Psychoanalytic Practice: Principals

Means, Ways, and Goals

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Means, Ways, and Goals

8.1 Time and Place

The structure of numerous social events is based on the categories of time and place. The regular club evenings, the Wednesday meetings in Freud's apartment, church on Sunday, and summer vacations at the same place every year are just a few examples of the biologically and socially based rhythm of life. Regularity can reinforce identity. We now want to examine the issue of the frequency of treatment from this perspective about the organization of experience.

Even though Freud introduced his "principle of leasing a definite hour" for pragmatic reasons, the daily session was nonetheless important to prevent treatment from "losing contact with the present," by which he meant a patient's life outside analysis (1913 c, pp. 126-127). Yet we also must take into consideration the fact that the treatment itself can become a patient's present, i.e., the decisive factor in his life. More recently it has become possible to observe a tendency away from daily sessions, as Freud practiced them, and toward analyses of varying intensity. This tendency is motivated by strategic considerations, that is by the attempt to be flexible in finding solutions:

> The specialized yardstick for the temporal intensity of treatment is one which registers which combination of structuring. confrontation, and assimilation is optimal for the dynamic of treatment, given the observation and participation of the analyst and taking into consideration relevant events and the patient-s experiences outside the analytic situation, his assimilation of them between sessions, and the goals of treatment. (Fürstenau 1977, p. 877)

Alexander and French (1946, p. 31) suggested controlling the intensity of transference by varying the frequency of sessions — which met vehement resistance. What is it, then, that moves us to retain the frequency originally chosen and to alter this arrangement only after long and careful reflection? This raises an interesting point: on the one hand, the frequency of sessions is viewed as a variable dependent on the optimal combination of structuring, confrontation, and assimilation, but on the other hand, once settled it takes on the character of an independent variable, that is it becomes part of the setting and an object on which conflicts in the relationship can crystallize. The time agreed upon becomes the scene of struggle involving very different motives — on both sides. It can be just as much an occasion for conflict as

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the analyst's silence. Since adherence to the schedule of sessions in the analyst's office is an important general condition, it is an especially attractive target for the patient unconsciously to attack. This is a sensitive area because the patient can threaten the analyst's autonomy by attacking his use of time as a basis for organization. The more uncompromising the analyst is in defending the established frequency, the more intense the struggle can become.

The arrangement of frequency is an issue which can be derived from the theory of technique only to a limited extent. Deciding on six, five, four, three, two or even only one hour per week does not in itself enable us to make predictions about the consequent scope for the maneuvers that can make therapy possible under extremely variable conditions, such as were described by Rangell (1981) in his retrospective on twenty-five years of professional experience. Frequency does, of course, influence the amount of space available for unconscious processes to unfold. This leads us to the stage metaphor, which we, like Sharpe (1950, p. 27) and Loewald (1975) before us, take seriously. While the size of the stage, i.e., the space available for enactment, provides a general frame, more is demanded of the director than simply putting actors on the stage. Loewald (1975, pp. 278-279) speaks of transference neurosis as a drama that the patient creates and enacts together with the analyst. In addition, we are especially interested in the question of the length of time that the individual patient requires to enact his unconscious conflicts in the analytic relationship. Today it seems obvious that standardized policies, e.g., that four hours is a minimum to enable transference neurosis to develop, are the remnants of an orthodox understanding of psychoanalysis. It can be shown that whenever a reduction in the weekly number of hours has been necessary for real economic reasons — such as in France, where as a rule analyses are conducted in three sessions a week — the substance of the analytic activity does not necessarily depend on this external factor. In occasional cases it may be possible to establish and maintain a therapeutic process only if treatment is very frequent (five or six sessions a week). In such circumstances this frequency is justified. We believe, however, that a myth of uniformity currently obscures psychoanalytic thought, preventing any objective discussion of the individual case — such as the number of sessions per week a patient requires.

We regard the argument that it would be possible to determine the differences between patient's reactions to the standardized situation more satisfactorily if all patients had the same frequency of sessions to be the expression of a false and restrictive understanding of the rules. In his comparison of

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psychoanalytic procedure with the preparation of a specimen for microscopic study, which requires that the correct procedure be followed in order to ensure the comparability of the results, Bachrach (1983) committed the fundamental error of assuming that identical data could also be accumulated in a social situation by employing a prescribed set of external procedures. Bracketing out the specific meaning of such external procedures creates an illusion, as we have made clear in discussing the issue of analyzability.

The significance of the frequency and the desired intensity of treatment can only be adequately understood, however, if the question of how an analysand comes to terms outside analysis with his experiences in analysis is included in the theoretical and clinical discussion. Patients who require a long time to create a connection between individual sessions — who retreat into a kind of defensive capsule and who obstruct the development of the self-analytic process — obviously require a greater frequency of treatment than patients who develop this ability early and are able to use it. The "analytic space" (Viderman 1979) thus also refers to the intrapsychic world of experience opened by the analytic process and not just to the concrete treatment periods themselves. Freud wrote in this regard that "for slight cases or the continuation of a treatment which is already well advanced, three days a week will be enough" (1913c, p. 127).

Candidates in training are exposed to special burdens; they are, for example, required to adhere to a prescribed frequency of four sessions a week. If a patient desires to reduce the frequency to three or even two sessions, after thorough consideration of the situation it is often impossible to evade his questions of whether fewer sessions would not be sufficient and what the reasons are that a reduction cannot even be attempted. In most cases and situations there are no convincing arguments; the candidate in training, in contrast, must stick to four sessions in order to obtain formal recognition as a psychoanalyst. He is faced with a difficult decision. If he were to accept the reduction, the analytic process would proceed under altered conditions and might often even be more productive, because the patient has increased autonomy. Yet the candidate might then have to bear a considerable burden: analysis with only three sessions per week will not be recognized and consequently the length of his training would be increased considerably, possibly by three years or even more. Worst of all is when the struggle over frequency leads to termination. However, if the patient submits to the regulation without being convinced of its correctness, the analytic process is subject to a severe strain, at least temporarily, and

therapeutic effectiveness is endangered.

The duration of an individual session is almost always 45 50 minutes. "Occasionally, too, one comes across patients to whom one must give more than the average time of one hour a day, because the best part of an hour *is* gone before they begin to open up and to become communicative at all" (Freud 1913c, pp. 127-128). It seems to be unusual for us to meet such patients today, or do we not want to meet them? The complaint that a 45-50 minute session is too short is not uncommon.

How the time is experienced subjectively is determined by what has or has not been achieved in therapeutic work in the time available; it is determined by the interaction. Even though, obviously, the analyst cannot simply comply with nagging wishes but must analyze them, there is still Freud's reference to "the average time of one hour a day." The word "average" implies there is variation around a mean. Deviation from the hourly session in modern practice is probably minimal, however, although time is money. Greenson, in particular, has criticized the analyst's material interest in maintaining an exact schedule of sessions; he pointed especially to the practice of not taking a suitable break between sessions.

> I believe that the decline of the 50-minute hour is symptomatic of a materialist trend in psychoanalytic practice, at the expense of a humanistic and scientific point of view. It is obvious that taking patient after patient on an assembly-line schedule is an act of hostility, subtle and unconscious though it might be. (Greenson 1974, pp. 789-790)

Greenson's criticism expresses the necessity for the analyst to create sufficient distance from the subjective world of one analytic process to enable him to pay undivided attention to a new patient. In view of the great diversity in style of work, we believe that each analyst should decide individually on the duration of the break that he requires.

The manner of experiencing time that stems from the anaclitic-diatrophic phase of development is viewed as an essential factor in the success of the patient's fundamental experience in the psychoanalytic situation (Stone 1961). Kafka (1977, p. 152) points out that the psychoanalyst's special interest in time feeling may arise from the fact that he is continuously observing how past experiences are structured in the present. However, special sensitivity to the temporal aspects of psychoanalytic activity is necessary. It is difficult to answer theoretically the question of how old, schematically stored knowledge with an inherent, condensed temporal structure is transformed into the current flow of time (Bonaparte 1940;

Ornstein 1969; Schachtel 1947; Loewald 1980). The "psychopathology of time" represents another important area for the analyst (Hartocollis 1985). The work of Schilder (1935a), who attempted to apply the phenomenological studies of Straus (1935), von Gebsattel, and Minkowski (1933) to psychoanalysis, has unfortunately been forgotten. Loewald has rekindled this theoretical discussion, whose relevance for actual treatment is greater than often assumed (Loewald 1980, pp. 138-139).

Kafka (1977, p. 152) makes a special reference to the following points: "The patient's analytic hour" is an "extended 'time out' (from work, from usual activity, from usual style of behavior, and from usual style of communication)." One factor which determines the nature of this time out, i.e., the degree to which the patient can step out of his everyday activity and time feeling, is the analyst's manner of using the hour, including the true function of the analyst's silence:

> The world outside the room is put into the background. The quiet acts like a lampshade modifying a too bright light. The pressing nearness of material reality becomes remote. It is as if the silence of the analyst already marks the beginning of a quieter, less immediate way of looking at others and at oneself. (Reik 1949, p. 123)

The analyst's silence, if well dosed, can support the patient's time out and help him to turn to his inner, subjectively experienced time feeling. The regularity of sessions, which provides the structure for frequency-specific rhythms, makes it possible for patients to develop their own analytic time feeling, i.e., a personal understanding of time outs. For the analyst the session is an "extended and relatively usual 'time in"' (Kafka 1977, p. 152). How the analyst uses it is determined both by his personal equation and by the rhythm which develops in the relationship. In other words, the analyst's use of the analytic hour is determined by his personal conceptions of time, of the time available, and of the sensual quality of unconscious timelessness. "The analyst, more than the patient, assumes that contiguity of communication (and of experience) has *possible* 'meaning' implications transcending contiguity as such" (Kafka 1977, p. 152). The analyst has his own theory-dependent hypotheses about the temporal structure which is contained in the patient's material in a linear temporal way. He can view utterances made at very different times as "meaningful connections." This constructive activity is at first relatively new to the patient, who must first be convinced of the truth of this view of the matter. Kafka thus refers to the analyst as a "'condenser' and 'dilator' of time."

The patient is supposed to internalize this bold, constructivistic form of gaining access to the

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dimension of time, in the sense of the assimilation of life history as described by Habermas.

> I think that the process of connecting events and feelings differently — in a sense, bringing new information to bear on episodes reexperienced during psychoanalysis permits a reorganization and reinterpretation of time feeling. The reorganization may enhance the sense of continuity and facilitate the widening of temporal perspective and its extension into the future. (Kafka 1977, p. 154)

The individual time outs of analytic sessions combine to form a period of time, the duration of which is difficult to predict, especially at the beginning of treatment. "An unwelcome question which the patient asks the doctor at the outset is: 'How long will the treatment take? How much time will you need to relieve me of my trouble?"' (Freud 1913c, p. 128). Freud's ingenious advice was to refer to Aesop's fable:

> Our answer is like the answer given by the Philosopher to the Wayfarer in Aesop's fable. When the Wayfarer asked how long a journey lay ahead, the Philosopher merely answered 'Walk!- and afterwards explained his apparently unhelpful reply on the ground that he must know the length of the Wayfarer's stride before he could tell how long his journey would take. This expedient helps one over the first difficulties; but the comparison is not a good one, for the neurotic can easily alter his pace and may at times make only very slow progress. In point of fact, the question as to the probable duration of a treatment is almost unanswerable. (1913c, p. 128)

If we look at current practice, we find laconic comments about the so-called standard procedure, for example that "it takes place in four or five sessions per week, usually lasts four to five years, rarely lasts less than three years, and can even last longer than six years in certain cases" (Nedelmann 1980, p. 57). Even though the majority of the forms of psychoanalytic therapy are conducted in a much shorter period of time, the question of why the neoclassical technique has led to such an increase in length of treatment that the effort and result are in such a precarious balance is nonetheless timely. When Freud mentioned "long periods of time," he meant "half a year or whole years — of longer periods than the patient expects" (1913c, p. 129)

In Sect. 8.9 we will discuss in greater detail the factors which have contributed to an increase in the length of psychoanalytic treatment. We would like to point out at this juncture, however, that discussion of the period of time required for psychoanalytic treatments tends to contain the danger of confusing the subjectively experienced time (Minkowski 1933) with the objectively transpired period of time. Precisely for these reasons, we have subjected the policies which we take to be expressions of a reified understanding of the psychoanalytic process (according to Gabel 1975) to critical examination.

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> Time is a dialectical dimension not only because, contrary to space, it is impossible to conceive of it in a state of rest, but also because its progression effects a dialectical synthesis constantly being reborn from its three dimensions: present, past, future. It is a totality which can be dissociated by reification of the past or the future …. (Gabel 1975, p. 107)

The study of the psychoanalytic space, in contrast, must start from the concrete space and describe its extension in meaning metaphorically. The patient molds the analytic space on the basis of his subjective experience, i.e., his individual scheme of apperception, and expects to meet the analyst in this space. Viderman (1979, p. 282) phrased it in the following way:

> The transference neurosis does not develop in a space devoid of affects …. The analytic process is possible only in a specific environment created by the technical rules in which the affects and counteraffects of the two organizers of the analytic space interact

The analyst's office forms the external framework in which the therapeutic process unfolds. Secluded and safe behind a sign saying "Do not disturb," a space is created for the dyadic activity which is temporally limited and whose physical features can have a positive or a negative influence.

Although there is very little in the literature about the room in which treatment takes place, the photograph of the room Freud used is familiar to all psychoanalysts. It has been described in detail by Engelman (1976); for H. Doolittle (1956) it was the sanctum. Freud stimulated the development of transferences by means of his person and his treatment room, and did not understand the mirror metaphor in the sense of a blank screen. In contrast, anecdotes are told about analysts who attempt to standardize all external influences by using a very monotonous room, having a tailor make them the same suit over and over, and trying in other ways to become a perfect mirror. This attitude attracted Fenichel's criticism (1941, p. 74).

If we apply the maxim that the analyst must feel comfortable in the analytic space so that the patient can also sense it, then the actual arrangement of the space may vary considerably. The specific arrangement can then be studied to determine the extent to which it expresses a congruence between the analyst's attitude and behavior. The prime feature of the analytic space is the analyst himself, who sits still or moves around and who personally furnishes his office. Goffmann's (1961) studies on role theory are relevant for understanding the analytic space as the setting for treatment. A multitude of minor details regarding the analyst's use of the therapeutic relationship have repeatedly been made the

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object of extensive discussions; this is a clear indication that the reality of the relationship is part of the system of roles in a model describing how specialized services are provided (Goffmann 1961). The analyst decides where analysis is to take place, i.e., where a psychoanalytic relationship can develop, and makes himself an object of discussion as a result of how he has arranged the setting. The treatment room should have the quality of a "facilitating environment." We attribute the analyst the capacity for "concern" (Winnicott 1965), and the ability to sense the room temperature and whether the patient needs a blanket. Difficulties resulting from understanding the space as an extension of the real analyst are less frequent with neurotic patients, whose curiosity about objects in the room or the furnishings can be answered and handled in accordance with our recommendations for dealing with questions (Sect. 7.4). Difficulties arise where severely disturbed patients experience the treatment room as a transitional object. Greenson illustrated this with the experience of one patient who, by stroking the wallpaper, was able to find comfort that Greenson was unable to provide with his voice: "Even the analyst's office may take on extraordinary power in serving the patient as a haven against the dangers in the external and internal world" (Greenson 1978, p. 208).

The explicit use of the analyst's office as a facilitating environment implies, furthermore, the importance of the analyst being continuously aware of the separation process. If the patient treats the room and the objects in it as if they belonged to him, and if the analyst does not act quickly enough to clear up the patient's confusion of "mine" and "yours," the result is repudiation of the fact that the patient's share in the room is temporally limited and in principle incomplete. Misunderstandings then result which impede the therapeutic process. In this way ego boundaries, an abstract theme in Federn's (1952) theory, become technically relevant. They are, of course, of supreme importance in all borderline cases. The problems involved in making meaningful demarcations are often difficult for the practicing analyst to answer in his office because the demarcations have to be made individually. In institutions, in contrast, there are sometimes difficulties in making a room available which the analyst has personally arranged.

The patient's perceptions in the analyst's office are an important precondition for him to be able to enrich his limited identifications with human features and personal experiences by forming transitional objects. The patient also detects thresholds and boundaries, and thus the analyst's autonomy and personal space, everywhere. If the analyst's office is in his home, the personal rooms are not accessible for

the patient, while in institutions patient and analyst might meet in the toilet. A tension results between the patient's inquisitive desire to share in the analyst's private life and his respect for the analyst's personal space. By setting spatial and temporal limits, the analyst provides an example for individuation and autonomy. In order to be able to reach this goal, the patient voluntarily sacrifices part of his independence for a while in order to attain an autonomy which is greater and freer of anxiety.

8.2 Psychoanalytic Heuristics

"Eureka — I've found it!" This is what the Greek mathematician Archimedes is said to have cried on discovering the law of displacement. Heuristics is defined as an art of discovery and as a methodological guide to the discovery of something new. Taken together, a patient's small triumphs amount to discoveries of great therapeutic significance, even if they affect only the situation of one person and his close relatives, and do not go down in history like Archimedes' exclamation. If the patient has worked his way to a new insight, the analyst is pleased that an idea which he conceived on the basis of his professionally trained empathy fell on fruitful ground.

Despite his pleasure that the joint search has been successful, the analyst remains reserved, for several reasons. He does not want to relativize the patient's pride and satisfaction in the creative accomplishment of having found an unusual and surprising solution. And perhaps he will wait a little too long to signalize his agreement with the patient, because he views even limited confirmation as an improper additional suggestive influence. In such a moment he might even think of the saying that one swallow doesn't make a summer. And finally, heuristics is plagued by the complex question as to the foundation of the conviction that something important has been identified or even discovered. In any case, the issue is to determine the plausibility of the presumed connection by considering it critically from completely different perspectives. In Freud's words,

> we give the patient the conscious anticipatory idea and he then finds the repressed unconscious idea in himself on the basis of its similarity to the anticipatory one. This is the intellectual help which makes it easier for him to overcome the resistances between conscious and unconscious. (1910d, p. 142)

We agree with Boden (1977, p. 347) that "a heuristic is a method that directs thinking along the paths most likely to lead to the goal, less promising avenues being left unexplored." Algorithmic strategies can be described, in contrast, as systems of rules which can be prescribed or defined in a step-

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by-step manner; nothing can go wrong if the algorithm is followed in the prescribed way. If situations exceed a certain degree of complexity, the steps prescribed by algorithmic strategies become increasingly intricate; in this case the use of heuristic rules is advantageous.

Freud's chess metaphor makes it clear that he was aware of the complexity and indeterminacy of the psychoanalytic situation. Although he did not distinguish between the algorithmic and heuristic methods, his technical recommendations nonetheless largely correspond to our understanding of heuristic strategies. An algorithmic quality foreign to the essence of the psychoanalytic technique is present to a degree proportional to the loss of flexibility in the application of these recommendations. Understanding the fundamental rule as a heuristic strategy emphasizes our conception that the psychoanalytic situation is a complex situation with several meanings, which can be understood only if the analyst obtains more information than is initially available.

The primary purpose of heuristic strategies is to collect and organize the relevant information. Good heuristic strategies reduce insecurity, complexity, and ambiguity, and increase the probability of understanding what is important at any particular moment. These procedures start from the assumption that the information they collect can add to the knowledge we have already gathered, and that criteria for including or excluding material emerge from the search process itself. The algorithmic procedure reduces complexity and identifications in a manner which is artificial and much too rapid. It attributes meaning to material on the basis of prior knowledge, and thus terminates the search process in an artificial and unacceptable way.

It is possible to extract from Freud's works a large number of technical rules, i.e., recommendations for treatment which are intended to direct immediate activity, as demonstrated by a study group in Frankfurt (Argelander 1979, pp. 101-137). If technique is understood as the means and ways of applying the method (see for example Rapaport 1960), it is possible to classify rules into types according to their function in the analytic process.

Strategies which promote the process of participant observation, i.e., concern the attitude toward psychoanalytic perception, recommend that the analyst stay very close to the patient's emotional experiencing and at times identify with the patient in order to participate in his subjective experience.

The analyst's general rule of maintaining evenly suspended attention and passing everything that the patient tells him to *his own unconscious mental activity* defines precisely the kind of participant observation which promotes the perception of unconscious motivations. The significance of the analyst's "free association," which has to occur within his evenly suspended attention, emphasizes the necessity for him to enrich the patient's fragmentary descriptions with his own experience (Peterfreund 1983, p. 167).

There are strategies for speaking, in addition to those for listening, which the analyst can employ to help the patient emphasize the significance of his statements. The analyst supplements these general strategies, aimed at promoting the subjective aspect in the patient's comments, by directing his and the patient's attention particularly to unusual, rare, or unique phenomena which are not part of the everyday flow of experience. In this regard, Argelander (1979) refers to the Dora case, where only "certain details of the way in which she expressed herself" provided a guide (Freud 1905e, p. 47). Manifestations termed "interference phenomena" occur when statements organized according to primary and to secondary processes coincide. These strategies lead to an interruption in the evenly suspended attention, then to a condition of readiness, and finally to a focussing of attention (Chap. 9): the readiness for analytic perception becomes the readiness for analytic action. Following the heuristic search, inner mental processes review the new information from different points of view. The analyst calls upon the case-specific, individual, and generalized working models at his disposal, and prepares an intervention.

We will now consider the form the underlying processes take in theory. Starting from a discussion of the concept of empathy, Heimann (1969) expanded her ideas about the analyst's cognitive process to include three functional states; she referred to suggestions made by Greenson (1960), who had spoken of a working model which the analyst devises for himself. It is noteworthy that Heimann was stimulated to these ideas by a review article in which Holt (1964) discussed the state of cognitive psychology. We consider this to be one of the interfaces where it is possible to recognize the influence of cognitive psychology on the revision of psychoanalytic metapsychology. The development of cognitive psychology and of research on artificial intelligence (Lindsay and Norman 1977) led to substantial differentiation of the concepts that Greenson used in his working model, which we now want to describe following Peterfreund (1975, 1983).

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Many analytic concepts are based on ideas about the organization of memory. In cognitive psychology this dynamically structured system is referred to using the terms "maps," "models," "representations," "knowledge structures," "schemata," or "scripts." Peterfreund employs the term "working model." The information constituting the different working models is based on the data the organism has selected and organized in the course of its life. Learning can be grasped as the establishment of working models. Although innate genetic programs form the basis of these models, they continue to develop throughout life. The systems constituting working models can be described using terms such as "information," "data processing," and "stored programs." When a working model is activated, most processes occur at a preconscious level.

A large number of different working models are plausible, extending from "general knowledge about the world" to "knowledge about one's own life history." It is also useful to differentiate "cognitive models for the ideas of developmental psychology" from a "cognitive model about the therapeutic process."

These working models are not contained one within the other, like a set of Russian dolls, but must be understood as parts of a networklike structure with numerous temporal and spatial cross-references. The analyst usually works with these models at a preconscious level; they presumably function like schemata in cognitive psychology (Neisser 1976). They are immersed in the flow of experience, and at the same time determine what the subject accepts:

> A schema is that portion of the entire perceptual cycle which is internal to the perceiver, modifiable by experience, and somehow specific to what is being perceived. The schema accepts information as it becomes available at sensory surfaces and is changed by that information; it directs movements and exploratory activities that make more information available, by which it is further modified. (Neisser 1976, p. 54)

The establishment and dismantling of the structures of experience take place at different rates and under different conditions in the different working models. The abstract concepts of metapsychology are stable because they can never be seriously threatened by experience. In contrast, working models closer to experience are influenced by clinical verification. The development of the theory of hysteria shows vividly how Freud was only able to realize the full potential of his conceptual approach by replacing real trauma with the fantasized trauma of seduction (Krohn 1978).

8.3 Specific and Nonspecific Means

8. 3.1 General Points of View

Since its beginnings psychoanalysis has distinguished between different means of therapy. In fact, the psychoanalytic method was constituted by its differentiation from *suggestion* and by its emphasis on *insight* and *remembering* on the part of the patient, supported by the analyst's interpretations. Despite the doubts arising from the meaning assigned to the concepts "specific" and "nonspecific" (Thomä 1980; Cheshire and Thomä 1987), therapeutic means are better classified within this frame of reference than in the contrast between object relationship and interpretation.

Half a century ago psychoanalysis became polarized, the effects of which can still be felt, moving Cremerius (1979) to ask whether there are two psychoanalytic techniques. He referred on the one hand to classical *insight therapy* with its emphasis on interpretation, and on the other to *therapy based on emotional experience,* which credits experiencing in the object relationship with the essential therapeutic function. This polarization goes back to the contrast drawn by Ferenczi and Rank (1924) between the therapeutic effect of experiencing and that achieved by a certain interpretation fanaticism; they even described the psychoanalytic form of experiencing as therapeutically superior to reconstruction by remembering. There are many indications that, in reaction, advocates of the classical technique tended to counter the overemphasis on experiencing right up to Freud's late study on *Constructions in Analysis* (1937d).

At the beginning of the 1950s experiencing was again discredited, this time as a result of the manipulative use of corrective emotional experience in the technique propounded by Alexander, who in 1937 had been one of Ferenczi and Rank's strongest critics (Thomä 1983 a). The extremes moved even further apart when Eissler (1953) introduced the basic model technique with its guiding concept of the "parameter." In Sect. 8.3.3 we will provide a more detailed description of insight therapy centered on pure interpretation, but first we must point out that even more problems are associated with this rigid contrast between the two techniques. One element in the controversy was the claim that the therapy of emotional experience was especially effective in correcting preoedipal defects, i.e., those which originate in the preverbal phases of development. Thus Balint refers to a contrast between interpretation, insight,

and object relationship (see Sect. 8.3.4). Even Kohut's self psychology retains the scheme of disturbances of oedipal or preoedipal origin, or for short, two- or three-person psychopathology. Although Kohut's understanding of the empathic compensation for self defects differs greatly from Ferenczi's therapy of deficiency, they have many practical aspects in common. These similarities are located where previously insufficient mothering should be balanced in some way. Since in the purely interpretative technique the therapeutic effectiveness of confirmation and gratification is underestimated and these actions appear to violate the norm of abstinence, "empathy" became, in reaction, a collective term describing deep, averbal, and confirmatory understanding beyond, prior to, or independent of the interpretation.

In the development of the technique there were instances of negligence and underestimations on both sides, with corresponding consequences on practice. In one version the therapeutic function of confirmation and gratification is given as a nonspecific factor, which is contrasted to specific interpretations (Heigl and Triebel 1977). In the other version the wordless look of narcissistic admiration becomes the remedy for a damaged self image. Simple processes of finding new values and meaning by means of interpersonal agreement during critical discussions of realistic perceptions in the here-and-now take on a mystical quality.

Obviously, classification according to specific and nonspecific factors may lead to a dead end if they are not viewed as interactive. Depending on the situation, a factor which is generally nonspecific and forms part of the silent background may move to the forefront in a certain moment of the interaction and become a specific means. It seems obvious that this change should be conceptualized as a figure-ground inversion, as it is termed in gestalt psychology.

Bibring (1937) attributed the silent background a stabilizing effect independent of the interpretive technique.

> Even if these anxieties are later resolved analytically, I would still like to believe that the experience of the certainty of not losing the analyst's support *immediately* consolidates the feeling of security which was not acquired, or only too weakly, in childhood, perhaps as a result of not having such an experience of certainty. However, such immediate consolidation has lasting value only in the context of the analytic process, even though it is actually not part of the analytic therapy. (Bibring 1937, pp. 30-31)

As already indicated (Thomä 1981, p. 73), the analysts's contribution to the patient's security and consolidation is an essential part of the psychoanalytic situation; it stands in a complementary

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relationship to specific means. Strupp (1973, p. 35) also emphasized that the specific and nonspecific factors are not given, opposing quantities, but that they are interdependent.

8. 3. 2 Remembering and Reconstruction

We would like to begin with the therapeutic effect of remembering:

> Strictly considered — and why should this question not be considered with all possible strictness? — analytic work deserves to be recognized as genuine psycho-analysis only when it has succeeded in removing the amnesia which conceals from the adult his knowledge of his childhood from its beginning (that is, from about the second to the fifth year). This cannot be said among analysts too emphatically or repeated too often. The motives for disregarding this reminder are, indeed, intelligible. It would be desirable to obtain practical results in a shorter period and with less trouble. But *at the present time theoretical knowledge is still far more important* to all of us than therapeutic success, and anyone who neglects childhood analysis is bound to fall into the most disastrous errors. The emphasis which is laid here upon the importance of the earliest experiences does not imply any underestimation of the influence of later ones. But the later impressions of life speak loudly enough through the mouth of the patient, while it is the physician who has to raise his voice on behalf of the claims of childhood. (Freud 1919e, pp. 183-184, emphasis added)

There is still controversy as to which partial processes of the complex event should be considered necessary conditions and which sufficient conditions. Some remembering is accompanied by few affects and does not lead to a change either in or outside therapy. There is also emotional abreaction of no lasting import. Apparently something essential must be added to remembering and abreacting in order to achieve a therapeutic effect. Is it the security of being able to deal differently and better with pathogenic experiences than in the traumatic situation? How does the patient become more self-secure in order to overcome his helplessness, like the dreamer who finally masters his repeated nightmares? Is it the presence of an understanding psychoanalyst, with whom the patient identifies, which provides him with additional strength by letting him use the psychoanalyst as an auxiliary ego? Is understanding, wordless communication sufficient? Do identification with the psychoanalyst and establishment of a working alliance provide the patient so much security that emotional remembering becomes possible without this itself having much additional therapeutic significance? Are abreaction and remembering secondary manifestations of a favorable course of therapy instead of its precondition? We confront these questions when evaluating the therapeutic value of insight in the therapeutic process. Does insight fall like fruit from the tree of knowledge, and does the change follow in consequence? As the necessity of working through demonstrates, this is plainly not the case.

It is essential in attempting to achieve integration and synthesis that the patient's regression does not exceed what his ego can endure; only then are the conditions for integration and synthesis favorable. In our opinion, Freud's view that the synthesis occurs on its own after analysis cannot be maintained. We believe that the psychoanalyst must never lose sight of the goal of creating the best possible preconditions to facilitate the patient's integration and synthesis.

Kris (1956b) emphasized, in his study on the recovery of childhood memories, that reconstruction can at the very best achieve an approximation of the actual facts. The fact that, according to Kris, the primary goal of interpretations is not to elicit memories has very important consequences for technique. For Kris, their task is to create favorable conditions to enable the patient to remember. The patient's task is eased if a certain degree of similarity between a current and the earlier situation can be created by means of interpretation. Kris distinguishes between dynamic interpretations, which relate to the current conflicts, and genetic interpretations, which relate to archaic impulses or early unconscious fantasies. One goal of analysis is to establish a continuum connecting the dynamic and genetic interpretations (Fine et al. 1971, p. 13). This theme is implicit in the interpretation of transference and in the controversy about the here-and-now and the then-and-there (Sect. 8.4).

The meaning of the relevant component parts of the act of remembering is probably dependent on the particular state of the ego's synthetic function. Because the transformation and development of the ego depend on the unfolding of both affective and cognitive processes, and because both, despite their reference to the past, occur in the present and point to the future, it is obvious that more weight has been attached to the here-and-now of emotional experience since Ferenczi and Rank's (1924) important study. Nonetheless, its importance is still neglected compared to that of reconstruction. There are more substantial reasons for the controversies, and it is impossible to trace them back to Alexander's manipulative creation of a corrective emotional experience. The strong reaction to Alexander's interventions in the course of transference neurosis could hardly be comprehended if a problem central to the theory and technique of psychoanalysis were not involved. We will now turn to this problem.

The diversity of ways that the psychoanalytic process can reflect both childhood development and the analyst's theory of childhood development was demonstrated recently at the International Psychoanalytical Congress in Helsinki in 1981. All four main speakers — Segal (1982), Solnit (1982),

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Etchegoyen (1982), and Schafer (1982) — mentioned this interdependence. Schafer in particular drew consequences which we would like to utilize to support our line of argument. The reconstruction of memories does not become truer because the psychoanalyst adheres to the idea that they are independent of his theory, are not influenced by his behavior and interventions, and manifest themselves in pure form in transference. On the contrary, his theories and actions are instrumental in determining the psychoanalytic process, whose features are the reconstruction of the pathogenesis on the basis of the patient's verbal and nonverbal communication in transference, and the uncovering of the patient's memories. Because the general theories of neurosis are referred to in ideographic reconstructions, i.e., in case descriptions, the plausibility of each reconstruction depends in part on the degree of validity that the general theories can claim.

For Freud and his followers, the archaeological model was decisive for the analytic process. Although the psychoanalyst has more difficult methodological problems to solve than the archaeologist, Freud believed that the task of psychoanalysis is easier because we are able to communicate in the present with the person suffering from injuries which occurred in the past. Freud made comparisons to archaeology and the study of classical antiquity in numerous places. His discussion in *Civilization and Its Discontents* (1930a, p. 69) is a representative example. The assumption that "in mental life nothing which has once been formed can perish — that everything is somehow preserved and that in suitable circumstances (when, for instance, regression goes back far enough) it can once more be brought to light" is his starting point for a comparison with the development of the Eternal City. His vivid description of Rome's development and his attempt to present the "historical sequence in spatial terms" makes it possible for him to reach the particular features of mental life:

> The fact remains that only in the mind is such a preservation of all the earlier stages alongside of the final form possible, and that we are not in a position to represent this phenomenon in pictorial terms.
>
> Perhaps we are going too far in this. Perhaps we ought to content ourselves with asserting that what is past in mental life *may* be preserved and is not *necessarily* destroyed. It is always possible that even in the mind some of what is old is effaced or absorbed — whether in the normal course of things or as an exception — to such an extent that it cannot be restored or revivified by any means, or that preservation in general is dependent on certain favourable conditions. It is possible, but we know nothing about it. (1930a, pp. 71-72)

If the issue is to fnd new ways and seek new solutions, everything which occurs to the patient in the present moves to the center of attention and the reconstruction of the past becomes a means to a goal.

Freud always retained his belief in the great resemblance, even identity, between the reconstructive work of the archaeologist and the psychoanalyst, "except that the analyst works under better conditions and has more material at his command to assist him, since what he is dealing with is not something destroyed but something that is still alive" (1937d, p. 259). The analyst also "works under more favourable conditions than the archaeologist" because he can rely on "repetitions of reactions dating from infancy" in transference (1937 d, p. 259).

It has been shown with regard to the reliability of reconstructions that precisely the fact that the analyst deals with something which is still alive, initially assumed to be an advantage, creates considerable complications. It is beyond doubt that the idea of how something might have been related or might have fit together originates in the archaeologist's mind on the basis of extant knowledge, and that the resulting construction provides convincing proof for his idea's validity. Unidentified pieces have no active role, but are adapted to the construction and fill the gaps. In contrast, for the psychoanalyst the patient has the last word and the reconstruction is not an end in itself. "The analyst finishes a piece of construction and communicates it to the subject of the analysis so that it may work upon him" (Freud 1937d, p. 260).

Thus the ideas of the two processes must be adjusted to each other, but the successful re-creation of an interrupted process of mental development does not uncover a figure that had been buried. First, a meaningful connection is discovered. But have the parts that the psychoanalyst collects and fits together from associations ever formed a whole? Has the idea of this whole been retained in the patient's unconscious, or do we use memories in order to be able to make changes through a comparison with the present? The archaeologic model of psychoanalysis unites reconstruction of the past with a cure.

Freud's analogy with sculpture, as a model for therapy, contains a different principle, that of creative change (1905a, p. 260). It always remains important to know the regularities according to which mental formations petrify. Yet if the point is to seek other solutions and find new ways, everything which occurs to the patient in the present moves to the center of attention. Freud introduced the sculpture model to distinguish psychoanalysis from the technique of suggestion. He compared the work of the painter and that of the sculptor in order to describe the therapeutic model of psychoanalysis:

Painting, says Leonardo, works *per via di porre,* for it applies a substance — particles of colour — where there

> was nothing before, on the colourless canvas; sculpture, however, proceeds *per via di levare,* since it takes away from the block of stone all that hides the surface of the statue contained in it. In a similar way, the technique of suggestion aims at proceeding *per via di porre;* it is not concerned with the origin, strength and meaning of the morbid symptoms, but instead, it superimposes something a suggestion in the expectation that it will be strong enough to restrain the pathogenic idea from coming to expression. Analytic therapy, on the other hand, does not seek to add or to introduce anything new, but to take away something, to bring out something; and to this end concerns itself with the genesis of the morbid symptoms and the psychical context of the pathogenic idea which it seeks to remove. (1905a, pp. 260-261)

We would now like to turn to Loewald's (1960, p. 18) interpretation of this comparison, which can be summarized as follows: In analysis we bring the true form to the surface by removing the neurotic distortions. Like the sculptor, we need to have an image, if only a rudimentary one, of the goal. The analyst does not only reflect on transference distortions. His interpretations contain aspects of the reality that the patient begins to grasp hand in hand with the transference interpretations. This reality is communicated to the patient by chiseling away the transference distortions, or as Freud described it, by using Leonardo da Vinci's elegant expression, *per via di levare* as in sculpture, and not *per via di porre* as in painting. A sculpture is created by removing material, a picture by putting something on a canvas.

The attentive reader will have noticed that Loewald employs Freud's analogy in the context of working through transference. The real questions relate to the quality and source of what is new. In sculpture nothing is found in the stone which was already there in a certain shape or which could have let us imagine the final shape. Everything was in the sculptor's mind. The situation is different for a psychoanalyst, who discovers something in the unconscious, intervenes, and thus changes the appearance and nature (externally and internally) of the original substance. His ideas, his images, and his way of communicating them lead to transformations.

The two models share a basis in unconscious preforms. The difference between them is that the psychoanalyst as sculptor exerts a much greater influence on the formation than the archaeologist could possibly do with his material. Since no comparison is perfect, we can, in summary, say that the psychoanalyst contributes to the changed and new forms in a genuine way. The work of both the sculptor and the archaeologist is based on the ideas with which they form the material. Yet the ideas have very different scopes for influence: The marble block is unformed, the fragments of a vase are given. The psychoanalyst is an artist sui generis: the material he encounters is present in a flexible and not yet petrified form.

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It is fascinating to discover that all stages, and not just the final form, are retained in psychic processes. The natural regression in sleep promotes the tendency of the dreamer to remember images from long-forgotten periods which are stored in the long-term memory. The apparently ahistorical elements are those containing fixations which are visited in regression. The early fixations stimulate motivations for the formation of symptoms and stereotypical behavior. Repetition compulsion and the rigidity of typical character structures represent descriptions which lead to genetic explanations if the relationship between the preliminary stages and the final form can be clarified.

Psychoanalysis has concerned itself especially with the reconstruction of the preconditions of illnesses, and has in the process moved further and further back in life, as far as early childhood. Problems resulting from the clarification of the relationship between the early stages and the final form are discussed in Chap. 10.

8.3.3 Intervention, Reaction, and Insight

The reestablishment of "severed connections" (A. Freud 1937, p. 15) is the primary goal of analysis, and the analyst's interpretations facilitate the synthesis. The classical psychoanalytic technique is thus characterized by the fact that interpretation is its most important instrument or means. Whether the analyst does something or not, whether he explains the patient a rule or stays silent, whether he utters a significant or meaningless "hm" or makes an interpretation, his mere presence has an effect, even if he acts in a completely inobtrusive way. It is helpful to understand interventions as referring to everything that the psychoanalyst contributes to the course of analysis, especially that which helps the patient to gain insight. Among the different kinds of interventions, interpretations occupy a qualitatively prominent position and are characteristic of the psychoanalytic technique. We share the enthusiasm of a patient who once said, "If such connections are established, then I expect I will be able to say, 'Okay, goodbye, I'm healthy."'

What constitutes an interpretation? Why does an analyst intervene at a particular moment? How do we evaluate the effect of our interventions? If we agree that an intervention has been effective, how was it effective? These questions make it obvious that we cannot get very far in examining interpretations and other interventions without taking the patient's reaction into consideration. This leads us to the subject

"insight." How can we distinguish between insight and other reactions? Can we classify the kinds of reactions? What is insight, and what role does it play in the therapeutic process (Fine and Waldhorn 1975, p. 24)? Such questions cannot be avoided when interpretations are examined (Thomä and Houben 1967; Thomä 1967b). For the sake of better orientation, we first refer in general to technical variations such as interpretations of transference and resistance, and deep interpretations (Loch 1965b). Freud distinguished between the interpretation of isolated parts of a patient's material, e.g., a parapraxis or a dream, and the reconstruction of important events in a patient's past, suggesting the term "construction" for the latter (Freud 1937d).

In passing, we would like to mention the division of the interpretation process into preparation (Loewenstein 1951), confrontation (Devereux 1951), and clarification, in the sense of the word used by Bibring (1954). The more complete the protocol of a session, the easier it is to recognize which kinds of interpretation an analyst favors in a particular case or in general. Transcriptions of tape recorded sessions allow detailed studies by independent researchers.

Since transference interpretation is credited, correctly, with the greatest therapeutic effectiveness, and yet since it also raises special problems, it is discussed in detail in Sect. 8.4.

It is possible to distinguish different aspects of an analyst's interpretations. They provide a preconscious or unconscious context for the patient's associations. It is useful to distinguish several types of problems: How does an interpretation originate? How does it work? How can its accuracy be recognized? Combined consideration of association and interpretation makes it possible to draw consequences about the *accuracy* of an interpretation, i.e., about the connection between the analyst's idea, the formulation of the interpretation, the goal of the interpretation, and the effect of the interpretation. This takes us to a level accessible to everyone, from which it is also possible to draw conclusions about inaccuracies. Thus, *indirectly* something is discovered about the origin of the interpretation, and it can be assumed that in this indirect way something can be learned, especially about highly conflictual processes within the analyst (e.g., caused by intensive countertransference). Yet regardless of how a single interpretation originated — whether primarily through unconscious or preconscious intuition or through theoretical deduction, from below or from above — knowledge of its origin does not provide any indication of its accuracy.

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Since interpretations constitute the analyst's most important means of intervention, the response they evoke from the patient is decisive. Isaacs (1939, pp. 153-154) summarized the patient's reactions to interpretations as a criterion of their accuracy and effectiveness; her catalogue provides a basis for orientation:

> 1. The patient may give verbal assent ….
>
> 2. There may now be conscious elaboration of images and the meaning of images, with conscious co-operation and appropriate effect.
>
> 3. There may be further associations which from their specific nature confirm our view ….
>
> 4. There may be a change of associations and of attitude …. E.g. there may be a conscious repudiation, in such terms as to provide a confirmation, if it expresses guilt and terror such as would be felt and only felt if our previous interpretation had been correct.
>
> 5. The patient may on the following day bring a dream which carries on and elaborates and make much plainer the unconscious phantasy or intention which had been interpreted. Not only so, but he may recount a dream immediately upon our interpretation, one which he had not told us up to that point ….
>
> 6. Memories of past real experience may be recovered as a result of interpreting present unconscious trends, memories which link these trends to real experiences and make both intelligible.
>
> 7. Inferences as to external situations which had previously been rejected by the patient may be admitted, or voluntarily brought up by the patient ….
>
> 8. One of the most important tests of the correctness of our specific interpretations is the resulting diminution in specific anxieties. This may be shown in a number of different ways. E.g. there may be bodily signs of relief from anxiety, such as relaxing of rigid muscles, stilling of restless or stereotyped movements, change in tone of voice ….
>
> 9. The resolution of anxiety is seen also in the patient's associations, which may shew that the whole unconscious phantasy situation has been changed, with new material emerging as a result of the right interpretation ….
>
> 10. These changes in amount and direction of anxiety have their greatest significance in the transference situation. It is what happens in the transference situation, indeed, which provides us with an acid test of the correctness of our perceptions. A valid interpretation may change the phantasy picture of the analyst from a dangerous to a helpful figure….if interpretation has been both true and adequate, phantasies will unfold more richly, and memories stir more freely ….

Although these features are indications for the accuracy of interpretations, they cannot be taken as proof (Thomä and Houben 1967). In addition to them, according to Isaacs (1939, p. 155) the following general rules also apply to interpretations referring to earlier feelings and actions in the attempt to reconstruct the patient's life history:

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> *Confirmation* of these inferences then comes in various ways: E.g. (a) New memories, either not yet told to us or long forgotten by the patient, emerge as a result of our interpretations; (b) such memories may directly corroborate what has been inferred, may be new instances of the same kind, or whilst different, may yet be linked with our inferences, historically or psychologically; (c) further associative material may arise which makes intelligible the forgetting of this and other experiences, as well as present attitudes; (d) corroboration may be gained from outside sources such as friends and relations. Such corroboration from outside is not necessary for the analytic work itself, but it is useful from the scientific point of view, as an additional and independent proof.

Our introductory comments on nonspecifc and specific means explain our reasons for attributing interpretation a special position in the psychoanalytic technique. On the other hand we view interpretation in interaction with the non-specific background, which can move to the foreground at certain moments of therapy and then has a special effectiveness. This is the reason that we maintain a critical distance to Eissler's interpretive purism. Eissler (1953) introduced the basic model technique in his attempt to detect *the* decisive and truly psychoanalytic variables from among the numerous variables which characterize or determine the analytic process and the cure. For the time being we will adopt this position, because we agree with the analysts who believe that "interpretation is the most powerful and consequential intervention at our disposal" (Eissler 1958, p. 222).

Eissler goes even further. In his opinion, the classical technique of psychoanalysis is a therapy "in which interpretation remains the *exclusive* or leading or prevailing tool" (Eissler 1958, p. 223, emphasis added). This technique does not exist anywhere in pure form; in Eissler's own words, "no patient has ever been analyzed with a technique in which interpretations alone have been used" (1958, p. 223). Eissler introduced the concept of the parameter from mathematics, where the term is used to describe values in equations which either remain unknown or are kept constant and which appear *in addition to the true variables.* Eissler borrowed the term to describe everything beyond interpretation, the true psychoanalytic variable.

The conditions of the basic model technique are still fulfilled, according to Eissler (1953, pp. 110-113), if a parameter satisfies four criteria:

> (1) A parameter must be introduced only when it is proved that the basic model technique does not suffice; (2) the parameter must never transgress the unavoidable minimum; (3) a parameter is to be used only when it finally leads to its self-elimination; that is to say, the final phase of the treatment must always proceed with a parameter of zero .... [(4)] The effect of the parameter on the transference relationship must never be such that it cannot be abolished by interpretation. (1953, pp. 111, 113)

In the same study Eissler refers to two other parameters that might be essential in the therapy of schizophrenics or seriously ill neurotics; they are *goal construction* and *reduction of the symptoms.* These two parameters do not satisfy the four conditions, and in employing them the analyst abandons the basic model technique and cannot return to it. Yet interpretations in fact also contain a final aspect, i.e., a goal, and the purist technique thus becomes adulterated. Eissler demonstrates the features of what he calls parameters by referring to the deviations from the basic model technique that Freud resorted to in response to one patient's (the Wolf Man) personality structure and symptoms. He illustrates the first of the above-mentioned criteria for parameters with reference to Freud's active interventions in the therapy of phobic patients.

The fact that the basic model technique has caused more problems that it has solved in the history of psychoanalysis is associated with the fact that attention was not paid to the context. The restrictive perspective based on this technique determined from then on the view of practice as it *should* be. Yet, as Eissler also had to admit, since a systematic description of psychoanalytic hermeneutics had not yet been written (1958, p. 226), the analyst is provided with a set of tools which must get filthy when used and whose hermeneutic technology cannot be systematically worked out until the therapeutic function becomes the center of attention. Interpretive purism can prevent a therapeutically favorable atmosphere from developing. Insight then lacks affective depth.

The concept of "insight" is, on the one hand, central to psychoanalytic theory, which claims to be able, in contrast to other forms of therapy, to achieve changes by means of insight. Interpretation, the most important instrument of therapy, is directed at the patient's ability to achieve a change in his disturbances by means of insight. On the other hand, in recent years insight has increasingly been contrasted with the curative effect of the therapeutic relationship. The reservations regarding the leading role of insight come from two different camps. Kohut's school is rather skeptical about the concept of insight because it is allegedly irresolvably linked to the therapy of psychic conflict, and the curative factors in the self-psychological theory of cure are decisively dependent on the internalization of the psychoanalyst's empathic understanding. The second reservation stems from the fact that the concept of insight is attributed to one-person psychology; in the critical evaluation of the latter, the accentuation of the curative effect of the therapeutic relationship displaces even insight (Appelbaum 1975, 1976; Eagle 1984). This happens by virtue of the fact that the curative effect of the discovery of a new object is made

dependent on the internalization of the analyst's functions or on learning in the framework of a new relationship (Loewald 1960; Thomä 1981).

Among the large number of authors who continue to believe in the significance of the concept of insight, there are major controversies about substantive questions, which have so far made it impossible to arrive at a uniform definition. The definition given in the Glossary of Psychoanalytic Terms seems to be unsatisfactory to many; according to it, insight refers to "the subjective experience or knowledge acquired during psychoanalysis of previously unconscious, pathogenic content and conflict" (quoted in Blacker 1981, p. 659).

Looking at the different implicit and explicit definitions of insight in the considerable literature on the subject, it can be noted that they are influenced by the interaction of at least three different points of view.

1. For Freud, insight is linked with the discovery of unconscious reality (Bush 1978). Here insight proves to be the capacity to explain present behavior on the basis of earlier events, as Fisher and Greenberg (1977, p. 350) demonstrate. Insight refers to unconscious pathogenic childhood conflicts and their subsequent derivatives and consequences (Blum 1979, p. 44). Wherever, in therapy or research, insight is defined in this way, separate proof must be supplied that the cognition of unconscious processes is actually linked with a curative effect.

2. In the examples given by many authors, becoming aware of something that had been unconscious is understood in a different sense. Becoming conscious often means that psychic contents are given a new meaning. Blum (1979) quotes in this connection the definition of insight given in *Webster's Dictionary:* penetrating into or apprehending the inner nature of things. Noy (1978) emphasizes the connection between insight and creativity.

3. The fact that therapeutic insight and the desired therapeutic change are frequently far apart — a circumstance that Freud had also complained of — has led to attempts to limit the concept of insight by linking it with therapeutic change. Yet each change has to prove itself in concrete behavior or in acts. In this approach the concept of insight is linked very closely with behavior and action.

The intensive study of the phenomenon of pseudoinsights has strengthened the tendency for

analysts not to view those moments in which a patient's aha experience solves major problems as being prototypical for insight. Instrumental in this regard was a study by Kris (1956a), who described insight in a framework of a "good hour" and grasped it as a process. He thus corrected a false conception which had its origin in Freud's *Remembering, Repeating and Working Through* (1914g). Freud had thought that insight is the decisive cognitive act and that working through is subsequent to it, while in fact insight and working through are intimately connected and are part of the therapeutic process from the very beginning.

Kris' study also emphasizes the trend toward not attaching the concept of insight only to contents but also to the patient's accessibility to his thoughts. While Strachey (1934) stated firmly how the patient must see the analyst if an interpretation is to have a mutative character, authors like Reid and Finesinger (1952), Richfield (1954), Kris (1956a), and Hatcher (1973) describe in minute detail the access that patients have to their thoughts in phases of insight. It is important to be alert to the fact that the dichotomy of content and patient's access refers to different, though related phenomena. The word "insight" suggests that some mental content is seen and understood in a different way. The moment of internal change in a patient *cannot* be directly observed by the analyst; it can only be indirectly deduced. When reference is made to an altered access, it would be better to speak of "seeing in" than of insight. This distinction might possibly end the old controversy about whether insight is the cause or effect of the psychotherapeutic process. "Change," if viewed as a fictive instantaneous event, refers to a result, while "seeing in" and "changing" characterize a process.

The discussion about pseudoinsights led very quickly to a correction of the idea that change is achieved exclusively by means of cognition. Fenichel (1941) continued to rely on the polarity of feeling and thinking. Almost all authors commenting on the concept of insight express the opinion that "true" insight or seeing in lies between the poles constituted by emotions and intellect. There are differences in how these poles are described. Reid and Finesinger (1952) refer to them as emotions and cognitions. Richfield (1954), in contrast, describes two forms of knowledge. Valenstein (1962) uses the German word Er*lebnis* to refer to the emotional pole. Finally, Hatcher (1973) distinguishes "experiencing" self-observation from a more reflective form.

The insight process is described as connected with an act of integration, which contains the

potential for new solutions and thus for change as well as for creativity. Differences result from the ways that this integration is conceptualized. For Kris (1956a) and Reid and Finesinger (1952) certain psychic *contents* are integrated. Kris describes this process as the ego's integrative function and discusses the relationship between this function and Nunberg's (1931) concept of the synthetic function of the ego. Myerson (1965) also considers the reintegration in the context of the synthetic function of the ego. For authors like Pressman (1969) and Valenstein (1962) it is more an issue of a specific, i.e., integrated, *access* to thought contents. Although the difference appears insignificant at first sight, it marks two different ways of conceptualizing integration: either as the union of psychic entities or as an activity recombining a certain psychic content, which had been split into separate aspects, under a more general point of view. Scharfman (see Blacker 1981) emphasizes the integrative function. In the psychoanalytic process, insight fulfills the function of "bridging different levels of mind."

Understanding insight as an integrating psychic activity makes it possible to grasp the points where the psychoanalytic concept of insight and the various experimental results on gaining insight intersect. We find integrating activities, e.g., the combination of different psychic entities under general points of view, in very greatly varying fields of mental activity. The special features of the integrating activity in the psychoanalytic process of insight are the result of the fact that the different psychic levels, in Scharfman's sense, are in opposition. The integration of opposing mental levels is a special psychic accomplishment requiring the mastery of a state of tension. Integration of the experiencing and intellectual forms of access to one's own internal processes, which is a prominent topic in the psychoanalytic literature on insight, differs from cognitive insight experiments principally in that experiencing and intellectual forms are in opposition and are liable to produce conflicts.

8.3.4 New Beginning and Regression

Balint related his theory of the genesis of psychic and psychosomatic illnesses to the technical concept of the new beginning in his book *The Basic Fault: Therapeutic Aspects of Regression* (1968). New beginning and basic fault are the two sides of one coin: the new beginning is a therapeutic concept, the basic fault an explanatory one. For Balint, the basic fault is a necessary condition for every serious psychic or psychosomatic illness. New beginning referred ultimately for him to all of those processes which can be observed in the therapeutic elimination or inactivation of the conditions causing the illness, i.e., in the

resolution of the basic fault. Basic fault and new beginning comprise a theory of the genesis and treatment of psychic illnesses (Thomä 1984).

The basic fault belongs to the area of the early mother-child relationship. Intrapsychic conflicts which are tied to the oedipal three-person relationship do not arise in the small child. Balint describes the basic fault as a defect in the psychic structure, specifically in the sense of a deficiency (Balint 1968, pp. 2122). Starting from the theory of a basic fault, neuroses and character difficulties, and perhaps even psychoses and psychosomatic illnesses, are explained as symptoms of one and the same etiology. Since everyone experiences this earliest and fundamental deficiency, it could thus be viewed as a necessary condition of any and every illness.

The deficiency hypothesis can be found in many psychosomatic theories, whose common denominator is that they locate the genesis of the deficiency in an early, preoedipal phase of development. If the psychoanalytic treatment technique is restricted to the interpretation of intrapsychic conflicts, it is inapplicable where these conflicts cannot yet be present. It now becomes clear why preverbal empathic understanding and wordless experiencing receive special attention in the elimination of deficiency states. In contrast, the therapeutic means of remembering and insight via interpretation move to the background. The balance between insight and emotional experience — the two prime components of the therapeutic process is altered in favor of experience.

The new beginning is achieved, according to Balint, by means of *regression* in the psychoanalytic situation. Regression, too, is not a process that occurs in the patient naturally or on its own (Loch 1963). Balint reminded us that

> regression is not only an intrapsychic phenomenon, but also an interpersonal one; for its therapeutic usefulness, its interpersonal aspects are decisive. In order to understand the full meaning of regression and to deal with it in the analytic situation, it is important to bear in mind that the form in which the regression is expressed depends only partly on the patient, his personality, and his illness, but partly also on the object; in consequence it must be considered as *one* symptom of the interaction between the patient and his analyst. This interaction has at least three aspects: the way (a) in which regression is recognized by the object, (b) in which it is accepted by the object, and (c) in which it is responded to by the object. (1968, pp. 147-148)

We will now discuss the relationship of the new beginning to those regressive states which lead behind the traumatization and which Balint described within the framework of object relationship

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psychology. These states are inaccessible to associations and interpretations. In Balint's opinion the most important of the additional therapeutic means

> is to help the patient to develop a primitive relationship in the analytic situation corresponding to his compulsive pattern and maintain it in undisturbed peace till he can discover the possibility of new forms of object relationship, experience them, and experiment with them. Since the basic fault, as long as it is active, determines the forms of object relationship available to any individual, a necessary task of the treatment is to inactivate the basic fault by creating conditions in which it can heal off. To achieve this, the patient must be allowed to regress either to the setting, that is, to the particular form of object relationship which caused the original deficiency state, or even to some stage before it. (1968, p. 166)

This deficiency state "cannot be 'analysed' out of existence," but remains as a scar (1968, p. 180). It is obvious that the description of the attitude which is desirable for the analyst, which can lead to a compensation of the deficiency state, depends on the theoretical understanding of the crises which precede or accompany the basic fault.

Balint's impressive images of permeation, entwinement, and fetal harmony make it possible for him to postulate the unconscious longing to regain this unity. With regard to the accuracy of his theory, Balint adds:

> If my theory is correct, then we must expect to come across all these three types of object relationships — the most primitive harmonious interpenetrating mix-up, the ocnophilic clinging to objects, and the philobatic preference for objectless expanses in every analytic treatment that is allowed to regress beyond a certain point. (1968, pp. 71-72)

The phenomena as such are not controversial. There are certainly very few people to whom the feeling of being part of the world, the pleasure in holding on to objects, and the joy in the depth of space are foreign. Balint himself mentioned many striking everyday examples of ocnophilic and philobatic ways of experiencing in *Thrills and Regressions* (1959). Philobatism and ocnophilia are suited to serve as poles of a typology in which mixed forms predominate.

Here, just as with the new beginning, we are dealing with problems that result from Balint's attempts not only to describe certain phenomena but also to explain them by means of his psychoanalytic object relationship theory. The comprehensive concept of regression links object relationship psychology both with dream theory and with Iying on the couch, which at least invites regression and, together with free association, could even be termed a regressive act. According to the theory devised by Balint, who

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himself was not unaware of its contradictions (1968, p. 129), a new beginning can take place if a primitive, preverbal object relationship develops between the analyst and the deeply regressed patient (1968, pp. 165-167).

Balint distinguishes chronologically and phenomenologically between three forms of primitive object relationships:

> (a) the most primitive, which I called *primary love,* or primary relationship, a sort of harmonious interpenetrating mix-up between the developing individual and his primary substances or his primary object; (b) and (c) *ocnophilia* and *philobatism* which form a kind of counterpart with one another; they already presuppose the discovery of fairly stable part and/or whole objects. For the predominantly ocnophilic individual, life is safe only in close proximity to objects, while the intervening periods or spaces between objects are felt as horrid and dangerous....in contrast, the predominantly philobatic individual experiences the objects as unreliable and hazardous, is inclined to dispense with them, and seeks out the friendly expanses separating the treacherous objects in time and space. (1968, p. 165)

Although the new beginning in the here-and-now takes place in a favorable object relationship and in principle cannot be derived from the then-and-there it is still understood as regression to an early pretraumatic phase of development. The unsolved problem of the relationship between reconstruction and therapeutic change immediately becomes apparent if we focus on one significant point from among Balint's criteria for the new beginning: a new beginning always takes place in transference, i.e., within the object relationship, and leads to a transformation in the patient's relationship with his objects of love and hate and, consequently, to a considerable reduction in anxiety. Transference is not understood here in a narrow sense, as repetition, but rather as a comprehensive type of relationship with substantially new elements.

Innovative experiences in the new beginning are beyond repetition compulsion, and they also cannot be explained by means of theoretical recourse to the pretraumatic harmony which existed before the basic fault developed. By attributing the earliest "object relationship" a special therapeutic role in the new beginning of regressed patients suffering from a basic fault, Balint neglected the situational and creative elements in the therapeutic situation. The concept of the new beginning receives its comprehensive meaning in the theory of therapy when it is understood as an event in the here-and-now which is made possible by the analyst (Khan 1969).

For this purpose, both of the technical means (interpretation and object relationship) are essential,

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presumably in different dosages and in connection with further curative factors. The division of all of psychopathology into two classes, with the basic fault a condition of every serious illness, is not satisfactory. Of course it is possible for us to project all our creative potential and every new beginning back to the earliest moment in our development and ultimately to find our true selves there in a retrospective utopia. Having shifted the original creative phase to the beginning of life, Balint succumbed to his own theoretical prejudices and localized the new beginning there. We, in contrast, conceive the new beginning as a creative process which is linked to many psychic acts, trial actions, and their realization, which must be tried repeatedly (Rothenberg 1984).

Using this conception, we attempt to link two views of regression, that of ego psychology and that of object relationship theory. The danger that regressions will degenerate in a malignant way is very large inasfar as they are not in the service of the ego (Kris 1936). Alexander (1956) pointed this out emphatically. In general, neither works of art nor cures result from regression alone; otherwise there would be many more artists and far fewer emotionally disturbed individuals.

8.4 Transference Interpretations and Reality

Since Strachey's studies (1934, 1937) transference interpretations have been considered the mutative instrument par excellence. Since the mutative effect of the transference interpretation, i.e., the change, is tied to the exchange between patient and analyst, Strachey's innovation became the prime example for therapeutically effective exchange processes and for object relationships and their impact on intrapsychic structures.

According to Strachey, in mutative interpretation there is an exchange of superego contents; the attitudes which the analyst communicates by means of his interpretations are internalized by the patient as new and mild parts of the superego. The result of this exchange is thus that the patient partially identifies with the psychoanalyst. Since identification plays such a significant role in therapy, we will discuss it later in detail. Strachey described a type of transference interpretation which alters the patient's experiencing and behavior. The patient arrives at his new identifications because the analyst assumes the functions of an auxiliary superego.

The concept of mutative interpretation directed attention to exchange processes and thus became the pattern for an interactional understanding of therapy. This evaluation of Strachey's paradigmatic work is the result of independent studies presented by Klauber (1972 a) and Rosenfeld (1972). Both of these authors emphasize that Strachey's innovation has had a lasting influence on psychoanalytic treatment technique. The contents of mutative transference interpretations have since been substantially extended. Strachey had assumed that especially parts of the superego are projected onto the analyst. Yet the important issue in the theory of projective and introjective identification is no longer the superego, but good and evil parts of the self. Rosenfeld (1972) therefore supplemented the contents of Strachey's mutative interpretation according to the interpretive contents of the Kleinian school.

At the level of the relationship the psychoanalyst functions as more than merely an auxiliary superego, whose stepwise introjection by means of mutative interpretations is, for Strachey, the condition for a cure. Using the terminology of the structural theory of psychoanalysis it is possible to call the psychoanalyst an auxiliary ego. In this function, he helps the patient to gain new insights and thus to interrupt the neurotic repetition compulsion. Although the analyst contributes to an immediate dissipation of anxiety, it would be wrong to equate his function as auxiliary ego with direct support of patients who have weak egos. Strachey limited himself to describing the psychoanalyst's introjection into the patient's superego, but we are today moving toward a two- and three-person psychology as a consequence of the development of psychoanalytic object relationship psychologies, which assign the patient's identification with the analyst a central position. While it was once possible to assume, in working with a patient displaying superego pathology, that a reliable relationship would develop on its own because the healthy parts of the patient's personality would form a link with the task of analysis despite resistance and repression, in many of today's patients this is no longer possible. It speaks for itself that Kohut (1977) attributes the analyst a function of a selfobject. Here we are dealing with exchange processes in the sense of a primary identification, which creates something shared as the basis for reciprocity and mutuality.

The discovery of the patient's readiness to enter into a therapeutic relationship with the psychoanalyst, to work together to some extent, and to identify with him was paradigmatic. Strachey expressed his surprise

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> at the relatively small proportion of psycho-analytical literature which has been concerned with the mechanisms by which its therapeutic effects are achieved. A very considerable quantity of data have been accumulated in the course of the last thirty or forty years which throw light upon the nature and workings of the human mind; perceptible progress has been made in the task of classifying and subsuming such data into a body of generalized hypotheses or scientific laws. But there has been a remarkable hesitation in applying these *findings* in any great detail to the *therapeutic process itself:* (Strachey 1934, p. 127, emphasis added)

This observation can be explained by the fact that no specifically psychoanalytic vocabulary was available to describe the curative factors, i.e., those processes that lead out of transference neurosis. The description was thus necessarily vague. Some use was made of the terminology of preanalytic, hypnotic psychotherapy, which was not free of the disrepute attached to suggestive influence. In the model of mutative interpretation, Strachey established a new foundation for the analyst's influence even if it was limited to the exchange of superego contents. Thus it was no longer necessary to borrow elements from preanalytic theories or from general concepts to explain therapeutic change in certain respects.

How much is still unclear and controversial can be seen from the contradictions in the theories of the therapeutic process and from the difficulties that have been encountered in trying to transform them into practical steps. What does the psychoanalyst contribute toward the creation of a common basis? How does he make it easier for the patient to identify with the joint task and with the analyst, who sheds new light on his problems in coping with life and on his symptoms? An answer to these questions cannot be found by relying on the working relationship in general, but requires that this relationship be translated into individual technical steps. The same is also true for the application of the theory of identification to therapeutic exchange processes. Mutative interpretations are today recognized as belonging to a larger category of interventions. To ease comparison, we would like to refer to two representative passages from a study by Strachey:

> It is not difficult to conjecture that these piecemeal introjections of the analyst occur at the moments of the carrying through of transference-interpretations. For at those moments, which are unique in the patient's experience, the object of his unconscious impulses simultaneously reveals himself as being clearly aware of their nature and as feeling on their account neither anxiety nor anger. Thus the object which he introjects at those moments will have a unique quality, which will effectually prevent its undifferentiated absorption into his original superego and will on the contrary imply a step towards a permanent modification in his mental structure. (1937, pp. 144-145)

Strachey then compares the therapeutic effects of the analyst with those of a therapist who employs suggestion:

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> It is true that the analyst, too, offers himself to his patient as an object and hopes to be introjected by him as a super-ego. But his one endeavour from the very beginning is to differentiate himself from the patient's archaic objects and to contrive, as far as he possibly can, that the patient shall introject him not as one more archaic imago added to the rest of the primitive super-ego, but as the nucleus of a separate and new super-ego.... He hopes, in short, that he himself will be introjected by the patient as a super-ego — introjected, however, not at a *single gulp* and as an archaic object, whether bad or good, but little by little and as a *real person.* (1937, p. 144, emphasis added)

It is improbable that Strachey actually hoped to be consumed as a real person. On the contrary, he probably hoped for a *symbolic internalization* which coincidentally is said to be characteristic of many cannibalistic rituals (Thomä 1967a, p. 171). In the course of such internalizations both the relation to reality and the self-feeling undergo a change. It is thus possible to say that reality changes as a result of the symbolic interaction.

The current phase of psychoanalytic technique is characterized, according to Klauber (1972a, pp. 386-387), by the attempt to distinguish transference from nontransference elements and to describe more precisely the reality of the analytic situation. We hope that the discussion in this section will contribute toward this goal.

Klauber gives the following description of the phases since Strachey's unusually influential work. In the first phase, attention was directed by what may be the most creative of all the subsequent studies — A. and M. Balint's paper "Transference and Countertransference" (1939) — to the fact that every analyst has an emotional need to do his work in a way which conforms to his personality, and that he thus creates a totally individual and characteristic atmosphere. The question was thus raised whether it were at all possible for the analyst to have a mirrorlike attitude, as recommended by Freud. The *second* phase began after World War II. The therapeutic significance of the analyst's reaction was especially emphasized by Winnicott's study "Hate in the Countertransference" (1949) and by Heimann's paper "On Countertransference" (1950). Central for the *third* phase were the descriptions by Searles (1965) and Racker (1968) of the complex interaction between patient and analyst.

Both mutative interpretations and Strachey's thesis that the analyst in his benign role is introjected into the patient's superego put special emphasis on the problem of reality in the therapeutic situation and on the question of how the analyst's "real person" has an effect. These issues are as old as psychoanalysis itself. Now, in the midst of the *fourth* phase, it appears to be becoming possible to resolve

them technically. We regard the present development as a major step toward integration of the here-and-now and the then-and-there.

We begin by referring to those solutions mentioned by Strachey and emphasized by Klauber, who exhorts us not to overestimate the content and specificity of interpretations, because they have to be seen in the context of a relationship. The analyst's attitude signalizes, "I will stay friendly anyway and will not act like the old object; I behave differently than the obsolete anxiety conditions would lead you to expect." The analyst does not adhere to the principle of an eye for an eye and a tooth for a tooth, thus making it possible to interrupt the *circulus vitiosus* that Strachey so forcefully described. After all, in the theory of ego development the concept of the superego stands for ways of experiencing and acting that belong to the category of commandments, prohibitions, and ideals. The reevaluation of these norms is the goal of mutative interpretations according to Strachey. Klauber's argument that this process means the internalization of parts of the psychoanalyst's value system is convincing. A cautious formulation of this view can even be found in some of Strachey's comments.

The real person of the psychoanalyst manifests itself as a "new object" in the second phase of Strachey's mutative interpretation. In this phase the patient's sense of reality plays a decisive role, and the analyst becomes an archaic transference object during the development of anxiety. The result of the second phase of interpretation depends on the patient's

> ability, at the critical moment of the emergence into consciousness of the released quantity of id-energy, to distinguish between his phantasy object and the real analyst. The problem here is closely related to one that I have already discussed, namely that of the extreme lability of the analyst's position as auxiliary super-ego. The analytic situation is all the time threatening to degenerate into a 'real' situation. But this actually means the opposite of what it appears to. It means that the patient is all the time on the brink of turning the real external object (the analyst) into the archaic one; that is to say, he is on the brink of projecting his primitive introjected imagos on to him. In so far as the patient actually does this, the analyst becomes like anyone else that he meets in real life — a phantasy object. The analyst then ceases to possess the peculiar advantages derived from the analytic situation; he will be introjected like all other phantasy objects into the patient's super-ego, and will no longer be able to function in the peculiar ways which are essential to the effecting of a mutative interpretation. In this difficulty the patient's sense of reality is an essential but a very feeble ally; indeed, an improvement in it is one of the things that we hope the analysis will bring about. It is important, therefore, not to submit it to any unnecessary strain; and that is the fundamental reason why the analyst must avoid any real behaviour that is likely to confirm the patient's view of him as a 'bad' or a 'good' phantasy object. (Strachey 1934, p. 146)

This hesitation to react, whether in the sense of a good or a bad object, should make it possible for

the patient "to make a comparison between the fantasy external object and the real one" (Strachey 1934, p. 147). The patient's sense of reality is strengthened as a result of this comparison between the different imagos projected onto the analyst and a more realistic perception. Thus, according to Strachey, there is adjustment to external reality and recognition that the current objects are not good or bad in the archaic sense. Strachey apparently means that differentiated insight relativizes the infantile perceptions, and concludes his argument with the following comment:

> It is a paradoxical fact that the best way of ensuring that his ego shall be able to distinguish between phantasy and reality is to withhold reality from him as much as possible. But it is true. His ego is so weak so much at the mercy of his id and super-ego *that he can only cope with reality if it is administered in minimal doses.* And these doses are in fact what the analyst gives him, in the form of interpretations. (Strachey 1934, p. 147, emphasis added)

The technical problems of Strachey's theses may well be rooted in the contradictions attached to the definition of reality in the analytic situation. Indeed, it is not only in Strachey studies and the discussion of them that this problem is unsolved. The general difficulties result from the fact that

> Freud assigns an important part to the notion of *reality-testing,* though without ever developing a consistent theoretical explanation of this process and without giving any clear account of its relationship to the reality principle. The way he uses this notion reveals even more clearly that it covers two very different lines of thought: on the one hand, a genetic theory of the learning of reality of the way in which the instinct is put to the test of reality by means of a sort of 'trial-and-error' procedure — and, on the other hand, a quasi-transcendental theory dealing with the constitution of the object in terms of a whole range of antitheses: internal-external, pleasurable-unpleasurable, introjection-projection. (Laplanche and Pontalis 1973, p. 381)

Strachey had apparently thought in terms of antithetical regulatory principles, i.e., in the framework of the pleasure and reality principles. Since, according to theory, the pleasure principle is merely modified by the reality principle, the search for gratification on a real (material) object remains the determining factor. On the other hand, *psychic* reality is molded by unconscious wishes and fantasies. Freud believed it necessary to assume a contradiction between these realities, because the incest taboo and other inevitable frustrations limit material gratification while at the same time constituting the actually desired reality:

> It was only the non-occurrence of the expected satisfaction, the disappointment experienced, that led to the abandonment of this attempt at satisfaction by means of hallucination. Instead of it, the psychical apparatus had to decide to form a conception of the *real circumstances* in the external world and to endeavour to make a *real alteration* in them. A *new principle of mental functioning was thus introduced;* what was presented in the mind was no longer what was agreeable but what was real, even if it happened to be disagreeable. (Freud 1911 b, p. 219, emphasis added)

Assuming that the object relationships are regulated by the pleasure and reality principles, then the experienced reality is determined by the dominance of the one or other principle. It is characteristic of psychoanalytic theory to view the pleasure principle as the primary and archaic fact, which is inexhaustible and derives from the unconscious, the id. It certainly makes a big difference whether I only imagine something or whether I can actually grasp an object or in some way immediately perceive it (Hurvich 1970; Kafka 1977). Yet this is not a contradiction between different realities, which would have to be taken into consideration and would inevitably lead to the irresolvable problem of "why the child should ever have to seek a real object if it can attain satisfaction on demand, as it were, by means of hallucination" (Laplanche and Pontalis 1973, p. 381). Since transference interpretations also involve the analyst as an individual, we have to add a few more comments on psychic reality. Referring to the *real* person of the analyst precipitates concerns, as if psychic levels were supposed to be sacrificed and replaced by materialization, i.e., wish fulfillment.

Reflection on the theory of psychic reality is necessary. Like McLaughlin (1981), we believe that we can come closer to a solution to these problems by viewing the analytic meeting from the perspective of *psychic reality,* i.e., as a *scheme* which is both comprehensive and contains different meanings. Patient and analyst naturally experience the situation very concretely, with their subjective wishes, affects, expectations, hopes, and ways of thinking. As soon as we reflect on our different psychic states, a plan develops for ordering our experiences and events with regard to space and time. To a great extent a person follows his subjective schemata for thinking and acting, which thus govern his behavior, without reflecting on them. He experiences the fact that psychic reality is constituted situationally in interpersonal relations. Psychic reality in McLaughlin's sense refers both to concrete subjective experiences and to their unconscious roots. The analyst constructs a patient's psychic reality within the framework of the psychoanalytic theory he uses. Such constructions are aids to orientation. McLaughlin also includes the analyst's countertransference in his comprehensive understanding. The many levels of meaning of the concrete psychic realities, including the underlying theories held by both the patient and analyst, are interrelated and understood interactionally. The security which the analyst could have drawn from the mirror analogy is thus lost. McLaughlin shows that reflection on psychic reality is very productive, even though the analyst may initially have to put up with insecurity since, according to McLaughlin, he can no longer proceed from an understanding of himself as a real person who enters into

a realistic relationship with the patient. Everything is relativized by the patient's perspective. Reality develops in this two-person relationship by means of an interactive process in which the participants' subjective perspectives are continually tested and a certain consensus is reached. Patient and analyst learn to make themselves understood. The result of a successful analysis is a gradual and mutual confirmation of the psychic realities and their authentication, a term McLaughlin uses to describe a process of change. In this way both participants acquire *relative* security with regard to their perspectives.

The analyst is affected by the critical discussion that takes place in the psychoanalytic dialogue. He is the expert, not only employing common sense but also expressing opinions that he has acquired during his training. His professionalism has molded his thinking. His view of a patient's psychic reality (as well as his experience of his own) is not independent of the theories that he uses. In testing authentication we have to go further than McLaughlin and raise the question of whether the indirect source of some of the problems we face should not be sought in Freud's theories on psychic reality.

We are dealing with a region of high tension between poles marked by the antithetical concepts of psychic reality vs material reality, reality principle vs pleasure principle, pleasure-ego vs reality-ego. Ultimately we arrive at reality testing as the act that distinguishes between internal and external, or between what is merely imagined and what is actually perceived. Freud opposed psychic reality to material reality after he was forced to give up his theories of seduction and of the pathogenic role of real infantile traumata. Fantasies not derived from real events possess the same pathogenic value for the subject which Freud originally attributed to unconscious memories of actual events. The contrast between the two realities is thus linked to contents characterizing the realities. Psychic reality is the world of the subjective, conscious, and unconscious wishes and fantasies, and material reality is characterized by the actual gratification or nongratification of instinctual needs on objects.

According to Laplanche and Pontalis (1973, p. 363) psychic reality designates the "unconscious desire and its associated fantasies." Is it necessary to attribute reality to unconscious desires? Freud asks this question in the context of dream analysis, answering:

> If we look at unconscious wishes reduced to their most fundamental and truest shape, we shall have to conclude, no doubt, that psychical reality is a particular form of existence not to be confused with material

reality. (1900a, p. 620)

Thus there is both psychic reality and material reality. The decisive sentence with regard to the psychoanalytic view of the genesis and nature of neuroses reads: "The phantasies possess *psychical* as contrasted with *material* reality, and we gradually learn to understand that *in the world of the neuroses it is psychical reality which is the decisive kind"* (Freud 1916/17, p. 368).

In Freud's theory, psychic reality is regulated by the pleasure principle, which itself is molded in human development by life's necessities by means of the reality principle. Reality testing is subordinate to the reality principle. The growing child learns to postpone immediate gratification in order to find a more realistic gratification of its needs, i.e., one based on mutuality and congruence with the needs of fellow man. The tension between psychic and material realities is thus based on the assumption that there is a surplus of desires continually seeking gratification but not finding it because of life's necessities in general and the incest taboo in particular. To create more favorable conditions a certain amount of gratification in the therapeutic situation is necessary; otherwise the old frustrations would simply be repeated. The problem of frustration and gratification in the analytic situation becomes easier to solve if the theory of psychic reality is deepened and not linked with *frustration* in a one-sided fashion. In fact, it is necessary and essential therapeutically that the patient be enabled to reach many joyful congruences with the object, i.e., the analyst, and to discuss differences of opinion. This facilitates the path to the frustrated unconscious childhood desires seeking gratification in the present.

The purpose of these comments is to indicate the consequences of a comprehensive conception of psychic reality. The patient seeks and hopes for an improvement or cure of his symptoms and difficulties, that is, he hopes to achieve a positive change with the help of an expert. His attempt to relate all of his feelings and thoughts reveals a multifaceted image of the world in which he lives. He describes different views of his world depending on his mood and on the predominance of different desires, expectations, hopes, and anxieties. Although the patient also distinguishes between his perceptions of people and things and his ideas about them, he does not divide reality into a psychic sphere and a material one. This is true despite his awareness that his desires and ideas may conflict and that he is dependent on external objects in his search for pleasure and gratification. Very diverse processes take place in the analyst when he listens and lets his emotions and thoughts reach a conclusion. If the analyst intervenes

at any point with a comment, the patient is confronted with information. Yet, as Watzlawick et al. (1967) say, it is impossible not to communicate, since negative information, e.g., the analyst's silence, also constitutes a communication, particularly when the patient expects some kind of response. The psychoanalyst's comments introduce points of view that the patient must confront in some manner — he can ignore them, accept them, reject them, etc. Sooner or later there will be joint reflection on various issues. Present during this reflection, either consciously or unconsciously, are many third parties: family members, other relatives, and people the patient knows, works with, and lives with. The analyst's own experiences, desires, longings, old anxieties, and current struggles are constantly touched on. Since he himself is not the one who is suffering, he can for the good of the patient find a distance from which he can presume the existence of a wish when the patient momentarily reacts with anxiety. The emotional and intellectual burdens of this activity on the analyst would of course be too great to bear if he did not have a wealth of explanatory sketches at his disposal which reflect typical conflict patterns. They facilitate his orientation during therapy.

Relating these points to Strachey's understanding of reality, we find the following. In his statement that "the analytic situation is all the time threatening to degenerate into a 'real' situation," Strachey refers to the pleasure principle in a wide sense of the term (Strachey 1934, p. 146). He starts from introjected imagos that are then projected onto the analyst without taking situational precipitating factors into consideration. Noteworthy is that Strachey assumes fixed quantities both here and when speaking of the real, external object, i.e., the psychoanalyst. It is clear from the passage quoted above that Strachey believed it possible to use *withdrawal of reality* to reinforce the patient's capacity for differentiation when *testing reality* at the time of the mutative transference interpretation.

By following the mirror analogy, the analyst may get involved in a role conflict which keeps him from confirming the patient's rather realistic perceptions in transference interpretations and thus prevents him from working against new denials and repressions. Heimann (1956) did not notice, despite her early innovative contribution on countertransference (1950), that it is impossible to be, on the one hand, a mirror having no self and no independent existence, but only reflecting the patient, and on the other, a person who is part of the analytic situation and of the patient's problems both at a realistic level and at a fantasy one. It suffices if the analyst demonstrates some restraint, enabling the patient to reenact in transference the relationship patterns which have remained active unconsciously.

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In the context of the extension of the theory of transference (in the sense of a comprehensive concept of transference) our considerations have to lead to the view that the analyst's so-called reality is constituted during the patient's constant unconscious and conscious testing. In the instant he makes a mutative interpretation, the analyst also reveals something of himself, as Strachey emphasizes. This certainly does not refer to just any personal confession. What is directly or indirectly expressed in helpful interpretations is enriched by the analyst's professionalism and by the fact that his experience is independent of an overly narrow subjectivity. The analyst's professional knowledge facilitates a cognitive process which opens up new avenues for the patient to find solutions. These are by no means personal confessions, but communications — whether nonverbal or in the form of interpretations — about how the analyst views a patient's problem, how he himself feels and thinks in this regard, and what and how he is in regard to the patient. In this sense we agree with Rosenfeld (1972, p. 458) that the psychoanalyst's interpretations may reflect very clearly what he is.

Especially important in this regard is the *spontaneity* of the analyst, as Klauber emphasizes:

> Various technical consequences follow from this emphasis on spontaneity. Spontaneous exchanges humanize the analytical relationship by the continual interchange of partial identifications. It is this human quality of the relationship which is the antidote to the traumatic quality of transference as much or more than the acceptance of impulses by an analyst who reinforces the benign qualities of the superego. (1981, p. 116)

The precondition for this cognitive process which includes the other ego, the analyst, is of course that the analyst does not withdraw by proffering purely reductive transference interpretations. Gill's (1982) systematic analysis of the factors precipitating transference and, especially, resistance to transference (see Chaps. 2 and 8) following very plausible preconscious perceptions makes it possible to provide an answer to the question of what the analyst is as a real person in the therapeutic situation. The here-and-now must be considered in its interrelationship with the then-and-there, and in the process new and innovative perspectives are opened. Freud (1933a, p. 74) contrasted the immutability of the repressed, the so-called timelessness of the unconscious, to analytic work, which overcomes the power of the past. The here-and-now is linked with the then-and-there in the process in which something becomes conscious, and precisely this is the mutative effect of transference interpretations.

The analyst must be patient, because it takes some time before unconscious processes manifest themselves in transference in such a way that therapeutically effective interpretations are possible. This

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is what is meant by Freud's statement that from "the physician's point of view I can only declare that in a case of this kind he must behave as 'timelessly' as the unconscious itself, if he wishes to learn anything or to achieve anything" (1918b, p. 10). Note that "timelessly" is in quotation marks; from the context it is clear that transferences also develop in severe cases if the analyst waits patiently. *Once* the timelessness of the unconscious has been overcome, it even becomes possible to significantly reduce the length of treatment for such severe illnesses, according to Freud, because it enables the analyst with increasing experience to make helpful transference interpretations, i.e., those linking the past with the present. The repetitions create the impression that time is standing still. The dreaming ego also has time feeling and is aware of objections (Freud 1900a, p. 326; Hartocollis 1980). It is therefore misleading to speak of the timelessness of the unconscious when referring to the time feeling at different levels of consciousness.

Our line of argument is important for understanding the mutative effect of transference interpretations because they link past and present. In Freud's view, past, unconsciously preserved wishes lose their effect when they reach consciousness. This leads to the conclusion that transference interpretations which assume that the patient's perceptions and experiences in the here-and-now are ahistorical repetitions miss the point just as much as interpretations of the here-and-now which ignore the unconscious dimension of the individual's life.

The emphasis on the ahistorical quality of unconscious processes and their interpretation in the here-and-now often goes together with a very strict application of the mirroring function. Ezriel's (1963) studies start from the assumption that the ahistorical reenactment in transference is more complete the more passive and abstinent the well-analyzed analyst is. Such an analyst directs his interpretations at the object relationships which are unconsciously sought or avoided. Ezriel recommends a type of transference interpretation oriented on the object relationship which is sought but anxiously avoided. For this reason his interpretations always contain an explanatory "because," as in the sentence, "You are now avoiding this wish to relate that fantasy *because you* fear rejection."

Close examination of Ezriel's work leads to the realization that his description of the psychoanalytic method as ahistorical is not justified. It is true that the therapeutic effectiveness of the psychoanalytic method is related to the here-and-now and to the knowledge that can be acquired in the analytic situation. Yet Ezriel's conception is based on the assumption that the unconscious is ahistorical. Thus the

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patient's present realistic perceptions also do not play an independent role even though only here-and-now interpretations are given; such interpretations refer exclusively to seemingly ahistorical, momentarily effective, unconscious forces and constellations. Mutative qualities could not be in the here-and-now if the unconscious constellations were timeless, excluded from the individual's past, and ahistorical. We have highlighted Ezriel's work here because he assigned the here-and-now a special methodological significance; however, his studies failed because, among other factors, he neglected to give the analyst's situational influence the same importance in practice as he did in theory.

The inclusion of personal influence and realistic perceptions in transference interpretations is the central issue distinguishing Freud's reconstructive genetic transference interpretations from the innovations which followed upon Strachey's publications. If the corrective object relationship in the analytic situation is referred to, as Segal (1973, p. 123) does, then the analyst is bound to include the influencing subject (the analyst) and the patient's realistic perceptions of the analyst in the formulation of transference interpretations. The importance of psychic reality and unconscious fantasies is by no means diminished by the discovery that realistic observations, for example the analyst's countertransference, play a role in their genesis.

The patient participates in the psychoanalyst's value system whenever it is of consequence for new solutions to neurotic conflicts. This identificatory participation, which Strachey described in his reevaluation of the superego, commandments, and proscriptions, is not only inevitable, it is therapeutically necessary. Trying to avoid it leads to a strained atmosphere which may be characterized by anxious avoidance of therapeutically necessary participation.

The findings of research in the social sciences make it essential that great importance be attached to the psychoanalyst's influence on the situational origin of perceptions and fantasies. The theories about the handling of real relationships also affect the structuring of the therapeutic situation. Since in Freud's theory the reality principle is secondary to the pleasure principle and real gratification is always sought — even though gratification may be delayed for varying periods of time — tension develops in the therapy as a result of frustration and renunciation. Creating an atmosphere of this kind can provide relief to a group of inhibited patients because alone empathy and tolerance toward the aggressions produced by frustration can lead to some alleviation of the superego. The transformation of an

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excessively strict superego into a mild one does not create the kind of therapeutic problems that have to be solved in the repair of defective ego functions or the construction of previously underdeveloped ones. The patient's identification with the psychoanalyst plays a decisive role in this. It seems as if this category of patients is increasing in number, and it is therefore important to determine the conditions under which identifications are formed.

The relationship of transference interpretations to the other aspects of the therapeutic relationship received too little attention in the one-sided reception of Strachey's position. Klauber's (1972a) work is the most outstanding of the few exceptions. Strachey had ascribed these other components, such as suggestion, lessening anxiety, and abreacting, an important role in treatment. The problem, however, of how the analyst presents his real self to the patient in small doses has not been solved.

As in the discussion between Greenson, Heimann, and Wexler (1970), controversies continue as to how the analyst should handle realistic perceptions in the here-and-now. Some analysts fear that this could ultimately lead to the gratification of needs and mean that treatment would no longer be conducted in a state of *frustration* and *abstinence.* These problems of technique can be solved constructively and to the advantage of therapeutic change if we understand their origin in the psychoanalytic theory of reality. In discussing this point we will start from the following observation by Adorno:

> On the one hand, "libido" is for it [psychoanalysis] the actual psychic reality: gratification is positive, frustration negative because it leads to illness. On the other hand, psychoanalysis accepts the civilization which demands the frustration, if not completely uncritically, then at least in resignation. In the name of the reality principle it justifies the individual psychic sacrifice without subjecting the reality principle itself to rational scrutiny. (Adorno 1952, p. 17)

Although the reality principle that the analyst represents is relatively mild, it should cause enough frustration "to bring this conflict to a head, to develop it to its highest pitch, in order to increase the instinctual force available for its solution" (Freud 1937c, p. 231). This statement from one of Freud's later texts shows that technical problems result from the psychoanalytic theory of reality.

Subjecting the reality principle to rational scrutiny can only mean, with regard to technique, that the patient's perceptions must be taken seriously. In the moment that this takes place, an intentional act finds its object, thus creating reality. We will return to this topic later when discussing the relationship

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between historical truth and perception in the here-and-now. Since the individual's conception of reality is determined in a sociocultural context, neither the one nor the other can be taken as absolute. The reality of the psychoanalytic situation is thus constituted in the exchange, assimilation, and rejection of opinions.

Neither the analyst nor the patient starts from a completely valid standpoint when testing reality. In the one case we would end up adjusting to the existing conditions, in the other in solipsism. At the one extreme the individual declares that his family or society is insane and the cause of his illness, at the other the individual is dependent on and made ill by external factors. Carrying this polarization to its limits, society as a whole could be declared insane and the emotionally disturbed could be considered to be the healthy individual revolting against sick society. Successful therapy would then adjust this person to the sick society without noticing it. Adorno goes this far when he writes, "By becoming similar to the insane totality, the individual becomes truly sick (1972, p. 57).

A mutative interpretation seems to have a special effect if it is devised to strengthen the working relationship, i.e., the patient's *identification* with the psychoanalyst in his role as *auxiliary ego.* As a result of the great influence exerted by Strachey's work a new form of "interpretation fanaticism" developed. This had been previously criticized by Ferenczi and Rank (1924), on the grounds that it referred to genetic reconstructions which neglect experience in the here-and-now and are thus therapeutically ineffective. Strachey (1934, p. 158) also examined this unsuccessful interpretation fanaticism and pointed to the emotional immediacy inherent in his mutative interpretation (as transference interpretation) at the decisive moment of urgency. At the same time he emphasized that the majority of interpretations do not refer to transference.

Nevertheless, a new form of interpretation fanaticism developed, this time with reference to "transference" in the sense of pure repetition. This limited the therapeutic effectiveness of psychoanalysis for a different reason than excessive intellectual reconstruction did- The consequence of understanding everything that occurs in the analytic situation or is mentioned by the patient primarily as a manifestation of transference is, as Balint (1968, p. 169) emphasized, that "the principal frame of reference used for formulating practically every interpretation is a relationship between a highly important, omnipresent object, the analyst, and an unequal subject who at Present apparently cannot

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feel, think, or experience anything unrelated to his analyst.

The inequality which develops can lead to malignant regressions if the external circumstances of a patient's life are neglected in favor of ahistorical transference interpretations. Such interpretations refer to those interpretations which exclude the present in all its forms — the analytic situation, the analyst's influence, and external circumstances. If the present is viewed solely as repetition of the past or of unconscious schemata derived from the past, which Freud described as templates or clichés, transference interpretations do not refer to a genuine situation which has a basis in the present reality Strictly speaking, the here-and-now is then nothing more than a new imprint of an old pattern or template.

In contrast to the ahistorical conception of transference and the interpretations associated with this view, authentic interpretations of the here-and-now provide new experiences because they take the present seriously. The psychoanalyst fulfills here a genuine task that cannot be reduced to that of father or mother. Heimann (1978) used the expression "supplementary ego" to describe this function, traced it back to the mother, and also called it the "maternal function." Because of the danger of a reductionist misunderstanding, we do not want to call the therapeutic supplementary or auxiliary ego maternal, but only to adopt the designation of the *function,* which is the essential aspect.

> The mother [in the person of the analyst], as supplementary ego, offers the child [the patient] concepts that it does not have itself. The mother teaches the child new concepts of thinking and thus sets it on the path of progress. (Heimann 1978, p. 228)

Freud's technical demand that "the patient should be educated to liberate and fulfill his own nature, not to resemble ourselves" seems to contradict the great therapeutic significance of the patient's identification with the analyst (Freud 1919a, p. 165). Another passage (Freud 1940a, p. 181) reads, "We serve the patient in various functions, as an authority and a substitute for his parents, as a teacher and educator." On the other hand, Freud warns:

> However much the analyst may be tempted to become a teacher, model and ideal for other people and to create men in his own image, he should not forget that that is not his task in the analytic relationship, and indeed that he will be disloyal to his task if he allows himself to be led on by his inclinations. (Freud 1940a, p. 175).

At a symposium on the termination of treatment, Hoffer (1950) described the patient's capacity to identify with the psychoanalyst's functions as the most important component of the therapeutic process

and its success. This topic thus has fundamental significance for understanding the therapeutic process if for no other reason than it closely associates the Psychoanalyst's *functions* with the patient's *identifications.*

Consideration must be given to a whole series of theoretical and practical problems which we would now like to outline by formulating a few questions. What does the patient identify with? What are the consequences of the psychoanalytic theory of identification for the optimization of practice, with the goal of making it easier for the patient to assimilate the functions mediated by the analyst? What does the psychoanalyst mediate, and how does he do it? With regard to the patient's experience, is it possible to distinguish the functions from the person who has them? How does the psychoanalyst indicate that he is fundamentally different from the expectations which characterize transference neuroses and the consequences they have on the processes of perception? Does it suffice for the patient to recognize that the way the psychoanalyst thinks and acts does not conform to the established patterns of expectations? Does it suffice for the analyst to define himself negatively, i.e., by not conforming to the patient's unconscious expectations? In our opinion, such a lack of conformity does not suffice to interrupt neurotic repetition compulsion and the therapeutic function is rooted in the fact that the psychoanalyst works in an innovative manner, introducing new points of view and enabling the patient to find previously unattainable solutions to problems.

The innovative elements occupy such a natural role in therapy that they have, almost unnoticed, become part of the point of view that a *synthesis* takes place apparently on its own. Yet the psychoanalyst's interventions in fact contain at least latent goals which help to determine how the released elements are reassembled. The fundamental therapeutic function of the psychoanalyst is that he is effective as a "substitute." Regardless of whether he is viewed as an auxiliary superego or an auxiliary ego, and however the current school-determined language of theory and practice deviates from Strachey's, it is a generally accepted psychoanalytic experience that support initiates the exchange processes which lead to new identifications. The result is a lack of independence on the part of the patient, leading among other things to the necessity that he speak his therapist's language, as Balint (1968, p. 93) described the situation showing great understanding for this connection between language, thinking, and acting.

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Learning from a model — or in psychoanalytic terminology, identification — has a significance in every therapeutic process which can hardly be exaggerated. Since the very different psychoanalytic object relationship theories of the various schools became a focus of attention, all concepts referring to the relationship of internal to external and of subject to subject (or object) are of special technical interest (Kernberg 1979; Meissner 1979; Ticho, according to Richards 1980). In his introduction to a conference on object relationship theory, Kanzer (1979, p. 315) calls special attention to the fact that the emphasis given to object relationships has made it possible to develop a dyadic understanding of the traditional treatment of adults. He also refers to numerous authors who have furthered this development (Balint 1950; Spitz 1956; Loewald 1960; Stone 1961; Gitelson 1962).

Common to internalization, identification, introjection, and incorporation is that they all refer to a movement from without to within, involving assimilation, appropriation, and adaptation (Schafer 1968; Meissner 1979; McDevitt 1979). Regardless of the meaning attached to these words — e.g., incorporation taken literally and too concretely, identification as symbolic equating — their common feature is that they refer to an object relationship. Balint (1968, pp. 6162) therefore pointed out that it is not possible to talk about identifications in a narrow sense of the word unless there is a certain distance between within and without or between subject and object. Freud's fundamental anthropological observation deserves to be mentioned in this connection; he noted that relinquished object relationships are expressed in identifications (1923b, p. 29). It hardly needs to be emphasized how significant this aspect of identification is in separation, bereavement, and the termination of analyses.

We believe that it is now possible to solve the old problem concerning reality in the psychoanalytic situation, and that fifty years after Strachey's important article psychoanalytic technique can and will considerably expand its therapeutic potential. Transference interpretations play a special role in this development. In our argument we have so far distinguished the following aspects:

1. Here-and-now interpretations can be taken to include every kind of reference to the analytic situation, but not to the patient's current circumstances outside of analysis or to those prior to analysis. The extension of the concept of transference, which we discuss in Chap. 2, creates two classes of intervention: one relates to everything that is outside the analytic situation, the other includes all interpretations concerning the here-and-now in the comprehensive understanding of transference. In the traditional form of transference interpretation, the analyst assumes there is a *repetition* and thus focusses

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his attention on the *genesis.* These statements are based on the assumption that there is a conditional relationship between current experiencing and behavior and earlier experiences. In other words, such transference interpretations read something like, "You are anxious because you are afraid that I will punish you just like your father did."

2. It is possible for transference interpretations to be directed more toward the genesis and toward the *reconstruction* of memories. In contrast, it is also possible for the here-and-now to move to the center of the interpretation if *unconscious processes* are assumed to be *ahistorical.* Of course, the subject matter of this kind of transference interpretation is the analyst as an *old* object. Furthermore, the momentary dynamic is nearly identical to the conserved (ahistorical) genesis. In the here-and-now interpretations, the differences between the material which has been transformed from the past into the present and the analyst's contribution to transference are levelled out. There is no investigation of the affective and cognitive processes creating the momentary psychic reality. The purpose of the analyst's mirrorlike attitude is to manifest the ahistorical unconscious fantasies and the unconscious defense processes directed against them in the purest form.

3. We come finally to the type of transference interpretations in the here-and-now which realize both the potential for dyadic knowledge provided by the psychoanalytic method *and* its therapeutic effectiveness. We are thinking of all those transference interpretations which consider in a comprehensive manner the impact of the patient's more or less realistic perceptions on the unconscious processes. In this context we can refer to Klauber's conception that one task of psychoanalysis in the current phase is to distinguish the transference from the nontransference elements in the psychoanalytic situation. In the meantime, however, transference theory has expanded so much that speaking of nontransference elements creates misunderstandings. Of course, it is essential to distinguish between the imaginative decorations and the wishful image of the world facilitated in the analytic situation, on the one hand, and the realistic elements of the analyst's behavior, on the other. This process of differentiating the kinds of dyadic knowledge constitutes the mutative effect of transference interpretations.

We can now mention Arlow's (1979) view that transference develops by means of metaphoric thinking. On the basis of unconscious schemata (Freud's templates), psychic reality is formed from the points of view of contrast and similarity. The patient compares the psychoanalytic situation and the psychoanalyst with current and previous experiences. If transference is viewed as a manifestation of metaphoric thinking and experience, as Arlow does, it is necessary to assume that the *similarity* makes it possible to establish a connection, to carry something from one shore to the other, i.e., from a previous to

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the current situation. Precisely from the therapeutic points of view, therefore, Carveth's (1984b, p. 506) criticism must be taken seriously. He points out that the analyst's *confirmation* of the similarity is *the* precondition for changing the transference templates, which according to psychoanalytic theory have been formed by the necessity to deny realistic perceptions and to repress affective and cognitive processes. Freud's unconscious templates are very similar to the linguistic category of "dead metaphors" (Weinrich 1968; Carveth 1984b). These can come to life, i.e., manifest themselves out of the dynamic unconscious, if similarities (in the sense meant by Gill) are admitted and acknowledged in transference interpretations. Otherwise there is a repetition of acts of denial, and the old templates maintain their influence. The moment that similarities are identified also marks the discovery of the here-and-now and the then-and-there. This differentiation of kinds of dyadic knowledge makes it possible for the mutative interpretation to exert a corrective emotional experience.

Finally, we would like to point out that our view draws its therapeutic application from Freud's fundamental assertion that "a fragment of *historical truth*" is contained in all emotional disturbances (1937d, p. 269). Freud emphasizes that if this historical truth were acknowledged, then:

> The vain effort would be abandoned of convincing the patient of the error of his delusion and of its contradiction of reality; and, on the contrary, the recognition of its kernel of truth would afford common ground upon which the therapeutic work could develop. That work would consist in liberating the fragment of historical truth from its distortions and its attachments to the actual present day and in leading it back to the point in the past to which it belongs. The transposing or material from a forgotten past on to the present or on to an expectation of the future is indeed a habitual occurrence in neurotics no less than in psychotics. (1937d, pp. 267-

It should be clear how we would like to make this conception therapeutically useful. The common ground can be found in the *recognition of the kernel of truth* in transference interpretations. In doing this, it is as a rule sufficient to acknowledge the general human disposition, as we suggest in Chap. 3. Constructions of historical truths are, in contrast, dubious; they lack the power of conviction emanating from current experience. We believe that the patient, in comparing the here-and-now and the then-and-there, ultimately establishes a distance to each, freeing himself for the future. We would therefore like to paraphrase a statement of Freud's (1937c, pp. 231-232) to the effect that the analytic work proceeds best when the patient establishes distance between himself and both past experiences and current truths, which then become his-

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8.5 Silence

Speech and silence are the two sides of every conversation; the participants must either speak or remain silent. Specifically, either one participant speaks, or both are silent, or both speak at the same time. The moment one person speaks, the other can only remain silent or interrupt him, and if both are silent, a space is created which is claimed by each and which only one of them can seize in order to speak for an indefinite period of time. The analyst's silence provides the patient with an opportunity to speak. (Incidentally, the doctor's office is called in German a *Sprechzimmer,* or room for talking.)

There are good reasons to encourage the patient to initiate the dialogue. A one-sided distribution of speech and silence, however, contradicts the rules of everyday communication. Deviations from the expected course of dialogue thus lead to surprises, irritations, and finally helplessness. For example, if the analyst behaves very passively in the initial sessions, he exerts an unusually strong influence on the patient, whose expectations have been formed by previous visits to physicians. The patient expects questions about his complaints and their history, usually phrased directly so that he can provide concise answers. The more the discussion deviates from his expectations and from the patterns of speech and silence characteristic of everyday communication, the greater the surprises.

These few comments should suffice to demonstrate clearly that the effects of employing silence as a tool vary greatly. It is impossible to make a general recommendation in this regard, since whether the silence is experienced as rejection or benevolent encouragement depends on many situational circumstances. It is thus all the more surprising that the view that psychoanalysts sit silently behind the couch is not limited to caricatures. On the contrary, analysts often make a virtue out of silence, as if the profession followed the motto "speech is silver, silence is golden."

There are in fact good reasons, from analytic points of view, to be reserved in the dialogue and not to ask importunate questions which hinder the patient from getting to the topics that are important to him. The patient can be invited in this way to take the first steps toward free association. By showing restraint, the analyst can motivate the patient into attempting to say everything that he feels a need to say and is currently able to express. In the long term, the analyst's silence also promotes the patient's regression, which is not self-serving but a part of the therapeutic process. For this reason alone, the dosage of silence and speech is of preeminent significance.

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In view of the practical necessity to be just as prudent in using silence as the spoken word, the fact that a stereotype is made of silence is a real cause of concern. It is not unusual for this stereotype to lead the analyst to behave in an extremely restrained fashion even in the initial interviews, i.e., to use them as a kind of miniature trial analysis in order to determine whether the patient is suited for the planned therapy.

Pauses are an essential part of therapy for both diagnostic and therapeutic reasons, and provide the patient with opportunities to introduce a new important topic. This can also be used as a means of gaining a first impression of the extent to which the patient tolerates the analyst's silence.

Since we oppose using this method to determine the suitability of a patient for analysis, and urge instead that it be adapted to the patient, it is important to examine the question of how it was possible for the analyst's silence to become a stereotype. Factors which contributed to this situation include, in our opinion, the high regard for free association and regression as self-curative processes, and the overemphasis on self-cognition as a means of therapy. Freud, for example, recommended that the analyst avoid making an interpretation until the patient himself has almost arrived at the same insight into a previously inaccessible constellation:

> We reflect carefully over when we shall impart the knowledge of one of our constructions to him and we wait for what seems to us the suitable moment — which is not always easy to decide. As a rule we put off telling him of a construction or explanation till he himself has so nearly arrived at it that only a single step remains to be taken, though that step is in fact the decisive synthesis. (Freud 1940a, p. 178)

This recommendation unites two points of view into one ideal: first, the principle that the patient be disturbed as little as possible, and second, the experience that the patient's own insight has a greater therapeutic effect than information provided by the analyst. Freud clearly indicates that there is an ideal moment or a particularly favorable junction between internal and external factors, and that it is important for the analyst to find this favorable moment for breaking his silence. The dichotomy of silence and speech is thus transformed into the polarization between silence and interpretation. This occurs, if at all possible, without the intermediate stages which naturally occur in every psychoanalytic dialogue even though they do not really fit into the ideal picture of psychoanalysis.

We now arrive at a surprising result: hand in hand with the highly stylized view that

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interpretation should be the analyst's only form of verbal communication, a high, even mystical, value has been attached to silence. Silence has become the inconspicuous, sheltering, and supportive origin of interpretation. We reject mystification, although it is beyond doubt that some momentary agreements between patient and analyst are based on deep, unconscious communication, as if interpretations were previously agreed upon, i.e., as if patient and analyst had exactly the same thoughts. We agree with Cremerius (1969) that silence based simply on custom, with no critical foundation, must be rejected. Silence is one of the tools, one of several technical operations, which have to be applied according to the situation to promote the analytic process.

The fundamental rule and its counterpart, evenly suspended attention, are rules of treatment constituting a special type of dialogue, which in the actual course of treatments is rarely as asymmetric as the theoretical discussion would seem to suggest. Verbatim protocols of analytic dialogues reveal that the analyst usually participates actively, even though according to the literature the quantitative ratio of verbal activity varies between 5:1 and 4:1 in favor of the patient. In this evaluation, pauses are generally considered part of the patient's time, a consequence of the fundamental rule and the fact that the issue of the analyst's interventions has not been formally regulated. We do not accept this approach and believe it more appropriate to consider longer pauses as joint discursive activity. The fundamental rule is effective for only a limited period of time if the dialogue has been exhausted. At some point the analyst is then faced with the question of whether he should end the silence. During longer periods of silence the intrapsychic processes of the partners in the dialogue do not stand still. Patients have numerous motives for remaining silent, covering the entire spectrum of the theory of neurosis; similarly there are many reasons for the analyst not to speak. A resistent silent patient may bring about a countersilence in the analyst. If both partners are silent, the processes of nonverbal communication become more prominent and are also perceived.

Cremerius (1969, p. 98) reported one patient who oriented himself on the number of matches the analyst lit during the breaks in speech: few matches were a sign of harmony, many matches indicated a disturbance of the communication.

A psychology of silence, the beginnings of which are now available, would contribute to establishing a technical basis for distinguishing the level of subject-object fusion from the level of refusal

to communicate. In both cases, the capacity to follow the fundamental rule reaches its limits. Nacht (1964) views silence as a kind of integrative, mystical experience shared by patient and analyst, and believes that this exchange without words may represent a reexperience (or new experience) of the state of fusion and total amalgation from early development. He thus ties silence to the idea of reparative change, i.e., of a cure by means of pregenital love as propounded by Ferenczi, in whose tradition he must be seen.

The ego psychological standpoint also suggests that interpretation not be used as a means of achieving change. Calogeras (1967) has demonstrated this in the treatment of a chronically silent patient. However, we view the detailed justification for the introduction of the parameter "renunciation of the fundamental rule" to be an example of what we discussed with regard to the basic model technique (Chap. 1). In the same sense, Loewenstein (see Waldhorn 1959), Zeligs (1960), and Moser (1962) argue in favor of allowing the silent patient the time he needs. Freud's guideline is also applicable here: all technical steps should be directed at creating the most favorable conditions for the ego.

In addition to the general aspects of the function and consequences of the analyst's silence, we would like to deal with the special topic of *power* and *impotence* in the psychoanalytic relationship. We believe that the analyst's silence, if used in a stereotype manner and brought to an end by interpretations which may be very far from what has occupied the patient's attention in the long period since either he or the analyst last spoke, may contribute in a highly unfavorable manner to a polarization of impotence and power between patient and analyst. Here is an example (composed of notes and a statement by the analyst):

> A longer analysis. The patient is often silent for long periods of time. So far no satisfactory explanation of this behavior. One day she relates that her mother was often silent for long periods and that this silence always announced trouble and made her afraid. After the patient was then silent for quite a while, the interpretation was made:
>
> A: You are announcing trouble and want to make me afraid, just as your mother did to you when she was silent.
>
> The patient agrees with the interpretation, but is then silent for a long time. Later she says that she was very hurt by the interpretation because she had to acknowledge that in a certain respect she is similar to her mother, whom she hates intensely. (Flader and Grodzicki 1982, pp. 164-165)

Since we want to use this example to support the thesis that precisely the constellation of obstinate silence on the part of the analyst followed by a sudden transference interpretation leads to a polarization of omnipotence and impotence, we must emphasize that Flader and Grodzicki believe this to be a good example of a transference interpretation for which it is possible to describe the discursive mechanisms of psychoanalytic interpretations. "In the above example of a transference interpretation the patient first accepted the interpretation and then relapsed into silence, probably for the purpose of assimilation" (Flader and Grodzicki 1982, p. 173).

We do not share this positive interpretation of the patient's reaction. Independent of the fact that the transference interpretation and the subsequent silence by the patient are linked to the defense mechanism of identifying with the aggressor — she acts like her own mother and treats the analyst like the child she herself used to be — the fact that the patient immediately accepts the interpretation implies that she subordinated herself rapidly to the analyst's unmediated intervention. Interpreting the subsequent long period of silence as an act of assimilation hardly meets Isaac's criteria for positive reactions to interpretations. It may well have been the silence of assimilation, but what the patient had to assimilate was probably her bewilderment at discovering that she resembles her hated mother. In this sense, the analyst's notes contain the comment that the interpretation hurt her very much, not that it moved her. This difference is important, especially in the context of a passage presented by a team consisting of a linguist and a psychoanalyst. One of the reasons that we chose this example is that it reminds us of our own unfavorable experiences with this technique.

The analyst's silence and subsequent sudden awareness of the answer to the question that the patient had not even raised — in the above example, "What am I really doing, and what do I really want?" — can lead in this way to a polarization of impotence and omnipotence which is both bipersonal and intrapsychic. The analyst becomes omnipotent and the patient impotent; the patient's unconscious fantasies of omnipotence are strengthened to the extent that he experiences humiliation in the psychoanalytic situation. Whenever somebody is made to feel impotent and helpless — whether by denying him a vital gratification or in some other way slighting his self feeling — there are attempts at compensation, which may begin simultaneously or at some later time.

Experiences of impotence may be compensated by fantasies of omnipotence. Pathological

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omnipotent behavior, in contrast to the fleeting omnipotence fantasies familiar to everyone, is generally a desperate attempt to defend oneself against overwhelming dominance and arbitrariness. The polarization following upon stereotypical silence and sudden interpretations is not immediately comparable with the situation of children, although in the course of normal development they too experience impotence and the unequal distribution of power between adults and children and have compensatory fantasies of grandeur. Indeed, we must go further and raise the question of whether additional severe mortifications might be created precisely by this analogy. Specifically, if the analyst views these compensatory fantasies as *distorted perception* derived from transference, he rejects the patient's criticism of his own extreme silence. In addition, the next step is that the compensatory fantasies of grandeur or omnipotence are interpreted as the consequence of a preserved infantile narcissism.

We thus have every reason to structure the psychoanalytic situation in such a way that the impotence-omnipotence polarization does not shift further in favor of reactive fantasies in the course of therapeutic regression.

How can a patient understand that his behavior, e.g., his silence, constitutes a question and that the analyst's interpretation is an adequate response? Flader and Grodzicki (1982) were able to show that the analyst can only detect the wish or motive contained in the patient's silence by breaking the rules of everyday communication. In a similar vein, Schröter (1979, pp. 181-182) described interpretations as negations of everyday forms of interaction.

> Interpretations are the analyst's comments on the patient's utterances and actions. In them, he attempts to bring out the unconscious meaning of the utterances and actions, or specifically, the unconscious fantasies, desires, and anxieties which are implied in them. Thus the patient is implicitly defined as not completely knowing what he says, at least with regard to the interpreted meaning of his utterance.

Since, as Schröter himself notes, the patient experiences this to be extremely foreign, anomalous, or even threatening, the maxim must be that deviations from everyday communication should be dosed according to the consequences on the analytic process. This recommendation is based on our experience that all patients — and not only those with narcissistic personality disorders — react with great sensitivity to violations of the normal form of everyday dialogue and that this is especially true if they are in a situation in which they require help. Schröter (1979, p. 181) notes that interpretations are very commonly experienced as criticism, slights, or humiliation, and we extend this mutatis mutandis to

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include silence. Therefore, a manner of conducting the dialogue must be found which is optimal with regard to treatment technique and which keeps unfavorable consequences to a minimum.

8.6 Acting Out

The general issue of action in psychoanalysis and the generally negative appraisal of acting out are good indications that it is easier for us to deal with the word than with the actual deed. Despite the efforts of some psychoanalysts to provide an adequate treatment of acting out from, for example, the points of view of developmental psychology and psychodynamics, the term is still used to refer to forms of behavior which are undesirable and may even endanger the analysis. Specific phenomena in the psychoanalytic situation have made this concept necessary and given it its negative image.

We have to analyze why acting out takes place and why it is considered a disturbance. In other words, which forms of behavior does the analyst evaluate negatively, i.e., in the sense of acting out? We choose this formulation to draw attention to the fact that the psychoanalyst (including the factors he takes as given, e.g., framework, policies, fundamental rule) exerts a significant influence, although apparently only the analysand can question or reject the rules that have been agreed upon and deviate from the desired structure of the dialogue and the relationship, specifically with *words* and by *remembering.*

Freud discovered the phenomenon he termed acting out in the context of Dora's transference, and described it in his *Fragment of an Analysis of a Case of Hysteria* (1905 e). Acting out did not take a meaningful place in psychoanalytic technique until after the publication of *Remembering, Repeating and Working Through* (1914g), in which Freud derived it from the psychoanalytic situation and transference. Freud compares the psychoanalytic technique with hypnosis, mentions several complications, and then continues:

> If we confine ourselves to this second type in order to bring out the difference, we may say that the patient does not *remember* anything of what he has forgotten and repressed, but *acts* it out. He reproduces it not as a memory but as action; he *repeats* it, without, of course, knowing that he is repeating it. (1914g, p. 150)

Kanzer (1966, p. 538) therefore refers to "the motor sphere of transference."

The expression "acting out" has two meanings, as Laplanche and Pontalis (1973, p. 4) point out:

Freud "fails to distinguish the element of *actualisation* in the transference from the resort to *motor action."* The combination of these meanings is related, on the one hand, to the discovery of the concept in the Dora case, and on the other, to the model of cognitive affective processes as related to movement. The structure of the mental apparatus generally lets the psychic process run from the perceptual end to the motor end (Freud 1900a, p. 537).

With regard to unconscious wishful impulses Freud comments that "the fact of transference, as well as the psychoses, show us that they [unconscious wishful impulses] endeavor to force their way by way of the preconscious system into consciousness and to obtain control of the power of movement" (1900a, p. 567). The description of both affective and nonverbal utterances in the psychoanalytic situation as acting out has resulted in confusion, as many authors have pointed out (Greenacre 1950; Ekstein and Friedman 1959; Rangell 1968; Scheunert 1973). In the words of Laplanche and Pontalis (1973, p. 5):

> But inasmuch as Freud, as we have seen, describes even transference on to the analyst as a modality of acting out, he fails either to differentiate clearly or to show the interconnections between repetition phenomena in the transference on the one hand and manifestations of acting out on the other.

In his later studies, Freud still emphasizes primarily the connection between remembering and acting out: "The patient ... acts it out before us, as it were, instead of reporting it to us" (1940a, p. 176). Of course, acting out also takes place outside of transference as such:

> We must be prepared to find, therefore, that the patient yields to the compulsion to repeat, which now replaces the impulsion to remember, not only in his personal attitude to his doctor but also in every other activity and relationship which may occupy his life at the time — if, for instance, he falls in love or undertakes a task or starts an enterprise during the treatment. (Freud 1914g, p. 151)

Acting out is not only related to remembering and repeating, but also has meanings and functions which make a purely technical classification and differentiation appear insufficient. Laplanche and Pontalis (1973, p. 6) have therefore recommended that the psychoanalytic theories of action and communication be subjected to a reconsideration that would have to include the following topics: affective and impulsive abreactions and controls; blind acting out and goal-directed action; motor discharge and highly organized acts such as play and scenic representation, structuring of relationships, creative achievement, and other ways of resolving tensions and conflicts by means of differentiated and complex courses of movement and action; acting out as the result and resolution of defense and

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adaptation potentials in the repertoire of an individual in relationship to his environment.

There are a large number of unconscious conditions which may increase the tendency to acting out. They include early traumas with a deficient capacity for the formation of symbols, since memory and remembering are connected with the acquisition of word symbols, which themselves lead to a state in which the memory apparatus has a useful structure (Blos 1963). Disturbances of the sense of reality, visual sensibilization, fixations at the level of the "magic of action" are different kinds of conditions which may put emphasis on action language in contrast to verbal language. At the same time, fantasies and action are possible preverbal means of problem solving and communication.

Actions can cause a stronger and more immediate feeling of self-modification that words, and there is also a greater potential for influencing external reality and the world of objects. Acting out can have the function of mastering tension and creating (or recreating) the feeling for reality. Finally, acting out also is a way of exploiting the external world for ruthless maximization of pleasure (Blos 1963).

Acting out can help to ward off passive desires and the associated anxieties, and also to undo the effects of experiences of impotence and traumatic helplessness.

Blos (1963) described acting out as a common and appropriate solution for the problems of separation in adolescence. The ego impoverishment resulting from the withdrawal of libido from the important (parental) objects is compensated by overcathexis of the external world or of the possibilities for interacting with it (which is naturally a source of important new experiences). In our opinion, this experience also throws light on the role that acting out plays during separation from loved ones as well as in the stages of development and the consequent separation from the past.

It would be possible to continue the list of meanings and functions of acting out indefinitely. The list demonstrates the ambiguity of the concept and the difficulty of defining it in terms of treatment technique. Boesky (1982, p. 52) has recommended speaking of acting out only in connection with repeating and working through. We have referred to several meanings because a differentiated understanding of acting out makes it possible to recognize it both within and outside the analytic situation, to integrate it, and to make it accessible to analytic work. It also limits the negative meaning to forms of behavior having primarily destructive consequences, serving denial and confusion, or seriously

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threatening the therapeutic cooperation. The fact that this is a process burdening the capacity and tolerance of the analyst should in itself not lead to a negative evaluation. Whether such behavior and reactions in the individual case are habitual or accidental is secondary.

Expressed in technical terms, interpretations — not evaluations and rules — should be the primary means of restricting acting out in the transference, so that a fruitful treatment process remains possible.

For practical and prescriptive reasons, Freud continued to assert that "nothing takes place in a psycho-analytic treatment but an interchange of words between the patient and the analyst" (1916/17, p. 17). The *word is the* feature of psychoanalytic treatment. For Freud, the purpose of lying on the couch was to block the expressive-motoric field of experiencing and behavior, for precisely defined theoretical reasons: by limiting movement, he wanted to interrupt the external discharge and strengthen the pressure within, in order to facilitate *remembering.* Abstinence and frustration were intended to increase the internal pressure in order to revive memories.

Since regression promotes fantasizing, the result is a certain tendency toward acting out, toward repetition through acting out, which runs counter to the demand that the patient verbalize and mentally rehearse actions. Infantile feelings, conflicts, and fantasies are repeated in transference, but the analysand's ego is supposed to function under the mature conditions of verbalization and introspection — conditions which determine the course and vitality of the analysis. Increased tension (increased pressure resulting from a reduction in the sphere of action, from abstinence, and from frustration) also opens up additional ways for manifesting regression (discharge, adjustment, defense). Since gestures are more difficult in the Iying position and there is no visual contact, speech remains the primary means of communication. It is not an effective substitute, however, for repressed or inhibited tendencies toward action. Blum (1976) particularly mentions preverbal experiences, which, just like certain affects, sensations, and moods, cannot be adequately expressed in words.

The conclusion is that analysis is not possible without some acting out. It is impossible for all aspects of experience (and of neurosis) to be expressed in words. Boesky (1982) refers to acting out as the potential for actualization inherent in the transference neurosis.

The skepticism toward acting out that is nonetheless present might also be connected with its

discovery and description in the Dora case, to be specific, with the patient's discontinuation of treatment. We would now like to quote the following description in order to comment on current points of view. Dora's analysis, in the year 1900, lasted only eleven weeks.

> At the beginning it was clear that I was replacing her father in her imagination, which was not unlikely, in view of the difference between our ages. She was even constantly comparing me with him consciously, and kept anxiously trying to make sure whether I was being quite straightforward with her, for her father 'always preferred secrecy and roundabout ways'. But when the first dream came, in which she gave herself the warning that she had better leave my treatment just as she had formerly left Herr K.'s house, I ought to have listened to the warning myself. 'Now,' I ought to have said to her, 'it is from Herr K. that you have made a transference on to me. Have you noticed anything that leads you to suspect me of evil intentions similar (whether openly or in some sublimated form) to Herr K.'s? Or have you been struck by anything about me or got to know anything about me which has caught your fancy, as happened previously with Herr K.?' Her attention would then have been turned to some detail in our relations, or in my person or circumstances, behind which there lay concealed something analogous but immeasurably more important concerning Herr K. And when this transference had been cleared up, the analysis would have obtained access to new memories, dealing, probably, with actual events. But I was deaf to this first note of warning, thinking I had ample time before me, since no further stages of transference developed and the material for the analysis had not yet run dry. In this way the transference took me unawares, and, because of the unknown quantity in me which reminded Dora of Herr K., she took her revenge on me as she wanted to take her revenge on him, and deserted me as she believed herself to have been deceived and deserted by him. Thus she *acted out* an essential part of her recollections and phantasies instead of reproducing it in the treatment. What this unknown quantity was I naturally cannot tell. I suspect that it had to do with money, or with jealousy of another patient who had kept up relations with my family after her recovery. When it is possible to work transferences into the analysis at an early stage, the course of the analysis is retarded and obscured, but its existence is better guaranteed against sudden and overwhelming resistances. (Freud 1905e, pp. 118-119)

If we consider Freud's description of Dora's acting out on the basis of our current state of knowledge, we have to admit that Freud was prompted to wait patiently by his overestimation of the importance of unconscious traces of memories compared to the significance of the situational factor precipitating transference, which in this case had negative consequences. He realized this himself after the termination of the analysis: did she notice something about *him* that made her mistrustful, as with Herr K., or did she notice something about *him* that created an attraction, as previously with Herr K?

Based on the retrospective analysis of this case history by Deutsch (1957), Erikson (1964), and Kanzer (1966), it is probable that Dora's acting out was motivated by situational factors. Freud subsequently emphasized this, although he had not drawn the conclusions from this fact in 1905.

Freud was searching for the sexual fantasies of this hysterical girl, who had become ill after Herr K. had twice attempted to seduce her. He attempted to ascertain the unconscious "truth" of her (ultimately

incestuous) fantasies. Dora's memories seemed to support such assumptions with regard to her agitation and her many and varied sensations after she had vehemently rejected the attempted seduction.

Dora, however, was concerned with another truth: she wanted to prove that her father and the other people around her were guilty of insincerity. Her father had an affair — secret, but known to Dora — with Herr K.'s wife, and when registering his daughter in Freud's office had emphasized that she was just imagining her scene with Herr K. Lidz and Fleck (1985, p. 444) have interpreted Dora's case history in terms of family dynamics. They show in detail that Freud, contrary to his own goals, did not pay sufficient attention to the purely human, social, and family relationships. They raise a number of questions, all of which indicate that Freud underestimated the consequences of Dora's complicated family relationships on her experiencing and illness. Freud did not consider, for example, the fact that Dora's father repeatedly violated the generation boundary, first using his daughter as a substitute for his wife and then as a means to distract Herr K., the husband of his lover. Lidz and Fleck raise other questions in connection with the concept of generation boundary, and reach the conclusion that Dora's parents, together with Herr and Frau K., repeatedly violated that boundary.

Erikson provided the following summary of the problem which resulted from the fact that Dora and Freud were searching for different truths:

> But if in the patient's inability to live up to his kind of truth Freud primarily saw repressed instinctual strivings at work, he certainly also noted that Dora, too, was in search of some kind of truth. He was puzzled by the fact that the patient was "almost beside herself at the idea of its being supposed that she had merely fancied" the conditions which had made her sick; and that she kept "anxiously trying to make sure whether I was being quite straightforward with her." Let us remember here that Dora's father had asked Freud "to bring her to reason." Freud was to make his daughter let go of the subject of her seduction by Mr. K. The father had good reason for this wish, for Mr. K.'s wife was his own mistress, and he seemed willing to ignore Mr. K.'s indiscretions if he only remained unchallenged in his own. It was, therefore, highly inconvenient that Dora should insist on becoming morbid over her role as an object of erotic barter.
>
> I wonder how many of us can follow today without protest Freud's assertion that a healthy girl of fourteen would, under such circumstances, have considered Mr. K.'s advances "neither tactless nor offensive.-' The nature and severity of Dora's pathological reaction make her the classical hysteric of her case history; but her motivation for falling ill, and her lack of motivation for getting well, today seem to call for developmental considerations. Let me pursue some of these.
>
> Freud's report indicates that Dora was concerned with the historical truth as known to others, while her doctor insisted on the genetic truth behind her own symptoms. At the same time she wanted her doctor to be 'truthful" in the therapeutic relation, that is, to keep faith with her on her terms rather than on those of her father or seducer. That her doctor did keep faith with her in terms of his investigative ethos she probably

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appreciated up to a point; after all, she did come back. But why then confront him with the fact that she had confronted her parents with the historical truth? (Erikson 1962, pp. 455-456)

Important for Dora were her own opinion of herself and its realization. Blos (1963) wrote, on the basis of his experience with adolescents, that acting out has an important function in cases in which reality has been concealed from the child by its environment in some traumatic way. Acting out then serves to reestablish the sense of reality. After a treatment has been discontinued, it becomes impossible to work through the function of acting out. The events Freud subsequently described show, however, that serious consideration of Dora's concerns would have reduced the risk of acting out or of breaking off treatment. Her acting out was determined by a mistake in Freud's attitude, i.e., in his focussing. In the specific treatment situation that Freud refers to self-critically, his mistake was insufficient interpretive activity.

What is the consequence that *Freud* drew from the instant of therapy that preceded Dora's acting out, i.e., her unannounced absence? Dora had listened without making any of her usual objections, as Freud had attempted to interpret at a deeper level the attempted seduction by Herr K. and her anger that her story was considered a product of her imagination: "I know now — and this is what you do not want to be reminded of — that you *did* fancy that Herr K.'s proposals were serious, and that he would not leave off until you had married him." Dora "seemed to be moved; she said good-bye to me very warmly, with the heartiest wishes for the New Year, and — came no more" (Freud 1905e, pp. 108, 109). Freud thus traced Dora's anger back to the fact that she felt her secret wish had been detected whenever he referred to her imagination.

In 1900 Dora was an 18-year-old girl in the phase of adolescent detachment. She was in a period of development in which, as we now realize, acting out (including interrupting treatment) is nothing unusual and even fulfills an important function in development (one similar to that of a trial action). Discontinuation of treatment must be judged in a different light, however, than those forms of acting out which do not threaten the therapeutic work or serve denial.

In this context the question remains unanswered whether even the discontinuation of treatment may in some circumstances constitute a kind of acting out that is the realistic form of action for a *patient* to follow (and is not only the result of the actualization of an unconscious conflict). Dora paid one further

visit to Freud a year later because of "facial neuralgia," but she did not alter her decision to end treatment. She did, however, officially terminate her treatment — she "came to see me again: to finish her story" (1905e, p. t20) — and told Freud enough to enable him and us to reach certain conclusions. Dora's decision not to continue the treatment but to clarify what she considered to be the real issue seems to have been important to her.

An act becomes *undesired* acting out especially as a result of its *consequences,* whether they are (unconsciously) intended or not. The consequences are also the reason for the recommendation, which used to be common, that the analysand not make any vital decisions for the duration of the analysis (Freud 1914g). This recommendation that important decisions be postponed may in fact have been sensible in short (several months) analyses, especially if the recommendation did not amount to more than a request that the patient reconsider his situation.

Today such an intervention is suspect. At any rate, it is indispensable that the consequences of such direct or indirect suggestions be followed carefully. Rules established to counteract acting out could have just the opposite effect and lead to unconsciously controlled substitute manifestations either within or outside the analytic situation which may be difficult to follow. In this way the analytic activity is inevitably further separated from the presumed transferred conflict, and the independent precipitants resulting from the current phase of the psychoanalytic relationship (e.g., Dora's disappointment with Freud) gain in significance.

As a result of his theoretical point of view, Freud had to assume that acting out is so intimately related to repetition that he consequently neglected his self-critical observation on the actual genesis of her disappointment and acting out in their relationship.

Today we are more aware for such developments because we know that the theoretical point of view (that emotionality and motor action precede remembering) runs counter to the model of treatment technique (remembering has priority). In addition, the increase in the duration of analysis can promote the regressions associated with the predominance of pre- and nonverbal modes of communication and action. In the history of the psychoanalytic technique, this tension has found its expression in the discussion of the therapeutic functions of experiencing and remembering ever since the book by Ferenczi

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and Rank (1924), as reflected in Balint's new beginning (1952 [1934]) and contemporary work (see Thomä 1983 a, 1984).

The emphasis put on repetition in transference and on its resolution by interpretation led to a neglect of the innovative, creative side of acting out (especially within the psychoanalytic situation). Balint describes these important components in the context of the new beginning. Viewed historically, this sanctioned the individual case of acting out (although under a different name).

A possible consequence of neglecting the innovative side is that patients are unintentionally forced into a blind form of acting out outside of analysis. Without a doubt, Freud's description is accurate:

> We think it most undesirable if the patient *acts* outside the transference instead of remembering. The ideal conduct for our purposes would be that he should behave as normally as possible outside the treatment and express his abnormal reactions only in the transference. (1940a, p. 177)

But if the acting out in the psychoanalytic situation, and in transference in particular, precedes remembering and belongs to genetically older strata, then remembering can only take place as a second step. If it is taken as the first step in analysis, the result is an absence of affective depth. As a consequence, there is primarily rational reconstruction within the analysis and an acting out of emotions outside it.

Zeligs (1957) understands "acting in," i.e., acting out in the psychoanalytic situation, to refer to all nonverbal communications. If limited, for example by means of understanding, interpretation, and a suitable technique and attitude, acting in can be included much more easily in the interpretation than can acting out outside the analysis, and can then lead to insight and change. In this sense, acting out is close to the change Balint described as a new beginning. Just as the negative evaluation of acting out was related to the theoretical understanding of repetition, which was supposed to be overcome by means of remembering and insight, it is now clear that acting out is inevitable, even desirable, in therapy in the form of acting in. Much more takes place in treatment than simply an exchange of words: nonverbal communication does not stop despite the limitations on the sphere of action imposed by the rules. Thus the analyst has no choice but "to accept acting out as a means of communication," even for patients not suffering from regression (Balint 1968, p. 178). The unique advantages of the interpretive method of psychoanalysis are not endangered if the conditions for the dialogue are structured in a manner which allows the analyst to express understanding for acting out. How much room there is for variation is

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demonstrated by the fact that Eissler (1950) thought it essential that any modification serving the goal of structural change be adopted.

Each manner of structuring the analytic situation and the verbal dialogue, whether rigid or flexible, must be examined with regard to its consequences. Deprivation achieves a special intensity in the pure, neoclassical mirror technique, and according to theory, especially fruitful memories should be brought to light. Yet just the opposite is often the case; antitherapeutic acting out often reaches a disturbing degree. The exclusion of psychomotoric and sensual communication and the concentration on verbal exchange with a partner who is unseen and hides his identity contradict human nature. Self-presentations rely on feedback which is positive or negative and emotionally modulated, and they usually employ all the senses and subliminal perceptions. It cannot be denied that the overevaluation of remembering and the associated neglect of sensations linked with the body ego, which can manifest themselves even on the couch as rudiments of, for instance, a desire to move, promote *malignant* acting out. In such acting out, whether within or outside the analytic situation, the patient seeks with all his resources acknowledgement of the bodily self-feelings which have not been recognized or named. These self-feelings, by the way, take the form of participation by the somatic symptoms (Freud 1895d) and are closely linked to remembering. The classification into remembering and acting out has theoretically severed the original connection. Since acting out refers to bodily experiences, it is logical to use this term to describe nonverbal or unreflected behavior.

The negative connotations associated with acting out are too large, however, to be overcome by adding a corrective adjective, e.g., *benign* acting out. Nonmalignant acting out must even be therapeutically desirable. Yet it is very improbable that the majority of analysts would answer yes to the question of whether they desire acting out to take place. This fact indicates that the fixed opinions about this concept cannot be altered by adding some prefix. We have mentioned and discussed several theoretical and technical reasons for this negative attitude, indeed anxiety, of many analysts toward acting out. We believe that one of the most important reasons for this attitude is the fact that acting out — with its impulsive, complex, bodily, and regressive features which often result from unconscious motives which are difficult to follow — places considerable demands on the analyst as a person and in his role as analyst.

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It is thus essential for analysts to realistically evaluate their competence and to retain a feeling of security in the treatment situation. One aspect of this is that the analyst needs to maintain an overview of what is happening in the analysis by limiting the number of variables and possibilities for expression. This is a precondition for the treatment that a patient is entitled to.

Whether the analyst allows acting out, how he works with it in the analytic situation, and how he makes new solutions possible probably depend to a large degree on the capacity and flexibility that the analyst demonstrates in confronting and reviewing the present analytic situation, and not only the psychogenesis. In other words, they depend on his ability to be receptive for phenomena in the current encounter — forms of behavior, ideas, and sensations which are usually more difficult to thematize in the here-and-now than as repetitions from the past. By following this principle of paying attention to current dynamic and intensive affects and ideas, it may be possible to recognize the past better and thus to make the present "more present," i.e., freer of the past.

8.7 Working Through

Working through played an important role in Freud's clinical work as early as his *Studies on Hysteria.* Therapeutic working through is grounded in the overdetermination of symptoms and the narrowness of consciousness:

> Only a single memory at a time can enter ego-consciousness. A patient who is occupied in working through such a memory sees nothing of what is pushing after it and forgets what has already pushed its way through. (Freud 1895d, p. 291)

Thus even at that time the therapeutic procedure was conceived causally: if the pathogenic memories and the affects related to them reach consciousness and are worked through, then the symptoms dependent on them must disappear completely. The explanation given for the variation in the intensity of symptoms during therapy and for their final resolution was that the pathogenic memories were being worked through and that association resistance was encountered. The matter is not taken care of if a single item is remembered and a "jammed affect" is abreacted, or in today's terms, if a patient achieves insight into an unconscious connection:

> Thanks to the abundant causal connections, *every pathogenic idea* which has not yet been got rid of operates as a motive for *the whole of the products of the neurosis,* and it is only with the last word of the analysis that the

> whole clinical picture vanishes …. (Freud 1895d, p. 299, emphasis added)

Pathogenic ideas repeatedly cause new resistance to association; working through the resistance in moving from one stratum to the next toward the pathogenic core removes the basis for the symptoms and finally leads to the abreaction. This was Freud's initial description of the therapeutic process. Working through was then mentioned prominently in the title *Remembering, Repeating, and Working-Through* (1914g), although Freud discussed this problem of technique on only one page. This problem has not yet been conclusively solved (Sedler 1983).

The present controversies and the recommendations for resolving them revolve around questions that become more accessible if we look at the more important passages from Freud's pioneering study. It was shown to be a mistake to believe that "giving the resistance a name" would "result in its immediate cessation." Freud continued:

> One must allow the patient time to become more conversant with this resistance with which he has now become acquainted, to *work through* it, to overcome it, by continuing, in defiance of it, the analytic work according to the fundamental rule of analysis. Only when the resistance is at its height can the analyst, working in common with his patient, discover the repressed instinctual impulses which are feeding the resistance; and it is this kind of experience which convinces the patient of the existence and power of such impulses. (1914g, p. 155)

The joint labors thus lead to resistance "at its height," where working through "is a part of the work which effects the greatest changes in the patient and which distinguishes analytic treatment from any other kind of treatment by suggestion" (1914g, pp. 155-156).

After the discovery that "giving the resistance a name" does not suffice, and that arduous working through is necessary to achieve permanent change, much of what Freud and subsequent analysts discussed remained obscure. There is a clear assertion about causality: once the resistance has been properly worked through, the symptoms must disappear like ripe fruit falling from the tree of knowledge. No new symptoms should take their place. However, we should know more exactly what the modifying change resulting from working through consists of. If the causally grounded therapeutic prognosis is accurate, then the following theoretical questions must be clarified and tested in therapy: What is the state of the joint labors? Did the analyst contribute too little or too much toward resolving the resistance? Is working through exclusively a matter for the patient? What is the relationship of working

through to experiencing, to abreaction, and to insight? Where does working through take place — only in the therapeutic situation, or also outside it? Within and outside — does this antithesis indicate that working through refers apparently to the transformation of insight and self-knowledge into practical action and a change in behavior? This incomplete list of questions makes it obvious that we are in the middle of psychoanalytic practice and its theory of therapy; this also means trying to explain failures in order to improve practice.

The history of working through demonstrates that advances in theory and practice do not always go hand in hand. This is connected with Freud's attempts to explain the *failure* of working through, i.e., therapeutic failure. We are taking this indirect route because it makes the solutions being suggested today more plausible. Although therapeutically effective working through initially referred to the repetition of fixations from the patient's life history and their recurrence in transference (Freud 1914g), Freud attributed the failure 10 years later to resistance of the unconscious (1926d, pp. 159-160). We have already discussed this form of resistance and Freud's speculative explanation of repetition compulsion in Sect. 4.4. We have also explained why Freud's philosophical speculations on repetition compulsion are such a burden precisely for the depth-psychological understanding of working through, as Cremerius (1978) convincingly demonstrated.

The conservative nature of the instincts, the adhesiveness (1916/17), the inertia (1918b), or the sluggishness of the libido (1940a), and the tendency to return to an earlier state — the death instinct — appeared to impede therapy or even to prevent working through, in its role as an important act of change. These are, in fact, speculations about constitutional factors which may be present in one form or another without being accessible to examination by the psychoanalytic method. The limits to the therapeutic range of working through must be marked on the original field of the method. It must therefore be emphasized that because of the theory of the death instinct (which, incidentally, is not accepted by any reputable biologist — see Angst 1980) Freud neglected to clarify to the logical conclusion the psychological conditions for repetition and its working through both within and outside the analytic situation. What does this mean? It is important for us to investigate the approaches to explaining repetition compulsion which are contained in Freud's work and then to examine the analytic situation to determine whether its standardized form as an ideal type optimally mobilizes the potential for change in the average patient.

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Therapeutically fruitful alternative explanations for repetition compulsion are available, for example, for the recurrence of traumatic events in dreams. Freud viewed this, just like the traumatic neurosis, as an attempt by the ego to reestablish the psychic balance. Originally Freud had assumed the existence of an "instinct for mastery" (1905d, p. 193), which Hendrick (1942,1943a,b) later attempted to revive. Examples of such an instinct are the acquisition of new skills, the intense curiosity of children, and the desire to move. Freud put repetition at the focus of his interpretation of childhood play but disregarded the pleasurable testing of new actions and perceptions which also take place; this neglect led to some one-sided views in the psychoanalytic understanding of theory and practice. Knowledge of the conditions leading to fixation and regression and to the repetitions associated with them is only one side of the coin. Freud's favorite object of scientific study was how and why people come to unconsciously seek and establish perceptual identities, i.e., to stick to their habits and pathological tendencies despite knowing better and wanting to change. On the other hand, there is the question of change. Pleasure seeks not only to become eternal and to repeat itself. We are anxious to learn and understand something new, and the greater the security that has formed or forms on the basis of interpersonally confirmed identities, the further we venture into the unknown.[1]

Since steps in an unfamiliar region may be accompanied by discontent and anxiety, it is essential that conditions favorable to change (the context of change) be created in the therapeutic situation (in contrast to the conditions of genesis the context of discovery). Some developments in theory have influenced the psychoanalytic technique in a one-sided manner and limited its range. Working through was, for example, often neglected despite Freud's initial demands and although it had an integrating function: "The treatment is made up of two parts — what the physician infers and tells the patient, and the patient's *working-over* of what he has heard" (Freud 1910d, p. 141, emphasis added). Hearing and telling are not enough; acting is what is important. Working through takes place at the junction between the internal and external and has an integrating function. Each point of view which is disregarded can make it more difficult for the patient to integrate the "severed connections" (A. Freud 1937).

Where Freud saw himself compelled to explain a failure by id resistance, we can today take full practical advantage of the continued theoretical development of his alternative idea regarding the meaning of repetition in playing, in the sense of mastery, as described by Loevinger (1966), White (1959, 1963), and Klein (1976, pp. 259-260). Freud described this alternative idea in the following

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way:

> The ego, which experienced the trauma passively, now repeats it actively in a weakened version, in the hope of being able itself to direct its course. It is certain that children behave in this fashion towards every distressing impression they receive, by reproducing it in their play. In thus changing from passivity to activity they attempt to master their experiences psychically. (1926d, p. 167)

According to Klein's comments on this alternative idea, the individual still has an unconscious intention to transform actively an event which was suffered passively and which has remained foreign to the experiencing self. Such events are traumatic, cause anxiety, and lead to repression. Attempts at self-cures fail because of the repression, since the consequences of unconscious intentions cannot be perceived in feedback loops. We must add that the analyst's interpretive assistance in working through lie in helping the patient to learn to perceive and control the unconscious intentions of his actions and behavior. For Klein, following Erikson, this mastery is no special, independent need striving for gratification, but a self experience — the self experiences itself as the initiator of an act. The self scheme is thus differentiated according to the processes of assimilation and accommodation and the other processes described by Piaget.

In 1964 a panel of the American Psychoanalytic Association on working through (see Schmale 1966) also referred to points of view from learning theory, which we will discuss in Sect. 8.8.

It is precisely a comprehensive understanding of theory and practice which raises questions about the nature of the relationship between resistance analysis and insight. Fenichel (1941) and Greenacre (1956) described working through as intensive and concentrated resistance analysis. Greenson (1965, p. 282) put insight and change at the center of his definition of working through, as the following passage shows:

> We do not regard the analytic work as working through before the patient has insight, only after. It is the goal of working through to make insight effective, i.e., to make significant and lasting changes in the patient. By making insight the pivotal issue we can distinguish between those resistances which prevent insight and those resistances which prevent insight from leading to change. The analytic work on the first set of resistances is the analytic work proper; it has no special designation. The analysis of those resistances which keep insight from leading to change is the work of working through. The analyst and the patient each contributes to this work.

This conception of working through resolves some of the technical difficulties. Its explanatory value lies in the fact that it makes it possible to comprehend the *effecteness,* or lack of it, of the circular processes

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(insight — therapeutic benefits — ego change — new insight) described by Kris (1956a, b). However, there is not always progress around this circle. Insights are not regularly translated into changes. In Freud's words, "as you can imagine, there are likely to be difficulties if an instinctual process which has been going along a particular path for whole decades is suddenly expected to take a new path that has just been made open for it" (1926e, p. 224). Leaving old paths and finding new ones, i.e., separation and saying farewell — this aspect of working through suggests a comparison with the process of mourning.

Fenichel (1941), Lewin (1950), and Kris (1951, 1956a, b) have pointed out the similarities and differences between mourning and working through. We believe that the differences are even greater than Stewart (1963) assumed. He draws our attention to the fact that the task of mourning is to reconcile oneself with the loss of a loved object, while the purpose of working through is to change the form and goals of preceding gratifications and to find new ones. With a real loss, time also contributes to the healing process, and the dialogue with the dead changes with the conscious and unconscious process of mourning.

Neurotic processes are different. They are often not interrupted by insight alone because new confirmations of unconsciously anchored dispositions can be sought and found in the outer world over and over as a result of internal psychic conditions. Thus despite the patient's insight during the interviews, the symptoms can repeatedly stabilize outside analysis according to the old templates. We would like to emphasize our agreement with Ross (1973, p. 334) that working through does not take place exclusively in the analytic situation.

The division, indeed cleavage, into insight and action (into internal and external) can take place all the more easily if the analyst limits himself to transference interpretations or views working through primarily as a part of the terminal phase. Waelder (1960, pp. 224ff.) emphasizes that mourning and working through generally last 1-2 years. Yet if every inconspicuous step is viewed against the backdrop of separation and loss, the patient will also postpone working through until the final year of the analysis, when mourning and separation are prominent, instead of viewing it as a continuous task. The example of working through in the terminal phase that Waelder (1960, p. 213) gives is a patient's autosuggestive comment, "I should stop behaving this way and make peace with myself." The prospects for successful working through are not positive if at the end the proverbial good intention is the only thing left.

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The purpose of working through is for insight to become effective. We are especially interested, therefore, in those cases in which insight leads no further than to good intentions, i.e., where the patient does not succeed in making peace with himself. Why does the insight gained through the analysis of resistance not lead to the changes that the patient desires and strives for? There are many answers to this question, most of which assert that the insight was simply not deep enough or that it lacked conviction because it did not result from interpretations within an intensive transference relationship.

Balint (1968, pp. 8, 13), for example, assumes that working through is linked to interpretations of resistance and is only possible in those patients who are accessible to words. Yet not everyone is willing to accept the gulf between verbal exchange and nonverbal relationship as a given fact. Indeed, Balint himself called for us to bridge the gulf. It is thus important to scrutinize resistance interpretations for implicit negative consequences. The latter seem to consist in an unresolved tension between the analyst formulating an image of the patient's unconscious wishes and potential and endeavoring to maintain neutrality and respect for the patient's liberty to make decisions by giving his interpretations in an open manner. This form of analytic behavior contributes to unsettling the patient and thus, in an indirect way, to a reaction which stabilizes habits.

On the other hand, the inequality between patient and analyst shifts even further in favor of the latter if primarily genetic interpretations are made. The patient then experiences the analyst, as Balint has shown, as omniscient with regard to the past and the origin of resistances. The analyst believes that all he has to do — in fact, that he may do nothing else — is to interpret resistances in the context of unconscious instinctual impulses and memories. In doing so he follows Freud's assumption that the synthesis, i.e., the creation of a new constellation of psychic elements, occurs on its own in analysis (Freud 1919a, p. 161)

It is true that interpretations can indirectly contribute to this synthesis because the new configurations which become possible are codetermined by the purposive ideas that the analyst has — and it is impossible not to have any. Yet an atmosphere is created which does not make it easier for the patient to overcome the *horror vacui* that may be linked with the new beginning and to translate his insight into real experience. The inevitable question is thus how many good insights and trial actions are necessary to attain a modification of symptoms and behavior in real life. Patient and analyst may feel so

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comfortable in the regression that they postpone the real test. There are always more or less plausible reasons for doing this, for example, because the patient does not believe that he is already able to change the forms of behavior tormenting him and those around him, and the analyst keeps looking in the past for deeper reasons for this inability.

Ultimately, working through is the process concerned more than any other with the patient bringing psychic acts to their conclusion and having positive experiences in doing so. Such positive experiences in analysis are all too comprehensible, and thus are discussed less than negative ones. This imbalance may increase just at those moments in working through when a good starting point for a trial action, i.e., confirmation and acknowledgement, is being sought. The fragile self-confidence which has just resulted from insight and experience is then lost again. Instead of working through leading to an increase in self-confidence, which could facilitate the patient's ability to cope with subsequent problems in "regression in the service of the ego" (Kris 1936, p. 290), it could lack any therapeutic effect and even result in a malignant regression. The structure of the psychoanalytic situation may constitute such a substantial factor contributing to this consequence that Cremerius (1978, p. 210) has recommended changing the setting in such cases. Still to be clarified is the analyst's contribution to the genesis of a malignant regression. Usually it is not too late to start over again by changing the technique or the setting. The criticism that the analyst manipulates the patient is inappropriate if he is frank to the patient and if changes are founded and handled interpretatively.

Working through has qualitative and quantitative aspects which can also be observed in learning processes, especially in relearning. Many patients ask themselves, as well as their analysts, how often they will have to endure a certain situation before they will be able to cope with it in a different and better way. For example, how many times must a patient have a positive experience when dealing with someone with authority in order to overcome his social anxiety and the more fundamental castration anxiety? Working through thus takes place both *within* and *outside* the analytic situation. We will discuss the points of view of learning theory in Sect. 8.8.

We believe that the problems posed by working through were relatively neglected in psychoanalysis in the last few decades because it also takes place outside the analytic situation and because learning theory must be taken into consideration to explain relearning. Our experience leads us

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to believe that Greenson's definition of working through — the analysis of the resistances preventing the transformation of insight into changes — is too narrow and onesided. Even in working through the resistances which are manifest in the analyses of those patients who are *not* successful, the central issue is how to be successful within and outside the analytic situation.

What can the analyst do to ensure that the patient's hesitant attempts, his trial actions, will be successful and that, following the encouragement in analysis, he will continue his efforts outside? Patients have a greater desire and need for reassurance and the other interpersonal experiences which strengthen the ego than healthy individuals do. In the standard technique the patient receives little support, which is completely eliminated if at all possible. It seems that the patient can only accept those aspects of the analyst's interpretations that he unconsciously seeks or that relate to the internal forces keeping him from reaching his goal.

Many interpretations provide indirect encouragement. Yet if the analyst believes that he may not provide any support, he puts the patient in a predicament or trap. The analyst unknowingly creates, according to Bateson et al. (1963), a double bind by providing contradictory information. On the one hand, the interpretation of unconscious desires opens up new opportunities, and the patient agrees with his therapist. If, on the other hand, the analyst limits his approval because he fears influencing the patient, the security which has been gained can be lost again. The ambiguity of half-hearted interpretations perplexes the patient and impedes working through the transference relationship. Working through is no exception: views about it, just like those about transference neurosis, vary from school to school; and the analyst's contribution to it, just as to the specific transference situation, is not small even in very typical illnesses. Kohut (1971, pp. 86ff., 168ff.) deserves special credit for having pointed out the significant role confirmation plays in establishing and working through transference. As Wallerstein (1983) and Treurniet (1983) have shown, Kohut's technical suggestions are not tied to his views on narcissism and his self psychology. All patients have narcissistic personalities inasmuch as their self-feeling is dependent on confirmation, but this is true for every individual. The uncertainties which are inevitable in any working through to attain restructuring are easier for a patient to bear if his curiosity about his unconscious desires and goals is reinforced by a supporting relationship.

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8.8 Learning and Restructuring

The limited explanatory value of Pavlov's model of learning became clear soon after the first attempts were made in the 1930s, when this was the most prominent model, to use the results of experimental research into learning psychology in order to improve our understanding of complex human learning. The later cognitive models of learning, which take, for instance, conceptual modifications and internal cognitive restructuring into consideration, are more helpful and stimulating for a comprehensive understanding of what happens in psychotherapy. The use of appropriate learning models seems advantageous especially where psychoanalytic thought is contradictory or incomplete, as in the case of working through. In this regard we would like to refer to French, who as early as 1936 expressed the hope that

> by always keeping the learning process underlying analytic therapy in mind we may be able to somewhat improve our perspective and sense of proportion about the significance and relative importance of the great multitude of unconscious impulses and memories that press toward the surface in psychoanalytic treatment. (French 1936, p. 149)

In this section we would like to focus attention on a few of the factors which support symptoms and on some of those which lead to therapeutic changes. The former play a special role in psychoanalytic treatment when we are concerned with their resolution, with therapeutic change, and with relearning, which is very close to working through. In this context we will disregard those processes and factors leading to the genesis of symptoms and neuroses; in doing so we are completely aware that we are introducing a somewhat artificial distinction between the genesis and the maintenance of symptoms. In the following, we refer to learning processes, or learning, for short, if there is a change in the likelihood that a certain behavior (act, thought, idea, affect) will manifest itself under comparable circumstances.

> If somebody repeatedly does something, or does not do it, in a certain situation although he previously would not have acted in this way under similar circumstances, or if his actions are more rapid and more secure than earlier, then we speak of a learning process. This is not the case if we have good reason to assume that the changed behavior is caused by other factors (e.g., intoxication, brain injury, or simply normal processes of maturation). (Foppa 1968, p. 13)

As is well known, there are three different paradigms for learning:

1. Classical conditioning (signal learning, stimulus-response learning), which is associated especially with Pavlov and (in psychotherapy) Eysenck and Wolpe

2. Operant or instrumental conditioning (learning by success), which is associated with the work of Thorndike and Skinner

3. Social learning (learning with models or by identification), as described by Bandura

In laboratory experiments it is possible to distinguish between these learning paradigms, and thus to study them separately, by varying the conditions. However, in real life, characterized as it is by a much greater multiplicity and complexity of internal and external conditions, learning processes seem as a rule to be determined according to the processes described by all three paradigms to different and changing degrees.

The most convincing paradigm of learning with regard to describing the course of psychoanalytic treatment seems at first to be learning with models, specifically, the analyst's model. This refers to how the patient accepts the analyst's ego functions — the manner in which the analyst identifies connections, common aspects, and differences in interpretations, which strategies he adopts to achieve affective and cognitive solutions to conflicts, how he phrases questions, and how he handles affects and the therapeutic relationship. The theory of social learning formulates a series of conditions which may influence the effects of social learning. Examples are the similarity between the model person (psychoanalyst) and the observer (patient) with regard to personal features such as social status, age, sex, and psychological personality structure; and the nature of the relationship between model person and observer, for instance, whether the observer desires the affection of the model person, fears its loss, or tries to avoid punishment by the model person.

Such conditions of interaction can determine to a large extent how the transference neurosis unfolds. This is by no means a reference to simple imitations of the psychoanalyst's manner of behavior or way of thinking, although they of course may also occur. More importantly, according to the findings of the theory of social learning we must expect sustained and internalized learning effects (changes), i.e., those which become integrated into the observer's entire repertoire of behavior and experiencing. This is especially true if the analyst's functions are mediated in a cognitive manner using symbols. This explanation shows that learning with a model goes far beyond the imitation of external forms of behavior, and emphasizes the similarities between this paradigm of learning and the processes of identification, as conceptualized in psychoanalysis. Empirical studies also reveal that the rapidity and

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permanence of model learning can be decisively improved by the mediation of verbal symbols.

The other two paradigms for learning exhibit a much less direct relationship to the events in psychoanalytic therapy. In the early 1930s several psychoanalysts (e.g., French 1933; Kubie 1935) applied the classical conditioning paradigm to the psychoanalytic treatment technique and attempted to use the former to justify the latter. These efforts were sharply rejected by Schilder (1935b); in his opinion Pavlov's theory of learning could not be applied to more complex human learning processes and was thus unsuited to explain psychoanalytic thinking and action. Schilder instead attempted to describe a psychoanalytic understanding of conditioned reflexes, an approach which seems just as unproductive (see the fundamental study by Straus 1935).

Heigl and Triebel (1977) have reviewed several of the learning principles mentioned here with regard to their relationship to psychoanalytic therapy. They extended their usual psychoanalytic treatment technology to include those variants of "confirmation of even the smallest learning advances within the transference relationship" which are founded in learning theory, paying special attention to corrective emotional experience. Yet we have our doubts whether such global conceptions and the restricted therapeutic instructions derived from them are suited to significantly expand or deepen our understanding of the process of psychoanalytic therapy and of the analyst's influence on its course. Wachtel (1977) has provided a fundamental and comprehensive discussion of this issue.

We would like to direct our attention to a specific pair of concepts from learning theory that play a central role in all three paradigms for learning and also seem to be helpful for understanding learning processes in psychoanalytic therapy. These concepts are *generalization* and *discrimination.*

In accordance with the accepted learning theories, we understand generalization to refer, for short, to the tendency to react in a similar manner in comparable circumstances, and discrimination to the tendency in similar circumstances to notice the differences and to react accordingly, i.e., discriminatingly. Within the framework of the above-mentioned basic paradigms for learning theory we now want to attempt to use this pair of concepts to provide an exemplary description of transference phenomena.

In a strongly simplified form, *transference* in psychoanalytic therapy is characterized by the fact that the manner in which the patient forms and perceives his relationship, at least with regard to certain,

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conflict-specific aspects, to his analyst (not to mention to many others outside the therapeutic situation) is especially oriented on the patterns of the relationships to his mother and father, siblings, and other significant persons which he formed in early childhood (see Chap. 2). The external features of the analytic situation and the analyst's behavior should promote the development of transference; obviously, the analysis of transference, an essential component of psychoanalytic therapy, cannot begin until the transference has become sufficiently intense and differentiated. The features that are the same or similar in the transference relationship and in specific relationships outside of therapy are further clarified and given special emphasis by the analyst in the course of transference analysis. When the transference is full bloom, the differences between the therapeutic relationship, its genetic predecessors, and the relationships outside therapy become increasingly clear. By means of various activities the analyst offers the patient — at least indirectly, and surprisingly often unknowingly and unintendedly, yet always inevitably — an incentive and opportunity to develop and test alternative and, in particular, flexible patterns of relationships in the therapeutic situation. Ultimately the patient cannot avoid applying outside therapy the ability to form relationships in a different and flexible way which he has acquired and even tested in therapy and to adapt it to changing circumstances.

This brief description reveals similarities with the course of some learning experiments. The new learning experience is introduced by generalization processes; similarities are sought in different configurations of stimuli. If a stable pattern of responses has been formed in this manner, the experimenter can then promote discriminatory processes by changing the experimental conditions, especially the reinforcement scheme; the organism learns to respond differently to different configurations of stimuli. Yet before response patterns acquired in this way can be generalized to apply to the conditions outside the immediate experimental situation, it may be necessary for the patient to go through further learning experiences under nonexperimental conditions. Thus the psychoanalytic process and some learning experiments display a whole series of common features. French (1936, p. 191) even speaks of the "experimental character of the transference" and emphasizes

> the importance of reality testing in the transference. Striking as are the manifestations of the repetition compulsion, the transference is nevertheless not only a compulsive repetition of earlier events. It 1S also an experimental attempt to correct the infantile patterns.

Within the *basic* learning paradigms it is not possible to attain any substantial increase in

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knowledge from such analogies beyond such global statements. This concept of access via basic learning theory proves to be too cumbersome and not vivid enough to comprehend complex affective and cognitive learning processes. While it is possible to understand such very complex learning processes within the framework of the generalization-discrimination theory of learning, as emphasized by Mowrer (1960) in particular, a series of new ideas (e.g., the concept of secondary reinforcer and viewing the response as a discriminatory stimulus) would then have to be introduced. Although the learning theory model would then be complex, it would also be cumbersome and lack clarity. Thus we want to end our discussion of the basic learning model here and to select a level of verbal description which is high enough to allow examination of cognitive learning models and the restructuring processes that they should reflect.

When talking of learning, people also think of childhood learning and the sometimes vain efforts of teachers. Traditional teaching can be termed "superego education," as Balint (1952) emphasizes; children should be raised to be moral, decent individuals. Balint contrasts this to "ego education" in psychoanalysis, linking it with general considerations of the educational aspects of psychoanalysis. As can be demonstrated, the educational element in psychoanalysis was never completely rejected and achieved special importance in child analysis (A. Freud 1927).

Looking at the history of science, it is possible to draw a line linking the attempts to apply educational ideas in psychoanalysis and Piaget's "genetic epistemology." In experimental clinical investigations Piaget studied different stages of learning and development in childhood. His findings have recently been taken up by Tenzer (1983, 1984), who related them to some details of working through. Yet the precondition for this connection — that the process of working through unfolds in a manner analogous to the development and learning stages in childhood described by Piaget — is dubious. Of even greater significance for our understanding of working through seems to us to be Piaget's conception of the "cognitive scheme" made up of the developmental processes of accommodation and assimilation. We would now like to turn to these three concepts.

The cognitive scheme should be understood in the sense of a screen that structures perceptual and intellectual experiences and whose own structure and complexity is organized according to the developmental stages described by Piaget. The term "assimilation" is used when a new experience is

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incorporated into the existing cognitive scheme and increases the entire wealth of experience structured by the scheme. If a new experience cannot be incorporated into the existing cognitive scheme, the consequence may be a modification of the scheme (or, in contrast, the neglect or warding off of this alien new experience). The process of modification is called accomodation. It is not difficult to recognize how these concepts could be applied beneficially to our understanding of change in psychoanalytic therapy. Wachtel (1980) has demonstrated convincingly that this assimilation-accommodation approach can be productive for the theoretical and clinical understanding of transference phenomena.

We now want to undertake a similar attempt and try to clarify this theoretical approach with regard to *working through.* In this context we will also refer to the extension and expansion of Piaget's approach by McReynolds (1976) and, with reference to the psychoanalytic technique, by G. Klein (1976, pp. 244ff.).

The phase of *working through* begins after the patient has gained insight into the connections and processes marking the dynamics of previously unconscious conflicts. The goal is to use cognitive and affective insight to change behavior. While some patients achieve such behavioral changes without the analyst's assistance, this generally cannot be expected. We know from learning psychology that the different areas of cognition, autonomous processes, and psychomotoric ability can develop largely independently of each other (see Birbaumer 1973). Special processes of generalization are required to integrate endopsychic processes by means of feedback.

In psychoanalytic therapy this occurs in the process of working through. Deeper analysis of the unconscious past determinants of the genesis of the incapacity is postponed in favor of the integration or reintegration of psychodynamic details. Alexander's (1935) description of the integrative function of interpretation, based on the integrating or synthetic function of the ego (Nunberg 1931), deserves special mention in this context. Achieving this integration is the patient's task; he can rely on the analyst's support, although this could even turn into an obstacle.

It can regularly be clinically observed that the uncovering of unconscious material relevant to a patient's conflicts can create a substantial degree of destabilization, unrest, and anxiety. Such a lack of orientation can also be understood in terms of the conceptual framework of the processes of

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generalization and discrimination described above, and has been convincingly described and interpreted by McReynolds (t976) from the perspective of cognitive psychology. McReynolds formulated his theory of assimilation with reference to Piaget, distinguishing between congruent and incongruent ideas and perceptions. Cognitive congruence refers to the conflict-free assimilation (integration) of new perceptions into the existing structure, while incongruence refers to the transitory or persistent inability to assimilate new perceptions into the existing structure. It is possible for previously congruent, assimilated ideas or perceptions to be deassimilated as a result of changes in the cognitive structure. The relationship of unassimilated to assimilated ideas and perceptions is designated assimilation backlog; this backlog is viewed as a prime determinant of anxiety. Rules have been formulated for three elementary operations for the functioning of the cognitive-affective system:

1. The attempt is made to resolve cognitive incongruences.

2. The backlog in cognitive assimilation should be kept to a minimum.

3. Cognitive innovations (e.g., curiosity, suggestions, search for stimulation) should be kept at an optimal level.

These operational rules are described with regard to their utility for biological adaptation. Accordingly, there is an especially sudden and drastic increase in the assimilation backlog, and thus in anxiety, when cognitive changes at a higher level result in a deassimilation of previously congruent, integrated ideas, and consequently of the numerous points at which these ideas have contact with others.

With regard to working through in psychoanalytic therapy, assimilation theory provides an explanation for the fact that "striking" interpretations can create abrupt deassimilations accompanied by unrest and anxiety. In such a case the interpretation tears apart hierarchically superior, previously congruent ideas and thus contributes to the disintegration of subordinate ideas that were also congruent. This last effect can, however, also be achieved by integrating interpretations, for instance when distant and previously unconnected ideas are linked, possibly leading to the abrupt deassimilation of subordinate ideas. The analyst can help save the patient unnecessary unrest if his interpretations are well prepared and carefully dosed, for example by restricting them temporarily to hierarchically lower ideas. In an attempt to keep the assimilation backlog to a minimum, the patient may at times refuse to recognize or accept interventions which would have a deassimilating effect; this refusal is manifested

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clinically as resistance. The analyst's encouragement, acknowledgement, and reassurance that he will provide support in the work of assimilating integration may help the patient undertake the risky endeavor despite the anticipated disturbances.

It is necessary that such endopsychic cognitive restructuring be tested and tried out with regard to its viability for coping with the reality of life and for structuring relationships outside of therapy in a satisfactory way. We consider this to be an essential aspect of working through. The various transference configurations offer the patient a relatively risk-free chance to test different relationship patterns. With the analyst's support the patient will then transfer these reinforced activities to relationships outside therapy (generalization); he will then naturally become aware of the differences between the transference and working relationship in therapy and the more varied kinds of relationships outside of therapy (discrimination). The patient may have positive experiences, which strengthen and thus stabilize the modified cognitive scheme and the new pattern of behavior.

The patient's changed social behavior can, however, also lead to unexpected experiences for partners, friends, acquaintances, and colleagues as well as to negative experiences for the patient himself. The continued existence of the recently acquired and still insecure cognitive scheme is then endangered, and the patient is threatened by a relapse. In this case, the patient will look to the analyst for more confirmation and support in order to continue his uncertain endeavor of testing novel trial actions. The failure of the analyst to react appropriately can also have negative consequences for the patient and his efforts to try out new patterns of behavior. Here again, the patient's newly gained and fragile self-confidence can be lost. Such inappropriate abstinence by the analyst may frustrate the patient's need for security, even leading to malignant aggression, regression, or depression.

Alterations in the cognitive scheme, i.e., cognitive restructuring, cannot be directly observed, but must be inferred from lasting changes in observable behavior (see Strupp 1978). For this reason, the psychoanalyst's presumptions about the structural changes that have been achieved by a patient must in principle be empirically verifiable with regard to specific forms of observable behavior, including of course verbal behavior. Furthermore, such empirical verification must actually be performed. This means that it must be possible to derive verifiable predictions about the patient's future behavior, including how he will react in specific conflicts (e.g., strategies for conflict resolution, coping and defense mechanisms,

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symptom development, and structuring of relationships), from the presumptions about structural changes. Otherwise all discussion of structural change is meaningless (Sargent et al. 1983).

Thus it is often possible to close gaps in the psychoanalytic understanding of clinical phenomena by referring to concepts developed by other disciplines. Moreover, the psychoanalyst needs a good knowledge of neighboring disciplines to be able to use their concepts and consequently to attain a comprehensive understanding of his own theoretical concepts and clinical action.

8.9 Termination

8.9.1 General Considerations

However long and arduous an analysis may have been, the terminal phase creates its own problems for both participants. Not infrequently there is an incongruence between the patient's and the analyst's conceptions of the goals of the treatment (E. Ticho 1971). Whether the analyst is successful in convincing the patient that the analytic work must be limited to goals accessible to treatment and that the terminable analysis be distinguished from the interminable has great practical significance. At the end of a psychoanalytic treatment the patient should have developed the capacity for self-analysis. This means simply that the patient learns and employs the special form of reflection that characterizes the psychoanalytic dialogue. Tied to this ability is the expectation that the capacity for self-analysis will work against the inclination toward regression which may still arise after analysis when new problems are encountered, and thus that the renewed development of symptoms will be hindered. This view is opposed quite often by "the myth of perfectibility," i.e., of the complete analysis, which molds the attitudes of some analysts toward the terminal phase as a result of the pressure exerted by their own exaggerated ideals (Gaskill 1980). It is not difficult to grasp that wealthy patients accept any offer such analysts make in order to continue the analysis.

It is possible to imagine which unconscious fantasies are associated with termination if we consider the metaphors used in the literature to describe the final phase. Weigert's (1952) comparison of the terminal phase with a complicated disembarkation maneuver in which all the libidinal and aggressive forces are in action clearly indicates that dramatic scenes can be expected. The danger of disillusionment

does in fact exist if the entire course of treatment has been characterized by the striving for narcissistic perfection, the complete resolution of transference, and similar myths. This mythology of completeness has negative consequences if the analyst — measuring himself and the patient against ideal types — is disappointed about his work with the patient at the end of treatment while the patient, in contrast, expresses his gratitude. This demand for perfection denies the finite and limited nature of human actions and prevents the analyst from being proud and satisfied with his work. Moreover, the patient cannot separate himself because he consciously or unconsciously senses the analyst's disappointment. He will then make protracted efforts to convince the analyst of the success of the treatment or will identify with the analyst's disappointment. The literature sometimes contains reports describing just the opposite of this mutual dissatisfaction. More commonly, however, the inevitable imperfections of psychoanalytic practice, familiar to every one of us, are disguised in reports describing the termination of treatment in a way conforming to theory.

Referring to the final reports of 48 candidates in training, Gilman (1982) used a catalogue of questions to examine how they handled the terminal phase. All of these analysts reported a resolution of the symptoms and a complete working through of the neurotic conflict, although there was otherwise a large amount of variation. Furthermore, the termination was allegedly never initiated by external events such as changes in the patient's life or financial difficulties, but always by mutual agreement. These final reports serve a special function — to show that the analysts are worthy of admission to one of the professional associations — which in our opinion makes the conformist description of the terminal phase very comprehensible. In Earle's (1979) study of candidates in training, the criterion of mutual agreement on termination was satisfied in only 25% of the cases, a result which differs only slightly from the percentage reported for qualified analysts.

We would now like to end the discussion of perfection vs premature termination and to look for perspectives which can do justice to the multiplicity of reasons that psychoanalytic treatment may ultimately be terminated. Analyses should be terminated when the joint analytic work no longer produces significantly new insights. This makes it clear that the termination is a dyadic process, which in principle is incomplete if we assume that two persons will always have something else to say to each other. Disregarding external circumstances, we can assume that patients stop when the therapeutic exchange loses its importance and the burdens associated with the treatment are no longer balanced by

an increase in knowledge. At this point even the interminable analysis will be terminated.

We must also overcome the idea that the right indications are a guarantee for a satisfactory terminal phase and a good conclusion, as Glover (1955) still assumed. The analytic process is determined by too many imponderables for the end to be predictable on the basis of the diagnosis (indication and prognosis) of an individual (see Chap. 6). The attitude linked with such a conception of predictability is closely associated with the basic model technique, whose erroneous fundamental assumptions have been the source of numerous faulty discussions of detailed issues. Successful and satisfactory termination always occurs, in both frequent and infrequent treatments, if a good working relationship has developed, creating the preconditions for regressive processes to be structured in productive fashion (Hoffmann 1983).

8.9.2 Duration and Limitation

At no time has it been possible for the psychoanalytic procedure to promise the illusion of a rapid, miraculous cure. As early as 1895, Breuer and Freud reported that the procedure was arduous and time-consuming for the doctor. Yet since the psychoanalytic method was initially tried out "only on very severe cases" — on patients who had gone to Freud "after many years of illness, completely incapacitated for life" — Freud hoped that "in cases of less severe illness the duration of the treatment might well be much shorter, and very great advantage in the direction of future prevention might be achieved" (1904a, p. 254). Yet Freud also expressed mild skepticism toward setting an appropriate limit on therapy. Although such efforts required no special justification, Freud nevertheless wrote that "experience has taught us that psycho-analytic therapy — the freeing of someone from his neurotic symptoms, inhibitions and abnormalities of character — is a time-consuming business" (1937c, p. 216).

The use of the limitation of treatment as a technical measure was introduced by Freud in the case of the Wolf Man in reaction to a standstill in treatment: "I determined — but not until trustworthy signs had led me to judge that the right moment had come — that the treatment must be brought to an end at a particular fixed date, no matter how far it had advanced" (1918b, p. 11). Ferenczi and Rank (1924) took up this idea. Both of them considered termination, the "period of weaning," to be one of the most important phases of the entire treatment. Yet as early as 1925 Ferenczi revised this view; in the article

"Psychoanalysis of Sexual Habits" (1950 [1925], pp. 293ff.) he greatly restricted the efficacy of using a fixed date as a means to expedite the termination of treatment and as "an effective means of hastening separation from the analyst." And in his paper "The Problem of Termination of the Analysis" (1955 [1928a], p. 85) he argued that "neither the physician nor the patient puts an end to it, but ... it dies of exhaustion, so to speak." Ferenczi then continued:

> To put it another way, one might say that the patient finally becomes convinced that he is continuing analysis only because he is treating it as a new but still a fantasy source of gratification, which in terms of reality yields him nothing. When he has slowly overcome his mourning over this discovery he inevitably looks round for other, more real sources of gratification.

This point of view agrees with the two conditions Freud established for termination:

> First, that the patient shall no longer be suffering from his symptoms and shall have overcome his anxieties and his inhibitions; and secondly, that the analyst shall judge that so much repressed material has been made conscious, so much that was unintelligible has been explained, and so much internal resistance conquered, that there is no need to fear a repetition of the pathological processes concerned. (1937c, p. 219)

According to Freud, the factors determining the possible result of psychoanalytic treatment are traumas, the constitutional strength of the instincts, and the alteration of the ego. Furthermore, the traumatic etiology of neuroses is the reason that the chances for a cure are especially high. "Only when a case is a predominantly traumatic one will analysis succeed in doing what it is so superlatively able to" (1937c, p. 220). Successful integration of the instincts into the ego depends on their strength (whether constitutional or momentary). Yet Freud is skeptical whether analysis is successful in permanently and harmoniously integrating the instincts in the ego in certain circumstances since the instinctual strength can increase accidentally or as a result of new traumas and involuntary frustrations.

We know today that Freud, looking back at his analysis of Ferenczi, reached the conclusion that it is not possible in analysis to influence a dormant instinctual conflict, and he considered the manipulative activation of conflicts to be immoral.

> But even if he [the analyst] had failed to observe some very faint signs of it [negative transference] which was not altogether ruled out, considering the limited horizon of analysis in those early days — it was still doubtful, he thought, whether he would have had the power to activate a topic (or, as we say, a "complex") by merely pointing it out, so long as it was not currently active in the patient himself at the time. (1937c, pp. 221-222)

Thus although the strength of the instincts and its modification depend on unforeseeable

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imponderables, Freud put special emphasis on analysis of changes in the ego, by which he meant changes in the ego resulting from defense and from the distance to a fictive normal ego. Analysis is supposed to create the conditions most favorable for the ego functions. Freud thus took up ideas that A. Freud had included a year earlier in her book *Ego* and the Mechanisms of Defense(1937). Reich had pointed out as early as 1933 that resistance rooted in the individual's character, which Reich considered as acquired ego armor, often stands in the way of progress in analysis. The changes which occurred in psychoanalytic theory after the introduction of structural theory and the theory of defense mechanisms, together with the increased significance of analysis of resistance and character, due to Reich's influence, led to the increase in the duration of analyses.

Yet this lengthening of analysis actually has many causes. The opinion voiced by Glover, for many years responsible for research at the London Psychoanalytic Institute, is alarming:

> When coming to a decision on this question of length it would be well to remember that the earlier analysts were accustomed to conduct analysis of six to twelve months' duration which as far as I can find out did not differ greatly in ultimate result from the result claimed at the present day by analysts who spin their analyses to four or five years. (Glover 1955, pp. 382-383)

Balint's (1948, 1954) studies of the consequences of analytic training and the training analysis on the duration of therapeutic analyses deserve special mention because of their great frankness. Subsequent developments have confirmed Balint's findings. The increase in the duration of therapeutic analyses apparently depends the world over on the duration of training analyses. Balint showed that supertherapy goes back to a demand Ferenczi raised in 1927:

> I have often stated on previous occasions that in principle I can admit no difference between a therapeutic and a training analysis, and I now wish to supplement this by suggesting that, while every case undertaken for therapeutic purposes need not be carried to the depth we mean when we talk of complete ending of the analysis, the analyst himself, on whom the fate of so many other people depends, must know and be in control of even the most recondite weaknesses of his own character; and this is impossible without a fully completed analysis. (Ferenczi 1955 [1927], p. 84)

Balint referred to this fully completed analysis as "supertherapy" and used Freud's words to describe its goal:

> What we are asking is whether the analyst has had such a far-reaching influence on the patient that no further change could be expected to take place in him if his analysis were continued. It is as though it were possible by means of analysis to attain to a level of absolute psychical normality a level, moreover, which we could feel confident would be able to remain stable .... (1937c, pp. 219-220)

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What is alarming is that, according to Balint, the formation of schools within the psychoanalytic movement and the burdens of the profession were the causes of the increased length of training analyses. The continuation of such analyses even after the official end of training coincided with the fact that this voluntary analysis (as a completely private matter) was held in high esteem. Balint reported that only the first shy protests had been heard about the correctness of supertherapy. According to them, the issue in supertherapy was then no longer therapy or even the immediate goal of training analyses, but rather pure self-knowledge.

According to Balint the first period in the history of training analysis was concerned with teaching, the second with demonstration, and the third with analysis as such; he also referred to a fourth period, concerned with research. In our opinion, the transformation into supertherapy for its own sake lacks everything commonly understood as research. Precisely what goes on in the prolonged training analysis has not been made the object of scientific study. The fact that the entire psychoanalytic movement was taken by the idea of the supertherapy, in fact thrives on it, is especially instructive. Training and supervisory analyses were the means by which schools constituted themselves around the various forms of supertherapy. The result is now exactly the opposite of what Ferenczi had hoped from the perfection of training analysis, which he called the second fundamental rule of psychoanalysis:

> Since the establishment of that rule the importance of the personal element introduced by the analyst has more and more been dwindling away. Anyone who has been thoroughly analysed and has gained complete knowledge and control of the inevitable weaknesses and peculiarities of his own character will inevitably come to the same objective conclusions in the observation and treatment of the same psychological raw material, and will consequently adopt the same tactical and technical methods in dealing with it. I have the definite impression that since the introduction of the second fundamental rule differences in analytic technique are tending to disappear. (Ferenczi 1955 [1928], p. 89)

Balint's comment on this was:

> It is a pathetic and sobering experience to realize that although this idealized, utopian description gives a fairly true picture of any of the present cliques of the psycho-analytic movement, it is utterly untrue if applied to the whole. Ferenczi foresaw correctly the results of *one* "supertherapy," but he had not even thought of the possibility that the real development would lead to the co-existence of several "supertherapies" competing with one another and leading to a repetition of the Confusion of Tongues. (1954, p. 161)

This competition would have to be decided on the basis of qualitative criteria. Since these, however, cannot be made the object of research in the case of private supertherapy, people resort to numbers: the

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longer analyses last, the better they are. The competition is decided by the duration of the supertherapy

The identifications which develop in the course of training and supervisory analyses lead analysts to compare therapeutic analyses (and their duration) with their own experience. The result is that the duration of analyses of patients increases with that of training analyses. The latter is naturally not the only reason, but we have dealt with it here since this aspect of this unusually complex subject is not commonly discussed.

The discovery of preoedipally rooted pathological conditions is given as the primary reason for the increased length of therapeutic analyses. The use of object relationship theories in long analyses showed promise that narcissistic disturbances and borderline personalities could be treated successfully. This led indirectly to the lengthening of the treatment for neurotic patients, in whom narcissistic personality traits were now also being increasingly diagnosed. However much the theories about disturbances of early origin differ, they are all concerned with deep layers, which allegedly can only be reached with difficulty and after protracted work. A contradiction first pointed out by Rangell (1966) becomes immediately apparent here; he considered it impossible for early preverbal experiences to be revived in analysis. Therefore the analysis of deeper layers of psychic life cannot lead where object relationship theorists in the tradition of Ferenczi or Klein and where the self theorists in the tradition of Kohut believed it did. "Where are we then?" is the question that can be asked of every school with regard to the constantly increasing length of analytic treatment.

Freud clearly described a quantitative and qualitative relationship between the length of therapy and the chronic nature and severity of the illness:

> It is true that the treatment of a fairly severe neurosis may easily extend over several years; but consider, in case of success, how long the illness would have lasted. A decade, probably, for every year of treatment: the illness, that is to say (as we see so often in untreated cases), would not have ended at all. (1933 a, p. 156)

Freud summarized the result in his terse statement, "An analysis is ended when the analyst and the patient cease to meet each other for the analytic session" because the patient is no longer suffering from his symptoms and "there is no need to fear a repetition of the pathological processes concerned" (1937c, p. 219).

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If we take these justifications seriously, the length of an analysis is then tied to decisions which place high demands on the analyst's responsibility. Together with many other analysts, we urge greater frankness with regard to decisions about duration and frequency. Our recommendation is to let the severity of the symptoms and the aims of therapy be the guide. Of course, the severity of the illness and the frequency of treatment cannot simply be related quantitatively according to the equation that therapy must be more intense (and thus more frequent) the more severe the illness. The decisive factors are obviously the quality of what the analyst mediates and what the patient can accept and work through. Especially the severely ill, who seek much support, have great difficulties regulating their needs for closeness and distance. Critical questions of dosage then make it necessary to consider the situation qualitatively.

It is therefore particularly disturbing that quantitative aspects (length and frequency) play such an important role in analyses which take place within the framework of psychoanalytic training. Psychoanalytic societies set a minimum number of hours for such supervised treatment. The candidate's own interest in attaining his professional goal thus almost inevitably interferes with his decision as to the length and frequency of treatment that are in the patient's best interest. For example, the German Psychoanalytic Association set 300 hours as the minimum length for training cases at the time of the final examination; this is linked with the expectation that the analysis will continue thereafter. This requirement creates additional complications because, under the limits imposed by the German health insurance system on the extent of psychotherapy and psychoanalysis, the financing of psychoanalytic therapy beyond 300 hours of treatment is subject to very special criteria (see Sect. 6.6). Under these circumstances it is difficult for any analyst, and not just candidates in training, to find satisfactory answers based on qualitative evaluation.

8. 9. 3 Criteria for Termination

Analysts are always in danger of setting their criteria for termination and their goals according to personal and/or currently fashionable ideas and theories. Some limit the formulation of their goals to the level of metapsychology, where they are least open to criticism, while others orient themselves at the level of clinical practice.

The kinds of questions that analysts ask about goals determine the kinds of answers that they reach. Weiss and Fleming (1980) ask what state the patient's personality should be in when he leaves treatment. In their opinion, well-conducted analyses are characterized by the fact that the patient is freer from conflict and more independent than previously, and also has more confidence in his own capabilities. There is an increase in secondary process thinking and in the ability to test reality critically and to sublimate. There is an improvement in object relationships. The patient has developed a better understanding of the distinction between the analyst as a professional and as an object of transference.

A different kind of question concerns whether the patient has sufficient means and instruments to continue the analytic process independently. We would like to return to the topic of self-analysis because of its great significance. As we described with regard to the processes by which the patient identifies with the analyst (Sect. 8.4), we view identification with the analyst and his analytic technique as the most decisive step for the future progress of an analysis. We agree with Hoffer (1950), G. Ticho (1967, 1971), and E. Ticho (1971) that the acquisition of the capacity for self-analysis is a prime goal of psychoanalytic treatment. However, this goal stands in contrast to the fact that so far very little has been described in concrete terms about what actually goes on in the patient when he tries self-analysis after the termination of treatment. After interviewing colleagues, G. Ticho (1971) devised a scheme which is of assistance for further research. For Ticho, self-analysis is a process composed of different steps of work which have to be learned in sequence.

> 1. The ability is formed to pick up signals of an unconscious conflict; for example, an irrational or exaggerated response is perceived without having to overcompensate for it immediately with defense mechanisms such as displacement and projection.
>
> 2. Managing, without too much anxiety, to let thoughts run their own course, to associate freely, and to create a relatively free access to the id.
>
> 3. Being able to wait for a longer period of time to understand the significance of an unconscious conflict without becoming disappointed and giving up. The development of this ability is an indicator of how far the patient was able to identify with that part of the analyst which confidently waited during the analysis for the analysand to be ready to solve the conflict.
>
> 4. Following the insight that has been gained and attaining a change in himself [and/or in his environment]. This ability is formed as soon as the ego is sufficiently strong, and if the analysand was able in analysis to actually experience that insight can really lead to modifications of the ego. (G. Ticho 1971, p. 32)

We assume that the analysand acquires the capacity to self-analysis in a continuous, almost

incidental learning process in which he identifies with the analytic functions (see Sect. 8.4). It is possible for the analyst to plan the end of treatment when he feels able to expect that the analysand has acquired the capacity for self-analysis. Once this goal has been achieved, other criteria for termination can be relativized. Firestein (1982) compiled a list of such criteria, including improvement of symptoms, structural change, reliable object constancy in relationships, and a fair balance between the realms of the id, the superego, and defense structures. *Relativization of these criteria* does not mean their rejection, but only *careful evaluation of them compared to the other goals that might be achieved given a lengthening of the analytic work.* Setting one's goals in terms of personality traits instead of abilities such as self-analysis fails to satisfy Freud's admonishing words in his essay "Analysis Terminable and Interminable" (see 1937c, p. 250).

The ability to change is often more limited than we want to believe. Gaining knowledge of his own limits may often be more important to the patient than chasing after a utopia. This opinion may come as a surprise since we have referred throughout to the change as proof of the precious link between treatment and research (see Chap. 10). Yet "structural change" is a goal of treatment which seems to be one of the most difficult constructions of the psychoanalytic psychology of the personality to grasp, both theoretically and empirically; we therefore content ourselves with putting the patient in a position to structure his life in a way that it is more congruent with his desires and limitations than before treatment. Freud's (1933 a, p. 80) words "Where id was, there ego shall be" describe realistic goals of analytic treatment when the ego has reacquired insight and the ability to act.

8.9.4 The Postanalytic Phase

The analyst's handling of his relationship to the patient after the termination of psychoanalytic treatment has received little attention. Comments on this topic are rather rare, even in verbal communication among psychoanalysts, in great contrast to the otherwise intense exchange of experiences. Our view of how Freud dealt with these questions is distorted by the fact that the reports on treatment conducted by him that have become known to the analytic world all come from patients in exceptional positions, e.g., Blanton, an analyst, or Doolittle, an author Freud held in high esteem. They thus do not permit us to draw conclusions about Freud's behavior in general. Today there is general agreement that the postanalytic phase has great significance for the further course and development of

the processes of maturation initiated in the treatment. Yet in Menninger and Holzman's textbook (1958, p. 179), all we find is the matter of-fact statement: "The parties part company. The contract has been fulfilled."

The subject of what occurs after the real separation of analyst and patient is an area in which "analysts, by falling so short of the scientific approach, have deprived themselves of the data and the contradictions so vital to the growth of psychoanalysis as a science" (Schlessinger and Robbins 1983, p. 6). Systematic follow-up studies were not common for a long time. The few thorough studies, that we will discuss, show more than clearly that our ideas about the postanalytic phase and the further reaching assimilation of the experience of psychoanalytic therapy belong to the gold mines that we have overlooked for too long. We must be very cautious in transferring the experience of self-analysis, as described by Kramer (1959), G. Ticho (1971), and Calder (1980), to patients. After training, analysts belong to a professional group, have constant contact to other analysts, and must always rely on self-analysis in their daily work. The conception of a postanalytic phase, as introduced by Rangell (1966), fits our understanding of events in the therapeutic process. The form that such postanalytic contacts should take is a matter of controversy and is determined by the inappropriate conception of the resolution of transference (see Chap. 2) and the corresponding anxiety regarding a revival of transference.

Is the analyst supposed to work toward a state in which the patient no longer seeks contact, with the goal that the analysis is so integrated into the patient's life that it succumbs to amnesia, like infantile memories? Or should the analyst stay open for renewed contacts? E. Ticho (according to Robbins 1975) supports the view that the analyst should not provide the patient the assurance that he is available for further consultation, because this would undermine the patient's confidence in himself. In contrast, Hoffer (1950) provides support to patients in this phase inasmuch as they require it. For Buxbaum (1950, p. 189), it is a sign of a successful analysis if the patient can say that he can take or leave the analyst. In her opinion, this is easier if the analyst permits the patient to renew contact if he wants to and thinks it necessary, even in the absence of symptoms. It is her experience that patients occasionally take up this offer but never abuse it. A strict "never more" would rather have a traumatic effect on the patient because it puts him in a passive position. Dewald (1982) suggests handling the question of postanalytic contact with intuition. While the refusal of further contact is a source of torment for some patients, such contact may be an unhealthy encouragement to be ill for others. Greenson (see Robbins 1975)

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experimented in one treatment by seeing one patient every four weeks for several months after the analysis. In this way the role of the analyst changed from psychoanalyst to listener to the former patient's selfanalysis.

It seems obvious that the analyst should adopt a flexible attitude. If postanalytic contacts are clearly necessitated by the survival of some attitudes from transference neurosis, therapy in the form described by Bräutigam (1983, p. 130) seems appropriate. It is generally sensible to inform the patient that if his own self-analysis is insufficient to help him cope with current burdens, he can seek renewed contact to his previous or another analyst (see Zetzel 1965).

How the analyst handles real posttreatment contacts, whether coincidental or professional, is another matter. It is no longer appropriate and can only be inhibiting and harmful to maintain an attitude characterized by analytic distance. Yet the other extreme is characterized by the attempt to avoid neutrality by stimulating the patient into a premature and intensive familiarity; he often then reacts as if this were a dangerous temptation. The consequences of both attitudes are unfavorable, the first leading to inhibition and regressive dependence while the other precipitates confusion, anxiety, or hypomanic acting out. The best way to organize social and professional contacts after the termination of treatment lies somewhere between these extremes (Rangell 1966).

With regard to the further development of the analytic relationship following the termination of treatment, we would like to suggest that radical separation be generally replaced by the model of the unconscious structure characterizing an individual's relationship to his family doctor. As Balint demonstrated, the decisive aspect of the relationship to the family doctor is the feeling that he is available when needed. In our opinion, the analyst should lead the patient in working through the problems of separation on the basis of this feeling. To compare separation with death is an inappropriate exaggeration of the analytic relationship. This would only lead to artificial dramatization, so strengthening the unconscious fantasies of omnipotence and their projections that separation becomes even more difficult. It should remain possible to actualize the patient's latent readiness to enter a relationship, if it becomes necessary, because anyone can be so affected by changes in his life that he would like to turn to an analyst again. Whether this is the same analyst or, for external reasons, another one is secondary. Important is the basic feeling of having had a good experience, which gives people the

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confidence to again seek the help of an analyst.

Long-term observation following completed analyses is one of the neglected fields of study into which Waelder (1956) encouraged research. It is sensible to distinguish between unsystematic clinical investigations and systematic, empirical follow-up studies. Each has its own significance. The practicing analyst can make important long-term observations. The usually exaggerated concern about over an unnecessary revival of transference has excessively restricted analysts' curiosity and readiness for contact.

Pfeffer (1959) introduced a procedure of follow-up investigation which conforms to the self-understanding of psychoanalysis. This procedure took the form of psychoanalytic interviews, and its utility was confirmed by later studies (Pfeffer 1961, 1963). In each of the examined cases, the consequences of persisting unconscious conflicts — related to the originally diagnosed conflicts — were demonstrated clearly. The benefit gained from psychoanalytic treatment consisted primarily in the patient's ability to handle these conflicts in a suitable way.

Analysts seem to be gradually accepting the view that such follow-up studies not only provide external legitimation of psychoanalysis, but also represent a fruitful method of studying postanalytic change (Norman et al. 1976; Schlessinger and Robbins 1983). Previous case studies have demonstrated the stability of recurring patterns of conflict; such patterns are acquired in childhood and as such are relatively immutable. They form the individual product of the processes of maturation and development, structure childhood experiencing, and constitute the kernel of neurosis. Psychoanalytic treatment does not lead to the dissolution of these patterns of conflict, but to an increased capacity for tolerance and coping with frustration, anxiety, and depression based on the development of the ability for self-analysis. This capacity is established as a preconscious strategy to cope with conflicts by means of an identification with the analyst's endeavor to observe, understand, and integrate psychological processes. This is how Schlessinger and Robbins (1983) summarize the results of their follow-up studies. We believe that these findings remove a burden from us as analysts. They are also a source of satisfaction in that the analytic work can be portrayed more realistically and equitably by such follow-up studies than by any other method.

Systematic follow-up studies pursue other goals, especially those which have become possible at psychoanalytic outpatient clinics since Fenichel's (1930) first study of the results at the Berlin Psychoanalytic Institute (see Jones 1936; Alexander 1937; Knight 1941). Such studies attempt to evaluate the influence of different factors on the therapeutic process and its result, and are only possible with large samples of data (see, e.g., Kernberg et al. 1972; Kordy et al. 1983; Luborsky et al. 1980; Sashin et al. 1975; Weber et al. 1985; Wallerstein 1986). A survey of the state of research on the results of psychotherapy is given by Bergin and Lambert (1978).

Very few analysts have recognized the importance of such global evaluations of results despite their great value for social policy. In Germany, follow-up studies of this kind have contributed decisively to the inclusion of psychoanalysis in the treatment covered by health insurance (Dührssen 1953, 1962). Precisely because the current state of research on therapeutic outcomes goes far beyond simplifying procedures (Kächele and Schors 1981), systematic follow-up studies on the legitimacy of the inclusion of long-term psychoanalysis in the treatment covered by the public health insurance system is urgently required, especially in view of the impressive results achieved by psychodynamic short therapies (Luborsky 1984; Strupp and Binder 1984).

Notes

1 We disregard the pain and pleasure of lonely discoverers and inventors. It is perhaps possible to say that such individuals are successful largely independently of interpersonal confirmation. They find ascetic pleasure the moment they demonstrate that their expectation, contained in their fantasy, construction, or scientific understanding, coincides with a previously unknown reality, whether in external nature or human nature. It is not unusual for this aspect of reality to be named after the discoverer or inventor, who is then identified with what he discovered.

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