The clinical material on which this presentation is based is derived from patients who developed unexpected difficulties in the course of psychoanalytic therapy. Some of these patients had undergone one or more analyses with other analysts; others were patients of mine who returned for further analysis. In this group there were patients who were unable to get beyond the preliminary phases of analysis. Even after several years of analysis they were not really 'in analysis'. Others seemed interminable; there was a marked discrepancy between the copiousness of insight and the paucity of change. The clinical syndromes these cases manifested were heterogeneous in diagnostic category, ego functions, or dynamics of personality. The key to understanding the essential pathology as well as the therapeutic stalemate was in the failure of the patient to develop a reliable working relation with the analyst. In each case the patient was either unable to establish or maintain a durable working alliance with the analyst and the analyst neglected this fact, pursuing instead the analysis of other transference phenomena. This error in technique was observable in psychoanalysts with a wide range of clinical experience and I recognized the same shortcoming in myself when I resumed analysis with patients previously treated.

In working with these seemingly unanalyzable or interminable patients I became impressed by the importance of separating the patient's reactions to the analyst into two distinct categories: the transference neurosis and the working alliance. Actually this classification is neither complete nor precise. However, this differentiation

Presented before the Cleveland Psychoanalytic Society, May 1964. An earlier version was presented before the Los Angeles Psychoanalytic Society, May 1963.

From the Department of Psychiatry, University of California School of Medicine, Los Angeles.
helps make it possible to give equal attention to two essentially different transference reactions.

My clinical experiences in regard to the working alliance were enhanced and clarified by Elizabeth Zetzel in Current Concepts of Transference (32). In that essay she introduced the term 'therapeutic alliance' and indicated how important she considered it by demonstrating that one could differentiate between the classical psychoanalysts and the British school by whether they handled or ignored this aspect of the transference. Leo Stone (31) gave further insight and fresh impetus in my attempts to clarify and formulate the problem of the working alliance and its relation to other transference phenomena.

The concept of a working alliance is an old one in both psychiatric and psychoanalytic literature. It has been described under a variety of labels but, except for Zetzel and Stone, it either has been considered of secondary importance or has not been clearly separated from other transference reactions. It is the contention of this paper that the working alliance is as essential for psychoanalytic therapy as the transference neurosis. For successful psychoanalytic treatment a patient must be able to develop a full-blown transference neurosis and also to establish and maintain a reliable working alliance. The working alliance deserves to be recognized as a full and equal partner in the patient-therapist relationship.

**DEFINITION OF TERMS**

Transference is the experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which are inappropriate to that person and are a repetition, a displacement of reactions originating in regard to significant persons of early childhood (4), (6), (11). I emphasize that for a reaction to be considered transference it must have two characteristics: it must be a repetition of the past and it must be inappropriate to the present.

During analysis several transference phenomena can be distinguished. In the early phases we see usually sporadic, transient
reactions, aptly called 'floating' transference reactions by Glover (17). Freud described more enduring transference phenomena which develop when the transference situation is properly handled. Then all the patient's neurotic symptoms are replaced by a neurosis in the transference relation of which he can be cured by therapeutic work. 'It is a new edition of the old disease' (9), (11). I would modify this concept and say that the transference neurosis is in effect when the analyst and the analysis become the central concern in the patient's life. The transference neurosis includes more than the infantile neurosis; the patient also relives the later editions and variations of his original neurosis. The 'floating' transference phenomena ordinarily do not belong to the transference neurosis. However, for simplification, the phrase, transference neurosis, here refers to the more regressive and inappropriate transference reactions.

The term, working alliance, is used in preference to diverse terms others have employed for designating the relatively nonneurotic, rational rapport which the patient has with his analyst. It is this reasonable and purposeful part of the feelings the patient has for the analyst that makes for the working alliance. The label, working alliance, was selected because it emphasizes its outstanding function: it centers on the patient's ability to work in the analytic situation. Terms like the 'therapeutic alliance' (32), the 'rational transference' (2), and the 'mature transference' (31) refer to similar concepts. The designation, working alliance, however, has the advantage of stressing the vital elements: the patient's capacity to work purposefully in the treatment situation. It can be seen at its clearest when a patient, in the throes of an intense transference neurosis, can yet maintain an effective working relationship with the analyst.

The reliable core of the working alliance is formed by the patient's motivation to overcome his illness, his conscious and rational willingness to cooperate, and his ability to follow the instructions and insights of his analyst. The actual alliance is formed essentially between the patient's reasonable ego and the analyst's analyzing ego (29). The medium that makes this
possible is the patient's partial identification with the analyst's approach as he attempts to understand the patient's behavior.

The working alliance comes to the fore in the analytic situation in the same way as the patient's reasonable ego: the observing, analyzing ego is split off from his experiencing ego (30). The analyst's interventions separate the working attitudes from the neurotic transference phenomena just as his interventions split off the reasonable ego from the irrational one. These two sets of phenomena are parallel and express analogous psychic events from different points of reference. Patients who cannot split off a reasonable, observing ego will not be able to maintain a working relation and vice versa.

This differentiation between transference neurosis and working alliance, however, is not absolute since the working alliance may contain elements of the infantile neurosis which eventually will require analysis. For example, the patient may work well temporarily in order to gain the analyst's love, and this ultimately will lead to strong resistances; or the overvaluation of the analyst's character and ability may also serve the working alliance well in the beginning of the analysis, only to become a source of strong resistance later. Not only can the transference neurosis invade the working alliance but the working alliance itself can be misused defensively to ward off the more regressive transference phenomena. Despite these intermixtures, the separation of the patient's reactions to the analyst into these two groupings, transference neurosis and working alliance, seems to have clinical and technical value.

**SURVEY OF THE LITERATURE**

Freud spoke of the friendly and affectionate aspects of the transference which are admissible to consciousness and which are 'the vehicle of success in psychoanalysis …' (6p. 105). Of rapport he wrote: 'It remains the first aim of the treatment to attach him [the patient] to it and to the person of the doctor. To ensure this, nothing need be done but to give him time. If one exhibits a serious interest in him, carefully clears away the resistances.
that crop up at the beginning and avoids making certain mistakes, he will of
himself form such at attachment... It is certainly possible to forfeit this first
success if from the start one takes up any standpoint other than one of
sympathetic understanding' (8pp. 139-140).

Sterba (30) wrote about the patient's identification with the analyst which
leads to the patient's concern with the work they have to accomplish in
common—but he gave this aspect of the transference no special designation.
Fenichel (2p. 27) described the 'rational transference' as an aim-inhibited
positive transference which is necessary for analysis. Elizabeth Zetzel's
emphasis on the importance of the 'therapeutic alliance' was discussed above.
Loewald's paper on the therapeutic action of psychoanalysis is a penetrating
and sensitive study of the different kinds of relations the patient develops
toward the analyst during psychoanalysis (23). Some of his ideas are directly
concerned with what I call the working alliance. Leo Stone devotes himself to
the complexities in the relation between analyst and patient. He refers to the
'mature transference' which he believed to be: (a) in opposition to the
'primordial transference' reactions and (b) essential for a successful analysis
(31p. 106).

The Symposium on Curative Factors in Psychoanalysis presented before
the Twenty-second Congress of the International Psychoanalytical
Association (1962) contained many references to the special transference
reactions that make for a therapeutic alliance and also some discussion of the
analyst's contribution to the 'good' analytic situation. Gitelson (16) spoke of
the rapport on which we depend in the beginning of analysis and which
eventuates in transference. He stressed the necessity for the analyst to present
himself as a good object and as an auxiliary ego. Myerson (25), Nacht (26),
Segal (27), Kuiper (22), Garma (13), King (21), and Heimann (20) took issue
with him on one or another aspect of his approach. In some measure the
disagreement seems to be due to failure to distinguish clearly between the
working alliance and the more regressive transference phenomena.
This brief and incomplete survey reveals that many analysts, including Freud, recognized that in psychoanalytic treatment another kind of relation to the analyst is necessary besides the more regressive transference reactions.

DEVELOPMENT OF THE WORKING ALLIANCE ABERRATIONS

The first clinical examples show how the course of development of the working alliance deviated markedly from that of the usual psychoanalytic patient. The reason for proceeding this way stems from the fact that in the classical analytic patient the working alliance develops almost imperceptibly, relatively silently, and seemingly independently of any special activity on the part of the analyst. The irregular cases highlight different processes and procedures which take place almost invisibly in the usual analytic patient.

Some years ago an analyst from another city referred an intelligent middle-aged man who had had more than six years of previous analysis. Certain general conditions had improved but his original analyst believed the patient needed additional analysis because he was still unable to marry and was very lonely. From the beginning of the therapy I was struck by the fact that he was absolutely passive about recognizing and working with his resistances. It turned out that he expected them to be pointed out continuously as his previous analyst had done. It also impressed me that the moment I made some intervention he had an immediate response, although often incomprehensible. I discovered that he thought it his duty to reply immediately to every intervention since he believed it would be a sign of resistance, and therefore bad, to keep silent for a moment or so to mull over what had been said. Apparently his previous analyst had never recognized his fear of being silent as a resistance. In free association the patient searched actively for things to talk about and, if more than one idea occurred to him, he chose what seemed to be the item he thought I was looking for
without mentioning the multiple choices. When I requested information, he often answered by free association so that the result was bizarre. For example, when I asked him what his middle name was he answered: 'Raskolnikov', the first name that occurred to him. When I recovered my composure and questioned this he defended himself by saying that he thought he was supposed to free associate. I soon gained the impression that this man had never really established a working relation with his first analyst. He did not know what he was supposed to do in the analytic situation. He had been lying down in front of an analyst for many years, meekly submitting to what he imagined the previous analyst had demanded, constant and instant free association. Patient and analyst had been indulging in a caricature of psychoanalysis. True, the patient had developed some regressive transference reactions, some of which had been interpreted, but the lack of a consistent working alliance left the whole procedure amorphous, confused, and ineffectual.

Although I realized that the magnitude of the patient's problems could not be due solely or even mainly to the first analyst's technical shortcomings, I thought the patient ought to be given a fair opportunity to see whether he could work in an analytic situation. Besides, this clarification would also expose the patient's pathology more vividly. Therefore, in the first months of our work together, I carefully explained, whenever it seemed appropriate, the different tasks that psychoanalytic therapy requires of the patient. He reacted to this information as though it were all new to him and seemed eager to try to work in the way I described. However, it soon became clear that he could not just say what came to his mind, he felt compelled to find out what I was looking for. He could not keep silent and mull over what I said; he was afraid of the blank spaces, they signified some awful danger. If he were silent he might think; if he thought he might disagree with me, and to disagree was tantamount to killing me. His striking passivity and compliance were revealed as a form of ingratiating, covering up an
inner emptiness, an insatiable infantile hunger, and a terrible rage. In a period of six months it became clear that this man was a schizoid 'as if' character who could not bear the deprivations of classical psychoanalysis (1). I therefore helped him obtain supportive psychotherapy with a woman therapist.

A woman I had previously analyzed for some four years resumed analysis after an interval of six years. We both knew when she had interrupted treatment that there was a great deal of unfinished analysis, but we agreed that an interval without analysis might clarify the unusual obscurities and difficulties we encountered in trying to achieve a better resolution of her highly ambivalent, complaining, clinging, sadomasochistic transference. I had suggested her going to another analyst, since, in general, I have found a change in analysts is more productive than a return to the old one. It usually offers new insights into the old transference reactions and adds new transference possibilities. However, for external reasons this was not feasible and I undertook the resumption of her analysis, although with some reservations.

In her first hours on the couch I was struck by the strange way the patient worked in the analysis. Then I quickly recalled that this had often happened in the past; it appeared more striking now since I was no longer accustomed to it; it seemed almost bizarre. After a certain moment in the hour the patient would speak almost incessantly; there would be disconnected sentences, part of a recital of a recent event, an occasional obscene phrase with no mention of its strangeness or that it was an obsessive thought, and then back to the recital of a past event. The patient seemed to be completely oblivious to her odd way of speaking and never spontaneously mentioned it. When I confronted her with this she at first seemed unknowing and then felt attacked.

I realized that in the previous analysis there had been many such hours or parts of hours whenever the patient was very anxious and tried to ward off her awareness of anxiety as well as
analysis of it. I recalled that we had uncovered some of the meanings and historical determinants of such behavior. For example, her mother had been a great chatterer, had talked to the child as a grownup before she could understand. Her incomprehensible talking to me was an identification with her mother and an acting out in the analytic situation. Furthermore, the mother had used a stream of talk to express both anxiety and hostility to her husband, an essentially quiet man. The patient took over this pattern from her mother and re-enacted it in the analytic hour whenever she was anxious and hostile and when she was torn between hurting me and holding onto me.

We came to understand that this mode of behavior also denoted a regression in ego functions from secondary process toward primary process, a kind of 'sleep-talking' with me, a re-enactment of sleeping with the parents. This peculiar way of talking had recurred many times during the first analysis and although various determinants had been analyzed it still persisted to some degree up to the interruption of that analysis. Whenever I tried to confront the patient with a misuse of one of the analytic procedures, we would be sidetracked by her reactions to my confrontation or by new material that came up. She might recall some past event which seemed relevant or, in the next hours, dreams or new memories would appear and we never really returned to the subject of why she was unable to do some part of the psychoanalytic work. In her second analysis, I would not be put off. Whenever the merest trace of the same disconnected manner of talking appeared, or whenever it seemed relevant, I confronted her with the problem and kept her to this subject until she at least acknowledged what was under discussion. The patient attempted to use all her old methods of defense against confrontations of her resistances. I listened only for a short time to her protestations and evasions and repeatedly pointed out their resistive function. I did not work with any new material until convinced the patient was in a good working alliance with me.

Slowly the patient began to face her misuse of the basic rule. She
herself became aware of how she at times consciously, at others preconsciously, and, at still other times, unconsciously, blurred the real purpose of free association. It became clear that when the patient felt anxious in her relation to me she would let herself slip into this regressive 'sleep-talking' manner of speech. It was a kind of 'spiteful obedience'—spiteful in so far as she knew it was an evasion of true free association. It was obedience inasmuch as she submitted to this regressive or, one might say, incontinent way of talking. This arose whenever she felt a certain kind of hostility toward me. She felt this as an urge to pour out a stream of poison upon me that led her to feel I would be destroyed and lost to her and she would feel alone and frightened. Then she would quickly dive into sleep-talking as though saying: 'I am a little child who is partly asleep and is not responsible for what is coming out of me. Don't leave me; let me sleep on with you; it is just harmless urine that is coming out of me.' Other determinants will not be discussed since they would lead too far afield.

It was fascinating to see how differently this analysis proceeded from the previous one. I do not mean to imply that this patient's tendency to misuse her ability to regress in ego functioning completely disappeared. However, my vigorous pursuit of the analysis of the defective working alliance, my constant attention to the maintenance of a good working relation, my refusal to be misled into analyzing other aspects of her transference neurosis had their effects. The second analysis had a completely different flavor and atmosphere. In the first analysis I had an interesting and whimsical patient who was frustrating because I was so often lost by her capricious wanderings. In the second, though still a whimsical patient she also was an ally who not only helped me when I was lost but pointed out that I was being led astray even before I realized it.

The third patient, a young man, entered analysis with me after he had spent two and one half years with an analyst in another city, which had left him almost completely untouched. He
had obtained certain insights but had the distinct impression that his former analyst really disapproved of infantile sexuality even though the young man realized that analysts were not supposed to be contemptuous of it. In the preliminary interviews the patient told me that he had the greatest difficulty in talking about masturbation and previously often consciously withheld this information. He had informed the former analyst about the existence of many conscious secrets but nevertheless stubbornly refused to divulge them. He had never wholeheartedly given himself up to free association and reported many hours of long silence. However, the patient's manner of relating his history to me and my general clinical impression led me to believe that he was analyzable despite the fact that he had not been able to form a working alliance with his first analyst.

I undertook the analysis and learned a great deal about this patient's negative reactions to his previous analyst, some of which stemmed from his way of conducting that analysis. For example, in one of the first hours on the couch the patient took out a cigarette and lit it. I asked him what he was feeling when he decided to light the cigarette. He answered petulantly that he knew he was not supposed to smoke in his previous analysis and now he supposed that I too would forbid it. I told him that I wanted to know what feelings, ideas, and sensations were going on in him at the moment that he decided to light the cigarette. He then revealed that he had become somewhat frightened in the hour and to hide this anxiety from me he decided to light the cigarette. I replied that it was preferable for such feelings and ideas to be expressed in words instead of actions because then I would understand more precisely what was going on in him. He realized then that I was not forbidding him to smoke but only pointing out that it was more helpful to the process of being analyzed if he expressed himself in words and feelings. He contrasted this with his first analyst who told him before he went to the couch that it was customary not to smoke during sessions. There was no explanation for this and the patient felt that his first analyst was being arbitrary.

- 165 -
In a later hour the patient asked me whether I was married. I countered by asking him what he imagined about that. He hesitantly revealed that he was torn between two sets of fantasies, one that I was a bachelor who loved his work and lived only for his patients; the other that I was a happily married man with many children. He went on spontaneously to tell me that he hoped I was happily married because then I would be in a better position to help him with his sexual problems. Then he corrected himself and said it was painful to think of me as having sexual relations with my wife because that was embarrassing and none of his business. I then pointed out to him how, by not answering his question and by asking him instead to tell his fantasies about the answer, he revealed the cause of his curiosity. I told him I would not answer questions when I felt that more was to be gained by keeping silent and letting him associate to his own question. At this point the patient became somewhat tearful and, after a short pause, told me that in the beginning of his previous analysis he had asked many questions. His former analyst never answered nor did he explain why he was silent. He felt his analyst's silence as a degradation and humiliation and now realized that his own later silences were a retaliation for this imagined injustice. Somewhat later he saw that he had identified himself with his first analyst's supposed contempt. He, the patient, felt disdain for his analyst's prudishness and at the same time was full of severe self-reproach for his own sexual practices which he then projected onto the analyst.

It was instructive to me to see how an identification with the previous analyst based on fear and hostility led to a distortion of the working relationship instead of an effective working alliance. The whole atmosphere of the first analysis was contaminated by hostile, mistrustful, retaliative feelings and attitudes. This turned out to be a repetition of the patient's behavior toward his father, a point the first analyst had recognized and interpreted. The analysis of this transference resistance, however, was ineffectual, partly because the first analyst worked in such a way as to justify constantly the patient's infantile neurotic behavior.
and so furthered the invasion of the working alliance by the transference neurosis.

I worked with this patient for approximately four years and almost from the beginning a relatively effective working alliance was established. However, my manner of conducting analysis, which seemed to him to indicate some genuine human concern for his welfare and respect for his position as a patient also mobilized important transference resistances in a later phase of the analysis. In the third year I began to realize that, despite what appeared to be a good working alliance and a strong transference neurosis, there were many areas of the patient's outside life that did not seem to change commensurately with the analytic work. Eventually I discovered that the patient had developed a subtle but specific inhibition in doing analytic work outside the analytic hour. If he became upset outside he would ask himself what upset him. Usually he succeeded in recalling the situation in question. Sometimes he even recalled the meaning of that event that he had learned from me at some previous time, but this insight would be relatively meaningless to him; it felt foreign, artificial, and remembered by rote. It was not his insight; it was mine, and therefore had no living significance for him. Hence, he was relatively blank about the meaning of the upsetting events.

Apparently, although he seemed to have established a working alliance with me in the analytic situation, this did not continue outside. Analysis revealed that the patient did not allow himself to assume any attitude, approach, or point of view that was like mine outside the analytic hour. He felt that to permit himself to do so would be tantamount to admitting that I had entered into him. This was intolerable because he felt this to be a homosexual assault, a repetition of several childhood and adolescent traumas. Slowly we uncovered how the patient had sexualized and aggressivized the process of introjection.

This new insight was the starting point for the patient to learn to discriminate among the different varieties of 'taking in'. Gradually he was able to re-establish a nonhomosexual

---

1 This case is described in greater detail in a paper entitled The Problem of Working Through. In: Tribute to Marie Bonaparte. Edited by Max Schur. (In process of publication.)
identification with me in adapting an analytic point of view. Thus a working relation that had been invaded by the transference neurosis was once again relatively free of infantile neurotic features. The previous insights that had remained ineffectual eventually led to significant and lasting changes.¹

Those patients who cling tenaciously to the working alliance because they are terrified of the regressive features of the transference neurosis should be briefly mentioned. They develop a reasonable relation to the analyst and do not allow themselves to feel anything irrational, be it sexual, aggressive, or both. Prolonged reasonableness in an analysis is a pseudo-reasonableness for a variety of unconscious neurotic motives.

For about two years a young social scientist who had an intellectual knowledge of psychoanalysis maintained a positive and reasonable attitude toward me, his analyst. If his dreams indicated hostility or homosexuality he acknowledged this but claimed that he knew he was supposed to feel such things toward his analyst but he 'really' did not. If he came late or forgot to pay his bill he again admitted that it might seem that he did not want to come or pay his bill but 'actually' it was not so. He had violent anger reactions to other psychiatrists he knew, but insisted they deserved it and I was different. He became infatuated with another male analyst for a period of time and 'guessed' he must remind him of me, but this was said playfully. All of my attempts to get the patient to recognize his persistent reasonableness as a means of avoiding or belittling his deeper feelings and impulses failed. Even my attempts to trace the historical origins of this mode of behavior were unproductive. He had adopted the role of 'odd ball', clown, harmless nonconformist in his high school years and was repeating this in the analysis. Since I could not get the patient to work further or consistently

- 168 -
on this problem, I finally told him that we had to face the fact that we were getting nowhere and we ought to consider some alternative besides continuing psychoanalysis with me. The patient was silent for a few moments and said 'frankly' he was disappointed. He sighed and then went on to make a free associationlike remark. I stopped him and asked him what in the world he was doing. He replied that he 'guessed' I sounded somewhat annoyed. I assured him it was no guess. Then slowly he looked at me and asked if he might sit up. I nodded and he did. He was quite shaken, sober, pale, and in obvious distress. After some moments of silence he said that maybe he would be able to work better if he could look at me. He had to be sure I was not laughing at him, or angry, or getting sexually excited. I asked him about the last point. He told me that he often fantasied that perhaps I was being sexually excited by what he said but hid it from him. This he had never brought up before, it was just a 'fleeting idea'. But this fleeting idea led quickly to many memories of his father repeatedly and unnecessarily taking his temperature rectally. He proceeded to a host of homosexual and sadomasochistic fantasies. The persistent reasonableness was a defense against these as well as a playful attempt to tease me into acting out with him. My behavior, in the hour described above, was not well controlled, but it led to awareness that the patient's working alliance was being used to ward off the transference neurosis.

The working alliance had become the façade for the transference neurosis. It was his neurotic character structure hiding as well as expressing his underlying neurosis. Only when the patient's acting out was interrupted and he realized he was about to lose the transference object did his rigidly reasonable behavior become ego-alien and accessible to therapy. He needed several weeks of being able to look at me, to test out whether my reactions could be trusted. Then he became able to distinguish between genuine reasonableness and the teasing, spiteful reasonableness of his character neurosis and the analysis began to move.
THE CLASSICAL ANALYTIC PATIENT

The term classical in this connection refers to a heterogeneous group of patients who are analyzable by the classical psychoanalytic technique without major modifications. They suffer from some form of transference neurosis, a symptom or character neurosis, without any appreciable defect in ego functions. In such patients the working transference develops almost imperceptibly, relatively silently, and seemingly independently of any special activity or intervention on the part of the analyst. Usually signs of the working alliance appear in about the third to sixth month of analysis. Most frequently the first indications of this development are: the patient becomes silent and then, instead of waiting for the analyst to intervene, he himself ventures the opinion that he seems to be avoiding something. Or he interrupts a rather desultory report of some event and comments that he must be running away from something. If the analyst remains silent the patient spontaneously asks himself what it can be that is making him so evasive and he will let his thoughts drift into free associations.

It is obvious that the patient has made a partial and temporary identification with me and now is working with himself in the same manner as I have been working on his resistances. If I review the situation I usually find that prior to this development the patient has experienced some sporadic sexual or hostile transference reaction which has temporarily caused a strong resistance. I patiently and tactfully demonstrate this resistance, then clarify how it operated, what its purpose was, and eventually interpret and reconstruct its probable historical source. Only after effective transference-resistance analysis is the patient able to develop a partial working alliance. However, it is necessary to go back to the beginning of the analysis to get a detailed view of its development.

There is great variety in the manner in which a patient enters into the preliminary interviews. In part this is determined by his past history in regard to psychoanalysts, physicians, and
authority figures and strangers, as well as his reactions to such conditions as being sick or needing and asking for help (15). Furthermore, his knowledge or lack of it about procedures of psychoanalysis and the reputation of the psychoanalyst also influence his initial responses. Thus the patient comes to the initial interview with a preformed relationship to me, partly transference and partly based on reality, depending on how much he fills in the unknowns inappropriately out of his own past.

The preliminary interviews heavily color the patient's reactions to the analyst. This is determined mainly by the patient's feelings about exposing himself as well as his responses to my method of approach and my personality. Here too I believe we see a mixture of transference and realistic reactions. Exposure of one's self is apt to stir up reverberations of past denuddings in front of parents, doctors, or others, and is therefore likely to produce transference reactions. My technique of conducting the interviews will do the same the more it seems strange, painful, or incomprehensible to the patient. Only those methods of approach that seem understandable to him may lead to realistic reactions. My 'analyst' personality as it is manifested in the first interviews may also stir up both transference and realistic reactions. It is my impression that those qualities that seem strange, threatening, or nonprofessional evoke strong transference reactions along with anxiety. Traits the patient believes indicate a therapeutic intent, compassion, and expertness may produce realistic responses as well as positive transference reactions. The clinical material from the third case indicates how the manner, attitude, and technique of the analyst in the beginning of both analyses decisively colored the analytic situation.

By the time I have decided that psychoanalysis is the treatment of choice, I shall have gained the impression that the patient in question seems to have the potential for forming a working alliance with me along with his transference neurosis. My discussion with the patient of why I believe psychoanalysis is the best method of therapy for him, the explanations of the frequency of visits, duration, fee, and similar matters, and the patient's
own appraisal of his capacity to meet these requirements will be of additional value in revealing the patient's ability to form a working alliance.

The first few months of analysis with the patient lying on the couch attempting to free associate can best be epitomized as a combination of testing and confessing. The patient tests his ability to free associate and to expose his guilt and anxiety-producing experiences. Simultaneously he is probing his analyst's reactions to these productions (10), (18). There is a good deal of history telling and reporting of everyday events. My interventions are aimed at pointing out and exploring fairly obvious resistances and inappropriate affects. When the material is quite clear I try to make connections between past and present behavior patterns. As a consequence, the patient usually begins to feel that perhaps I understand him. Then he dares to regress, to let himself experience some transient aspect of his neurosis in the transference in regard to my person. When I succeed in analyzing this effectively then I have at least temporarily succeeded in establishing a reasonable ego and a working alliance alongside of the experiencing ego and the transference neurosis. Once the patient has experienced this oscillation between transference neurosis and working alliance in regard to one area, he becomes more willing to risk future regressions in that same area of the transference neurosis. However every new aspect of the transference neurosis may bring about an impairment of the working alliance and temporary loss of it.

**ORIGINS OF THE WORKING ALLIANCE**

**CONTRIBUTIONS OF THE PATIENT**

For a working alliance to take place, the patient must have the capacity to form object relations since all transference reactions are a special variety of them. People who are essentially narcissistic will not be able to achieve consistent transferences. Furthermore, the working alliance is a relatively rational, desexualized, and deaggressivized transference phenomenon. Patients must have been able to form such sublimated, aim-inhibited relations...
in their outside life. In the course of analysis the patient is expected to be able to regress to the more primitive and irrational transference reactions that are under the influence of the primary process. To achieve a working alliance, however, the patient must be able to re-establish the secondary process, to split off a relatively reasonable object relationship to the analyst from the more regressive transference reactions. Individuals who suffer from a severe lack of or impairment in ego functions may well be able to experience regressive transference reactions but will have difficulty in maintaining a working alliance. On the other hand, those who dare not give up their reality testing even temporarily and partially, and those who must cling to a fixed form of object relationship are also poor subjects for psychoanalysis. This is confirmed by the clinical findings that psychotics, borderline cases, impulse ridden characters, and young children usually require modifications in the classical psychoanalytic technique (13), (14), (17). Freud had this in mind when he distinguished transference neuroses which are readily analyzable from narcissistic neuroses which are not.

The patient's susceptibility to transference reactions stems from his state of instinctual dissatisfaction and his resultant need for opportunities for discharge. This creates a hunger for objects and a proneness for transference reactions in general (3). Satisfied or apathetic people have fewer transference reactions. The awareness of neurotic suffering also compels the patient to establish a relationship to the analyst. On a conscious and rational level the therapist offers realistic hope of alleviating the neurotic misery. However, the patient's helplessness in regard to his suffering mobilizes early longings for an omnipotent parent. The working alliance has both a rational and irrational component. The above indicates that the analyzable patient must have the need for transference reactions, the capacity to regress and permit neurotic transference reactions, and have the ego strength or that particular form of ego resilience that enables him to interrupt his regression in order to reinstate the reasonable and purposeful working alliance (Cf. 23). The
patient's ego functions play an important part in the implementation of the working alliance in addition to a role in object relations. In order to do the analytic work the patient must be able to communicate in a variety of ways; in words, with feelings, and yet restrain his actions. He must be able to express himself in words, intelligibly with order and logic, give information when indicated and also be able to regress partially and do some amount of free association. He must be able to listen to the analyst, comprehend, reflect, mull over, and introspect. To some degree he also must remember, observe himself, fantasy, and report. This is only a partial list of ego functions that play a role in the patient's capacity to establish and maintain a working alliance; we also expect the patient simultaneously to develop a transference neurosis. Thus his contribution to the working alliance depends on two antithetical properties: his capacity to maintain contact with the reality of the analytic situation and also his willingness to risk regressing into his fantasy world. It is the oscillation between these two positions that is essential for analytic work.

**CONTRIBUTIONS OF THE ANALYTIC SITUATION**

Greenacre (18), Macalpine (24), and Spitz (28) all have pointed out how different elements of the analytic setting and procedures promote regression and the transference neurosis. Some of these same elements also aid in forming the working alliance. The high frequency of visits and long duration of the treatment not only encourage regression but also indicate the long-range objectives and the importance of detailed, intimate communication. The couch and the silence give opportunity for introspection and reflection as well as production of fantasy. The fact that the patient is troubled, unknowing, and being looked after by someone relatively untroubled and expert stirs up the wish to learn and to emulate. Above all the analyst's constant emphasis on attempting to gain understanding of all that goes on in the patient, the fact that nothing is too small, obscure, ugly, or beautiful to escape the analyst's search for comprehension—all
this tends to evoke in the patient the wish to know, to find answers, to find causes. This does not deny that the analyst's probings stir up resistances: it merely asserts that it also stirs up the patient's curiosity and his search for causality.

Freud stated that in order to establish rapport one needs time and an attitude of sympathetic understanding (8). Sterba (29) stressed the identificatory processes. The fact that the analyst continuously observes and interprets reality to the patient leads the patient to identify partially with this aspect of the analyst. The invitation to this identification comes from the analyst. From the beginning of treatment, the analyst comments about the work they have to accomplish together. The use of such terms as 'let us look at this', or 'we can see', promotes this. Loewald stressed how the analyst's concern for the patient's potentials stimulates growth and new developments (23).

Fenichel (2) believed it is the analytic atmosphere that is the most important factor in persuading the patient to accept on trial something formerly rejected. Stone (31) emphasized the analyst's willingness to offer the patient certain legitimate, controlled gratifications. I would add that the constant scrutiny of how the patient and the analyst seem to be working together, the mutual concern with the working alliance, in itself serves to enhance it.

CONTRIBUTIONS OF THE ANALYST

It is interesting to observe how some analysts take theoretical positions apparently in accord with their manifest personality and others subscribe to theories that seem to contradict their character traits. Some use technique to project, others to protect, their personality. This finding is not meant as a criticism of either group, since happy and unhappy unions can be observed in both. Some rigid analysts advocate strictest adherence to the 'rule of abstinence' and I have seen the same type of analyst attempt to practice the most crass manipulative, gratifying 'corrective emotional experience' psychotherapy. Many apparently care-free and easy-going analysts practice a strict 'rule of abstinence'
type of therapy while some of this same character provoke their patients to act out or indulge them in some kind of mutual gratification therapy. Some analysts practice analysis that suits their personality; some use their patients to discharge repressed desires. Be that as it may, these considerations are relevant to the problems inherent in the establishment of the working alliance. Here, however, only a brief outline of the problems can be attempted. The basic issue is: what characteristics of personality and what theoretical orientation in the analyst will insure the development of a working alliance as well as the development of a full-blown transference neurosis?

I have already briefly indicated how certain aspects of the analytic situation facilitate production of a transference neurosis. This can be condensed to the following: we induce the patient to regress and to develop a transference neurosis by providing a situation that consists of a mixture of deprivation, a sleeplike condition, and constancy. Patients develop a transference neurosis from a variety of different analysts as long as the analytic situation provides a goodly amount of deprivation administered in a predictable manner over a suitable length of time. For a good therapeutic result, however, one must also achieve a good working relationship.

What attitudes of the analyst are most likely to produce a good working alliance? My third case indicates how the patient identified himself with his previous analyst on the basis of identification with the aggressor, on a hostile basis. This identification did not produce a therapeutic alliance; it produced a combination of spite and defiance, and interfered with the psychoanalytic work. The reason for this was that the personality of the first analyst seemed cold and aloof, traits which resembled the patient's father and he was not able to differentiate his first analyst from his regressive transference feelings. How differently he reacted to me in the beginning. He was clearly able to differentiate me from his parent and therefore he was able to make a temporary and partial identification with me, and thus to do the analytic work.
The most important contribution of the psychoanalyst to a good working relationship comes from his daily work with the patient. His consistent and unwavering pursuit of insight in dealing with any and all of the patient's material and behavior is the crucial factor. Other inconsistencies may cause the patient pain, but they do not interfere significantly with the establishment of a working alliance. Yet there are analysts who work consistently and analytically and still seem to have difficulty in inducing their patients to develop a working alliance. I believe this may be due to the kind of atmosphere they create. In part, the disturbance may be the result of too literal acceptance of two suggestions made by Freud: the concept of the analyst as a mirror and the rule of abstinence (7), (10), (12). These two rules have led many analysts to adopt an austere, aloof, and even authoritarian attitude toward their patients. I believe this to be a misunderstanding of Freud's intention; at best, an attitude incompatible with the formation of an effective working alliance.

The reference to the mirror and the rule of abstinence were suggested to help the analyst safeguard the transference from contamination, a point Greenacre (18) has amplified. The mirror refers to the notion that the analyst should be 'opaque' to the patient, nonintrusive in terms of imposing his values and standards upon the patient. It does not mean that the analyst shall be inanimate, cold, and unresponsive. The rule of abstinence refers to the importance of not gratifying the patient's infantile and neurotic wishes. It does not mean that all the patient's wishes are to be frustrated. Sometimes one may have to gratify a neurotic wish temporarily. Even the frustration of the neurotic wishes has to be carried on in such a way as not to demean or traumatize the patient.

While it is true that Freud stressed the deprivational aspects of the analytic situation, I believe he did so because at that time (1912-1919) the danger was that analysts would permit themselves to overreact and to act out with their patients. Incidentally, if one reads Freud's case histories, one does not get the impression that the analytic atmosphere of his analyses was
one of coldness or austerity. For example, in the original record of the case of the Rat man, Freud appended a note, dated December 28, to the published paper (5), 'He was hungry and was fed'. Then on January 2, 'Besides this he apparently only had trivialities to report and I was able to say a great deal to him today'.

It is obvious that if we want the patient to develop a relatively realistic and reasonable working alliance, we have to work in a manner that is both realistic and reasonable despite the fact that the procedures and processes of psychoanalysis are strange, unique, and even artificial. Smugness, ritualism, timidity, authoritarianism, aloofness, and indulgence have no place in the analytic situation.

The patient will not only be influenced by the content of our work but by how we work, the attitude, the manner, the mood, and the atmosphere in which we work. He will react to and identify himself particularly with those aspects that need not necessarily be conscious to us. Glover (17) stressed the need of the analyst to be natural and straightforward, decrying the pretense, for example, that all arrangements about time and fee are made exclusively for the patient's benefit. Fenichel (2) emphasized that above all the analyst should be human and was appalled that so many of his patients were surprised by his naturalness and freedom. Sterba (30), stressing the 'let us look, we shall see' approach, hints at his way of working. Stone (31) goes even further in emphasizing legitimate gratifications and the therapeutic attitude and intention of the psychoanalyst that are necessary for the patient.

All analysts recognize the need for deprivations in psychoanalysis; they would also agree in principle on the analyst's need to be human. The problem arises, however, in determining what is meant by humanness in the analytic situation and how does one reconcile this with the principle of deprivation. Essentially the humanness of the analyst is expressed in his compassion, concern, and therapeutic intent toward his patient. It matters to him how the patient fares, he is not just an observer or a
research worker. He is a physician or a therapist, and his aim is to help the patient get well. He keeps his eye on the long-range goal, sacrificing temporary and quick results for later and lasting changes. Humanness is also expressed in the attitude that the patient is to be respected as an individual. We cannot repeatedly demean a patient by imposing rules and regulations upon him without explanation and then expect him to work with us as an adult. For a working alliance it is imperative that the analyst show consistent concern for the rights of the patient throughout the analysis. Though I let my patient see that I am involved with him and concerned, my reactions have to be nonintrusive. I try not to take sides in any of his conflicts except that I am working against his resistances, his damaging neurotic behavior, and his self-destructiveness. Basically, however, humanness consists of understanding and insight conveyed in an atmosphere of serious work, straightforwardness, compassion, and restraint (19).

The above outline is my personal point of view on how to resolve the conflict between the maintenance of distance and the closeness necessary for analytic work and is not offered as a prescription for all analysts. However, despite great variation in analysts' personalities, these two antithetical elements must be taken into account and handled if good analytic results are to be obtained. The transference neurosis and the working alliance are parallel antithetical forces in transference phenomena; each is of equal importance.

SUMMARY

Some analyses are impeded or totally thwarted by failure of patient and analyst to form a working alliance. Clinical examples of such failure are examined, showing how they were corrected. Formation of the working alliance, its characteristics, and its relation to transference are discussed. It is contended that the working alliance is equally as important as the transference neurosis.

REFERENCES

DEUTSCH, HELENE Some Forms of Emotional Disturbance and Their Relationship to Schizophrenia Psychoanal. Q. XI 1942 pp. 301-321
FENICHEL, OTTO Problems of Psychoanalytic Technique New York: The Psychoanal. Q., Inc., 1941
FREUD Notes upon a Case of Obsessional Neurosis 1909 Standard Edition X p. 303
FREUD The Dynamics of Transference 1912 Standard Edition XII
FREUD Recommendations to Physicians Practicing Psychoanalysis 1912 Standard Edition XII
FREUD On Beginning the Treatment 1913 Standard Edition XII
FREUD Remembering, Repeating and Working Through 1914 Standard Edition XII
GARMA, ANGEL Contribution to Discussion on The Curative Factors in Psychoanalysis Int. J. Psychoanal. XLIII 1962 pp. 221-224
GILL, MERTON M. Psychoanalysis and Exploratory Psychotherapy J. Am.
Psychoanal. Assoc. II 1954 pp. 771-797

GILL, MERTON M.; NEWMAN, RICHARD; AND REDLICH, FREDERICK


GREENACRE, PHYLLIS The Role of Transference. Practical Considerations in Relation to Psychoanalytic Therapy J. Am. Psychoanal. Assoc. II 1954 pp. 671-684


HEIMANN, PAULA Contribution to Discussion on The Curative Factors in Psychoanalysis Int. J. Psychoanal. XLIII 1962 pp. 228-231

KING, PEARL Contribution to Discussion on The Curative Factors in Psychoanalysis Int. J. Psychoanal. XLIII 1962 pp. 225-227

KUIPER, PIETER Contribution to Discussion on The Curative Factors in Psychoanalysis Int. J. Psychoanal. XLIII 1962 pp. 218-220

LOEWALD, HANS On the Therapeutic Action of Psychoanalysis Int. J. Psychoanal. XLI 1960 pp. 16-33
MACALPINE, IDA The Development of Transference *Psychoanal. Q.* XIX 1950 pp. 501-539 [→]


NACHT, SACHA The Curative Factors in Psychoanalysis *Psychoanal. Q.* XIX 1950 pp. 206-211 [→]

SEGAL, HANNA The Curative Factors in Psychoanalysis *Psychoanal. Q.* XIX 1950 pp. 212-217 [→]


STERBA, RICHARD The Fate of the Ego in Analytic Therapy *Int. J. Psychoanal.* XV 1934 pp. 117-126 [→]

STERBA, RICHARD The Dynamics of the Dissolution of the Transference Resistance *Psychoanal. Q.* IX 1940 pp. 363-379 [→]


ZETZEL, ELIZABETH R. Current Concept of Transference *Int. J. Psychoanal.* XXXVII 1956 pp. 369-376 [→]