FREUD TEACHES PSYCHOTHERAPY

BEGINNING THE TREATMENT

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An important comment on beginning the treatment is made by Freud on the first page of his *Introductory Lectures on Lectures on Psychoanalysis* (1916X;15:15). He teaches that at the very beginning we point out the difficulties of the method to the patient, ...its long duration, the efforts and sacrifices it calls for; and as regards its success, we tell him we cannot promise it with certainty, that it depends on his own conduct, his understanding, his adaptability and his perseverance." I believe it is most important to confront the patient at the very beginning with the expense and the difficulty of what he is proposing to undertake in the process of intensive psychotherapy, and never in any way to minimize its length or hardships, or to try to "sell" the prospective patient on the procedure.

Continuing, Freud describes the role of the psychotherapist as follows: "The doctor listens, tries to direct the patient's processes of thought, exhorts, forces his attention in certain directions, gives him explanations and observes the reactions of understanding or rejection which he in this way provokes in him" (1916X;15:17). Although Freud later modified this position to a more neutral stance, and less and less frequently employed the word "doctor," it is still an excellent description of the challenges of intensive psychotherapy.

One of Freud's most famous statements applicable to the first phase or

beginning of psychotherapy comes from the paper "On Beginning the Treatment":

> Anyone who hopes to learn the noble game of chess from books will soon discover that only the openings and end-games admit of an exhaustive systematic presentation and that the infinite variety of moves which develop after the opening defy any such description. This gap in instruction can only be filled by a diligent study of games fought out by masters. The rules which can be laid down for the practice of psychoanalytic treatment are subject to similar limitations (Freud 1913C;12:123).

It should be noted that Freud follows this quotation with a warning that any such rules are only recommendations and may have to be modified as the case requires.

Following the chess analogy, we speak of strategy and tactics in psychotherapy. One of the most common student mistakes in the conduct of psychotherapy occurs when the tactics are not consistent with the strategy. *Strategy* refers to our ultimate goals and to decisions about our general approach in helping a given patient in the light of the patient's psychodynamics; while *tactics* refers to the day-by-day operation of the psychotherapeutic process. Thus, for example, if our strategy in the psychotherapy is decided to be one of general support and education and we find ourself employing the tactics of interpretation, something is going to go wrong with the treatment. In another example, Freud contrasts a strategy in which a case is used primarily for scientific research, with a strategy in which

treatment is the primary goal. He notes, "Cases which are devoted from the first to scientific purposes and are treated accordingly suffer in their outcome; while the most successful cases are those in which one proceeds, as it were, without any purpose in view, allows oneself to be taken by surprise by any new turn in them, and always meets them with an open mind, free from any presupposition" (1912E; 12:114).

This is not to suggest that the therapist should never change the strategy of the treatment in accord with the vicissitudes of the case; but on the whole the overall strategy and goal of the treatment should remain consistent and relatively permanent. The tactics, then, should be chosen on a day-to-day basis to match the strategy.

One must also be aware that the strategy of the patient's unconscious is to resist uncovering, and that the patient uses a number of tactics in the service of such resistance. For example, in the first of his six papers on technique Freud (1911E;12:86-96) points out how the patient may overwhelm the therapist with a mass of dreams far beyond what is possible to analyze in the given time. Worrying about the thorough understanding of any given dream or taking a "scientific" interest in dream material can interfere with the therapy, and one of Freud's therapeutic rules is to keep in touch all the time with the current thoughts, problems, and emotions occupying the patient's mind even though it means the inevitable loss of understanding of

some dream material due to time limitations. However, the therapist may certainly be confident that any dream material "lost" by not completely interpreting an interesting dream will recur again in one form or another. Furthermore, a dream incompletely interpreted in one session should not be picked up in the next session unless the patient does so—thus in the subsequent session we deal with whatever the patient brings in at the beginning of the session, including new dreams, and we need not feel uneasy about neglecting the old dreams. These recommendations are even more important in intensive psychotherapy than in psychoanalysis, since in the former, a smaller frequency of sessions necessitates the loss of a certain amount of dream material.

Probably the most important and most difficult precept to learn in the practice of intensive psychotherapy is the achievement of evenly hovering or evenly suspended attention. Freud explains that the therapist:

> ... 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 (1912E;12:115-116).

To use this procedure, which requires a certain innate talent, Freud points out that the therapist may not tolerate any resistances in himself or herself which

hold back from consciousness what has been perceived by his or her unconscious—that is, every unresolved repression in the therapist constitutes a "blind spot" in the therapist's analytic perception and understanding in the patient's psychodynamics.

This brings us back to the chess model of psychotherapy. In chess, the incapacity to see what is going on condemns one to permanent mediocrity. The disease of "chess blindness" *(amaurosis schacchistica)* was first delineated by the famous chess master Dr. Siegbert Tarrasch, and is briefly described in a fine book by Evans (1970). The famous championship game in which one grand master left his Queen *en prise* and his opponent was afraid to take it off and did not do so, fearing some clever trap, is also described by Evans.

"We must above all see what is more or less hidden," wrote Tarrasch (1959); but how does one learn how to do this? The problem is amazingly parallel to the problem of learning how to conduct the middle phase of psychotherapy. How often we hear the novice complaining that he does not "see" what the supervisor has picked up in the material, and therefore could not make the needed interpretation.

The more one studies the chess champions and their games, the more one becomes aware of the amazing complexity of mental functioning and the

prodigious memory that is required to be a fine chess player. To isolate the factor of "seeing" the potentials on the board is almost impossibly difficult; perhaps the chess book that concentrates most on it is a chess book that presents programmed instruction, by the great chess master Bobby Fischer (1966). The entire subject is badly in need of our attention, not only because of its intrinsic interest but because of the obvious parallel to psychotherapy.

Freud was the first to point out the chess parallel, since taken up many times by many authors. Perhaps the most thorough discussion of the "chess model" of psychoanalysis is that of Szasz (1957), in a very different and controversial paper. He points out the little-noted analogy that in chess, as in psychotherapy, "each player influences the other continuously," more in keeping with current intersubjective and relational approaches in psychoanalytic therapy.

With the exception of a few remarks by Colby (1951) no author to my knowledge has pointed out in detail the parallel between teaching the middle phase of chess and the middle phase of psychotherapy. It is even difficult to admit that some psychotherapists have the analog of "chess blindness" when confronted with patient material. It seems incredible that the years of supervision have not uncovered this blindness and perhaps inclined the therapist to some other way of making a living. An additional benefit to the required study of chess in a psychotherapy training program, beside the usual

virtues of developing patience, logical thought, and an understanding of the chess-model theory of psychotherapy, would be an improved awareness of the inherent difficulties in "seeing" what the patient is trying to communicate in the myriad of material. We need to focus much more on the problem, which is essential to the successful conduct of psychotherapy.

This brings us again to my favorite subject, stressed in all my books and more than once in this one: the absolute necessity for a thorough intensive psychotherapy of the psychotherapist. Freud also again and again points out the importance of the analyst's own analysis and explains that if this is neglected not only will the psychotherapist be penalized by an incapacity to learn from his or her patients, but will also risk a more serious danger. This may also become a danger for others for, as Freud explains, "He will easily fall into the temptation of projecting outwards some of the peculiarities of his own personality, which he has dimly perceived, into the field of science, as a theory having universal validity; he will bring the psycho-analytic method into discredit, and lead the inexperienced astray" (1912E;12:117).

There is a parallel between the overall strategy of uncovering in psychotherapy—the amount of evenly suspended attention that the psychotherapist demands from himself or herself—and the amount of free association one hopes to understand from the patient. This is just another way of rephrasing what has already been said, in that the more we wish to

learn about the patient's unconscious, the more we have to use the techniques of empathic identification with the patient by using our unconscious like a receptive organ aimed at the transmitter of the unconscious of the patient. Again, I stress that such procedures as taking copious notes or tape recording during sessions will invariably represent serious interference with the procedure of uncovering psychotherapy, and no psychotherapist should fool himself or herself into believing that the presence of a tape recorder in the room makes no difference to the patient or that the patient and the therapist "get used to it." If the strategy of the psychotherapy is to uncover the patient's unconscious, it may be generalized that any deviation from the procedure of the psychotherapist's evenly suspended attention—for example, answering the telephone during the session—will interfere with the pure transmission and reception of the unconscious. In psychotherapy it is at times unavoidable to step away from this strategy, but such steps should occur only when absolutely necessary and with a full understanding of the dangerous consequences and the possibility of countertransference enactment.

This brings us to the famous and highly controversial and misunderstood notion introduced by Freud: "I cannot advise my colleagues too urgently to model themselves during psychoanalytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation

as skillfully as possible" (1912E;12:115). This quotation has been badly misunderstood because the remainder of the paragraph has not been studied. A full examination of paragraph "(e)" in Freud's paper indicates that Freud is warning against two major disrupting factors in uncovering psychotherapy. First, he warns against the narcissism of the psychotherapist as manifested in the ambition to cure. Second, he warns against an overidentification with the patient, where sympathy replaces empathy and the patient begins to disrupt the personal life of the therapist. There is no reason to believe that Freud was ordering us to be cold and impassive toward our patients, although taken in context with a later statement: "The doctor should be opaque to his patients and like a mirror, should show them nothing but what is shown to him" (p. 118)—his comments have been used as an excuse by sadistic or schizoid psychoanalysts and psychotherapists to inflict suffering on their patients or to avoid any normal ordinary human or physicianly (Chessick 1974) involvement with their patients altogether. One glance at the photos in *Bergasse 19* (Engelman 1976) tells us that Freud was anything but opaque to his patients. Looking at the office he occupied at once reveals the character of Freud the psychotherapist, as it would of any psychotherapist. There is not the slightest question that Freud was at all times a concerned physician, putting the basic welfare of his patients first and taking his obligation to his patients very seriously indeed.

Looking again at the pitfalls Freud was trying to avoid with his

"surgeon" analogy, it is clear that the therapeutic ambitions of the therapist can be very destructive to the patient. The thorough analysis of the psychotherapist's reasons for becoming a psychotherapist is absolutely necessary before he or she attempts to undertake intensive psychotherapy. Unfortunately this is one of the salient defects in current training of psychotherapists. Those therapists who manifest an unresolved narcissistic problem in their need to be a magic healer are a public menace and are unfortunately all too common. This narcissistic ambition may be cleverly hidden behind ministerial humility, altruistic social work, psychological research, and medical treatment. The other equally lethal countertransference problem lies in overidentification with the patient and usually hides a wish to destroy the patient out of frustration with the case, either because the therapist does not understand what is going on in the case, or because the patient is not responding by fulfilling the therapist's neurotic need for dramatic cures, or providing other forms of gratification. This destructive wish also can be explained away by the insufficiently treated psychotherapist through a whole variety of rationalizations. Freud makes clear what he has in mind in the "surgeon" analogy by mentioning the quotation from the famous French surgeon Ambroise Pare, who wrote, "I dressed his wounds, God cured him."

Freud agrees that a psychotherapist may have to combine a certain amount of analysis with some suggestive influence, but he points out that this

is not "true psycho-analysis." This is a correct statement but has led to a lot of unfortunate acrimony because of the irritating status problem involved, Freud was attempting to present a theoretical ideal model of a "true psycho-analysis" in which the therapist listens with evenly suspended attention and by empathic identification receives the transmissions from the patient's unconscious, then transmitting these back to the patient via appropriate interpretation. In my judgment it is never possible to do only this in the years of an ongoing treatment relationship with a patient, since the treatment relationship is, of course, also an important human relationship—probably the most important human relationship the patient has ever had. The question therefore is not whether we should deviate from Freud's theoretical model but rather when and how often. There is a spectrum between the most theoretically pure possible psychoanalysis at the one end and essentially primarily supportive psychotherapy at the other. Although the width of this spectrum remains a matter of controversy (Chessick 1969, 1977, 1996, 2000), any conscientious psychotherapist would agree that deviations from the theoretical model when there is a strategy of uncovering intensive psychotherapy must be performed deliberately, for good reason, and certainly not out of countertransference problems of the therapist.

The presence or absence of such deviations must be noted and even necessary by the psychotherapist from the very beginning of the treatment. Thus Freud's recommendations on beginning the treatment are clearly aimed

at minimizing any deviations from his theoretical model of true psychoanalysis. I have made my own recommendations on the beginning of the treatment in intensive psychotherapy (Chessick 1969, 1974, 1992, 1996); they are based essentially on Freud's recommendations, but with modifications for the 21st century United States and for the needs of intensive psychotherapy, especially those dealing with the current plurality of cases other than classic neuroses.

For example, Freud's recommendation of taking on the patient provisionally for a period of one to two weeks means, in the context of psychotherapy, that we should not generally try to make recommendations to the patient in one interview, but rather, if possible, have three or four sessions with the patient over a period of one or two weeks before reaching any long-range plans or conclusions. His advice of mistrusting all prospective patients who want to make a delay before beginning their treatment, and his warning about the special difficulties that arise when the therapist and his or her new patient (or their families) are on terms of friendship or have social ties are just as appropriate today as they were in Freud's time. I can see no good reason to undertake the psychotherapy of a friend, or of members of families with whom one is on social terms, and I extend this to a refusal to undertake the psychotherapy of any neighbors within walking range of the psychotherapist's home. There is no shortage of psychotherapists in most major cities and it is more ethical to try to refer such patients to others.

As I stated previously (Chessick 1977), certain special difficulties arise, especially at the beginning treatment of any psychiatrist's family members. The fact that a person is a psychiatrist or psychotherapist does not necessarily mean that he or she is free of major pathology, or that psychiatrists and psychotherapists can make objective judgments about their family, or that they believe in the efficacy of psychotherapy at all. It also does not mean that they are so sufficiently free of narcissistic developmental pathology that they do not regard their family members as selfobjects or can empathize with their difficulties. So, when the chips are down, such parents and spouses who are psychiatrists and psychotherapists sometimes may tend to put fear for their professional reputations above their empathic considerations of the need for treatment of their wives and children.

For example, the experience of an adolescent child is an assault to the narcissism of any parent. The experience of having a disturbed adolescent child is a many times more profound assault to the narcissism and idealized self-image of the parent who is also a psychiatrist. The parent with unresolved preoedipal problems will feel most assaulted. As Cohen and Balikov (1974) point out, "Many adults have made relatively stable developmental adaptations which provide compensation for many character problems which arise from poorly achieved separation-individuation from archaic objects. However, it is precisely in the parenting roles where these adaptations may break down. Derivatives of early developmental experience

intrude and create transferences to the child which are once again internalized into the psychic structure." Of course, a similar danger point for the breakdown of such adaptations is in the marital relationship, especially after the late marriages commonly seen in physicians.

So first, a dangerous delay can take place in referral for psychotherapy; in extreme examples, I have seen the most overt schizophrenic psychopathology blandly ignored by a highly respected psychiatrist father or husband. In two cases this happened twice with first an older and then a younger sibling; only when the patient began calling attention to himself in school by very bizarre behavior was treatment reluctantly employed.

Second, whether due to middle-age depression, too many years in the office, or to other factors, a peculiar loss of confidence in psychotherapy itself sometimes seems to occur in these psychiatrist fathers and husbands, a loss of confidence also communicated to their wives and children. Paradoxically, this may be true even though the psychiatrist is actively engaged in a busy psychotherapeutic practice. It produces a sense of despair in the prospective patient, and tends to delay self-referral for psychotherapy among the wives and relatives of psychiatrists.

Third, one should be very alert for the family "secret." I have observed this in several cases during treatment of both wives and children. Some

important "secret" had to be kept from me in order to preserve the father's or husband's reputation. This often represents a factor in the delay of seeking psychotherapy, and is a great block to the beginning phase of the treatment. Interestingly, the most common "secret" is serious alcoholism, although I have encountered one case of drug addiction and several of perversion or impotence. These "secrets" of highly respected and successful professionals are known only to the immediate family.

Fourth, one may encounter a remarkable refusal of recommendations for treatment among the spouse or parent psychiatrists. Some of them (in my series, Chessick 1977b) already had clearly unsuccessful or limited treatments, and some of them had none at all. All admitted they were in need of treatment, but when the matter came up, every one refused to seek psychotherapy, even though it was made clear that their marital problems or their problems with their children made such therapy mandatory.

My impression was that these people were primarily frightened; I was surprised at the profound fears and insecurity so prevalent in these apparently successful husband or father psychiatrists. One cannot react to this with anything but compassion for their intense suffering, which seems to be increased by the very act of sending a family member for intensive psychotherapy—and with a resolve to be as gentle and tactful as possible. Except in two cases where the adolescent was still living at home, I did not consider

it my part to directly recommend psychotherapy for the father or husband. The recommendation often repeatedly and emphatically brought up to him by the family member involved in treatment almost always was ignored. Since then I have observed the same phenomena with the mothers or wives who were psychiatrists or psychotherapists.

Fifth, there is no reason to believe that the pathology of the fathers and their "secrets" were the cause of the patient's disorders, any more than in the usual cases we treat. In general, after one sweeps aside these special considerations, the treatment of the spouses and children of psychiatrists and psychotherapists must proceed exactly like that of any other psychotherapy; the fact that spouse or parent is a psychiatrist or psychotherapists becomes more and more irrelevant unless the spouse or parent tries to intrude upon or manipulate the therapy, which is a different problem.

However, certain other considerations, especially in the beginning phase of psychotherapy of professionals or their family members, are important, and I now turn briefly to these. The psychotherapist should be alert for what Loewenstein (1972) has called the "reinstinctualization'' of certain normally autonomous ego functions. The most common of these, in a person who has grown up in an atmosphere of much verbal communication and psychiatric jargon, is the use of sophisticated psychoanalytic terminology to fool the therapist into thinking the patient is really observing, under-

standing, and commenting on himself or herself, whereas the use of such terminology is just gibberish to serve as resistance and test the therapist. Conversely, because someone is a psychiatrist, it does not follow that he or she communicates at home with spouse and family. For example, one teenaged son of a psychiatrist was raised in an atmosphere where the television played constantly and there was almost no talk in the house.

In certain cases where great narcissistic problems are present in the psychiatrist or psychotherapist husband or father, the psychotherapist must be prepared for problems regarding fee. The same is true in this day and age where the wife is the psychiatrist or psychotherapist and the principal source of family income. The therapeutic contract and fee should be carefully spelled out at the beginning of treatment, and there should be no "favors," as this represents to the patient a tacit alliance between the psychotherapist and the husband or father (or wife or mother) of the patient. If there is a refusal to pay the bill, the psychotherapist must be prepared with strategies, for the psychiatrist husband or father (or wife or mother) here projects his narcissism onto the psychotherapist and assumes he is wounding the narcissism of the psychotherapist in revenge for the narcissistic wound inflicted on him by the psychotherapy of his wife or child. Problems of the fee and the challenge it presents to the narcissism of psychotherapists are reviewed in a masterful paper by Eissler (1974).

Similarly, the psychiatrist or psychotherapist father and husband (or mother or wife) with especially narcissistic pathology is constantly on the lookout for "criticism" from his wife's or child's psychotherapist, and can be expected to frequently "pump" the patient for details about each session. At the first hint of criticism an explosion can be anticipated, including attempts to end the treatment or to force a change of therapists, or refusal to pay the fee or bring the patient to the sessions, and so forth. It is usually unwise to request a direct confrontation or consultation with the psychiatrist or psychotherapist spouse or parent at this point, since this prevents helping the patient recognize and work through a realistic appraisal of the psychiatrist spouse or parent, and again sets up a tacit alliance against the patient between the two "authorities." Generally speaking, a crisis often occurs when the psychiatrist or psychotherapist spouse or parent of this type realizes he or she is not going to be able to control the psychotherapy of his or her wife or child. At this point he or she may become outraged, severely criticize the psychotherapist, and try to stop the treatment.

The authority problem shows itself especially in the treatment of psychiatrists' or psychotherapists' wives, who often have great difficulty at the beginning in contradicting their husbands' gratuitous "interpretations" and pronouncements. Even some of the most bizarre pronouncements—for example, "It is normal for us not to have sexual relations since we are over thirty"—create conflict since they come from somebody who is supposed to

be an expert. Such pronouncements carry a further danger of acting out on the part of the patient, who, by subtly bringing home selected tidbits from her psychotherapy, can set up an intense "lets you and him fight" interaction between the psychotherapist and psychiatrist husband or father. The alert psychotherapist, if his or her narcissism doesn't get involved, handles the problem by a careful investigation to determine what the patient has been carrying home. Evidence that such acting out has been worked through is present when the patient confronts the psychiatrist or psychotherapist spouse or parent at home with an admission that for resistance purposes she has set up the situation. Such an investigation is far more therapeutic in dealing with acting out than setting up extra therapeutic conferences with the spouse or parent psychiatrist, as would again be the first tendency with a colleague, although in adolescent cases it may be necessary—preferably in the presence of the patient.

This brings us to the special countertransference problems encountered immediately on undertaking psychotherapy of the husbands, wives and children of psychiatrists and psychotherapists. These problems clearly revolve around narcissistic use of the patient as a selfobject to demonstrate to the colleague-husband or father, wife or mother, that one is a fine psychotherapist indeed. "How will I do? What will he or she think of me? What will he or she tell other colleagues?" become countertransference preoccupations especially if the husband or father, wife or mother (a) has a

more lucrative practice with an overflow of patients that he or she refers to other psychiatrists or (b) is in an important political position in local psychiatry, with the power to influence others. As a general rule it is always unwise to accept referrals of other patients from the husband or father or wife or mother psychiatrist or psychotherapist while his or her husband, wife, close friend, or child is in therapy with you, and also unwise to accept as a patient the spouse or child of a psychiatrist or psychotherapist who has real immediate power over you, such as the chairman of your department, and so on. Simply refer these to others.

Finally, special problems arise in the psychotherapy of the spouses or children of residents in psychiatry or trainees in a psychotherapy program. In my judgment it is frankly unethical to take on as a patient any resident or trainee or the spouse or child or a resident or trainee over whose career one has great power. This situation obviously puts the resident or trainee in an awkward position and is certain to destroy the treatment. Such patients are easily referred to others. In general, the loyalty problems involving residents or trainees are even greater than those involving practicing psychiatrists and psychotherapists. Since the future career of the resident or trainee is uncertain, "secrets" in these cases are especially troublesome and cannot possibly be brought out to someone who could literally destroy the career of the resident or trainee.

Another interesting phenomenon shows itself in phallic-narcissistic, competitive women married to psychiatrists or psychotherapists-in-training. When the psychiatric resident or psychotherapy trainee is undergoing so-called training psychoanalysis and his wife is in psychotherapy, serious competitive problems may result. Some that I have encountered are: (a) distortion of the psychotherapy so that, for example, the wife insists on referring to her once-weekly psychotherapy as "my analysis"; (b) rage at the psychotherapist—why am I getting only "second rate" treatment?; (c) literal breakup of the psychotherapy with the wife getting herself accepted at the Psychoanalytic Institute on some basis or another, for example as a training case for a candidate, and so forth. These problems are more the usual derivatives of psychopathology rather than true special problems, but they certainly can be deleterious to the treatment. Similar problems can arise with the husband if the psychiatrist or psychotherapist trainee is the wife.

Freud's principle of leasing a definite hour that the patient has to pay for, six days a week, is not applicable to intensive psychotherapy except in those cases where the therapist feels that the patient is acting out by skipping therapy sessions. With most patients, over a period of years, the matter of missed hours is a minor issue and the occasional hour missed for illness or for a scheduled vacation where the time of the vacation is set by the patient's employer or spouse or so on, calls for a reasonable and humane response by the psychotherapist. A few patients make missed sessions and the fee for the

sessions central issues in the psychotherapy and these of course must be dealt with very strictly—even if it forces termination of the treatment—since they are essentially resistances to treatment and bring the patient's entire motivation for therapy into question. In this regard, it is helpful to remember Freud's comment that the treatment usually takes longer than the patient expects and that it is our duty to tell this to the patient before he or she finally decides upon the treatment.

In those cases where uncovering is the strategy of the psychotherapist I do not hesitate to explain the fundamental rule of free association to the patient at the beginning of treatment, even though certain authorities do not agree with this procedure. In uncovering psychotherapy I want the patient to free-associate as much as possible even if in a sitting up and face-to-face position. I realize that this position is much more limited in psychotherapy than in psychoanalysis, but the basic principle is a valuable concept for the patient to understand if possible, since it encourages the patient to say a number of things one would not ordinarily reveal in a social relationship, including many bizarre, offensive, or insulting remarks. It is important to encourage the patient to say whatever comes to mind and to contrast the therapy situation with a social encounter.

Many patients find it is easier to say inappropriate, embarrassing, or uncomplimentary things when they do not have to face the therapist, and for

that reason I am willing to use the couch in intensive uncovering psychotherapy when I think it is appropriate; but under no circumstances should the average psychotherapy patient be placed on the couch. This means that the psychotherapist will be stared at a number of hours each day, and like Freud, I am sure he or she will find this to be rather unpleasant but unavoidable. The facial expressions of the psychotherapist, as Freud pointed out, will influence the patient's material and distract the patient; but keep in mind that a whole variety of other manifestations of the psychotherapist, such as the ambience of the office, tone of voice, and so on, give the patients similar material. It *is* impossible to remain opaque to a patient.

Finally, in answer to another debated issue, I firmly believe it is important to take a formal detailed history following the textbook form and directly from the patient (not as a written "homework" assignment) at the beginning of intensive psychotherapy. This history serves as legal protection for the psychotherapist, as a source of valuable clues to future exploration, and as vital data for review later on. If the patient is unable to give a history in the first few sessions, responsible members of the family should be called upon to provide what information they can, after requesting the patient's permission. This matter should not be neglected out of preoccupation with immediate psychodynamic material, and is best attended to at the beginning of the treatment.

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