which arise from within the patient. Such a view of resistance enables the concept to be extended from psychoanalysis to all forms of treatment, and we can see the manifestations of resistance even in ordinary medical practice, in the form of forgotten appointments, misunderstanding of the doctor's instructions, rationalizations for breaking off treatment, and the like. Different methods of treatment may stimulate different sources of resistance, and this may account for the fact that one method may succeed with a patient when another would not. Indeed, some methods of treatment may owe their success to the fact that they by-pass certain sources of resistance, but it must be equally true that others may fail because no provision has been made for the adequate handling of the resistances which may arise.

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