Psychoanalytic Practice: Principals

The Psychoanalytic Process

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Table of Contents

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Although we have discussed various aspects of psychoanalytic treatment in the foregoing chapters, we have not focussed our attention on the role these aspects play in the therapeutic process as a whole. We have concentrated on segments of greatly varying duration within the course of treatment and alternated between macro- and microperspectives of the analytic process (see Baumann 1984). We have on the one hand used a magnifying glass to concentrate on small facets of treatment, such as the patient's questions, and on the other hand investigated the analyst's general treatment strategies — while maintaining the necessary distance to detail.

Psychoanalytic treatment can be characterized in many ways. A wide variety of metaphors have been used to delineate the characteristic and essential features of psychoanalysis. We have discussed Freud's comparison of the analytic process with chess, as well as the analogies that he saw between the analyst's activities and those of the archaeologist, painter, and sculptor (Chaps. 7 and 8). Although Freud left no doubt that the analyst can decisively influence the course of analysis, either for better or for worse, he placed more emphasis on the autonomous course of analysis:

> The analyst ... sets in motion a process, that of the resolving of existing repressions. He can supervise this *process*, further it, remove obstacles in its way, and he can undoubtedly vitiate much of it. But on the whole, once begun, it goes its own way and does not allow either the direction it takes or the order in which it picks up its points to be prescribed for it. (1913c, p. 130, emphasis added)

Implicit in these metaphors are theories and models which we now want to identify. Sandler's (1983) demand that the dimension of private meaning in concepts be worked out in order to achieve real progress is also directed at the practicing analyst:

> Research should be directed toward making explicit the implicit concepts of practising psychoanalysts, and it is suggested that this process will result in the accelerated development of psychoanalytic theory. The essentials of that theory must be those aspects which relate to the work the psychoanalyst has to do, and therefore its main emphasis needs to be clinical. (p. 43)

To aid in accomplishing this task, the following sections contain discussions of the function of process models (Sect. 9.1) and of the features essential for evaluating them (Sect. 9.2), and a description of various conceptions of the process (Sect. 9.3), including our own (Sect. 9.4).

9.1 Function of Process Models

If we focus our attention on the therapeutic process, i.e., on the entire distance that the patient and analyst together cover between the initial interview and the termination of analysis, it is necessary to relegate the vast majority of the events that occur to the background. We have to restrict ourselves to essentials, otherwise we run the risk of not seeing the woods for the trees. The heart of the matter with regard to the function *and* general difficulties of process models is that events are not essential per se, but are made essential by the *significance* that we attach to them. What the psychoanalyst considers to be of great significance during the course of therapy depends on the pattern of meanings he has internalized regarding the organization and course of the psychoanalytic process. We can postpone answering the question of how explicit and differentiated the ideas about the analytic process are or should be. At this juncture we wish solely to emphasize that no therapist can conduct or evaluate treatment without having a model of the possible courses of therapy which provides him with instructions for action and with criteria to use in evaluation.

The analyst's conception of the process fulfills an important regulatory function in the transformation of his goals into interventions. The understanding of the process is thus not merely abstract and theoretical. On the contrary, it is, in a more or less elaborated form, a component of every therapist's daily activity. Yet this is the point where the qualitative differences between the more implicit views of the analytic process and the detailed models begin to emerge. The less explicitly or more generally a model is formulated, the more easily it evades critical reflection. For this reason, the models handed down from one generation of analysts to the next are often formulated in such general terms that it is impossible for them to be refuted by observation. It is dubious, however, whether such models are adequate for the object they refer to.

One of the factors decisive in determining whether analysts' ideas about the analytic process are adequate is the position these ideas occupy on the scales "degree of complexity" and "degree of inference." We attribute the status of a model to a conception located near the poles "complex" (in contrast to "undifferentiated") and "inferential" (in contrast to "observable").

According to Klaus and Buhr (1972, p. 729), a model is

> an object which is introduced and used by a subject on the basis of a structural, functional, or behavioral analogy in order to be able to solve a certain task .... The use of a model is especially necessary in certain situations in order to gain new knowledge about the original object.

This definition is based on an understanding of "model" that originated in the fields of science and technology, as Klaus and Buhr made clear:

> A common feature of all models is that they cannot be arbitrarily created (chosen or produced) by a subject, but instead are subordinated to their own inner regularity, which is the real object of analysis in the subject's model experiment, cognition, behavioral adaption etc. (P 730)

This definition of the concept of the model does not apply to models of the psychoanalytic process. The act of cognition as practiced by an analyst during treatment, in his role as participant observer, is clearly different from that in the sciences, where the object is not altered by the researcher's observations. The scientific researcher influences the object only as part of a controlled experiment. Most importantly, however, the researcher himself, as a person exerting influence, is not part of the object being studied (see also Sect. 3.1). Although this epistemological view of science is increasingly being questioned, for instance in modern physics, qualitative differences nonetheless remain between the modes of cognition of a scientist and a psychoanalyst. The analyst who approaches his object, the analytic process, with a specific conception of a model *influences, by means of his expectations, the occurrence of events* which agree with his model. Thus, an analyst who views therapy as a sequence of predetermined phases looks carefully for signs marking the transition to the next phase. He will, at the same time, selectively pursue those of the patient's utterances which fit his model of the analytic process. He may thus actually determine the direction the process takes, although he believes that he has only observed it. In this way, he transforms his model of the process, which he takes to be *descriptive,* into therapeutic action in a *prescriptive* manner.

The reason that we have emphasized this aspect is not that we consider such a procedure to be reprehensible. On the contrary, the analyst has no choice but to understand the therapeutic process on the basis of his model of it, to derive hypotheses from this model, and to conduct therapy according to these hypotheses. The critical question is not whether the analyst derives his course of action from his model, but whether he follows this course of action in a strictly prescriptive way.

In our discussion of therapeutic rules and strategies (see Chaps. 7 and 8), we have placed great

value on the distinction between stereotypical and heuristic strategies. Process models can also be used by the analyst in a stereotypical way, i.e., as if they were algorithms. An algorithm lays down a precise sequence of individual steps which lead inevitably to the prescribed goal if followed exactly. Process models cannot adopt such a prescriptive function; they must always be employed in a heuristic and creative manner (Peterfreund 1983). A model can be used as an algorithm only if it is all-encompassing, a condition that will probably never be satisfied with regard to the psychoanalytic process. Process models provide suggestions as to how the highly complex, dyad-specific information accumulated over a long period of time can be organized. Even after this form of organization has been chosen, it must still be tested over and over again as to whether it can integrate new information.

The analyst must pay special attention to information that does *not* fit his model. He will always be able to find items among the wealth of material which confirm his model; however, this says little about the utility of his understanding of the analytic process. Information which cannot be integrated serves, in contrast, as an incentive for him to modify his understanding of the analytic process in such a way as to make it compatible with the new information. In this way, the analyst's image gradually becomes a more accurate approximation of the object.

We realize how great a mental effort is required and how much of an emotional burden it is on the analyst to admit that the conception of the analytic process that he has used is inappropriate, and thus consciously to create the insecurity which inevitably results. An essential function of process models is, after all, to introduce order into the multiplicity of information, to steer the therapist's perception and behavior, and thus to ensure continuity in his therapeutic measures. It is understandable that nobody likes to lose such support, even if only temporarily. Such a short-term loss of orientation is easier to tolerate if the analyst has resisted the seductive idea that there is a true model of the psychoanalytic process. In our opinion, the notion of a true process model is just as fictive as that of a true psychoanalytic process which follows natural laws and immanent regularities as long as the analyst's interventions do not disturb it. Process models have a direct impact on therapy. Whether an analyst adheres to the fiction of a natural process, or rather views treatment as a dyadspecific, psychosocial process of negotiation, thus has very real consequences for the patient. An analyst holding the latter view must repeatedly determine whether his assumptions regarding the analytic process are still compatible with his observations of the interaction in each individual case.

It is primarily up to the individual analyst whether he (erroneously) takes his process model for reality, and consequently directs his interventions in a stereotypical way, or whether he views it as a tool in the organization of the process which must be revised as soon as information incompatible with it is acquired by means of heuristic strategies. Of course, certain characteristics of models tend to lead to *stereotypical* interpretations, while others tend to promote the use of *heuristic* strategies. We would now like to discuss different characteristics of process models from this point of view.

9.2 Features of Process Models

As we have explained above, the issue is not to distinguish between true and false process models. At issue is rather the suitability of different process models to provide effective therapeutic strategies. The central criterion in this regard seems to us to be whether a model presumes the psychoanalytic process to follow a quasi-natural course. Such models do not inevitably lead to a stereotypical application by the analyst, but they do support any tendency he may have to orient himself rigidly on the expected, natural course. Observations that do not fit into a course conforming with the model are often ignored or interpreted as manifestations of resistance.

This can be seen particularly clearly in the way analysts deal with utterances by patients which indicate that they either have failed to understand or do not accept particular interpretations. If a patient's rejection of an interpretation is then interpreted on the basis of the very hypothesis that the patient did not understand or accept, and is thus understood as resistance, the analyst will remain a captive of his preconception and the patient will be deprived of a possibility to make major corrections to it. Although the concept of resistance is well founded, as we discuss in Chap. 4, it must still be possible in the everyday communicative situation in analysis for a patient's rejection of an interpretation to be accepted as valid (see also Thomä and Houben 1967; Wisdom 1967).

Prominent among the models suggesting a quasi-natural course of treatment is the widespread view that the process of therapy is analogous to development in early childhood. In Sect. 9.3 we will discuss Fürstenau's (1977) process model as a typical example of this type. The most common assumption in such models is that the patient progresses from early to later stages of development in the course of therapy. That this is not inevitably the case can be seen in Balint's account of "a peculiar phase

in the analytic treatment of patients." He described it in the following way:

> My clinical experience was briefly this: At times when the analytic work has already progressed a long way, i.e. towards the end of a cure, my patients began very timidly at first to desire, to expect, even to demand certain simple gratifications, mainly, though not exclusively, from their analyst. (Balint 1952, p. 245)

The patients Balint refers to here are not in a position to examine their basal pathogenic assumptions (in the sense described by Weiss and Sampson 1984) during therapy until after the primarily oedipal conflicts have been dealt with and the patients experience the resulting increase in ego strength and security. A. E.#. Meyer (personal communication) suggests calling this "the chronological retrograde model."

Patients' process models also have a place in this discussion; they are an accurate reflection of how patients experience the process. Patients often speak of analysis as the exploration of their own house. This metaphor invites reflections on the interior structure of the building. Even if careful observation from the outside can give an experienced architect some clues to the interior design, knowledge about the layout, use, and furnishings of the rooms can only be gained by seeing inside. Of course, houses have many things in common that we can infer on the basis of our knowledge of their construction and function. Similarly, human psychic development takes each of us inevitably through certain stages, as has been described by many authors (e.g., Erikson 1959). We acquire our psychic structure in grappling with the developmental tasks facing every one of us: separation from symbiosis, triangulation, Oedipus configuration, adolescence, etc. The accessibility of these structures to therapeutic work depends on a multitude of different factors which interact with the treatment technique and which we grasp as intrapsychic defense and acts of psychosocial adjustment (see Mentzos' [1982, p. 109] description of his three-dimensional model of diagnosis).

Viewing the process of therapy and development in early childhood as parallel phenomena is certainly often accurate and may provide a fruitful guide for intervention. Yet this approach becomes problematic if applied inflexibly, e.g., if the analyst overlooks the fact that the therapeutic process, as formed together with the adult patient, differs from early childhood experiences in some essential aspects, not the least of which is the quality of subjective experience. Early experiences *cannot* be reexperienced authentically; the therapeutic process is always concerned with the overdetermined

experiences of an adult.

A process model oriented toward psychological development must also do justice to these experiences.

The seductive element of these models is, as described above, the implication that the individual phases follow an inevitable sequence. The result can be that the analyst considers and uses only information which fits into the current phase, disregarding the rest. Thus one phase after the other may be *created* interactively, while their sequence is interpreted as a process-immanent regularity. In models based on the idea that the psychoanalytic process follows a natural course, the patient's development is logically at the center of attention. If, in contrast, the psychoanalytic treatment is considered to be a dyad-specific interactional process (see Sect. 9.4), the therapist's contribution is very important.

Another, essential criterion for the evaluation of process models is provided by the answers to the questions: What does a model say about the analyst's role? Which function in the formation of the process is attributed to him? Generally it is possible to assume that the more "natural" or autonomous a process is conceived to be, the less there is to say about the analyst's role (and about the responsibility he assumes for it). In the extreme case, he fulfills his function merely by being aware of the process regularities postulated by his model and not disturbing their course. In this case, the employment of heuristic strategies by the analyst is neither necessary nor desirable. His behavior is in any case not oriented primarily around the patient, but rather around his "natural" view of the process, which he as a rule attempts to support with neutrality and interpretations.

In such an approach an important role is logically played by the question of whether a patient the analyst has just seen for an initial interview is at all suited for this process, since its course is determined by the "nature of things." An adaptive indication, in the sense we propose (see Chap. 6), is not possible in this framework because it demands great flexibility on the part of the analyst, who has to offer himself in changing roles as a partner for interaction.

We have described an extreme case in order to clarify a risk that becomes greater the more "naturally" the analyst views the analytic process, namely the danger that he will evade his obligation to see that the therapeutic process is structured in a responsible and flexible way. We believe he may thus

incorrectly classify a growing number of patients as nonanalyzable.

We would like to describe the view put forward by Menninger and Holzman (1958) as an example of an understanding of the analytic process which hardly specifies the analyst's role. These authors propose a process model according to which a suitable patient makes a contract with the analyst and, at the end of a typical process, has changed his psychic structure and resolved his transference. This view is, by the way, refuted by the follow-up studies conducted by Schlessinger and Robbins (1983). According to them the resolution of transference at the end of successful therapy is a myth; on the contrary, even successfully analyzed patients soon showed clear manifestations of transference in follow-up interviews. For Menninger and Holzman the analyst seems to be not much more than a usually silent companion whose patience and friendliness convince the analysand that his love and hate transferences lack all positive and negative foundation in the present.

This fiction of a psychoanalytic process purified of the real person of the analyst presumes the existence of an average analyst and a suitable patient. Disregarding the fact that there is no such patient-analyst pair, this conception also prevents the findings of social science research commensurate with the essence of the therapeutic relationship from entering the psychoanalytic situation. The pressing problems of psychoanalytic technique cannot be solved by upholding as a kind of counterreaction to the identity crisis — an increasingly rigid conception of treatment. On the contrary, we assign the analyst a central role in codetermining the structure of the therapeutic process. He fulfills this role in a dyad-specific way which depends on his own personality and on the patient. This view of the therapist's role cannot be reconciled with the conception of the psychoanalytic process as a natural event.

Each of these two opposing conceptions of the psychoanalytic process is at first nothing more than a statement of belief. Information on the suitability of process models can ultimately only be provided by the observation of psychoanalytic processes. A precondition for this is that the models be formulated in a way which makes it possible to validate or refute them by observation. We consider this question of the empirical validation of process models to be an important criterion for the evaluation of different models; it is in fact the only way to determine their utility.

This precondition requires that models be made as explicit as currently possible. The closer to the

level of observation the models are formulated, the more clearly operational hypotheses can be derived which then can be tested on observable events in interviews. It must be possible to test hypotheses and especially to collect data incompatible with the model. This means that a model which can effortlessly explain an outcome diametrically opposed to the original prognosis is useless. Yet precisely in the formation of psychoanalytic theories, there is a widespread tendency to devise such irrefutable models. This is certainly due partly to the initial helplessness which inevitably overcomes analysts when they are confronted with the highly complex subject matter. It is risky to make prognoses if human behavior is overdetermined, if the struggle between wish and defense is undecided. The uncertainty increases with the length of time for which the prognosis is supposed to be valid. Thus the formulation of process models is always an uncertain undertaking. This is especially true if the models are supposed, ideally, to provide a grid enabling the analyst to classify a large number of interactive, interdependent events without detailed knowledge about the nature of the relationship between them.

There are two conceivable ways out of this difficulty. One is to formulate process models in such an abstract manner that they become universally valid and thus irrefutable. This form of theorizing is a dead end and distorts, rather than sharpens, one's eye for new material. An expression of such abstract generalization is the apparent ability of some analysts to fit a case into a comprehensive theoretical framework after only a short presentation, a fact that is a frequent source of wonder at clinical seminars. The case is forced into the Procrustean bed of a theory, and information which does not fit is passed over, while information which is lacking is presumed to be compatible with the theory.

The other way of coping with the complexity of the psychoanalytic process is to limit the model's claim to provide a comprehensive conception of the process. A fruitful approach is initially to propose hypotheses in the form of if-then statements concerning various events which commonly recur in the course of therapy. Both the "if' and the "then" components should be specified as exactly as possible in order to ensure the refutability of the hypotheses.

9.3 Models of the Psychoanalytic Process

Freud's technical recommendations for the conducting of treatment, and thus for the process, are rather cursory, intentionally vague, and indefinite with regard to the overall course of treatment.

Although a whole series of rules (Chap. 7) and strategies (Chap. 8) can be compiled, no understanding of the process can be discerned which does more than simply label the initial, middle, and concluding phases of analysis, as Glover (1955) noted. We have already mentioned Menninger and Holzman's understanding of the process; regardless of how the substance of their position is evaluated, their attempt to outline an understanding of the entire process is an expression of awareness of the problem and was warmly welcomed upon its publication in 1958. The development of a theory of psychoanalytic therapy which is more than a loose collection of technical principles has been an unsolved task since Bibring's presentation at the Marienbad congress in 1936. The number of coherent process models which have collected statements about individual issues in order to provide an overall understanding nonetheless remains small. This is probably related both to the preference of most analysts for an essayistic presentation of case studies (Kächele 1981) and to the complexity of the subject matter. The following descriptions of several of the attempts to formulate process models reflect this state of development.

One common feature of thinking about the process is the concept of *phase.* The differentiation of individual stages of treatment according to the accepted substantive patterns is a feature both of the case descriptions by candidates in training, characterized by the frequent use of headings rich in images, and of the approach taken by Meltzer (1967), who describes the following phases of the typical processes in children's analyses conducted according to Klein:

1. The gathering of transference
2. The sorting of geographical confusions
3. The sorting of zonal confusions
4. The threshold of the depressive position
5. The weaning process

According to Meltzer (1967, p. 3), this sequence of phases expresses a truly natural, *organic process* which originates when a treatment is conducted strictly according to Klein's methods. The sequence of stages from early to later development is obvious in the understanding of child analysis, but becomes problematic if used in an attempt to understand the analytic process in adults. This is illustrated by

Fürstenau's (1977) model of the "progressive structure of nonfocal psychoanalytic treatment." This progressive structure results from the interplay of dynamic factors in the analytic situation which we have already described in numerous ways.

In the psychoanalytic process it is important to distinguish two interwined dimensions which together constitute the progressive structure. According to Fürstenau (1977, p. 858), these two partial processes are:

1. The process of the gradual structuring and normalization of the self, with recurrent phases of severe structurally formative relapses in regressive crises, and of the analyst s manner of dealing with it in a substitutive and supportive way.

2. The process of the scenic unravelling and processing of fixations, layer by layer, through the analysis of transference and countertransference.

We will now briefly describe the seven phases of Fürstenau's progressive model and mention the problems it brings. According to Fürstenau, each phase is described from the general points of view of "working through the rigid patterns which the patient carries over" and "constructing a new pattern of relationships."

In the first phase the analyst fulfills a maternal role for the patient; he behaves in a way intended to provide security.

In the second phase the patient unravels his symptoms; he still has little interest in understanding unconscious connections, but makes important discoveries with regard to the analyst's reliability and firmness.

In the third phase negative aspects of the early relationship to the mother are dealt with.

In the fourth phase a turn to oneself takes place by handling the concealed aggressions and affronts from the early mother-child relationship; this is accompanied by improvement in the diffuse depressive symptoms. In the analytic relationship, the patient learns that the analyst is interested in his secret fantasies without being obtrusive or making him feel guilty because of his narcissistic withdrawal.

In the fifth phase the patient's sexual identity is defined; analysis takes different courses for male

and female patients. This theme is continued in the sixth phase, the phase of oedipal triangularity.

The termination of treatment in the seventh phase is facilitated by newly developed relationships which the patient has been able to establish both to himself and to partners. The working through of mourning is the focus of attention.

Fürstenau distinguishes between two classes of psychic disturbances, which he calls the relatively ego-intact neuroses and the structural ego disturbances. The latter class includes psychotic, narcissistically withdrawn, asocial, addicted, perverted, and psychosomatic patients. In contrast to the therapy of ego-intact patients, which proceeds in the described manner throughout the phases, especially in the first of the two partial processes outlined above, in the nonfocal psychoanalytic treatment of patients with structural ego disturbances the partial processes become intimately entwined. In addition, for the latter group there are changes especially in the first three phases of treatment. For instance, in the first phase the analyst must increasingly assume substitutive functions. Furthermore, there is no clear transition to the fourth phase, and the second half of the process is dominated by the patient's alternating occupation with himself and with others. "Corresponding to this, there is a continuous *alternation* in the analyst's interventions between working on transference and resistance, on the one hand, and strengthening the patient's self, on the other" (Fürstenau 1977, p. 869).

In contrast to our own process model (Sect. 9.4), Fürstenau's progressive structure is characterized by fixed content. This has a therapeutic function in itself because it provides the analyst security. Fürstenau developed this model structure on the basis of his experience in clinical supervision. One important aspect of agreement with our own view is the idea that the treatment process consists of phases characterized by different themes. Less accurate, in our opinion, is the assumption that the sequence of phases in every process is organized in the sense of a linear reworking of ontogenetic development. From the point of view of the social sciences, it is improbable that this model's claim to generality can be achieved; yet the establishment of a model of a typical course of treatment would certainly represent a great advance in the description of the course and outcome of psychoanalysis.

The advantage of such a model is that it adapts the psychoanalytic method to the real characteristics of two large groups of patients. This obviates continuous redefinition of the range of a more or less

narrowly defined understanding of "classical technique." Consequently, it eliminates the source of the controversies — neither advantageous for psychoanalysis nor helpful to patients — which generally result in limiting the application of the so-called classical technique to patients with intrapsychic conflicts at the oedipal level, referring everyone else to analytic psychotherapy or so-called psychodynamic psychotherapies, or founding a new school of therapy for their treatment. Orientation on the method's potential could ultimately still lead to the differentiation according to type of illness which Freud (1919a) called for. This implies the necessity for a certain degree of flexibility, in the sense of adjustment to the individual patient's needs, which has not yet been achieved. It is not difficult to recognize that Fürstenau's model of therapeutic activity also refers to the area of so-called narcissistic disturbances, in that it includes the partial process "of the gradual structuring and normalization of the self."

Kohut, in his later writings (1971, 1977), makes a fundamental distinction between a technique based on instinct theory and ego psychology, and his understanding of analysis and the restoration of the self. The process model in Kohut's theory of restoration of the self is determined by the following theses:

1. The selfobject seeks itself in others.

2. There is a lack of empathic resonance by the mother. The degree to which the empathic resonance is absent ultimately determines the deficit in the self. Empathic resonance is composed of several stages determined by development: mirror transference, twinship transference, and idealizing self transference. These determine the form taken by empathic resonance and are described as man's basic needs.

3. Deficits in self provide the decisive basis for all disturbances. In his later works Kohut (1984, p. 24) considers even oedipal pathology as an emanation of the nonempathic mother or father. In his view, if there were no primary self damage, there would be no castration anxiety with its *pathological* consequences.

4. After the resistances directed against renewed selfobject frustrations (frustrations because the other is not how we would like) have been overcome, there is a mobilization of "selfobject transferences" in the therapeutic process, with inevitable conflicts in the analytic relationship. The conflict is between the constant need for appropriate selfobject reactions on the one hand, and the patient's fear of injury of the self on the other. If the patient feels he has been understood, archaic, disavowed needs are revived on the selfobject in the selfobject transference.

5. The relationship between the analysand's self and the selfobject, i.e., the analyst's self function, is inevitably incomplete. Since the attempt to establish complete empathic harmony with the analysand is doomed to failure, there are self regressions with symptoms which are understood as disintegration products.

6. By means of his empathic resonance, the analyst senses the patient's legitimate needs for his selfobject function, which are buried under distorted manifestations. He clarifies the sequence of events and corrects his own misunderstandings.

7. The goal of therapy is the transformation of the "selfobject function of the selfobject analyst to a function of the analysand's self' (Wolf 1982, p. 312). This is known as transmuting internalization. What is significant is that the increase in self structure does not mean any independence from selfobjects; on the contrary, it means a greater capacity to find and to use them.

The application of these theses to the process of a classical transference neurosis, which by definition can be limited to oedipal conflicts, leads to the following structure of phases (Kohut 1984, p. 22):

1. A phase of "generally severe resistances"

2. A phase of "oedipal experiences in the traditional sense dominated by the experience of severe castration anxiety" (Oedipus complex)

3. A renewed phase of severe resistances

4. A phase of disintegration anxiety

5. A phase of "mild anxiety, alternating with joyous anticipation"

6. A final phase, for which Kohut suggests the term "oedipal stage in order to indicate its significance as a healthy, joyfully undertaken developmental step, the beginning of a gender-differentiated firm self that points to a fulfilling creative-productive future"

Kohut himself points out that the "one theoretical assumption" underlying this classification of phases is that "the process of analysis generally leads from the surface to the depth," from which he concludes that "transference sequences generally repeat developmental sequences *in the reverse order"* (1984, p. 22). The goal and motor of this process is to show the patient that "the sustaining echo of

empathic resonance is indeed available in this world" (1984, p. 78).

In his last, posthumously published study, Kohut no longer shied away from using the well-known but disreputable expression "corrective emotional experience" to describe his position. As he points out, the controversy originally surrounding the expression arose from the manipulative use of the emotional experience as a replacement for working through. At the end of his life Kohut considered his position to be firmly anchored in the classical technique despite all changes, inasmuch as neutrality and abstinence constituted his basic position, supplemented by "dynamic (transference) interpretations and genetic reconstructions."

Critical evaluation of the theory of self must orient itself on the fact that the explanatory device which Kohut employs throughout his work is a contemporary version of the principle of security. Instinctual desire has been replaced by the regulation of the relationship to the meaningful other, which, however, is conceived according to the theory of narcissism.

Balint's early work on primary love intersects here with the social psychological theses of Cooley and Mead. Kohut rejected symbolic interactionism even in the form represented by Erikson, to the great disadvantage of his own theory and practice. In this context mention must also be made of the first efforts to integrate Piaget's process of adaptation and accommodation into the psychoanalytic theory of development (see Wolff 1960; Greenspan 1979, 1981) Psychoanalytic object relationship psychologies do not do justice to the capacity for social interaction. In its first 6 months a baby learns "how to invite his mother to play and then initiate an interaction with her" (Stern 1977). Applying this new perspective to the psychoanalytic process, the question of regulatory competence becomes the focus of all considerations and leads to an understanding of process which possibly overcomes Kohut's one-sidedness and unnecessary generalizations, and which yet makes it apparent that Kohut discovered an important central factor: that the regulation of well-being and security is hierarchically superior to the realization of particular desires.

Our discussion of Moser et al.'s process model (which we outline below) is limited by the fact that the sphere of cognitive psychology (see Holt 1964) is still foreign to many psychoanalysts, and thus by the difficulty in presenting the conceptions in a manner compatible with a textbook. Moser et al (1981)

presented a theory of the regulation of mental processes in which they described object relationships, affects, and defense processes using the terminology normally employed in the development of computer simulation models. In their model, the analyst-analysand relationship is understood as the interaction of two process systems according to explicit or implicit rules. It is important to be able to imagine the concept of process systems in order to understand the following discussion. It might be helpful to refer to the familiar psychoanalytic structural model as a process system in which three regulatory contexts — ego superego, and id — interact. "Context" refers to a loose grouping of affective cognitive functions whose interaction is (more or less) tense, comparable with Waelder's (1960) image of border traffic which is normal in peacetime but prohibited m times of war. Von Zeppelin (1981) emphasizes that the main assumption of the process model is that analyst and patient continuously make images (models) of the state of the regulatory system, both of their own and the other's, and of the presumed interaction. An important characteristic of the model is that a special regulatory context is established for the creation and maintenance of relationships, and that the context contains the wishes and rules for the realization of the relationships. The rules governing relationships also include those which belong to the communicative "hardware" of interaction regulation and have to be classified as part of, for instance, Habermas' theory of universal pragmatism. Such rules are not of interest in the therapeutic process unless they are severely disturbed and manifest themselves as pathological phenomena. Of general clinical significance are the so-called self-relevant rules of the relationship, which are important for maintaining the stability of the entire regulatory system. Subordinate to them are the (object-) relevant rules, which follow the given social rules of relationship. A first understanding of transference results from the distinction between these two sets of rules: transference occurs only where self-relevant rules are involved.

The therapeutic process is set in motion when the analysand seeks the help of the analyst's regulatory competence. He does this in his own typical way as determined by his development. It is the task of the therapeutic process to clarify the unconsciously introduced expectations which the analysand places on the analyst's assistance. For this purpose, the model defines four main functions of the therapeutic relationship (von Zeppelin 1981):

1. The extension of the cognitive affective search process with regard to regulatory activity, especially the extension of self-reflective capabilities

2. The preparation and introduction of an ad hoc model of the relationship between analyst and analysand; a better interactive competence is thus acquired in the here-and-now, which then must be transferred to the real relationships outside the analysis

3. The gradual modification of the therapeutic interaction in the sense of a revised distribution of regulation between analyst and analysand

4. The modification of the analysand's regulatory system by means of greater differentiation of self-reflective functions

The analysis of transference and countertransference originates in the application of these four main functions to the therapeutic relationship. The resulting processes pass through various phases in which different focal points are worked through again and again (see Sect. 9.4). Insight can be described as the construction of progressively more exact modes, which have to be sought in an iterative manner.

Without being able to go further into the differentiated descriptive and representative possibilities offered by this formalized model, we would like to emphasize the central significance of the concept of regulatory competence, whose strategic and tactical task is at the center of the hypothetical ' subject processor." Although the images of the terminology employed here appear foreign, they accurately describe the concept of *security* that we can also identify in the process model of the Mount Zion Psychotherapy Research Group led by Weiss and Sampson, which we will now outline.

In a series of studies since 1971, this group has devised, on the basis of a clinically and theoretically elaborated conceptualization of the analysis of defense, new empirical approaches to verification. Without here going into the details of individual, empirically described psychodynamic configurations, the group characterizes the course of psychoanalytic treatment as a conflict between the patient's need to express his unconscious pathogenic beliefs and the analyst's efforts to pass these critical situations (called "tests") in such a way that the patient does not experience any confirmation of his negative expectations. If the outcome of the test is positive, the patient can acquire the security afforded by knowing that there is no longer any justification for his systems of beliefs consisting of infantile wish-defense patterns, and can therefore inactivate their regulatory function. This view, derived from the critical analysis of Freud's early (instinctual) and later (ego psychological) theories of defense, can be found in the works of Loewenstein (1969, p. 587), Kris (1950, p. 554), Loewald (1975, p. 284), and

Greenson (1967, p. 178). A precursor of this concept of test was Freud's statement that the ego interpolates, "between the demand made by an instinct and the action that satisfies it, the activity of thought which, after taking its bearings in the present and assessing earlier experiences, endeavours by means of experimental actions to calculate the consequences of the course of action proposed" (1940a, p. 199). This was applied by Weiss (1971), the Mount Zion Group's theorist, to the transference situation; Rangell (1971) and Dewald (1978) have expressed similar considerations.

The course of a psychoanalytic treatment is consequently viewed as a sequence of tests in which the themes specific to individual patients are tried out and worked through. Weiss and Sampson's special achievement was to have tested this process hypothesis empirically against the frustration thesis. Although both positions take the same segments of treatment to be decisive, the prognostic power of the Weiss-Sampson thesis proves to be far superior to that of the frustration thesis. The progress in treatment can in fact be viewed as the consequence of the successful refutation of unconscious pathogenic assumptions. It was further shown that if the analytic climate offers the security which the patient feels is necessary, repressed contents can manifest themselves without anxiety even if there is no explicit interpretation (Sampson and Weiss 1983).

A central theme has thus been conceptualized and empirically tested, although the processes studied by the Mount Zion Group account for only one section of the complex of events. A more comprehensive model still cannot be devised because there has been no explicit elaboration of the goal of the entire process; only individual steps of the process have been considered. One could perhaps assume that a satisfactory conclusion of therapy has been reached according to this process model when all of the patient's pathogenic assumptions have been refuted. This utopian goal raises the question of which of the patient's pathogenic assumptions are actualized in a concrete process in such a way that they stumble into the cross fire of transference.

According to Sampson and Weiss, the formal steps characterizing the course of therapy take place at every point in time in every therapy and are independent of whether the analyst follows this theory. The model thus claims a general validity regardless of the patient's particular illness, the stage of therapy, or the therapist's technique. And it is only concerned with one aspect out of the entire course of therapy: the patient's attempt to induce the analyst to act in a particular way and the analyst's reaction. The entire

process is apparently viewed as a series of such sequences, and no consideration is given to the possibility that there might be a change in the sequences in the course of therapy. The only distinction is between the short-term and long-term effects of the refutation of assumptions. An immediate effect is that the patient's anxiety decreases; he is more relaxed, takes a more active role in the analytic work, and is more courageous in confronting his problems. The manifestation of new memories is considered, in contrast, more as a long-term effect.

It can be expected that the more the authors attempt to integrate further clinical observations and the results of process research into their model, the more necessary it will be for the model to be made more specific and supplemented with further assumptions. This might well make the model better able to describe the complexity of the psychoanalytic process, although its compelling simplicity would probably suffer as a result.

9.4 The Ulm Process Model

The development of the psychoanalytic technique has from its very beginnings been the object of two antagonistic tendencies, one toward methodological uniformity and the other toward syndrome-specific variation of the technique. On the subject of *therapeutic activity,* for example, Freud mentions technical modifications for phobias and compulsion neuroses: "another quite different kind of activity is necessitated by the gradually growing appreciation that the various forms of disease treated by us cannot all be dealt with by the same technique" (1919a, p. 165). In the general and specific theories of neurosis, hypotheses of the genesis of psychiatric and psychosomatic illnesses have been developed which are empirically more or less well founded. By making diagnoses and prognoses we apply our imprecise knowledge of what would have to happen in the psychoanalysis of anxiety neurosis, anorexia nervosa, or depressive reaction, to name just a few examples, in order to achieve an improvement in the symptoms or a cure.

The therapeutic process begins before the first session of treatment. The very fact that a potential patient approaches the analyst, and the way he establishes contact and makes an appointment are factors which themselves establish patterns influencing the beginning of treatment and determine whether the initiation of treatment is successful. Even at this early stage the question is raised as to how much

openness and flexibility the analyst may use in shaping the situation so that an analytic situation results. The termination of a therapeutic process is another occasion for handling the topics of separation and parting in such a way that the specific relationship can be favorably concluded. We comprehend the transference neurosis as an *interactional representation* (Thomä and Kächele 1975) in the therapeutic relationship of the patient's inner psychic conflicts, the concrete arrangement of which is a function of the analytic process. This is unique for each dyad, and thus psychoanalysis can legitimately be called a historical science; on the other hand, at a higher level of abstraction it permits the identification of typical patterns of the course of analysis. Implicit in the simplifications that this involves, however, is the danger that the contribution of the therapist's personal equation and theoretical orientation to this development might be overlooked. Whether the intended, syndrome-specific strategy of treatment can be achieved depends, of course, on numerous imponderables beyond the influence of the analyst. Thus, events which take place in a patient's life often create new situations requiring a modification in strategy.

A serviceable process model must therefore combine flexibility in approaching the individual patient with regularity structured around the therapeutic task. In trying to do justice to this requirement, we base our process model on the following set of axioms:

1. The patient's free association does not lead by itself to the discovery of the unconscious portions of conflicts.

2. The psychoanalyst makes a selection according to his tactical (immediate) and strategic (long-term) goals.

3. Psychoanalytic theories serve to generate hypotheses, which must constantly be tested by trial and error.

4. The utility of therapeutic instruments can be judged by whether the desired change is achieved; if the change fails to occur, the treatment must be varied.

5. Myths of uniformity in psychoanalysis and psychotherapy lead to self-deceptions.

This list clearly outlines our conception of psychoanalytic therapy as a process of treatment regulated according to strategic considerations. This point of view is definitely unusual inasmuch as our call for evenly suspended attention on the one hand and for free association on the other seems to

express just the opposite of a plan of treatment. In order not to create an objectively unnecessary contradiction it is advisable to refer to Freud's justification for his recommendation on evenly suspended attention: it is an excellent means for correcting theoretical prejudices and for more easily discovering the origin (focus) of each individual illness. Evenly suspended attention and focussing thus fulfill complementary functions: the functional state of gaining a maximal amount of information (the evenly suspended attention) and the organization of this information according to the most significant points of view (the focussing) alternate at the forefront of the analyst's mind.

We have now introduced a central concept of the Ulm process model: the focus. Before examining the numerous meanings attached to this term in the psychoanalytic literature, we would like to refer to its etymology. Focussing means bringing rays of light together at one point, and at the focus it burns. The fact that we assign focussing an important position in our conception of the analytic process does not mean a rigid commitment to one topic. Rather we would like to call attention to man's limited capacity to absorb and process information, which permits no more than selective perception and, consequently, focussed attention.

At the beginning we mentioned that process models should enable us to make rule-like statements about the course of treatment. A focal conception of the process fulfills this function. Although ultimately we can do justice to psychotherapeutic activity (regardless of its orientation) only by ideographic means, i.e., by considering individual dyads, we still find regularly recurring topics in the psychoanalytic process. If the patient speaks about his anxieties, for instance, this topic then becomes the psychodynamic focus if

1. The analyst can generate hypotheses about unconscious motives which seem sensible to the patient
2. The analyst succeeds in leading the patient to this topic by using appropriate interventions
3. The patient can develop active emotional and cognitive interest in this topic

Our response to the question of whether a focus leads an existence in the patient independent of the analyst's structuring interventions is affirmative in that the patient has after all developed his own symptoms, but at the same time negative in terms of treatment technique. In view of the high degree of

interrelatedness of unconscious structures of motivation, it is hardly possible for any focal diagnostic activity not to influence the interactional form of the focus activity (see the empirical results reported by Gabel et al. 1981). The analyst's cognitive processes, which regulate his reactions and selections and are discussed under terms such as "empathy" and "trial identification" (Heimann 1969), presumably take place largely below the threshold of conscious perception. They only become accessible to the analyst as a result of his work on his affective and cognitive reactions. For our understanding it is generally unimportant whether the analyst reaches his formulation of the focus in a largely intuitive, empathic manner, or whether he derives it to a greater extent from theoretical considerations. It is vital for focussing to be understood as a heuristic process which must demonstrate its utility in the progress of analysis. An indication for a correct formulation of focus is the thematization of a general focal topic, e.g., unconscious separation anxiety, in numerous forms. These different manifestations in the patient's everyday life are the object of the detailed interpretive work, which must be oriented around ideographic knowledge, i.e., around the detailed knowledge of the individual course of treatment.

In working through a focus we expect, in a favorable case, that the manner in which the patient (and perhaps even the analyst) deals with the focal topic will change in a specific way. More exact statements about this process of change can be made during analysis only if the constellation of transference and resistance, the working relationship, and the capacity for insight are also taken into consideration in a differentiated manner. If the same focus reappears at a later point in time, the questions raised are in principle the same. It can be expected, however, that the progress achieved earlier has not been lost and that the treatment can be continued at a higher level.

The result can be summarized as follows: We consider the interactionally formed focus to be the axis of the analytic process, and thus conceptualize psychoanalytic therapy as an *ongoing, temporally unlimited focal therapy with a changing focus.*

This model adequately reflects the clinical experience that the course of *transference neurosis* is a variable largely dependent on the analyst. There are a large number of studies in psychotherapy research on the influence of different *therapist variables*, and these variables have to be considered within the framework of an understanding of the psychoanalytic process (see Parloff et al. 1978; Luborsky and Spence 1978). We cannot return to the state prior to the discovery that the psychoanalytic

process is constituted and develops interactively. Thus, in contrast to several of the models discussed above, we believe the sequence of the focusses to be the result of an unconscious exchange between the patient's needs and the possibilities open to the analyst. A change of analyst leads as a rule to completely new experiences. While this phenomenon has frequently been reported orally, it has only rarely found its way into the psychoanalytic literature (for example, in Guntrip 1975). The process that a patient and his analyst experience together comes to a standstill when their productivity is exhausted, even if the treatment continues indefinitely. Some processes never really get going because the two participants are not successful in establishing this interactional meshing in working through focal topics (see Huxter et al. 1975).

The analyst's process model, and not just his personality, exerts an influence on the course of therapy. If an analyst assumes, for instance, that the treatment must proceed according to a supposedly natural sequence of particular developmental phases, he will structure the treatment accordingly. The intensity and quality of the work on individual topics are also influenced by the importance the analyst attaches to the topics within the framework of his particular view of the analytic process.

Our view of the process does not exclude the possibility that therapy may proceed according to a regular developmental scheme (see Sect. 9.3).

Before beginning our detailed presentation of the Ulm process model, we would like to discuss the historical predecessors of the focal concept which have obviously influenced and motivated us. French (1952) first conceived of his idea of focus within the context of his systematic dream analyses:

> We think of the cognitive structure of a dream as a constellation of related problems. In this constellation, there *is* usually one problem on which deeper problems converge and from which more superficial problems radiate. *This was the dreamer's focal problem* at the moment of dreaming. Every focal conflict *is* a reaction to some event or emotional situation of the preceding day which served as a "precipitating stimulus." (French 1970, p. 3l4)

This model, developed as a paradigm to help understand dreams, was employed in the well-known consensus study carried out at the Chicago Institute to record the dominant conflicts in individual treatment sessions, in which Kohut was one of the participants (Seitz 1966, p. 212). The assumption was that preconscious thinking tends in every interview to concentrate on a central (admittedly, highly condensed and overdetermined) problem. A multitude of associations capable of entering consciousness

are concentrated at one point, similarly, "associated, unconscious, genetic conflicts are activated .... the emotional charges of which are characteristically transferred to the single, hypercathected, *focal* conflict in the preconscious." Seitz (1966, p. 212) suggests, following Freud, that

> the focal conflict usually consists of the current transference to the analyst, and is best understood theoretically in terms of the dynamics of day-residues. Because these hypercathected, preconscious conflicts constitute points of convergence of dynamic forces within the mind, they provide a useful focus for unifying and integrating interpretive formulations of the complex, seemingly heterogeneous associational maternal of individual interviews

According to Seitz, the focal conflict is identical to the dominant transference in the interview. The further development of the concept of focus in the Focal Therapy Workshop, described by Malan (1963), led to the crystallization of a focus. This concept was intended to express the idea that the focus is not chosen by the analyst, but gradually develops out of the joint work of patient and therapist.

Balint's ideas on these issues, as reflected in his report on the focal therapy of patient B. (Balint et al. 1972), were themselves influenced by the "flash" experiences of the Focal Therapy Workshop. Balint, however, goes further and demands that no focal plan may be designed without a precise formulation of the focus, which itself is a translation into words of the flash experience. The formulation of the focus as a guideline for treatment was supposed to be "specific (not a general idea like 'homosexuality' or the 'Oedipus complex'), sharply delineated (not as vague as 'the patient's relationship with his mother'), and unambiguous" (Balint et al. 1972, p. 152). This demand for specific formulations appears to us to be necessary, even outside this context. The customary case discussions are very unsatisfactory if the participants stop at overly general and consequently almost meaningless descriptions such as "oedipal" or "preoedipal." Such terms neither help us to understand an individual pathogenesis, nor provide instructions for appropriate action.

The choice of the appropriate level of abstraction seems to us to be the problem most easily solved in focal therapy. It involves bridging the gap between diagnosis and therapy, so that we can go from one to the other. The demand that the focus should be expressed in the form of an interpretation seems to reflect the wishful thinking of many analysts. Even Balint seems to have succumbed to this idea when he advised "that the focus should be expressed in the form of an interpretation that could be given meaningfully to the patient towards the end of the treatment" (Balint et al. 1972, p. 152).

Our understanding of focus, following Balint's Workshop formulation, goes beyond French's conception inasmuch as it refers to a structure which extends over a longer period of time. There is, of course, no reason not to formulate a focus for individual interviews, but from the point of view of treatment strategy it is desirable to work through a basic topic continuously over a longer period of time. What period of time is best, and whether it is better defined by a specific number of sessions or by the rate of the patient's progress are clinical questions and must be decided empirically.

Indications for a suitable division of the treatment process into segments can be found in the final reports of candidates in training, who as a rule break the treatment process into four to five phases with thematic headings. These reports, however, also illustrate that the length of the phases depends on the analyst's technical procedure to a significant degree. We therefore have to distinguish our understanding of focus from Balint's description of the focal conflict as the focal plan which the analyst formulates for conducting treatment. It may appear convincing that in a psychoanalytic short therapy *one* focus is selected and that *only* this one is worked through, although the experience in the Hamburg focal therapy project (Meyer 1981b; especially Gabel et al. 1981) raises some doubts. We, however, put more emphasis on the cooperative aspect, the continuous work of patient and analyst, whose efforts to establish a focus reflect a creative process of agreement and disagreement.

In the controversy surrounding the work of Alexander and French (1946), one constant point was the criticism that the therapist manipulates the patient in the focus-centered procedure. This objection is unfounded with regard to our understanding because of the emphasis we put on joint work on the focus. On the contrary, there is more openness in our approach than in the standard technique, in which the analyst proceeds in a concealed way and often manipulates without sufficient reflection. Peterfreund (1983, pp. 7-50) has provided several instructive examples of this procedure from his own work and the literature.

In the following we describe the course of treatment for a hypothetical patient in order to illustrate our ideas about the analytic process. As is by now clear, we use "focus" to refer to the major interactionally created theme of the therapeutic work, which results from the material offered by the patient and the analyst's efforts at understanding. We assume that the patient can offer different material within a certain period of time, but that the formation of a focus is only achieved by selective activity on the part of

the analyst. With regard to the process, we expect the joint work on a focus to lead to further major points of substance, which can only be formed on the basis of the preceding work.

Let us consider an example in which the patient offers four different topics in the initial phase. We understand these four offers in the sense of French's "nuclear conflicts" (1952, 1970), as infantile conflict constellations which are unconscious, psychogenetically acquired structures determining the patient's symptoms and character.

The designation of a certain number of initial offers is arbitrary inasmuch as a large number of infantile conflicts have been conceptualized in psychoanalytic theory. We will identify more, fewer, or different core conflicts according to where we direct our attention, which itself depends on our theory. The expected number of nuclear conflicts will probably fall with increasing specificity of the disturbance, and rise with increasing severity of the disturbance. In the diagnostic phase of the initial interview (time T_0, see Chap. 6), the analyst attempts to gain a first impression of possible conflicts, at this point independent of therapeutic interventions. When first therapeutic steps are tried in the further course of the initial interview (time T_1), a first focal constellation (F_1) *is* formed; its utility must be demonstrated in the first phase of treatment. In the identification of the substance of this constellation, we closely follow French's criteria for the description of the *focal conflict*, which require information about the source (unconscious, infantile stimuli), precipitating causes (recent and current events), principal forms of defense, and attempted solutions.

In contrast to French, we would not like to make a quantitative statement about the period of time a given focal theme is dominant. At some point — we do not dare to be more precise — the work on the first focus makes a second focus (F_2) accessible. The work on this second focus leads in our example back to the first focus, which then again becomes the center of work, although in a qualitatively different form (F_1).

In our example, the initial and diagnostically founded focus F, also represents a major motif of the entire process. This corresponds to the well-verified clinical finding that the individual focusses are linked to one another via a central conflict. A schematic example is hysterical disturbance; in an uncomplicated case the primary conflict is in the area of the positive oedipal relationship. At the same time, however, the disturbance may implicate the negative oedipal area (F_2) or anal (F_3) and oral (F_4)

conflict themes, which might, and depending on the structure of the analytic process probably will, appear as a secondary focus in the analysis.

In this regard we follow a suggestion made by Luborsky (1984), who was able to demonstrate empirically that this classification of conflict themes is accurate. He termed this major transference issue the core conflictual relationship theme. This theoretically and practically well-grounded conception of a central conflictual dynamic which guides therapy also provides the foundation for a focal procedure (Balint et al. 1972; Klüwer 1985; Malan 1963; Strupp and Binder 1984) whose object is the handling of such a main conflict, which supposedly can be grasped in the first interview (see also Leuzinger-Bohleber 1985). The other focusses in our example *(F_2, F_3, F_4)* are, as is easy to imagine, encountered and handled in the course of treatment, each providing a new means of access to the major transference issue F_1.

We have chosen a relatively crude example of the course of treatment for didactic reasons. Using our model it is possible to describe the process at different degrees of differentiation, depending on the purpose.

To return to the metaphor of psychoanalysis as the exploration of a house, exploration of the interior revolves primarily around a room which by virtue of its central position controls the access to the other rooms, but which itself can also be entered from various neighboring rooms.

We do not want to go into detail on the wealth of further assumptions which are part of our model. Our sole intention was to present a scheme for conceptualizing the psychoanalytic process which satisfies a number of the criteria we believe to be relevant. It should have become clear that a stereotypical view of the process introduces unnecessary rigidity into the psychoanalytic work. Our model provides a framework for understanding psychodynamic processes in very different settings, and can be applied to both short- and long-term therapies. It is compatible with various theoretical approaches in psychoanalysis which are used to help gain an understanding of the material the patient initially offers. We consider our conception of process to be genuinely social scientific, and to be in complete opposition to those process theories which start from a view that the process is a naturally occurring phenomenon and which develop where the formation of schools and a tendency to ideology go

hand in hand.

The psychoanalytic process as we understand it lives from a diversity and openness which leaves room for creativity, but which has to restrict itself whenever it becomes concrete. The model therefore does not dictate whether the next session will continue the same topic or whether another focus will be revived as a result of situational stimuli. In every session a situation inevitably arises in which a decision must be made as to which direction to take. The analytic process lives in the dialectic tension between the conception that "the way is the goal" (von Blarer and Brogle 1983, p. 71) and the fact that there is no such thing as aimless wandering. There will always be times when the two wanderers pause and become engrossed in a topic which appears significant to both of them. Von Blarer and Brogle's attractive metaphor of the psychoanalytic process as a path that analyst and analysand "have taken since the first interview" can be adopted if the path leads from problems to their solutions.

We would like to contrast the conception of the process as an ongoing temporally unlimited focal therapy with qualitatively changing focus to the fictive notion of a puristic psychoanalytic process. We strongly favor a flexible process model, i.e., a technique which is heuristically oriented, suitable for searching, finding, and discovering, and directed at creating the best possible conditions for change. We are convinced that the traditional rules of psychoanalytic procedure contain much that is useful but which becomes counterproductive when the method is cultivated as an end in itself. The same is true of conceptions of process. They have the function of providing orientation, and are primarily instruments to help the analyst organize his own work and to facilitate the necessary communication between analysts. They become a threat to therapy if they are taken for unchallengable reality and are thus no longer subjected to the constant reexamination which is necessary.