3

Speaking to the Preconscious

Its importance in the analysand's understanding[1]

One of the most important changes in technique that evolved over the last 35 years revolves around working more closely with what is most accessible to the analysand in the clinical moment rather than what is least accessible. We've learned, belatedly and not always consistently, *that one cannot interpret what is unconscious without preparation for making it accessible to preconscious thinking. Working in the preconscious cuts across theoretical lines, and is the basis for one element in a new common ground. Further, it is a crucial ingredient in creating a psychoanalytic mind. If the analysand cannot grasp how understanding comes from his own mind, it is difficult to see how he can use his mind to analyze the struggles the mind creates*.

In 1993 I introduced the term *in the neighborhood*, which came from Freud's (1910) paper, "'Wild' Psycho-Analysis." It was an attempt to capture a way of working analytically that was closer to what was available to a patient in a way that was deeper than what was conscious, but wouldn't arouse undue anxiety. It seemed to me that this was the most advantageous way of helping patients move slowly into the realm of the unconscious. When I wrote the paper my interest was primarily in understanding the role of the ego in this process, but over time it became clear to me that I was also suggesting interpreting to what was *preconscious* (Busch, 2006a). More on this later.

Let me go back briefly to describe how Freud came to the term *in the neighborhood*. In his paper Freud tells of a woman consulting him after having gone to a young physician for problems with anxiety after a recent divorce. The physician diagnosed the women's problems as due to lack of sexual satisfaction and suggested various sexual activities as a remedy. Freud chided the physician for assuming that the woman's primary problem was a lack of information, and providing this would result in cure. He presented the difficulty with this approach using captivating metaphors:

> If knowledge about the unconscious were as important for the patient as people inexperienced in psycho-analysis imagine, listening to lectures or reading books would be enough to cure him. Such measures, however, have as much influence on the symptoms of nervous illness as a distribution of menu-cards in a time of famine has upon hunger … Since, however, psycho-analysis cannot dispense with giving this information, it lays down that this shall not be done before two conditions have been fulfilled. First, the patient must, through preparation, himself have *reached the neighborhood of what he has repressed*, and secondly, he must have formed a sufficient attachment (transference) to the physician for his emotional relationship to him to make a fresh flight impossible.
>
> (1910, pp. 225–226; italics added)

By introducing the concept of the analysand needing to be "in the neighborhood" Freud is noting the centrality, among the principles of clinical technique, of the preconscious. The patient must be able to make some

connection between what he is aware of thinking and saying, and the analyst's intervention. No matter how brilliant the analyst's reading of the unconscious, it is not useful data until it can be connected to something the patient can be preconsciously aware of. From this perspective the young physician Freud described did not consider what his patient might understand, let alone if she might find his intervention objectionable. The potential difficulties with this approach are succinctly captured by Freud (1910) in the following:

Attempts to "rush" him at first consultation, by brusquely telling him the secrets, which have been discovered by the physician, are technically objectionable. And they mostly bring their own punishment by inspiring a hearty enmity towards the physician on the patient's part and cutting him off from having any further influence.

(p. 226)

Freud (1914) elaborated this changing view of the psychoanalytic method when he stated,

Finally, there was evolved the consistent technique used today, in which the analyst gives up the attempt to bring a particular moment or problem into focus. He contents himself with studying whatever is present for the time being *on the surface of the patient's mind*.

(p. 147, italics added)[2]

However, Freud remained ambivalent towards this perspective in future writings (Busch, 1993), and it remains more honored in the breach. Indeed, for much of

our history an analysand's associations were used as sparks for the analyst's attempt to make unconscious contact with the unconscious derivatives in the surface material, and interpretations were expected to deeply penetrate into the unconscious.[3]

Freud's espousal of two different principles for bringing what was unconscious into consciousness (i.e., first and second theory of anxiety) remained as the basis for two different paradigms for interpretation. These are:

(a) Making direct contact with the unconscious.

(b) Interpreting to what is in the preconscious neighborhood.

The validity of each approach was captured in two papers published simultaneously by Sterba (1934) and Strachey (1934), which will be discussed in more detail in in the final chapter.

Preconscious thinking

Buried in Freud's (1915) paper on the unconscious he briefly conceives of *complex preconscious thinking with infusions of unconscious elements*. In a few sentences, Freud, still in his topographical model, presents a view of *preconscious thinking that goes from a permeable border of the system Ucs to the permeable border of the system Cs*. However, Freud remained ambivalent about this idea, and in his last published paper Freud (1940) returns again to define the concepts of conscious, preconscious, and unconscious, by stating that everything that isn't conscious, in the everyday use of this term, is (descriptively) unconscious. Preconscious

thoughts become, again, as thoughts that are capable of becoming conscious. The preconscious remained in this murky territory until rescued by French psychoanalysts. In a key paragraph, Green (1974) captured two elements of the significance of preconscious thinking for the psychoanalytic method … i.e., the psychic levels at which we listen and respond to our patients.

The analysis of the preconscious and in particular the use of the patient's analytical material (in his own language) has been neglected since Freud. The reason for this appears to be straightforward in that, since the preconscious can be reached by the conscious, the importance of the preconscious is negligible and language is superficial. To me, however, this viewpoint is superficial itself. The preconscious, as we have seen, is a privileged space where both the analyst and the patient can meet to share part of the transference and go forward together. *There is no point in the analyst running like a hare if the patient moves like a tortoise*.

(1974, p. 421, italics added)

In this paragraph Green highlights the significance of the preconscious in two ways: (1) the importance of a patient's preconsciously driven verbalized associations; and (2) the analyst's interpretation taking into account what is
preconsciously available for the patient to hear. In general, working with the preconscious in mind leads to:

1 Listening for what derivatives are available to the patient in her associations as a guide to the patient's capacity to understand and utilize an intervention in an

emotionally and cognitively meaningful manner, and the ways the analyst functions that may foster or hinder this process.

2 Listening to patient material and thinking about the interpretive process differently than we did earlier in our history, where interpretations seemed based less on what patients could hear, and more on what the analyst could understand at a deep level.

We can see the essence of these views articulated by analysts of very different theoretical persuasions.

- The interpretation arises at the moment when the analyst considers that he has understood the point of urgency *and worked out how to make it accessible, at least in part, to the patient's understanding* (Baranger, 1993, p. 23).

- No interpretation can be seen as a pure interpretation or explanation but *must resonate in the patient in a way that is specific to him and his way of functioning* (Joseph, 1985, p. 447).

- *I do believe, however, that it is essential to respect the patient's threshold for tolerating interpretations, and to recognize that a feeling of persecution in the session is a glaring sign of excessive insistence* (Ferro, 2003, pp. 189–190).

How does all of this look in the clinical moment? Here is an example from a supervisee.

The patient, a 30-year-old man, came to analysis because of his never having had a long-term relationship with a

woman, often feeling inadequate, and unable to even approach a woman he was interested in. His analyst is a woman. Around the sixth month of treatment, after another failed attempt to make an impression on a woman, the patient remembered a time when he was about 5.

Patient: I was in the schoolyard, playing baseball, and I wanted to hit the ball very hard to show how big and strong I was. I wanted to show off. I hit the ball and it dribbled off my bat. When I ran to first base I fell down. I hit my head on the concrete and started to cry. The girls who were watching found it very funny, and started to laugh. I felt like an idiot.

Analyst: I wonder if you feel I don't appreciate your strength.

We can all understand how the analyst might come to this interpretation. However, *it's about what's not there in the patient's thoughts, what's hidden, what's absent, rather than what is there that might be preconsciously available*. I would think about saying:

"At one time you wanted to show off for a girl how strong you were, but you associate it with being made to feel like an idiot. It seems to be linked to why it's difficult for you to approach a woman. In your mind, to try is to fail."

In this I would be trying to stay closer to what is available to the patient. After this unsuccessful evening with a woman he has a memory of feeling like an idiot when he tries to show off his 5-year-old maleness. He is

able to make this association, and therefore it is possible to link them together. The patient isn't showing any resistance to the analysis at this moment, or holding back thoughts, so why bring in the transference? We tend to bring in what's least available, while avoiding what's still new and available. Further, the analyst is not helping the patient see how his mind works. He might rightfully wonder why the analyst thought this had to do with her. It can lead to a routinized search for transference, rather than a dynamic living out that gives transference interpretations credence for the analysand.

Going deeper by determining preconscious availability

There is no easy answer to how we determine the availability of material to the analysand's preconscious. Descriptively, the music of the words tells us a lot about the patient's state of mind. Further, it is only over time we learn whether we learn such things as whether telling a dream is part of a newly found ability to represent unconscious derivatives, or the beginning of an obsessive monologue. *In general, the availability to preconscious awareness is based upon a combination of the state of the ego, along with the drive to enact*.

Thus, one of the first considerations is the degree of anxiety or threat (to the ego), as seen in the strength of the resistances. When resistances are lowered, the analysand is often able to have narrative associations that open up new meanings. However, as almost anything can be used as a resistance, when the patient is in a more resistant mode it can sometimes be difficult to determine. Any outward sign of a productive analysis can be its opposite. Free association, reporting dreams,

agreeing with an interpretation, etc. … all can be potential resistances. Over time the analyst can better understand these activities, and their potential readiness for preconscious accessibility, by their role in the progression or regression of the analysand.

It is my impression that we have the greatest difficulty in considering the degree of resistance *when interpreting transferences*. Often we confuse our ability to see transference implications with the patient's readiness to preconsciously understand them. Here is an example, which demonstrates our readiness to interpret transferences when the patient is resisting such an interpretation.

In the first year of his analysis, a young man comes into a session angrily denouncing a professor who lectures, "without thinking of whether the students can follow." As he continues in this vein, he slips and says that he hates "to have
him treat – I mean, teach me." He then challenges the analyst with the comment, "I suppose you will make something of that." When the patient continues to complain about the professor, then the analyst tells him, "Aren't you trying to run away from your anger toward me?"

As we can see, from the beginning of this vignette the analyst seems not to be taking into account what may be preconsciously available to the patient. As with the analysand's complaint about his professor, he does not consider "whether the students can follow." The patient challenges the slip, which indicates the patient has already made the unconscious connection between his

feelings about the analyst and the professor. It is clear the patient is in a feisty mood, and connections between the analyst and the professor will not be welcome. However, the analyst ignores this, and goes ahead and makes the transference connection anyway. What he did not pursue was the patient's reluctance to make a connection between the analyst and the professor (i.e., the most observable component of the resistance at that time).[4]

Interpreting split-off enactments

One of the most difficult times to determine preconscious availability is when the patient is driven to enact something, while it is simultaneously split off from the ego. The analyst is in the position of observing a crucial dynamic, while the analysand is desperately protecting herself from awareness of that same dynamic. In general it is most helpful to approach this issue from the protective side. That is, the patient isn't aware of the panic that drives the split-off nature of her behavior, and the analyst's appreciation of this side of the dynamic helps the patient approach what is driving the enactment. In general, understanding in terms of *self-preservation and/or object preservation*[5] is most readily available to the patient. The idea that the patient is *protecting* him or herself, or another (whether from the past or present), is usually accurate and less anxiety provoking than whatever else may be going on. However, with the narcissistic/borderline character, it may even be difficult to do this at times, as the analyst assuming he knows anything about the patient, or the idea that the patient has

a problem, can feel denigrating to him. A typical example is the following.

A businessman in his fifties, with narcissistic rage barely covered by reaction formations, and a sexual perversion, spoke in a manner I would call tightly controlled associations. That is, his thinking had the appearance of freely associating, but it rarely led to any deeper understanding, and was often confusing. His sudden bursts of crying were mystifying, and seemed like a parody of a patient in analysis. The analysand later was able to talk about how he planned out everything he was going to say in the sessions, and that while his crying was genuine, it was what he felt he should do whenever he recalled a painful memory after reading a novel where the primary character did this in his analysis. After several months of interpreting the content with little change occurring, the analyst said that *it seemed like the patient was having difficulty freely saying what was on his*
mind, but instead kept returning to specific traumatic events in his life to relive them. After a long silence, the patient said, "It felt like you just threw cold water on me." In subsequent sessions the patient transferred ownership of this comment to the analyst, and continued his idealization of the analyst while subtly returning to his particular use of free association.

In this example when the patient's control of the method of free association (i.e., emoting as a defense) is questioned, we can see how his anger is projected, split off, and continued at the same time. Careful attention to these defenses, *the catastrophic fears that motivated*

them, and the continued appreciation of the way the patient needed to keep in control of what was coming to mind to ward off narcissistic humiliation, eventually proved fruitful. The patient who continues to feel outraged, while blaming the analyst for his feelings, is one of the knottiest problems for psychoanalysts. One of the major challenges for the analyst at these times is to contain one's countertransference reaction, while paying attention to what it may tell us about the myriad possibilities of what is being enacted with us. However, it isn't easy to appreciate the patient's narcissistic vulnerability when our incompetence is constantly pointed out in an arrogant fashion, leading to our own narcissistic imbalance.

Going deeper by going slower – an extended clinical example

In the example to follow, gauging the availability of the analysand's preconscious via careful attention to the fluctuating state of his defenses, leads the patient to deeper material. Though I may be thinking about deeper unconscious meanings while listening to my patient, it is my ongoing evaluation of the many factors that determine preconscious availability that leads me to intervene as I do.

The patient, Michael,[6] a man in his mid-thirties, had been unable to practice his profession, despite a brilliant academic record. When he came to analysis he was unclear about what had led him to leave his most recent position. He could cite only vague feelings of anxiety and irritation. Similar problems had occurred through undergraduate and graduate school, but with supportive

therapy over many years he finally completed his studies. He came to analysis after having left several positions. His relations with both men and women were superficially pleasant but devoid of any sustained involvement or emotional depth. Recently, hints of homosexual anxiety came to the foreground. The patient's early history was dominated by the early divorce of his parents, in conjunction with his mother's mercurial temperament and his father's self-absorption. Yet there was a basic structural integrity to the family, with both parents continuing to offer a presence, despite their emotional absence.

Michael is in the fifth year of his analysis. After a rocky start, including frequent absences and moving between the chair and the couch, the analysis has seemed to move productively. His increasing freedom with a range of feelings and thoughts has been accompanied by a sustained, if tumultuous, relationship with a woman in which marriage has been proposed, and steps toward a professional position commensurate with his interests and skills.

Michael's girlfriend was at his place for the entire weekend, which seemed another symbolic step in cementing their relationship. He came in describing how upset he had been most of the weekend. His speech was pressured, with a panicky tone to it. This was unusual at this time in the treatment. The primary conscious focus of his upset was a sore on the side of his mouth that had seemed to get worse over the weekend. He struggled with a tendency toward feeling convinced this was a spreading cancer, the result of an AIDS virus, and noted

that there was significant swelling in a lymph node on his neck. Although he "knew" this was a premature diagnosis, his mind kept going back to the most frightening possible causes of the sore with a sense of certainty that led to a feeling of terror and doom. This alternation between worrying over a potentially fatal illness and assuring himself it wasn't so was repeated in the session. For example, after stating how absurd his concern was at this point, he would go to thoughts that clearly indicated that he needed further reassurance; for example, one thought he used to reassure himself was that he remembered giving blood just last month and had been screened for the AIDS virus. He had fooled around with a woman from work a few weeks ago, but neither of them had taken their clothes off. Yet all weekend he had kept looking in the mirror, convinced the area was rapidly spreading. His girlfriend's assurances were only temporarily comforting.

Noteworthy during this part of the session was the fluid state of Michael's ego, with a tendency toward more regressed functioning. He was in the grip of a powerful unconscious force. In spite of his brief preconscious "awareness" that it was premature to panic, he kept being drawn to do so. The regression was notable in that it harkened back to earlier times in the analysis, when he could easily feel panicky. We see the theme that he is being punished for his sexual activity; however, given Michael's ego regression at the moment, it would be difficult to interpret in a way that could be meaningfully integrated by him. Michael is not sure at this moment whether his panicky feeling is based on a realistic possibility or is all in his mind. (The diagnosis, made

later in the week, was that he had a cold sore.) An interpretation might alleviate some of his anxiety via acceptance of my perspective on the basis of authority. However, given Michael's general psychological resilience at this point in the analysis, and his growing capacity for and interest in self-exploration, it seemed in his best interest to see what he could do with these feelings on his own – a decision based also on the principle that the analytic process should be viewed as a growing partnership (Busch, 1995a; Gray, 1994). With a patient who was less resilient, if I felt sure of my judgment, I might intervene more quickly as a way of helping him understand that this feeling he was having was potentially understandable. However, I think it is imperative that we not move too quickly to interpret Michael's experience. It is Michael's fear, and we should treat it respectfully and seriously. It should be interpreted when he is ready to have it interpreted, or we run the risk of dismissing the authenticity of his experience.[7] *While the work of analysis necessarily includes*

investigating the analysand's views based on unconscious fantasies and relational models, this is far subtler than I believe we have considered. Every interpretation can be viewed as an attempt to balance the questioning of perceived meaning in a way that does not iatrogenically undermine the analysand's appreciation of his thoughts. We want patients to end up with curiosity about their thoughts, and this goal is compromised by our seeing those thoughts primarily as raw material for content interpretations, and by our not taking their experience into account in considering what is closest to preconscious availability. While at a given

moment it may be necessary to privilege the analyst's perspective, as an unquestioned, constant therapeutic attitude the approach has drawbacks.

Michael's thoughts then went to the past weekend, and how he had kept vacillating between thinking he would marry his girlfriend or break off the relationship. Something similar had happened earlier with regard to taking a high-powered position he'd been offered. At times he was convinced he would take it; at others he thought of leaving his profession completely. He then described how, in the midst of sex with his girlfriend over the weekend, he had lost his erection. He then went into familiar obsessional detail about whether, or to what degree, he finds her sexually attractive. He focused on the smallness of her breasts. He then noted, with some irony, that on occasion during the weekend he had found himself thinking longingly about a woman who lives in his neighborhood, and whom he frequently sees jogging in the morning. He was struck by the fact that, when he thought about it, she was built remarkably like his girlfriend, with smallish breasts.

Here in the session we see a beginning shift in ego functioning, whereby Michael can begin to observe his thoughts. He recognizes that the jogger he is attracted to has the same characteristics as his girlfriend, who he feels is not sexually attractive enough. The panic is now gone from his voice, and his whole manner is shifting to a more reflective mode. Given that this shift is taking place, I find it prudent to see what develops next. Such a shift in the ego's relation to its own thoughts often heralds an elaboration of what has just occurred. While

at this point we don't know what has caused the shift, and though an explanation would certainly be of interest, I have opted for privileging whatever area Michael is ready to explore. If one believes that Michael's attempt to use the method of free association involves an unconscious scanning by the ego to determine where it is safest to go in the context of a wish to understand oneself, then analytic listening is best conducted by privileging his use of free association. While the analyst may have many questions or observations, these should take a back seat to Michael's associations. Most often, patients will tell us, if we allow them to, which area they are ready to explore. Thus the link I had considered making earlier in the session between his anxiety and sexuality has now been raised by him, and seems more preconsciously available. After he talks about his panic, his associations eventually turn toward what occurred sexually over the weekend. In the context of the change in ego functioning we have just observed, why not follow Michael's thoughts to see what he can elaborate?

Michael's thoughts then turned to a time when he was driving with his girlfriend to her mother's home. They had a number of things to do before leaving, and realized they would be a few minutes late. He found himself getting very upset. In retrospect, he wondered why. (*Again we see a greater ability to think about his thinking*.) On the ride there his girlfriend indicated, in what he felt was a snide fashion, that she didn't like the radio station he had on. He slammed off the radio, and she got mad at him, which infuriated him even further. Yet he wonders why he turned the radio off the way he

did. He must have been feeling angrier than he thought, and sensed he was being provocative. He must have felt criticized by her statement about the radio station, yet he wasn't sure that's what she meant.

F.B.: It seems to be a continuation of what you describe feeling all weekend – that is, someone or something is doing something to you that is threatening or dangerous. This feeling seemed to reach its height in your conviction that you had a fatal illness caused by sex, although you had some inkling this was a premature diagnosis.

Of all the possible interventions, why would I choose this one? There are two components to my answer. The first is that this issue is one Michael was struggling with all weekend, and it was therefore emotionally alive for him. Second, his thoughts keep returning to this theme, with an increasing capacity to observe them, suggesting a greater preconscious readiness to think about the events leading to the panic. My intervention is an attempt to work with what is most meaningful to Michael, both emotionally and in terms of his preconscious readiness to accept the ideas. At this point in the session Michael senses he is reacting to something. What I judge to be preconsciously available in my intervention is based on Michael's readiness to think of himself as playing a role in his reactions, rather than primarily reacting as if something bad were happening to him, whether a fatal illness or his girlfriend's scolding him. In each individual moment he was aware, to varying degrees, that his reaction might possibly be off-base. He was unaware, however, of the consistency, throughout the

weekend, of this feeling of being threatened. The linking of the various events is what gives them their power. To this point in the session, Michael is unaware of the connections between his reactions over the weekend. There seems to be no point in suggesting possible causative factors until I can see Michael's reaction to the linked power of these multiple reactions. Will he need to deny the connection? Will it become part of what he experiences as a series of snipes at him? Or will his associations lead us to a deeper understanding of the link between his sexual thoughts and the punishment he has been waiting to befall him?

After some reflective moments, Michael stated that it felt like he's been waiting his whole life for some calamity to happen. (I had never heard him say anything like this before.) He reminded me of various times through college and graduate school when he ended up in the emergency room, convinced he had a fatal illness. The strange thing, he now realized, was that he always felt calmest when there
was something actually wrong with him. He found himself thinking about a time, after his first year of graduate school, when he was being considered for a prestigious fellowship. He was a basket case until he came down with mononucleosis that summer, and all his anxiety seemed to flow away.

His thoughts then turned to his other preoccupation that weekend – what to do regarding his profession. He found himself "disgusted" by all his prospects. He was surprised that he used that word. He realized it wasn't how he was actually thinking about things, and it seemed

to be a word that he has more often thought of in relation to sex. As always, he said laughingly, "the plot thickens."

F.B.: There being something terribly wrong about sex seemed prevalent in your feelings over the weekend, especially in your conviction that you were dying from a sexually transmitted disease. You seem to feel you are doing something disgusting, and are expecting to be punished for it.

Michael: I'm always waiting for something bad to happen to me after sex.

After my earlier intervention, Michael's associations led to confirmation of the interpretation, with the recognition of a lifelong unconscious expectation of being punished, along with a beginning elaboration of a feeling (i.e., disgust) that seems part of what triggers the expectation. Michael now feels free to explore his thoughts. My intervention here is intended to synthesize the disparate elements that individually are capable of coming into consciousness, but that remain at the level of individual observation. In the midst of his increasing emotional openness, within the context of an affectively alive conflict, an interpretation is given that offers a set of constructs to organize his thinking while lending further structural clarity to the problem. The intervention tries to respect the structural elements operative at the time, while attempting to build structure. It offers Michael a new way of conceptualizing what happens when he is in a particular difficulty.

Over time we understood this material as based on homosexual anxiety stirred by the weekend separation that led to a fantasy of taking in the analyst's breast/ phallus. This stimulated both his feeling of panic over the conviction that he had AIDS, and the loss of his erection during intercourse. In speaking about the latter, Michael focused on his girlfriend's small breasts – more like a man's – while he noted feeling turned on by a woman with a similar breast size. While elaboration of this fantasy over time proved important in Michael's understanding, I considered it a significant piece of analytic work first to identify the underlying feeling during the weekend that dominated Michael's associations (e.g., imminent danger) but that was experienced by him as discrete incidents. It is this step of clarifying what we can see in a patient's associations (e.g., feelings of pleasure followed by depression, successes undermined by self-sabotage) that are too often bypassed as we look for what is hidden by the associations.

I can imagine some readers wondering why I didn't interpret the homosexual transference. I will give my answer to this question in greater detail in Chapter 10 on 'Working within the transference." For now, let me mention two factors.

1

I didn't see his homosexual anxiety in the transference as being "in the neighborhood." Michael's neighborhood in this session was his anticipation of a catastrophic disease after sex with his girlfriend. Given his regression over the weekend and in the beginning of

the session, I felt it prudent to see if he could re-find a reflective stance. For the sake of helping him towards finding his psychoanalytic mind, it wouldn't have been useful to rush in and "explain" what was going on. Of course, if he remained in a regressive stance I would try to help him find his mind. However, it would have been in trying to help him see how psychologically endangered he felt, rather than focusing on the unconscious danger. Once he could re-find his mind on his own, I tried to stay with what I saw as most preconsciously available rather than what was unconscious. Over time it led to exploration of his homosexual anxiety, but in a way that was emotionally understandable for Michael. An interpretation of his homosexual anxiety in this session would have led Michael towards intellectualization. I could observe the process working as Michael went from regressive thinking to the capacity to reflect and associate to the material as the session progressed, even producing a "slip" indicating his fears were connected with a feeling of disgust.

2 *Many may wonder why I didn't at least raise the issue that his fear was of a disease often associated with sex between men, thus confronting his homosexual anxiety in displacement. This brings us to a basic question about how we best bring what is unconscious to consciousness so that what was unthinkable will be thinkable. Many analysts believe that it is only by bringing unconscious derivatives into awareness that begins this process. Some, like Green, add the proviso that the derivatives are close to preconscious awareness. Not said, but implied, is that the analyst can do this due to his position*

as a benign ego or super-ego, which moderates the patient's anxiety about being judged. My own view is that by slowly expanding what is available to the ego via respecting the dangers that lead to unconscious resistances, understanding them, and not causing undue anxiety with our interpretations, the patient will gradually find the freedom to approach what has been so frightening.

The power of unconscious fantasy comes alive in the context of patients' first seeing how irrational thoughts and destructive behavior impact on their lives via a close following of their associations. By staying with what is preconsciously available we help the patient move in gradual steps to what is deeper. To quote again from Green, "There is no point in the analyst running like a hare if the patient moves like a tortoise" (1974, p. 421). Michael was able to grasp how his weekend was ruined by a persistent feeling of danger, while also discovering an unconscious feeling (i.e., disgust) that was linked to his thoughts and difficulties over the weekend. Such a process, by providing a powerful demonstration of unconscious forces at work, brings the analysis alive for the patient in a way that more abstract interpretations of unconscious fantasy cannot.

In thinking about this session with Michael we can see how at the beginning, whatever preconscious awareness he had was drowned out by feelings of panic that his fantasy of having AIDS was real. With another patient I might have pointed out this process (i.e., how in spite of his thoughts that these concerns couldn't be real, he kept being drawn back to the feeling they were real). That is,

I would try to highlight what was preconsciously available, to see if I could help him gain the necessary distance to explore what was going on. Michael had reached the point in treatment where I thought he would be able to see this for himself. This was borne out, and as he continued to associate I could stay with what was potentially preconsciously available to deepen the process.

In summary, while there have been major changes in how closely analysts work "in the neighborhood," I still find many analysts tend toward deeper interpretations than I think are preconsciously available. In this chapter I've considered some of the factors involved in what it means to work preconsciously, and its importance to the patient's capacity to develop a psychoanalytic mind.

Notes

1 The reader will find some overlap between this chapter and the previous one. This is because, in part, there are certain ways of working that are at the core of what I'm describing. However, in this chapter I will explain the importance for working in this way for *understanding*, while previously I elaborated this perspective as a method for *appreciating psychoanalytic knowledge as a process*.

2 The theoretical basis for Freud's clinical observation wasn't articulated until his appreciation for the power of unconscious resistances, which was one important part of the move to the Structural Theory, and the articulation of the second theory of anxiety. In his first theory of anxiety Freud saw anxiety as due to dammed up libido,

and the psychoanalytic method was based upon freeing the unconscious wishes leading to deep interpretations. In his second theory of anxiety, Freud (1926) saw it as due to the unconscious ego anticipating a danger, leading to the importance of analyzing the unconscious resistances, which hasn't been fully integrated into our psychoanalytic method. This will be explored later in Chapter 9 on resistance analysis and working through.

3 As Freud (1912b) put it,

> To put it in a formula: he must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone. Just as the receiver converts back into sound waves the electric oscillations in the telephone line which were set up by sound waves, so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free associations.
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> (pp. 115–117)

4 The example is from Greenson (1967). It is especially interesting that Greenson was presenting it as a way of working with resistances, while from my perspective it was antithetical to this approach (see Busch, 1992, 1993).

5 Schmidt-Hellerau (2006) has pointed out that what many consider as the aggressive drive might more usefully be

considered as the intensification of the preservative or sexual drives. It is enormously helpful in understanding a patient's aggression not primarily as a bedrock feeling, but as a reflection of an attempt to protect the self and/or reach the object.

6 Explored earlier in Busch (2000).

7 In general, we underestimate the fear factor in the formation of the psyche.