CLASSICAL PSYCHOANALYSIS

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Classical Psychoanalysis

The man of skill," wrote Nathaniel Hawthorne in 1850, "the kind and friendly physician strove to go deep into his patient’s bosom, delving among his principles, prying into his recollections, and probing everything with a cautious touch, like a treasure seeker in a dark cavern. Few secrets can escape an investigator, who has an opportunity and license to undertake such a quest, and skill to follow it up. A man burdened with a secret should especially avoid the intimacy of his physician. If the latter possesses native sagacity, and a nameless something more—let us call it intuition; if he show no intrusive egotism, nor disagreeably prominent characteristics of his own; if he have the power, which must be born in him, to bring his mind into such affinity with his patient's, that this last shall unawares have spoken what he imagines himself only to have thought; if such revelations be received without tumult, and acknowledged not so often by an uttered sympathy as by silence, an inarticulate breath, and here and there a word, to indicate that all is understood; if to these qualifications of a confidant be joined the advantages afforded by his recognized character as a physician, then, at some inevitable moment, will the soul of the sufferer be dissolved, and flow forth in a dark, but transparent, stream, bringing all its mysteries into daylight.[1]

Here, before Freud was born and almost in caricature, Hawthorne portrays for us the very archetype of the popular image of the psychoanalyst:

removed but empathic; silent yet alert to nuance; listening with quiet understanding and without moral judgment or prejudice; passive in appearance only, as, midwife to the soul, he awaits the propitious moment to deliver the guilty secret from his patient's breast.

The popular notion of the psychoanalyst is, of course, incomplete. It seizes on the obvious and the visible, with no awareness that the analyst's apparent inactivity is only the first step in a series of technical maneuvers aimed at uncovering and altering the elements of a psychological conflict that produces symptoms and disease. Hawthorne's physician was adept at eliciting information. For the modern analyst, that is only the beginning of the process of therapy—a clinical activity that has evolved over the past two centuries into a set of analytic procedures that can be both practiced and taught. Let us approach a discussion of these procedures through a brief historical survey of their development.

The Development of Psychoanalysis

Mesmer

Franz Anton Mesmer (1733-1815) is generally thought of as being the *fons et origo* of modern psychotherapy; and from the early techniques of mesmerism, it is said, have evolved the more elaborate and sophisticated

therapeutic measures of the analyst and his colleagues. Although Mesmer was certainly dealing with individuals suffering from a variety of neurotic disorders, and though the clinical successes he achieved were the result of psychological processes that his procedures induced in his patients, Mesmer s theoretical formulations, his understanding of the nature of the treatment he elaborated, and his specific procedures were all totally different from those of the twentieth-century analyst.

Mesmer’s basic therapeutic maneuver was the "magnetic pass." Patient and "magnetist" sat opposite one another, and as the latter clasped the knees of the former between his own, he repetitively drew his hand in great, sweeping movements from the patient’s face downward over his chest and abdomen and thighs—sometimes actually touching the patient’s body, at others holding his hand an inch or two away. In response, the patient would feel a sense of warmth suffuse his body. After a period of time (especially when the treatment was effective) he would lose consciousness in a hysterical seizure (the so-called *mesmeric,* or *magnetic, crisis),* from which he would recover to discover his symptoms markedly improved if not completely gone.

Mesmer saw in this the result of physical, mechanistic forces. Borrowing heavily on the speculations of Paracelsus and on the scientific climate of his day, he attributed the phenomenon to the effect of a subtle, invisible but real magnetic fluid that, if not similar to the force that held the planets in their

regular orbits, was at least related to it and could be controlled and manipulated by the operations of one human being on another. This so-called "animal magnetism" was at the basis of both disease and its cure. In the normal individual the magnetic fluid flowed smoothly and unnoticeably throughout his body. If, however, the flow of the fluid was obstructed for whatever reason, it would be dammed up and accumulate in one organ or another, producing symptoms at the site of its stasis. The mesmeric treatment relieved symptoms because the mesmerizer, with his passes, not only increased the amount of magnetic fluid in his patient's body but also intensified its flow, so that the obstructions were overcome, the pathological accumulation of the fluid was dissipated, and its normal flow and balance restored (Mesmer, 1971).

There are several characteristics of Mesmer's approach to his patients that should be noted. In the first place, although he was clearly aware of the importance of the setting as it influenced the individual's response, his theory was mechanistic and based on a physical, materialistic view of the nature of the universe. He conceived of illness as having a physical basis, and his treatment techniques were as much aimed at restoring a physiological balance as were those of the more traditional physicians of the day, with their purgings and cuppings and bleedings and emetics. The concept of psychotherapy was totally alien to his scheme of things. Secondly, despite the fact that Mesmer was aware of the importance of a special rapport between

patient and therapist, he was not concerned with the inner mental life or psychological conflicts of the patients he was treating. His aim was solely, through the operations of the magnetist, to restore the balance of the magnetic fluid and overcome its pathological accumulation in bodily organs. Finally, in his therapeutic system, the patient remained entirely passive. The therapist acted upon him with his mesmeric passes, and the patient was merely the recipient of external influences that affected him, without his in any way contributing to the process of treatment (other than by virtue of the fact that he submitted himself to the mesmerist's manipulations).

The Nineteenth Century

Those who followed Mesmer worked within the same frame of reference. De Puységur (1807), it is true, through his interest in the somnambulistic state, focused his attention on the experience of both patient and therapist as this contributed to the relief of symptoms; but he held to the theory of magnetic fluid, and the patient remained a passive recipient of the therapist's operations. There was little significant development in the theory until Braid (1960) challenged the notion of the magnetic fluid and explained the clinical phenomena as being the result of internal factors within the patient himself. Hypnotism (as Braid named it) was effective not because of any fluid instilled in the patient by the therapist but because of his idea of what the therapist expected him to experience. This was the basis for the

modern concept of suggestion, which over the succeeding decades gradually replaced the fluidic theory, culminating in the triumph of the Nancy School over that of Jean-Martin Charcot and his colleagues at the Salpètrière in Paris —of psychology over physiology. But despite this fundamental change in theoretical outlook, the patient remained the passive recipient of ideas and suggestions provided him by the hypnotist. He was no more the active participant in his treatment than were his predecessors in the days when magnetism held sway.

Although the Salpètrière remained closer to biological concepts than did Bernheim (1897) at Nancy, whose espousal of suggestion placed the emphasis on the psychological basis of hypnosis, it nonetheless made a number of important psychological observations that helped to explain symptom formation. In particular, it recognized that traumatic events in an individual's life could lead to the dissociation of memories related to these events, and that the form of the individual's symptoms was often determined by these dissociated memories.

Later, the clinical investigations of Pierre Janet led (in his hands) to a highly sophisticated elaboration of the concept of dissociation. But Janet's clinical observations and theoretical formulations were overshadowed by the rising star of Sigmund Freud, and by the excitement over the discoveries and ideas that he began to make public in the 1890's.

Freud’s Early Theoretical Formulations

The rich variety of intellectual and scientific forces that influenced Freud’s thinking has not yet been fully explored, but certainly his own observations during his visit to the Salpètrière in 1885-1886, as well as his familiarity with the clinical experiences of his older colleague, Josef Breuer, played an important part in his early practices and formulations. At the Salpètrière Freud was able to observe patients with major hysteria and to see how the unconscious memories of traumatic events not only determined the form of symptoms but also could be recovered under hypnosis. From Breuer he learned that the recovery of the memories *and* the affect associated with traumatic events could lead to a removal of the symptoms determined by them. These were the clinical experiences that directed Freud’s attention to hysteria; they formed the launching pad from which he soared into his own original ideas about the pathogenesis of hysteria. His initial theoretical formulations provided a basis for innovative techniques of exploration, which then evolved into the practices of classical psychoanalysis. Let us look at these each in its turn.

The Salpètrière investigators developed a theoretical scheme to explain their observations that reached its apogee in the formulations elaborated by Pierre Janet. We have already hinted at the fact that they were aware that unconscious memories of traumatic events could determine the form of

symptoms. Janet (1893), for example, describes the origin of a woman’s phobia by reference to a painful loss. His patient, Gu, suffered from "a singular horror of the color red" and from time to time had typical attacks of hysterical somnambulism in which she would enter a state of altered consciousness and lose contact with people around her. During her waking state she had absolutely no knowledge of the reason for her terror of the color, which was an entirely ego-alien symptom. One day Janet overheard the patient speaking as follows during one of her hysterical attacks: "Take it away! Take the coffin away! Close it up! I don’t want to see his head any more. Oh! That bunch of red flowers—take them away!"

Janet, suspecting that the patient in her somnambulistic state was undergoing a hallucination of the scene relevant to her fear of the color red, by a clever maneuver transferred her spontaneous somnambulism into one over which he had control and during which he could converse with her. His surmise turned out to be correct. While the patient was in a period of somnambulistic altered consciousness her range of memory was wider than in her normal waking state, and she revealed events in her past of which she had no trace of memory while awake. "Gu," wrote Janet, "explained to us very well during her somnambulism how her attacks were provoked by the recurrence of an old emotion dating back many years. She had seen her father’s corpse at the moment that they were closing the casket, and with each attack she beheld this cruel sight afresh. She also accounted for her

horror of the color red by the memory of the flowers which had been on the coffin."

The basic mechanism involved here was a *dissociation* of the memories of the traumatic events. As the result of the dissociation, certain elements of the psychic contents were rendered unconscious—became unavailable to conscious, voluntary recall—but, though unconscious, nonetheless determined the nature of the surface symptoms. Dissociation was, then, a key process in symptom formation, and the problem lay in trying to understand how dissociation occurred in the first place.

The Charcot school, represented in its most sophisticated form by Janet, proposed a theoretical explanation that was essentially biological in character (1893). Each individual, it postulated, is endowed at birth with a certain quantum of nervous energy, the function of which is to bind the elements of brain and mind into a functioning, coordinating whole;

the acme of this process is the sense of the self as a distinct, real entity. In certain individuals, however, the quantity of energy is pathologically diminished, either because of a hereditary inadequacy or because it is exhausted by excessive emotions. When this occurs, the unity of the personality is compromised. Clusters of associated mental events fall away from the main body of psychic elements that constitute the self and become

unavailable to that self. They are now dissociated and unconscious and therefore, by definition, pathological, since in the normal human being mind is coextensive with consciousness.

Freud was, of course, exposed to the observations and ideas that surrounded him during his visit to the Salpètrière. In his early work (Breuer, 1955) with his collaborator, Breuer, he focused on the traumatic nature of hysterical symptoms and the phenomenon of dissociation that formed the basis of symptom formation. To explain the genesis of the dissociation, he somewhat reluctantly adopted Breuer’s concept of the "hypnoid" state. This concept, based on the physiological approach of the French school, postulated that the patient was in a pathologically altered state of consciousness when the emotionally traumatic event occurred; when normal consciousness returned, the memories and related affects pertaining to the traumatic event failed to be incorporated into consciousness, but remained behind in a dissociated, unconscious state to provide the pathogenic source of the hysterical symptoms. At the same time, Freud—at first softly and then in an increasingly audible voice (1962)—proposed an alternate explanation for the occurrence of dissociation: ideas and affects that were unacceptable to the individual were *forced* out of consciousness; and, thus rendered unconscious, formed the focus of hysterical symptoms. He suggested the term *defense hysteria* (as distinct from Breuer’s *hypnoid hysteria)* to designate hysterical symptoms arising on this basis.

The concept of "defense" introduced an entirely new theoretical view of symptom formation. It laid the groundwork for all subsequent psychoanalytic theory and the therapeutic techniques derived from it. Freud's novel view of psychic functioning was entirely different from that of those in the French school. The latter, as we have seen, based their concepts on physiological notions; for them, unconscious mental processes were pathological in nature, and symptoms resulted from a passive falling away of mental elements in a patient predisposed to illness by hereditary factors. Freud (in spite of his physiological predilections and although he was at the time still struggling to construct a physiological model of the neuroses) was a psychologist; in his scheme, symptoms arose from the conflict that resulted from the active operations of the psychic apparatus to push undesirable mental elements out of consciousness. Ultimately, in his *conflict psychology,* repression and unconscious mental processes were viewed as normal attributes of the human personality.

The Development of Psychoanalysis as Therapy

At first Freud's formulation did not lead to any change in his therapy of the patients he saw. Instead he continued to employ the cathartic method which Breuer had discovered in the course of his treatment of "Anna O." The cathartic method, although it employed hypnosis, represented a radical departure from the usual procedures of hypnotic therapy. The aim of the

latter was to remove symptoms by direct suggestion—and indeed it was with this goal in mind that Breuer began his treatment of Anna O., a young woman with multiple hysterical symptoms. In the course of therapy, however, the patient began actively to revive and to recount ordinarily unconscious memories while she was under hypnosis or in spontaneous somnambulistic trances. As Breuer listened to her recitation, he recognized that she was describing the past traumatic events related to the onset of her symptoms, and was at the same time giving vent to the emotions that were associated with them. As she raised both the memories and the affects into conscious expression, her symptoms disappeared.

Breuer commented:

When this happened for the first time . . . I was greatly surprised. It was in the summer during a period of extreme heat, and the patient was suffering very badly from thirst; for, without being able to account for it in any way, she suddenly found it impossible to drink. She would take up the glass of water she longed for, but as soon as it touched her lips she would push it away like someone suffering from hydrophobia. As she did this, she was obviously in an *absence* for a couple of seconds. She lived only on fruit, such as melons, etc., so as to lessen her tormenting thirst. This had lasted for some six weeks, when one day during hypnosis she grumbled about her English lady-companion whom she did not care for, and went on to describe, with every sign of

disgust, how she had once gone into that lady's room and how her little dog—horrid creature!—had drunk out of a glass there. The patient had said nothing, as she had wanted to be polite. After giving further energetic expression to the anger she had held back, she asked for something to drink, drank a large quantity of water without any difficulty and woke from her hypnosis with the glass at her lips; and thereupon the disturbance vanished, never to return. A number of extremely obstinate whims were similarly removed after she had described the experience which had given rise to them. She took a great step forward when the first of her chronic symptoms disappeared in the same way— the contracture of her right leg, which, it is true, had already diminished a great deal. These findings—that in the case of this patient the hysterical phenomena disappeared as soon as the event which had given rise to them was reproduced in her hypnosis—made it possible to arrive at a therapeutic technical procedure which left nothing to be desired in its logical consistency and systematic application. Each individual symptom in this complicated case was taken separately in hand; all the occasions on which it had appeared were described in reverse order, starting before the time when the patient became bed-ridden and going back to the event which had led to its first appearance. When this had been described the symptom was permanently removed (Breuer, 1955).

Following this discovery, Breuer and Freud made use of hypnosis, not to suppress symptoms by direct suggestion but to uncover the dissociated

pathogenic memories and affects. After his formulation of defense hysteria, Freud continued to employ hypnosis as a means of bringing into consciousness the repressed mental contents that produced the surface symptoms. His ultimate abandonment of the cathartic method resulted not from his innovative theoretical concepts but because he had difficulty with the techniques themselves. He soon discovered that many patients were not capable of being brought into a hypnotic trance of sufficient depth to enable them to recover the relevant memories and affects, and he apparently himself felt uncomfortable in the role of hypnotist. Accordingly, the number of patients who could he helped by hypnosis was limited, and Freud experimented with a variety of techniques that would permit the emergence of the pathogenic mental contents in those individuals for whom hypnosis was impossible. He maintained the reclining position of the patient in hypnosis (as have analysts ever since, by "putting the patient on the couch"), hut instead of inducing hypnotic trance, he used other methods to deliver the unconscious material. Initially he would press the patient’s forehead with his hand and instruct him to report on all the thoughts and images that came into his mind in connection with specific symptoms and other important events. He soon abandoned this technique, however, and moved to the procedure of free association. The nature of this procedure and the rationale for its use will be dealt with in more detail later. Suffice it to say here that it required the patient to report *every* thought, feeling, memory, and image that came into the

center of his consciousness as he let his mind wander freely and without voluntarily focusing attention on any specific detail. No matter how painful, shameful, disgusting, or trivial his thought, it was to be revealed to the analyst.

From that point on in its development, free association became the hallmark of psychoanalytic treatment. At the same time it disclosed further technical difficulties and led to the discovery of two phenomena that became central features in the process of psychoanalysis: resistance and transference. As Freud required his patients to free associate in his search for the unconscious origins of symptoms, he soon recognized that free association, so simple in principle, was very difficult for his patients to carry out in practice. Despite themselves, however eager they might be to cooperate in the treatment, they were unable to bring themselves to report every thought that crossed their minds, and with a variety of rationalizations they would withhold much of that which they were conscious of. Furthermore, quite involuntarily, their minds would go blank or they could not maintain a sequence of thoughts, with the result that their train of verbalized associations would be incomplete, fragmented, and often unintelligible to the listener. Freud soon recognized that the repression that had banished the pathogenic material from consciousness in the first place exerted a continuous force against its revival in free associations; it created a *resistance* on the part of the patient to full divulgement of all that his mind contained. At

the same time as Freud recognized the force of resistance, he observed that in the course of the analysis he became a person of special and central importance for his patients. They developed a variety of intense feelings for him that recapitulated their ties to earlier important people in their lives and recreated earlier patterns of relationships. This *transference* provided important observations about the patient's conflicts but also led to yet further resistances to the therapeutic processes; these in turn had to be analyzed if the patient was to progress toward a resolution of his difficulties.

The Development of Ego Psychology

The clear conceptualization of the phenomena of resistance and transference enabled Freud to develop a variety of technical maneuvers, which he described in a series of papers on technique published between 1911 and 1915.[2] Although during much of this time Freud was in the process of revising his concepts of the structure of the psyche, these papers are based on his earlier *topographic model* of psychological functioning. In this view, the psyche is conceived of as a system of two opposing dynamic forces: the sexual instincts—their ultimate form and quality determined by their shaping during the crucial early years of childhood sexuality and its development from infancy onward—are countered and controlled by the ego, motivated by the self-preservative instincts. The ego is roughly equitable with consciousness, whereas much of the instinctual life is hidden from conscious

awareness through its repression into the unconscious. In this view, then, treatment is aimed at making the unconscious instincts and their derivatives available to the control of the conscious ego through the analysis of resistances and transference, and the emphasis is on delivering from below the repressed sexual conflicts deriving from the oedipal struggle of the early years of childhood.

In his earlier model, Freud's interest and emphasis were on the instinctual components of the psychic apparatus, but his observations of the phenomena of narcissism gradually led him to a more detailed consideration of the nature of the ego. After a decade and more of reconceptualization, this resulted in the *structural model* of psychic functioning. Instead of two major elements in the psyche (the ego and the unconscious), the personality is conceived of as tripartite, consisting of ego, id and superego. Elements of each of these may be unconscious; that is, the unconscious is thought of not as a region but as an attribute of mind. Furthermore, the old duality of ego instincts and sexual instincts is replaced by a *dual instinct theory* of sexuality and aggression, with both instincts deriving from the id, being pitted against one another, and requiring control by the Ego. Finally, anxiety, seen in the earlier model as the physiological derivative of repressed, undischarged sexual libido, is viewed in the structural model as an *ego affect,* serving the function of signaling danger to the ego from the underlying id instincts. Anxiety, in other words, is considered to be the cause rather than the result of

ego defenses.

The new model of psychic functioning did not bring about a change in the basic therapeutic goals of psychoanalysis, which remained founded on the analysis of resistance and transference. It did, however, result in a shift of emphasis on what was to be analyzed, for it was now seen that unconscious elements of the ego and superego had to be dealt with in the analytic process. Attention was increasingly focused on *ego analysis:* on the unconscious aspects of ego defenses; the intricacies of character structure; and the pathogenic influence of the unconscious pressures of the superego. Concomitantly, further clinical observations—primarily in the realm of ego psychology—were reported not only by Freud but also by many of his co-workers, such as Anna Freud (1947) (ego defenses), Alexander (1925) (superego functions), and Reich (1949) (character analysis), all setting the stage for an elaboration of the theories of ego functions and the development of parameters in the classical psychoanalytic techniques. Despite the more recent introduction of such parameters, however, the procedures described in Freud's publications on technique between 1911 and 1915 remain the method of classical psychoanalysis as it is still practiced today. This will shortly be described in greater detail, but first let us compare and contrast the therapeutic approach invented by Freud with that of his predecessors.

As we have seen, from the distant origins of psychotherapy in Mesmer's

magnetic passes to Freud’s time, the patient was consistently the passive recipient of the doctor’s active interventions. Whether his symptoms have been viewed as stemming from physical or psychological disturbances, he has been subjected to therapeutic maneuvers aimed at restoring his deranged physiology or suppressing unwanted symptoms without his taking any active part in the procedures or assuming any responsibility for his cure, other than allowing the therapist to treat him. With the advent of Freud and the development of the psychoanalytic method there was a radical change in outlook. The patient was now seen as having both autonomy and responsibility in regard to his illness and its cure. Not only were his symptoms viewed as being the result of inner psychological conflicts, those conflicts were also conceived of as stemming from inner, autogenous needs and drives that motivated the individual from within and became a source of difficulty when they ran contrary to the sanctions and codes imposed by his conscience and by society. In therapy it became the task of the patient to "know himself," to join the therapist in an active search for the inner, often irrational drives hidden from consciousness by repression. In that search the patient had to confront himself with courage and to push ahead with his self-exploration despite the pain and anxiety this might cause him. This alteration in the patients’ role was reflected in a comparable change in the therapist’s stance, for instead of being the active manipulator of an individual passively submitting himself to treatment, he became more the aiding midwife,

working together with his patient in the struggle to deliver into the light of conscious awareness the unconscious pathogenic forces that only the patient himself could reveal. In this therapeutic partnership lies both the unique power of psychoanalysis as a curative agent and, as we shall see, its limitations as a treatment for emotional disorders.

The Strategy of Psychoanalysis

The fundamental aim of psychoanalysis is to bring into conscious awareness the unconscious elements of the psychological conflicts that underlie symptoms and character problems, and to trace these roots to their genesis in the childhood distortions of the normal process of growth and development. The two basic strategical operations employed to achieve this ultimate goal are the analysis of resistances and of transference.

Resistances

We have seen how Freud, when he began to employ the techniques of free association, recognized the phenomenon of resistance in the breaks that occurred in the free flow of those associations. Theoretically, if an individual allows a completely unguided, uncontrolled, unfocused, unwilled play of ideas to pass across the stage of his consciousness, its form, nature, and content will be determined by and an expression of the underlying drives and emotions

pressing for discharge. In fact this rarely happens—even in the dreaming state, when ego-controlling functions are diminished. On the contrary, as undesirable and anxiety-provoking elements begin to surface, ego defenses are automatically brought into play to counteract and contain them. The resistances to free association observed by the analyst are the visible effects of the operation of these ego defenses. Resistance, then, is a function of the ego, its nature being determined by the nature of the defense behind it. Hysterical repression, for example, will be manifested by a sudden drying up of thoughts or by the forgetting of significant links in the chain of associations. Isolation will be manifested as a failure to include references to emotional reactions despite a ready flow of associations describing the more cognitive, perceptual aspects of events or fantasies.

From an analytic and therapeutic point of view it is essential for the analyst to deal with resistances. He must himself he alert to their existence, must help the patient to see them, and must analyze them along with the related defenses in order to penetrate through to the underlying, unconscious, anxiety-provoking drives and affects that constitute the driving force of the pathological psychic conflict. Without this fundamental maneuver analysis cannot proceed.

Transference

Transference is the source of special and often stubborn resistances that need particular attention during the process of analysis. The phenomena named transference are found in a variety of human relationships (student-teacher or employee-employer relationships, for example), but they are particularly encouraged to appear in the patient-analyst relationship by the very nature of the analytic process itself. The individual displaces onto the analyst old patterns of relationships developed with the significant figures in his childhood. As these old patterns are repeated with the analyst, they tend to be viewed by the patient as having a reality and legitimacy of their own in his current relationship with the analyst. This tends to prevent him from remembering the earlier events and the relationships that gave rise to them, a particularly effective form of resistance known as *transference resistance.*

A distinction is generally made between transference and *transference neurosis.* Transference, the more general term, refers to readymade, irrational attitudes toward the analyst that the patient brings to the analysis. As the analysis proceeds, however, and previously unconscious conflicts come closer to the patient's awareness, the transference phenomena are intensified into a neurosis. The patient regresses to earlier forms of relating that he may not initially have manifested, and behavior patterns that stem from his early childhood appear in his relationship with the analyst.

Far from being an unwanted artifact, the transference neurosis becomes

a central focus of the analytic process; for here, in a controlled and almost laboratory-like situation, the patient brings into the view of both himself and the analyst attitudes and patterns of behavior intimately related to his neurotic problems. It then becomes possible to define the nature of these patterns, to trace them to their origins in childhood, and to discover their role and function in the patient's psychic economy.

Resistance is related to the transference in two ways. There may be a *resistance to the transference:* that is, the patient resists the development of a transference neurosis and thereby deprives himself and the analyst of a vital avenue to the analysis of his conflicts. In transference resistance, on the other hand, the transference itself is used as a resistance, as has been already noted: rather than remembering the early experiences that lie behind the transference manifestations, the patient stubbornly maintains his transference patterns and tends to insist on the legitimacy of his feelings for the analyst.

As is implied in the references to the childhood roots of transference, it may contain many colorings related to the variety of relationships the patient has had with significant figures in his past (notably mother, father, and siblings), and the analyst may be reacted to as several different people in turn. The transference may be loving, dependent, or hostile, the quality being determined by the nature of the earlier relationship that at the moment is

determining the patient’s behavior in analysis.

Countertransference

Just as the patient has irrational and inappropriate attitudes toward and feelings for the analyst that are displaced from his relationship to early childhood relationships, so too, and for the same reason, the analyst may have similarly irrational and inappropriate attitudes toward and feelings for his patient. This is called countertransference. As with the patient’s transference, the analyst’s countertransference is determined by his unconscious conflicts. It may be manifested by unrealistic feelings (anxiety or hostility, for example) or by unnecessary if not outright antitherapeutic behavior (forgetting an hour, for instance, or falling asleep repeatedly). It is, of course, essential that the analyst examine his own behavior and analyze any manifestation of counter-transference as it arises.

The Therapeutic Alliance

Not all the attitudes and feelings a patient has for his analyst are necessarily the manifestations of transference. Indeed, in the patient who is a good subject for analysis, it is assumed that his childhood relationships have enabled him to develop basic trust, so that he comes to analysis with a genuine faith in the good will, skill, and reliability of the analyst. Classical

psychoanalysis cannot proceed very far unless it rests on this fundamental sense of mutual trust between analyst and patient. The trust, furthermore, is the basis for the *working*, or *therapeutic alliance* (Greenson, 1965), of patient and analyst that is essential for the progress of the analysis. The working alliance is founded not only on this basic trust but also on the capacity of the patient to achieve an inner split between one part of his mind, which relives and expresses his psychic conflicts, and another, which maintains a distance on himself that enables him to observe his own behavior and feelings and to recognize their irrational quality.

The Tactics of Psychoanalysis

If the goals and strategy of psychoanalysis can be simply stated and adequately painted in the sweeping strokes of generalizations, the tactics by which the goals are accomplished are impossible to convey, for they are as richly variegated and complex as the infinite variety of human personalities with which they deal. "Anyone who hopes to learn the noble game of chess from books," wrote Freud (1958), "will soon discover that only the openings and endgames 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's discouraging if not despairing comment was subsequently extensively documented by Glover (1968), who in a survey of the practices of English analysts in the late 1930s found a wide diversity in the application of techniques generally thought to be clearly defined and standardized in their usage. And more recently a committee of the American Psychoanalytic Association (Rangell, 1954) had to abandon a comparison of the effectiveness of psychoanalysis and psychotherapy when its members could come to no agreement as to an operational definition of either. It would be rash, therefore, in the space allowed here, to make definitive or dogmatic statements about the tactics of psychoanalysis. What follows must be viewed as empirical generalizations describing some of the more common clinical problems with which the analyst must deal and how he attempts to approach them. These will be discussed under four main headings: (1) the selection of the patient; (2) the preparation of the patient; (3) the process of analysis; and (4) the evaluation of the effects of analysis.

The Selection of the Patient

Psychoanalysis, especially when it is restricted to the classical techniques, has a limited applicability. Quite apart from the fact that it is time-consuming and expensive, it requires of patients a degree of discipline and psychological strength that is lacking in many individuals. Originally developed by Freud in his work with neurotic patients, analysis is still best

suited for the treatment of the neuroses and for dealing with individuals with character problems that are compatible with the requisite strength of personality. In addition to the nature of the symptoms, there are a number of criteria that help to determine the suitability of any given patient for analysis.

Motivation

The presence of ego-alien symptoms and character traits that cause the individual person distress and discomfort is a strong motivating force for seeking help and is a sine qua non for the long, rigorous, often painful process of psychoanalysis. The person who lacks such motivation, who undertakes analysis because of external pressures from friends or family or simply out of curiosity, is not liable to stick to it—with the possible exception of the psychiatrist or other therapist who may be strongly motivated to a self-knowledge that will help him in dealing with others.

Capacity to Form Object Relationships

A degree of narcissism is normal for all people, but when it is so extensive as to compromise the individual's capacity to make genuine object relationships, classical psychoanalysis cannot easily be carried out. The patient must have a sufficient degree of basic trust to make an early working alliance with the analyst and to maintain this intact throughout the stormier periods of the process. He must also be capable of developing a transference

neurosis, investing the analyst with love, hate, and other feelings that, though displaced from earlier figures, become attached to a real person external to the patient. It is further helpful if he has at least one good relationship in his real adult life.

Psychological-mindedness

Many patients bring to analysis a curiosity about their inner psychological life and a capacity for introspection that is invaluable to them in carrying out the tasks required of them by analysis. Analysis itself will, of course, help to develop skills in this regard, and one must not expect every patient to come to treatment fully adept in self-examination, but he must have the potential for it if analysis is to he in any degree successful. The ability to achieve a therapeutic splitting of consciousness should he included here—that is, the capacity to set one part of consciousness over against the other so that the former can observe with a reasonable detachment the flow of fantasies and feelings through the latter.

Availability of Emotions

In general, patients should be able to reach, experience, and report on their emotions if analysis is to proceed. A possible exception to this is the individual with an obsessional character structure, who may bring to analysis a well-developed defensive isolation that makes him at first appear to be

without strong emotions. This tends to lead to a longer analysis than in an individual whose emotions are more accessible, but unless the isolation is inflexible, the patient's emotions can ultimately be freed from their prison house as the analysis reaches a successful conclusion.

Intelligence

Although it has not been subjected to experimental testing, it is generally felt that a reasonable degree of intelligence is a prerequisite for analysis. It is required for the ready grasping of connections and nuances and for the capacity to understand the nature and goals of the treatment.

Age

There have been a few attempts to analyze patients in the later years of life. The results have surprised the investigators with the plasticity and adaptability of some older people. These few analytic experiences, however, do not yet justify discarding the general consensus that younger individuals are fitter candidates for analysis because they are less liable to be set in rigid patterns of thinking and behavior and hence have greater capacity for change.

Freedom from Environmental Turmoil

Anxiety and emotional upset arising from disturbed and chaotic

external situations in an individual’s life are usually inimical to the successful search within for internal conflicts rooted in the individual’s past. A degree of external calm and order is necessary for the orderly progress of an analysis. In general, analysis should not be undertaken with a patient, however suitable he is in other respects, if his life is not free from serious environmental crises. This is not to imply that other forms of therapy involving supportive measures should not be employed. These, indeed, may help a patient through to a more tranquil situation in which analysis may be started.

The Preparation of the Patient

Once the patient has been evaluated and the decision reached to proceed with analysis, certain preliminaries are necessary before the analysis proper begins. In the early days of psychoanalysis an extensive preparation and education of the patient was often carried out, in which he was informed in general terms of the nature, theory, and goals of analysis. This was before the widespread popularization of psychoanalysis, which underlies the current general knowledge about it and makes such detailed instruction unnecessary.

It is wise, however, not to take too much for granted, and to make sure that the patient understands the basic ground rules of operation. One often starts by asking the patient exactly what he knows about analysis and the

techniques for carrying it out. One proceeds from there, either correcting the patient's misinformation or supplementing what he does know with the appropriate facts. The patient should understand the use of the couch and the nature and importance of free association and what is to be expected of him in this regard. The time and frequency of hours are arranged and his responsibility for keeping his appointments should be made clear to him. General guidelines about vacations and holidays should be clarified, fees set, and agreement reached as to what lines of communication are to be used when either analyst or patient needs to be in touch with one another about canceling or changing appointments or other similar issues. Finally, if the patient has no physician and has not recently been examined, it is generally considered wise to refer him to an internist with whom the analyst has a comfortable professional working relationship. In the younger population with whom analysis is usually carried out, serious physical illness is not liable to occur; but in those instances when it docs, the best care of the patient and the least disruption of the analytic process are ensured if both patient and analyst have a trusted physician who is prepared to assume the responsibility for his intercurrent medical or surgical problem.

The Use of the Couch

Having the patient lie horizontal as the analyst sits out of sight behind him is, it is commonly pointed out, a relic of the position assumed in the early

days of hypnosis. While this may be true, the horizontal position has a justification in its own right. It removes from the patient the multiple cues he could obtain about his analyst's responses from watching his face and gestures; and by minimizing this intrusion of reality, it allows a freer play to the patient's fantasies and emotions and the impulses that lie behind them. At the same time it frees the analyst from the need to police his mien and behavior, and it allows him to relax into that frame of mind of *free-floating attention* (discussed below) that is so essential to his task of understanding his patient's associations. The power of the simple maneuver of having the patient lie on his back and stare at the ceiling, with his analyst out of the range of his vision, is attested to by the frequently rapid deterioration of reality testing and emergence of psychotic productions in those patients with borderline psychotic personality organizations who, through an error in diagnosis, are sometimes mistakenly started in analysis.

Frequency of Hours

In the early days of analysis, patients were generally seen an hour a day, six days a week. When analysis was imported to England, the six-day week, as Glover (1968) commented, "did not . . . withstand the impact of the British week-end habit," and five days a week became the usually accepted custom. With the yet farther westward movement of analytic treatment to American shores, analysis has frequently been shorn to four sessions of fifty minutes a

week by the American penchant for technical efficiency and assembly-line production. Anything less than this, especially in the initial stages of analysis, is generally thought to be incompatible with effective analysis. If the patient goes too long between hours, there is a tendency (especially in those with obsessional character structures) to "seal over." That is, defenses that may have been loosened in the process of analysis become stronger again, and the momentum gained in reaching the underlying conflictual material is lost. This is often particularly noticeable after a vacation break of several weeks and, in some, even after the two days of the weekend, a phenomenon colloquially termed the "Monday-morning crust."

Abstinence and Prohibitions

In the early days of analysis, stringent restrictions were often imposed on the patient with respect to his bodily (especially sexual) appetites, on the assumption that his motivation for analysis would wane were he to experience too full a gratification of his drives. Such specific prohibitions are not customarily enforced in contemporary analytic practice, but care is exercised by the analyst not to gratify the patient’s dependency needs. Requests for medication, questions about the analyst’s life or attitudes, and a variety of bids for lose and attention are not responded to or gratified by the analyst. He may, furthermore, make specific injunctions about major changes that the patient may be considering in his life, such as marriage or a new

career, especially when these moves appear to be significantly motivated by the neurotic conflicts or the forces of the transference neurosis. In such cases the patient is warned of the dangers of a poorly-understood decision and is strongly urged to postpone action until such a time as his contemplated behavior has been thoroughly analyzed.

Trial Analysis

Once the patient has been evaluated in one or more face-to-face interviews as well as through the employment of any adjunctive studies that are indicated, such as psychological testing, the patient is ready to lie down on the couch and begin the analysis proper. In some patients, however, this may not mark the end of the analyst's evaluation of his suitability for analysis. On occasion, despite an extensive initial evaluation, questions may still remain as to the patient's ability to withstand the stresses of analysis, to free associate, to form a working alliance, or even to maintain basic ego functions intact in the analytic position. In such cases the analyst may recommend to the patient a period of trial analysis of limited duration (no more than a few weeks) to determine, from the early responses to the analytic process, whether analysis is the treatment of choice for him, or whether some other therapeutic measure would be more helpful.

Free Association

The requirement that the patient tell the analyst every thought, fantasy, and feeling that enters his consciousness has been termed the "fundamental rule of analysis." *We* have already seen that completely free association is an ideal, rarely achieved skill. Indeed, it has been said that when the patient does truly associate freely, analysis has been completed. And we have noted that the variety of impediments to the process of free association reveals resistances that point to the psychological conflicts needing analysis. Most patients coming to analysis at the present time are sophisticated enough to have heard of free association, but the analyst should nonetheless discuss the process with the patient to reinforce what he does know, to correct his misapprehensions, or to fill in any gaps in his knowledge. Free association is still the central tool of analysis; it should not be slighted or passed over lightly by either patient or analyst.

Free-Floating Attention

The counterpart of free association in the patient, free-floating attention forms the basic stance of the sensitive and effective analyst. A state of mind hard to define, it is perhaps easier to describe in negatives than in positives. The analyst avoids an active, voluntary focusing of his attention on specific aspects of his patient’s associations. He does not single out a conflict or set of conflicts that appear to him to be significant, and he eschews any attempts (especially during analytic hours) to put the pieces together intellectually, to

define a pattern, to determine mechanisms, or to arrive at a rational formulation of the patient’s problem. Rather, he focuses his attention on the patient himself and immerses himself in the whole stream of associations, allowing them to flow through his alert, receptive mind without any concentrated effort at intellectual understanding. His is a passive, unguided attention that, in absorbing all of the patient’s associations, permits the unconscious, intuitive elements of his mind to sense connections among associational fragments and to see patterns and significant relationships in the seemingly amorphous productions of the patient. In due course these connections and patterns are delivered into the analyst’s consciousness seemingly unbidden, without his voluntarily trying to raise them. Like the *donée* of the poet, they are a gift to his conscious awareness. They emerge accompanied by the same sense of insight and discovery that the artist often experiences. The work of the analyst is a truly creative act. This fundamental approach to his patient’s associations provides him with the basis for his subsequent therapeutic interventions as well as for his more theoretical, intellectual formulation of the nature of the patient’s psychopathology.

The First Hour

Much has been made of the mystique of the first hour and the far-reaching predictions the seasoned analyst can make from his observations of the patient during that initial session. No doubt the patient’s conflicts and

patterns of behavior are indeed visible then. But the analyst who is unable to unravel all of his patient's mysteries after that single hour need not turn in his couch in despair, for there are many hours of observation to come.

Each patient, of course, approaches analysis in his own unique way, but there are several general categories of initial behavior that may be mentioned. Most patients begin analysis with some degree of anxiety, especially over the idea of lying on the couch. In a few this is sufficiently great to he disorganizing, sometimes to the point of making the patient barely able to talk, if not altogether mute. In such cases, general and quiet support from the analyst—a question or two to get things started, or an open recognition of the patient's anxiety—is sufficient to quiet his nervousness so that he can carry on. Some individuals come with a hitherto unconfessed guilty secret, which they proceed to pour forth, often with considerable apprehension and anxiety. The analyst's simple acceptance of the patient's recital is generally a sufficient response, and the patient usually feels better after his emotional catharsis.

Patients also vary in the form and content of their productions. Some begin with a detailed account of current conflicts and problems, others with an intellectualized analysis of their own characters, and still others with an orderly chronological account of their life histories. The more obsessional patient tends to talk without much affect, and has often rehearsed what he

plans to say during his hour long before he arrives. In contrast, those with hysterical traits may be more openly emotional and effusive in their speech. Certainly, these early observable patterns of behavior give the analyst a clue as to the patient's style and what lies ahead, but it is, after all, only the opening engagement between the two of them. Much remains to come, as the transference neurosis develops and unconscious material begins to appear in consciousness as a result of the analytic process.

The Course and Stages of Analysis

The usual analysis requires from three to five years, if the goal includes an analysis of character traits as well as of symptoms (which often disappear early in the development of the analytic relationship). Many individuals come to analysis without having sharply defined symptoms and seek help, instead, for difficulties in their human relationships.

As Freud suggested in his metaphor of the chess game, each analysis unfolds in a unique way, depending on the infinite combination of variables that go to make up human personality. Thus it is impossible to describe sharply-defined categories of stages in the unfolding of the analytic process. There are, however, certain general phases that characterize the course of analysis in most patients.

1. In the initial phase, the patient often continues very much as he has

started in his opening hours, recounting problems, reviewing the history of his life, and revealing his own conscious introspections about himself as a person. The gratification involved in being able to talk freely about oneself to an interested listener, the support provided by the basic trust in his analyst and the positive transference felt for him by the patient, and the relief attendant on confessing guilty secrets or on the early disappearance of painful symptoms—all these carry the patient along without undue disruptions of the analytic process.

2. Although in the initial phase there may have been early minor evidences of resistance, resistances become more prominent and the analysis begins in earnest with the development of the transference neurosis and the gradual emergence of unconscious conflicts closer to the surface. A prominent feature of this next phase is the regression of the patient to early forms of relating, and to the expression of drives and emotions—erotic, aggressive, and dependent—that have characterized earlier relationships (especially those in childhood) and are now transferred onto the figure of the analyst.

3. Though not sharply delineated from the previous stage, the phase of working through (discussed below) can be a protracted and tedious process. It may constitute the longest period of the analysis, as the patient repeats over and over his early patterns of relationships, gradually frees himself of neurotic behavior and reactions, and develops new ways of viewing himself

and other people.

4. In the terminal phase of analysis, early material relating to losses and separations are often revived that have not emerged beforehand. Dependency issues are dealt with in this context and the transference neurosis is resolved. The patient is finally freed of crippling neurotic patterns so that he can carry on by himself, made more effective in his work and relationships by the self-knowledge he has gained during his analysis.

Specific Techniques

Much of the time, as we have seen, the analyst is cpiiet during a session. However, he is by no means passive or inactive, for he is following his patient's associations closely, searching for patterns of behavior, for signs of psychological conflict, for resistances, and for evidence of transference. His therapeutic goal is to uncover, through the analysis of these surface manifestations, the unconscious determinants of the patient's neurotic disorder and their genesis in his early childhood experiences. Especially since the pioneering work of Wilhelm Reich (1949) on character analysis, it has been a general principle that patient and analyst must begin their work of analysis with the outermost layers of the psychic structure— that is, with the psychological defenses and the resistances that result from them. Since the defenses serve the function of protecting the patient from the painful ego

affects of anxiety and depression by rendering unconscious his undesirable impulses, affects, and fantasies, the patient must be able to tolerate the emergence of both these affects as the defenses are modified by analysis. At the same time he must be helped to discover, to experience, and to integrate into his consciousness the impulses and their derivatives that underlie his painful anxiety and depression and are the ultimate source of his neurotic difficulties. In carrying out this therapeutic task, the analyst's active interventions are generally limited to three basic tools: (1) confrontation; (2) clarification; and (3) interpretation.

Confrontation

Many aspects of the patient's neurotic problems are ego-alien. That is, he recognizes them as being painful, undesirable, and distasteful, or as an impediment to his goals. This is particularly true of symptoms, which are usually felt as phenomena imposing themselves upon the patient from without and against his will. He may also experience certain of his character traits and patterns of relationships with others as being unacceptable to him because of the problems they pose for him. But more often than not, the distortions in his personality and relationships go unrecognized by him. They are the "way he is," and he accepts them without question; they are ego-syntonic. This is especially true of the resistances and transference manifestations that arise in the course of the analysis, and it is a primary task

of the analyst to confront the patient with his behavior, his attitudes, and his irrational affects. When successful, this has the effect of making the patient, for the first time, look objectively at an aspect of himself and raise questions about the meaning, origin, and obligatory nature of what he sees.

Clarification

When, through confrontation, the patient has been made to see himself in a new light, the next step is to pass through the door that has thus been opened and explore the room into which it leads. With the guidance and questions of the analyst, the patient's behavior is examined in depth. The details of his behavior patterns, character traits, and resistances and transference attitudes, as well as the situations in which they occur, the consequences to which they lead, and their beginnings in the past, are all made explicit. Further questions are raised as to their meaning and function and their relations to the neurotic symptoms and conflict.

Interpretation

Confrontation and clarification are only the prelude to interpretation—that is, to making conscious the unconscious roots of the patient's observable surface behavior. Interpretation involves a weakening of habitual defenses. It helps the patient to discover previously unrecognized character traits, long-repressed drives, isolated affects, and connections among significantly related

phenomena that had been kept separate in his mind by isolation, until ultimately he finds the childhood roots of his adult neurotic disorder. The proper timing of interpretations—a function of the analyst's experience and skill—is essential, since premature interpretations not only will be rejected by the patient but may even increase his resistances. Interpretations ideally are made only when the unconscious material is on the verge of emerging into the patient's awareness as a result of the analysis, through confrontation and clarification, of his defenses and resistances.

Working Through

The technical procedures that have just been described form, as we have said, the analyst's classical *modus operandi.* However, it is important to recognize that the simple application of confrontation, clarification, and interpretation usually has only a temporary effect on the material thus under analysis. Human behavior patterns tend to be stubborn in their persistence; early in the development of analytic procedures, Freud and his colleagues discovered that the repetition of such patterns (the *repetition compulsion*) was a fundamental characteristic of human psychological functioning.

Practically speaking, therefore, any symptom or other neurotic manifestation must be "worked through" over a period of time. That is, it takes repeated confrontations, clarifications, and interpretations to enable

the patient to make a permanent change in his psychic structure and resulting behavior. Patients, of course, vary in their flexibility and in the ease with which they can alter their behavior patterns; but at best, change is a slow and painstaking process. Just as the nature of tissue regeneration limits the speed of wound healing, so does the necessity for working through pose an inherent limitation on the rapidity with which analysis can be completed.

Dream Analysis

Before concluding with the classical techniques, we must say a word about the role of dream interpretation in analytic treatment. Freud, as we know, considered dreams to be "the royal road to the unconscious," and the momentous discoveries he made about the human psyche from the analysis of his own and others' dreams are presented in his classic *The Interpretation of Dreams* (Freud, 1947). Perhaps because dreams and dream analysis proved such a powerful tool in unlocking the mysteries of the unconscious, Freud and the early analysts who worked with him placed a great deal of stress and reliance on the extensive analysis of individual dreams. This often took up several analytic sessions in sequence, as analyst and patient followed each element of the dream from the highways to the remotest byways of the territory it revealed. Analysts nowadays are less inclined to be so exhaustive in their analysis of the dreams their patients report. They may pursue the associations to selected dream elements that appear clearly related to

problems the patient is currently working on, and occasionally may direct the patient back to his dream in the hour or two following its recital, but often they are content with hearing only the patient's spontaneous associations to his dream, viewing all the productions of the patient as equally important signposts of conflict and resistance.

Variations in Technique

As the practice of analysis has grown over the years, and as larger numbers of patients have been treated for longer periods of time, analytic methods have been applied to individuals with a wide variety of clinical disorders and character problems. The classical procedures were initially developed in the context of working with patients with neurotic difficulties that derived mainly from oedipal problems, and for many analysts this still remains the main indication for psychoanalysis. The striking effectiveness of analysis in many clinical situations, however, quite understandably led to its experimental application to the more serious conditions (such as the psychoses and narcissistic disorders) for which it was generally felt to be contraindicated. As a result, a number of variations in technique have been proposed that are aimed at overcoming the difficulties that many of these patients pose for the application of classical procedures alone.

Ferenczi was one of the first to advocate modifications when, in the

early 1920s, he suggested "active treatment" (Ferenczi, 1952; Ferenczi, 1952) for patients in whom the defense of phobic avoidance or the gratification of erotic impulses precluded the raising into consciousness of important pathogenic affects. Such patients, he recommended, should either be forced to expose themselves to the phobic situation or should be prohibited from erotic gratification in order to make them more accessible to analysis.

It is important to note that Ferenczi’s suggestions were concerned only with the activity of the patient. Apart from his injunctions, the analyst restricted himself to the classical methods of analyzing resistances and transference in the traditional manner. With the tremendous expansion of interest in analysis in the United States after World War II, further modifications of techniques were suggested that involved activities on the part of the analyst constituting a considerable departure from the more restricted, traditional procedures. Eissler (1953; 1958), for example, recommended the use of "parameters" with patients with serious ego defects that precluded a response to classical analysis—variations that permitted the analyst to be actively supportive and directive when necessary. Alexander (1954) proposed varying the number of analytic sessions to control regressive transference, which was in his view an often harmful artifact of analysis. At the same time he suggested that the analyst should manipulate the transference by purposely assuming specific roles different from those the patient had known in previous relationships, in order to provide the

patient with a "corrective emotional experience" (Alexander, 1925) In a series of symposia and papers, others (Loewenstein, 1958; Stone, 1954) have made further proposals for modifications in techniques so that analysis might be adapted to serious disorders such as schizophrenia or sexual aberration. These proposals have not gone unchallenged by adherents of the more classical form of analysis; and, lacking adequate data to settle the matter definitively, the debate continues (Freud, 1947).

Termination and Follow-up

Termination

Mention has already been made of the fact that as analysis enters its final phase, a date is set for termination. This should not be confused with forced termination, a minor parameter first employed by Freud in his famous case of the "Wolf Man" (Freud, 1955). Freud's aim in this instance was to motivate a patient locked into a comfortable dependent transference to make a renewed effort at analytic self-examination; the setting of the termination date, in other words, was a one-sided decision used by the analyst in the interests of furthering the analytic process. In the usual termination this is not the case. The date for ending is arrived at by mutual agreement between patient and analyst, and it is set far enough ahead in time to allow for the proper resolution of the conflicts that usually arise at the prospect of

separation. Some analysts cut down on the number of weekly sessions during the terminal phase, with a view to enhancing the patient's return to complete autonomy, but many maintain a full schedule of hours right up until the last. There is no consensus either as to the indications for or the value of such a modification.

Follow-up

There is no general rule with regard to seeing the patient again after the analysis is terminated. The fact that the more formal, systematic procedure of analysis is completed does not mean that its effect is no longer felt. On the contrary, many patients continue to grow and change, either because of the forces set in motion by the analysis itself, or because they can apply to themselves the process of analysis they have learned in their work with the analyst. Analysis, furthermore, is no certain protection against further emotional difficulties in the future, in the face of environmental stress or the biological changes associated with the continuing phases of life. Freud (1964), in a pessimistic paper written late in his life, came to the conclusion that analysis worked best for those patients whose neurotic problems were primarily traumatic in nature, and he doubted that analysis could activate and preventively influence latent conflicts that might at some future time cause the patient difficulty. Analysts vary in the readiness with which they will see patients again after the analysis is ended. Many will at least be available to a

patient who runs into difficulties, to help him evaluate the new situation and to obtain further treatment if it should be necessary.

Evaluation of Therapeutic Results

When we turn to a consideration of the therapeutic results of analysis, we find ourselves in a morass of methodological complexities. Analysts, when they have focused their attention on this question, have been more concerned to examine the theory of therapeutic results than the actual nature of the therapeutic outcome itself. Critics such as Eysenck (1952), have martialed statistics to show that prolonged psychotherapy, including analysis, is less effective as a treatment than are simpler measures involving support and suggestion, or than no treatment at all. And yet despite dire predictions about its imminent demise, and despite a recent and probably salutary falling-off of applicants for analytic training, analysis and analysts continue to thrive.

It is perhaps easier to explain than to resolve this paradox. The methodological problems inherent in evaluating the results of psychoanalysis are so complex as to be overwhelming. There is neither agreement nor consistency among analysts as to the criteria for selection of patients, the technical procedures to be included under the term "psychoanalysis," or the criteria for improvement or cure. Some analysts, for example, restrict their patients to those with transference neuroses, whereas others are willing to

apply it to psychotic individuals. Some stick strictly to the methods of classical analysis; others are flexible in their introduction of parameters. Some judge improvement by the amelioration of symptoms; others turn more to changes in personality structure and quality of relationships as their indications of improvement. The variables introduced by these differences alone (to say nothing of the difficulty in collecting large series of patients or establishing adequate controls) make the task of evaluating the effectiveness of analysis a Herculean if not impossible one.

Aerodynamics engineers, it has been said, have proven that given the ratio of wing area to body weight, it is impossible for the bumblebee to fly; but the bumblebee, ignorant of their mathematically arrived-at conclusions, continues happily to remain aloft. Certainly, in the intimate relationships between analyst and patient, many things happen that are hard to record or document but that are emotionally and experientially convincing to each-—of the power of analytic procedures to induce changes in the patient, to bring him to a wider knowledge of himself, and to enable him to learn new ways of living that make him a richer, more effective person.

The individual patient has no doubt of the value of the knowledge he has gained. But the knowledge is not intellectual alone; it involves a change in perceptions, attitudes, and responsiveness to life. The heart has reasons of which the head knows nothing, as Pascal long ago recognized. For the patient,

his immediate knowledge of the effect of analysis is sufficient evidence of its worth, however skeptical the outside observer may be and however lacking the statistics to "prove" its usefulness.

Perhaps its effectiveness can never be shown by scientific methods, and possibly, because of the complexity and nature of the analytic process, it is a mistake even to attempt such a demonstration. Perhaps the experience of analysis is like that of beauty, of mysticism, of love—self-evident and world-shaking to him who knows it, but quite incommunicable to another who does not. This, of course, is entirely unsatisfactory (if not evidence of downright folly) to the uninitiate, and he will and should demand more scientific evidence for the practical value of analysis. Fortunately, so do many analysts, and there is now an increasing interest in the better definition of analytic procedures. These are being investigated, not in the almost impossibly complex situation of psychoanalysis but in the more restricted area of briefer analytically-oriented psychotherapies, where the variables are fewer and more manageable (Sifneos, 1972). There is hope that sharper definitions and valid statistical statements will come from these investigations, and that further insight into the nature of analysis will arise from these more limited observations. Meanwhile, let the bumblebee fly.

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Notes

1 Hawthorne, N. *The Scarlet Letter,* p. 98. Garden City, N.Y.: Doubleday, 1970.

2 See references 20 through 25.