

individuals themselves (*wiederherstellen* is a standard expression for 'restore to health').]

12. [*Massenpsychologie*. In the *Standard Edition* this term is routinely translated as 'group psychology'.]

13. [*Umbildung*.]

Remembering, Repeating, and Working Through

It seems to me by no means superfluous to remind the student of psychoanalysis again and again of the profound changes that psychoanalytical technique has undergone since its first beginnings. First of all, in the phase of catharsis as practised by Breuer, the technique was to focus directly on the factor of symptom-formation, and make a rigorously sustained attempt to reproduce the psychic processes of that situation in order to resolve them through conscious activity. Remembering and abreacting¹ were the goals at that stage, to be achieved with the help of hypnosis. Once hypnosis had been discarded, the task that then demanded our attention was to use the free associations of the patient to work out what he himself was failing to remember. The process of interpretation and the communication of its results to the patient were seen as the means to overcome the resistance within him; there was still the same focus on the situations in which the symptoms first arose, and any others that proved to underlie the onset of the illness, whilst abreaction diminished in importance and appeared to be replaced by the considerable effort that the patient had to expend when forced to overcome his hostility towards his free associations (in accordance with the basic rule of psychoanalysis). Then finally the rigorous technique of the present time evolved whereby the physician no longer focuses on a specific factor or problem, but is quite content to study the prevailing surface-level of the patient's mind, and uses his interpretative skills chiefly for the purpose of identifying the resistances manifest there, and making the patient

conscious of them. A new kind of division of labour then comes into being: the physician reveals the resistances that were hitherto unknown to the patient; and once these have been overcome, the patient often recounts without any difficulty the situations and contexts that he had forgotten. The goal of these various techniques has of course remained the same throughout; in descriptive terms, to fill the gaps in the patient's memory; in dynamic terms, to overcome the resistances brought about by repression.

The old technique of hypnosis still deserves our gratitude for having shown us in discrete and schematized form a number of psychic processes that occur in analysis. It was thanks to this alone that we were able to develop the boldness, within psychoanalytic practice itself, to create complex situations and keep them transparent.

'Remembering' took a very simple form in these hypnotic treatments. The patient reverted to an earlier situation, which he appeared never to confuse with his present one, conveyed the psychic processes of that earlier situation in so far as they had remained normal, and in addition conveyed whatever resulted from translating the unconscious processes of that time into conscious ones.

I shall add a few remarks at this point that every analyst has seen confirmed by his own experience.² The forgetting of impressions, scenes, experiences comes down in most cases to a process of 'shutting out' such things. When the patient speaks of these 'forgotten' things, he rarely fails to add: 'I've always known that really, I've just never thought about it.' He not uncommonly expresses disappointment that so few things seem to want to come to mind that he can acknowledge as 'forgotten', things that he has never thought about again since the time they happened. Even this yearning, however, is capable of being gratified, particularly in the case of conversion hysterics.³ The term 'forgetting' becomes even less relevant once there is due appreciation of the extremely widespread phenomenon of screen-memories.⁴ In quite a number of cases of childhood amnesia,⁵ that familiar condition so important to us in

theoretical terms, I have gained the impression that the amnesia is exactly counterbalanced by the patient's screen-memories. These memories contain not merely *some* essential elements of the patient's childhood, but *all* such elements. One simply has to know how to use analysis to retrieve these elements from the memories. The latter represent the forgotten childhood years as completely as the manifest content of dreams represents the dream-thoughts.

The other group of psychic processes which, as purely internal acts, can be contrasted to impressions and experiences – fantasies, relational processes,⁶ emotional impulses, thought-connections⁷ – need to be considered separately as regards their relationship to forgetting and remembering. Something that occurs particularly frequently here is that something is 'remembered' that can never have been 'forgotten', since it was never at any point noticed, never conscious; moreover it appears to make no difference whatsoever to the psychic outcome whether such a 'connection' was a conscious one that was then forgotten, or whether it never reached the status of consciousness in the first place. The conviction that the patient arrives at in the course of analysis is entirely independent of this kind of memory.

Particularly in the case of the many forms of obsessional neurosis, forgetting is limited in the main to losing track of connections, misremembering the sequence of events, recalling memories in isolation.

A memory usually cannot be retrieved at all in the case of one particular group of extremely important experiences, namely those occurring at a very early stage of childhood that are experienced at the time without understanding, but are then *subsequently* understood and interpreted. We become aware of them via the patient's dreams, and are compelled to credit their existence by overwhelming evidence within the overall pattern of the neurosis; we are also persuaded by the fact that, once the patient has overcome his resistances, he does not see the absence of a memory or sensation of familiarity as grounds for not accepting that they took place. This topic needs to be approached with so much care, however, and introduces so much that is new and disturbing, that

I shall deal with it quite separately with reference to appropriate material.⁸

Now the introduction of the new technique has meant that very little, and in many instances nothing whatever, has remained of this splendidly smooth progression of events. Here, too, there are cases that initially develop just as they would under the hypnotic technique, only to diverge at a later stage; other cases behave differently right from the outset. If for the purposes of defining the difference we stick to the latter type, then we may say that the patient does not *remember* anything at all of what he has forgotten and repressed, but rather *acts it out*. He reproduces it not as a memory, but as an action; he *repeats* it, without of course being aware of the fact that he is repeating it.

For example, instead of the patient recounting that he remembers having been defiant and refractory *vis-à-vis* his parents' authority, he behaves in just such a manner towards the physician. Instead of remembering that he became hopelessly stuck in his infantile sexual explorations, he presents a mass of confused dreams and associations, wails that he is no good at anything, and sees it as his fate never to bring any undertaking to a successful conclusion. Instead of remembering that he was intensely ashamed of certain sexual activities and fearful of discovery, he exhibits shame regarding the treatment that he has embarked upon, and tries to keep it secret from all and sundry – and so on.

More particularly, he *begins* the treatment with just such a repetition. Often when one has explained the basic rule of psychoanalysis to a patient with an eventful life story and a long history of illness, and asks him to say whatever comes into his mind, and then expects a stream of utterances to come bursting forth, the first thing one discovers is that he has no idea what to say. He remains silent, and maintains that nothing at all has come into his mind. This is of course nothing other than the repetition of a homosexual stance, which manifests itself as a resistance to remembrance of any kind. He remains in the grip of this compulsion to repeat for as long as

he remains under treatment; and in the end we realize that this is his way of remembering.

What is chiefly going to interest us, of course, is the relationship that this repetitional compulsion bears to the transference and the resistance exhibited by the patient. We soon realize that the transference is itself merely an instance of repetition, and that this repetition involves transference of the forgotten past not only onto the physician, but onto all other areas of the patient's current situation. We must therefore expect that the patient will yield to the compulsion to repeat – which now takes the place of the impulse to remember – not only in his personal relationship to the physician, but in all other activities and relationships taking place in his life at the same time; for example, if during the course of the treatment he chooses a love-object, takes some task upon himself, involves himself in a project of any sort. The role played by resistance is also easy to recognize. The greater the resistance, the more thoroughly remembering will be replaced by acting out (repetition). After all, in hypnosis the ideal form of remembering corresponds to a condition in which resistance is completely pushed aside. If the treatment begins under the aegis of a mild and tacit regime of positive transference, this initially encourages submergence in the domain of memory (just as happens in hypnosis), during the course of which even the symptoms of the patient's illness are mute; however, if this transference subsequently becomes hostile or unduly intense, and therefore needs to be repressed, then remembering immediately gives way to acting out. From that point onwards it is the resistances that determine the sequence of what is repeated. The patient uses the arsenal of the past to arm himself with weapons to fight against the continuation of the treatment – weapons that we have to wrest from him one by one.

Now having seen that the patient repeats rather than remembers, and does so under conditions of resistance, we may now ask what it really is that he repeats or acts out. The answer is that he repeats everything deriving from the repressed element within himself⁹ that has already established itself in his manifest personality – his inhibitions and unproductive attitudes, his pathological

characteristics. Indeed, he also repeats all his symptoms during the course of the treatment. And we can now see that in emphasizing the compulsion to repeat we have not discovered a new fact, but merely arrived at a more coherent view. It is now quite plain to us that the start of a patient's analysis does not mean the end of his illness, and that we need to treat the illness not as a matter belonging to the past, but as a force operating in the present. Piece by piece the entire illness is brought within the scope and ambit of the treatment, and while the patient experiences it as something intensely real and immediate, it is our job to do the therapeutic work, which consists to a very great extent in leading the patient back to the past.

Getting the patient to remember, as practised in hypnosis, inevitably had the air of a laboratory experiment. Getting the patient to repeat, as practised under the more modern technique of analysis, means summoning up a chunk of real life, and cannot therefore always be harmless and free of risk. The whole problem arises here of 'deterioration during treatment', a phenomenon that often proves unavoidable.

Most importantly, the very inception of the treatment itself necessarily induces a change in the patient's conscious attitude to his illness. As a rule he has been content up to then to bemoan his illness, to despise it as so much nonsense and to underestimate its significance, whilst for the rest applying the same repressive behaviour, the same head-in-the-sand strategy, to the manifestations of his illness that he applied to its origins. Thus it can happen that he does not properly appreciate the conditions under which his phobia functions, does not listen carefully enough to what his obsessional ideas are saying to him, or does not grasp the real intention of his obsessional impulse. This of course is the last thing his treatment needs. He has to find the courage to focus his attention on the manifestations of his illness. He must no longer regard the illness as something contemptible, but rather as a worthy opponent, a part of his very being that exists for good reasons, and from which he must extract something of real value for his subsequent life. The way is thus prepared from the outset for him to be

reconciled with the repressed element within himself, which expresses itself in his symptoms, whilst at the same time allowing for a certain tolerance towards his illness. And if as a result of this new relationship to his illness the patient's conflicts are exacerbated, or if symptoms are forced into the open that had previously remained in the shadows, then one can easily reassure him on this score by pointing out that these merely constitute a necessary but transitory deterioration in his condition, and that one cannot destroy an enemy if he is absent or out of range. However, the resistance can exploit the situation for its own ends and seek to abuse the licence to be ill. It then seems to exclaim: 'Look what happens when I really do let myself become involved in these things! Wasn't I quite right to consign them all to repression?' Juvenile and child patients are particularly prone to use the focus on their illness necessitated by their treatment as an excuse to wallow in their symptoms.

Further dangers arise as treatment progresses, in that new, more deep-seated drive-impulses – still nascent rather than fully established – can emerge as repetition. Lastly, the patient's actions outside the transference process can cause temporary harm in his everyday life, indeed can be so chosen as to permanently undermine that very condition of health that the treatment is meant to achieve.

The tactic that the physician has to adopt in this situation is easily justified. The goal that he holds fast to, even though he knows it to be unattainable under the new technique, remains the old form of remembering, that is, reproducing things within the psychic domain. He prepares himself for a constant battle with the patient, in order to keep within the psychic domain all those impulses that the patient would prefer to divert into the motor domain, and regards it as a therapeutic triumph when he successfully uses the remembering process to resolve an issue that the patient would rather get rid of in the form of an action. If the bond formed through transference is at all effective, then the treatment will successfully prevent any really significant acts of remembering on the part of the patient, and will use the nascent stage of any attempts at such acts as material contributing to the therapeutic process. One can best protect the patient from being damaged

through giving rein to his impulses if one puts him under an explicit obligation not to make any decisions during the course of his treatment that vitally affect his life, such as choosing a career or a definitive love-object, but instead to wait until he is fully recovered.

In doing this, however, it is sensible to give scope to such aspects of the patient's personal freedom as are consistent with these precautions, and not to stop him from carrying out intentions which, though foolish, are without consequence, whilst also bearing in mind that people can really only achieve insight through their own hurt and their own experience. There are indeed also cases in which the patient cannot be prevented from entering upon some wholly inappropriate undertaking, and which only later become ripe for psychoanalytical treatment, and responsive to it. Occasionally there are also bound to be cases where one does not have the time to put the bridle of transference on a patient's rampant drives, or where the patient in the course of an act of repetition destroys the bond that ties him to the treatment. As an extreme example of this I might mention the case of an elderly lady who, when afflicted by twilight states,¹⁰ had repeatedly left home and husband and fled somewhere or other without ever becoming conscious of the force impelling her to 'run away' in this manner. On starting her treatment with me she displayed a well-developed form of affectionate transference, this intensified with uncanny rapidity over the first few days, and by the end of the week she had 'run away' from me too, without my having had the time to say anything to her that might have prevented this repetition.

However, the chief means for controlling the patient's compulsion to repeat, and turning it into a means of activating memory,¹¹ lies in the way that the transference is handled. We render the compulsion harmless, indeed beneficial, by allowing it some sovereignty, by giving it its head within a specific domain. We offer it transference as a playground in which it has licence to express itself with almost total freedom, coupled with an obligation to reveal to us everything in the way of pathogenic drives that have hidden themselves away in the patient's psyche. The patient's cooperation need extend only as far as respect for the conditions of existence

of the analysis, and, provided this is the case, we can routinely succeed in giving all the symptoms of his illness a new meaning in terms of transference; in replacing his ordinary neurosis with a transference neurosis, of which he can be cured through the therapeutic process. Transference thus creates an intermediate realm between sickness and a healthy life by means of which the transition from one to the other is accomplished. The new condition has assumed all the characteristics of the illness, but it constitutes an artificial illness that is in all respects amenable to treatment. At the same time it is a real, lived experience, but one made possible by particularly favourable conditions, and purely temporary in nature. The repetition reactions exhibited in transference then lead along familiar paths to the reawakening of memories, which surface without any apparent difficulty once the patient's resistances have been overcome.

I could close here if it were not for the fact that the title of this essay obliges me to demonstrate one further element of psychoanalytical technique. As is well known, what opens the way to the overcoming of resistances is that the physician identifies the resistance that the patient himself had never recognized, and reveals it to him. Now it seems that beginners in the practice of analysis are inclined to think that this purely preliminary phase constitutes the entire task. I have often been asked for advice in cases where the physician complained that he had shown the patient his resistance, yet nothing had changed; indeed, the resistance had merely intensified and the entire situation had become even more impenetrable than before. The treatment seemed to be going nowhere. But this gloomy assessment invariably proved to be wrong. In most cases the treatment could not have been going better, the physician had simply forgotten that identifying the resistance can never result in its immediate cessation. One has to give the patient time to familiarize himself with the resistance now that he is aware of it, to *work his way through it*, to overcome it by defying it and carrying on with the therapy in accordance with the basic rule of analysis. Only when the resistance is at its most intense can one

manage in cooperation with the patient to detect the repressed drive-impulses that sustain the resistance; and it is only by directly experiencing it in this way that the patient becomes truly convinced of its existence and power. The physician need do nothing other than wait, and allow things to take their course – a process that cannot be prevented, and cannot always be accelerated. If he bears this steadfastly in mind, he will often save himself from the delusion that he has failed, when in fact he is conducting the treatment along entirely the right lines.

This process of working through the resistances may in practice become an arduous task for the patient and a considerable test of the physician's patience. But it is the phase of treatment that effects the biggest change in the patient, and which distinguishes psychoanalytical treatment from any form of suggestion-based therapy. Theoretically speaking, one can equate it to the 'abreacting'¹² of the emotional quanta pent up through repression that hypnotic treatment entirely depended on for its success.

(1914)

Notes

1. [*Abreagieren*. The term, together with the attendant therapeutic concept, was introduced by Freud and Breuer in their *Studien über Hysterie* (*Studies in Hysteria*, 1895). 'Abreaction' is defined in the *OED* as follows: "The liberation by revival and expression of the emotion associated with forgotten or repressed ideas of the event that first caused it. Hence "abreact", to eliminate by abreaction'. In *Inhibition, Symptom, and Fear* (published twelve years after *Remembering, Repeating, and Working Through*), Freud was to comment that he had long since 'abandoned the abreaction theory'.]
2. [This paragraph and the three that follow – all printed in smaller type than the rest of the text when first published in 1914 – amount to an extended parenthesis, interpolated between two paragraphs that essentially belong together.]
3. [*Konversionshysterien*. 'Conversion' in Freud's sense is defined in the *OED* as "The symbolic manifestation in physical symptoms of a psychic

conflict'; the *OED* entry also includes the following quotation from Freud's disciple Ernest Jones: "The energy finds an outlet in some somatic manifestation, a process Freud terms "conversion"."]

4. [*Deckertinnerungen*. The *deck*-element of the neologism means 'cover', 'conceal'.]
5. [*Kindheitsamnesie*. 'Childhood amnesia' in Freud's sense is amnesia concerning childhood – not amnesia during childhood.]
6. ['Relationary processes' is more a guess than a translation. Freud's neologism is *Beziehungsvorgänge* – and there is no clue as to which of the various meanings of the word *Beziehung* he had in mind. The *Standard Edition* offers 'processes of reference'.]
7. ['Thought-connections' is also a guess – all the wilder for the fact that in itemizing the various 'psychic processes', Freud chooses a word (*Zusammenhänge*) that cannot by any stretch of the imagination be used to describe a 'process' . . .]
8. [Freud is referring to the case of the 'Wolf-man'.]
9. [*aus den Quellen seines Verdrängten*. Freud's key term *das Verdrängte* is not easy to render in English: the direct translation is 'the repressed', but substantivized past participles tend in English to refer to *people*, not to things or to abstracts ('the damned', 'the defeated', 'the oppressed', etc.). The traditional 'techno'-translations of Freud have long since established 'the repressed' as the English jargon-word, but in many contexts the term would not be readily comprehensible to the non-specialist reader.]
10. [*Dämmerzustände*.]
11. [Here – as also in the penultimate sentence of the preceding paragraph, and on numerous other occasions throughout these essays – Freud uses the term *Motiv*. The *Standard Edition* routinely translates this as 'motive', but this is potentially misleading: whereas 'motive' commonly refers to the *purpose* of an act, i.e. the end result envisaged by its perpetrator ('the killer's motive was money'), *Motiv* in Freud's usage almost invariably seems to be a quasi-scientific, not to say mechanistic term meaning 'motive force', thus relating to the *generation* of an act or event, not to any supposed aim or purpose.]
12. [The inverted commas are Freud's.]