Psychoanalytic Practice: Principals

Rules

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7.1 The Multiple Functions of Psychoanalytic Rules

Freud compared the rules of psychoanalytic treatment with the rules of chess: both give rise to an infinite variety of moves which are limited only in the opening and closing phases:

> Among them there are some which may seem to be petty details, as, indeed, they are. Their justification is that they are simply rules of the game which acquire their importance from their relation to the general plan of the game. I think I am well-advised, however, to call these rules "recommendations-' and not to claim any unconditional acceptance for them .... The plasticity of all mental processes and the wealth of determining factors oppose any mechanization of the technique; and they bring it about that a course of action that is as a rule justified may at times prove ineffective, whilst one that is usually mistaken may once in a while lead to the desired end. These circumstances, however, do not prevent us from laying down a procedure for the physician which is effective on the average. (Freud]913c, p. 123)

The comparison with chess is an obvious one when seeking to illustrate the diversity of the ways in which treatment can be conducted. The complex interactional sequences which, in a certain form, underlie defense or the end game in chess bear similarities to the strategies used in conducting treatment. Recommendations can be formulated which express strategic considerations in the form of rules. The actual rules of play in chess, e.g., those which lay down how the pieces may be moved and which have, as it were, the function of laws, have to be understood differently, since if they are not followed, there is no game at all.

In chess it is simple to differentiate between moves which are against the rules and those which are inexpedient, but in psychoanalysis such distinctions are more difficult. This is due on the one hand to the historical development of psychoanalytic theory and technique, on the other to the different functions that psychoanalytic rules have. As is well known, in analyses conducted by Freud the psychoanalytic situation had very much the character of an association experiment serving the purpose of exploring the genesis of the neurosis. Even in his later cases, Freud retained elements of this experimental situation (Cremerius 1981). His strictest and most unequivocal directions related to the parameters for this situation. The rules seemed to produce a "social null situation":

> For Freud, however, the psychoanalytic situation was not simply his own version of contemporary professional

> trends; it was essential to both his working technique and his theorizing. It allowed him to confront both the patient and the scientific public — Freud's double audience — with the fact that the patient's productions could not be dismissed as artifacts of the particular situation, nor as having been induced by the therapeutist, but had, instead, to be explained on the basis of the patient's own psychic activities. (De Swaan 1980, p. 405)

It became clear long ago that this ideal is not appropriate for the social sciences. It has never been possible to produce the social null situation in a concrete form, although in its role as the leading utopian fantasy of psychoanalysis, it has had a detrimental influence on practice. The strict handling of the parameters can be attributed to the fact that analysts construe them predominantly as *rules,* not as means to a more favorable *treatment strategy.* Wittgenstein dealt aphoristically with the question of how reliably even such apparently clear rules lead to the desired goal.

> A rule stands there like a sign-post. Does the sign-post leave no doubt open about the way I have to go? Does it shew which direction I am to take when I have passed it; whether along the road or the footpath or cross-country? But where is it said which way I am to follow it; whether in the direction of its finger or (e.g.) in the opposite one? And if there were, not a single sign-post, but a chain of adjacent ones or of chalk marks on the ground — is there only *one* way of interpreting them? So I can say, the sign-post does after all leave no room for doubt. Or rather: it sometimes leaves room for doubt and sometimes not. And now this is no longer a philosophical proposition, but an empirical one. (Wittgenstein 1953, pp. 39-40)

Referring to Wittgenstein's concept of rules, Habermas (1981) elaborated the connection between the introduction of rules and the resultant possibility of producing an identity of meaning and intersubjective validity for simple symbols:

> Both aspects marking the use of simple symbols are united in the concept of rule: identity of meaning and intersubjective validity. The general quality which constitutes the meaning of a rule can be portrayed in any number of exemplary actions. (Habermas 1981, vol.2, p. 31)

Rules create an identity of meaning, because they ensure that phenomena following the rules can be sought out as constants from among the multitude of events. They produce "the unity in the multiplicity of their exemplary manifestations, different forms they take in reality, or application" (Habermas 1981, vol. 2, p. 32). These considerations are of great importance for the understanding of the psychoanalytic situation and the rules which constitute it; they emphasize that the meaning of the behavior of analyst and patient is bound to the existence of common rules. The pettiness of some rules, spoken of by Freud in the quote above, is the result of the striving after identity of meaning, even beyond the boundaries of the given treatment situation. Precisely in the field of psychoanalysis, marked by so many uncertainties and contradictions, rules have acquired the function of keeping the group together

and stable. In this context the fact that all psychoanalysts follow the same rules serves as a sign of professionality. This explains, for example, why the use of the couch and the frequency of the sessions have become important criteria of whether a treatment may be termed "analysis."

The meaning of rules derives from their interpersonal acceptance. In fact, one important function of rules is to enable an intersubjective exchange to take place. This is particularly true in psychoanalysis. A uniform framework ensures that findings are comparable, etc., thus enabling standardization of the psychoanalytic process (Bachrach 1983). Standardization is necessary in order for an analyst to be able to compare clinical data and generalize observations; he would otherwise merely observe and describe phenomena from a random standpoint. Patients react in many different ways, for example to the couch and to lying down, but the analyst has a certain breadth of experience with these reactions and can therefore draw diagnostic and therapeutic conclusions. However, the standardization of the external framework often provides only the appearance of uniformity, since the impact of the rules depends largely on additional factors. Standardization must not be carried so far that it obstructs the therapeutic process. To use Wittgenstein's term, we are dealing here with empirical propositions concerning comparisons between rule, way, and goal. And indeed we do modify the rules if they are counterproductive, for example, if lying on the couch inhibits the patient.

The diversity of the parameters is also the reason why psychoanalytic treatment rules do not form a closed, structured system, but are rather a collection of directives in various areas and of differing imperative content. Freud's most important treatment recommendations are spread among at least a dozen of his works. A study group at the Sigmund Freud Institute has listed 249 such recommendations and attempted to categorize them. The classification into 11 categories, ranging from rules for behavior to rules for determining indication, highlights their diversity in content and in degree of abstraction (Köhler-Weisker 1978; Argelander 1979).

It is difficult to ascertain how many of these numerous guidelines constitute the core of real rules of psychoanalytic chess. In contrast to chess, there are no rules whose only effect is that two people meet for a game. Psychoanalytic rules are always also rules of strategy which must be negotiated and continually confirmed in every individual relationship. This differentiates psychoanalysis from chess, in which game rules and rules of strategy are clearly separated.

Treatment rules are fundamentally goal oriented; as stated by Tafertshofer (1980), they can be conceived as individual steps in the psychoanalytic method and thus compared with other scientific methods. However, this goal orientation forbids just that canonization of rules which is self-evident in chess. Freud was aware of this problem, and gave priority to efficacy.

We have the impression that critical analysis of the efficacy of rules is still rather poorly developed in psychoanalysis. All too often, rules are justified not by their usefulness, but by the fact that they are anchored in psychoanalytic theory. This theoretical anchoring of rules is a tricky business. Westmeyer, in a critical review of behavior-therapy rules, raised considerations which are also valid for our understanding of the rules governing psychoanalysis. He demonstrates that the logical derivation of technological rules from the findings of basic science is a utopian illusion: "Technological rules are therefore also not true or false, like laws and statements of scientific theories, but rather more or less efficient or effective — in the degree to which the target states ensue after realization of the measures recommended" (Westmeyer 1978, p. 123). We will discuss this problem in more detail in Chap. 10.

As for psychoanalysis, one can see that while the theories are predominantly concerned with the determinants of genesis, the rules of technique are oriented toward achieving the necessary and sufficient conditions for change: psychoanalytic technique is not simply application of theory.

The relationship between rule function and strategic function in every individual treatment rule is in a constant state of flux. The analyst's need for security and problems of identity encourage him to absolutize the rules. Difficulties arising in the therapeutic process often compel one to scrutinize the appropriateness of the method and thus to question the treatment recommendations. Patients contribute to this fluctuation. It cannot escape the notice of an alert patient that the analyst proceeds according to certain rules, even when he does not say that he is doing so. The patient himself often queries the legitimacy of proceeding in this way. It is therefore only a matter of time until the parameters of the analysis are themselves questioned critically. They then temporarily lose the status of framework and are fiercely disputed until the unconscious determinants leading the patient to call them into question have been understood and resolved, or the parameters modified accordingly. Treatment rules have a natural tendency to become the scene of the conflict between patient and analyst; this is an experience which cannot be avoided, and which perhaps even should not be avoided.

Using the example of patients with superego disturbances, Cremerius (1977) demonstrated convincingly that patients conversely make their analysts' rules their own and begin to treat them as absolute. It is hardly necessary to point out that the effectiveness of the treatment is endangered just as greatly by absolutization of the rules as by unrestricted questioning of every agreement contributing to the structure. Therapeutically, it is indispensable that the analyst vary the rules according to the situation and the individual patient's disturbances. To paraphrase the proverb, in psychoanalysis exceptions are the rule. Whether and how the analyst explains the rules he has introduced is determined very largely by the character of the therapeutic relationship. We agree that the therapeutic purpose of rules should be painstakingly explained, without playing down the advantages for the analyst in his work or the disadvantages for the patient's current well-being. The analytic process develops in an interplay of questioning of treatment rules and their reestablishment in reinforced form. Optimally, in the course of this interplay analyst and patient develop an understanding of the rules which is the best for the analysis in question.

We have already mentioned that psychoanalytic treatment recommendations mirror the whole spectrum of basic theoretical assumptions, purposive ideas, and clinical experience. We do not want to attempt to provide an exhaustive description of all important treatment rules; rather, we want to discuss a few particularly crucial recommendations, among which the advice on the problem of abstinence has a special place, as it embodies a basic principle of treatment technique. We refer to this in various places: in the Introduction, and in the chapters on the initial interview, transference, countertransference, and the psychoanalytic process (Chaps. 2, 3, 6, 9). Abstinence is of course an important factor in the fundamental rule of psychoanalysis and in the analyst's evenly suspended attention, which we will look at more closely in Sect. 7.2.3. The problem of abstinence, however, will be dealt with here, because it demonstrates particularly clearly the multiple functions of psychoanalytic rules and the difficulties which arise from them.

There are two aspects to abstinence in psychoanalysis: as a rule it aims to impose specific limitations on the patient, as a recommendation of analytic neutrality it aims to place restrictions on the therapist. Laplanche and Pontalis (1973) define the principle of abstinence as the "rule according to which the analytic treatment should be organized so as to ensure that the patient finds as few substitutive satisfactions for his symptoms as possible" (p. 2). Neutrality is "one of the defining

characteristics of the attitude of the analyst during the treatment" (p. 271). Substantively, the two aspects belong together; they are based on the one hand in the characteristics of all professional relationships, on the other in the peculiarities of the analytic situation. Cremerius (1984) has described the destiny of the concept and rule of abstinence in striking terms. He points out that Freud's first resort to this rule was necessitated specifically by the problems Freud encountered in treating women suffering from hysteria. Their wishes for concrete love-relationships threatened the professional relationship. First of all, then, the commandment of abstinence has the function of a "game rule" to ensure the continuation of the analysis: "The love-relationship in fact destroys the patient's susceptibility to influence from analytic treatment. A combination of the two would be an impossibility" (Freud 1915a, p. 166). Freud cites in this context the generally accepted morality, which he wanted to replace by methodological considerations. Strictly speaking, it is a matter not so much of general morality as of a quite specific norm which establishes the framework of the relationship between analyst and patient in the manner of a game rule.

However, the rule of abstinence receives its outstanding significance from Freud's attempt to replace normative argumentation with one oriented on his method. While medical ethics would urge strict rejection of the patients' feelings of love, Freud recommends that their development should not be disturbed, but rather that they should be used in order to reach and better analyze the suppressed wish impulses. Not only on grounds of medical ethics, but also on grounds of method, he stated that the erotic wishes should not be satisfied:

> The treatment must be carried out in abstinence. By this I do not mean physical abstinence alone, nor yet the deprivation of everything that the patient desires, for perhaps no sick person could tolerate this. Instead, I shall state it as a fundamental principle that the patient's need and longing should be allowed to persist in her, in order that they may serve as forces impelling her to do work and to make changes, and that we must beware of appeasing those by means of surrogates. (Freud 1915a, p. 165)

The purpose of this recommendation is to maintain a favorable tension potential, which is assumed to keep the therapeutic process in motion. It should be stressed that Freud bases his argument on plausibility: the appropriateness of maintaining tension can be investigated and proved in the individual case. The warning to therapists not to appear to comply with the patient's wishes, whether out of kindness or from therapeutic motives, is also based on plausible arguments which can be supported by clinical observation.

Matters did not rest here, however. These technical arguments became allied with the assumptions from instinct theory which underpin abstinence and the corresponding attitude of strict neutrality on the part of the analyst. Freud himself played an essential part in this development. Four years after his first exposition of the rule of abstinence, he wrote:

> *Analytic treatment should be carried through, as far as possible. under privation — in a state of* abstinence .... You will remember that it was *frustration* that made the patient ill, and that his symptoms serve him as substitutive satisfactions. It is possible to observe during the treatment that every improvement in his condition reduces the rate at which he recovers and diminishes the instinctual force impelling him towards recovery. But this instinctual force is indispensable; reduction of it endangers our aim — the patient's restoration to health .... Cruel though it may sound, we must see to it that the patient's suffering, to a degree that is in some way or other effective, does not come to an end prematurely. (Freud 1919a, pp. 162-163)

In this context, he recommends that the analyst should "re-instate it [the patient's suffering] elsewhere in the form of some appreciable privation," detect "substitutive satisfactions," and "require him [the patient] to abandon them," in order that "the energy necessary to carrying on the treatment" cannot escape. This is especially necessary in the case of secret transference gratifications. In contrast to 1915, when he recommended only a favorable tension potential, Freud now opts for the maximum possible tension, thus greatly strengthening the rule of abstinence. This rule is justified both by the theory of symptom genesis and by economic considerations.

We have already explained that derivation of rules from theory is utopian and often harmful, because the question of the suitability of the rules is relegated to the background. The rule of abstinence is a particularly good example having had clearly unfavorable effects on the development of psychoanalytic technique. Cremerius (1984) points out that the specific features of the treatment of hysteria were, without justification, incorporated into the treatment of other forms of neurosis. Wishes that are quite characteristic of resistance in women suffering from hysteria can have completely different meanings in obsessives, phobics, and anxiety neurotics. The analyst's concern that a patient might find secret substitutive gratification in the transference leads to a defensive approach. The function of the rule of abstinence is no longer to produce a favorable tension potential and thus actuate development, but rather to prevent developments which are viewed with apprehension. The conception that necessary frustration constitutes the motive force for change has become more than questionable and has above all distracted attention from the unfavorable consequences which exaggerated neutrality on the part of the analyst has on the therapeutic process.

Arguments derived from instinct theory are not necessary to justify the demand for neutrality on the part of the analyst, as it can also be substantiated methodologically. The call for neutrality refers to various areas: with regard to work on the material offered by the patient, the analyst should not pursue his own advantage; with regard to therapeutic ambition, the analyst should renounce suggestive techniques; with regard to the problem of goals, the analyst should not pursue his own values; and finally, with regard to the problem of countertransference, the analyst should reject any secret satisfaction of his own instinctual wishes.

As a fundamental principle of the psychoanalytic method, the neutrality rule had from the outset immense significance in ensuring objectivity and establishing a psychoanalytic identity. The scientific ideal played a decisive role. For these reasons, hardly any other analytic rule is in so much danger of being absolutized, although meanwhile a widely based countermovement has formed. In 1981, none of the participants in the panel of the American Psychoanalytic Association favored unconditional affirmation of strict analytic neutrality (Leider 1984). The experience that sometimes more and sometimes less gratification had to be allowed moved Freud to take a flexible attitude toward the rule of abstinence. We also have nothing against pragmatic compromises, as long as they are compatible with medical ethics and can be vindicated methodologically. We would like to go a step further, and believe that nowadays psychoanalysts can, for fundamental reasons, face the rule of abstinence with greater assurance. As we have already pointed out, the professional concern about possibly allowing the patient too much gratification is considerably reinforced by the principles of instinct theory. Under their influence the ideal of complete abstinence was established, with the aim of raising endopsychic pressure by way of denying oedipal gratification and redirecting the psychic energies (whose discharge is thus blocked) into the revitalization of memories. Despite the continuing use of the jargon, most analysts have taken leave of the theory of cathexis (that is, of the principle of economy) in their clinical work. This process began decades ago when Balint (1935), referring to Freud's neglect of the alternative theory of tenderness, credited tenderness with an importance of its own. As long as approval and gratification are not misunderstood as sexual stimuli, the analyst's anxiety that the slightest concession could lead down the wrong path is unfounded. The liberation from the chains of the rule of abstinence can be seen most clearly in Kohut's technique of narcissistic gratification. In view of our strong doubt about the existence of an independent narcissism, we would assume that narcissistic gratification might have an oedipal

connotation, so that it will definitely have a bearing on libidinal transference. Nevertheless, Kohut is right when he says that the rule of abstinence must today be understood differently. In view of the multiple functions of rules, which we have discussed, changes in one single area are sufficient to set in motion a correction of the whole.

7.2 Free Association: The Fundamental Rule of Therapy

7.2.1 Features and Development

It is not only in the hierarchy of the rules that free association takes first place. In a letter to Stefan Zweig on February 7, 1931, Freud (1960a, pp. 402-403) mentioned — and clearly agreed — that the technique of free association was regarded by many as the most important contribution made by psychoanalysis. Jones (1954, p. 265) counts the devising of the method of free association as "one of the two great deeds of Freud's scientific life, the other being his selfanalysis through which he learned to explore the child's early sexual life, including the famous Oedipus complex." Jones bases this view on the fact that in the interpretation of dreams, free association helps to find the way to the latent dream thoughts. Dream formation can be reconstructed because "when *conscious* purposive ideas are abandoned, *concealed* purposive ideas assume control of the current of ideas" (Freud 1900a, p. 531). The associations are seen as indicators of those purposive ideas and fantasies which the patient cannot reach without the analyst's interpretative assistance because they are located in the psychodynamic unconscious.

Free association was only later expressly accorded the status of fundamental rule. In a third-person account of his own technique, Freud described its development as follows:

> The writer therefore endeavoured to insist on his unhypnotized patients giving him their associations, so that from the material thus provided he might find the path leading to what had been forgotten or fended off. He noticed later that the insistence was unnecessary and that copious ideas almost always arose in the patient's mind, but that they were held back from being communicated and even from becoming conscious by certain objections put by the patient in his own way. It was to be expected — though this was still unproved and not until later confirmed by wide experience that everything that occurred to a patient setting out from a particular starting-point must also stand in an internal connection with that starting point: hence arose the technique of educating the patient to give up the whole of his critical attitude and of making use of the material which was thus brought to light for the purpose of uncovering the connections that were being sought. (Freud 1923a, p. 238)

Strictly speaking, there are significant differences in meaning between the two German words *Einfall* and *Assoziation,* which are both customarily rendered as "association" in English and are indeed often used synonymously in German. A good *Einfall* (spontaneously occurring idea) has a creative quality about it, whereas the word *Assoziation* stresses a connection. At least for subjective experience, an *Einfall is* the spontaneous expression of thought processes which lead to a new configuration. The patient's *Assoziationen,* however, are assembled by the analyst into a meaningful whole. An *Einfall* has an integrating function that comes close to insight, as Niederland (see Seidenberg 1971) pointed out.

Strachey discussed the difficulty of rendering *Einfall* in English in a footnote to his translation of the chapters on parapraxes in the *Introductory Lectures on Psycho-analysis:*

> If a person is thinking of something and we say that he has an *Einfall,* all that this implies is that something else has occurred to his mind. But if we say that he has an association, it seems to imply that the something else that has occurred to him is in some way connected with what he was thinking before. Much of the discussion in these pages turns on whether the second thought *is* in fact connected (or *is* necessarily connected) with the original one — whether the *""Einfall" is* an "association". So that to translate "Einfall" by "association" is bound to prejudge the issue. Nevertheless it *is* not always easy to avoid this, more especially as Freud himself sometimes uses the German *"Assoziation"* as a synonym for *"Einfall"* especially in the term *"freie Assoziation,"* which must inevitably be translated "free association".
>
> Every endeavour will be made in the present discussion to avoid ambiguity, even at the cost of some unwieldy phraseology; later on, the need to avoid the word "association" will become less pressing. (Freud 1923a, p. 48)

The contexts of discovery and of origin regarding free association are — how could it be otherwise — inextricably interwoven into the history of ideas. We will limit ourselves to a few remarks on the contemporary historical context. It was a part of the tradition of the Helmholtz school, in which Freud (through his teacher Brücke) stood, for psychic phenomena to be included under the postulate of continuous psychic determinism, to which Freud then also ascribed free associations. Equally strong was the influence Herbart and Fechner had on psychology in the last century; Freud was familiar with it through his teacher Meynert and the latter's association theory. Herbart even formulated concepts such as "inner apperception" and "freely rising ideas" as dynamic entities, i.e., from the point of view of their mutual inhibition. In order to at least hint that the history of free association is not limited to scientific thought, we would like to mention a completely different source: Bakan (1958) conjectures that the origin of free association could lie in the meditation techniques of Jewish mysticism.

This is not the place to define the originality of free association vis-a-vis various forerunners. What

is certain is that Freud's technique developed gradually out of hypnosis and Breuer's cathartic methods. In his self-analysis, Freud was greatly helped by free association. It is no exaggeration to say from today's viewpoint that in the experiment on himself Freud discovered by means of association the importance of fantasizing in the recognition of unconscious psychic processes (Freud 1926c).

Association psychology played godfather during the introduction of the method of free association. It emerged that the patient's associations, which can be fitted together into series with linkages and junctions, are steered by "unconscious complexes." One could in brief say that the "complex" conceived by Jung (1906), which steered the reactions in the experimental association studies, found its earliest counterpart in Freud's thought in the conviction that all psychic phenomena are determined by unconscious wishes. In an early comment on this topic (1906c, p. 112), Freud said: "The aim of psycho-analysis is absolutely uniform in every case: complexes have to be uncovered which have been repressed because of feelings of unpleasure and which produce signs of resistance if an attempt is made to bring them into consciousness." Freud attempted to get to these complexes by means of hypnocatharsis, the pressure procedure, and finally free association. He commented that Jung's association studies made it possible "to arrive at rapid experimental confirmation of psycho-analytic observations and to demonstrate directly to students certain connections which an analyst would only have been able to tell them about" (Freud 1914d, p. 28).

The method of free association — the fundamental rule of psychoanalysis — is in Freud's opinion in the tradition of Wundt's experimental psychology, which was continued in Jung's association experiments. Critical historical appraisal of the theory of associationism has had considerable consequences for our understanding of the fundamental rule (Rapaport 1974; Bellak 1961; Colby 1960; Wyss 1958). We learn from Zilboorg's study (1952, p. 492) not only that Freud was familiar with the English school of associationist psychology — it is well known that he translated a work by John Stuart Mill — but also that he may have known about a first self-experiment by no less a scientist than Galton.

Since therapy consists in integrating the parts into a whole, connecting the elements like the pieces in a jigsaw puzzle, the gestalt psychological principles set forth by Bernfeld (1934) were implicated from the very beginning. Because of the importance of this relatively unknown and, as far as we know,

not previously translated piece of work, we would like to quote from it at length:

> Dream interpretation, the therapeutic process of psychoanalysis, every individual session of analysis, and extensive areas of applied research work by psychoanalysts are all based on series of thoughts, images, actions and affects which are in essence present in words and sentences presented to the therapist or researcher. His task, or preliminary task, is to get to know the law these sequences follow. On the basis of this law he can then explain, interpret, and influence. In the impoverished terminology of earlier psychology, "idea" *[Vorstellung]* was the word used to describe the research material of psychoanalysis — an imprecise term even then, but one which served an initial purpose. The sequences whose law the analyst has to discover can thus be roughly termed associations of ideas. In the early days of psychoanalysis it was all the more justified to speak of associations, in that the sequences were generally not object-related, but rather determined by "inner" forces and goals. But by no means does this make psychoanalysis an "associationist psychology." (Bernfeld 1934, p. 43)

The transition from theme-centered to free association took place in the light of experiences Freud had in the treatment of his patients, experiences which led him to recognize "resistance" and "transference" as constituent features of the patients' unconscious dispositions. Material which in hypnosis was completely hidden (and thus unavailable for therapeutic elaboration) could, with the introduction of the new method, be understood as essential. We are referring here to the close intermeshing and interrelationship between the substance and the method of psychoanalysis and to the fruitful consequences which free association was to have on Freud's further theoretical deliberations. A notable factor is the help Freud got from his patients in the development of free association. Emmy von N., for example, responded to the insistence with which he sought the origin of a symptom by saying that he shouldn't always ask where this and that came from, but let her say what she had to say (Freud 1895d, p. 63). The conversation, then conducted increasingly in the manner of free association, was not "so aimless as would appear. On the contrary, it contains a fairly complete reproduction of the memories and new impressions which have affected her since our last talk, and it often leads on, in a quite unexpected way, to pathogenic reminiscences of which she unburdens herself without being asked to" (Freud 1895d, p. 56). This "unburdening" seems to be next door to abreaction. From then on, Emmy von N. spontaneously contributed her thoughts to the conversation as a "supplement to her hypnosis," as Freud noted (1895d, p. 56). With the discovery of free association, the "talking cure" was born as an expression of personal spontaneity and freedom of opinion. In addition came the turnabout from the patient's previous passivity — answering questions or abreacting under hypnocatharsis — to his active participation in the structuring of the dialogue. This extension of treatment technique facilitated free association. Freud stressed (1900a, pp. 102-103) that some patients find it difficult to impart the thoughts which come to them. At the same time, however, he reported: "Nevertheless, ... the adoption of an attitude of uncritical

self-observation is by no means difficult. Most of my patients achieve it after their first instructions" (p. 103). Free association, in contrast to earlier hypnotic techniques, developed toward "a conversation between two people equally awake" (Freud 1904a, p. 250).

7.2.2 Instructing the Patient About the Fundamental Rule

The context in which the patient is instructed about the fundamental rule demands *special* attention. Often, the formalities of the treatment, i.e., the restrictive arrangements regarding payment, appointments, and holidays, none of which arouse particularly pleasurable feelings in most people, are discussed in the same session and almost in the same breath as the fundamental rule. And in fact the various aspects of the agreement become so closely associated that the fundamental rule is very often seen mistakenly as almost equivalent to a contract, like the arrangements concerning fees and the procedure to be followed in the event of interruptions and missed sessions. The patient's already existing anxieties are strengthened by the unaccustomed prospect of having to disclose his best-kept secrets to a stranger. While being informed about the fundamental rule, many patients think of something which they decide to keep to themselves, which if we are lucky we hear about later. Initially, at any rate, not much remains of the pleasure in telling stories. Freud attempted to make it clear by means of an anecdote why the patient cannot be allowed to make an exception and keep a secret: if an extraterritorial refuge in St. Stephan's Church had been created for the tramps of Vienna, that is exactly where they would have stayed (Freud 1916/17, p. 288).

The fundamental rule leads to a conflict with the patient's preexisting ideals and behavior norms, which are functions of the superego. The patient classifies the demand for free association in the same category as a whole series of old precepts (on whose acceptance powerful counterforces had gone underground). Is it really inevitable that there will be a struggle over adherence to the fundamental rule, as A. Freud (1937) expressed it? What is decisive is how the patient experiences the fundamental rule, and this experiencing is obviously not a preexisting quantity, but situative and processual: the more sacrosanct the fundamental rule, the more powerful the counterforces! Words have their own weight, which creates realities. Talking in terms of a struggle brings a struggle into being. Should one struggle at all, when just mentioning the word wakes counterforces because the patient would like to win for once at last? There are many methods of self-assertion. Analytic experience teaches that a great deal can be

symbolically linked with the *reservatio mentalis:* many patients keep some secret for a long time or for ever. According to analytic theory, derivatives of this secret and its unconscious roots have to enter treatment *indirectly.* In this case we would perhaps even expect symptoms pointing to a psychodynamically effective, i.e., pathogenic, focus. Freud permitted no exceptions to the fundamental rule and made his patients commit themselves to absolute honesty; in his opinion experience showed that it does not pay to make exceptions. In one case where he did allow an exception, the patient, a senior official bound to secrecy by his oath of office, was satisfied with the outcome of the treatment; however, Freud himself was not, and attributed his dissatisfaction to the fact that he had made the exception (1916/17, pp. 288-289). But what sense is there in obliging a patient to be honest if at the same time one knows that complete honesty is prevented by inner resistances? The demand for absolute honesty augments the patient's bad conscience and his unconscious feelings of guilt, leading to reactions which have a negative effect on the therapy. We have repeatedly found that it can pay not to fight over the fundamental rule, but rather to permit exceptions, in the hope and belief that the establishment of a relationship of trust will finally give the patient enough security to tell us even his well-guarded secrets. Freud seems to have had similar experiences: "How small is the effect of such agreements as one makes with the patient in laying down the fundamental rule is regularly demonstrated" (1913c, p. 135).

Our criticism of authoritarian formulations of the fundamental rule should not be taken as a plea for its abolition. We hope, though, that our arguments contribute to an application of the rule which increases the patient's freedom and capacity for associating. Gill (1984, personal communication) has drawn our attention to the fact that it is no sign of tolerance to use the patient's associations for purposes of interpretation without having familiarized him with the point of the fundamental rule, but rather a sign of concealed authoritarianism. The patient must know that he can contribute to the progress of the treatment and make the analyst's task easier — or harder. The *conscious* bracketing out of certain themes and the suppression of associations is a complication which is often *iatrogenically* reinforced: the patient struggles against the caricature that the analyst has drawn.

The call for free association seems to lead to a dilemma. As far as his conscious endeavor and his freedom of decision go, the patient is in the position to say anything. The rule should encourage him to forsake conscious selection in favor of a spontaneous free play of thought. If the feelings and thoughts now described by the patient are considered from the point of view of their determination, they seem

unfree in the sense that they are motivated. The patient cannot control the latent context of motivation because the unfolding of the unconscious and preconscious thoughts and wishes is interrupted by the so-called censorship. Interpretive assistance in the overcoming of censorship helps the patient to experience his dependence on unconscious wishes and imperative needs, as well as the enrichment which results when he regains access to them. Free association thus does not lead to a genuine or even insoluble logical paradox, although it does of course manifest contradictions inherent in the tension between dependence and autonomy. The rule could even be viewed as a symbol of contradiction: we become freer when we reconcile ourselves to our dependence on our bodies and their demands and on the fellow men we all rely on.

In communicating the fundamental rule to the patient, one technique which suggests itself is to use *metaphors* which can lead from the strict obligation of *"you must* say everything" to the inner freedom of "you *may* say everything." Whether this function is fulfilled by the metaphors reported in the literature — some of which we would now like to discuss — is dependent on many factors, not least on their semantic import.

We begin with Freud's famous travel metaphor:

> What the material is with which one starts the treatment is on the whole a matter of indifference — whether it is the patient's life-history or the history of his illness or his recollections of childhood. But in any case the patient must be left to do the talking and must be free to choose at what point he shall begin. We therefore say to him: 'Before I can say anything to you I must know a great deal about you; please tell me what you know about yourself.'
>
> The only exception to this is in regard to the fundamental rule of psycho-analytic technique which the patient has to observe. This must be imparted to him at the very beginning:
>
> One more thing before you start. What you tell me must differ in one respect from an ordinary conversation. Ordinarily you rightly try to keep a connecting thread running through your remarks and you exclude any intrusive ideas that may occur to you and any side-issues, so as not to wander too far from the point. But in this case you must proceed differently. You will notice that as you relate things various thoughts will occur to you which you would like to put aside on the ground of certain criticism and objections. You will be tempted to say to yourself that this or that is irrelevant here, or is quite unimportant, or nonsensical, so that there is no need to say it. You must never give in to these criticisms, but must say it in spite of them — indeed, you must say it precisely *because* you feel an aversion to doing so. Later on you will find out and learn to understand the reason for this injunction, which is really the only one you have to follow. So say whatever goes through your mind. Act as though, for instance, you were a traveller sitting next to the window of a railway carriage and describing to someone inside the carriage the changing views which you see outside. Finally, never forget that you have promised to be absolutely honest, and never leave anything out because, for some reason or other, it is unpleasant to tell it.' (]913c, pp. 134-135)

This metaphor shows what is meant by "free," namely not excluding anything consciously and deliberately. While Freud uses a metaphor of travelling great distances, Stern (1966, p. 642) prefers the analogy of a dangerous journey in a confined space. He tells the patient that the analyst's office is like the control room of a submarine, and asks him to look through the periscope and describe everything he sees outside. No analyst will have any trouble in supplying associations here, reaching perhaps from Lewin's (1946) "blank dream screen" (the wide open sea) to projective identification (an enemy warship), to say nothing of Ferenczi's "thalassal regressive trend." But how will the patient feel in a cramped control room? He might first enjoy the metaphor, because he has seen a cartoon in the *New Yorker* representing Kohut's unconscious "twinship transference" in terms of two submarine commanders watching each other's progress through their periscopes in order to steer identical courses. However, it is more likely that no stress-relieving joke like this will occur to him, quite apart from the fact that the cartoon is our own invention.

Let us assume that the patient has never been in the control room of a submarine and has equally little personal experience of the analytic situation, and further that he is not too inhibited and has a modicum of gumption. What would the analyst answer if the patient's first free association were to ask the commander of the submarine to show him how the periscope works because he has no experience with it and cannot see anything? The analyst can now make it easy for himself and wait for further associations, using the opportunity to familiarize the patient with another rule, the one stating that questions are generally not answered, but clarified through further associations, i.e., by the patient himself. We leave it to the reader to decide whether the patient's trust in the commander will have grown or shrunk by the end of this imaginary dialogue. Obviously, our reaction to this metaphor of the fundamental rule is ironic.

Apparently most analysts do not find it easy to translate the "sacred rule" (Freud 1916/17, p. 288) into a productive, secular form. One can see this from the fact that the various preferred formulations of the rule have been discussed in minute detail. We will give a few examples. Altmann (1976) tells the patient: "You are entitled to say anything here." Glover (1955) voiced criticism:

> The form of the association rule most frequently communicated to patients seems to be: 'Say what is in your mind'. And this is taken by the patient to mean: Say what you are thinking'. Whereas if the instruction were: 'Tell me also all about your feelings as you observe them rising into your conscious mind', in a great number of cases the ideational content would follow of necessity. (p. 300)

Schafer's (1976) statement of the fundamental rule conveys the sense of: "I shall expect you to talk to me each time you come. As you talk, you will notice that you refrain from saying certain things" (p. 147). Schafer goes on to say: "Similarly, rather than 'What comes to mind?,' the kind of question that is conceptually and technically exact according to the action model is, 'What do you think of in this connection?' or 'What do you now connect with that?' or 'If you think of this, what do you think of next?"' (p. 148). He spurns formulations like "'Say everything that comes to mind' and its variants, 'What does that bring to mind?' 'What comes to mind?', and 'What occurs to you?'," saying that their content increases passivity and encourages regression. He sees such formulations as remnants of hypnosis which go along with the patient's disavowal of responsibility for his own mental rehearsal of actions. By addressing himself to the acting, thinking patient, Schafer extends the patient's responsibility from the outset to include his unconscious motives. The patient is thus no longer the passive recipient of his associations, but their active creator. Schafer's action language therefore extends the individual's sphere of responsibility to include unconscious wishes.

Spence (1982b) criticized Schafer's formulations because they intensify the already strong superego aspect of the fundamental rule. Just because our character is revealed by our associations does not mean that they can be counted as motivated actions for which we are responsible as for our deeds. This responsibility exists only in the wider sense, as Moore (1980) explains. One does not reach the level of responsibility for unconsciously motivated speech acts until the associations are *appropriated* as part of one's own ego. The therapeutic problem is thus how the analyst can facilitate this process of appropriation, i.e., how he conducts the struggle over adherence to the fundamental rule. It is decisive that the analyst succeed, step by step but as quickly as possible, in familiarizing the patient with the fundamental rule to the point where he follows it willingly, because with the analyst's help his associations lead him to make enriching discoveries about himself. Morgenthaler (1978) has supplied some striking examples and contrasted them with the deformation that results when the fundamental rule is communicated to the patient in a manner that reinforces the superego.

One patient even completely misunderstood the widespread question: "What are you thinking of?" Instead of seeing it as an encouragement, she took it as a rebuke: "What *are* you thinking of?" This unusual misunderstanding draws our attention to the unconscious overtones this question can have for many patients. It is to be hoped that Morgenthaler's arguments will change attitudes to the fundamental

rule and put an end to the controversies which have continued over the decades, although Little (1951) put forward a similar argument over 30 years ago: "We no longer 'require' our patients to tell us everything that is in their minds. On the contrary, we give them permission to do so" (p. 39). E. Kris (1956a, p. 451) attributed far-reaching consequences for the structure of the analytic situation to this change in emphasis: the situation is made more personal when the analyst no longer requires free association but permits it, like a parent who does not object to bad behavior.

We do not consider it sufficient to impart the fundamental rule only once, but we also put little stock in a kind of trial analysis with an introduction to free association, as suggested by Greenson (1967). Greenson's aim is to assess the patient's capability for free association, which varies enormously and is unquestionably dependent on the patient's illness. Therefore, typical restrictions and resistances to association have been described in the literature. Consistent with our general approach, the aspect which particularly interests us in the discussion of the fundamental rule is what the analyst does to make it easier — or even possible — for the rule to be followed.

Despite the provocative title of his article — "Psychoanalysis Without the Fundamental Rule" — Schlieffen (1983) does not recommend doing away with free association; without it the analyst would be lost. Rather, with reference to Morgenthaler (1978) he shows that strict enforcement of the fundamental rule can have an effect on the patient's capacity for association which is nothing short of deforming. We would like to elucidate this point of view by asking whether, from the association theory point of view, Stern's metaphorical introduction (described above) of the fundamental rule is more likely to facilitate or to hinder free association and the development of therapeutic regression. Since the analyst's office generally bears little resemblance to the control room of a submarine, transference-neurotic associations relating to the analyst's professional surroundings will be hindered. The metaphor puts the patient in a completely foreign situation, making him even more helpless than he is in any case. Of course, regarding treatment technique, the question is not only how the analyst introduces the fundamental rule, but also what he later does to make free association easier or more difficult.

Freud's statements concerning the fundamental rule, which — strangely, considering his skepticism about abiding to agreements — never wavered in strictness from his technical writings right up to his description of the conclusion of a "pact" (1940a), must today be analyzed as to their effects

["never forget that you have promised to be absolutely honest" (t9 13 c, p. 135)]. It is not sufficient for the analyst to do what Epstein (1976) suggests and talk of a "basic condition" rather than a "basic rule." Epstein holds that in contrast to "condition," the word "rule" relates clearly and expressly to superego functions. However, it is certainly not just a matter of toning down the superego aspect of the fundamental rule by changing terminology: one can, like Altmann (1976) doubt whether the patient can ever be made to feel so at home in the therapeutic situation that the initial anxiety disappears. Hardly any patient will think of the pleasurable aspect of association when the fundamental rule is revealed to him.

How what the analyst says comes across to the patient depends on both timing and choice of words. The more superego, the less free association — it is on this formula that we base our advice that the analyst familiarize the patient with the rules step by step, paying particularly close attention to timing, choice of words, and above all the patient's reactions. All the analyst's statements on rules are important for the transference relationship, and the way in which he reacts to questions from the patient, particularly those concerning the fundamental rule, has repercussions on both transference and the working alliance.

For the evaluation of the specific context, one can, as we have already described, draw profitably on association theory. How is a patient supposed to learn to take pleasure in telling stories when he simultaneously hears about the restrictive obligations concerning payment and attendance which he will have to observe for an indefinite length of time. Discussing holidays and the duration of the treatment — again, there are many ways of doing this — changes the cluster of meanings which form around the various formulations of the fundamental rule.

In a panel discussion (Seidenberg 1971, p. 107), Greenson said that he gives quite detailed information, stressing the advantages of the couch-chair position and the avoidance of eye contact. Greenson also answers the patient's questions generously. Clearly this willingness to oblige moved an unnamed analyst in the auditorium to pose the probably sarcastic question of what Greenson does when a patient asks him to demonstrate free association. Greenson answered that he would do so only after he had tried to find out what had motivated the patient to make the request. [1]

One of our patients understood the statement that he could follow his fantasies more freely lying on the couch than sitting in a chair as meaning that he was not permitted to direct his critical gaze at the analyst. This drastic misunderstanding, to which the analyst contributed, was not cleared up until late in the analysis. Correction of the repercussions on the patient's unconscious defense mechanisms was laborious and time-consuming.

For the reasons described, care must be taken to avoid unfavorable concatenations. The formulation we recommend therefore runs roughly as follows: "Please try to say everything you think and feel. You will find that this is not easy, but it is worth the effort." We place particular importance on recommending that the patient try to say everything; the rest seems to us to be of secondary significance. The advantage of a certain standardization is that the analyst can refer back to a fixed point of departure if the patient begins to discuss the changing "misunderstandings" or the way he has understood the rule. On the other hand, precise stipulations contain the danger of ritualization, of no longer considering how the manner of imparting the fundamental rule should perhaps be varied for a particular patient. So-called lower class patients are particularly likely to be deterred by stereotyped formulas (Menne and Schröter 1980).

We hope that we have shown how important it is for the analyst to consider from the very beginning what he can do to make free association easier for the patient. The establishment of the therapeutic relationship and the interpretations together enable continuous correction of unfavorable courses taken at the beginning of the therapy.

7.2.3 Free Association in the Analytic Process

According to one very widespread view, the patient develops the ability to associate freely only late in the course of treatment. Often it is said that when a patient is genuinely in the position to associate freely, his case is closed (Merloo 1952, p. 2 1).

The structure of the first sessions and the manner in which free association is explained cannot neutralize even the conscious resistance of the patient, much less his unconscious resistance. Nevertheless, one should realize the possible unforeseen side effects that strict rules can have if they are sucked into the wake of compulsive confession and the desire for punishment. At issue in the struggle

over adherence to the fundamental rule (A. Freud 1937) are both free, spontaneous, and nonselective communication by the patient and his resistance to it. The theory of resistance concerns the relationship between association and the conscious or unconscious opposition to association. The later typology of the forms of resistance and the differing explanations for them (which we have dealt with in Chap. 4) all go back to the observation of association resistance.

Freud writes:

> Thus a psychical force, aversion on the part of the ego, had originally driven the pathogenic idea out of association and was now opposing its return to memory. The hysterical patient's 'not knowing' was in fact a 'not wanting to know' — a not wanting which might be to a greater or less extent conscious. The task of the therapist, therefore, lies in overcoming by his psychical work this resistance to association. (1895d, pp. 269-270)

We would be moving too far away from treatment technique if we were now also to discuss the theories which Freud used in his attempt to explain the association resistance he observed. He soon realized (1904a) that inner resistance, in the role of censor, has a deforming influence on all mental processes.

An important measure of the freedom a patient has won is indeed his ability to give himself up to his associations in the protected environment of the analytic situation. Considering that observations of this are an everyday occurrence for the analyst, it is amazing that there are so few painstaking studies of association. We base this statement on the comprehensive account by Mahony (1979), to whom we are also indebted for other important suggestions. Mahony complained that the relevant psychoanalytic literature consists largely of free association on the subject of free association. The examples given by A. Kris (1982) are probably representative; most analysts view everything the patient communicates, verbally and otherwise, as free association. Like Kanzer (1961), Kris includes everything in the process of free association: the agreement of appointments and fees, the entering and leaving of the consulting room, the position the patient takes on the couch, etc. Everything can be seen as an expression of free association.

A. Kris thus has a comprehensive understanding of the method and process of free association: it is a shared process, the patient trying to verbalize all his thoughts and feelings, the analyst — guided by his own associations — helping him to fulfill this task (A. Kris 1982, pp. 3, 22). The ability to associate freely

(or more freely) can be viewed as an expression of inner freedom and thus as a desirable treatment goal. So far, so good. However, it is not the analyst's accompanying associations or evenly suspended attention as such which eases the patient's progress. How helpful interpretations originate in the analyst and what effect they have on the patient are of essential importance. Directly after every kind of intervention, which, true to the word's etymological provenance, interrupts the patient's flow of speech, the theme of the intervention is continued for the time being: it is precisely when the patient ignores the proposed interpretation that he will set the analyst thinking. Now it is the analyst's evenly suspended attention which concentrates on the theme. The more polymorphic the patient's associations are and the more he changes the subject, the more difficult it gets to find any meaning in what he says. Is the method then being taken *ad absurdum?* No, because it only now becomes properly clear that the patient cannot ignore the presence of the other person, the analyst. So he simply communicates nonsense to him.

Of course, the analyst quite rightly finds a meaning even in genuine or feigned madness. In fact, jumbled association often serves to restore the balance of forces, as no good gestalt can be constructed out of miniscule fragments of information. The analyst is at his wits' end, checkmated. This fact itself is not changed by our seeing a deeper meaning in the situation. This has to be recognized in order to make the patient grasp what power he has and how very dependent on him the analyst is. However great the inequalities in the division of power and dependence may be, they are reduced to bearable proportions when patients realize, in these and other situations, how much the analyst depends on them. Not infrequently, such experiences mark a therapeutic turning point. It is therefore advisable, on the one hand, to consider what the patient says from the point of view of continuity — Which theme from the last session is being continued today? — and on the other hand to regard the present session as a unit — Which problem is the patient trying to solve today ?

We will now discuss a study of case reports where one would strongly expect to find descriptions of free association. The reports we are talking about are those with which young German analysts demonstrate their qualification for the profession. In a representative sample, Schlieffen (1983) found not a single description of the way in which the fundamental rule is introduced or of the consequences of the various formulations of the rule. How about the more important question: How does the association process unfold in the course of an analysis, and how is it described? In ten reports chosen at random, we found no descriptions of association sequences, nodal points reached by the patient in the sense of

association resistance, or their interpretation. There is also no evidence to indicate that patients become more spontaneous in the later stages of the analysis as shown by the increasing freeness with which they make associations. Whereas there is an almost constant lack of revealing chains of association leading analyst and patient to latent meanings, we find many *indications* that the patient had individual spontaneous ideas. One could say that Freud preferred to speak of spontaneous ideas. His own self-analysis and Farrow's years of self-experiment (1942) could be considered as examples which have still not found a fitting place in the history of medicine (Schott 1983).

Only occasionally in the psychoanalytic literature is any attempt made at systematic investigation of connections between individual spontaneous ideas (Thomä 1961; Hohage and Thomä 1982). In our opinion this is linked to problems of method which are very hard to solve: Where is the line to be drawn between free association and the not-so-free statements made during treatment? If spontaneous ideas lead to a deeper meaning, this indicates that they may constitute free association. Spontaneous ideas about dreams are still those most frequently gathered. However, many analysts these days are plainly rather cautious concerning the individual dream elements, i.e., cautious about gathering spontaneous ideas in a theme-centered way in the sense of Freud's classic technique.

The analyst's reserve makes it easier for the patient to say everything that occurs to him. But where do his communications lead? And should we consider everything which could be a pointer toward latent meanings as a free association? Or do we wait until the patient himself recognizes his unconscious wishes? If this were the case, self-knowledge could be achieved by conducting a sufficiently long monologue under the conditions of free association. The analyst does not expect the patient to supply ever more meaningless associations and finally come so close, in self-hypnosis, to a primary process mode of thinking that his ego becomes his id and his id becomes his ego. No, he listens until something occurs to him which, after careful deliberation, he believes he can communicate. In *An Outline of Psycho-Analysis* we read:

> We reflect carefully over when we shall impart the knowledge of one of our constructions to him [the patient] 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)

Whether one calls the patient's communications free association or not, in every case the analyst's

interpretations add a new element, even when he tries (like Rogers' extremely nondirective, client-centered therapist) to add nothing and only stress one or another part of a sentence in an encouraging way. Even a parrot-like repetition adds something. The more a patient sinks into an apparent monologue and moves away from verbalizing and toward a hypnogogic state, the more important becomes the analyst's manner of sustaining the relationship. In all such regressive states, however, the appearance of a monologue is deceptive. These retreats into certain forms of monologue in the presence of the analyst have several aspects. M. M. Gill (1982) has pointed to the aspect of resistance in them. Even in regression, the patient remains within the transference relationship. He may perhaps be seeking a transitional object that the analyst can put a name to, even when it belongs to the prelinguistic period of development.

Freud's travel metaphor also raises the question of the transformation of images into words. Spence (1982a) particularly draws attention to this aspect of free association and to the loss of information involved in description (p. 82). He emphasizes that the patient is not merely a passive viewer of images, but actively constructs them. In addition, sentences that have been begun follow the rules of grammar, even when the psychoanalytic dialogue proceeds in a relaxed fashion. According to Spence, the fundamental rule contains two contradictory instructions. As partner in the dialogue, the patient cannot simultaneously be introspective, and when he gives himself over to his most secret thoughts he cannot participate in a conversation. Spence believes that this paradox in therapy is solved, in successful treatments, by each of the two participants contributing to the development of a language differing from their everyday language (1982a, p. 85). Our experience also shows that meaningful metaphors develop in many analyses, and that they are unique to the respective dyads.

We hardly need to point out that free association — like everything else — can be used as resistance. It is no coincidence that Freud described this problem in compulsive neurotics. The translation of thoughts into words always involves a selection, and only a patient who pours everything out quickly and without thinking would appear to adhere fully to the fundamental rule. The thoughtful patient has the occasional association, and will, when he speaks, reject or defer the occasional word or partial thought. The deferred material is not lost to free association, but the highly ambivalent compulsive neurotic shows that rules can be taken *ad absurdum.* Indeed, two different thoughts cannot be expressed simultaneously.

We do not want to get involved here, however, with what patients make out of the fundamental rule on the basis of their individual pathology. Rather, we want to consider what the analyst contributes to their particular understanding of the rule. Many patients understand free association as a demand for disconnected, unordered, or nonlogical thinking or for them to conduct a monologue in the presence of a silent analyst. In any case, the imparting of the fundamental rule is the occasion for many misunderstandings which need both elucidation and interpretation. If a patient reacts to the analyst's stimulus by conducting a monologue, one must ask what the analyst has contributed to this state of affairs. In this connection anecdotes are revealing. Loewenstein reports a patient who said: "I was going to free-associate, but I'd better tell you what is really on my mind" (Seidenberg 1971, p. 100).

The patient's ability to free-associate might increase as the treatment goes on. Eissler, though, points out that "it is questionable whether anyone has ever lived up to [this requirement] completely" (1963b, p. 198). Certainly, every patient has at some time during the therapy planned to hold something back. Particularly portentous are preconscious processes of selection which restrict the patient's flow of associations because he has discovered that his analyst has sensitive spots which seem to be genuine sources of irritation (see Chaps. 2, 3). Finally, we can add one further approach to the study of the motivational contexts of decision-making processes, i.e., of their determined nature, looking at them from the point of view of ego autonomy. Let us assume that a patient has resolved to keep something back and sticks to his decision. Has the analyst then lost the struggle over adherence to the fundamental rule? We believe the answer is no, because we assume that the patient's behavior can be seen as displaying a certain reserve, a *reservatio mentalis,* as a documentation of inner freedom. Kanzer (1961, 1972) has long stressed that with many patients it is inappropriate, even a mistake, to insist on the fundamental rule. The need to differentiate the self from others is in his view one part of healthy individuation, and even a necessary developmental step for patients with disturbances of separation. Giovacchini (1972) shares this view when he concedes the patient the right to keep a secret from him. The patient understands that the analyst does not envy his autonomy and concedes him the right to withdrawal and demarcation. The right to hold something back means that the patient does not have to be constantly and rigidly on guard against an all-devouring imago projected on the analyst.

Eissler's statement above can only be interpreted to the effect that the *reservatio mentalis* (the partial refusal to tell everything) is an expression of self-determination. We may conjecture that the

reason that no one can fulfill the demands of free association completely is that this would be the equivalent of total self-relinquishment. But why does the patient balk at one particular revelation? Why does he anchor his autonomy to precisely one part of his experience and memories? Analysis of the motivation for this resistance must be pursued ever further. On the other hand, the patient understandably seeks to establish a foothold in the one area where he can assert his independence from the analyst: in bracketing out one theme or another entirely.

Dewald, however, in his book *The Psychoanalytic Process* (1972, p. 613), took the view that free association leads to the primary process: "In essence, the form and content ... of free association tends ... in the direction of the primary-process mode of thinking, and hence further to foster the process of regression in the service of the ego." Both Holt's investigations into the primary process (1967b) and clinical experience argue against the view that free association becomes less structured as the analytic process goes on. We even hesitate to express the expectation that all patients will have more creative and spontaneous associations at the end of the treatment than at the beginning. Greater inner freedom can express itself in a multitude of ways — in silence, in speech, and in action.

7.3 Evenly Suspended Attention

Freud (1912e, p. 115) described the close links between the analyst's evenly suspended attention and the patient's free association. The complementary nature of the two processes is underlined by some writers' preference for the term "free floating attention," although this is an incorrect rendering of the original German *gleichschwebende Aufmerksamkeit*.

The analyst who follows this rule remains open for all the patient's associations and leaves him complete freedom to unfold his ideas and fantasies. Most important of all, he does not permit himself to be influenced by his abstract theoretical knowledge, but sees every patient as unique and incomparable and is eager to hear and experience something new. He deliberately avoids drawing comparisons in order not to hinder his access to the unknown. If he follows Freud's recommendation (1912e, p. 114), he swings over "according to need from the one mental attitude to the other" and postpones the "synthetic process of thought" to the end of the treatment. As long as the treatment continues, new material can constantly emerge which can correct the previous image i.e., the provisional reconstruction. The

technique of evenly suspended attention should remind the analyst that every case could turn out differently than one would be led to expect by the general (and always provisional) theory and by one's limited personal experience.

While listening passively, the analyst tries to let everything impress him to the same degree and — his attention evenly suspended — not to select. In the process he discovers his own limitations, which exist on two levels. His evenly suspended attention is disturbed by his countertransference (in the traditional sense), such as results from his personal presuppositions regarding particular human problems. This disturbance occasions self-reflection and self-analysis. In the newer understanding of countertransference, such disturbances of evenly suspended attention can be made therapeutically productive (see Chap. 3). In addition, the analyst notices that his evenly suspended attention is steered involuntarily in certain directions: not everything can be kept suspended evenly. When an interpretation comes to mind, he has chosen one of many possibilities, for both the patient's free associations and the analyst's interpretations are motivated.

On the basis of these considerations, we see the rule of evenly suspended attention as containing the demands — far from easy to fulfill — for self-critical examination of one's own attitude to this patient at this moment and for constant grappling with the general and specific problems of psychoanalytic theory and treatment technique. We also share Freud's opinion (1915c, p. 117) that we always listen actively, inasmuch as our understanding of what we observe is affected by preexisting ideas. Therefore it is in principle impossible to devote the same attention to everything, and we do not do so in practice. However, it is both possible and necessary to account for our ideas, and for what lies behind them, to ourselves and to the scientific community, and to correct presuppositions in light of observations. The exchange with the patient contains numerous possible occasions for this, especially when assumptions that the analyst has expressed as interpretations are revealed to be erroneous.

You may say, "Surely it should be plain to analysts, of all people, that they should not approach the patient with fixed prejudgments. There's no need for a rule! And analysts do not need to be reminded that they have many and varied ideas on the phenomena, because that is where the controversies between the various schools began. In this way the psychoanalytic routine reflects one aspect of the philosophical notion that all observations are theory-laden."

We could content ourselves with these remarks on evenly suspended attention and count on agreement from all sides when we say that the analyst should strive for openness and that his attention should not be determined by presuppositions or even prejudgments. However, the story does not end there; the consequences of an alternative tradition of thought, developed by Freud with a metaphorical explanation of evenly suspended attention, reach right down to the present day. Freud attributed to the analyst's unconscious the special ability to act as a receiving organ for the transmissions of the patient's unconscious:

> Just as the receiver converts back into sound waves the electric oscillations in the telephone line which were set up by sound waves, so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free associations. (Freud 1912e, p. 116)

This statement provided a foundation for the rule of evenly suspended attention as well as for the requirement that the analyst be purified of countertransference (see Chap. 3). Freud conceptualized this capacity to receive the unconscious according to the then usual model of sensory perception. It was assumed that external reality was perceived directly and correctly. This model was therefore later also called the "mirror theory" or the "doctrine of immaculate perception" (see Westerlundh and Smith 1983).

It was thus in keeping with the zeitgeist to explain perception of the unconscious with the mirror or telephone metaphor. Only recently has the direction of research into the early mother-child relationship been determined by the fact that even a baby does not assimilate its world passively, but constructs it (Stern 1977). Freud's metaphor thus seemed at first to solve a whole series of practical and theoretical problems so well that it founded a tradition of psychoanalytic thought and practice which is still influential today. Evenly suspended attention was popularized through Reik's "third ear," which contains important elements of the specific empathy around which Kohut (1959) later established a school. Isakower technicized evenly suspended attention as an "analyzing instrument" (Balter et al. 1980). A special location within the analyst's psychic apparatus was now postulated as accounting for his ability to hear his patient's unconscious. At the same time, Spence (1984) called his critical essay "Perils and Pitfalls of Free Floating Attention"; the title speaks for itself. After a psychoanalytic investigation of the process of understanding and empathy which incorporates concepts from the philosophical hermeneutics of Gadamer and Habermas, he comes to the conclusion that evenly

suspended attention as *passive* listening *without* preconception does not exist.

By replacing the hermeneutic term "preconception" with "idea," we can easily draw a parallel with Freud's above-mentioned description. If the analyst listens *actively*, he can by all means keep his ideas, his fantasies, his feelings his preconceptions evenly suspended and remain open for new experiences. Spence even provides convincing psychoanalytic arguments to show that it is precisely self-deception which opens the way for immaculate perception of the unwitting, unconscious — and therefore not easily accessible to reason — projection of one's own ideas.

The myth of evenly suspended attention — that is how Spence regarded ostensibly theory-free passive listening — has many functions, like all the myths which could be construed as prototheories in the history of science. Evenly suspended attention is indeed a hybrid which we have now separated into its two original components. It owes its survival to just this mixture of wellgrounded rational elements — radical openness instead of reserve — and mystical expectations of fusion and unity, connecting one's own unconscious with the other's, as in Freud's telephone metaphor. Looked at soberly, the rule of evenly suspended attention contributes to the patient's feeling that he is understood and therefore helps to create a *rational* basis for the treatment. However in order to come closer to the process of exchange between patient and analyst, we must forfeit a degree of fascination, as we will show when we discuss Kohut's concept of empathy in Chap. 8 and in the discussion which now follows on listening with Reik's "third ear."

We begin by introducing the third ear and its functions in Reik's own words:

> Psychoanalysis is in this sense not so much a heart-to-heart talk as a drive-to-drive talk, an inaudible but highly expressive dialogue. The psychoanalyst has to learn how one mind speaks to another beyond words and in silence. He must learn to listen "with the third ear. ' it is not true that you have to shout to make yourself understood. When you wish to be heard, you whisper. (1949, p. 144)

and

> One of the peculiarities of this third ear is that it works two ways. It can catch what other people do not say, but only feel and think; and it can also be turned inward. It can hear voices from within the self that are otherwise not audible because they are drowned out by the noise of our conscious thought-process. (1949, pp. 146-147)

The third ear is, according to Reik, closely related to evenly suspended attention:

> Do you picture the psychoanalyst as a man leaning forward in his chair, watching with all five senses for minute psychological signs, anxious lest one should escape him? I've talked about tiny signals, the faint stimuli that flit and waver, slip past, and attain such suggestive significance for the conjecture of unconscious processes. In the face of such differentiated data, so hard to take hold of, you would think that the keenest attention is called for. Do you imagine the analyst not just attentive but tense?
>
> The picture is false, and the analyst's attention is of a different kind. Freud defines this particular kind of attention as "gleichschwebend. "The word is difficult to translate; simultaneously with its connotation of equal distribution, it also has the meaning of revolving or circling. The closest I can come to the Cierman is "freely floating." Another possibility, which emphasizes the psychological balance rather than the motion, would be "poised attention." Two factors induced Freud to recommend such free-floating attention.
>
> It saves tension, which, after all, it is not possible to maintain for hours, and it avoids the dangers that threaten in the case of deliberate attention directed toward a particular aim. If we strain our attention to a certain point, if we begin to select from among the data offered and seize upon one fragment especially, then, Freud warns us, we follow our own expectations or inclinations. The danger naturally arises that we may never find anything but what we are prepared to find. If we follow our inclinations, we are sure to falsify the possible perception. The rule that we must note everything equally is the necessary counterpart to the demand we make upon the patient to tell everything that occurs to him without criticism or selection. (1949, pp. 157-158)

Reik goes on to say

> And now, how can free-floating attention and taking note be brought into consonance? If from the wealth of a mass of passing data we want to take note of something, we must direct a keen gaze upon special points, turn our attention to them in particular, must we not? How can I take a note of anything, if I do not direct my whole attention to it, if I treat insignificant detail in exactly the same way as that which is important? Perhaps it will be said that the notion of "poised" attention aims precisely at taking note of everything and remembering everything. But is not that notion self-contradictory? Attention is always directed only to particular objects. Attention, we have always been taught, implies selection. How can we avoid the danger of selection, if we want to be attentive? (1948, pp. 158,159)

As is well known, Reik suggested solutions for these contradictions in that he described different kinds of "attention":

> The quality of the attention in psychoanalysis may be well illustrated by the comparison with a searchlight. Voluntary attention, which is restricted to a narrow sector of our field of experience, may be compared in its effect to the turning of the searchlight upon a particular piece of ground. If we know beforehand that the enemy is coming from that direction, or that something is going to happen upon that field, then we have anticipated the event, as it were. It is advantageous to illuminate that particular sector brightly. Let us assume a different case, that something, for instance a noise, has turned our attention to a particular zone. Only then do we turn the searchlight upon it. Our attention did not rush on in advance of the perception, but followed it. This is the case of involuntary attention. If we drive at night along a road near New York, we may notice that a searchlight in the middle of the road is scouring the surrounding country uninterruptedly. It illuminates the road, is then directed to the fields, turns toward the town, and swings in a wide curve back to the road, and so repeats its circuit. This kind of activity, which is not confined to one point but is constantly scouring a wide

radius, provides the best comparison with the function of free-floating attention. (1949, p. 163)

In this metaphor the third ear corresponds to a third eye which sees and assimilates everything around it without the slightest preexpectation. The third ear and the third eye are a tabula rasa, ideally completely blank and absolutely free of preexpectations.

Reik's solutions themselves lead to contradictions, because the exploratory, selective character of evenly suspended attention must, sometime and somewhere, halt the motion of the searchlight. Evenly suspended attention stays suspended only until it alights. From the point of view of perceptual psychology, the psychology of thinking, and the theory of knowledge, Reik's suggestion is naively positivistic, and he overlooks the fact that behind the beam of the searchlight is the observer's whole personal perceptual and thinking apparatus, including his theoretical expectations: his perception is "theory-laden."

Our rather casual statement that the suspension of attention only continues until the analyst offers an interpretation — whether accepted by the patient or not — passes over the preconscious (intuitive) or conscious processes of selection which precede it. One can see the psychoanalyst's receptive function as part of a fourfold process of passive and active listening, experiencing, perceiving, and interpreting (Thomson 1980). We make our perceptions, observations and resulting interpretations in light of conscious and unconscious theories. This principle also applies to prescientific experience, however naive its expectations may be. Thus we fnd that patients' perceptions ft the theory that is a fixed scheme in their unconscious, and that their expectations are thus fulfilled.

We go along with the explanations the patient gives for his fears and inhibitions, and enter his world without reservation. How else could we understand him? We listen for undertones, we notice interruptions. Yet in situations where the patient is bewildered, where he cannot comprehend compulsive symptoms or phobias, we would also get no further if we were equipped with no more than ordinary common sense. But the receiver and the third ear would also not get any more sense out of the patient's association without the many programs stored there which provide the analyst with comparative explanatory models. The third ear and the receiver would in any case not be able to hear anything of the unconscious if they were not the organs of an analyst who has absorbed as much knowledge and gathered as much experience as possible. Flexibility in listening is not guaranteed by a

third ear with extrasensory faculties. On the contrary, every mystification which leads to the unconscious fixation of presuppositions must be an obstacle to the scientific legitimation of psychoanalysis.

The notion that the third ear hears best when the analyst otherwise behaves as if he were deaf has retained a certain mysterious fascination. Thus for Bion (the "psychoanalytic mystic" according to Grotstein 1982), the passive, receptive analyst's self-emptying takes on mystical qualities. In order to attain the state of mind he believes essential for the practice of psychoanalysis, Bion avoids all memorization, resisting any temptation to remember the events of a particular session or to go strolling in his memory. He chokes every impulse to remember anything that has happened previously or any interpretations he has made on earlier occasions (Bion 1970, p. 56). At the same time, he demands that the patient must be shown the evidence behind an interpretation, even if it relates to a period of several years of acting out (p. 14). In one way, the idea of a final conquest of all countertransference in both the specific and the general sense also underlies this notion, since Bion refuses to let any wishes or yearnings enters to his thought.

Since a balanced relationship between the two attitudes — feeling and thinking — is not easy to achieve, this problem continues to be discussed by every successive generation of psychotherapists and analysts. Fenichel's (1934) criticism of Reik's one-sidedness remains as valid as ever and is now, in the context of the current discussion of empathy, once again topical. Fenichel quoted Ferenczi, who had said:

> Analytic therapy, therefore, makes claims on the doctor that seem directly self-contradictory. On the one hand, it requires of him the free play of association and phantasy, the full indulgence of *his own unconscious*.... On the other hand, the doctor must subject the material submitted by himself and the patient to a logical scrutiny, and in his dealings and communications may only let himself be guided exclusively by the result of this mental effort. (Ferenczi 1950 [1919a], p. 189)

Finally, we hardly need to point out that we have drifted further and further away from the concept of evenly suspended attention as a rule of treatment and toward the analyst's complex process of cognition. Indeed, a direct line can be drawn from Freud's evenly suspended attention via Reik's third ear to Kohut's (1959) introspective empathic kind of psychoanalytic observation (Cohler 1980, p. 81). Another line leads to those aspects of feeling and thinking that are described today as processes of inference within the analyst (Ramzy 1974; Meyer 1981 a; Kächele 1985). All these themes will be pursued further in the following chapters.

7.4 The Psychoanalytic Dialogue and the Counterquestion Rule: To Answer or Not to Answer, That Is the Question

Is it unduly dramatic of us to use a paraphrase of Hamlet's "To be or not to be, that is the question" in the title of this section on the problems posed by patients' questions and the appropriate responses from the analyst? Is it permissible to attribute the significance of "to be or not to be" to the questions that crop up in the course of analysis? Indeed it is: we would not have chosen this wording if we had not believed that an element of drama is inherent in the psychoanalytic dialogue. The patient comes to the analyst seeking answers to questions he cannot solve by himself. In none of his many discussions — with friends and colleagues, with clergymen, doctors, and quacks — has he been given satisfactory answers, i.e., answers which cure his symptoms. The last resort is then psychoanalysis, in which it can literally be a matter of to be or not to be, life or suicide. We have already spoken of the profound, agonizing questions which the patient cannot formulate but which his unconscious conflicts confront him with. It no longer needs to be emphasized that ultimately the clarification of these unanswered questions constitutes the beneficial effect of the analysis. However, what about the questions the patient can and does ask? How should they be dealt with? Let us first give some examples: Will the treatment cure or at least improve my symptoms? How does it work? How long will it last? Have you treated similar illnesses before? Do I have the same illness as my father? Soon the patient takes an interest in the analyst's private life and family, wants to know his holiday address or — for emergencies — his home telephone number.

If the reader puts himself in the place of the analyst, he will sense something of the tension these questions create. They force the analyst's hand: the patient has urged him to give an answer, and will understand everything he now does as a response. Even silence is in this sense an answer.

Through the patient's questioning, the initiative passes to the analyst, whether he likes it or not. The compulsion arises from the fact that analyst and patient have entered into a dialogue and are therefore subject to rules of discourse, on which they must be in at least partial (tacit) agreement if they want to be in any position to conduct the dialogue in a meaningful way. It is in the nature of a question that the person asking it wants an answer and views every reaction as such. The patient who is not yet familiar with the analytic situation will expect the conversation with the analyst to follow the rules of everyday communication. If questions are left unanswered, he may take this as a sign that the analyst cannot answer, is not willing to answer, or both.

The question is thus a means by which one person can induce another to enter into a verbal exchange, a dialogue. Since psychoanalysis lives from conversation, from the "interchange of words" (Freud 1916/17, p. 17), it is extremely important what and how the analyst replies — and not just to questions. Questions serve here as an excellent example of a broad spectrum of direct and open attempts by the patient to involve the analyst ad hoc in an exchange; requests and criticisms are further examples. Questions can also contain hidden attempts of this nature, as our examples above will probably already have shown; also, something which initially seems to be purely a question to obtain information can later turn out to be, for example, an accusation. Questions are difficult to deal with because they invite interaction in such a multiplicity of ways. What mother has not occasionally been exasperated by her child's insistent inquisitiveness! The analyst's situation is no different when questions put him under pressure.

One rule of treatment which has ossified into a frequently encountered stereotype seems to cut through all difficulties like Alexander's sword through the Gordian knot. This stereotype is to respond to a question from the patient with a counterquestion: "What leads you to ask that question?" For example, if a treatment report mentions that a given question came up and was "analyzed," one can be fairly sure that the patient asked a question which was then thrown back at him with a request for the thoughts behind it. Such information is also often invited indirectly by silence. This answering of questions with questions is, for the general public, one of the characteristic features of analysis. Indeed, the text on the jacket of the German edition of J. Malcolm's book *Psychoanalysis: The Impossible Profession* (1980; *Fragen an einen Psychoanalytiker,* 1983) contains the following: "The author asks the questions which every patient always wanted to ask, but to which he knew the analyst would only respond 'What occurs to you when you ask yourself why you wanted to ask me that question?"' We, too, followed this stereotype for many years, until the unfavorable consequences taught us better. We discovered how deeply entrenched in the professional superego this rule can be from the guilty conscience we suffered when we disregarded it, and we assume that many other analysts may have had the same experience. As can be seen from the following anecdote, the stereotype is obviously passed on from one generation to the next through training and control analyses, on the assumption that answering questions with questions plays a not insignificant part in ensuring a particularly profound and rigorous analysis. Be that as it may, this anecdote, which in essence is not fictive, shows that candidates follow this rule especially strictly. Shortly

before the end of the preliminary session, a candidate says to his first analysand: "If you have any more questions, please ask them now. From the next session onward, I'll be bound by the principle of abstinence and will no longer be able to answer your questions."

The following overview of the literature (Sect. 7.4.1) will show that this stereotype derived from the discharge model of mental functioning. It is assumed that the withholding of an answer will result in the patient more quickly expressing thoughts which will lead to the latent meaning of the question. Thus the rule is justified by the hoped-for gain in therapeutic insight. An unintended result, however, is that the patient often interprets the failure to answer his question as a rejection. What influence does this rejection have on the transference relationship and on the desired process of restructuring the patient's self-and object-representation? We believe that we have to assume that only a few patients have an ego so intact that they experience the rejection represented by the stereotyped nonanswering of questions without feeling offended and without all the implications this has for unconscious defense mechanisms.

At least in the introductory phase, a patient will not be able to see any sense in the counterquestion — as we will refer to it from now on for the sake of brevity — and the rejection and offense he experiences can arouse unconscious defense mechanisms which lead to imperceptible transformations of the thoughts he contributes. Thus the analyst's withholding of answers, intended to stimulate the patient's flow of associations, achieves the opposite.

From studying the literature and from personal experience we have come to the conclusion that the counterquestion rule, far from ensuring the depth of self-recognition, in fact disturbs, and can even occasionally destroy, the very basis of self-recognition, namely the dialogue. This conclusion is supported by another result of the following investigation — by the exception to the rule. With which patients may the analyst waive the counterquestion rule? With those who do not have an intact ego with a high threshold of tolerance, i.e., with a large proportion of the patients who consult an analyst! What happens, then, when the analyst no longer follows the rule? Are the patient's questions simply answered? By no means. We merely abandon rigid adherence to a rule which can no more be reconciled with the bipersonal theory of psychoanalytic process than it can with experience in practice. Just as ego- or self-development is tied to the principle of dialogue, therapeutic self-discovery and further development of the ego are tied to the response of the new object. In this respect the exceptions to the rule predominate.

However, it is not only with those patients who display insecure object relationships that we have become skeptical of previous practice. Since in analysis all objects are constituted principally through the verbal agency of a responding subject, we can explain why the variation of a time-honored rule is called for to make the psychoanalytic dialogue more fruitful. It is not a matter of simply answering the questions; rather, the counterquestion rule must be replaced by a reasonable attitude, as described by Curtis (1979, p. 174): "It is of course a matter of analytic judgement whether an answer, explanation, or acknowledgement of a patient's question about the analyst is in the best interest of the analytic process." Since the counterquestion rule provides an apparently easy way of dealing with a complicated problem, it is not surprising that it has survived for decades. Let us now examine the foundation of the stereotype and its history.

7.4.1 The Foundation and History of the Stereotype

One justification for the stereotype of not answering the patient's questions seems to derive from the rule of abstinence: the answering of a question is said to represent an unacceptable gratification of the patient's instincts, hindering the progress of the analytic process. It is assumed that if the analyst has given an answer once, there might be a danger that the patient will ask more and more questions, with his questioning eventually developing into a resistance which the analyst himself has induced.

Another problem is posed by the personal questions the patient asks in order to find out something about the analyst. It is assumed that answering such questions destroys the analyst's therapeutic incognito or reveals his countertransference, disturbing the development of transference.

Because of these fears, the nonanswering of questions has become a stereotype of therapeutic technique. This did not originate with Freud, who was flexible in this respect. In his report on the introductory phase of the analysis of the Rat Man (Freud 1909d), we find that he answered his patient's many questions concerning the mechanisms of the psychoanalytic treatment and the prognosis directly, without making the patient's questioning an object of interpretation.

Blanton (1971) relates that during his own analysis he often asked Freud about his scientific views. According to Blanton, Freud answered his questions directly, without making any interpretations.

Neither in his specifically analytic writings nor anywhere else in his oeuvre did Freud explicitly address the technical problem of how to deal with patients' questions, apparently because for him it was not a problem.

To our surprise, our survey of the literature revealed that it was Ferenczi who, in 1918, formulated the rule of never answering patients' questions:

> I made it a rule, whenever a patient asks me a question or requests some information, to reply with a *counter interrogation* of how he came to hit on that question. If I simply answered him then the impulse from which the question sprang would be satisfied by the reply; by the method indicated, however, the patient's interest is directed to the sources of his curiosity and when his questions are treated analytically he almost always forgets to repeat the original enquiries, thus showing that as a matter of fact they were unimportant and only significant as a means of expression for the unconscious. (1950 [1919al, p. 183, emphasis added)

Ferenczi believed that counterquestioning enabled him to arrive quickly at the unconscious determinants, the latent meaning, contained in the question. We are not of the opinion that this assertion can claim universal validity. To start with, there is no small likelihood that a rigid application of this rule will discourage the patient from asking questions altogether, leading him to withhold not only the questions but also the related thought processes, without this necessarily being clear to the analyst. Moreover, conventional answering by the analyst of questions from the patient on the level of everyday communication does not automatically entangle them in a question-and-answer game whose unconscious determinants are inaccessible to further analysis. Our experience was the opposite, namely that well-considered answers according to the rules of everyday discourse help a patient for the first time to talk about the feelings of rejection he has experienced as a result of an all too inflexible application of the counterquestion rule. Our subsequent interpretation of his avoidance of questions then enabled the patient for the first time to ask further, profounder questions, which could then be comprehended as deriving from hitherto unconscious tendencies and interpreted.

Many analysts have had similar experiences and varied their technique accordingly, and for this reason Ferenczi's rule has not won universal acceptance. This is shown by Glover's survey (1955, pp. 261ff.), which was carried out in the 1930s but whose results Glover regarded as still representative in the 1950s. Among other things, he asked his colleagues whether they would admit their moods, anxieties, or illnesses to their patients. The majority were prepared if necessary to confirm the patient's observations to this effect. Some made their decision according to the conjectured effect on the patient,

i.e., were flexible in this respect. Only a small minority had made it a rule to neither confirm nor deny patients' speculations or questions. As for nonpersonal questions, a large majority in this survey were prepared to give information on sexual and nonsexual matters, although for only a quarter of the analysts questioned was this unproblematic. There was widespread agreement that questions should be analyzed, but it was felt that it would be a mistake to make a question the point of departure for an analysis of motivation if giving an answer were realistically justified. The stereotyped analysis of questions was thought to increase the patient's indifference or resistance and also to be a sign of inappropriate anxiety on the part of the analyst.

The results of this survey show that psychoanalysts are flexible in how they respond to questions from the patient. However, only rarely does one find in the literature a statement opposing the stereotype of ignoring questions which is as clear as that by Kohut (1971, p. 89):

> To remain silent when one is asked a question, for example, is not neutral but rude. It goes without saying that — given specific clinical circumstances, and after appropriate explanations — there are moments in analysis when the analyst will not pretend to respond to the patient's pseudorealistic requests but will instead insist on the investigation of their transference meaning.

A high regard for interpretations, which we fully share, has led a good many analysts to overlook the fact that a positive therapeutic climate is created when the patient's questions are taken seriously on the manifest level. In our view analysts resort to the counterquestion technique because they fear that patients could otherwise remain at a superficial level. We find an example of this in Dewald's study (1972) of the course of an analysis, which, by virtue of verbatim protocols, has the particular merit of permitting exact inspection. At the end of her first session the patient asked what she should do if she were pregnant. Dewald replied that it was necessary to understand what lay behind the question in order to be able to recognize meanings other than those contained in the question itself. The meaning of the question on the manifest level remained obscure, and the analyst made no attempt to find out anything on that level.

As Lipton remarks in his critique (1982), by using this technique Dewald influences the patient in such a way that her utterances take on a disconnected and illogical character; this is what Dewald strives for, because he hopes in this way to gain the material for his purely historical genetic interpretations. He achieves this by signalling to the patient with his response to her first question that the manifest meaning

of the question is of no interest to him and by repeatedly interrupting her in the course of the session, almost always only to ask for thoughts or details. We agree with Lipton that the analyst can comprehend hidden, latent meanings only when he has understood what the patient is saying to him on a manifest level. Through his form of counterquestioning and his insistence on additional associations before even the manifest meaning of the patient's question was clear, Dewald deprived himself of the possibility of understanding and interpreting the transference aspects of the question. To do this, it would have been necessary to understand what the patient's question meant on a manifest level and to know which situational precipitating stimuli had induced her to ask it. In this case, however, the counterquestion rule was directly to blame for the fact that material which would have been highly significant for the patient's current transference remained inaccessible to analysis. It emerged much later that the patient was already 2 months pregnant when she asked Dewald her question.

Our misgivings about the counterquestion rule do not, however, rest only on the fact that it is by no means always conducive to deeper understanding. Rigid application of the technique can also lead to serious complications in the development of transference.

Greenson (1967, p. 279) describes a patient whose previous analysis had been unsuccessful, probably because the analyst had employed a very rigid technique whose features included not answering questions and never explaining this course of action to the patient. Greenson was able to structure the analysis more productively by telling the patient why he could not answer his questions. Greenson's recognition that patients have a right to an explanation of the strange — in comparison to the everyday situation — rules of discourse in analysis enabled this patient to talk about the profound feelings of humiliation and of being ignored that he had had with his previous analyst. In this way, the patient's negative transference, which had led to deadlock in the previous analysis, became accessible to elaboration and interpretation.

The reader will probably be astounded to learn that Ferenczi, the very analyst who was the first to believe that deficiency states and defects of early origin could be corrected, pleaded the case for rigidity in such a sensitive area of communication. At the time (1950 [1919b]), he formulated the counterquestion rule, he was of course firmly oriented on the discharge model of therapy and advised forced fantasies or heightened tension as part of the nascent active technique. Is it futile to speculate on a

connection between rigidity on the one hand and mothering of regressed patients on the other? No, because our present knowledge indicates that it is very probable that the refusal to answer questions can, in patients so disposed, precipitate severe, psychotic-like regressions. Of course, we are not claiming that Ferenczi's counterquestion rule was solely responsible for the severe regressions suffered by the patients he treated in the 1920s. Assuming that he followed the rule strictly when treating severely ill patients — as indeed he did — on the basis of our present knowledge we can say almost with certainty that iatrogenic regressions were inevitable.

Particularly instructive in this respect are the findings discussed by a panel on "severe regressive states during analysis" (Weinshel 1966). Numerous case reports by leading analysts in the course of this discussion led Frosch (see Weinshel 1966, pp. 564, 567) to refer to silence on the part of the analyst as the most important of the factors which can precipitate a severe regression and to recommend that analysts should "speak more often" and "answer questions more readily" when working with patients at risk. This conclusion became obvious after it had been recognized that rigid application of the counterquestion rule and the use of silence, either as a general technical expedient or by ignoring an individual question or request, were partially responsible for iatrogenic damage. For various reasons, however, the appropriate flexibility is not easy to realize. If you simply treat according to rules, you delegate your responsibility to them. If you accept rules without further ado, you overlook the tendency toward manipulation which is always inherent in them. Only when you forsake strict adherence to the rule and decide for yourself whether, how, and why you answer a patient's question do you become conscious of your responsibility. Seen from the point of view of the exponents of the rule system, however, the flexible analyst manipulates even if he justifies his decisions pragmatically and scientifically. Even that which is advisable or has been proven beneficial for the patient becomes manipulation. Accordingly, Frosch described his recommendation that the analyst demonstrate flexibility in the treatment technique of patients at risk, by saying that this involves "manipulation" (e.g., staying seated during treatment sessions, giving one's private telephone number, prescribing psychotropic medication, or changing the frequency of sessions). However, the rule system does not have the last word:

> If the climate, the attitude, and the thinking are analytic from the outset, I believe that the smooth, imperceptible shift to the classical psychoanalytic technique will be absolutely natural and that the beginning of the treatment will merge continuously and organically into the subsequent therapy. (Weinshel 1966, p. 567)

Since the counterquestion rule in the context of a rigid rule system, as advocated for example by Menninger and Holzman (1958), can have unfavorable side effects in every phase of therapy — and not just in patients at risk — the cultivation of the kind of analytic climate described by Frosch is always crucial. In each individual case the prescribed mixture of therapeutic agents must be adjusted in order to be able to realize the aim of psychoanalytic treatment, namely to achieve structural changes through the interpretation of transference and resistance. There will then be some psychoanalyses in which the analyst leaves many questions unanswered, and others which are more strongly supportive. The classification of therapies into supportive, expressive, and strictly analytic becomes questionable. Let us consider the following short exchange reported by G. and R. Blanck (1974, p. 330):

> *Mr. Forrester:* I feel as though I hate everyone today, especially all women. (Pause.) You never seem to mind when I say that. (Pause.) You're a cool cookie. I feel sad. Why don't you say something?
>
> *Therapist:* I will. I don't mind when you say what you feel.

Important here is not the content of the intervention, but the Blancks' statement that in the treatment of a borderline patient it is permissible, *contrary to the psychoanalytic technique,* to accede to the request for a comment. Our experience with the counterquestion technique up to the present day speaks against viewing it as a sound technical rule.

7.4.2 Rules Governing Cooperation and Discourse

Asking questions and giving answers are verbal behavior aimed at creating a dyadic structure, in contrast to the more monologue-like patterns of verbalization when the patient free-associates. The counterquestion rule has the purpose of transforming an interactive pattern of verbal action initiated by the patient back into a monologue. In order to be able to grasp the implications of a digression from everyday rules of conversation, it is appropriate to take a look at some of the rules governing cooperation and discourse which form the bounds of experience and expectation for each person. We will limit ourselves to those patterns of verbal action which belong to the theme of question and answer.

Austin (1962), in his theory of speech acts, proceeds from the observation that things get done with words. In the patterns of verbal action, there are specific paths of action available for interventions to alter reality (Ehlich and Rehbein 1979). However, speech, if it is to become effective as a means of action,

is dependent on the existence of interpersonal obligations which can be formulated as rules of discourse. These rules of discourse depend partly on the social context of a verbal action (those in a court of law differ from those in a conversation between two friends), and conversely, a given social situation is partly determined by the particular rules of discourse. Expanding this observation psychoanalytically, one can say that the implicit and explicit rules of discourse help to determine not only the manifest social situation, but also the latent reference field, i.e., transference and countertransference.

If any kind of meaningful dialogue is to take place, each partner must be prepared (and must assume that the other is prepared) to recognize the rules of discourse valid for the given social situation and must strive to formulate his contributions accordingly (the general principle of cooperation enunciated by Grice 1975). If the discourse has been disturbed by misunderstandings or breaches of the rules, metacommunication about the preceding discourse must be possible which is capable of removing the disturbance. For example, one of the participants can insist on adherence to the rule (e.g., "I meant that as a question, but you haven't given me an answer!"). In such metacommunication, the previously implicit rules which have been broken can be made explicit, and sometimes the occasion can be used to define them anew, in which case the social content and, we can add, the field of transference and countertransference can also change. In Greenson's above-mentioned case (1967, p. 279), we see the analyst's intervention as an example of this type of communication about the discourse: the counterquestion rule is explicitly introduced and explained, and in this way the analyst frees the patient of the anxiety that the analyst is dealing with him in an arbitrary way, i.e., not adhering to the general principle of cooperation. The transference relationship is then relieved of a source of aggressive tension.

In every speech act, the general principle of cooperation is supplemented by further specific rules according to the intention of the speech act; this allows the addressee to identify it (e.g., to distinguish questions from requests or from accusations) and to determine the appropriate reaction. Thus, for example, the appropriate reaction to a question is either an answer or the reason for not giving an answer. We would now like to consider silence and counterquestioning against the background of some rules of discourse.

When the analyst responds to a patient's question with silence, the silence is accorded a meaning. Since silence can be interpreted in any number of ways, the patient has a multiplicity of possibilities, and

his choice depends on the situational context and on the current form of the transference relationship. In view of the rules of discourse, the patient must assume either that the analyst does not wish to observe the general principle of cooperation, or that the analyst wants to tell him silently that one of the prerequisites which would make his utterance a question is not fulfilled. If the patient assumes the former, this can lead to treatment being broken off. This does not happen if the patient is ready, because of transference, to accept the definition of the relationship by which the analyst may behave arbitrarily. In this case the analyst has, through his silence, contributed to the formation of this transference pattern of submission to an arbitrary regime, or at least reinforced it. Yet also if the patient assumes that the second possibility is in fact the case, he will quite likely find the silent way in which the information is "communicated" particularly rude, which will also inevitably have repercussions on the transference relationship.

A relatively favorable situation can still develop if the patient interprets the analyst's silence as meaning that the latter is not in possession of the information requested. In this case the repercussion on transference could take the form of the patient reducing his overidealization of the analyst.

Ferenczi's counterquestion technique — especially if used without explanation — may be understood by the patient as meaning that the analyst does not want to impart the information requested although he has it. There are indeed social contexts in which the relationship between speaker and addressee is asymmetrical (often corresponding to an imbalance of power), and this is expressed in the absence of willingness to convey information. For example, in a court case the defendant is not permitted to ask the judge for information (except perhaps to ensure verbal understanding), but the converse is certainly permissible. Ferenczi's rule (even in Greenson's modification) boils down to explaining the analytic situation as a field of interaction in which no genuine questions of information from the patient are permissible. The patient incorporates this into his transference phenomena, the exact manner depending on his disposition. One possibility would be that he fantasizes the analytic situation as a court scene. If he has the appropriate transference disposition, he can also assume that the general cooperation principle is not being adhered to. We have already dealt with this above in the discussion of silence on the part of the analyst. This danger is especially great in the introductory phase, when the patient still cannot grasp the sense of the rules of psychoanalysis.

A somewhat different situation emerges if the analyst follows Greenson's suggestion and explains to the patient the purpose of the counterquestion technique. Such explanations do not have a long-lasting effect, but do strengthen the working relationship, especially if the information about rules is enriched interpretatively.

We would like to summarize our reflections prompted by speech act theory as follows: The patient enters the analysis with a largely preconscious knowledge of rules of discourse, mainly from his everyday experience. Irritations and corresponding influences on the transference pattern set up by the patient can result whenever the analyst diverges from everyday rules of discourse or implicitly or explicitly introduces new rules of discourse. By doing this, the analyst guides the patient in the direction of a transference pattern which fits the new rules of discourse. Which transference pattern then emerges depends on the patient's transference dispositions.

7.4.3 Object Finding and Dialogue

Our reference to speech act theory, specifically to the verbal pattern of question, answer, and response, has shown that the rules of discourse form a very differentiated system of interrelated reactions on the part of the dialogue partners. Similarly, interrelated and coordinated patterns are known at the level of nonverbal interaction between mother and child. Rene Spitz (1965) called this mother-child behavior a dialogue and worked out the significance of this dialogue as a precondition for the child being able to gain internal object constancy. The natural next step is to apply Spitz' considerations to the verbal dialogue in analysis, which is after all supposed to lead to the restructuring of self-representations and object representations.

According to Spitz, not only the patterns of action interconnect in the dialogue between mother and child, but also their previous and current affects. It is not the case that the mother could or even should maximally fulfill the child's every wish, but the dialogue must proceed gratifyingly for the child often enough to enable the development of the image of a good object relationship *(nihil est in intellectu quod non prius fuit in sensibus).*

On the other hand, the child's patterns (his image of the object relationship) also become

differentiated, in that the mother avoids fulfilling all the child's wishes and the child thus learns to gain control of his impulses and to cope with the (initially only temporary) absence of the real person without affective overflow.

The analogy of the preverbal dialogue, as Spitz described it, with the verbal pattern of question-answer-response is clear. Stretched between direct answer and response is the arc between gratification and frustration. Like the mother, the analyst must find the right mixture of the two if he wants to promote his patient's development. Here it becomes plain that rigid application of the counterquestion rule represents too simple a solution to the problem. Some questions must be answered at the level thematized by the patient if we want to facilitate the development of a sound working relationship. There are bound to be some frustrations, for a variety of reasons, for example because the analyst does not know the answer or because he wants to protect his private sphere (just as the mother must protect herself against excessive claims made on her by her child), and also because wholly natural frustrations promote a differentiation of the patient's relationship patterns which is appropriate to reality. In this way the analyst remains entirely within the framework of the everyday rules of discourse.

We do not want to suggest that the analyst should follow the everyday rules of discourse when answering patients' questions, or indeed at all in the therapeutic setting. However, we do want to emphasize that the explicit and implicit rules introduced by the analyst by means of his technique are essential determinants of the form taken by the patient's transference. Flader and Grodzicki (1978) conjecture that the fundamental rule and the rule of abstinence induce transferences which repeat the child's relationships to the people it was dependent on. Of course, there is probably no mother who evades or leaves unanswered all her child's questions, and thus the iatrogenic component must be borne in mind in the repetition (see Chap. 2). Moreover, the repetition takes place under more favorable conditions. The stereotype discussed above does not create a fruitful climate for the patient to find better answers today than he has found in the past. The analyst must carefully assess how much a patient can bear in the way of digressions from the everyday rules of discourse according to the foreseeable consequences on the transference relationship.

The unique possibilities of the analytic dialogue derive from the fact that its rules of discourse are in certain respects wider in scope than those of everyday discourse. The purpose of this widening of

scope, with interpretation as the single most important component, is to enable the unconscious to be brought into the sphere of the conscious. This is also the purpose of the counterquestion rule, which is, however, not achieved when the rule is applied rigidly. Thus the analyst has not done his job properly if he simply answers the patient's questions conventionally; he must understand what is unconsciously behind the question. Flader and Grodzicki (1978) state that he must ultimately answer questions that the patient cannot yet even ask consciously. An example will make this clear: The child, afraid of being alone, asks the departing mother, "When will you be back?" The mother will answer the question and perhaps add a few words of consolation. The patient who asks his analyst the same question at the beginning of the summer holidays will possibly get the following interpretation in reply: "You are asking that now to make sure that I will come back and that your anger about me going away doesn't endanger our relationship"

In this way the analyst partially avoids answering the question (although in this example it is answered insofar as the analyst implicitly says that he will come back). This evasion contains frustration. Thus the analyst instead begins a special kind of metacommunication with the patient with the intention of throwing light on the unconscious components of the patient's relationship to him in an interpretation of transference, thereby providing an answer to the question which the patient cannot pose: "Why am I so aggressive, and why can't I express my aggression?"

To the extent that he feels the analyst has understood him in this interpretation and that he thus learns to understand himself better, the patient gets something which certainly contains a measure of gratification, but which beyond that helps him to overcome his conflicts. In this way he is more than compensated for the frustration caused by the analyst's refusal to answer his question directly. However, in order for this stage to be reached, i.e., in order for the analyst to be able to make a helpful interpretation, a therapeutic relationship with conscious, unconscious, and transference components must first develop. The analyst contributes to this development with everything he does or leaves undone. In patients at risk, rigid adherence to the counterquestion rule increases the danger of malignant regression or limits the accessibility of the patient for interpretations. On the other hand, the therapeutic objective will also not be achieved through simple adherence to the everyday rules of discourse. It is essential that the analyst strive for clarity concerning what his interventions have precipitated and that he take the patient's reactions into account in further interventions.

Notes

1 We deal with the answering of questions in Sect. 7.4, where we explain why we find Greenson's hypothetical answer wrong. Knowledge of motivation would yield no elucidation which can be achieved clearly, given the division of tasks. The patient must know that, and why, free association is his task, not the analyst's.