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The Couch in Psychoanalysis

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> "You can't imagine how staggering it is
> To rediscover the power of the couch –
> What lies behind one's eyelids once closed
> Against the daylight trivialities" (Shevrin, 2003, p. 243).

"It suddenly hit me that everybody in the world knows that when you talk to people, you talk face-to-face – except psychoanalysts. … So we decided to get rid of the couches. (Cummings by Yalom, 2009).

Abstract

The couch has been the default position for patients in virtually all psychoanalytic treatments for more than 100 years, despite the development of a diversity of analytic theories and practices. It is hypothesized that this unexamined, routine use of the couch is a function of each analyst's identification with his/her own analyst's use of the couch and experience with it; its iconic representation of analytic identity; its numerous defensive functions for the analyst; and the impression that it facilitates the free association assumed to be central in analytic treatment. Alternatively, choosing a position for the patient should consider the analyst's theory and the patient's diagnosis and characteristics in the light of the unique attributes

of the specific dyad. The decision, made mutually by patient and analyst, requires of the analyst the same thoughtful, empathic considerations as all other clinical judgments.

Introduction

Psychoanalysis has undergone many changes over the last 100 years, with increasing momentum in the last 30 years. The couch, however, continues to hold its unexamined place in psychoanalytic treatment largely in the same routine, automatic fashion as it did over a century ago. Goldberger (1995a) writes that "Use of the couch in psychoanalysis is almost universal because of its many advantages" (p. 23). The official position of the American Psychoanalytic Association, enshrined in the Association's Standards, is that "The candidate learns to use the free associative method with a patient lying on the couch" (p. 14). The New York Freudian Society and Institute also require use of the couch for analytic treatment. For American psychoanalysis the couch is the default position for analytic treatment: "no couch, no analysis" (Kelman, 1954, p. 65). The couch is an icon (Friedberg and Linn), an intrinsic element of the psychoanalyst's identity, and, at the same time, the aspect of psychoanalysis that is most ridiculed (Robertiello, 1967).

In addition to the widespread use of the couch by "traditional" analysts, the data from a pilot questionnaire study of recent analytic graduates of the William Alanson White Psychoanalytic Institute (WAW), an interpersonal institute, indicate that the couch is also used widely by

interpersonal analysts. Seventy-seven per cent of the recent graduate respondents had used the couch either all the time or frequently throughout their own training analysis. Additionally, J.S. has observed that current WAW candidates routinely advise the patients to use the couch when converting clinic psychotherapy patients to analysis. This reflects a striking institutional transformation since, at its onset, the use of the couch was eschewed at WAW. A congruent institutional transformation has taken place at the Columbia University Psychoanalytic Center for Training and Research which was established in 1944 by Rado, then a psychoanalytic radical who rejected libido theory (Rado, 1969). Currently, this Center has become a traditional, even conservative group within APsaA.

A 2009 Dutch meta-analysis study of the effectiveness of psychoanalytic therapy in 1431 patients (de Maat, de Jonghe, F., Schovers, R. and Dekker, J.) defined psychoanalysis simply by external criteria: “the patient lies on a couch, and there are at least three sessions a week” (p. 2). Thousands of analysts world-wide automatically place their analytic patients on the couch, and assert their treatment is effective. That’s intimidating if there is an attempt to consider an alternative conception. Does this reflect the accumulation of the independent experiences of many analysts that the couch enables optimum treatment, or does it reflect acceptance of the

'received wisdom' to which all have been exposed? To highlight the role of 'received wisdom' and to put that question in context, lets turn the clock back 50 years to examine analytic attitudes toward homosexuality 50 or more years ago, before acceptance of the newer conception of homosexuality. The titles of 44 listings of homosexuality prior to 1960 uniformly categorized homosexuality as a form of abnormality or psychopathology. Homosexuals had been reported to be 'cured' by electroshock treatment (Eissler, 1942). This uniform view of homosexuality as psychopathological may well have been a product of the accumulated 'received wisdom' of that day.

That example suggests that we should not dismiss the possibility that in another 25 or 50 years from now analysts may have reconsidered using the couch as the default position for analytic treatment having concluded that today's approach, similarly, may have reflected the transmission of 'received wisdom'. Stern (1978) notes, "Because identification is one of the earliest and strongest learning mechanisms, it often persists in the face of reason and even opposition. This may help explain why the use of the couch is carried on without too much examination of the process" (p. 69).

This focus on the couch is not meant to imply any question about the importance of the patient-analyst relationship in the therapeutic effectiveness of treatment.

A Brief Annotated History of the Couch

Here is a brief report of the first recorded 'psychoanalytic' treatment:

Therapist: Come, lie down here.

Patient: What for?

Therapist: Ponder awhile over matters that interest you.

Patient: Oh, I pray not there.

Therapist: Come, on the couch.

Patient: What a cruel fate.

Therapist: Ponder and examine closely, gather your thoughts together, let your mind turn to every side of things. If you meet with difficulty, spring quickly to some other idea: keep away from sleep.

The "analysis" goes on until the patient, under the therapist's urgings and interpretations, eventually thinks of controlling the waxing and waning of the moon so that the months will cease and his monthly bills never come due.

Any idea who the therapist is? The treatment took place about 433 B.C. at the Dionysium, an open air theater nestled against the southeast slope

of the Athenian Acropolis. The ‘therapist’ was Socrates and the ‘patient’ was a Greek farmer. This description in Aristophanes play, “The Clouds”, (found in Stern, 1978, p. 59, quoted from Alexander and Selesnick, 1966, p. xiii), seems remarkably contemporary.

Much later, Freud initiated modern psychoanalysis. Unable to continue his scientific studies in prestigious academia because he was a Jew, he reluctantly went into medical practice to earn a living. He had admired the scientific achievements and world-wide fame of Darwin, who had “discovered” evolution, and of Koch who had discovered the cause of tuberculosis. Influenced by the fame and power of science, despite his isolation from academia, he conceived of a scientific goal, discovering the cause of mental illness using a scientific approach (Schachter, 2002). As he told his American analysand, anthropologist/analyst Abram Kardiner, in 1918, he [Freud] was interested in theory, not in therapy (Kardiner, 1977).

Freud’s focus on psychoanalysis as a scientific enterprise aimed at discovering the cause of mental illness required that the analyst strive to be a scientific-like observer, objectively analyzing the patient’s thoughts. Rules defined all treatments, including the patient’s use of the couch. Throughout his life he remained concerned that suggestions by the analyst might be seen as playing a role in analytic treatment, contaminating its scientific

observations, and likening it to hypnosis. He attempted to protect psychoanalysis from derogation by his colleague Viennese psychiatrists who regarded hypnosis as not only fraudulent, but possibly dangerous (Stern, 1978).

Freud first suggested that analytic patients lie on a couch, *not* to enhance the patient's treatment, but because "I cannot put up with being stared at by other people for eight hour a day (or more)." (1913, p. 134). Jones, for one, found Freud's explanation of this odd statement unconvincing (Gedo & Pollock, 1967). Freud apparently felt a need for protection – from what? If the patient's inspection of the analyst is hostile, there would of course be a strain involved in face-to-face therapy (Roazen, 1975; Moraitis, 1995).

A clue to a further hypothesis of why Freud needed protection from patients may be the subsequent history of Freud's intolerance of disagreement or dissent by his colleagues. He summarily ejected Rank, Adler, Jung and others from his circle when their views diverged from his. Today, without diminishing his stature or contributions, we regard him as an authoritarian and patriarchal man (Bergman, 1997). When Jung reportedly offered to analyze him, to help him with some of his neurotic symptoms, he refused, saying it would undermine his authority. We may well conclude that

Freud found disagreements and criticisms from patients equally disturbing - Dora being an example - and sought protection from them by placing them supine on the couch.

Lying on a couch creates a mood of acquiescence and submissiveness (Byerly, 1992; quoted by A. Frank, 1995) which may inhibit direct critical, hostility and anger in some patients. Freud reports that the "Rat Man", when angry, got up from the sofa and roamed about the room. Kelman (1954) observed that "An arrogant-vindictive patient frightens them [analysts]. They want him [patient] on the couch as soon as possible" (p. 75). Lichtenberg (1995) gives an example from his practice; a woman patient got off the couch, faced him and demanded emphatically an answer to her question whether she should be in analysis. Lichtenberg adds, "In ordinary life, adversarial antagonism and controversy is best conducted face-to-face or nose-to-nose. The current vernacular phrase "in your face" refers to this preference" (p. 286). Minimizing patients' expression of anger may have been part of a less-than-conscious reason Freud suggested his analytic patients lie supine on a couch.

Does The Couch Inhibit Candidate Disagreement in Training Analysis?

Does the couch play a similarly inhibitory role in the candidate's relationship to the training analyst? Bernfeld (1962) opioned that the

inventors of our training system had hoped that the training analysis would be a barrier against heterodoxy; would squelch a candidate's questions, disagreements and criticisms. Other inhibitory factors in the training analysis, certainly more discussed than the supine position, are the candidate's transferences, identifications and idealizations of the training analyst. The latter (Waugamen, 1995) may lead to uncritical acceptance of the training analyst's theory, as well as the training analyst's technique of practice. Young graduate analysts tend to practice exactly as their training analyst had with them (Moser, 1977; Cooper, 1985).

The glacial rate of change of analytic theories and practices as generation after generation of analysts spent increasing numbers of years in supine training analyses in the last century, suggests that the training analysis is relatively successful in blocking heterodoxy (Balint, 1948; Brazil, 1975; Casement, 2007; Cooper, in press; Engel, 1968; Kernberg, 1986, 2006, 2007; Kirsner, 2000, 2009; Lothane, 2007; Reeder, 2004). The candidate's supine position may have been one small factor that contributed to limiting candidates' questions and criticisms. The few individual analytic innovators who resisted conformity compared to the thousands who adopted traditional theory and practice is consistent with its effectiveness. Those few analysts who abandoned the use of the couch, in part as an expression of

non-conformity, include Alfred Adler, Harry Stack Sullivan, Erich Fromm, Frieda Fromm-Reichmann and Clara Thompson (Stern, 1978).

The Couch as a Facilitator of Analytic Treatment

Even though self-protection may have been the original reason that Freud used the couch, it may have had fortuitous consequences, namely facilitating free association, described by Kris (1982) as essential to psychoanalytic process, and by Rosegrant (2005) as intrinsically therapeutic. In practice, use of the couch is almost always associated with high frequency of sessions, so it is not possible to determine which factor may be responsible if free association seems enhanced. Further, there is no evidence that free association is related either to the person's functioning in his daily life (Bordin, 1966) or to therapeutic gain in treatment.

Many analysts consider that without undue interference by the analyst, free association expresses the various components of the conflicts that led the patient to treatment and is key to understanding and interpretation (Greenson, 1959; Arlow, 1987; Frank, 1995; Busch, 1997). Levenson, (2003) the interpersonal analyst, maintains that free association is the primary instrument of analytic praxis; that it allows more play of the imagination, more creative collaboration and more unconscious and intuitive

leaps than did the early interpersonalists' meticulous attention to real experience.

On the other hand, Thomä and Kächele (1994) are not alone in pointing out that free association, like everything else, can be used as a resistance. Clara Thompson was more emphatic; she gave up free association, not because she didn't believe in it, but because patients couldn't do it – "they just nattered on" (Levenson, 2003, p. 247).

The patient lying on the couch doesn't see the analyst, and, if the analyst's verbalizations are limited, the analyst may become an unseen, idealized presence behind a veil of relative silence, who, like the Wizard of Oz, may be thought capable of and the source of the wished for cure. The magic of hope may energize regenerative efforts in some, while others may wait passively for the analyst's cure.

The couch may also be experienced by the patient as relaxing and soothing and as a 'holding environment' representing a distinctive experience of warmth and wholeness, like an infant being held in mother's arms (Nachmani, 2009), which may be restitutive for some, especially for a fragmented patient who may then be enabled to try, in Winnicott's terms, to "use the object," to engage in a relationship with the analyst. However, the

contrary is also possible; the patient may so enjoy the soothing comfort of the couch as to be unable or unmotivated to try to "use the object".

Some analysts have suggested that when working with relatively healthy patients, such as analytic candidates, that face-to-face dialogues may be more likely to deal with superficial aspects of their current reality, and that use of the couch may expose deeper feelings and fantasies (Klann, 1979). For both patient and analyst, loss of visualization tends to heighten the auditory sensitivity of both.

A Patient's Reluctance to Lie on the Couch

The patient's use of the couch as the default position signifies for many that the treatment is psychoanalytic. Brenner (1976) believed that "Analysis is not possible if a patient does not use the couch … (p. 182). Brenner adds that since the analyst advises that use of the couch is advantageous, "it follows that avoidance of the couch must be a symptom of psychic conflict" (p.184). This conception is reflected in the report that one of the reasons an analytic candidate's graduation paper was refused was that the patient sat up (Aruffo, 1995).

With the couch as the default position for analytic treatment, the patient's unwillingness to use the couch is ipso facto uncooperativeness, and is interpreted in the analysis by the pejorative term "resistance". This

characterization loses the richness of discovery of those feelings and motives for not using the couch which are unrelated to being uncooperative (Goldberger, 1995a; Jacobsen, 1995). Pressuring a patient to use the couch (Kulish, 1996, Cabaniss & Graver, 2008) is less desirable than trying "to accept, understand, and explain its necessity in terms of the psychological dangers being mobilized by the analytic process" (Kohut, 1984, p. 427, quoted by Richards, 1994, p. 150). A candidate's possible concern about criticism by mentors if the patient does not lie on the couch or leaves treatment with possible loss of 'credit' towards graduation might well interfere with a candidate's flexible use of empathy.

Risks Associated with the Use of the Couch

Wolf (1995) and Aruffo (1995) emphasize that the couch facilitates regression, heightening the patient's inner life in a desirable way. The regression, however, may be intensified if the analyst fails to provide necessary auditory feedback. Gill (1984) wrote that "the very idea that an earlier state can be reinstated as such is an illusion" (p. 170), and Inderbitzin and Levy (2000) concur: "The belief that regression is the sine qua non of psychoanalysis, and that it is the analyst's task to promote it in order to reach or revive the infantile neurosis is a fundamental misconception …" (p. 208); they favor abandoning the concept of regression. The literature is replete

with misgivings and/or warnings regarding the promotion of regression in analysis (Gill, 1984; Lipton, 1977; Palombo, 1978; Reiser, 1990; Renik, 1995, 1998; Stone, 1961).

Haak (1955) has cited three patients on the couch who became chaotic and were about to lose control completely. Inderbitzin and Levy also cited an example, and Gill (1954) observed that "The instances of rather sudden onset of psychosis shortly after beginning psychoanalysis are to be attributed to the regressive pressure of the technique *per se* in a precariously balanced personality." (p. 780). I (J.S.) witnessed such a dramatic decompensation with a carefully evaluated young married woman assigned to me for analysis early in my training. After several face-to-face history taking sessions we began her analytic work on the couch. Within a few sessions her associations loosened and shortly afterwards she became psychotic and was admitted to a psychiatric hospital; a destructive experience for her and a devastating one for J.S. Fortunately, psychotic decompensation on the couch seems a relatively rare occurrence.

Some analysts maintain that such decompensation may be a necessary route to a higher level of adaptation (Romm, 1957; Wallerstein, 1967; Bromberg, 1991; Inderbitzin and Levy, 2000).

Undesirable Effects of the Patient Using the Couch

The patient on the couch inevitably diminishes patient-analyst visual interaction. Levenson (2003) reverses the usual conception of therapeutic action when he asserts the importance of vision: "the detailed inquiry, particularly the deconstructed detailed inquiry, is really *visual,* not, as one might reasonably expect, verbal, and that, indeed, the entire psychoanalytic practice takes place in a visual-spatial modality" (p.233). Reis (2004), too, attempts to re-integrate the subject of vision into psychoanalysis, arguing from the preverbal primacy of the infant-mother's visual interactions. Lieberman (2000), similarly, asserts "It is time for the therapeutic lens to focus on the important but neglected role of vision" (p. 15). Her review of authors attesting to problematic aspects of the loss of visual interaction consequent to using the couch include Goldberger (1995b) who emphasizes that the couch may serve as a distancing device, enabling the patient to avoid shameful topics, and to avoid a fear of looking at the analyst. Lichtenberg (1995) believes that the analyst, if unable to see the patient, may miss visual affective expressions. Bucci (1997) describes that the patient's sub-symbolic processing is often expressed first in gestures or facial expression and only later is elaborated verbally. Haglund (1996) believes that facilitation of the therapist's affective tuning is enhanced in face-to-face talking. Finally,

Fenichel (1953) has observed that lying on the couch may permit the patient to isolate his treatment from his external life.

One proposed presumably positive function of the lack of visual contact is the clarification of transference responses by preventing the patient from monitoring the analyst's reactions. Gedo (1996), however, describes the obverse, that when the patient can't see the analyst, the visual feedback of the analyst's gestures and facial expressions are lost. Further, Couch (1999) believes that it is beneficial to the understanding of transference if the outer manifestations of the real relationship are much clearer when the patient is not on the couch, and the genuine and appropriate feelings of the patient and the analyst toward each other as real persons are experienced. Inability of the patient to see the analyst may foster the idealization of the analyst, which may be a particular problem in training analyses. Thomä and Kächele (1994) insist that an authentic sense of relatedness is the necessary experiential background without which transference is not perceivable, let alone alterable. Bromberg (2002) concurs that the analyst's existence as a real person is a *necessary* factor in the analysis of transference.

Some analysts believe that some unique real aspects of the analyst's personality with which the patient may identify are considered to play a

therapeutic role (Dos Santos et al., 2006). Since identification with qualities of caretakers contribute to growth throughout life, we assume this functions in analytic treatment as well. Blatt and Luyten (in press) are more specific about the parallel; the patient's development in the psychotherapeutic process is similar in fundamental ways to the processes of normal psychological development. The patient's inability to observe the analyst visually may, by limiting interactions, restrict opportunities for growthful identification with the analyst. Levenson, too, appears to recognize the importance of identification in treatment when he refers to "assuming the mantles of our fathers and simultaneously disowning them. Surely that sounds familiar" (p. 282). Mutative transactions in analytic treatment are associated with the formation of internal object representations of the 'other', as well as incorporation of characteristics of the therapist as integral aspects of the self (Diamond, Kaslow, Coonerty & Blatt, 1990; Gruen & Blatt, 1990; Blatt, Stayner, Auerbach & Behrends, 1996; Geller, 2005; Harpaz, Rotem & Blatt, 1905).

The Couch as Defense for the Analyst

The hypothesized defensive use of the couch by Freud touches one of many possible aspects of analysts' defensive use of the couch. Wolf (1995) agrees with Freud that it is easier and more "comfortable" for an analyst to

work unobserved with a patient supine in analysis than to work with a patient in face-to-face psychotherapy. To the degree that the couch predisposes the patient toward passivity with associated feelings of inferiority, we may infer that the analyst enjoys the relative superiority, authority and power of his /her position (G. Adler, 1967). Reluctance of some analysts to retire may involve the relinquishing of these attributes. Jackson and Haley (1963) criticize the analytic setting, including the use of the couch, because it predisposes the patient toward regression and the sick role, in contrast to the analyst's health.

Goldberger herself concluded that if an analyst feels compelled to focus on a particular symptom, such as not using the couch, it is likely to reflect the analyst's need for the patient to use the couch. However, she does not distinguish the candidate's internal needs from those engendered by the candidate's reality needs in training.

Greenson (1967) earlier observed that many analysts are uncomfortable with contact with patients in a face-to-face situation such as during initial interviews. J.S.'s observations confirm that often when the analyst meets his/her patient outside the analytic office, whether in the hallway, or street in the outside world or at a social gathering, the analyst appears ill at ease without the protection of the couch.

Empirical Studies of the Couch

Wilson, in a dialogue with Stern, commented that it was his impression that the quantity and quality of the patients' associations remained the same whether the patient was sitting or lying down (Stern & Wilson, 1974). Free association was measured in a variety of non-patient, student populations, comparing the couch to the chair. Berdak and Bakan (1967) found that lying down was more conducive to the recall of early memories than sitting in a chair; Kroth and Forrest (1969) reported that those lying on a couch had higher free association scores, with low anxiety subjects having the highest free association scores; Kroth (1970) also reported higher free association scores in the supine position, although no difference in affectivity was noted with position; Heckmann et al., (1987) found no difference in free association as a function of position.

There have been two empirical studies of analytic patients. Hall and Closson (1964) recruited two different groups of 13 experienced psychotherapists, many of whom were psychoanalysts, as judges; they were unable to select in which of four sessions a male patient in the ninth month of treatment on the couch was changed to the chair, and the second group of judges was unable to identify random sessions as being either couch or chair sessions. The authors noted it could well be held that there was, in fact, no

actual difference in the therapeutic process when this patient changed position.

Lable et al. (2009) reported that the shift from sitting to the couch promoted increased focus to early memories and interpersonal relationships in one of two analytic patients, but not in the other. They compared the Psychotherapy Process Q-Set scores of each patient in each position with scores of a prototype analytic session. There were no differences in how close each patient's scores were to the prototype as a function of the patient's position. Thus, there were no differences in analytic process as a function of position. Taken together, these inconsistent findings suggest that the position of the patient may change the mental content but not the affectivity in some dyads but have no impact in others. Thus, there is no evidence that position influences analytic process or therapeutic outcome. Jones (2002) concluded, based upon other empirical studies, that the subjective meaning of observable processes, including use of the couch, will vary across patient-therapist dyads.

In summary, we concur with Friedberg and Linn, who reviewed more than 400 papers on the use of the couch, that there is no empirical evidence that the use of the couch enhances the therapeutic benefit of analytic treatment. That does not mean that the couch does *not* influence therapeutic

outcome, only that we don't know if it does influence therapeutic outcome. Further, since an empirical test would be difficult to conduct, there is unlikely to be any empirical evidence any time soon.

Analytic Theory and the Choice of Position

The choice of couch or chair for the patient should be considered in the context of the analyst's theories of the mutative elements in treatment which differ markedly in, e.g., traditional compared to interpersonal/relational analysts. We use the example of a theory, the Boston Change Group Theory (2005) to illustrate how a theory might influence the choice of position for the patient. The Change Group theory is derived from the results of empirical, pre-verbal developmental studies of infant-caretaker interaction. Infants interact with caregivers on the basis of a mass of procedural knowledge (implicit and outside focal attention and conscious verbal experience) lying organized in a domain of 'implicit relational knowing'. Events in the intersubjective relationship of infant and caretaker or of patient and therapist impact and rearrange *implicit relational knowing* for both. An event, or 'moment of meeting' is the basic unit of subjective change in the domain of *implicit relational knowing.'* The concept that new contexts lead to new assemblies of a system's constitutive elements is a tenet of general systems theory. "At the moment when the dyadic system is

created, both partners experience an expansion of their own state of consciousness (brain organization)" (Tronic, 2007, p. 408).

As an example of a 'moment of meeting': "imagine a young child visiting a new playground with his father. The child rushes over to the slide and climbs the ladder. As he gets near the top, he feels a little anxious about the height and the limits of his newly emerging skill. In a smoothly functioning dyadic system, he will look to his father as a guide to help him regulate his affective state. His father responds with a warm smile and a nod, perhaps moving a little closer to the child. The child goes up and over the top, gaining a new sense of mastery and fun." (Stern et al., 1998, p. 909). In this example, the father's non-verbal support constitutes a 'moment of meeting' that changed both father and child.

In a 'now moment' patient and analyst experience each other as authentic individuals, outside their professionally prescribed roles. An 'authentic' meeting reveals a personal aspect of the self that has been evoked in this affective response to another. "Change takes place in the implicit relationship at 'moments of meeting' through alterations in 'ways of being with'" (Stern et al., 1998, p. 918).

Parenthetically, in relation to the efficacy of supportive interventions, Schachter and Kächele (2007) have argued that Freud proposed analytic

neutrality to protect the scientific nature of psychoanalysis, and suggest that having the analyst provide the patient with support, (as the father did), as well as encouragement and consolation, all of which healers have utilized for thousands of years, could augment the therapeutic benefit of analytic treatment. Winnicott (1958) had described how an available mother's capacity to provide her infant with gratifying experiences fostered the infant's development of the ability to recognize an external object. Bush (in prep.) confirmed this hypothesis about support when the results of his questionnaire study of analyst's own training analyses indicate that the training analysts' supportive interventions with the candidates were significantly correlated with Overall Satisfaction with the training analysis. In addition, Wallerstein's (1986) finding in the classical Menninger study that the therapeutic effects of the analysts' supportive interventions were as wide ranging and long lasting as the effects of the analysts' interpretive interventions. Freud himself was explicitly supportive and encouraging in his impressively beneficial treatment of the "Rat Man" in 1907 as well as in the treatment of a young woman in 1936. Brenner (1982) warns that support and the analyst's warmth, like all interactive expressions, can be used defensively.

If the analyst senses the patient is seeking the analyst's support, the analyst has several options including directly providing the support, or, examining Levenson's evocative aphorism, "What's going on around here?" (Levenson, 1983, p. ix), what's making the patient feel a need for the analyst's support ?; or, directly provide the support and then explore.

We would suggest that an analyst using the Boston Change Group should consider having an analytic patient sit in a chair so patient and analyst would be face-to-face in order to optimize the perception both of patient and of analyst of the authentic, real qualities of the other, and to minimize the professional role characteristics of patient and analyst.

Personality and Diagnosis in the Choice of a Position

When initiating treatment, in deciding which position to consider not only theory but the patient's personality and diagnosis need to be evaluated. Blatt (2004) summarizes his research on two types of personality configurations: anaclitic for a personality focused predominantly on interpersonal relatedness and introjective which distinguishes a personality organization primarily concerned with self-definition. Anaclitic psychopathology is characterized by distorted and exaggerated attempts to maintain satisfying interpersonal relationships; introjective psychopathology attempts to establish an effective sense of self, often involving issues of

anger, aggression, separation, control and independence (Blatt, 2008). Anaclitic patients in the Menninger Psychotherapy Research Project had greater therapeutic gain in Supportive Expressive Psychotherapy than in Psychoanalysis; the reverse was true for introjective patients (Blatt, 1992; Blatt and Shahar, 2004).

These observations suggest that patients in whom anaclitic psychopathology predominates might initially relate better to the analyst when sitting in a chair, face-to-face. Conversely, patients in whom introjective psychopathology predominates might feel more comfortable starting treatment using the couch at a greater psychological distance from the analyst and feeling enhanced independence and control, although many patients have mixtures of both attributes.

Beyond personality types and dynamics we also examine the difficult subject of diagnosis in considering a position for the patient. One common diagnosis, borderline personality disorder (BPD) can be used to illustrate how diagnosis may influence the selection of position for the patient. Koenigsberg et al. (2000) describe primitive defenses and identity diffusion as distinguishing individuals with borderline organization from those with neurotic personality organization. Kernberg (1991) emphasizes the chaotic internalized representations of part objects in BPD, although Abend, Porter

and Willick's (1983) earlier work did not correspond to Kernberg's characterization; Adler (1988) stressed that BPD patients exhibit aloneness, a need-fear dilemma and primitive guilt as central attributes. Mentzos (2002) described the inconstancy of borderline patients, alternating between self-directedness and object-directedness (cycling between the two characterizations of personality by Blatt and associates). The study group around Kernberg (Koenigsberg et al., 2000) have enlarged the concept of Borderline Personality Organization to encompass narcissistic, histrionic, antisocial, paranoid and schizoid personality disorders, in addition to BPD.

Chessick (1971) describes using the couch in twice weekly psychotherapy with 14 borderline patients; four of whom became much worse and had to sit up, while six improved and two showed no change. He concluded that it was not the use of the couch that was important, but the psychotherapist. Robbins (1996) believes that the couch deprives borderline patients of self-organizing visual feedback and therefore is undesirable. Despite Koenigsberg et al.'s (2000) belief that borderline patients rarely show an initial positive alliance, which we speculate might be enhanced by initial face-to-face work, they and others prefer to treat less disturbed borderline patients by transference-focused psychoanalytic treatment on the couch. Face-to-face psychoanalytic psychotherapy is recommended for more

severely disturbed borderline patients, though the distinction between the more severely disturbed and the less seriously disturbed is not delineated clearly. Our suggestion is that in all treatments of BPD, both patient and therapist initially acknowledge that selection of a position is likely to fluctuate frequently as treatment progresses.

Discussion

The thesis of this paper, that consideration of the chair or the couch for the patient requires flexibility, was delineated in great detail fifty-five years ago (Kelman, 1954). The notion that the couch is the default position for all analytic patients is a residue of Freud's earlier rules of treatment, which were designed to protect Freud and to safeguard the scientific status of psychoanalysis, not to enhance therapeutic benefit for the patient. We have no way to predict whether the couch or the chair will evoke a particular state of mind or feeling state in a patient. (Gill, 1984; Celenza, 2005). Casement (1991) rejects the notion of a default position, asserting that "Unlike many analysts I do question whether the couch is necessarily 'the best or only way to listen to or to help patients' (p. 740).

The default selection of the couch for analytic treatment has persisted, virtually unexamined, for more than 100 years, probably for a confluence of factors: each analyst's identification with his/her own training analyst's use

of the couch; its iconic representation of identification as a psychoanalyst; its numerous defensive functions for the analyst; and the impression that it enhances treatment by facilitating free association. The therapeutic value of regression induced by lying on the couch is controversial. Although the couch may influence the mental content of free association for some patients, no empirical study has examined whether the couch enhances the *therapeutic outcome* of treatment.

Recognizing that the start of treatment is so critical (31% of training cases dropped out of analysis in the first six months, Hamilton, Wininger, MacCornac and Roose, 2007) and is to some degree predictive of outcome (Luborsky, 1996; Barber, 2009) patient and analyst together might discuss which position seems more likely to help attain the initial goals of patient and analyst getting to know each other, developing mutual trust, and thinking of how to work together on some of the patient's concerns in the light of the analyst's approach to those problems, and then reach a mutual decision. Changing conditions of treatment and relationship, would then open the possibilities of useful experiments with a change in position.

Further, we think that the dichotomous distinction between psychoanalysis which uses the couch and psychoanalytic psychotherapy which uses the chair is not tenable. Although Wallerstein (1991) initially

argued that it is useful to distinguish psychoanalysis from psychoanalytic psychotherapy, he later 1997) acknowledged that the distinctions between the two modalities are "both much more ambiguous in both theory and practice" (p. 253). We believe, although it remains controversial, in agreement with Winnicott, 1958; Gill, 1984a; Fosshage, 1997; and S. Cooper (In Press) that attempting to distinguish between psychoanalysis and psychoanalytic psychotherapy is futile.

However, in attempting to define psychoanalytic treatment an unresolved epistemological problem confronts us; there is no consensually-agreed definition of psychoanalytic process. Unfortunately, psychoanalysis is a field lacking clear boundaries. We can say what it is not; we cannot say what it is. Although not reflecting consensual agreement, we propose that a suggestion by Gill (1984a) and Fosshage (1997) is useful, that any treatment that focuses on the analysis of "transference" constitutes psychoanalytic treatment. The term "transference" does not refer to, as it is often used loosely, all patient-analyst interaction, but rather specifically to Gill's concept of "transference" as "stereotyped rigidity" (Gill, 1984b, p. 513). Of course, what constitutes "stereotyped rigidity," a function of pathological introjects or templates, involves a subjective clinical judgment, such as analysts regularly make in treatment, and raises the question of whether the

patient's judgment or the analyst's judgment shall be privileged. This definition should take into consideration Gill's observation that often there are elements of plausibility in the patient's responses to the analyst.

Conclusion

The routine, automatic use of the couch should neither be suggested to every patient at the outset of analytic treatment nor taught and required in psychoanalytic education.

The selection of a position should be made mutually on the basis of discussion between patient and analyst.

Consideration, initially, of using either the couch or the chair involves a significant clinical judgment by the analyst requiring careful, thoughtful, empathic evaluation of the unique attributes of the specific dyad.

Exploring the use of each position, both with the same patient and with different patients, should provide the analyst with experiences with the process of selecting a position with different kinds of patients.

References

Abend, S.M., Porder, M.S. & Willick, M.A. (1983). *Borderline Patients: Psychoanalytic Perspectives,* New York: International University Press.

Adler, G. (1988). How useful is the borderline concept? In Alexander, F. & Selesnick, S. (1966). *The History of Psychiatry.* New York: Harper & Row.

American Psychoanalytic Association Principles and Standards for Education in Psychoanalysis. Approved by the Board on Professional Standards of the American Psychoanalytic Association December 15, 1999. Revised June 19, 2008, p. 14.

Arlow, J.A. (1987). The dynamics of interpretation. *Psychoanalytic Quarterly,* 56: 68-87.

Aruffo, R.N. (1995). The couch: Reflections from an interactional view of analysis. *Psychoanalytic Inquiry,* 15: 369-385.

Balint, M. (1948). On the psychoanalytic training system. *International Journal of Psychoanalysis,* 29: 163-173.

Barber, J.P. (2009). Toward a working through of some core conflicts in psychotherapy research. *Psychotherapy Research,* 19: 1-12.

Bernfeld, S. (1962). On psychoanalytic training. *Psychoanalytic Quarterly,* 31: 453-482.

Blatt, S.J. (1992). The differential effect of psychotherapy and psychoanalysis on anaclitic and introjective patients: The Menninger Psychotherapy Research Project revisited. *Journal of the American Psychoanalytic Association,* 40: 691-724.

Blatt, S.J. (2004). *Experiences of Depression: Theoretical, Clinical and Research Perspectives.* Washington, DC: American Psychological Association.

Blatt, S.J. (2008). *Polarities of Experience: Relatedness and Self-Definition in Personality Development, Psychopathology, and the Therapeutic Process*. Washington, DC: American Psychological Association.

Blatt, S.J & Luyten, P. (in press). *Contemporary Directions in Psychopathology: Toward DSM-V*, ICD-11*, and Beyond*. Eds. T. Millon, R. Krueger & E. Simonson, New York: Guilford.

Blatt, S.J. & Shahar . (2004). Psychoanalysis: For what, with whom and how: A comparison with psychotherapy. *Journal of the American Psychoanalytic Association,* 52: 393-447.

Blatt, S.J., Stayner, D., Auerbach, J. & Behrends, R.S. (1996). Change in object and self representations in long-term, intensive, inpatient treatment of seriously disturbed adolescents and young adults, *Psychiatry: Interpersonal and Biological Processes,* 59: 82-107.

Bordin, E.S. (1966). Free association: an experimental analogue of the psychoanalytic situation. In L.A. Gottschalk & A.H. Auerbach, Eds. *Methods of Research in Psychotherapy,* New York: Appleton-Century-

Cooper, S. (In Press). *A Disturbance in the Field: Essays in Transference and Countertransference,* London: Routledge.

CROFTS, PP. 189-208.

Boston Process Change Study Group (BPCSG) (2005). The "something more" than interpretation revisited: sloppiness and co-creativity in the psychoanalytic encounter. *Journal of the American Psychoanalytic Association,* 53: 693-729.

Brazil, H.V. (1975). The dilemma of training analysis. *Contemporary Psychoanalysis,* 11:243-245.

Brenner, C. (1982). *The Mind in Conflict,* New York: International University Press.

Bromberg, P.M. (1991). On knowing one's patient inside out: The aesthetics of unconscious communication. *Psychoanalytic Dialogues,* 1: 399-422.

Bromberg, P.M. (2002). "Speak to me as to thy thinkings" Commentary on "Interpersonal Psychoanalysis' radical façade" by Irwin Hirsch. *Journal of the American Academy of Psychoanalysis,* 30: 605-620.

Broucek, F. (1991). *Shame and the Self.* New York: Guilford.

Bucci, W. (1997). Discourse in good and troubled hours. *Journal of the American Psychoanalytic Association,* 45:155-187.

Busch, F. (1997). Understanding the patient's use of the method of free association: An ego psychological approach. *Journal of the American Psychoanalytic Association,* 45: 407-423.

Bush, M. (in prep.) The effectiveness of psychoanalysis among analysts.

Byerly, L. (1992). Unresolved separation-individuation, masochism and difficulty with compliance. In. *When the body speaks.* In. ed, S. Kramer & S. Akhtar. Northvale, NJ: Aronson, pp. 113-130.

Casement, P. (1991). Psychoanalysis and the couch. *Lancet,* 337: 740.

Casement, P. (2007). Some problems with training analysis. International Psychoanalytical Association, IPA eNewsletter, July.

Celenza, A. (2005). Vis-à-vis the couch: Where is psychoanalysis? *International Journal of Psychoanalysis,* 86: 1645-1659.

Chessick, R.D. (1971). Use of the couch in the psychotherapy of borderline patients. *Archives of General Psychiatry,* 25: 306-313.

Cooper, A.M. (1985). Difficulties in beginning the candidate's first analytic case. *Contemporary Psychoanalysis,* 21: 143-149.

Cooper, A.M. (In press). American psychoanalysis today. A plurality of orthodoxies. *Journal of the American Academy of Psychoanalysis.*

Couch, A.S. (1995). Therapeutic functions of the real relationship in psychoanalysis. *The Psychoanalytic Study of the Child,* 54: 130-168.

Cummings, N. (2009) Interview by V. Yalom. Psychotherapy.Net. February 18.

De Maat, S., de Jonghe, F., Schoevers, R. & Dekker, J. (2009). The effectiveness of long-term psychoanalytic therapy: A systematic review of empirical studies. *Harvard Review of Psychiatry,* 17: 1-23.

Diamond, D., Kaslow, N., Coonerty, S. & Blatt, S.J. (1990). Change in separation-individuation and intersubjectivity in long-term treatment. *Psychoanalytic Psychology,* 7:363-397.

Dos Santos, M.J.P., Nunes, M.L.T. & Ceitlin, L.H.F. (2006). The clinical concept of analytic process: A conceptual investigation. *International Journal of Psychoanalysis,* 87: 403-422.

Eissler, K.R. (1942). Homosexuality and lesbianism treated with metrazol. Preliminary report. N.M. Owensky. *Journal of Nervous and Mental Disease,* 92:65-66, 1940.

Engel, G. (1968). Some obstacles to the development of research in psychoanalysis. *Journal of the American Psychoanalytic Association,* 16: 195-204.

Fenichel, O. (1953). *The Collected Papers of Otto Fenichel, First Series,* eds H.Fenichel, D. Rapaport. New York: Norton.

Fosshage, J.L. (1997). Psychoanalysis and psychoanalytic psychotherapy. Is there a meaningful distinction in the process? *Psychoanalytic Psychology,* 14: 409-425.

Frank, A. (1995). The couch, psychoanalytic process, and psychic change: A case study. Psychoanalytic Inquiry, 15: 324-337.

Freud, S. (1909). Notes upon a case of obsessional neurosis. *Standard Edition,* 10: 153-318.

Freud, S. (1913). On beginning the treatment. (Further recommendations on the technique of psychoanalysis I). *Standard Edition,* 12: 121-144.

Friedberg, A. & Linn, L. The Freudian couch as icon. Unpublished manuscript.

Gedo, J. (1996). *The Language of Psychoanalysis*. Hillsdale, NJ: Analytic Press.

Gedo, J. & Pollock, G. (1967). The question of research in psychoanalytic technique. In. ed. B. Wolman, *Psychoanalytic Techniques,* New York: Basic Books.

Geller, J.D. (2005). Boundaries and internalization in the psychotherapy of psychotherapists. In *Psychotherapists Own Psychotherapy. Patient and Clinician Perspectives*. Oxford, New York: Oxford Ubniversity Press, pp. 379-404.

Gill, M.M. (1954). Psychoanalysis and exploratory psychotherapy. *Journal of the American Psychoanalytic Association,* 2:771-797.

Gill, M.M. (1984a). Psychotherapy and psychoanalysis: A revision. *International Review of Psychoanalysis,* 2: 161-179.

Gill, M.M. (184b). Transference. A change in conception or only in emphasis? *Psychoanalytic Inquiry,* 4: 489-523.

Goldberger, M. (1995a). The couch as defense and as potential for enactment. *Psychoanalytic Quarterly,* 64: 23-42.

Goldberger, M. (1995b). The importance of facial expressions in dreams. *International Journal of Psychoanalysis,* 76: 591-593.

Greenson, R.R. (1959). The classic psychoanalytic approach. In Ed. S. Arieti, *American Handbook of Psychiatry,* New York: Basic Books, pp. 1399-1416.

Gruen, R. & Blatt, S.J. (1990). Change in self and object representation during long-term dynamically oriented treatment. *Psychoanalytic Psychology,* 7: 399-422.

Haak, N. (1955). Comments on the analytical situation. *International Journal of Psychoanalysis,* 38: 183-195.

Haglund, P.E. (1996). A clear and equal gloss: reflections on the metaphor of the mirror. *Psychoanalytic Psychology,* 13:225-245.

Hall, R.A & Closson, W.G. (1964). An experimental study of the couch. *Journal of Nervous and Mental Disease,* 138: 474-480.

Hamilton, M.S., Wininger, L., MacCornac, V., & Roose, S.P. (2007). Drop-out rate of training cases: Who and when. Poster Session, Annual Meeting, American Psychoanalytic Association, January 17.

Harpaz-Rotem, I. & Blatt, S.J. (2005). Changes in representations of a self-designed significant other in long term intensive inpatient treatment of seriously disturbed adolescents and young adults. *Psychiatry: Interpersonal and Biological Processes,* 68: 266-282.

Heckmann, H., Hölzer, M., Kächele, H. & Robben, H. (1987). Resistance and transference are two main constitutants in an "experimental analogue" of free association. In Ed W. Huber. *Progress in Psychotherapy Resaerch.* Louvain-la – Nueve: Presses Universitaire de Louvain, pp. 582-593.

Inderbitzin, L.B. & Levy, S.T. (2000). Regression and psychoanalytic technique. The concretization of a concept. *Psychoanalytic Quarterly*, 69: 195-223.

Jackson, D.D. & Haley, J. (1963). Transference revisited. *Journal of Nervous and Mental Diseases,* 137: 363-371.

Jacobson, J. (1995). The analytic couch: Facilitator or sine qua non? *Psychoanalytic Inquiry,* 15: 304-313.

Jones, E. E. (2002). Interaction and change in psychoanalytic long-term therapy. In Eds. M. Leuzinger-Bohleber & M. Target. *Outcomes of Psychoanalytic Treatment. Perspectives for Therapists and Researchers.* New York: Brunner-Routledge, pp. 280-293.

Kardiner, A. 1977). *My Analysis with Freud: Reminiscences.* New York: Norton.

Kelman, H. (1954). The use of the analytic couch. *American Journal of Psychoanalysis,* 14: 65-82.

Kernberg, O.F. (1986). Institutional problems of psychoanalytic education. *Journal of the American Psychoanalytic Association,* 34: 799-834.

Kernberg, O.F. (1991). Transference regression and psychoanalytic technique with infantile personalities. *International Journal of Psychoanalysis,* 72: 189-200.

Kernberg, O.F. (1999). Psychoanalysis, psychoanalytic psychotherapy and supportive psychotherapy: Contemporary controversy. *International Journal of Psychoanalysis,* 80:1075-1091.

Kernberg, O.F. (2006). The coming changes in psychoanalytic education. Part I. *International Journal of Psychoanalysis,* 87: 1649-1673.

Kernberg, O.F. (2007). The coming changes in psychoanalytic education. Part II. *International Journal of Psychoanalysis,* 88: 183-202.

Kirsner, D. (2000). *Unfree Associations.* London: Process Press.

Kirsner, D. (2009). *Epilogue* 2009. *Unfree Association: Inside Psychoanalytic Institutes.* London: Process Press.

Klann, G. (1979). Die Rolle affektiver Prozesse in der Dialogstruktur, In D. Flader & R. Wodak-Leodolter, Eds. *Therapeutische Kommunication*. Konigstein: Scriptor, pp.117-155.

Koenigsberg, H.W., Kernberg, O.F., Stone, M.H., Applebaum, A.H., Yeomans, F.E. & Diamond, D. (2000). *Borderline Patients. Extending the Limits of Treatability.* New York: Basic Books.

Kohut, H. (19840. *How Does Analysis Cure?* A. Goldberg & P. Stepansky, Eds. Chicago:University of Chicago Press.

Kulish, N. (1996). A phobia on the couch. A clinical study of psychoanalytic process. *Psychoanalytic Quarterly,* 65:465-494.

Lable, I., Kelley, J.M., Ablon, J.S., Levy, R., Waldron, S & Ackerman, J. (2009). The effect of the couch on psychoanalytic process. Poster Session, American Psychoanalytic Association Annual Meeting, Friday, January 16.

Levenson, E. (1983). *The Ambiguity of Change.* New York: Basic Books.

Levenson, E. (2002). And the last shall be first. Some observations on the evolution of interpersonal psychoanalysis. *Contemporary Psychoanalysis,* 38: 277-285.

Levenson, E. (2003). On seeing what is said. Visual aids to the psychoanalytic process. *Contemporary Psychoanalysis,* 39: 233-249.

Lichtenberg, J.D. (1995). Forrty-five years of psychoanalytic experience on, behind and without the couch. In *The Relevance of the Couch in Contemporary Psychoanalysis,* ed. G. Moriatis. Psychoanalytic Inquiry 15:290-293.

Liebermaqn, J.S. (2000). *Body Talk. Looking and Being Looked at in Psychotherapy.* Northvale, NJ: Jason Aronson.

Lipton, S.D. (1977). Clinical observations on resistance to the transference. *International Journal of Psychoanalysis,* 58: 463-472.

Lichtenberg, J.D. (1995). Forty-five years of psychoanalytic experiences on, behind and without the couch. *Psychoanalytic Inquiry,* 15:280-293.

Lothane, Z. (2007). Ethical flaws in training analysis. *Psychoanalytic Psychology,* 27:688-696.

Luborsky, L. 1996). Theories of cure in psychoanalytic psychotherapies and the evidence for them, *Psychoanalytic Inquiry,* 16:257-264.

Mentzos, S. (2002). A clinically oriented psychodynamic classification of borderline states. In *Outcomes of Psychoanalytic Treatment. Perspectives for Therapists and Researchers,* Eds. M. Leuzinger-Bohleber & M. Target. New York: Brunner-Routledge, pp. 92-102.

Moraitis, G. (1995). The couch as a protective shield for the analyst. *Psychoanalytic Inquiry,* 15: 406-412.

Moser, T. (1977). *Years of Apprenticeship on the Couch.* New York: Urizen Books.

Nachmani, G. (2009). Personal communication

Palombo, S.R. (1978). *Dreaming and Memory: A New Information Processing Model.* New York: Basic Books.

Rado, s. (1969). *Adaptational Psychodynamics: Motivation and Control,* eds. J. Jameson and H. Klein. New York: Science House.

Reeder, J. (2004). *Hate and Love in Psychoanalytical Institutions. The Dilemma of a Profession,* New York: Other Press.

Reis, B. (2004). You are requested to close the eyes. *Psychoanalytic Dialogues,* 14: 349-371.

Reiser, M.F. (1990). *Memory in Mind and Brain.* New York: Basic Books.

Renik, O. (1995). The ideal of the anonymous analyst and the problem of self-disclosure. *Psychoanalytic Quarterly,* 64: 466-495.

Renik, O. (1998). Getting real in analysis. *Psychoanalytic Quarterly,* 67: 566-593.

Richards, A. (1994). Extenders, modifiers, heretics. In eds. A.K. Richards & A.D. Richards. *The Spectrum of Psychoanalysis. Essays in Honor of Martin Bergmann,* pp.145-160.

Robertiello, R.C. (1967). The couch. *Psychoanalytic Review,* 54: 69-71.

Romm, M.E. (1957). Transient psychotic episodes during psychoanalysis. *Journal of the American Psychoanalytic Association,* 5: 325-341.

Rosegrant, J. (2005). The therapeutic effects of the free-associative state of consciousness. *Psychoanalytic Quarterly,* 74: 737-766.

Ross, J.M. (1999). Once more onto the couch. *Journal of the American Psychoanalytic Association,* 47: 91-111.

Schachter, J. (2002). *Transference. Shibboleth or Albatross?* Hillsdale, N.J.: Analytic Press.

Schachter, J & Kächele, H. (2007). The analyst's role in healing: Psychoanalysis-Plus. *Psychoanalytic Psychology*, 34: 429-444.

Shevrin, H. (2003). *The Dream Interpreters. A Psychoanalytic Novel in Verse.* Madison, CT.: International Universities Press.

Stern, D.N., Sander, L.W., Nahum, J.P., Harrison, A.M., Lyons-Ruth, K ., Morgan, A.C., Bruschweilerstern, N & Tronick, E.Z. (1998). Non-interpretive mechanisms in psychoanalytic therapy: The 'something more' than interpretation. *International Journal of Psychoanalysis,* 79: 903-921.

Stern, H. (1978). *The Couch. Its Use and Meaning in Psychotherapy.* New York: Human Sciences Press.

Stern, H. & Wilson, B. (1974). Use of the couch in psychoanalysis, a dialogue. (Unpublished paper).

Stone, L. (1961). *The Psychoanalytic Situation.* New York: International University Press.

Thomä, H. & Kächele, H. (1994). *Psychoanalytic Practice* Volume 1 *Principles.* Northvale, NJ: Jason Aronson.

Waugaman, R.M. (1995). The analytic couch as transference object. *Psychoanalytic Inquiry,* 15: 338-357.

Wallerstein, R.S. (1967). Reconstruction and mastery in the transference psychosis. *Journal of the American Psychoanalytic Association,* 15: 551-583.

Wallerstein, R.S. (1991). Psychoanalysis and psychotherapy. *International Journal of Psychoanalysis,* 72: 165-166.

Wallerstein, R.S. (1997). Merton Gill, psychotherapy and psychoanalysis: A personal dialogue. *Journal of the American Psychoanalytic Association,* 45: 230-256.

Winnicott, D.W. (1958). *Collected Papers: Through Paedetrics to Psychoanalysis,* London: Tavistock.

Wolf, E.S. (1995). Brief notes on using the couch. *Psychoanalytic Inquiry,* 15: 314-323.