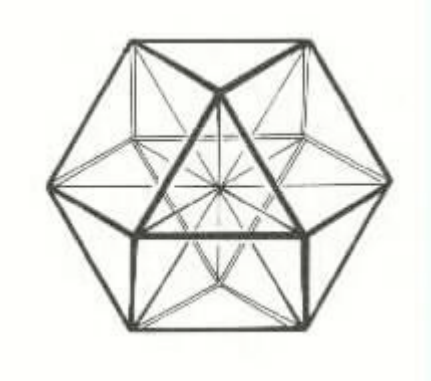
Nodal Points

Critical Issues in Contemporary Psychoanalytic Therapy

Joseph Schachter & Horst Kächele



International Psychoanalytic Books (IPBooks),
30-27 33rd Street, #3R
Astoria, NY 11102
Online at: www.IPBooks.net

E-book formatting by Maureen Cutajar
www.gopublished.com

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How It All Began

Dr. Joseph Schachter was presenting a paper at the meeting of the International Psychoanalytic Association in 2004 in New Orleans when Dr. Helmut Thomä, from the audience, made several responsive comments about the paper that struck Dr. Schachter as especially prescient.

Subsequently, Dr. Schachter returned to his home in New York City, and he, and his psychoanalyst wife, Dr. Judith Schachter invited Dr. Thomä, then in the city for another meeting, to join them for lunch. He agreed and asked if he could also bring his Ulm colleague, Dr. Horst Kächele. The foursome had a stimulating lunch; each found reciprocal and mutual interests which were intellectually engaging.

When Dr.s Thomä and Kächele returned to Germany, they resumed their work on the English translation of volume III of their classic psychoanalytic text, and decided to invite Dr. Joseph Schachter to help them with this translation work. Initially, Dr. Schachter, as asked, focused on revising their English translation, but increasingly became involved in discussions and disagreements about the psychoanalytic content itself. Subsequently Dr. Schachter, on the one hand, and Dr.s Thomä and Kächele on the other then found themselves engaged in long detailed transatlantic discussions that ended in resolution of the differences.

When they concluded their work the first author Dr. Kächele and Dr. Thomä, the senior author, then graciously concluded that Dr. Schachter's contribution had become psychoanalytically significant, and made Dr. Schachter a co-author of volume III of their psychoanalytic textbook "Psychoanalytic Practice. The joint work, titled "From Psychoanalytic Narrative to Empirical Single Case Research. Implications for Psychoanalytic Practice published by Routledge in 2009 became a well appreciated piece of work.

Drs. Schachter and Kächele both appreciated the unique collegial interchanges and the relationship that had evolved during the translation and disagreement period and began to collaborate on writing psychoanalytic papers, the first of which is included in this volume; Schachter, J. & Kächele, H. (2007) The analyst's role in healing; Psychoanalysis-PLUS; 3 Psychoanalytic Psychology 24:429-444. Their productive collaboration has continued to date.

Introduction

Decline in Psychoanalysis

Mounting evidence attests to a decline in psychoanalysis in the Western world. For example the APsaA (American Psychoanalytic Association) analytic practice survey of 2006 demonstrates that the average number of analytic patients per member continues steadily to decline. Follow-up studies of recent analytic graduates at three institutes, Columbia University Center, New York indicate that four out of five analytic graduates devoted almost all their practice to other-than-four-session per week analytic treatment. The number of new candidates continues to decline; several pairs of institutes have merged in the hope of attracting a combined number of new candidates sufficient to start a class.

Serious problems with psychoanalytic education have been identified in Anglo-American and European countries. Psychoanalysis has scant presence in universities or in departments of psychiatry or of psychology; university libraries are subscribing to fewer psychoanalytic journals. Psychiatric texts pay little attention to psychoanalysis. Fewer publishers are printing psychoanalytic books.

We believe that neither public relations, advertising nor outreach community programs can reverse this decline in psychoanalysis. The only effective response will be analytic research programs which by testing the tenets of analytic theory and practice will reestablish respect for the integrity and effectiveness of psychoanalysis in both the general public and in the scientific community.

The Training Environment and the Development of Research

Many years ago Engel (1968) emphasized the necessity for psychoanalysis to develop a strong research cadre within its ranks and, therefore, that the clinical goal and the research goal should be held in equal honor within our training programs. He noted that we have not developed more than a handful of skilled scientists. Candidates with research interest were considered over-intellectualized or even obsessional; a candidate questioning and asking for evidence was seen as resistant. Candidates have little exposure to analytic researchers: "Literally, there is no way in which a young analyst can learn by precept and example and by identification with a researcher how to become a psychoanalytic scientist and carry on research" (p. 199). It is distressing to consider how fitting these statements remain for the present situation.

Despite Engel's clear prescriptions, psychoanalytic education has failed to develop a research orientation in candidates and few candidates or graduates become involved in research projects. Few American institutes teach analytic research or equip their candidates to read and understand research reports. The certification procedure, which is prerequisite for training analyst appointment and presumably assesses analytic competence, now is based on the write-ups of two analytic treatments. Not only is research not included in the certification procedure, but there is no query into whether the candidate can read and critique a research paper.

In agreement with many esteemed colleagues we are convinced that the training analysis system, by its nature, creates obstacles that interfere with the candidate becoming interested in and involved

in analytic research, and therefore, we open this volume on critical issues in contemporary psychoanalytic therapy with a brief discussion of training analysis.

The training analysis is widely considered the most significant part of psychoanalytic education. Of necessity, the training analyst, with whom the candidate will, to some degree identify and emulate, is a clinician, and often a significant power in the institute. Immersed in analysis with a clinician-analyst, dealing with clinical matters in supervision and in didactic courses, and without contact with researchers, the candidate will most likely become identified with clinical values. Because the training analysis, required for graduation, straddles conflicting goals, on one hand, to teach about analysis, and, on the other, to foster personal development

Changes in the Conception of a Psychoanalyst, in Psychoanalytic Leadership and in Psychoanalytic Education

While recognizing that psychoanalysis has failed to develop a scientific tradition (Michels, 2007), we are convinced that empirical research is our most effective response to the current decline in psychoanalysis. In order to develop the necessary research cadre we propose that the conception of a psychoanalyst be changed from that of a competent clinician to someone who encompasses *both* clinical and research expertise, which a few analysts have accomplished. In order to effect such a change, psychoanalytic leadership on every level must be shared equally between clinicians and researchers. This ongoing interaction might benefit each group, and energize a focus on empirically-based examination of psychoanalytic theory and practice. To accommodate this change in the educational and political establishment, psychoanalytic education itself must be appropriately modified.

In order for psychoanalytic education to enable candidates to develop both clinical and research expertise, we propose that *all* didactic teaching as well as supervision be conducted jointly. Due to the limited number of analytic researchers, researchers from allied professions might be called upon, to everyone's advantage. Supervisors could be asked to contribute their fees to provide funds to pay researcher-teachers. Candidates should be taught both research techniques and clinical techniques, and engage in both research experience and clinical experience. Importantly, this would provide roughly equal opportunity for candidates to identify with a research model as well as with a clinical model in proportions individually determined.

A shift to a model in which the candidate engages in a personal analysis de-linked from professional advancement has been recommended for many years. Many share the impression that the conflicting goals of the training analysis may interfere with personal therapeutic goals; it is well known that many analysts seek additional treatment after termination of a training analysis. Since the candidate's analysis is widely considered the most important part of psychoanalytic education, it is critical that the candidate experience an optimal personal analysis. The candidate's selection of an analyst should be entirely by personal choice, neither limited to designated training analysts nor to analysts associated with the candidate's institute.

We are under no illusion that our proposed response to dramatically reconceive and reorganize psychoanalysis and education has much likelihood of being implemented, despite the current intense, ongoing controversy about the training analyst system. We propose it because of our conviction that *our existing professional system is unable to cope with the exigencies confronting American psychoanalysis and unable to reverse its diminishing status and prestige.* A rejection of this proposal should entail the obligation to present an alternative proposal that is considered equally promising and more feasible.

Conclusion

We are impressed by, and embrace, Popper's (1962) assertion that knowledge grows by a process of falsification; our most useful beliefs are not those that are most strongly verified, but those that have best survived criticism and refutation. We disagree, however, with his conclusion that psychoanalysis cannot be tested empirically and agree with Grünbaum's (1984) argument that, in principle, elements of psychoanalysis are falsifiable. There have been few serious attempts to refute the fundamental tenets of psychoanalysis and the most compelling evidence of that failure is the fragmentation evident in the persistent, diverse, conflicting views of the basic principles of psychoanalysis. There is no consensual agreement about the definition of psychoanalytic process, about theories of therapeutic action, about the goals of psychoanalytic treatment or about how to assess whether the goals have been reached (Smith, 2007). The failure of dialogue to resolve these disagreements indicates that none have been falsified or rejected. We assert that only empirical research can provide an opportunity to falsify or refute different axioms of psychoanalysis. Such refutation may provide optimal conditions for the growth and development of psychoanalytic knowledge.

The most recent effort to confront the legitimation crisis has been just published in JAPA. Kernberg and Michels (2016) focus on present problems (and possible solutions) in psychoanalytic education as we have been involved in. Among the rich and diverse commentaries we would like to endorse the one by Fonagy and Allison (2016):

„Their paper links the vulnerability of the educational system to the troubles that beset psychoanalysis. They point to the field's increasing distance from the nucleus of modern culture and the central position it occupied for much of the last century. The standards that most psychoanalytic institutes use to assess appropriate knowledge, skill, and competence for qualification as either analyst or training analyst are loosely specified, subjectively assessed, and prone to perverse incentives, and therefore do not adequately protect individuals or groups from potentially iniquitous processes. The authors' basic claim, that mechanisms for quality control in psychoanalysis are lacking, finds echoes in many recent appraisals of its system" (p.495).

The papers included in the book focus on a variety of clinical and research issues that circle exactly on the situation characterized above.

Chapter One

The Analyst's Role in Healing: Psychoanalysis-*PluS*[1]

"In the absence of clear-cut evidence, doctors must work in the realm of instinct and faith, and these intangibles necessarily have personal roots. This sort of situation comes up daily, even in cardiology, the font of evidence-based medicine. It is rare that incontrovertible evidence exists for our medical decisions. So you intuit, make a judgment, and hope that your hunch will serve your patient well" (Jauhar, 2005).

Abstract

We argue that the original structuring of psychoanalytic treatment is based upon an unsound foundation. The questions we raise about the bases of early treatment make understandable the subsequent evolution of substantial changes, and make plausible our recommendation of still further changes. We propose that the nuanced use of techniques of explicit support, consolation, suggestion, persuasion and advice, all used in healing across many ages and societies, be added to traditional psychoanalytic treatment. These techniques are inconsistent with the analyst's neutrality, a fundamental characteristic of the analyst's stance in the original model. The demonstration that the analyst's own values, beliefs, expectations and theories profoundly influence all of the analyst's interventions, leads us to reconsider the concept of neutrality. The possible risks associated with using these recommended explicit techniques mandate that their use requires the same discriminating judgment as is used to determine whether and when an interpretation is presented. Whether use of these additional techniques, which we have termed "psychoanalysis-*plus*," will enhance treatment effectiveness is an empirical, not a theoretical, question.

Classical Psychoanalysis's Exclusion of the Proposed Techniques

In the past, classical psychoanalysis has emphasized that understanding and insight *alone* are more effective than understanding *plus* explicit suggestion, persuasion, consolation, support and advice. Freud warned about diluting the pure gold of psychoanalysis with the dross of suggestion, and in 1933, (quoted by Collins, 1980) believed that "[u]nderstanding and cure almost coincide, that a traversible road leads from the one to the other" (p. 145).

We propose adding to the analyst's armamentarium the use of explicit support, consolation, persuasion and advice. The banning of these techniques by classical theory is based on the validity of the classical analytic theory of praxis, itself based on Freud's etiological theory of neurosis. We will briefly review the early history of analytic treatment. If there are questions about the roots of the original structure of treatment, then it is plausible to consider changes and additions to that treatment. In addition, the validity of classical theory of treatment assumes the independence of free association, a fundamental of that analytic praxis. We explore this assumption in terms of more recent, sophisticated understanding of the roles of suggestion and of placebo effect. Further, since

justification for excluding these modalities rests on proof that classical treatment is more effective than comparable treatments that include those humanistic modes, we review studies of the comparative therapeutic effectiveness of classical analytic treatment. Finally, we examine the question of whether support, consolation and suggestion may be contraindicated or especially relevant for certain diagnostic groups.

A Brief History of the Origin of Psychoanalytic Practice

Freud created his etiological theory of neurosis in 1892, writing to Fliess in December that his theory was going to be published (Masson,1985, p. 36). When Freud started his private practice six years earlier, he used the standard neurological treatments of rest and massage as well as hypnosis, but in 1889 he modified his hypnotic treatment by adopting Breuer's cathartic method, consisting of interrogating a hypnotized patient about thoughts and experiences related to their symptoms.

By 1892 Freud had largely dispensed with hypnosis, treating Frau Elizabeth v R mainly without it, relying on what became the new technique of free association. He pressed on her forehead to bring out new pictures and ideas; "I brought it about that from that time forward my pressure on her head never failed in its effect" (1893-1895, p. 154). Prior to that change in technique, however, Freud had formulated his etiological theory of neurosis. Analysts commonly believe that it was derived inductively from Freud's patients's productions, but they fail to recognize that the pre-1892 productions were of hypnotized patients treated *prior* to his use of free association. Stated conversely, to the degree his etiological theory was based on patient material, it was not based on patients who free associated but rather *it was entirely derived from those earlier hypnotized patients with whom he was using the cathartic method.* Freud initially structured analytic technique and theory on the basis of his etiological theory.

We focus on this historical fact both because it is acknowledged that hypnotized patients are extremely suggestible, and, because evidence suggests that Freud was unaware of making covert suggestions to his patients. Consider Freud's (1896c) claim that "In some eighteen cases of hysteria I have been able to discover this connection [to a childhood sexual trauma] in every single symptom, and, where the circumstances allowed, confirm it by therapeutic success" (p. 199). This finding in eighteen consecutive cases is unlikely to occur by chance; we instead assume that it was due to Freud's covert suggestions. Supportive evidence is found in Freud's later painful decision to abandon his seduction hypothesis. There is no indication that Freud ever considered that the reason for his mistaken belief about childhood sexual traumas might have been his own covert suggestions to patients of putative traumatic childhood sexual experiences. To the degree that Freud's etiological theory was developed from the productions of highly suggestible hypnotized patients, plus his failure to recognize his own covert suggestions to patients, raises question about his theory and the structure of treatment derived from it.

Freud's contemporaries were explicit about their belief that suggestion was involved in his presented cases. Breuer himself (1893-1895) was among the early contemporary critics of Freud, writing about his own treatment of Anna O that "As regards the symptoms disappearing after being 'talked away,' I cannot use this as evidence; it may very well be explained by suggestion" (Studies in Hysteria, p.43). Grünbaum (1993b) notes that Freud was stung and indignant when his friend Fliess charged him with projecting his own thoughts into those of his patients instead of reading their thoughts and abstaining from tailoring them to his expectations (Bonaparte et al, 1954, pp. 334). Von Krafft-Ebing (quoted by Ellenberger, 1970) tried the Breuer-Freud method on a few hysterical patients and found that bringing the causal trauma to light did not suffice to cure the symptom (1896). He also emphasized that the memory of the repressed trauma could emerge into

consciousness in a fantastic and distorted fashion, an observation subsequently confirmed empirically (Dywan and Bowers, 1983).

These early doubts of Breuer, Fliess and Von Krafft-Ebing support our question of why elucidating the cause became entrenched in praxis and was expected to relieve neurotic symptoms. Strenger (1986) notes that even if classical treatment was superior, that "This would still not mean that the original repression of this specific content was causally responsible for the onset of the neurosis. All we could claim is that the maintenance of the repression was causally responsible for the *maintenance* of the symptom. We can thus not infer from processes occurring during therapy any causal connection between childhood events and the present neurosis" (p. 257). Schachter (2002), in a detailed review, reiterates that conclusion. These criticisms point to the lack of evidence for the theory of treatment that opposes the open use of the proposed explicit techniques.

Why Freud Proscribed Time Honored Healing Techniques

Freud, who was well-read, knew of ancient healing techniques. Why did he prohibit their use in analytic treatment? Freud had wanted to pursue a scientific career but, unable to get an academic appointment in Vienna entered private practice to marry and earn a living. Nevertheless, his continuing drive to engage in science led him to shape his theory of practice into a scientific enterprise. As he told his American patient Abram Kardiner (1977), he was interested in theory, not therapy. He structured his treatment to produce documentary evidence of his etiological theory of neurosis. Freud hoped that developing treatment as a scientific endeavor would lead to the outstanding scientific discovery of the cause of neurosis, equivalent to discovering the *caput Nili* (the source of the Nile) (Freud, 1896c, p.203).

To achieve this, he developed psychoanalysis within the context of a (nineteenth century) scientific enterprise: Psychoanalysis, Freud (1933a) wrote, "[i]s a part of science and can adhere to the scientific *Weltanschauung*) (p. 181); "The stress on arbitrary personal views in scientific matters is bad; it is clearly an attempt to dispute the right of psychoanalysis to be valued as a science … Anyone who sets a high value on scientific thought will rather seek every possible means and method of circumscribing the factor of fanciful personal predilections as far as possible …" (1914d, p.59); "But scientific work is the only road which can lead us to a knowledge of reality outside ourselves" (1927c, p.31). "[*o]ur* science has as its object that [psychical] apparatus itself" (1940a, p.159).

Suggestion was the greatest threat to the scientific status of psychoanalysis because of its association with hypnosis, then in bad repute. We hypothesize that Freud proposed neutrality, abstinence and anonymity to try to assure the analyst's objectivity, and insulate psychoanalysis's scientific status from the contamination of suggestion: "The analyst who wishes the treatment to owe its success as little as possible to its elements of suggestion (i.e. to the transference) will do well to refrain from making use of even the trace of selective influence upon the results of the therapy ..." (1913c, p.131); "I cannot advise my colleagues too urgently to model themselves during psychoanalytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible" (1912e, p. 115); "The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him" (p.118); If the transference is able to remove the symptoms of the disease by itself, "In this case the treatment is a treatment by suggestion, and not a psychoanalysis at all" (1913c, p. 143). To assure the scientific status of psychoanalysis Freud urged that all patients be treated under standard conditions, appropriate for research, but, as we have learned, inappropriate for psychotherapeutic treatment. Freud's lifelong concern about analytic

objectivity, about the scientific status of psychoanalysis, focussed particularly on the role of suggestion in undermining that status (Fogel, 1993).

The analyst's neutrality and abstinence served an additional unstated function for Freud and his colleagues; it codified a self-imposed inhibition against troublesome erotic feelings toward women patients (Stone, 1961; Anzieu, 1986; Glenn, 1986; Moi, 1990). Later, Freud described neutrality and abstinence as barriers to the analyst's interventions impinging on the patient's independence (1912e, 1923b, 1940a).

Ferenczi, focused on therapy, not science, disagreed with Freud's emphasis on neutrality, abstinence and anonymity (Thompson, 1943). Since he was convinced that the cause of neurosis was the parents's failure to provide the child with needed love, he believed treatment had to take the form of a human relationship in which the analyst provided the missing childhood love. Ferenczi, therefore, expanded analytic technique to include those time honored healing techniques that Freud had recognized and then rejected. We know that Freud never gave up the theoretical ideal of the analyst's objectivity (Fogel, 1993), but he was actually warm and friendly with his patients, on occasion providing food and loaning money (Lipton, 1977, 1983), though not considering such acts as part of technique.

This early Freud-Ferenczi debate has continued throughout the history of analytic treatment. So many analysts have contributed to the evolution of treatment that a list will necessarily be incomplete: Harry Sullivan, Clara Thompson, Erich Fromm, Freda Fromm-Reichman, Winfred Fairbairn, Donald Winnicott, Karen Horney, Franz Alexander, Otto Will, George Groddeck, Harry Guntrip, Hans Loewald, John Bowlby, Leo Stone, Heinz Kohut, Merton Gill, Irwin Hoffman, Robert Stolorow, Anton Kris, Arnold Modell, Benjamin Wolstein, Edgar Levinson, Lewis Bromberg, Stephen Mitchell, Jay Greenberg, Stuart Pizer, Jessica Benjamin, Owen Renik, Lewis Aron, Theodore Jacobs, Irving Hirsch and Mark Blechner.

The History of Healing

Frank (1973) reviews psychotherapy, primarily in America, and concludes that much of the effectiveness of different forms of psychotherapy may be due to features that all have in common rather than those that distinguish one from another. Although he believes that failures of adaptation arise from early life experiences, psychotherapy aims to help the patient correct current problematic attitudes. He refers to Whitehorn's (1947) contention that the cause of a symptom should not be confused with its current meanings, which often can be changed regardless of their cause. Strupp et al. (1969) characterize the patient's image of a "good therapist" as a "keenly attentive, interested, benign and concerned listener – a friend who is warm and natural, is not averse to giving advice, who speaks one's language, makes sense and rarely arouses intense anger" (p. 117). Frank, building on Strupp's earlier paper, notes that directive therapies seem at least as effective as evocative (analytic) ones for many types of patients, and for some produce improvement more rapidly. Success in therapy depends in large part on the analyst's ability to combat the patient's demoralization and heighten his hopes of relief. Success also depends on the patient's conviction that the therapist cares about him/her and is competent to help him/her – that the analyst has confidence in his/her theory.

The history of the healer-sufferer relationship, extending over thousands of years and across societies and cultures, was examined by Jackson (1999), who extracts commonalties similar to Frank's: influence is brought to bear by suggestion and persuasion plus consoling and bringing of comfort as well as a search for insight and self-understanding – of 'knowing' what all the suffering has been about.

Classical Views of Neutrality

Whether the analyst will experience his feeling or action as a deviation from prescribed technique will vary with the analyst's own interpretation of "neutrality." Stone (1981), for example, characterizes the true analytic attitude as compatible with human friendliness and warmth, but the analyst "[g]ives no affective response to the patient's material or evident state of mind, nor opinions, nor direction, not to speak of active interest, advice or other allied communications" (p. 99). Kris (1990) believes that analysts need to depart from neutrality by expressing an affirmative attitude toward the patient in order to help the patient overcome punitive unconscious self-criticism. Akhtar (2007) describes Thomä's analytic work as "unabashedly therapeutic, flexible yet firm, supportive yet interpretive and deliberate yet spontaneous" all within a classical theoretical frame. Blatt and Behrends (1987) and Blatt and Shahar (2004), unlike Kris, expand neutrality to encompass the analyst being accepting and compassionate.

Rothstein (2005), a classical analyst, acknowledges how intersubjectivity limits the objectivity of neutrality: "[t]he best anyone can do is be more or less able to subjectively reflect on his or her experience, while simultaneously being more or less influenced by the subjectivity of the collaborating analysand" (p. 419). Aron (2005), commenting on Rothstein's paper points out that: "under the guise of neutrality, analysts encouraged their patients to renounce their [infantile] impulses, once they had become conscious" (p. 492). … So much for neutrality!" (p. 443). Benjamin (2005) takes another tack; intersubjectivity should encompass the capacity to identify, to get inside the other's mind and let the other inside us – in Winnicott's sense, to use the object. Ideals of objectivity, she feels, are not only unrealizable but may well create deep impediments to empathy. She conceives of neutrality as a nonjudgmental acceptance, a loving attitude that allows us to incorporate within our understanding even our mistakes and failures.

The Classical Psychoanalytic View of Explicit Support in Treatment

Freud (1909d) himself used explicit support treating the Rat Man (Dr. Lorenz). Mahoney (1986) characterized Freud's role in that treatment as that of a "befriending educator." At one point Dr. Lorenz expressed doubts to Freud that treatment would be able to help him modify the obsessions which had plagued him since childhood. Freud's response to this expression of anxious hopelessness was that "[h]is youth was very much in his favor as well as the intactness of his personality. In this connection I said a word or two upon the good opinion I had formed of him, and this gave him visible pleasure" (p. 178). Clearly, Freud as practitioner had no qualms about the utility of explicit verbal support.

Contemporary classical analysts have diverse views about support. "Psychoanalytic therapy," cites Leichsenring (2005) "operates on an interpretive-supportive continuum, and the use of more interpretive or more supportive interventions depends on the patient's needs (Wallerstein, 1989; Gunderson and Gabbard, 1999; Gabbard, 2004)" (p.844). Blatt (2005, personal communication) writes about support: "With any patient I prefer that the patient struggle to manage their difficulties themselves. But I would offer support only if I thought the patient could not manage the difficulties alone."

Free Association: The Basic Rule of Psychoanalytic Treatment

Although Freud's etiological theory of neurosis antedated his use of free association, free association soon became the fundamental rule of analytic treatment (A. Kris, 1982); and remains so in contemporary psychoanalysis (Gabbard and Westen, 2003). Not all agree about its centrality;

Grünbaum (1984) critically quotes Eissler's (1969) hyperbolic statement that free association "[i]s one of those glorious inventions that can hold its own with Galileo's telescope" (p. 461). Levenson (2001) remembers Clara Thompson's less glowing view; she gave up free association with some regret, largely because no one seemed to be able to do it. Mostly, she said, they "just natted on" (p. 380).

Since the data of free association are used to interpret causal connections between the patient's thoughts, feelings and symptoms from which a personal narrative is constructed, Grünbaum argues that these causal interpretations must be evaluated by "modes of inquiry that were refined from time-honored canons of causal inference pioneered by Francis Bacon and John Stuart Mill" (1984, p. 47). Holt (1981) concurs: "[s]cience is defined by its methods, not its subject matter" (p. 133).

A more clinical criticism comes from many analysts recognizing, when reviewing patient material, that the analyst has substantially shaped the patient's associations (Marmor, 1962; Gill, 1982). Glover (1955) early on asserted that: "When therefore any two analysts or groups of analysts hold diametrically opposed views on mental mechanisms and content, it is clear that one of them must be practicing suggestion" (pp. 381) – (or possibly both). The power of such influence has been confirmed empirically (Greenspoon, 1955; Murray and Jacobson, 1971; Truax, 1966). Haley (1959) argues that the very subtlety and unobtrusiveness of the therapist's influence, coupled with his/her explicit disclaimer that he/she is exerting an influence, may increase his/her influencing power. It appears, concludes Frank (1973), that a therapist cannot avoid biasing his patient's performance in accordance with his/her own expectations. Thomä and Kächele (1987) assert similarly that "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. … He may thus actually determine the direction the process takes, although he believes that he has only observed it" (p. 333).

Masling and Cohen (1987), citing several clinical examples, replicate this conclusion: all psychotherapies generate clinical evidence that support their theoretical positions and so can be understood "[a]s instances of therapists systematically rewarding and extinguishing various client behaviors" (p. 65).

It follows that, due to the analyst's powerful influences upon free association, interpretations based on them will also reflect the analyst's influences. Glover (1952), quoted by Wallerstein (2006, p. 304) had declared that there is "[n]o effective control of conclusions based on interpretation, [and this fact] is the Achilles heel of psychoanalytic research" (p. 405).

"[w]e cannot exclude or have not excluded the transference effect of 'suggestion through interpretation" (p. 405). Spence (1992) observes that "The clinician … tends to listen to the clinical material with a favorite set of theoretical predispositions" (p. 562), and concludes that "Interpretations in a clinical setting have an unfortunate tendency to reflect the therapist's expectations rather than the underlying facts of the matter" (p. 559).

The sources of the analyst's implicit influences and suggestions are manifold, in part derived from the analyst's subjectivity which encompasses the analyst's realistic reactions to the patient, the analyst's transference responses to the patient, the analyst's theoretical orientation, the analyst's current, personal concerns about his/her own life, and the analyst's personal values; the influences of the latter have been widely discussed (Menninger, 1958; Roazen, 1972; Lichtenberg, 1983; Lytton, 1983; Meissner, 1983; Michels and Oldham, 1983; Person, 1983; Ramzy, 1983; Gabler Gockman, 1992). Strenger (2005) asserts that "[i]t is unrealistic to believe that a therapist's personal predilection, her sense of what constitutes the central dimension of meaning in life, does not crucially influence each and every one of her interventions" (p. 92).

Renik (1993, 1998, 2004) asserts that many elements of the analyst's subjectivity are unconscious at the moment of interaction, and therefore can only be understood retrospectively. Further, this retrospective understanding becomes accessible only through the analyst's limited and restricted self-analysis or through consultation. In any event, whatever the implicit suggestion expressed by the analyst, once out, it has already influenced the patient, though retrospective acknowledgement and understanding may modify that influence. An analyst striving consciously to minimize the influence of his own unconscious subjectivity in the service of neutrality, will inevitably have only limited success.

The Influence of Placebo Effect

In addition to suggestion, the placebo effect (Shapiro and Shapiro, 1997; Mosher, 1999) shapes associations. Frank et al. (1963) studied reactions of psychiatric patients to placebos in pill form and found that most of the drop in mean discomfort occurred *before* the administration of the placebo pill. They speculated that some patients may exaggerate their complaints initially to dramatize their desire for help and minimize them later in response to the demand character of the therapeutic situation. Alternatively, the patient's symptoms may be exaggerated by the evaluation apprehension in relation to a first visit to a psychiatric clinic.

In a German study Puschner et al. (2007) provide evidence that a waiting period before treatment may involve an expectancy or placebo effect. Psychoanalytic treatment was provided to 144 patients (2-3 sessions/week) and 472 patients received psychodynamic psychotherapy (1 session/week); repeated measurements were obtained along the course of treatment; at the end of the two years, outcome results were analyzed via hierarchical linear models. During the pretreatment period, a small number of observations indicate that, surprisingly, psychological distress (measured by SCL-90 GSI) declined already substantially in the interval from acceptance for treatment to the start of treatment: "More than one-third of the expected improvement over the full two-year observation period was achieved during this first phase." (No information is available whether probatory sessions were used before starting treatment). A pre-treatment waiting period is not generally considered an effective treatment for psychiatric disorder; it may even be assumed that patients may grow increasingly anxious anticipating the start of treatment. However, it is noteworthy that child analysts frequently observe that child-centered complaints ameliorate after the parents call for an appointment but before anyone is seen. Since the waiting period in this study is associated with a therapeutic effect, it can be characterized as an unintentional placebo (Grünbaum, 1993). Puschner et al. (2007) hypothesize that the prospect of starting "possibly long awaited treatment raises hope and entails swift initial symptom improvement" - in other words, an inadvertent, empirically assessed expectancy effect which will influence early associations.

In sum, these factors indicate that true independence for free association has not been established, and, therefore, that the rule of free association does not provide warrant for excluding the open, explicit use of the proposed techniques. More importantly, contrary to the classical analytic conception, complex suggestion and placebo effects should not be considered to be 'noise' in the treatment situation requiring minimization, but, rather, 'signal' and deserving of scientific study. No study of the effectiveness of analytic treatment has ever controlled for the possibility of a placebo effect (Imber, 1990). Wurmser (1989) notes ruefully: "If anybody knows how to use suggestion with such healing impact, I will gladly learn it; it surely would immensely abbreviate my work" (p. 237).

The Comparative Therapeutic Effectiveness of Classical Treatment

To return to our basic argument, we believe that outcome studies of classical treatment should show greater effectiveness than, for example, relational treatments, to justify excluding the proposed explicit techniques. The Menninger study (Wallerstein, 1989) was one of the first to report that patients treated primarily with supportive interventions showed therapeutic gains that were as extensive and long-lasting as those treated with classical, interpretive interventions. Wallerstein (2006) elaborated: "2) across the whole spectrum of treatment courses, the treatments carried more supportive elements than originally projected, and these elements accounted for substantially more of the changes achieved than had been originally anticipated; 3) the supportive aspects of analytic treatments deserve far more respectful consideration than they have usually been accorded in the analytic literature" (p. 318). This surprising result should be qualified since all the patients studied were generally sicker than in the usual outpatient analytic practice, and the therapists using supportive techniques were more experienced analysts than those using classical techniques.

A Swedish controlled study by Grant and Sandell (2004) evaluated 331 psychotherapy patients treated by psychotherapists licensed by the National Board of Health and Welfare, and 74 analytic patients treated by members of one of the psychoanalytic societies in Sweden. Therapist's theoretical framework was assessed by the Therapeutic Attitude Scale. Patients in psychotherapy (sometimes conducted by people with psychoanalytic training) were treated by therapists whose stance was comparable to that characteristic of behavioral and cognitive therapists. In general, the psychotherapy providers put greater value than the psychoanalytic providers upon life adjustment, additionally showing kindness, supportiveness and self-disclosure, combined with valuing insight and neutrality. Of the psychoanalytic treatments, 30% were by these more eclectically oriented psychoanalysts and 70% by classically oriented psychoanalysts.

Results indicated that those 43% of psychotherapy patients treated in an orthodox psychoanalytic milieu failed to show significant therapeutic benefit while the 57% treated more eclecticly showed more progress. Psychoanalytic cases showed no significant difference in therapeutic gain between those treated in an orthodox psychoanalytic milieu and those treated in an eclectic milieu. This study therefore provides no evidence that classical treatment is more effective than eclectic treatment in psychoanalysis, and is actually less effective in psychotherapy.

Contraindications or Indications For These Additional Techniques

Studies of analytic treatment outcome examining different diagnostic groups are few, although various analysts, starting with Rank, considered personality styles which require techniques other than classical. Blatt (2004) and Blatt and Shahar (2004), originally using a depressed patient population, developed a psychodynamic, dichotomous characterization of patients's personality styles: "introjective," patients are concerned about their sense of self, including self-worth, while "anaclitic," patients are concerned about maintaining harmonious relations with others. These researchers re-analyzed the original Menninger data set and found that introjective patients did better with classical analytic treatment whereas anaclitic patients improved more with supportive-expressive treatment.

This finding led us to question whether the use of the additional techniques of explicit support, suggestion, consolation and persuasion should be minimized with those introjective patients who appear to do better with classical treatment. Blatt (2005, personal communication) responded that he does not believe that "[t]hese findings lend themselves to conclusions about varying treatment

technique. Rather, I think these findings strongly suggest that we should be aware that we offer our patients two primary factors – a therapeutic relationship and interpretation and insight…"

Utilizing Additional Explicit Techniques

We propose utilizing these additional explicit, as distinct from implicit, techniques of support, consolation, suggestion, persuasion and advice, which we term, psychoanalysis-*plus*. It is difficult to determine how analysts actually behave in their office, but it is our impression that many analysts utilize implicit caring, support and consolation, while few are comfortable doing so explicitly, verbally, or exposing these interventions in public reports. Caring may be communicated implicitly by the analyst's expression or tone of voice, of which the analyst may or may not be conscious. An unfortunate consequence of deviating from prescribed neutrality, either consciously or unconsciously, may be discomfort and guilt, which may therefore deprive the analyst of comfortably examining its occurrence and meaning with the patient.

Implicit, nonverbal expression by gesture, tone or facial expression may imply, both to patient and to analyst, that these communications are somehow illicit. When the analyst doesn't openly "own" the expression, then the patient may not feel entitled to explore and express his/her reactions. This analyst-patient interaction, therefore, may not be analyzed. Explicitness, on the other hand, facilitates the patient identifying and responding to the interventions. If the patient explores his/her reaction, is there then risk that the intervention's effect, itself, may be vitiated? For example, if the analyst was explicitly supportive or encouraging, would identifying and analyzing the patient's reaction undermine the intervention's effect? If so, that, in turn, could be explored.

The patient's acceptance of the analyst's explicit interventions constitutes, in Winnicott's terms, making use of the object. By strengthening the patient's conviction that the analyst genuinely is trying to be helpful, it may also enhance the patient's capacity to explore resistance, and to examine feelings and experiences that feel shameful or humiliating. Further, these affirmative, helpful interventions may also facilitate the patient's identification with these authentic attributes of the analyst (Skolnick, 2006), which hopefully become actively integrated into the patient's internal schemas.

Two examples of such explicit interventions follow. One, from a recent case report (Schachter, 2005) combines the analyst's suggestion and advice. An analytic candidate's patient, George, announced after three-and-a-half years, that he was terminating analysis. The candidate felt strongly that this would be a premature termination, and, despite anticipating criticism from his supervisor, said to the patient: "I really think you're making a big mistake to leave me at this time. I think you should stay until our work is finished." The patient was surprised and moved and continued analysis for another year, deepening the analytic work.

A second example involves consolation and helping a patient deal with mourning (Frommer, 2005). Paul, a 38-year-old writer was in analysis for several years when his mother became ill and unexpectedly died. He claimed he had already mourned his depressed mother long before her actual death, and attempted to forestall missing or longing for her by a primitive introjection of her. Seven months later the analyst's own mother, died. Frommer told Paul he would be out of the office for a week because of a death in the family. Paul asked directly who had died and was told it was the analyst's mother; Frommer did not want his own grief to be off limits to Paul. In a detached, vaguely contemptuous way, Paul raised many questions about Frommer's relationship with his mother. Months later, Paul asked if Frommer was over his grief, yet? Frommer replied that his mother's death had affected him deeply, that he'd be grieving for her for the rest of his life, and that it fueled his desire to live the rest of his life as fully as he could. Paul slowly began to identify with the

analyst's mourning, resolve and revitalization; "there's so much you want to do in your life , and you can only do so much … she's really dead, but in some way it makes me joyful!"

Possible Risks Associated with Using These Explicit Techniques

Masling expresses concern about "possible misuse of support, suggestion, consolation and persuasion … relational psychoanalysis presents potential problems, some of them quite dangerous." One of us (J.S.) determined that a majority of the faculty at the William Alanson White Institute regularly use these explicit techniques. On the other hand, a continuous case seminar at the Columbia Psychoanalytic Center and other described cases indicate that some traditional analysts proscribe such interventions. J.S. asked Gabbard, an acknowledged expert on analysts's ethical violations, whether violations occurred more frequently with relational analysts. Gabbard replied: "I have seen well over 150 cases of boundary violations, and I do not have the impression that these problems are more common in relational analysts. I think the ... violations have much more to do with the analyst's personal characteristics and life stressors than their theory.""(Personal communication, 2006).

Several clinical risks should be considered. The analyst's healing gestures may augment idealization to the detriment of the patient's assessment of himself/herself, and also make it more difficult for the patient to express anger towards the analyst. When the analyst's suggestion for real life action is ill conceived, as we've learned some of Freud's proved to be, the application may prove disastrous. Additionally, while a patient may accept a well meaning suggestion or advice out of compliance, unconscious forces may assure a negative outcome. The focus on the patient-analyst interaction may itself overlook the importance of other relationships, while attention to the analyst's conscious interventions may minimize exploration of the patient's dynamic unconscious (Wilson, 1995). Wilson also warns that the analyst's helpfulness may shackle patient and analyst to an environmental position which entails blaming the other and avoiding understanding how the patient may have influenced or used the other.

In addition to these clinical issues, there is also the theoretical question, will the treatment still be psychoanalysis? We believe, as do Gabbard and Westen (2003), that as long as the analyst continues to interpret the patient's unconscious feelings, conflicts and fantasies and explore transference-countertransference interactions, that we should defer "[t]he question of whether these principles or techniques are analytic and focus instead on whether they are *therapeutic*" (p. 826). Wolstein (1992) asserts, similarly, "[p]sychoanalysis, Ferenczi made far clearer than did Freud, stands or falls as the therapeutic experience of clinical psychoanalytic inquiry" (p. 177). Westen (2002) refers to "a way of working clinically that is kinder, gentler, and [he adds] *I suspect more effective*" (p. 916, italics added); but, he is concerned that this moves us toward theoretical nihilism, by which he means undermining the rules of traditional technique.

Rather than proposing another model of treatment to incorporate these explicit techniques, we urge a reassessment of the "standard model" which aimed at neutrality, privileged free association and provided interpretations. Given the widespread recognition that the analyst's subjectivity limits neutrality and influences associations and interpretations, a reconceptualization of the standard model is needed.

Naso (2005) shares Westen's concern about vitiating the directives of standard technique. He argues, like Eagle (1993), that postmodern psychoanalysis is no more successful in dealing with the epistemological problems of influence and inadvertent suggestion than traditional or modern psychoanalysis – and we agree. He adds that the implications of the postmodern position would be that "[i]nterpretations enjoy no hegemony over nonpsychoanalytic ones and that their therapeutic

results may be indistinguishable from the effects of suggestion and influence that they ambivalently embrace" (p. 382).

Failing to solve the epistemological problems of contemporary psychoanalysis, however, does not mean that postmodern techniques may not enhance the therapeutic effectiveness of treatment. This translates, then, into an empirical, not a theoretical question.

Freud had been concerned that the treatment would destroy the "science" (1926e). On the contrary, "It is not the therapy that is destroying the science," writes Holzman (1985), "for it is the therapy that has given us the science" (p. 765). Enhancing treatment effectiveness may revitalize the science by generating empirically-based improvements in psychoanalytic praxis which will increase the respect for and interest in it by other scientific disciplines, and, perhaps, by the public at large.

Chapter Two

The Role of Friendship in Psychoanalytic Theory[2]

Abstract

The concept of friendship has been ignored in traditional psychoanalytic theory, except in interpersonal psychoanalysis. Although Freud had celebrated relationships with Breuer, Fliess, Jung and Ferenczi which were important to him both personally and professionally, surprisingly, he made no attempt to utilize the concept of friendship in a theory of psychoanalytic development. We hypothesize that Freud's primary goal was to discover the etiology of neurosis. He felt that the individual's neurosis was fully formed during childhood as a function of intra-psychic factors plus parental influences. Therefore, post-pubertal and later relationships in life, such as friendships, were irrelevant to Freud in regard to the etiology of neurosis.

Introduction

This paper will explore the role of friendship in psychoanalysis, its history and theory. Freud's celebrated friendships with males such as with Breuer, Fliess, Jung and Ferenczi, influenced Freud personally and professionally. It is therefore puzzling to recognize that Freud eschewed any role for friendship in his development of psychoanalytic theory, which focused exclusively on intra-psychic phenomena and family relations. In his 23-volume oeuvre, not one of his papers includes "friendship" in the title, and in his collected works the term "friendship" appears only 16 times compared to 17,863 for "mother" and 14,437 for "father" (PEP CD-ROM).

Subsequent generations of analysts followed Freud's lead in ignoring the role of friendship in their psychoanalytic theory building. In the later psychoanalytic literature, of 44,000 psychoanalytic references in the PEP CD-ROM, only four papers include the term "friendship" in the title (Stephen, 1939; Rangell, 1963; Mahony, 1979; Weinberg, 1989). Six additional papers discuss friendships between particular individuals; one includes "peers" in the title. Similarly, in the German psychoanalytic journal, "Psyche", in the years 1947-1987 not a single title included the term "friendship." Rangell (1963) acknowledged this dearth of papers, noting that friendship " has been left mostly to the philosophers, novelists and poets, in whose domain, indeed, it has been far from neglected" (p. 4).

Rangell began his discussion referring to Freud's view that friendship was aim-inhibited sexuality or aim-inhibited love, and developed his own theory that this involved both the homosexual instinctual stream as well as heterosexual instincts.

The relevant contributions concerning a role for friendship and psychosocial relations in a psychoanalytic theory of development by Harry Stack Sullivan and Erik Homburger Erikson will be presented briefly. Several of Freud's male friendships will be discussed, those with Breuer, Fliess and Jung briefly, and that with Ferenczi in more detail, to attest to their significance in Freud's life. (The role of his female friends will not be considered here; that's another paper, which surely should

include Minna Bernays.) Following that, in order to formulate an hypothesis about Freud's failure to incorporate the concept of friendship into psychoanalytic theory, a brief review of Freud's early development of psychoanalysis will be presented.

Harry Stack Sullivan

In the world of interpersonal psychiatry Sullivan (1953) asserted an important role for friendship: "In pre-adolescence … the need for intimate exchange with a fellow being whom we may describe or identify as a chum, a friend or a loved one …" (pp. 261, 262}. "Intimacy," he wrote, is that type of situation involving two people which permits validation of all components of self-worth" (pp. 245-246).

Sullivan recognized the influence of peers and extra-familial contacts – "invisible personae in traditional psychoanalytic development" (Gerson, 1993, p. 200). It was Sullivan who singularly introduced friendship as a developmental line in psychoanalytic theory. Sullivan defined interpersonal process, rather than intra-psychic fantasy, as the sine qua non of developmental theory (Levenson, 1984).

Sullivan's epigenetic model, distinct from an early formation theory, is a stage theory exemplar (Gerson, 1993). Levenson (1985) describes it thus: "For the intra-psychic therapist the expansion or regression is vertical, back in time, deeper. For the interpersonalist the regression is horizontal, mapping wider patterns of interaction" (p. 67).

Erik Homburger Erikson

We include a brief dicussion of Erikson, not because he explicitly endorsed a role for friendship in development, but because, like Sullivan, for Erikson, development is not a function of intrapsychic factors but of psychosocial forces that influence the shaping and bolstering of identity. Erikson referred to Sullivan when he wrote, "the term identity covers much of what has been called the self by a variety of workers … [including, referring to Sullivan] a marginalized "neo-Freudian" proponent of an interpersonal psychoanalysis largely outside the framework of the American Psychoanalytic Association" (p. 147, quoted by Wallerstein, 1995, p.569). Childhood was not the primary formative period in development for either Sullivan or Erikson; adolescence, rather than the Oedipal area, proves to be the nodal point in the individual's life cycle (Roazen, 2000). Freud never articulated a phase of development beyond latency. They both regarded patients' disturbances as aggravated life crises, rather than diseases (Ross, 1966). One conception on which they differ is that for Erikson, intimacy and sexual intimacy are one and the same thing, whereas Sullivan feels indifferent about whether intimacy involves sexuality (Goethals, 1976).

Erikson (1986) supported those, such as Balint and Winnicott, who stress the relevance of environment both in developmental theory and within the analytic setting for therapy. Although Erikson may have been ambivalent about remaining a member of the Freudian establishment, his work never found its proper integration into the dominant, American ego psychology paradigm (Wallerstein, 1995). In Wallerstein's (1995) obituary for Erikson he wrote, "After Freud no single psychoanalyst has more profoundly influenced world culture and society … (p. 173)

Friendship

A definition of friendship is called for. As early as the fourth century B.C. in Greece, Aristotle was already decrying the deterioration of friendship, which had gone downhill since his grandfather's day (Duck, 1983). While there is no consensual agreement about the definition of friendship, there is

agreement about a cluster of characteristics. Rawlins (1972) provides a representative definition: "It's ideal, typical characteristics include the freedom to choose and maintain one's bonds with others voluntarily, the personalized recognition of and response to particular individual's intrinsic worth as human beings, the pursuit of equality based on the corresponding validity of friends' subjective experiences, a shared orientation of mutual good will, understanding, trust, support and acceptance, and heartfelt feelings of platonic affection and concern. … A close friend is somebody to talk to, to depend on and rely on for help, support and caring, and to have fun and enjoy doing things with." (p. 271).

We think it useful to distinguish friendship from other forms of intimate, loving relationships such as analyst-patient, mentor-mentee and parent-child. An analyst does not expect a patient to validate his/her worth as a person, or to provide acceptance, support and help. Friendship is a singular form of an intimate, loving relationship between equals.

Both Fleming (1972) and Bowlby (1973) asserted that we all need to feel confident that there are one or more trusted persons that will come to our aid should difficulties arise; friendship, thus, should be considered in the frame of attachment theory (Zimmermann and Grossmann 1997).

We differ from Rawlin's characterization on one point, that of platonic affection; he explicitly excluded sexual relationships from friendship. Rather, we agree with Boswell (1980) that such a distinction between "friendship" and "love" is arbitrary. Boswell notes that it is "not easy to conceive of an experiment which might be performed to determine whether one person's love for another was friendly or erotic … it seems likely that "friendship" and "love" are simply different points on a scale measuring … responses to other humans" (p. 46). Our society promotes the possibility that a married couple can be friends, indeed, they can be best friends. When a senior Boston psychiatrist, Dr. Buie, was asked to whom he would turn for help: "He wasted no words. 'My wife', he said crisply" (Ely, 2009).

A distinction between comradeship and friendship is difficult to draw. Although comradeship has been characterized as lacking particularity – one comrade is essentially as good as another (Strikwerda and May, 1992), there are situations in which members who may be engaged in a single joint activity, such as a military squad or an athletic team, develop male bonding and intense friendships. In fraternal organizations, on the other hand, members may be more interchangeable, so that male bonding may not occur, and relations may not reach the level of friendship. Levy's (2005) empirical study of middle-aged white men supports his hypothesis that hegemonic complicity, marked by an image of an ideal type of masculinity, influences many men to engage in comradeship rather than friendship; those who resist hegemonic complicity are more inclined to have close friendships.

Friendship varies widely as a function of factors such as age, gender, race, society and culture. Empirical studies repeatedly report the pronounced likelihood that friends will be similar in age, gender, race, educational attainment, marital and career status, and socioeconomic level (rather like family members). By and large, females learn and practice communal friendship at a younger age than males and are more likely to describe sustained involvement with friends throughout their lives. Fewer males mention close same-sex bonds and their reported close male friendships are usually not as disclosive, emotionally involving or affectionate as comparable female dyads. Male bonds feature autonomy and activity-orientation, with married men frequently relying on their wives for intimacy and close friendships (Rawlins).

National or cultural identity is also a significant component influencing the nature of friendship. Self-disclosure is one of the most important factors affecting the quality of close relationships (Altman and Taylor, 1973; Hendrick, 1988; Hendrick, Hendrick and Adler, 1988). Japanese college

students, for example, reported self-disclosure significantly less frequently than did Americans (Kito, 2005).

Freud's Relationship with Breuer

This relationship was more a mentorship than a friendship. In 1880 the 24-year-old Freud met the 38-year-old internal medicine specialist, Breuer, at the Institute of Physiology, directed by Ernst von Bruecke. The well established physician, Breuer, played a paternal role for Freud, even financially supporting him during the early years of his family life. Freud turned to Breuer for medical help when an injection he gave a patient caused toxic effects. Freud's appreciation of Breuer's support was expressed by naming his first daughter, Mathilde, in honor of Breuer's wife.

Breuer had treated an hysteric girl, Anna O. from December 1880 to June 1882, using hypnosis and catharsis, and described this treatment to Freud in November, 1882. Freud reported Breuer's treatment to Charcot in 1885, but Charcot was uninterested. Freud's interest persisted, however, and in 1886 he asked Breuer to tell him more about Anna O's treatment. By 1888, actively collaborating with Breuer (Pollock, 1976) Freud abandoned hypnosis and worked solely with the cathartic method through 1892.

Breuer and Freud collaborated writing the "Studies on Hysteria" (1893-1895), in which their theoretical differences emerged. Breuer, the more cautious theoretician, wrote: "As regards the symptoms disappearing after being 'talked away' I cannot use this as evidence [whether the occasions and mode of origin of the phenomena were really as she represented them]; it may very well be explained by suggestion" (p. 43). Breuer believed that a "hypnoid state" played an important etiological role in symptom development; Freud did not agree.

Freud's collaboration with Breuer ceased after publication of "Studies on Hysteria," with Freud later attributing this rupture to Breuer's being disturbed by Anna O's expressions of sexuality (Freud, 1925d); Jones and Ferenczi support this account. The treatment had ended 10 years earlier than their collaboration in 1892. It hardly seems likely that if Breuer had been disturbed when her treatment ended that he would collaborate with Freud 10 years later to write about her treatment. This accusation was not true. Breuer clearly endorsed the sexual etiology of the neuroses (Muller, 1992). Breuer wrote that "it was impossible for a 'general practitioner' to treat a case of that kind (hysteria, Anna O) without bringing his activities and mode of life completely to an end, and I vowed I would not go through such an ordeal again" (quoted by Cranefield, 1958, p. 319), which seems a plausible explanation for Breuer's choosing not to continue to work with such patients.

Breuer was critical of Freud in a letter to Auguste Forel in 1907, commenting that "Freud was a man given to absolute and exclusive formulations: this is a psychical need which, in my opinion, leads to excessive generalization" (Quoted by Cranefield, 1958, p. 320). Breuer's daughter-in-law remembers walking with Breuer as an old man; suddenly he saw Freud coming straight at him, and Breuer instinctively opened his arms. Freud passed by, pretending not to see him … (Roazen, 1974, p. 80).

Freud's Relationship with Fliess

Fliess, a confident, urbane young man, an oto-rhino-laryngologist, is described as the closest friend Freud ever had (Kris, 1950; Masson, 1985b). In 1886, when Fliess was 28 he attended the 30-year-old Freud's neurological lecture, and they began to correspond. Freud became more open with Fliess than with anyone else in expressing his feelings, thoughts and professional and personal concerns. Freud wrote to Fliess on January 1, 1896, "How much I owe you: Solace, understanding, stimulation in my loneliness, meaning to my life that I gained through you" (Masson, 1985b, p.2). Fliess,

however, felt free to be critical of Freud; Grünbaum (1993) notes that Freud was stung and indignant when Fliess charged him with projecting his own thoughts about childhood sexual traumas into those of his patients, instead of reading their thoughts and abstaining from tailoring them to his expectations (Freud-Fliess letters, in Kris 1954, pp. 334). Further friction occurred when Fliess insisted Freud remove a dream from "Interpretation of Dreams," because he was concerned that it was too revealing about Freud. Freud reacted by falling into a creative paralysis, halting his work on the "Interpretation of Dreams" for more than a year. Mautner (1994) considered this to be the catalyzing element in the dissolution of their relationship, while others point to Fliess' withdrawal. The most intense phase of Freud's relationship to Fliess was over by the spring of 1897 (Schur, 1972). Freud seemed unaware that beginning about 1900, after their last "Congress" (get-together) at the Lake of Achensee (Tyrol), Fliess was withdrawing from him and gradually dissolving the friendship. Fliess criticized Freud for leaking Fliess's ideas about bisexuality to someone, (which Freud had done "inadvertently"), who published them. The actual end of this friendship was particularly painful for Freud, and later in life he rarely mentioned Fliess (Masson, 1985b).

Freud's Relationship with Jung

Jung, aged 32, initiated contact with Freud, aged 51, in 1907 by sending Freud a book he [Jung] had written which contained a dream Jung had attributed to a friend. Freud correctly suspected that Jung was the dreamer. Jung's gesture may be considered an overture to Freud for help, probably because at that time Jung was intensely conflicted about his Russian patient, Sabina Spielrein, who Jung was analyzing; he was strongly erotically infatuated with her (Lehmann, 1986). Thus, at the start, Jung's relationship to Freud was very unequal, with Jung turning to a senior man for help.

Freud, concerned that psychoanalysis was becoming seen as a "Jewish profession", had looked for a non-Jewish, Aryan leader for psychoanalysis and Jung seemed a good candidate. Jung accompanied Freud to America in 1909 for Freud's academic lectures at Clark University. Before the lectures, Freud and Jung were admiring the Palisades from Riverside Drive in New York City, and Freud suddenly urinated in his pants. Jung interpreted this as an expression of Freud's conflicts about ambition, an interpretation Freud rejected (see Leclaire 1968[3]). Jung offered him some analytic help with this symptom which Freud, concerned about a recurrence of the enuresis during his lectures, accepted. Although this might seem like an expression of an equality, of two mountaineers, faced with stress, supporting each other, but Mahony (1993) regarded this episode as the beginning of Freud's break with Jung.

There were numerous theoretical disagreements between Freud and Jung. Jung criticized the broad scope of Freud's conception of libido, the energy of the sexual instincts. Jung proposed, instead, the conception of a holistic, vital drive concerned with self-preservation (Lothane, 1997). He also criticized Freud's failure to acknowledge the value of spirituality and religion. In addition, Jung rejected Freud's interpretation of Schreber's work as resulting from repressed homosexuality. When Jung again offered to analyze Freud to help him with his bit of neurosis. Freud refused, saying he could not submit to analysis without losing his authority, and Jung responded critically, "your technique of treating your pupils like patients is a blunder" (Lothane, 1997)[4].

In 1912, the tensions between them reached a peak when Jung felt severely slighted after Freud visited his colleague, Ludwig Binswanger, in Kreuzlingen at the Lake of Constance, without paying him a visit in Zurich (Wikipedia). The rupture seemed complete later that year when Freud wrote to Jones, December 26, 1912, "As regards Jung, he seems all out of his wits; he is behaving quite crazy" (p. 112)

Freud's Relationship with Ferenczi

Freud's relationship with Ferenczi is difficult to characterize neatly. Ferenczi, aged 35, met Freud, age 52, in 1908, shortly after Freud began to correspond with Jung. On the one hand, Ginsburg (1991) suggested that Freud may have chosen Ferenczi as a replacement for Fliess, who had separated from Freud in 1900, while Dupont (1994) believes Freud was not ready for a new, intense relationship. Much of Ferenczi and Freud's correspondence was devoted to psychoanalytic matters giving an impression that the relationship was primarily instrumental, more of a mentorship than a friendship, but one tinged with deep affection for each other.

One sign of their closeness was their mutual disclosure to each other of such personal matters as financial difficulties and worries about children and grandchildren (Haynal, 1992). For example, Freud wrote to Ferenczi that "I have never had a depression – this must be one" (Grubrich-Simitis, 1986, letter of 18 July, 1923). For many years they traveled together every summer, and Freud openly wished that Ferenczi would become his son [in-law] by marrying Mathilde, his eldest daughter (Dupont, 1994). Freud's concern about Ferenczi is reflected in his withholding criticism of Ferenczi and Rank's 1924 essay of the "Future of Psychoanalysis, saying that "I prefer to keep in the background so as not to disturb your productivity" (letter to Ferenczi of 22nd January, 1924; Grubrich-Simitis, 1986,). Freud referred to their relationship as involving "an intimate sharing of life, spirit and interests" (letter of 11 January, 1933, Grubrich-Simitis, 1986).

The relationship of Freud to Ferenczi was complicated by their intermittent patient-analyst relationship . Ferenczi had three different periods of analysis with Freud, two for three weeks and one for two weeks, at two sessions/day[5]. Aron and Frankel (1994) observed that the intermittent treatment – however short and limited - evoked transference and counter-transference reactions that tapped neurotic elements in both Freud and Ferenczi. Throughout their relationship Ferenczi was troubled by Freud's treating him as a junior partner and yearned to be Freud's equal (Dupont, 1995). When Ferenczi urged that he and Freud undergo a mutual analysis, Freud refused. In a 1931 letter, Freud undermined the friendly relationship by cruel criticism of Ferenczi's experimentation with non-erotic kisses with patients as part of an expression of maternal tenderness (Roazen 2001). Although this may reflect Freud's own concern about controlling his own counter-transferential erotic longings, Freud's criticism was wider in scope. He wrote about Ferenczi to Eitingon in October 1931, "Apart from the danger of his technique I am sorry to know him to be on a track which is scientifically not very productive." (Quoted by Molnar, 1992, pp. 110-111).

Ferenczi's last meeting with Freud was in September, 1932, when he read his "Confusion of Tongues" paper to Freud. Afterwards, Ferenczi told his patient, de Forest, who later told Erich Fromm: "The Professor listened to my exposition with increasing impatience and finally warned me that I was treading on dangerous ground and was departing fundamentally from the traditional customs and techniques of psychoanalysis … In the hands of unskilled analysts, my method, the Professor said, might easily lead to sexual indulgence. … The warning ended the interview. I held out my hand in affectionate adieu. The Professor tuned his back on me and walked out of the room (Fromm, 1955, pp. 64-65). The next day, September 3, 1932 Freud wrote to Anna, "He was totally regressed to the etiological views I believed in and gave up 35 years ago, that the gross sexual traumas of childhood are the regular cause of neurosis" (Quoted by Molnar, 1992, p. 131).

Freud (1937c) referred to his affective tie to Ferenczi in his famous statement, "not every good relation between analyst and his subject was to be regarded as transference: there were also friendly relations which were based on reality and which proved to be viable" (p. 222). This relationship profoundly influenced Freud's personal and professional development. It might be expected that

\zAccccaFreud would extrapolate from this and similar experiences to formulate a role for friendship in individual development. He never attempted to do so.

Review of Freud's Relationships with Breuer, Fliess, Jung and Ferenczi

Of these four relationships, the first one was a clear mentor/mentee relationship; Freud's relationship with Fliess can be considered to be a friendship in that they were truly equals. Although their relationship began as a professional relationship they each developed genuine affection and admiration for the other. They stimulated, encouraged and supported each other professionally, approaching a "mutual admiration society,"[6]with personal elements prominent. We prefer not to speculate on what unconscious factors were operating in Freud in regard to this relationship. Freud never acknowledged that his transmitting Fliess's bisexuality theory to someone else who proceeded to publish it, had destroyed Fliess's feelings for him, nor did he explore why he had done so.

Freud 's relationship with Jung, was, from the outset, a complicated relationship since initially Jung asked for Freud's help by presenting a dream of his own, but soon they turned into two seemingly equal, competitive explorers of the unconscious (Ellenberger, 1972) . However, this friendly relationships between equals was so full of political undertones for each that it cannot properly be characterized as friendship. We speculate that Freud, right from the outset, had ambivalent feelings about a man whom he needed as a Non/Jew but whom he also disliked for his offensive sexual conduct with his patient, Sabina Spielrein. Their inequality in many respects, leads us to believe that what they considered friendship was really an illusion.

Nothing that we have learned of these four relationships provides a compelling hypothesis about why Freud ignored the role of friendship in developing psychoanalytic theory. We considered whether Freud's conception of friendship as [only] aim-inhibited sexuality led him to underestimate its value; we propose, rather, a theoretical hypothesis.

An Hypothesis: Why Freud Omitted Friendship from Psychoanalytic Theory

The Early Development of Psychoanalysis

We would like to extrapolate a hypothesis about Freud's omission of the subject of friendship from psychoanalytic theory from our brief review of the early history of psychoanalytic theory. Freud's wish to continue his scientific career was thwarted by his inability to get an academic appointment. His only choice was to go into practice to earn a living. He had been impressed by, and was admiring of, both Darwin, discoverer of evolution and Koch, discoverer of the tubercle bacillus, and strove to achieve comparable fame himself. Freud, in a letter of 21 September, 1897, referred to "My expectation of immortal fame and of assured wealth was so agreeable …" (Kris, 1950, p. 113). Practice constrained him, but he did manage to fashion a scientific goal for himself; he would discover the cause of neurosis! (Garcia, 1987; May, 1999; Schachter, 2002). In 1896 Freud proposed his seduction theory, that the etiology of hysteria was "a passive sexual experience before puberty … with actual excitement of the genitals, resulting from sexual abuse committed by another person" (p. 152).

Soon, however, Freud became convinced that the stories patients had told him were not veridical. although he did not recognize or acknowledge that he might have suggested them. Freud was devastated, and on September 1897 he wrote to his friend, Fliess, that he was abandoning his seduction theory, and cited several reasons. Many analysts have explored and hypothesized the reasons for Freud's rejection, but don't agree (Masson, 1984; Krull, 1986; Kupfersmid, 1993; Tabin, 1993; Aron and Frankel, 1994). Freud adapted to relinquishing his theory that an actual childhood

seduction was etiological, by replacing it with the new hypothesis that an unconscious fantasy was the etiological agent; "it is psychical reality which is the decisive kind" (1917, p. 368); "What I have in mind are hysterical fantasies" (Masson, 1985, p. 234, quoted by Blass and Simon, 1994, p. 688).

In a well-known further reversal, shortly after disclaiming his seduction theory, Freud reiterated his earlier belief that traumatic childhood sexual trauma caused hysteria (Kupfersmid, 1993), and specifically enumerated nursemaids, governesses, domestic servants and teachers as the perpetrators (Garcia, 1987). Years later, however, he castigated Ferenczi for proposing this theory of the etiology of neurosis.

Freud (1896a) had reported earlier: "I have been able to carry out a complete psychoanalysis in thirteen cases of hysteria … In none of these cases was an event of the kind defined above [sexual abuse by another person in earliest youth] missing" (p. 152). Anna Freud in a letter to Milton Klein on January 13, 1982, wrote "That it [sexual abuse] occurred in the patients' material so frequently could in the long run not be attributed to reality, but only to a fantasy of overwhelming generality. … Keeping up the seduction theory would mean to abandon the Oedipus complex" (Quoted by Lothane, 2001, pp/ 692, 693). That every one of thirteen hysterical patients recalled a childhood sexual trauma seems unbelievable unless we hypothesize that Freud suggested these sexual experiences to at least some of the thirteen. Freud (1925d) later acknowledged, "When, however, I was at last obliged to recognize that these scenes of seduction had never taken place, and that they were only phantasies which my patients had made up or which I myself had perhaps forced on them … (p. 34, quoted by Blass and Simon,1994, p. 690) Anna Freud did not consider that Freud might have suggested these sexual experiences to the patients, as he had done explicitly to the "Rat Man". Nonetheless, this major shift from the individual's reported experience as the critical etiological factor, to elements within the patient's mind as the crucial etiological factor, became the core of developmental psychoanalytic theory. Blass and Simon, however, assert that "abandoning the seduction theory does not lead to a wholly new era in psychoanalytic thinking – one of fantasy as opposed to the supposedly 'pre-psychoanalytic' one centered on the etiological role of reality" (p. 690). Lothane, (2001), too, argues that the view that Freud abandoned the seduction theory is wrong. Blatt and Simon add, "While, ultimately Freud did centre his thinking on a model of Oedipal fantasy, a very gradual process was involved in this move … It would seem that no resolution emerges. … Freud may well have been driven by ambition to be the discoverer of *the* cause of hysteria, but beyond this there was a sincere struggle with an elusive truth" (p. 691).

Freud's aim to discover the etiology of neurosis would now focus primarily on what was in the patient's mind, rather than the experiences the patient had had with others. Transference was interpreted, as Aron (1990) notes, as "a process occurring within the mind of the analysand" (p. 479); thus a one- person model of psychoanalytic treatment was constituted. Freud's aim of creating a scientific discovery, like Darwin and Koch, required that psychoanalytic treatment and its data be the result of a scientific process. The analyst was to be a neutral, objective, scientific-like observer; analysts, therefore, were interchangeable, and the analyst's gender or other characteristics were irrelevant. Freud's primary concern was the possibility that the analyst might make suggestions to the patient, thereby undermining the scientific status of treatment, and thus likening it to derogated hypnosis. It is highly probable that Freud suggested the stories of childhood sexual trauma to at least some of his patients, so his concern about the analyst making unscientific suggestions to the patient is understandable. If etiological factors are to be discovered in the patient's mind, it is essential that the analyst avoid all suggestions.

We believe that Freud was convinced that the causative factors in neurosis were created in pre-Oedipal childhood, and that parental influence may have actually shaped these etiological factors. He

(1918) wrote: "I am of the opinion that *the influence of childhood makes itself felt already in the situation at the beginning of the formation of a neurosis, since it plays a decisive part in determining whether and at what point the individual shall fail to master the real problems of life.* (p.54, italics in the original, quoted by Lothane, 2001, p. 711). He reiterated this in 1940: "It seems that neuroses are acquired only in early childhood …" (p. 184, quoted by Lothane, 2001, p. 712).

In addition to Freud's goal of exploring the patient's mind for clues about the etiology of neurosis, he also examined information about the patient's parents and other caretakers who might influence etiological developments in the patients mind during childhood. They might effect how the child dealt with the Oedipus complex, the kernel of neurosis. The individual's later experiences or relationships, including friendships, marriage and parenthood, were, therefore, irrelevant to an analytic exploration of the etiological structure in the patient's mind. Freud neglected friendship, then, hypothetically because he believed friendships essentially are not present in pre-oedipal childhood, when etiological structures are completed, and, therefore, do not influence the formation of etiological factors in the child's mind. This hypothesis rests on several assumptions: although Freud's perspective on etiology broadened (Garcia, 1987), he remained focused on those elements of etiology of neuroses which the psychoanalyst could explore; Freud was convinced that the etiology of neurosis was established in pre-oedipal childhood, and developments later in life were essentially irrelevant to the structure of that etiology.

Freud as Therapist

In contrast to Freud's scientific concerns and goals that required the analyst's neutrality and objectivity, when actually working with a patient Freud as therapist displayed all the features of a humane, supportive and empathic therapist (Lipton 1977; Cremerius 1981b). For example he explicitly reassured the "Rat Man"; he gave money to the "Wolf Man"; and he strongly urged Ferenczi to marry Gizella rather than Elma, her daughter. Freud must have been aware that his responses would have an "unscientific influence" on the patient's mind. How can his clear responsiveness to his patients be reconciled with his intense conviction that the analyst remain objective and neutral to maintain a "scientific" exploration of the patient's mind? He (1910d) did comment, in relation to obsessional neurosis, e.g., that "modifications of technique … will be required … how far the instincts which the patient is combating are to be allowed some satisfaction during the treatment" (p. 145). Further, in 1919 he wrote: "We cannot avoid taking some patients for treatment who are so helpless and incapable of ordinary life that for them one has to combine with educative influence; and even with the majority, occasions now and then arise in which the physician is bound to take up the position of teacher and mentor" (p. 166).

Nevertheless, Freud's highest priority remained the discovery of the causes of neurosis, and he believed that the most effective approach to that problem was the one-person, scientific model of psychoanalytic treatment. He told Kardiner that he [Freud] was interested in theory, not in therapy, and remained concerned that the [analytic] treatment would destroy the 'science' [theory] (1927a, p. 254).

Publication Frequency of Journal Articles with Specific Titles

To compare the frequency of occurrence of articles with such terms as friendship and childhood in an interpersonal journal, Contemporary Psychoanalysis (CPS), in a traditional psychoanalytic journal, the Journal of the American Psychoanalytic Association (APA) and in all the remaining 24 journals in the PEP CD-ROM, we calculated the proportion of the total articles for a journal that contained each specific term, friendship, childhood, etc. That is, for each term, the number of articles

containing that term were divided by the total number of articles for that journal; the quotient was then multiplied by 1000. The resulting number represents the proportion of articles with that term in the title for each journal [or group of journals]. The larger the number, the greater the proportion of articles containing the specific term. Results are presented in Table 1.

Proportion of Journal Titles with Specific Terms

	CPS	APA	Journals
Friendship	1.8	0.3	0.1
Father	1.2	3.1	3.0
Mother	3.6	4.4	6.1
Sexuality	1.8	7.8	6.4
Childhood	2.9	12.5	11.3
Transference	16.8	24.7	16.0

Consistent with interpersonal psychoanalytic theory about the role of friendship, CPS had a larger proportion of articles about friendship than APA or the remaining 24 journals. In addition, the proportion of papers that included friendship for CPS were similar in magnitude to the proportions for other categories of other titles; for APA and the 24 other journals the proportion of papers containing friendship were smaller than all the other categories of titles.

Further, consistent with traditional psychoanalytic theory, the proportion of papers with the term, childhood, is large for APA and the 24 journals, both in relation to other categories (except transference) and in relation to the proportion for CPS.

Conclusion

We examined several of Freud's significant personal relationships in an effort to understand Freud's surprising failure to include a role for friendship in his psychoanalytic theory of development. Subsequent generations of analysts followed his lead with the result that the concept of friendship is missing from the psychoanalytic literature. On the other hand, Sullivan identified the importance of friendship and singularly introduced friendship as a developmental line in psychoanalysis. Sullivan defined interpersonal process rather than intrapsychic fantasy, as the sine qua non of psychoanalytic developmental theory. Erikson, similarly, emphasized that it is psychosocial forces, not intrapsychic factors, that determine the shaping of identity.

Review of Freud's relationships with Breuer, Fliess, Jung and Ferenczi indicate that on balance each of them was more positive than negative, and that each contributed to his personal as well as to his professional development. This examination of Freud's personal relationships failed to provide an hypothesis about Freud's ignoring friendship in psychoanalytic theory. Consequently, we propose a theoretical hypothesis: Freud's goal was to discover, scientifically, the etiology of neurosis; since he believed that pre-oedipal childhood was the domain of the etiology of neurosis, subsequent relationships, including friendships, were irrelevant to his development of the psychoanalytic theory of neurosis.

Chapter Three

The Couch in Psychoanalysis[7]

"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

For many American Psychoanalysts the couch is the default position used with all analytic patients. This paper reviews empirical studies of the relation between the patient's position, sitting or lying, and free association. Findings are inconsistent; the patient's position may have an effect in some dyads and not in others. There have been no studies of a possible relationship between the patient's position and therapeutic outcome. Therefore, there is no empirical foundation for putting all analytic patients on the couch. We propose that selection of a position for the patient requires a careful, empathic, flexible, clinical judgment by the analyst including consideration of the analyst's own theory, as well as of the patient's personality characteristics and diagnosis.

Introduction

The thesis of this paper is that the choice of chair or couch for the patient should utilize careful clinical judgment and flexibility in considering the characteristics of the dyad. Selection of the couch automatically for all analytic patients, i.e., utilizing the couch as the default position, which is the policy of the American Psychoanalytic Association (APsaA) as well as of the New York Freudian Society, has no empirical foundation and is inappropriate.

The official position of APsaA is enshrined in the Association's Standards: "The candidate learns to use the free associative method with a patient lying on the couch" (p. 14). For traditional American psychoanalysis, the couch is the default position: "no couch, no analysis" (Kelman, 1954, p. 65). The couch is an icon (Friedberg and Linn, Unpublished manuscript), an intrinsic element of the psychoanalyst's identity, and, at the same time, the aspect of psychoanalysis that is most ridiculed (Robertiello, 1967).

In contrast to the long-standing position about the use of the couch in APsaA is the practice of two founders of the William Alanson White Institute (WAW) who are giants in interpersonal psychoanalysis, Harry Stack Sullivan and Erich Fromm, who did not use the couch. Fromm (1980) denigrated the use of the couch: "the analyst … [whose] position of sitting behind the analysand …actually results during the hour in the analysand's feeling like a little child. From Freud's

standpoint this infantilization of the analysand was all to the good since the main intention was to discover or reconstruct his early childhood" (pp. 38, 39). Levenson (Personal communication) said that none of the candidates in training with him at WAW used the couch. Therefore, it is surprising that the data from a pilot questionnaire study of recent analytic graduates of WAW, an interpersonal institute, indicate that the couch is also used widely by interpersonal analysts at that institute. Seventy-seven per cent of the recent graduate respondents had used the couch either all the time or frequently throughout their own training analysis. Why this striking institutional transformation occurred in use of the couch during training warrants investigation. 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. If there is an attempt to consider an alternative conception, that is intimidating, although, no matter how many analysts adopt a practice – they may all be wrong. 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 possible 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 papers with homosexuality in the title prior to 1960 uniformly categorized homosexuality as abnormal or pathological. Homosexuals had been reported to be 'cured' by electroshock treatment (Eissler, 1942). This uniform incorrect view of homosexuality as psychopathological may well have been a product of the accumulated 'received wisdom' of that day.

Similarly, today's analysts who select the couch as the default position may also reflect the transmission of 'received wisdom'. Perhaps 25 or 50 years from now analysts may reconsider this policy of selecting the couch as the default position. 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 by traditional analysts is carried on without too much examination of the process" (p. 69).

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, 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: to discover 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 Viennese psychiatrist colleagues who regarded hypnosis as not only fraudulent, but possibly dangerous (Stern, 1978).

Freud had had patients lie on the couch when he conducted hypnotic treatment, and after he ceased hypnotizing patients he continued to put patients on the couch. He (1913c) cited several reasons for having the patient lie on a couch: "I cannot put up with being stared at by other people for eight hour a day (or more)." (1913c, 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, 1974; 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 may create 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.

Freud (1913c) added additional reasons for use of the couch: “I do not wish my expressions of face to give the patient material for interpretations or to influence him in what he tells me … I insist on this procedure, however, for its purpose and result are to prevent the transference from mingling with the patient’s associations imperceptibly , to isolate the transference and to allow it to come forward in due course sharply defined as a resistance “ (p. 134). Freud’s aim here may have been theoretical and/or therapeutic. Theoretically, he wanted a scientifically pure culture of the patient’s transference, uncontaminated by the analyst, to be projected onto the blank slate of the analyst to facilitate developing etiological hypotheses. Therapeutically, optimizing interpretation and resolution of transference should maximize benefit of treatment.

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) opined that the inventors of our training system had hoped 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, 2006a,b, 2007a; Kirsner, 2000, 2009b; 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

Regardless of the original reasons that Freud used the couch, its use 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; no studies have examined whether it is the couch or the frequency that may enhance free association. 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) an interpersonal analyst, maintains that free association is the primary instrument of analytic practise;

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 (1994a) 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). 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 near magical power of hope may energize regenerative efforts in some, while others may wait passively for the analyst to cure them.

Clearly, 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). This may be restitutive for some, especially for a fragmented patient who may then be enabled to try, in Winnicott's (1958) 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 the couch facilitates attunement to interior states. This may be particularly important when working with relatively healthy patients, such as candidates for either analytic training or psychotherapy training, for whom face-to-face dialogues may be more likely to deal with superficial aspects of their current reality, rather than deeper feelings and fantasies (Klann, 1979). Such individuals are often highly successful in defending against their personal problems. A reclining position may create an optimal ambiance for exploring concerns which are less well defended even in treatment only one session per week. For both analysand and analyst, reduction of visual contact tends to heighten their auditory sensitivity.

There have been reports of the patient shifting position during treatment, perhaps several times, as analyst and patient felt that the change might be facilitatory.

Finally, some patients may equate using the couch with psychoanalysis, and at least at the beginning of treatment, the couch may be a requirement of the patient.

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) 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

Many analysts regard the use of the couch as enhancing the patient's regression, but views about the effects upon treatment are conflicting. Some assert that it enhances therapeutic work (Romm, 1957; Wallerstein, 1967; Bromberg, 1991; Aruffo, 1995; Wolf, 1995; Inderbitzin and Levy, 2000); others assert that the regression can risk deterioration of the treatment work (Stone, 1961; Lipton, 1977; Palombo, 1978; Gill, 1984a; Reiser. 1990; Renik, 1995, 1998). Gill (1984a) wrote: "the very idea that an earlier state can be reinstated as such is an illusion" (p. 170). Inderbitzin and Levy (2000) assert similarly: "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 degree to which the couch fosters regression, and whether that is facilitatory or inhibitory of therapeutic work probably varies in different dyads, and should be evaluated in the context of a specific dyad.

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 (1994a) 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 growth promoting 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) – to Oedipal dynamics. 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. 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 (1995a) 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. One author, (J.S.), has the same impression, not corroborated by any data, 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. Berdach 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. Wille (1993) similarly noted no difference in free association with couch versus chair; however, female subjects often associated less freely than male counterparts, and test subjects associated more freely with the male experimenter than with his female colleague. Thus, findings in studies of the effect of position on free association in non-patient, student populations were contradictory.

There have been two empirical studies of position of analytic patients involving very small sample sizes. 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 by this measure 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. 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.

There have been no studies of whether the patient's position influences therapeutic outcome. 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 have objective evidence that it does influence therapeutic outcome. Although an empirical study would be difficult to conduct, there is clearly a need for more research.

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 Study Group (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)" (Tronick, 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 changes 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).

We would suggest that an analyst using the Boston Change Group theory 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. Of course, 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, Porder 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 primarily 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, 1984a; 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, 2009) 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 (2010) 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 with all patients has no foundation, and should neither be taught nor required in psychoanalytic education.

There have been no studies of a relationship between patient position and therapeutic outcome, so there is no clear empirical basis for choosing between couch and chair. Clearly, more research is needed.

The selection of a position should be made mutually on the basis of discussion between patient and analyst, not unilaterally by the 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, including the analyst's conviction about the value of the couch.

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.

Chapter Four

The Traditional Concept of "Psychoanalytic Process": Ready for Retirement

Abstract

Multiple unresolved methodological problems concerning traditional psychoanalytic theory, including the lack of a consensually-agreed definition of "psychoanalytic process", are among the principal factors responsible for the relative paucity and limited findings of empirical studies of "psychoanalytic process". Further, an encompassing formulation of an approach to the study of traditional "psychoanalytic process" is so complex and multi-dimensional that its use in empirical assessment is unlikely to be fruitful. Since the concept of "psychoanalytic process" can neither be defined nor empirically assessed, it should be retired.

A new approach to the empirical study of how psychoanalytic treatment works is suggested consisting of videotape studies, as theory-free as possible, modeled on the fruitful published studies of mother-infant and patient-analyst interaction.

The Board on Professional Standards (BoPS) of the American Psychoanalytic Association (APsA) requires candidates for Certification to demonstrate "psychoanalytic process" in their treatment reports. Since "psychoanalytic process", should no longer be considered a viable concept, BoPS should redefine its criteria of psychoanalytic competence for Certification.

Introduction

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. 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 have set the stage:

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)

This notion of process has acquired prominent signifying status. PEP lists 308 references to "psychoanalytic process", but empirical studies of traditional "psychoanalytic process" are relatively few in number when compared to the numerous studies of the outcome of psychoanalytic treatment. Luborsky and Spence (1971 and 1978) reviewing the field of systematic research on process offered ideas, concepts and measurement approaches; however, in subsequent decades the empirical literature on process remains sparse. Even the inclusion of the few studies focusing on interpretation by those conceiving of interpretation as central to "psychoanalytic process", leaves the number small (Blum, 1976; Davison et al.,1990; Canestri, 2007a).

Person (2000) more generally concluded that psychoanalytic research had yet to devise a research methodology to correlate change with a particular therapeutic action. Therefore it is not surprising to encounter voices such as Finlay and Evans (2009) saying "We would like to see future evidence-based research focusing on core therapeutic processes rather than simply on outcomes" (p. 53). Modell (2012), discussing the scientific validation of psychoanalysis, commented, "I was thinking of the enormous difficulties encountered if one applies scientific methodology to the clinical setting, to the psychoanalytic process itself" (p.511).

We suggest that this is the time for a major reorientation of approach to the empirical assessment of how psychoanalytic treatment works utilizing as a model the successfully employed videotape studies of mother-infant interaction and of patient-analyst interaction.

The Origin of the Traditional Concept of "Psychoanalytic Process"

Variations in conceptions of "psychoanalytic process" have been so extensive in recent decades that we have turned to an earlier period during which there was relative uniformity about it. We quote Rangell, an influential psychoanalyst of that era, to articulate these beliefs clearly and eloquently. "The analyst's neutral and objective intra-psychic position, observing and interpreting, is the essence and the *sine qua non of the psychoanalytic process"* writes Rangell (1969, p. 72). He believes that the analytic process can be said to begin when the patient really free associates and the patient develops a transference neurosis in his/her mind which the analyst attempts to resolve by interpretations; therefore the process itself, explains Rangell, "takes place within the patient" (1968, p. p.22). He defined the transference neurosis as the marker that is "pathognomonic for the analytic process" (p. 24).

The Lack of Consensual Agreement Regarding Conceptions of Psychoanalysis

"Psychoanalytic process" is a salient aspect of psychoanalytic treatment, and in order to study "psychoanalytic process" it must be possible to determine that the examined treatment is demonstrably psychoanalytic treatment. Oberndorf (1953) asserted that no consensually-agreed definition of psychoanalysis existed. Since then, unfortunately, there still exists no consensually-agreed definition of psychoanalysis. Therefore, even if all other methodological problems are put aside, attempts to study "psychoanalytic process" founder because in the absence of a consensually-agreed definition of psychoanalysis, treatment cannot be identified as psychoanalytic; research is stymied from the outset. Some studies define treatment conducted by a senior psychoanalyst as psychoanalysis, but this is not acceptable for research purposes. Not every treatment by a senior psychoanalyst is necessarily psychoanalysis and often a senior analyst's psychoanalytic case presentation may be met by categorical comments from the analyst audience that "That's not analysis!"

Wallerstein (1988,1990) attempted to override the many differences in definitions of psychoanalysis when he delineated and proposed a "common ground" conception of psychoanalysis, but that received little support. New York State licenses psychoanalysts and uses a definition of psychoanalysis not accepted or adopted by psychoanalytic organizations such as APsaA or the International Psychoanalytic Association (IPA).

Lack of Consensual Agreement about the Definition of "Psychoanalytic Process"

Consequently, no consensual agreement about the definition of "psychoanalytic process" itself is at hand. Abrams (1987) writes that "The psychoanalytic process conceptualizes what is fundamental to

the investigative and clinical potential of psychoanalysis. Yet, it is hard to imagine any term more burdened by ambiguity, controversy and diversity of usage. … It has become a Babel, a shibboleth, and a weapon. Is it worth saving at all? (p.441). [He concludes it is worth saving]. Gray (2002) asks cogently "How can we investigate "psychoanalytic process" if we cannot define it?" (p. 13). Zepf (2008) notes "that in studies attempting to relate the outcome of treatments to an analytic process, no two studies of outcomes have used the same definition of analytic process" (p. 53). Frank (1998) cited 19 references in his review of concepts of "psychoanalytic process", finding mostly differences of opinion. He was aware that APsaA had already carefully selected five analysts who shared a traditional view of psychoanalysis and had charged them with defining "psychoanalytic process". After five years of discussion the five analysts failed to agree: each wrote separate papers that were published together in the Psychoanalytic Quarterly in 1990 (Abend 1990; Abrams 1990; Boesky 1990; Compton 1990; and Weinshel 1990)

In his paper, Compton (1990) concluded that Rangell and Abrams de-emphasized the role of the analyst in "psychoanalytic process"; for them, what is essential in "psychoanalytic process" happens in the mind of the patient. They believe that the analyst's activity falls under the rubric of technique; his role is seen as 'analyzing'. Boesky (1990), another of those five analysts, grasped and summarized the conflict within the group and one that remains the polarizing issue: "Confusion about how to account for the interactional aspect of the psychoanalytic situation in a manner consistent with a one-person psychology emerged as an important source of the difficulty in arriving at a satisfactory definition of the "psychoanalytic process" (p.550).

Weinshel (1990) and Dewald (1987) separately appear to prefer an interactive model: two people are required for analysis to take place and the emphasis is on the means by which such changes are brought about, that is, the interaction of the patient and the analyst (Dewald 1987; Weinshel 1990).

The description of a "process model" by Thomä and Kächele (1987) described it as that idea in the mind of a given analyst of a sequence of expectable events derived from a general understanding of psychoanalytic treatment. They (1987, pp.331-352) discarded the alternative model, in which the process of treatment is viewed as a naturally occurring event in which the role of the analyst is hardly specified and in which the transference arises and is eventually resolved by the patient with the analyst as a more or less silent observer-companion. They criticize this view, which is similar to Freud's original model and close to the one Compton espouses of a "natural emergence model", as a "fiction of a "psychoanalytic process" purified of the real person of the analyst" (p.337).

In a fresh effort, Vaughan et al. (1997) developed the Columbia Analytic Process Scale to measure "psychoanalytic process". They noted that "psychoanalytic process" "has been used to define psychoanalysis such that if an analytic process does not develop, a 'real' analysis has not taken place regardless of the benefit to the patient" (p. 959). As result of their combined efforts they ended up concluding that "there is no meaningful consensual definition of the term AP (analytic process) among a group of training and supervising analysts from the Columbia Center for Psychoanalytic Training and Research. This is especially striking since we'd expect that a sample of analysts from the same generation and the same institute would bias the study towards finding agreement in the definition of AP …"(p.964).

Tuckett, in 2004, asserted that "psychoanalytic process" still eludes definition and now, fifteen years after Vaughan's study, despite a good deal of psychoanalytic research, we too cannot identify substantial progress in empirically validating the concept of "psychoanalytic process".

Methodological Problems in the Traditional Concept of "Psychoanalytic Process" Resulting from Suggestion

Freud, who admired the worldwide fame of two scientists, Darwin and Koch, also hoped that he too might gain fame by discovering the cause of mental illness (Schachter, 2002; Breger, 2009). To achieve that goal, he believed it was critically important that psychoanalysis be recognized as a nineteenth century scientific enterprise. If psychoanalysts made suggestions to patients, psychoanalysis might be viewed like hypnotic treatment (which Freud had practiced earlier and given up) and psychoanalysis might suffer that same low repute. In that context, Freud's conception of psychoanalysis as a "one-person" enterprise was scientifically- rather than therapeutically-based. To avoid the possibility of analytic suggestion the focus of analytic work was on the patient's unconscious and productions. By remaining anonymous, neutral, keeping the patient in abstinence, and providing only interpretations to his patient, Freud (1919a) hoped he could avoid effects attributable to the analyst's suggestion. He was presciently concerned about a future in which "the large-scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion" (p. 168).

Freud was not alone in recognizing that attempts to define or assess "psychoanalytic process" are vulnerable to the likelihood of obfuscation by the effects of the analyst's suggestion. Edelson (1984) raised this major methodological difficulty by questioning whether interpretation, the presumed mutative factor in "psychoanalytic process", is not itself influenced by suggestion. "Is there a psychoanalytic cure distinct from persuasion, a unique psychoanalytic process which is something more than, or better yet, other than, the therapist's molding the patient to his particular view of man? Is the therapist's vaunted system of meanings and interpretations merely a strategy to produce the change he deems necessary? … If the therapist knows where the therapy should go and what the outcome should be, it is *pari passu,* ideological and unavoidably persuasive." (p.2). He adds, "If we assume that psychoanalytic change depends on the specific truth and the relevance of the therapist's formulations or beliefs then I think we are on the razor's edge of ideology. Therapy technique then becomes technique for helping the patient arrive at insight which will be acceptance of the therapist's truth. What is this if not the art of persuasion?" Meehl (1994) continued this concern about the impact of the analyst's suggestion leading to obfuscation of "psychoanalytic process", and Josephs and Bornstein (2011) believe that suggestion may effect a temporary, illusory improvement in the patient.

The Introduction of Interpersonal/Relational Treatment Reduces Concern about the Methodological Problem of Suggestion

The shift from the 'one-person" to the "two-person" analytic situation "was a long time in coming in psychoanalysis, largely because of the fear that suggestion would be seen to be the motor that drives psychoanalytic change." (Pine, 1993, p. 202). In interpersonal/relational treatment the analyst's acknowledged suggestion is recognized as one aspect of patient-analyst interaction, and therefore itself becomes a subject for study; similarly, explicitly supportive interventions may be significant, acceptable interactions (deJonghe et al., 1992; Schachter and Kächele, 2007). The specific methodological problem of suggestion that Freud, Edelson, Meehl, and Josephs and Bornstein, among others, struggled with ceases to be a central methodological problem in interpersonal/relational treatment, though it remains of some concern to some scholars (Foehl, 2008).

Empirical Studies of "Psychoanalytic Process"

One of the earliest approaches to empirical study of analytic treatment was by F.Alexander at the Southern California Institute in the 1950's. He began research into analytic therapy using a one-way mirror (Shershow, 1996). The earliest study of actual multiple-session psychoanalytic treatment was by Bellak and Smith (1956) who tape-recorded two psychoanalytic treatments. Many years later, the case of Mrs. C analyzed by H. Dahl under the supervision of J. Arlow was completely audio-taped true psychoanalytic treatment. It subsequently served as the source of several research studies (e.g. Reynes et al. 1984; Dahl, 1988; Bucci, 1988; Jones and Windholz, 1990; Weiss, 1993; Spence et al. 1994; Bucci, 1997; Sammons and Siegel, 1999).

Waldron et al. (2004a; 2004b) audiotaped treatments designated as psychoanalytic and from their analytic process scale essayed a definition of psychoanalysis. Ablon and Jones' (2005) using the Psychotherapy Process Q-set concluded that the degree to which a treatment approximated traditional ego-psychology psychoanalytic treatment was positively associated with therapeutic outcome. They failed, however, to examine whether assessing whether approximating Kohutian, Kleinian, or interpersonal/relational psychoanalytic treatment might not also have correlated positively with treatment outcome.

In a German specimen case, the Ulm Process Study Group descriptively examined a number of treatment dimensions like emotional insight (Hohage and Kübler, 1988), change of self-esteem (Neudert et al., 1987), change of suffering (Neudert and Hohage 1988); change of dreams (Leuzinger-Bohleber & Kächele, 1988) and the Core Conflictual Relationship Theme (CCRT) (Albani et al. 2003), all of which have been summarized in Kächele et al. (2006 and 2009).

A Formulation of Empirical Approaches to "Psychoanalytic Process"

A great many different measurement variables have shown correlational association with the therapeutic outcome of psychodynamic treatment and therefore have been considered also to be operative in "psychoanalytic process". Marmor (1979) believed, based upon observations of psychoanalytic sessions through one-way mirrors, that what emerged "was a recognition of the subtlety, multiplicity and complexity of the interacting variables, *both verbal and non-verbal*, that enter into the "psychoanalytic process" (p.348). Boesky (1990), Levine (1994), Ablon and Jones (2005) and Bacal (2011) have all concluded that there is no one correct definition of "psychoanalytic process"; rather the many processes are *each unique to a particular analytic dyad*, and, in addition, the nature of "psychoanalytic process" probably also changes over time during treatment.

Bucci's (2012) distinctive approach asserts that "According to multiple code theory, modality-specific channels of bodily and sensory experience and motoric actions, which are largely subsymbolic in format, constitute the affective core of emotion schemas" (p. 281). She adds, "for the talking cure to have an opportunity to bring about change in an emotion schema, the feelings that constitute the affective core of the schema must be activated and alive at the moment [in both analyst and patient]" (p.282).

Thus, different measurement variables, different dyads and different times in treatment all influence assessment of the term "psychoanalytic process". We propose, therefore, the following theoretical formulation: "psychoanalytic process" is a function of: 1) Empirical Measure 1, Empirical Measure 2, ….Empirical Measure N; 2) Dyad 1; Dyad 2, … Dyad N; 3) Time in Treatment 1, Time in Treatment 2, … Time in Treatment N. Since simultaneous measurement of all these variables appears not to be feasible, this theoretical formulation provides another basis for our opinion that it has not been possible *either to define or to measure* the traditional concept,

"psychoanalytic process"; we propose, therefore, *that the concept be retired*. It is noteworthy that Eagle (2011a), a prominent scholar of psychoanalysis, in his recent comprehensive text, "From Classical to Contemporary Psychoanalysis" makes no mention of the term, "psychoanalytic process". We propose, further, a new conceptual approach to the empirical assessment of how psychoanalytic treatment works.

A New Approach to the Empirical Study of Psychoanalytic Treatment

Both audio-taping (Bierer and Strom-Olsen, 1948; Abell, 1963; Elliot, 1970; Shery, 1976) and videotaping of sessions were employed for supervision and treatment. Kächele et al. (1988) discussed scientific, clinical and ethical problems in audiotape recordings of psychoanalytic dialogue.

Levenson (2003) asserted that "the detailed inquiry, particularly the deconstructed detailed inquiry, [of psychoanalytic treatment] is really *visual,* not, as one might reasonably expect, verbal, and that, indeed, the entire psychoanalytic praxis, although annotated in words, actually takes place in a visual-spatial modality" (p.233). Retzinger (1985) noted that "video technology … enables investigators to observe and capture even very fleeting observations and to identify their association with specific emotions. Videotaping of facial behavior thus allows analysis of behaviors that would otherwise be impossible to examine" (p. 138). If shared with the treatment dyad, these videotape data may also prove to be a therapeutically useful adjunct, enabling both patient and analyst to observe interactions of which they were unaware. Certainly, objections that videotaping psychoanalytic sessions will negatively impact the psychoanalytic procedure need to be tested. There is evidence that research interviews of a patient after an analytic session do not negatively influence the process (Grande et al., 2004; Huber and Klug, 2004). Kächele et al. (2015) add that "microanalyses are the methods of the future when we want to understand what clinical facts are, what countertransference means and how therapists contribute to the process". A recent microanalytic study on the German specimen case Amalia X shows this point in great clarity (Buchholz et al. 2015).

To break out of the impasse that previous thoughtful approaches to the study of "psychoanalytic process" have faced, we now suggest modeling new approaches on videotape studies of mother-infant interaction. We hope that microanalyses of the proposed innovative videotape studies will provide new observations and will inform our knowledge of patient-analyst interaction as it has already enhanced our understanding of mother-infant interaction.

From the large literature we have elected to describe the work of two outstanding investigators of videotape studies of mother-infant interaction, Stern and colleagues (1977, 1983, 1985, 1988, Stern and Sander, 1980, and the Boston Change Process Study Group (2007) and Beebe and colleagues (2004, 2012a, 2012b, 2012c, 2016). Their method is consistent with the increased focus, in recent decades, on the importance of patient-analyst interaction in studies of treatment considered to be psychoanalytic. By deliberately trying to abandon preconceptions in examining videotapes of mother-infant interaction, Stern and colleagues were able to identify and formulate factors, newly informing our knowledge of the ongoing mother-infant relationship and providing material for the development of theoretical formulations.

Stern (1977), himself, referring to mother-infant interaction insists that: "Experimental situations would not do, not alone. They capture too small a slice of life and lack the context needed for full understanding. Before experiments, we needed (and need) descriptive observations. Second, we needed new methods for these observations, methods scaled down and adjusted to the split-second and nonverbal world of mother-infant interaction" (p.1). He adds, "When you have the wonderful

opportunity to be among the first people to see a new world, many of its surprising features are striking enough that they force you to reevaluate your preconceptions. You quickly grasp a new perspective and new realities such as the fact that nonverbal behaviors observed in animal ethology – a head pushed forward or tilted up, or turned away rapidly to the side and down – need to be starting points for observing human social behavior" (p. 2). Further, "This new approach taught me that the important actions occurred in seconds and split seconds … As a psychiatrist, I had been taught to identify behavioral (clinical) "units" such as "intrusiveness," "sensitivity, " and "rejection." These were too large, too global, too vague for what my colleagues and I were doing now" (p.3). Some years later in his influential monograph he notes that "interactions between patient and analyst instantiate the defensive exclusions or contradictions of the patient's implicit procedural knowings, including the resort to defensive distortion or exclusion of affective information" (Stern 1985, p.853). He proposes that these implicit procedural knowings are probably what constitute, in other terms, a variety of mental representations and their modification.

In the past decade there have been several key efforts to link detailed descriptions of early mother-infant face-to-face interaction with infant attachment outcomes. The work of Beebe and associates have importantly contributed to the now rich tradition of documenting the minute details of mother-infant face-to-face exchange, showing both partners to be active participants in the co-creation of many patterns of relatedness which the researchers connect to a theory of attachment. Utilizing a procedure based on the generation, by two video cameras, of a split-screen view of mothers playing with their infants, they were able to examine separate modalities of communication as well as formulate a composite measure of facial-visual engagement. They (2012a) argue that the recurrent nature of the infant's experiences leads to the development of internal representations or "working models" of self and others, generalized representations of events, that influence the infant's emotional expectations and create internal working models of attachment. Beebe et al. (2012b), for example, characterize the emerging internal working models of future disorganized infants as follows: "Future disorganized infants represent states of *not being sensed and known* by their mothers, particularly in moments of distress; they represent confusion about both their own and their mothers' basic emotional organization, and about their mothers' response to distress. This internal working model sets a trajectory in development which may disturb the fundamental integration of the person." (p.353)

Beebe et al. (2016) also creatively videotaped adult patient-analyst interaction in treatment designated as psychoanalytic and provide a vignette from a videotaped session of a female patient in a chair. We can observe the patient's increasing distress, as she spoke tensely, gestured rapidly with her hands, with her torso leaning forward tautly, her face screwed into a precry. The analyst originally silently listening, his face very attentive responded to the patient's agitation by slightly shifting the orientation of his chair toward the patient. As the agitation mounted, the analyst's foot made intermittent brief, rapid jiggles, matching the rhythm of the patient's body. At each escalation of the patient's agitation, the analyst participated, crossing and uncrossing his legs and nodding his head up and down in rhythm with the patient's movements and each time saying "Yes" softly. Gradually the patient began to calm down. Then slowly, they began to speak to each other. The analyst's efforts to regulate his inner state showed the patient that he was *with* her.

Beebe (2004) also videotaped another, 10-year thrice weekly treatment conducted sitting up. The patient, Dolores, was preoccupied with the faces of her childhood, and she wanted to be able to find her own face in her analyst's (Beebe's) face, but could not look at her analyst. Extremely fearful, withdrawen and dissociated, she nevertheless longed for attachment. Beebe made an unusual intervention: she made a series of videotapes of Dolores and herself together, and some focused only

on the analyst's face while interacting with Dolores. Seeing the analyst's face and hearing her voice responding to her, heightened her experience of her analyst's response; she came to recognize herself in her analyst's face that recognized her. Dolores declared, "You insinuated yourself into an interaction with me, into my closed system, where I had shut everything out" (p.44).

In neither of her two videotape studies of the dynamics of patient-analyst interaction, is there any mention of the traditional concept of "psychoanalytic process"; apparently, the term did not seem useful or contributory.

We propose that such observations of videotapes of treatment sessions by research-analyst teams might move investigators from their "psychoanalytic process" focus and enable them to take a fresh look at the interactions between patient and analyst "without memory or desire". Investigators might turn then to a re open-ended exploration of Levenson's well-known question, "what's going on here" between the two persons in the videotape. Birksted-Breen's (2008) methodological view conflicts with our atheoretical proposal. She asserts that to be psychoanalysis the two person situation must also include a theory as its 'third object' (p.1). Hinz (2008), too, asserts that "there is no observation independent of theory" (p.110). While true in its essence, this risks theory-dependent observations in which theory shapes the observation. Attempts to observe phenomena as theory-free as possible – as Stern and Beebe did – provide an opportunity for new observations and the formulation of new theory.

Following the lead of the Boston study group, we would also look forward to the formation of a study group joining clinicians and researchers who seek a more accurate understanding of "what's going on here?" in psychoanalytic treatment

Discussion

Whatever contributions the concept of traditional "psychoanalytic process" may have provided in the past, it no longer seems a viable or generative construct as the basis for empirical research and should be retired from center stage. As described, attempts to assess "psychoanalytic process" have been and will continue to be complicated by the fundamental methodological lack of a consensually-agreed definition of psychoanalysis, and by the obfuscating effects of suggestion by the analyst upon "psychoanalytic process". Although different empirical studies have demonstrated limited correlational connections with aspects of "psychoanalytic process", our including them all in the development of an extraordinarily complex, multidimensional theoretical formulation of "psychoanalytic process" suggests that attempting customary empirical assessment of this formulation is unlikely to prove productive.

The difficulties inherent in the empirical assessment of "psychoanalytic process" have fundamental implications for licensing and education in psychoanalysis, and in particular, for the Certification requirements for training analyst appointment in APsaA, which include the applicant demonstrating "psychoanalytic process" in his/her treatment report. The Certi-fication Guidelines of APsaA state that "The committee's assessment depends on the applicant's own description of the analysis and psychoanalytic process …", and add that "Psychoanalytic process is effectively described when it draws the reader into a sense of having been a participant" (p. 13). Further, "Questions have arisen when reports have not shown analytic process … Of course, if the problems with a case prevent the demonstration of an analytic process, it would be difficult to meet the requirement with that case" (p. 17). The Guidelines appear to imply that "psychoanalytic process" is a unitary and standard process present and observable clinically and demonstrable in all effective psychoanalytic treatments, an assumption lacking any empirical support. Our conclusion that

"psychoanalytic process" can neither be defined nor measured empirically, and, indeed, should be retired, therefore, calls for APsaA to redefine its criteria of psychoanalytic competence.

Conclusion

In sum, the traditional concept of "psychoanalytic process" should be retired for all the following reasons: 1. There is no consensually-agreed definition of psychoanalytic treatment, itself, so it is not possible to identify and examine an aspect of psychoanalytic treatment termed "psychoanalytic process"; 2. There is no consensually-agreed definition of "psychoanalytic process"; 3. There is likelihood that attempts to assess "psychoanalytic process" may be obfuscated by the analyst's suggestion; 4. Since "psychoanalytic process" is defined as the interpretation of the transference neurosis, and the concept of transference neurosis has been all but abandoned, the concept of "psychoanalytic process" should also be retired; 5. A theoretical formulation of "psychoanalytic process" which includes multiple empirical studies is so complex and multi-dimensional that customary empirical study is unlikely to be productive.

For clinical, educational and research purposes, abandoning the concept of "psychoanalytic process" provides a timely opportunity for a fresh approach to the empirical study of how psychoanalytic treatment works. Relatively theory-free videotape study of patient-analyst interaction, with its strong history of fruitful use in the study of mother-infant interaction and patient-analyst interaction, offers the promise of delineating new observations and constructs for assessing how psychoanalytic treatment works.

BoPS, the educational arm of APsaA, by relinquishing the concept of "psychoanalytic process" as a non-viable concept has the opportunity to develop new paradigms for assessing psychoanalytic competence.

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Chapter Five

Empirical Studies of Transference Interpretation: Implications for Freud's Concept of Transference[8]

Abstract

The concept of transference is central to theoretical and clinical psychoanalysis and psychodynamic psychotherapy. We summarize Freud's concept of transference, and then review, providing samples, the concepts of transference interpretation of O.F. Kernberg and P. Høglend, the two most prominent empirical investigators of transference interpretation. Analytic clinicians widely regard transference interpretations as unreliable. Kernberg did not report empirical estimates of reliability, either for the patient-therapist interaction aspect of transference or for Freud's concept of transference. Although Høglend reported that measures of the patient-therapist interaction aspect of transference were measured reliably, he found no evidence that Freud's concept of transference interpretation was measured reliably. Neither investigator assessed the validity of Freud's basis for transference interpretation; he hypothesized that the effects of some childhood experience or relationship persisted unchanged and caused a particular adult response. Further, since therapeutic action, and presumably transference as well, varies with each patient-analyst dyad, the fact that Kernberg and Høglend studied groups of individual patients, rather than dyads, makes it unlikely they could accurately assess the validity of transference interpretation.

Absent both empirical reliability and validity of Freud's transference interpretation, if such a transference interpretation is presented to a patient it should be acknowledged to be at best an hypothesis, evaluated with humility, and held lightly by the therapist.

Introduction

In their once standard text on "Theory of Psychoanalytic Technique" Menninger & Holzman (1958) differentiated three situations as main constituents of the patient´s "triple life" being in psychoanalytic treatment. 1. "Reality, i.e. the sum of ongoing relationships to his present family, his friends, colleagues, employers and so on. 2: The childhood situation, which reflects the fact that "a portion of his personality is a continuance of his infancy and represents an unjustifiably prolonged extension of his infantile period", and 3. The analytic situation itself.

The concept of transference is central to clinical and theoretical psychoanalysis and psychodynamic psychotherapy. Psychoanalytic Electronic Publishing (PEP) reports 1182 papers on transference, and Høglend and Gabbard (2012) report that more than 8000 papers and book chapters have discussed the concept of transference. Although "analyze the transference" has long been a shibboleth for conducting analytic treatment, the concept of transference and the use of transference interpretation remain highly controversial topics (Frances & Perry, 1983; Gabbard et al., 1994; Gunderson et al., 1997; Schachter, 2002).

We have selected the two most prominent empirical investigators of transference interpretation, O.F. Kernberg and P. Høglend, and will review their concept of transference and provide samples of their transference interpretations. We will follow this by discussion of clinicians' critiques of the concept of transference, and then by review of the reliability and validity of Kernberg's and Hoglend's concepts of transference interpretation. We will conclude by discussing the implications of these findings for the concept of transference.

First a brief review of Freud's concept of transference.

A Summary of Freud's Concept of Transference

In the postscript to the Dora case Freud (1905e) presented his first thorough description of transference:

"What are transferences? They are new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the process of the analysis, but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician … To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment" (p.116).

He restated his understanding of transferences in 1910:

"The part of the patient's emotional life which he can no longer recall to memory is re-experienced by him in his relation to the physician; and it is only this re-experiencing in the transference that convinces him of the existence and of the power of these unconscious sexual impulses" (p.51).

He elaborated his conception in 1912b:

"Transference to the doctor is suitable for resistance to the treatment only insofar as it is a negative transference or a positive transference of repressed erotic impulses. . If we "remove" the transference by making it conscious, we are detaching only these two components of the emotional act from the person of the doctor; the other component which is admissible to consciousness and unobjectionable persists and is the vehicle of success in psychoanalysis exactly as it is in other methods of treatment" (p.105).

Freud (1914) then stated that anyone who worked with transference and resistance was practicing psychoanalysis (p.16).

He reiterated his view in 1926e:

"The transference is made conscious to the patient by the analyst, and it is resolved by convincing him that in his transference attitude he is re-experiencing emotional relations which had their origin in his earliest object-attachments during the repressed period of his childhood" (p.43).

Freud's last comments on transference were issued in 1940a:

"The most remarkable thing is this. The patient is not satisfied with regarding the analyst in the light of reality as a helper and adviser who, moreover, is remunerated for the trouble he takes and who would himself be content with some such role as that of a guide on a difficult mountain climb. On the contrary, the patient sees in him the return, the reincarnation, of some important figure out of his childhood or past, and consequently transfers onto him feelings and reactions which undoubtedly applied to the prototype. This fact of transference soon proves to be a factor of undreamt of importance, on the one hand an instrument of irreplaceable value and on the other hand a source of serious dangers" (pp.174-176).

The Concept of Transference Used in Clinical Practice

To provide a context for evaluating Kernberg's and Høglend's definition of transference, we explored how the concept of transference is now used in clinical practice extracted from the illuminating and comprehensive paper by Kernberg (2007b) which summarizes the concepts of therapeutic action in psychoanalysis utilized by eight selected psychoanalysts: R. Lauder, M. Aisenstein, C.L. Eizirik, R.D. Hinshelwood, S.M. Abend, O. Renik, K. Newman and C. Spezzano. Although all but Spezzano mentioned "transference", none provided a definition of transference, leading us to conclude that the concept of transference, though widely used in clinical practice and alluded to in the literature, lacks clear definition. In addition, the reviewed approaches to therapeutic action were extremely heterogeneous. Spezzano, cognizant of this marked heterogeneity, soothingly suggested that analysts of different persuasion play the analytic game differently, but that whatever each does, each provides the patient with a chance to get better. Unfortunately, we lack the empirical evidence that each of the different conceptions of the eight analysts reviewed by Kernberg is as likely to benefit a comparable proportion of patients as any other. Therapeutic action is left in limbo.

Kernberg's Concept of Transference

Transference Focused Psychotherapy (TFP) was designed to treat patients with Borderline Personality Disorder. The main strategy in TFP "consists in the facilitation of the (re) activation … of the patient's split-off internalized object relations that are then observed and interpreted in the transference" (Kernberg et al., 2008, p. 603). "Transference analysis differs from the analysis of the transference in standard psychoanalysis in that … it is always closely linked with the analysis of the patient's problems in external reality, in order to avoid the dissociation of the psychotherapy sessions from the patient's external life. Transference analysis also includes an implied concern for the long-range treatment goals that, characteristically, are not focused upon in standard psychoanalysis, except if they emerge in the transference" (Kernberg et al., 2008, p. 609).

Transference for these purposes is defined "as a tendency in which representational aspects of important and formative relationships (such as with parents and siblings) can be both consciously experienced and/or unconsciously ascribed to other relationships" (Levy, 2009). However, Levy and Scala (2012) add that in TFP, "the connection to early experiences with caregivers is not always explicitly mentioned, particularly when working with certain patients who find such links disorganizing (e.g., patients with personality disorders)" (Levy & Scala, 2012, p.394). In such instances the concept of transference is limited to interpretation of patient-therapist interaction.

Kernberg's Studies of Transference Interpretation

A clinical illustration: "Ms. N, thirty years old and single, had been fired from her job as a waitress; still unemployed, she was living in her mother's home. At the insistence of her mother, Ms. N applied and was accepted to a randomized clinical trial for treatment of borderline personality disorder. Ms. Was large, overweight and overbearing. She dressed in baggy sweat pants and presented herself in an imposing and threatening fashion. As the weeks passed, Ms. N. became openly hostile and paranoid. Her feelings seemed to be organized around the requirement to attend sessions regularly and to begin and end on time. Eventually, she began to skip sessions. When she did attend, she generally arrived late and left early.

A month into the treatment, Ms. N began a session by immediately launching into a description of a fight she was having with her mother. From what the analyst (a woman) could gather, Ms. N was angry at her mother, who had decided to fence their cat out of the living room. The analyst was

having difficulty understanding what was happening at home, and felt unclear how Ms. N was experiencing her mother. When the analyst asked for clarification, Ms. N became agitated. It turned out that the cat was old, now incontinent, and that Ms. N's mother was trying to avoid the cats soiling her rugs. Ms. N began to rant about her mother's inconsiderate behavior, calling her a "sefish bitch" and saying "she doesn't give a shit about the cat or about anyone else's needs or feelings". Ms. N. became increasingly agitated, and the analyst realized she felt threatened; she was acutely aware that Ms. N quite easily could physically overpower her. Ms. N glared at the analyst and went on to explain, "I can't live in her house, even if she's supporting me. I can't stand her, selfish fucking bitch. If it were my house I could do whatever I want." Ms. N went on to say she wasn't going to let her mother "get away with it". She planned to open the gate and let the cat back into the living room as soon as her mother left the house to go to work.

The analyst responded by pointing out to Ms. N that she seemed to see her mother as someone who had power and abused it, doing whatever she wanted while caring nothing about the needs of others; her mother didn't care about the cats needs, and when she insisted Ms. N stick with her therapy, it seemed she didn't care about Ms. N either. The analyst could see that Ms. N had been listening to her, and sensed that she was feeling less agitated. The analyst pointed out that what was happening between Ms. N and her mother seemed also to be happening between Ms. N and herself, perceived as another person who was abusing power.

To this Ms. N replied, "That is *exactly* what I've been telling you! You make me come twice a week when I only want to come once – twice a week is too stressful for me. I keep telling you, but you don't listen." The analyst responded that she could see that meeting twice weekly was difficult, but that it seemed the problem went beyond the analyst's asking Ms. N to do something difficult. When the analyst insisted on regular appointments and on starting and stopping on time, she became in Ms. N's eyes just like Ms. N's mother with the cat – selfish, controlling, and caring about only her own needs. In this situation, Ms. N had only two choices: she could feel powerless and afraid, like the cat, or rebel by coming late and skipping sessions (Caligor et al., 2009, pp. 282-284).

"We think of this kind of intervention, describing and elaborating the patient's experience of the analyst, as providing cognitive containment of the patient's experience of the analyst in the transference, while at the same time providing the patient the experience of being understood … and of the analyst as genuinely attempting to understand …" (p.286).

Høglend's Concept of Transference

Høglend (2014) operationalizes the concept of transference for research purposes into five categories:

1. The therapist addresses transactions in the patient-therapist relationship:
Therapist: It sounds important what you're saying now. When you say you feel it in your body … that makes me curious.

2. The therapist encourages exploration of thoughts or feelings about the therapy, therapist, and the therapist's style and behavior:
Patient: Well, … in a way its just words. I feel it's silly to be that positive. Myself, I don't want to say something positive unless it's fully justified.
Therapist: You think I'm too positive?
Patient: Yes, I do think that … to be perfectly honest.
Therapist: So you feel I'm not always truthful?
Patient: Not exactly, but …

Therapist: Manipulative?
Patient: Maybe a little bit. Like in a therapeutic way.
Therapist: I say things I don't mean?
Patient: I think you do.
Therapist: How do you feel about going to a therapist like that for help?

3. The therapist encourages the patient to discuss how he or she believes the therapist might feel or think about the patient:
Patient: I always try to be my best around other people. My biggest problem is letting anyone see me sad and helpless.
Therapist: I noticed! So … how do you think I should respond when you show me that side of yourself?

4. The therapist includes him- or herself explicitly in interpretive linking of dynamic elements (conflicts), direct manifestations of transference, and allusions to the transference:
Patient: Others have shown me genuine care, and my reaction is to feel sad. I don't know if I want care or if it scares me. I don't like to be dependent on anyone, but …
Therapist: Are you afraid our relationship will become so important to you that you run the risk of being terribly disappointed?
Patient: It's different here …, but … I have been thinking a lot about the end of therapy. How will I manage on my own?

5. The therapist interprets repetitive interpersonal patterns (including relationships to parents) and links these patterns to transactions between the patient and the therapist.
Therapist: What should I expect?
Patient: That I show up on time, or else you'll get frustrated …, even angry.
Therapist: Like your father or your new boss?
Patient: Yes … (sigh) … I feel others expect things of me, and that I have to fulfill their expectations immediately. Even when I know it's not really like that, that it's mostly in my own head.

Høglend's Studies of Transference Interpretation

The following vignette illustrates how work within the transference may promote insight (Høglend, 2014, p. 7).
Therapist: So, here we are now (category 1)
Therapist: What effect do you think our conversations have had on your relationship to your mother? (category 2).
Patient: I'm still struggling. My mother called this morning. I interrupted her right away and told her that if it wasn't super important , I couldn't talk now. I hung up, but felt terrible afterward.
Therapist: When you tell me this, what do you think I feel about you? (category 3).
Patient: You think I'm a selfish person.
Therapist. Could that be how you feel about yourself?
Patient: I get a bad conscience, even for the smallest things.
Therapist: You have talked about how hard it is to say "no" at work and think of your own needs. You've had problems setting limits with colleagues, your mother, and father, because you were afraid of being rejected or punished. But today you managed to tell me that our next session had to be changed because of your meetings at school and work. (category 5).

Patient: I have to be focused here. Forty sessions is not a very long time. I can see I do hesitate to trust other people, but my husband is supportive, and I try to talk some sense into myself.
Therapist: And now – this morning you were able to hang up on your mother, and you got me to change our next appointment. Maybe you are developing less fear and more trust? (category 4).

Reliability of Transference Interpretation

Rubovitz-Seitz (1998) notes that the problem of the reliability of interpretation did not surface clearly until Glover (1952) recognized that there is "no effective control of conclusions based on interpretation, [and this fact] is the Achilles heel of psychoanalytic research" (p.405). Rapaport (1960), too, asserted: "There is [as now] no established canon [in psychoanalysis] for the interpretation of clinical observations" (p.113). Responding to that concern, a group of psychoanalysts in Chicago including T.M. French, W.C. Lewis, J.G. Kopecs, G.H. Pollock, F.P. Robbins , L.B. Shapiro, R.M. Whitman and P. Rubovitz-Seitz undertook a systematic investigation of that problem (Seitz, 1966) and reported that, despite working together for over three years and employing various amounts and kinds of clinical data, they were never able to reach satisfactory agreement on the blind interpretation of the same case material. Other investigators who have documented the reliability problem include Sklansky et al. (1966), Weber et al. (1966), Thomä et al. (1976), Fisher and Greenberg (1977), Werman (1979), Runyon (1981), Spence (1982), DeWitt et al. (1983), Peterfreund (1983), Rosenbaum & Muroff (1984), Fosshage & Lowe (1987), and Bernardi (1989). Further, there is poor agreement between individual clinicians' transference formulations and observers CCRT-guided formulations, while CCRT formulation itself showed moderately good agreement between observers (Luborsky & Schaffler, 1990). Aron (1999), sounding a similar note, declared that it is not possible to determine whether a given interpretation or intervention is "correct", because numerous other analysts and supervisors will propose a different interpretation or intervention.

Reliability of Kernberg's Transference Interpretation

Review of Kernberg's papers (Clarkin, et al., 2001; Clarkin et al., 2004; Clarkin et al., 2006a; Clarkin et al., 2007; Kernberg, 2007a; Kernberg, 2007b; Levy et al. 2006a) indicate that reliability of his concept of transference was referred to only in Levy et al. (2006b) who tested reliability of the Psychotherapy Process Rating Scale for Borderline Personality Disorder designed: "(1) to assess therapist adherence and competence vis-à-vis the TFP manual; (2) to differentiate TFP from other psychotherapeutic approaches; and (3) to assess specific observable key therapeutic approaches and facilitative behaviors in the psychotherapy process with patients diagnosed with BPD to allow for the examination of the relationship between psychotherapy techniques and outcome." (p.1328). They concluded that this study "provides preliminary support for the inter-rater reliability of the Psychotherapy Process Rating Scale for Borderline Personality Disorder (PPRS-BPD) for identifying the specific, nonspecific, patient and therapist factors in psychodynamic psychotherapy for Borderline Personality Disorder" (p. 1329). There is no indication that this PPRS-BPD provides any assessment specifically of the reliability of transference interpretation.

Reliability of Høglend's Transference Interpretation

Review of Høglend's papers (Høglend, 1993a; Høglend, 1993b; Høglend & Piper, 1995; Høglend 2004; Høglend et al., 2006; Høglend et al., 2007; Høglend et al., 2008; Høglend et al, 2011a; Høglend & Gabbard, 2012; Høglend, 2014) indicated that reliability of Høglend's concept of

transference interpretation was reported in only two papers. In Høglend et al. (2008) reliability of four scales including the Specific Transference Technique Scales (P. Høglend, unpublished 1995 manual) was based "on average four or five full sessions of each therapy (452 sessions) were rated by three clinicians who were blind to the group to which the patient belonged. With two raters per session, inter-rater reliability coefficients were generally high (range=0.70 to 0.97 for all the process scales." (p.766). However, the following critical detail had been published only in Bøgwald et al., "1999): "*Four of the five individual items of the STT-transference subscale were measured with acceptable to excellent reliability"* (p.268, italics added).

Høglend's inclusive concept of transference has a total of five elements, four elements that refer to patient-therapist interaction while only one element retains the essential feature of Freud's concept of transference; the analysis of disturbing effects that originate in earlier relationships. This latter, fifth element, is distinguishable from the other four, and while not so identified, probably represents the fifth element, Freud's conception, that failed to be reliable. Although the four measures of current patient-therapist interaction are different from the fifth element, Freud's concept of transference, Høglend lumps together those four with Freud's concept, and calls them all, "transference," without providing a rationale for doing so. An epistemological analogy to Høglend's conception would be that oranges and apples are different and readily distinguishable, so they would not be lumped together and all called by the name of one of them, "oranges," unless there was some rationale for doing so. The author had an alternative option, which was to combine all five items but to label them "patient-therapist interaction". By including four measures of current patient-therapist interaction plus the item which includes past relationships in his category of transference, Høglend creates such a broad definition of transference, that all patient-therapist interaction becomes transference; *there is nothing that is not transference,* which reduces the value of the term. Cooper (1987) had proposed a similar expansion of Freud's concept of transference in clinical work, but he acknowledged that the result would be that "we are no longer sure what in analysis is not transference, and if it is not, what it is" (p.97).

Høglend provides no rationale for this expansion, except, perhaps, his statement, "the use of classical linking interpretations seems to have fallen out of fashion …" (2014, p.8). Contemporary Freudian psychoanalysts such as Abend (2005) and Blum (1983), clearly employ numerous interpretations linking to the patient's earlier relationships, as does Davanloo (Johansson, Town & Abbas, 2014).

Høglend (2014) recently reported that "more than 30 studies have reported significant associations between transference work and outcome. … that transference work interventions are indeed active ingredients (*for better or for worse)* (italics added) (p.1). It may be that unless transference interpretations can be reliably assessed, that the effects of transference interpretation will remain inconsistent.

The Validity of Transference Interpretation

We turn now from the issue of reliability of transference interpretation to the validity of transference interpretation. Transference research customarily has been conducted on *groups of patients* despite the conclusions of numerous analysts that therapeutic action *varies with and is specific to each patient-therapist dyad* (Boesky, 1990; Kantrowitz, 1993b; Levine, 1994; Kantrowitz, 1995; Kantrowiz et al., 1989; Ablon & Jones, 2005; Gabbard & Westen, 2003; Bacal, 2011). Westen and Gabbard (2002) appear to agree when they urge that the most productive analytic stance is a function of "how the specific dyad can create a useful therapeutic process" (p. 126). It seems likely that transference interpretation, so intimately involved in therapeutic action, will also vary with each

dyad. Lumping together the patients of dyads, despite our awareness of the varying transference-therapeutic outcome relationships in each dyad, may yield results for the group of patients that obfuscate specific transference-therapeutic outcome relationships.

An illuminating comparison between the concept of transference and our current understanding of the microbiome comes to mind. The microbiome – the trillions of microbes that share our lives (Yong, 2014) "is the sum of our experiences throughout our lives: the genes we inherited, the drugs we took, the food we ate, the hands we shook. … The microbiome is complex, varied, ever changing and context-dependent – qualities that are the enemy of easy categorization" (p.4). Much the same can be said about the concept of transference.

On the other hand, studies of groups of *individual analytic or psychotherapy patients* have generated interesting findings in areas other than transference research. Both patient-therapist "fit" or "match" (Shapiro, 1976; Kantrowitz, 1986; Kantrowitz, 1990c; Kantrowitz, 1993a; Levine, 1994; Kantrowitz, 1995; Leuzinger-Bohleber, 2002; & Tessman, 2003) and therapeutic alliance (Samstag et al., 1998; Martin et. al., 2000; Curtis, 2001; Horvath & Bedi, 2002; Safran, 2003; Cooper et al., 2004; Meissner, 2007; Horvath et al., 2010; & Huggler, 2012) have been found to have significant, positive relationships to therapeutic benefit. Thus, a recent study (Leuchter et al., 2014) reports that therapeutic alliance predicted response to medication and placebo expectation of medication effectiveness. Why are these relationships demonstrable across different dyads? We don't know, but we speculate that the positive effect on treatment outcome of "fit" and of "therapeutic alliance" shifts "levels" and encompasses a more universal bed rock relationship evoking common, fundamental attachment attitudes, while the factors responsible for individual therapeutic action, such as those involved in transference interpretation, are unique to each patient-therapist dyad.

Evaluation of the Validity of Freud's Transference Interpretation

Diamond et al. (2014) approached the problem of validity of transference interpretation by comparing patients with co-morbid Narcissistic Personality Disorder (NPD) and Borderline Personality Disorder (BPD) with patients with Borderline Personality Disorder without Narcissistic Personality Disorder. Their findings "raise the question of whether the NPD/BPD group experienced *less frequent* childhood trauma, or whether they were *better defended* and/or more reflective about childhood loss and trauma." (p.187). These patients' reports are current views, and there are no ways to check the validity of their reports of childhood experiences.

Another critique that undermines efforts to validate transference interpretation is Gabbard and Westen's (2003) assertion that "single mechanism theories [such as transference interpretation] of therapeutic action, no matter how complex, are unlikely to prove useful at this point because of the variety of targets of change and the variety of methods useful in effecting change in those targets …" (p.823). "The mechanisms of change in analysis will always be individualized according to the characteristics of patient and analyst (p.824).

Schachter (2002) asserted that "Freud's "transference" was conceived as a "false connection" identifiable by the distorted or unrealistic nature of the patient's reaction. A most important, overt theoretical change occurred when Gill and Hoffman (1982) asserted that "transference" does not involve distortion, but utilizes realistic elements of the analyst; this removes the basis for categorizing the patient's reaction as a "false connection" or "transference," rather than as a newly created, realistic response to the analyst. … The attempt to substantiate the theory of "transference" by patient recall is fraught with problems, and Freud's tally argument fails to validate the hypothesis that a current feeling or fantasy is caused by a childhood feeling or impulse. Just as "transference" is influenced and shaped by interaction with the analyst, it is likely that the alleged infantile templates

of "transference" have also been affected by other significant figures. Consequently, the effects of childhood experiences are likely to have been substantially modified by subsequent relationships; they would not have persisted unchanged and directly caused adult characteristics." (pp. 69, 70.)

Our failure to find evidence of the validity of transference interpretation does not indicate that such interpretations may not be valid. The absence of evidence is not the same as the evidence of absence! The interpretations may still be valid, and our conclusion neither should, nor will, result in therapists discontinuing the use of transference interpretations. However, our conclusion should lead therapists to acknowledge the lack of evidence for the validity of transference interpretation and to recognize that a transference interpretation is an hypothesis which probably can't be validated. Belief in the efficacy of transference interpretation should be held lightly. Gabbard and Westen (2003) agree since "we no longer have a consensus in psychoanalysis about what works and why. In general, the current psychoanalytic scene is witnessing movement toward greater humility. This humility is reflected in tolerance for uncertainty … (p.826). "There is no single path to, or target of therapeutic change" (p.837).

Open Questions

Psychoanalysis, unfortunately, is a field lacking clear boundaries. We can say what it is not; we cannot say what it is. It is time, in agreement with Winnicott (1958), Gill (1984a), and Fosshage (1997) to be more definite in stating that attempting to distinguish between psychoanalysis and psychoanalytic psychotherapy is futile (see also Kächele, 2010). Having digested Sandell´s et al. (2007) report from the Stockholm study demonstrating how strongly therapist attitudes influence change during treatment, we think that the field should move on. We propose that Gill and Fosshage's suggestion, although not reflecting consensual agreement, is useful, that any treatment that focuses upon analysis of transference ("stereotyped rigidity," Gill, 1984b) be considered psychoanalytic treatment. However, many investigators use the term "transference" loosely to apply to all patient-analyst interactions (Høglend 2014). We propose that the term "transference" should be limited to patient behaviours that are characterized by "stereotyped rigidity," and are to some degree maladaptive. Of course, that 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. Given the complexity of assessing "stereotyped rigidity," analysts would have to undergo training in order to be able to achieve inter-rater reliability, especially if analysts of diverse orientations were included. Clearly, evaluating "transference" in the material of a single case has to be placed in some comparative perspective; to attempt such studies with large numbers of treated patients would be orders of magnitude more demanding. Therefore, if the intent is to study the causality in specifically psychoanalytic treatment (as defined by the presence of "transference"} the feasibility of doing so is greater in single case studies than in group studies.

In addition any psychoanalytic technique needs a strong focus on new experience to overcome the maladaptive patterns (Thomä & Kächele 1994a). This kind of new experience must be fostered by a number of techniques that Schachter & Kächele (2007) have termed Psychoanalysis-Plus. Processing the therapeutic relationship to a patient´s best use must be the clinical hallmark of good analytic work (Hill & Knox 2009; Jiménez 2009). How to capture these new experiences is still a task that lies ahead. At present a study group on conversational analysis at the Berlin International University has embarked to focus on micro-patterns of interaction:

Conversation analysis and psychotherapy process research is an evolving field promising new insights for therapeutic practice. For the specimen case of Amalia X, her 152nd session has been re-transcribed on a higher level of preciseness which allows for more detailed listening to the prosodic properties of this analytic dyad. Our findings show a) how analyst and patient co-create their common conversational object called psychoanalysis; b) how a lot of up-to-now not described analytical tools are applied, that can be described as "practices"; c) how a "dance of insight" is enacted by both participants in a common creation making patterns of interaction visible from "both sides"; d) how participants create metaphors as conversational and cognitive tools to reduce the enormous complexity of the analytic exchange and for other purposes; e) that prosodic rhythmicity and other prosodic features are best integrated in a threefold model for analytic conversation consisting of "interaction engine", "talking to" and "talking about" the patient (Buchholz et al. 2015).

Conclusion

Kernberg and Høglend have reported numerous empirical studies of transference interpretation. Kernberg did not report significant evidence of reliability either for the patient-therapist interaction aspect of transference or for Freud's concept of transference. Although Høglend reported that measures of the patient-therapist interaction aspect of transference were measured reliably, there was no evidence that the measure based on Freud's transference interpretation was reliable. Clinically, many analysts have asserted the unreliability of Freud's transference interpretation, and empirically there is no evidence to support reliability. Neither investigator attempted to assess the validity of transference interpretation. Absent reliability, plus the little likelihood of validating such an interpretation, if such an interpretation is presented to a patient it should be acknowledged to be at best an hypothesis, evaluated with humility, and held lightly by the therapist.

Many years ago Luborsky (1969) commented on the report of Strupp and Bergin (1969) by stating: "Research cannot yet influence clinical practice." Are we now in a different position today, do we encounter a fruitful collaboration between clinical practice and research now, or do we have to accept that the survival range of a basic notion of Freud's transference concept has outlived its acceptance in the field?

Chapter Six

"Correct" versus "incorrect" Psychoanalytic Dream Interpretation: Implications for Psychoanalytic Education

Abstract

This paper was stimulated by reading a published paper in which it was agreed that the analyst/teacher's dream interpretation was "correct" and the candidate's interpretation was "incorrect", which may have negatively impacted the candidate's analytic confidence. The wide variations in different analysts' dream interpretations raise a question about the likelihood that a specific interpretation can be judged to be "correct". The single empirical study of reliability of analysts' dream interpretations indicated a lack of reliability.

To illustrate the wide variations in analysts' dream interpretations, those of a traditional analyst, a self-psychologist and an interpersonal analyst have been culled from the literature and presented. These approaches to dream interpretation are so widely divergent that it raises a question of what the likelihood is that they would independently, reasonably agree on the interpretation of a dream of another patient. We conclude that, given the uncertainty about the "correctness" of an analyst's dream interpretation the analyst, particularly the analyst/teacher, should hold his/her interpretation lightly, and candidates should be taught to do the same in their interactions with their patients. This may reduce the possibility that the analyst/teacher's conviction about the "correctness" of his/her dream interpretation may reduce the candidate's analytic confidence and expose him/her to feelings of shame.

Introduction

Dream interpretation continues to play a salient role in psychoanalytic treatment, and, for that reason, occupies an important place in psychoanalytic education. One paper describing the teaching of dream interpretation to psychoanalytic candidates struck us both as unfortunate pedagogically and possibly have negatively impacted the candidate's feelings of analytic competence and possibly shame. The crux of the possible negative effect was that both the supervisor and the candidate agreed both that the analyst/teacher's dream interpretation was "correct" and the candidate's dream interpretation was "incorrect".

There is such wide variation in analysts' dream interpretations, that it raises the question whether different analysts are able to provide reliable, "correct" dream interpretations. The dream interpreter cannot help injecting some of his/her own psychology into the process of interpreting the dream (Blechner, 2001). Jung, reports Blechner, felt that working primarily from the patient's associations leads one *away* from the true meaning of the dream. It is likely that dream interpretation, like "psychoanalytic process" may well vary with each patient-analysts dyad (Boesky, 1990; Levine, 1994; Ablon and Jones, 2005; Bacal, 2011). Further, despite its iconic position, there is virtually no empirical evidence that dream interpretation improves the therapeutic benefit of psychoanalytic

treatment. Myers and Solomon (1989) reported that higher dream frequency in 25 psychoanalytic patients was correlated with a better treatment outcome, but they noted that Myers was especially interested in dreams, so that the patients were aware of what pleased him, and the better outcome itself may have been a function of a better patient-analyst "fit" rather than a product of the increased dream frequency.

The wide variations in the focus of dream interpretations by a traditional analyst, a self-psychologist and an interpersonal analyst presented in this paper provide evidence for this variability. Given the absence of substantial evidence of the reliability of analysts' dream interpretations, we propose that an analyst should acknowledge both to patients and to candidates that they cannot be certain of the "correctness" of their dream interpretation. Candidates should be taught by example that their dream interpretations – and those of their instructors – should be held lightly.

Teaching Dream Interpretation

J. Levy (1996) describes an example of teaching dream interpretation to a senior candidate in a dream interpretation seminar. The candidate's patient, Mr. A, was an articulate, fluent and intense man of 36 years who complained of unhappiness with his career choice, a return to smoking, and frightening and explosive anger. He felt himself to be a mere appendage of his mother and was enormously disappointed in his relationship with his father. He was mistrustful right from the beginning of treatment.

In the session prior to a dream, he had mentioned that he had been reluctant to paint and prepare a room for Joan, his 11-year old daughter from his first marriage, lest she want to stay overnight. His fears were interpreted as related to his sense of being unsuited to the role of father.

After that session he felt this huge weight lift off his shoulders and resolved to finish painting the room and tell her she is welcome. It is scary, but he then dreamed that he was talking to his analyst face-to-face, telling him he, himself, was a perfectly average guy, not a dangerous person. In a second dream his friend, Bill, drove up next to him. Bill has a nice white Prelude and the patient was in his old Datsun, yet Bill eyed the patient's car as if it was nicer.

His associations included that his work project had finally been published yesterday. He felt positive about the dreams. "The dream about us is a dream about equality". The candidate commented to the patient, "you aren't sure how I will take your positive feelings and feelings of strength". Patient responded that he feels they are getting nowhere.

The candidate said that the patient feels his analyst might retaliate for his going too far. Mr. A recalled that when he was happy his mother cautioned him that there was no room for that. He also recalled a memory of observing at some sand pit that an older guy was touching a boy and he didn't do anything about it. The candidate said to the patient "you feel your mother misinterpreted your enthusiasms as being out of control, like something bestial, like the man molesting the child". In a previous analytic treatment he had tried sitting up and was terrified of lying down because he feared he would never again sit up. The candidate commented to the patient that he sees his impulses as dangerous , and feels psychoanalyses should hold him down and control him. The patient responded "I feel I hurt others … or perhaps I killed my mother".

J. Levy wrote that "the father transference is the emotional context within which the dreams could have been interpreted. This perspective is significantly different from the negative mother transference around which the candidate organized his interpretations" (p.572). J. Levy believes that the dream interpretation he recommended was the "correct" one and that the candidate's dream interpretation was "incorrect"; he added that the candidate's "interpretive line had not advanced or

deepened the analytic process. The potential contribution of the dreams for furthering the therapeutic alliance was lost" (p.573). The candidate commented that this view of himself as representative of the helpful father was significantly different from his understanding of the material. He had failed to incorporate this perspective because he had missed the possible unconscious implications of the previous session.

They listened to the session following the dream and "We wondered whether the candidate's deafness to the patient's dream communication caused the patient to return to his previous defensive position. "The candidate quite frankly stated that he had personal difficulties regarding himself as a representative of the father toward whom the patient harbored latent fury. The candidate felt more comfortable with the "mother introject". (p.576). Levy summarized "the dialogues among the candidates provided opportunities for the participants to reflect on the sources for their common difficulties in integrating basic dream concepts with handling their dreams in a productive way". (p.578).

It is difficult to evaluate J.Levy's pedagogy. He did not articulate why he thought the candidate's dream interpretation might not *also* have been useful, why he thought it had not advanced the analytic process, and why the potential for furthering the therapeutic alliance was lost. Thus, J.Levy seemed to have a strong conviction that only his dream interpretation was the "correct" one, and the candidate's interpretation was not useful. Parenthetically, since the dream about the patient's friend, Bill, involved competitive feelings, we wonder about the absence of any discussion of the day residue which included his work project having finally been published. The candidate, who may be roughly the same age as the patient, may never have published a book.

Shaming Psychoanalytic Candidates

Buechler's papers about the shaming of candidates, (2008a, 2008b) are relevant here and we will summarize her observations which encompass the entire educational experience but are particularly relevant to the teaching of dream interpretation. She quotes Schafer (1984): "I think it's a good idea not to overwhelm a supervisee with all the clever ideas that you as a supervisor think you have. … Occasionally, supervisees who are working through the problems of speaking up against authority in their own analyses begin to indicate to me that I sort of make them feel stupid – things like that" (p.225). Buechler (2008a) writes "I believe that our shame experiences in training can have a lasting effect on our subsequent ability to deal with shame in the treatment relationship, as well as on other aspects of our professional and personal lives. Even when the training process seems successful, the possibility of evoking shame is present". (p.361). She observes that the candidate who receives a highly critical and generally negative evaluation may be profoundly, lastingly affected by this experience. She considers the shame inducing potential is accentuated by the *secrecy* that often surrounds it. Candidates often feel that if any problems occur in their training they should outwardly comply since complaint is often seen as evidence of a characterological flaw. Such feelings of failure may exert a powerful effect on self-esteem sometimes for long after graduation.

Buechler notes that in supervision, a focus on counter-transference seems especially conducive to evoke shame in the candidate since it involves examining the candidate's gaps in self awareness. The shame because of the delineated need of these defenses, arouses fears that he/she may be unfit to be an analyst. Consider that this may have been true for the candidate J. Levy supervised. The common interpretation that the content of the candidate's treatment is being enacted in the session with the supervisor may, if stated baldly, evoke shame in the candidate and subsequent feelings of shame about being ashamed (Szecsödy, 1990).

Buechler (2008a) acknowledges that in analytic training some shame may be inevitable and even adaptive. She refers to Sullivan (1953) who notes that how we learn to be social creatures is through experiencing varying degrees of failure, with its attendant discomfort. Berman (2004), too, notes that learning new skills unavoidably arouses feelings of impotence and helplessness. Criticism may always be experienced as hurtful, but, that, without criticism there is no growth

Variation in Psychoanalytic Dream Interpretation as a Function of Psychoanalytic 'School'

Examples of psychoanalytic dream interpretation by a traditional analyst, a self-psychologist and interpersonal analyst are presented below.

Traditional Psychoanalytic Dream Interpretation

Jiménez (2012) in an open description of his technique of dream interpretation has de facto assigned increasing importance to the so-called manifest dream. He cited a dream at the beginning of his patient, Carmen's sixth year of a 4 sessions/week analysis. Carmen's husband had been killed by the Pinochet dictatorship 15 years earlier, which had plunged her into profound mourning. She had felt empty and dead and lost emotional contact with her small children. Her attempt at therapy was aborted after a brief sexual relationship with a therapist and left him. After some years she remarried and had a child.

Her mourning, her guilt feelings and her idealization of her first husband occupied the first years of the analysis. Jiménez then presented a session after she had spent a week abroad for work reasons and a few days prior to a planned 10-day break by the analyst.

In the dream she was with her first husband and other men, all dressed in black. One of them lifted his shirt and showed an area of his skin, red, covered in eczema, oozing some excretion which effected her. Another man said, "at long last I find somebody who has the same I have" and showed some inflamed skin on his leg which was oozing some kind of juice. She told her husband they should leave. They had to go to some desolate stoney place, like the aftermath of a nuclear disaster. They came across a group of women wearing black. They had to cross a gully but it was very dangerous because at intervals the water gushed in and flooded everything. One of the women told her that to try and cross was extremely dangerous. She and her husband began crossing but in a weird direction; instead of walking across they walked lengthwise. It was full of caverns, creepy. They began to climb stairs, but her husband made some movement that left her hanging, about to fall into a very deep gully. She panicked, begged her husband to bring her down. She woke up, terrified!

Jiménez provides his thoughts including whether his impending break in sessions was represented by her being left hanging at the edge of a gully. Could those men, he speculated to himself, be castrated beings displaying their wounds? He wondered, what type of primitive tragedy was being staged in the dream? Oedipal? He kept thinking how she had snuggled up on the therapy couch, pulling the blanket over her.

Carmen said the dream has to do with her sexuality and it was terribly difficult for her to talk about it. Jiménez said he believe that she knew why the woman, M, appears. Carmen said that M is homosexual and enormously afraid of men. Carmen fears talking about her sexual fantasies. Jiménez commented, you're terrified of getting excited. That's quite dangerous. Apparently you've got to have sex but without getting excited, with no pleasure, no enjoyment. You may suddenly be flooded with dangerous pleasure.

Carmen said she had omitted something yesterday. For three nights while she was away she had intense erotic dreams about an attractive man, a delegate from another country. Jiménez commented that lying down [on the couch] snuggling up and beginning to feel good is very dangerous. Carmen said the Mexican man is a substitute for you. Jimenez thought to go to bed with one's analyst – a catastrophe. He thinks of the taboo of incest. He commented, little by little she was bringing him closer to her sexual fantasies.

A few weeks later, after he retuned, Carmen dreamed she was in a white car, the same color as the walls of his office. She also dreamed a gynecologist said she had an infected anal fistula which should be lanced immediately because the pus was contaminating her genitals.

Jiménez wrote that the unconscious situation became clear in a flash and he interpreted, "We must talk openly of a type of hidden relationship you have with me, that you in your fantasy, have concealed in your body, precisely between the anus and vagina. In this fantasy, you and I are engaged in a sort of permanent sexual intercourse, a 69, in which you suck my penis and I suck your vulva, and thus, you get to convince yourself that the penis is at times yours and at times mine. It is a confusing relationship that is causing you great distress." … She strongly rejected the interpretation. Some days later she reported a dream in which she had an enormous penis, with something like an allergy on the glans" (p.58).

Jiménez commented that in his technique the patient has a much more important role than usually granted in the classical technique. However, his focus on the centrality of penis envy seemed to warrant considering his description a variant representation of contemporary traditional psychoanalytic theory.

Self Psychology Dream Interpretation

Ornstein (1987) notes that the dream is *always about the self;* that is, the dream always presents various aspects of self-experience to the dreamer's attention. He commented it was important to recognize and accept the patient's disavowed feelings by calling attention to them before any interpretive effort. "Thus the self is represented in any and every dream."(p.101). Ornstein quotes Fosshage (1983) "To work with dreams … at the phenomenological level facilitates the dreamer's participation and conviction in understanding dreams and thereby increases the potency of dream work" (p.662).

Self psychologists categorize two types of dreams: one is "self-state" dreams whose associations failed to expose any latent dream thoughts or deeper understanding but amplify what the manifest dream imagery had already revealed. Their absence of deepening associations leads to attribution of a different psychological structure and function of these dreams; they "attempt to deal with the psychological danger by covering frightening, nameless processes with nameable visual imagery" (Kohut, 1977, pp.108-109). The other type of dreams, with illuminating associations, are non-self-state dreams.

Ornstein's patient, Mr. K, a bachelor in his late thirties undertook an analysis because of his life long suffering from severe work inhibition, low or non-existent self-esteem, feelings of emptiness and purposelessness, and an unusually high degree of social and emotional withdrawal. He became 'addicted' to the regularity of the analytic schedule and all interruptions, even weekends, played havoc with his emotional equilibrium. He took to his bed on weekends and rarely left his home. He neglected all household chores. He would feel "unconnected," "abstracted" "just an empty shell".

After a planned long weekend interruption (which included canceled Friday and Monday sessions) he reported the following dream: "Inside a rickety house or structures - of corrugated iron. There was a ladder in the middle – wobbly; it looked like it would soon collapse, too, just like the

house or structure." (p.92). He commented, "The house is me – the way I feel … not just now, always….There is no stability in my life and I am threatened by collapse all the time. I live in fear of that" (p.92). The analyst said, "So this time it was more the fear of it, rather than an actual collapse." Patient commented, "Yes, I even tried to do some repair work on the outside of the house, I got the ladder out of the garage – but never got as far as using it.".

The analyst asked what he thought of picturing the corrugated shack as depicting where he lived emotionally? The corrugated iron shack was shabby and reminded the patient of his own worthless self. Such a shack would be allowed to rust down and be scrapped. The analyst asked the patient if there was anything special about this weekend. The patient responded that the analyst's additional Friday absence meant that the analyst didn't care how he felt. By the end of the session, although the patient manifestly experienced the disruption subjectively as catastrophe, there was no actual catastrophe, and the dream revealed an improvement in the capacity for self-regulation since he'd only feared but successfully avoided the more serious collapse.

More than a year later he reported the following non-self-state dream: he was on the street in which the first house he lived in was located. A tractor with two trailers comes down a residential, dead-end street. It got stuck; impossible to turn around. "I thought I would help the driver turn around. I directed the driver to drive into the garage at the end of the driveway at the end of the street. That might make it possible to turn around. His brother was there watching. The dream ends before it is all accomplished" (p.98). The patient thought his brother in the dream represented the analyst. He was trying to turn it [referring to his stance of not having feelings] around.

The self psychological approach to dream interpretation assumes that wish fulfillment, "is only *one* possible regulatory function and no longer prime instigator of dreaming" (Ornstein,1987, p.103). Dreams can indicate the various ways in which patients deal with acute as well as chronic injuries to their self esteem.

Interpersonal Psychoanalytic Dream Interpretation

H. S. Sullivan (1953), one of the primary founders of interpersonal psychoanalysis, describes his stance regarding dream interpretation:

"The psychiatrist clears up as much as he can of what is irrelevant and obscuring in the reported dream, presents what he seems to hear in terms of a dramatic picture of some important problems of the patient's, and propounds the riddle [to the patient] "What does that bring to mind?"" (p. 338).

His skepticism as well as distance from the traditions of his contemporaries are clear when he says: "To deal with it on the basis that one can convert dreams or myths into consensually valid statements by intellectual operations seems to me such a misunderstanding … that I don't see how one can take it seriously". (p. 343)

Sullivan's example of interpretation of a dream is of a schizoid, obsessional patient who had described how for many years his mother had been vaguely annoying. The patient reported a dream of a Dutch wind mill: "It was a very beautiful scene with a carefully cared-for lawn leading up to the horizon on which this beautiful Dutch wind mill revolved in the breeze. Suddenly, he was within this windmill, and there everything was wrack and ruin, with rust inches deep; it was perfectly obvious that the windmill hadn't moved in years" (pp.338-339). Sullivan said, "That is beautiful, active on the outside – utterly dead and decayed within. Does it provoke anything?" The patient replied, "My God, my mother!" (p.339). Sullivan added, "You will note that I have not discussed the latent content of the dream…" (p. 339).

Bromberg's (2000) general principle was "to see a dream as part of a session rather than as a 'thing' brought into the session from the outside" (p. 697).

His patient, Daniel, a man in his early thirties had come for analysis because of mysterious leg pains and had cancelled the previous session because of those pains, which had not happened for a long, long time. Daniel reports the dream: "I'm running a race on a concrete surface with someone else who is running behind me. I'm a novice and he's a pro. I'm always thinking he'll catch up but he never does. … I effectively cut him off from passing me, and I end up winning'. Daniel reported another dream: I was in a room, sitting up and talking to you. You were telling me things that weren't fitting; you were wrong. We were near each other and I was thinking Carol would be a perfect match for you. I was pissed at you. She can't admit she's wrong". (p. 697).

Bromberg commented "I think I fit very well with that guy who keeps trying to get ahead of you. Actually, I was all ready to do it again today. I can feel how terribly hard it is for you right now to hang in with me. … maybe it's because a part of you might be scared that it's too much for our relationship to bear" (p. 700). Daniel replied, "Yea, it's hard to believe you are willing to hear this. It's hard to believe I haven't hurt you badly and that you're secretly hating me. … I also want to tell you I appreciate your saying …about how hard it was to hang in". (p. 701).

The dream, asserts Bromberg, "is the most familiar special case of the more general phenomenon of dissociation, the normal self-hypnotic capacity of the human mind, then dreaming might be considered among the most routine day-to-day dissociative activities of the mind – its nocturnal function being an adaptational effort to cope with minimal levels of not-me experience without interfering with the waking illusion of central consciousness" (p. 694).

Do the Variations in Dream Interpretation Mean that an Analyst Cannot Select a Single "Correct" Interpretation of a Particular Dream With Assurance?

The approaches to dream interpretation of traditional analyst, Jiménez, self-psychologist, Ornstein, and interpersonal analyst, Blomberg, are so widely divergent that it raises a question of what the likelihood is that they would independently, reasonably agree on the interpretation of the dream of another patient. French and Fromm (1964) had sounded the same note of caution, proposing that intuitive guesses at dream interpretation by the analyst should repeatedly be tested and retested against the relevant context or precipitating emotional situation. Lowy (1967) warned urgently against making overly hasty dream interpretations. Roland (1971) recommends simultaneously searching for the relevant context and exploring the dream. Specht (1981) similarly declares that "dream interpretations should also be comprehended as recommendations and not as descriptive statements" (p. 783), and he emphasizes, as Roland did, the decisive importance of the relevant context.

Fosshage and Loew (1987) conducted an empirical, clinical dream study in which they took six dreams from different points in one person's analysis and showed them to analysts from Freudian (Traditional), Jungian, Interpersonal, Object Relational, Phenomenological and Gestalt theoretical orientations. A brief description of the patient and of her treatment were provided, as well as some of her associations to the dreams, but no attempt was made to provide the day residue or "relevant context" in the patient's life for each dream. They asked the analysts to describe the meanings of the dreams. Fosshage and Loew concluded that "wide discrepancies in the selection, interpretation and evaluation of dream elements emerge". (p. 291). They add, "While the contributors often differ considerably in their understanding and evaluation of dream images, they not infrequently focus on the same central psychodynamic themes. … The Freudian (traditional) analyst's consistent translation of the dream elements into sexual imagery [as did the dream interpretations of traditional analyst Jiménez, presented earlier] and his continued utilization of massive transference interpretations cause his interpretations to be strikingly different compared to those of other

contributors" (p.274). These data, from the only available empirical study of dream interpretation, support the thesis of this paper that dream interpretation should be evaluated cautiously, as there is no way to be sure if any single interpretation is the "correct" or valid one. A similar note was sounded by Thomä and Kächele (1994a) that "The dream is thus a concentration of many different endeavors and has an infinite number of potential meanings; the number of possible interpretations of a dream runs, as a matter of principle, into the "tens of thousands". (p. 166). Blechner (2001) observes that "In any dream analysis you cannot help missing some of the themes because of your own counterresistance. (p. 143).

Discussion and Conclusion

We propose that psychoanalytic dream interpretation should be conceived as a two-step process: 1. Search for the relevant context or day residue; and 2. Interpret the dream in the light of the relevant context. There is no evidence that analysts independently can reliably identify the relevant context, and no evidence that analysts independently can reliably interpret dream content. Therefore, every interpretation of dream content should be regarded as a tentative hypothesis to be evaluated on the basis of further patient material. This is the concept of dream interpretation that we recommend be taught in psychoanalytic education.

While analysts need to feel confident about their clinical skill, this paper challenges the very conception of making the "correct" interpretation of the patient's dream. Dream interpretations by analysts of different 'schools' vary widely. Many analysts, including analyst/teachers, seem to assume that their own dream interpretation is the correct one, and other, different interpretations are off the mark. This apparent need for certainty may be dealt with by the support of the analyst's defensive attitude about correctness by what Jonathan Lear (1998) has termed "Knowingness" – a conviction that the analyst "knows" what is correct. While comforting to the analyst/teacher, this interferes with open-minded exploration of alternative dream interpretations; holding the interpretation lightly may serve the analyst and the treatment better, and may to some degree protect the candidate from the damaging loss of self-esteem and the experience of shame resulting from failure to have recognized the supervisor's "correct" dream interpretation.

Chapter Seven

Psychoanalytic Treatment of the Elderly[9]

Abstract

Elderly patients who may have been able to deal satisfactorily with earlier periods of stress may find that in latter life they are impacted by an array of devastating losses and crises subverting their abilities to adapt satisfactorily. Psychoanalytic treatment has been demonstrated to be helpful to many elderly patients, especially if the psychoanalyst chooses to relax a traditional analytic stance and actively engage the patient with the exploration of new relationships and activities which may relieve any residual loneliness.

We also propose that an alternative concept of termination be considered which includes the possibility of post-termination follow-up contacts between patient and analyst. We detail the advantages of this conception both for patient and analyst, which may be particularly useful for elderly patients.

Introduction

We know of no consensus definition of "elderly"; it varies with epoch and society. While defined as ages 55 and older in Freud's day, post-industrial retirement and government programs have moved the marker to 65. The American Psychoanalytic Association, for example, proscribes a training analyst from beginning a training analysis with a new candidate after the training analyst is 70-and-a-half years old, presumably to protect the candidate from loss. One concept of old age places it at those ages nearing or surpassing the average span of human beings. Wikipedia reports that white Americans born in 2010 are expected to live until age 75.9 African Americans to live to 75.1 years and Hispanic Americans to 81.2 years. We arbitrarily suggest (for this paper) that the elderly be considered 75 years or older

Psychotherapists/psychoanalysts treat individuals, and the concept of statistical averages has limited meaning. Many individuals today live far beyond age 75, and this group is the focus of our paper. Psychoanalytic treatment of the elderly revealed problematic attitudes at its start since Freud (1905a) (facing 50) believed that psychoanalysis was not appropriate for his age group and beyond; "On the one hand near or above fifty the elasticity of the mental processes, on which the treatment depends, is, as a rule, lacking" (p. 264). Freud may also have been influenced by his assumption that libidinal activity was sharply diminished in this age group, and, therefore access to, and the interpretation of those libidinal conflicts he considered central to analytic treatment, might not be feasible. Abraham (1919), however, fourteen years later, wrote about the value of psychoanalysis with patients "of advanced years". Recently Settlage (1996) felt that the matter had been settled by the subsequent reported treatment experiences of analysts: "The myth of the unsuitability of middle-aged and elderly individuals for psychoanalytic treatment has been dispelled" (p. 548).

Erikson (1959; Erikson et al., 1986) included old age in his articulation of lifecycle stages and Settlage added that "The concept of adult development, including in old age, has received increasing exposition and acceptance (Crusey, 1985; Gould, 1990; Griffin & Grunes, 1990; Levinson, 1985; Nemiroff & Colarusso, 1981, 1985, 1990; Settlage, 1996; Simberg, 1985)".

Settlage (1996) graphically described two periods of psychoanalytic treatment of a woman poet at ages 94 and 99 years. In his discussion he considered whether the described treatment was psychoanalysis:

"I believe that psychoanalysis as a method of treatment is most cogently defined by its therapeutic action—by structural change resulting from the engagement and progression of psychoanalytic therapeutic process.

The patient clearly had the capacities needed for optimal participation in psychoanalytic work: the ability to form a therapeutic relationship, psychological mindedness, abstraction, introspection, reflection, appreciation of symbolic representation and tolerance of surfacing memories, fantasies and feelings. Although the analytic couch and the usual frequency of four or five sessions a week were not employed, the treatment had the hallmarks of psychoanalytic work: free association, the use of dreams, transference, transference interpretation, resistance to the exposure of repressed mental content, insight, the resolution and working through of intra-psychic conflict and change in psychic structure. By these criteria, the work with this patient was psychoanalysis." (p. 558).

We concur with view that the relationship between psychodynamic psychotherapy and psychoanalysis is quantitative rather than qualitative (Kächele 2010).

Granting such, the treatment supports the observation that chronological age by itself is not an index of suitability or unsuitability for psychotherapy/psychoanalysis (Simburg, 1985, p.132.) There is no evidence that the psychotherapeutic/psychoanalytic process is age-related; the psychotherapeutic/psychoanalytic process may take place throughout life. Simburg characterizes psychotherapy/psychoanalysis as dealing with repressed infantile issues and later life-course issues. "Human object need and its derivative, transference, remain constant, insistent, and enduring throughout life" (Cath, in Panel Report, 1986, p. 164). "Whereas physical strength diminishes with age, the intensity of the unconscious mind remains 'timelessly intact" (Crusey, 1985, p. 158, p. 165).

Despite this growing acceptance of the value of treatment of the elderly, evidence suggests that psychotherapeutic/psychoanalytic treatment of the elderly remains limited. For example, a review of PEP yields only 24 papers about the elderly in contrast with 248 about adolescents and 1244 about children. In addition, it is noteworthy that while many American Psychoanalytic Association institutes and others provide courses about the treatment of children, adolescents and adults, few institutes provide a course in the treatment of the elderly. Our survey of institutes indicate that one institute provided a study group and another offered an elective course; 14 institutes provided neither a course nor a study group. In sum, none of the 16 responding institutes provided a required course in psychoanalytic treatment of the elderly.

The Elderly are Subjected to a Devastating Array of Losses

Settlage (1996) notes that the losses of old age have been documented and underscored (Berezin & Cath, 1965; Cath, 1962; Crusey, 1985; Goin, 1990; Hildebrand, 1985; King, 1980; Pollock, 1977; Sandler, 1984). The range of disturbing losses, taken together, may be relatively unique to this phase of development, except in wartime, natural disasters or epidemics; loss of loved ones and/or of friends, loss of parenting gratification, loss of health including physical prowess, vision, hearing and memory, loss of professional identity, loss of social status and income, and loss of self-esteem. In vulnerable individuals such losses may produce depression at any age, often accompanied by the risk

of suicide. The Centers for Disease Control and Prevention note that more people die of suicides yearly than in car accidents with suicide predominantly weighted towards both ends of the life arc; teenagers and the elderly. Of 100,000 people ages 65 and over, 14.9 died by suicide in 2007 compared to the 11.3 for our national average (Home Health and Education Publications). Elderly white men have the highest rate, 29 per 100,000.

The Nature of Loneliness
When I woke they did not care
Nobody, nobody was there
Come back early or never come
When my silent terror cried,
Nobody, nobody replied
Louis Macniece (Orr, 2013)

Loneliness is often a cardinal concern in the treatment of the elderly, and warrants some reflections on the concept. Fromm-Reichman's (1990) paper about loneliness, although it focused on its psychotic dimension, brought the concept of loneliness to analysts' attention as a facet of distress. Albert Murray in an interview described it graphically: "But nothing hurts quite like the loss of old friends. There are ways to cope at the time they die. But weeks and months later you realize you can't phone them and talk: Duke Ellington, Romare Bearden, Ralph Ellison, Alfred Kazin, Robert Penn Warren, Joseph Mitchell. It's hard to believe they're all gone" (Watkins, New York Times Obituary, 2013, p. A15). Sullivan (1953) clearly articulated how hard it may be to define loneliness: "I, in common apparently with all the denizens of the English-speaking world, feel inadequate to communicate a really clear impression of the experience of loneliness in its quintessential force" (pp.260-261).

Given marked variations both in biological endowment and in child rearing customs, we can assume a characterological variation in the need for relationships and intimacy, and pleasure or tolerance of being alone. Sullivan (1953) described loneliness as "the exceedingly unpleasant and driving experience connected with inadequate discharge of the need for human intimacy" (p.290). Loneliness is caused thus not by being alone but by being without some internally defined needed relationship. Weiss (1973) reports, similarly, that loneliness syndromes give rise to yearning for the relationship – an intimacy, a friendship, a relationship with a kin – that would provide whatever is at the moment insufficient. This form of loneliness, based on the absence of a close emotional attachment, to another human, can only be remedied by the integration of another emotional attachment or the reintegration of the one that had been lost. Some people may find comfort with pets or nature and not need psychoanalytic treatment. However, we are often confronted with those who may experience the loneliness of emotional isolation, of utter aloneness, whether or not the companionship of others is, in fact, accessible to them, and it is they who seek and are suitable for intensive analytic work throughout the age range. In contrast, the specific form of loneliness associated with the absence of an engaging social network – the "loneliness of social isolation" - can be remedied only by access to such a network. Since both elderly men and women are especially vulnerable to the loss of critically important social ties and to physical isolation, they are, therefore, at increased risk for loneliness. Weiss concludes that "It is easy to see the lonely as out of step, as unwilling to make necessary overtures to others, as lacking in qualities necessary to satisfactory human relations. In this way we blame even as we purport to explain" (pp.74-75).

Dealing with the Disturbing Losses of the Elderly

As we grow, multiple non-family members play increasing supportive roles in our lives, beginning in infancy, with nannies, grandparents, baby sitters and child-care workers, followed by teachers, friends, neighbors, coaches and mentors, and then often spouse(s), new family members and colleagues. The influence of family of origin members usually declines throughout life; the influence and importance of friends waxes in adolescence and increases again in the elderly period when, in a mobile society, friends and not family may well be the primary sources of love, care and support (Cath, 1997).

Both Fleming (1972) and Bowlby (1973) asserted that we all need to feel confident that there are one or more trusted persons that will come to our aid should difficulties arise. Buechler (1997) adds that in both attachment theory and the Sullivanian understanding of the human condition "we are struggling to maintain the security we need as a base from which to venture into the unknown" (pp.160-161).

Psychoanalytic Treatment of the Elderly

A subset of elderly patients who had developed reasonably satisfactory adaptations to the vicissitudes of earlier periods of development, with or without therapeutic interventions, may find the host of challenges and stresses of that stage exceeding their adaptive capacities. Numerous reports document that psychoanalytic treatment can be extremely helpful and beneficial to the elderly (references cited earlier by Settlage, 1996). A.M. Sandler (1984), importantly, points out that some psychoanalysts treating elderly patients may be too eager to discard the impact of external events and view the presenting symptoms entirely as a result of the breakdown of the mental agencies of the individual" (p.473). We conceive that the elderly person may previously have achieved a reasonably adequate adaptation, but defenses may no longer be adequate for the new developmental tasks and losses of being elderly. In addition, awareness of the shortness of time ahead may provide impetus for seeking help. Sandler concluded that "Mrs. A's illness should not be understood as due to the emergence of a neurosis … To me it seems evident that Mrs. A became depressed because she found herself unable to cope with the internal stresses and conflicts aroused in her by the process of aging" (pp.488-489). Nemiroff & Colarusso (1985) similarly view the treatment of older patients as specific to this discrete phase of development. Valenstein (2000) is even more focused and in agreement with our views when he describes "the transference serves two purposes: for reality-based attachment needs, where it is pivotally restitutional for the object-deprived older patient who has fewer opportunities for new attachments; and also, as far as feasible, for the facultative recapitulations of the past and their understanding as they experientially unfold" (p.1583). He adds that in working with the older patient "we are more accepting and inclined to be more responsive to the older patient's needs for attachment and support, even though that may depart in some measure from the priority traditionally given the analysis of the transference in its recapitulations of past conflicts and relationships" (p.1584-1585).

Changing the Role of the Analyst and the Frame of Treatment

We propose that after the apparent completion of extensive and intensive psycho-therapeutic/analytic work to repair endogenous, narcissistic, neurotic roots of loneliness, with or without supplementary pharmaceutical help, if the patient remains troubled by persistent feelings of reality-based loneliness, the psychotherapist/analyst may utilize a modified stance that actively suggests the remedial development of new friends and activities to remedy this loneliness, while exploring any resistances

to that suggestion. Although we have not collected data about the effect of such suggestion on treatment outcome, we do not anticipate significant negative impact while a positive outcome is plausible. We hope psychotherapists/analysts will consider applying this suggestion in stalemated treatments in which an isolated patient remains troubled by persistent feelings of loneliness. If tried, we hope that the results of such efforts will be reported.

Weinberg (1989) proposed this transition for the analyst to become the "ambassador" of friendship, a role possibly doubly difficult for an analyst unaccustomed to taking such an active role in treatment, and, perhaps due to age, background and personality thus unfamiliar with both the complexities of friendship in later life and local resources. The need for, and even the concept of generating friendships may be a challenge for both analyst and patient, possibly more so for some male analysts and male patient dyads, since usually at every life stage women focus more on, and have more friendships, than men.

Weiss (1973) prescribes, "I can offer no method for ending loneliness other than the formation of new relationships that might repair the deficit responsible for the loneliness. And I think this solution ordinarily is not easy" (p.231). A campaign of search for a single attachment figure is a risky enterprise simply in terms of the likelihood of success. Patients who enter treatment hoping to find a replacement for a lost attachment figure constitute therapeutic problems because of the limited probability of success. Rather, the focus should be revised to developing relationships with several others, engagement with various activities, and memberships in networks *on bases valid in themselves*. Cacioppo & Patrick (2008) similarly advise, "Don't focus on trying to find the love of your life or to reinvent yourself all at once. Just slip a toe into the water. Play with the idea of trying to get small doses of the positive sensations that come from positive social interactions" (p. 237).

Just as some psychoanalysts have acknowledged the limits of their pharmaceutical knowledge and have become comfortable in seeking consultation for pharmaceutical treatment, they may now need to acknowledge limited knowledge in social networking. Referring the patient to an experienced social worker or to a reputable service center may provide the necessary auxiliary support.

While we think that psychoanalysts should always be prepared to seek outside help for problems beyond their expertise, this need may arise more frequently in the treatment of the elderly with their multiplicity of losses, illnesses and stresses. The transference significance of the analyst turning to outside help may provide a bridge for the patient's own outreach and recognition of limits. The psychoanalyst may be supported by a functioning, trustful therapeutic alliance with the patient, which may help the patient deal with the ensuing concerns, negative reactions and failures in response to the analyst's suggestion.

Termination of Psychoanalytic Treatment of the Elderly

Traditional psychoanalytic theory prescribes total patient-analyst separation after termination to support mourning the loss of the analyst. There is no evidence that total separation influences mourning, or that occasional post-termination patient-analyst contact inhibits mourning (Craige, 2002). Kantrowitz (2014), based upon an empirical clinical interview study, agrees and notes that post-analytic experiences of grief and extended periods of mourning were not less intense for analysands who were part of the analytic community than for those who were not. She also notes that for some patients completing treatment was a very hard won achievement, and when it occurred joy, not grief, predominated in their feelings about ending; mourning was not the predominant emotion. She adds that older people may be more reluctant to end their analyses and feel more grief at ending it since the experience is likely compounded by the actual or expectable loss of others who

are emotionally important to them. In general, in her cohort, the way individuals remembered their analysis was affected by their post-treatment contact with their former analyst. Some analysands clearly felt that later contact with the former analyst was sustaining, though this was less likely to be true for analyst/patients. Further, she concluded that each analysis and each ending is shaped by the nature of the particular issues of the analysand and the particular analytic dyad.

Schachter and Kächele (2013) have presented an alternative concept of termination in which during the termination phase, if the patient has not considered the possibility of post-termination contact with the analyst, at an appropriate time the analyst should question why this has not been discussed. After an analytic exploration, the analyst may propose to the patient the possibility of occasional post-termination patient-analyst contacts and the benefits of such meetings. Kantrowitz believes that unless the former analysands chose to re-contact their former analysts, they would be left on their own to assimilate post-analytic experiences that might be unexpected, painful or confusing. The decision about whether to plan such follow-up contacts should be a mutually-agreed one. We believe that such contacts may provide the patient with the following benefits: 1. Enables the patient to re-experience the analyst's caring (especially relevant for elderly patients previously vulnerable to loneliness; (such contacts may occur informally, spontaneously with elderly patients); 2. May reinvigorate helpful introjections of the analyst; and 3. Provide additional opportunity to deal with unresolved idealization of the analyst if appropriate. Such follow-up contacts may also provide the analyst with information about the inevitable post-termination changes in the patient's life, positive and negative, which may help the analyst revise and improve his/her conceptions of the course of the analytic treatment. Since the follow-up contacts may be of use and of interest to the analyst as well as to the patient, we suggest that the analyst not charge for these follow-up contacts. The frame of the follow-up contacts has been modified from that of the treatment itself, becoming perhaps more person-to-person, with the patient's needs and welfare remaining paramount. Follow-up meetings may have to take place in other settings, hospital rooms or other venues, while maintaining the professional roles.

There are no data available to compare the therapeutic effects of traditional concepts of termination to those of Schachter and Kächele's concepts of termination. One study has reported that psychoanalyst-initiated follow-up contacts were beneficial to the patients (Schachter et al., 1997): "In the first case the meetings facilitated the patient's re-entering treatment, leading to significant further growth. In the second and third cases, the meetings re-ignited mourning for the analyst and furthered analytic gains. The authors' overall impression was that the post-termination contacts were helpful for all three patients" (p.1193).

Next, a clinical example of patient-initiated post-termination contact with an older patient is summarized (JSS). This treatment of a previously analyzed childless mental health professional suffering through a second failing marriage was assumed on a face to face basis at the patient's request. The previous analyst had been a well known older male; JSS was a woman, new to the analytic community, with a child analytic background and a focus, in this psychoanalytic therapy, on attachment and caretaking by the patient's mother who had early lost both parents and felt impelled to explicitly prepare her only son to become an orphan. Subsequently his father became more outlined as an active intelligent man whose first wife had died and who had abandoned their son to relatives. The patient himself had been sent to live for some time to an aunt who ran a depression-era boarding house while his parents were both ill.

The patient as a boy rose to the challenge of raising himself, abandoning his parents before they might leave him. He found a way to support himself successfully at a boarding school, college and graduate school. He remained relatively isolated though superficially adept both socially and

professionally throughout a career in the armed services and thereafter. After several years of therapy he chose to return to an analytic schedule on the couch during which he dealt with his narcissistic injuries, his hypochondriasis and isolation, and fearing of angering attachment object solicited specifically when his analyst drank iced tea during a session. His father became a more understandable and significant figure and he subsequently accepted responsibility for his aging mother, and brought her closer to his locale and installed her in a nursing home. Meanwhile he divorced, suffered the rage and narcissistic injury at the hands of his adopted grown step-sons who rejected him, and found and remarried a warm successful woman with adult children and grandchildren. Midpoint in this analytic phase, when he was well past 75, I asked him if I could present the analytic work in a European discussion group and he agreed. Both of us were disappointed when the dis-cussion focused almost entirely on the ethics of analyzing an elderly patient.

Termination took place after a two year discussion when the psychotherapist/analyst retired and relocated. He requested post-termination contacts and they were arranged by email and took place at approximately six month intervals at his choice of restaurants in her city except on rare occasions when the analyst returned to their old city to visit friends. On those occasions we also met at restaurants; he always paid for the meals and no fee was charged. We both enjoyed food and were comfortable together. When he became aware of mortal illness, the analyst increased the frequency of visits in both cities; the last two sessions took place in his home where, for the first time, the analyst met his wife and helped support her utilization of home hospice care. The last meeting between us was clearly a farewell. He summoned his strength and walked me to the car while pulling his IV line.

Kantrowitz (2014) in a general statement, concludes that nowadays psychoanalysts believe post-treatment returns may be helpful, and certainly are not viewed as harmful to patients' therapeutic gains.

Conclusion

Old age is the last developmental stage. Some elderly may be subjected to a devastating array of losses and crises that exceed in scope and nature those of those former, earlier stages of development which the patient managed satisfactorily. Widespread losses may generate intensely distressing feelings of loneliness and depression and call upon the universal need to feel confident that there is one or more trusted persons who will come to our aid when difficulties arise. This feeling of support may be often lost in the actuality of reality or psychologically lost during feelings of loneliness; the psychotherapist/analyst, realistically, may provide one such anchor.

If intensive psychoanalytic work with an elderly patient has proven helpful but left the patient isolated in reality with remaining, painful feelings of loneliness, the psycho-therapist/analyst has the option of enlarging the treatment by actively suggesting that the patient consider developing new relationships, interests and activities. Furthermore, proposed periodic post-termination patient-analyst follow-up contacts, in addition to providing the advantages delineated, can provide a form of maintenance therapy and caring which may assist the patient in continuing endeavors to avoid persistence of loneliness by supporting new relationships and activities.

Chapter Eight

An Alternative Conception of Termination and Follow-up[10]

Abstract

Traditional psychoanalytic theory prescribes total patient-analyst separation after termination to facilitate mourning the loss of the analyst. This paper provides a rationale derived from contemporary (especially relational/interpersonal) theory for an alternative conception of termination and follow-up based on the central role of the analyst as a real person involved in a mutually-caring patient-analyst relationship.

Patient-analyst follow-up may provide numerous positive benefits: the patient may re-experience the analyst's caring, may re-invigorate helpful introjections of the analyst, and have additional opportunity to deal with unresolved idealization of the analyst. The analyst may learn about the patient's unpredictable, inevitable post-termination changes, positive and negative, and improve his/her understanding of the course and outcome of treatment.

Introduction

"For the first fifty years of the twentieth century," writes Novick (2010), "psycho-analysis had little to say on the topic of termination and were rather cavalier in the way they dealt with termination" (p.792). Bergman (1997) observed that "in spite of the large literature on termination, no paradigm of termination has been made part of the professional equipment of the psychoanalytic practitioner" (p. 172). Kaplan (1997) semi-facetiously recommended that "in fact, a sign should be posted over the door of every consulting room simply reminding the participants – analysand and analyst alike – that, like their Oedipal relationships, 'This relationship has no real future'" (p.177). Glover (1955) presciently observed that "the opportunities of watching a classical analysis coming to a classical termination are much less frequent than is generally supposed" (p. 140). Actually, the data indicate that of patients who begin a traditional analysis, only approximately 50% remain in treatment until a mutually-agreed termination is achieved (Glover, 1955; Hamburg et al., 1967; Hendrick, 1967; Sashin, et al., 1975; Erle, 1979; Erle and Goldberg, 1984; Weber, et al., 1985a; Weber et al., 1985b; Novick, 1988; Kantrowitz, 1993a).

However long and arduous an analysis may have been, the terminal phase creates its own problems for both participants. Not infrequently it reveals an incongruence between the patient's and the analyst's conceptions of the goals of the treatment. It is of great practical significance whether the analyst has successfully enabled the patient to understand that the analytic work must be limited to goals accessible to treatment and that the terminable analysis be distinguished from the interminable. At the end of a psychoanalytic treatment the patient may have developed some capacity for self-analysis; the patient has learned and employs the special form of reflection that may include internalizations of the analyst. Tied to this ability is the expectation that the patient's constructive internalizations of the analyst and the capacity for self-analysis will work against the inclination

toward renewed development of symptoms which may still arise after analysis when new problems are encountered. This view is opposed quite often by "the myth of perfectibility," i.e., of the complete analysis, which molds the attitudes of some analysts toward the terminal phase as a result of the pressure exerted by their own exaggerated ideals (see Thomä & Kächele, 1994a). However the growing length of some analytic treatments seems to enlarge the problems connected with separation and –alas – achieving termination. "Good enough ending" (Salberg, 2010) has become an issue.

The lack of agreement among psychoanalytic authorities about the definitions either of psychoanalysis or of analytic process, make it unlikely that there will be consensual agreement about the concepts either of termination or post-termination follow-up. The traditional psychoanalytic conception, that complete separation is necessary to foster the patient's mourning, has little empirical support. This belief may have its historical root in Freud's loss of his relationship with Jung; "he lost his total control of the future of psychoanalysis. This loss of control required that he mourn its loss … but he could not" (Homans, 1999, p.77). Mendenhall (2009) notes that "much of the psychoanalytic literature on termination is steeped in ideals of autonomy, independence and permanent cessation of contact" (p. 117). This paper provides a rationale from contemporary theories for an alternative conception of termination and follow-up.

Each analytic dyad is unique, and it seems unlikely that any one theoretical approach would be optimally effective for all dyads (Mendenhall, 2009). The traditional approach may well be most appropriate for some analytic dyads, but not for others, and, therefore, the availability of alternate conceptions of termination and follow-up might be quite useful and provide a significant enhancement of our armamentarium. The very term, termination, with its guillotine-like implications, is a dreadful term, but we have been unable to create a useful alternative. Holmes (2010) writes, "ending therapy is a real loss; a significant segment of the client's life is no longer there. … Dependent on mood and perspective, the meaning of an ending can be a death, a bereavement, a completion, a liberation, a funeral … or a joyful moment of maturation and leaving home (p. 67).

Post-Termination Follow-up Contact with Patient

For good reasons medical practitioners traditionally included follow-up observation of their treated patients. Grand Rounds typically is an arena for such discussions. Why did Freud, a physician, and other early medical analysts not regularly utilize follow-up visits? While Freud did report follow-up material whenever it became available (Freud, 1905e; Freud, 1909b; Freud 1918b), he neither proposed nor sought post-analytic contact. Face-to-face follow-up probably would not have been feasible with those of Freud's patients, like Kardiner, who came from other countries. However, more significantly, Freud's priority was on delineating his patients' infantile traumas in order to fashion an encompassing scientific, etiological theory of mental illness rather than seeking corroboration of his theories in learning about his patients' post-treatment lives.

In the following section we want to invite the reader to follow us on a timeline focusing on the reasons why later physician-analysts have given for *not* following-up their treated analytic patients. Rangell (1966) referred to "the post-termination phase of therapy", but if this phase was examined at all, post-termination contact was characterized as deleterious to the former, "terminated" patient. He cautioned "there is sometimes a gratification or stimulation of the patient by a premature and excessive social intimacy which is reacted to as a threatened seduction" (p.162). In a 1969 panel five training analysts "preferred to avoid all contacts with former patients for an indefinite period …[because] it might interfere with post-analytic working through processes" (Panel, 1969, p.235). Likewise Ticho (Panel, 1975) cautioned against the need to 'reassure' patients that the analyst will

be available for future consultations, believing that this conveys the analyst's doubts about the patients' ability to continue to grow. Marmor (1979) asserted "letting the patient go is the final and quintessential therapeutic maneuver in the production of change in analytic treatment!" (p. 356). In 1982 Calef clearly recognized that "a taboo among analysts seems to exist against possible intrusion and invasion by follow-up studies" (p.94). He understood that analysts believed that, post-termination, patient-analyst contact for other than treatment would generate increased anxiety and regression in the patient. This theory-based position impaired analytic freedom to actually experience follow-up contact with treated patients, other than patient-initiated requests for help. Analysts who expressed interest in follow-up contact with a treated patient were criticized for having unresolved counter-transference problems. Hartlaub et al. (1986), critical of the avoidance of post-termination contact, noted that "we had all shared the unconscious fantasy that after a successful analysis the patient would not need further contact with the analyst, or, conversely, that re-contact somehow cast doubt on the completeness of the analysis" (p.895). Blum (1989) asserted that the analyst should not see the patient again, because, hypothetically "the patient's mourning cannot be completed prior to real separation" (p.290). Even Wallerstein – having completed his large scale substantial write-up of the 42 Menninger cases (1986) - cautioned that planning for contact after the end of treatment could impinge on the proper terminal mourning (Wallerstein 1992). And in 1997 Novick described "the fantasy of post-termination contact … is of a transformed relationship in which the doctor and patient will become equals, friends, colleagues, coworkers, or even lovers" (pp. 153, 154). The Swedish analyst Szecsödy (1999) agreed with critics that "Many analysts refrain from offering the analysand the opportunity for contact in the future because they see the self-analytic function of the analysand as the most essential benefit of treatment" (p. 59). Levine and Yanoff (2004) go further and assert that post-termination contact is a dangerous enterprise that may well place the analyst at risk for ethical violations and the patient at risk for exploitation. Davies (2005) later presented a more complex view that 'termination' involved multiple goodbyes, and each [goodbye] holds the potential not only for growth, emergence and liberation, but also for grief, despair and narcissistic collapse" (p.783). Elise (2011) concurred that further patient-analyst contact is undesirable since "saying goodbye is an experience that is necessary, valuable and instructive" (p.598). These widespread assertions of the potential destructiveness of post-termination contact are not based on experiences of follow-up but on theoretical assumptions, just as for many years it had been uniformly assumed in traditional theory that homosexuality was intrinsically psychopathological. Open discussion with the terminating patient of these assumptions and concerns was not considered.

Although the accessible literature describes failures of analytic treatment (for a summary see Goldberg, 2012), we could find no paper describing problematic follow-up contact. We agree with the qualification that major unresolved problems in the terminating analytic treatment may increase the risk that such follow-up contact may cause difficulty, and that it should be avoided.

Bergmann (1988) is prominent in questioning the dangers of post-termination contact, commenting on the strangeness of analysts' choosing to have no further contact with the patient they have treated, and noted that there is no analogue in human experience for the current conception of termination in which an intense, long-standing relationship is terminated with the prospect of future contact being 'nevermore' – except for death. Limentani (1982) discussed the consequences for the patient of unexpected termination of analysis: "It is the prospect of never seeing the analyst again that is likely to produce prolonged pathological reactions, either through an equation of the idea of separation with that of death … or through the loss of the omnipotent fantasy of fusion with the

loved object. This would account for the surprisingly violent responses to the analyst's announcement of an impending move to a different location, or illness" (p.438).

Early Research Follow-up Studies

The founder of Norwegian psychoanalysis, Harald Schjelderup, unknown to American analysts, conducted what may be the first questionnaire/interview follow-up study (1955) of his own 28 psychoanalytic cases. Nine cases showed a lasting symptomatic cure, 25 cases had improved interpersonal relations, and 22 cases demonstrated enhanced capacity for work and enjoyment of work. No mention was made of deleterious effects of the follow-up on the former patients.

Undeterred by assumptions that follow-up contact with the patient may be disturbing to the patient, Pfeffer (1959) courageously evaluated the results of analysis by conducting a series of individual interviews with two patients who had completed successful analyses with other analysts. He recognized that interviews conducted by an analyst other than the treating analyst are advantageous in order to avoid "a marked tendency … especially among less experienced analysts, to underestimate [therapeutic] results" (p.440). Pfeffer described the development, during follow-up, of a vivid transference neurosis in one patient, and noted there were no indications of harmful effects from the interviews. He later (1961) again reported the recurrence of a residue of the patient's analytic transference during his interviews. Pfeffer's last study (1963) was followed 12 years later by follow-up studies conducted by others (Oremland, Blacker and Norman, 1975; Norman et al., 1976; Schlessinger and Robbins, 1983) all of whom reported the persistence of the patient's transference feelings. Patients were quick to identify those responses close to conscious reflection, as did those subjects in Graff & Luborsky's (1977) longitudinal observational study. Kächele et al. (1985) distributed Strupp's follow-up questionnaire to 150 analytic and psychotherapy patients. Factor analysis revealed two dimensions; one was empathy and acceptance and the other was confidence and feeling accepted. No negative effects induced by the follow-up questionnaire study were observed.

Empirical Studies of Termination and Follow-up

A review of empirical studies provides a basis for developing an alternative conception of termination and follow-up rather than one based upon traditional analytic theory. Hartlaub et al. (1986) mailed a questionnaire to 39 graduate analyst members of the Denver Psychoanalytic Society; 16 responded with data about 71 completed analyses, 85% of which they considered successful. Average time elapsed after termination was 2.6 years. Approximately 50% of these patients had made contact with the analyst by letter, telephone, or other means since termination. Thirty-five percent saw the analyst in person for a brief office visit, 19% for brief psychotherapy and 2% for reanalysis. Patients contacted their analyst because of: a) reworking termination issues (17); b) due to unresolved issues from the analysis (6); c) life circumstances (8); d) issues previously unrecognized by the analyst (2); e) other (10).

Questionnaire data (Schachter and Brauer, 2001) were obtained in 1994 from 395 APsaA respondents constituting a 54% response rate. We assumed, as most were APsaA members at that time, that many utilized traditional analytic theory. Results indicate, consistent with traditional theory, that respondent analysts did not discuss or propose post-termination follow-up to their own patients. Most commonly, 31% of the respondents told the patient that they would be available if the patient needed additional help; the next most common statement (22%) said they would be available to see the patient again. The terminating patients´ view of the analyst´s avoidance of actively suggesting the possibility of post-termination contact has not been explored. The study also indicated

that a much higher percentage of former analytic patients contact their former analyst if that analyst had made some statement about future patient-analyst follow-up contact, in contrast to those analysts who made no statement about the possibility of future patient-analyst follow-up contact. Thus, what the treating analysts says or avoids saying about the possibility of future follow-up contact does influence the likelihood of future follow-up patient-analyst contact. This study also replicated another, earlier finding, that prior patients were much more likely to contact their former treating analyst if the analyst was a woman rather than a man. Perhaps women analysts value attachment and caring more highly, are less impressed that total separation is necessary to achieve autonomy, or do not value autonomy as a goal as much as male analysts who, conversely, believe that separation is required for achieving it. (It is noteworthy that traditional analytic theory is the product primarily of male analysts.) Psychoanalysis, assert Aron and Starr (2012), is epitomized by being civilized, masculine and promoting ego autonomy, whereas psychotherapy was primitive, feminine and relied on support and dependency. An interesting finding requiring replication is that prior patients were more likely to contact their former analyst if that analyst frequently thought about their *own* analyst – perhaps were more identified with their own analyst - compared to analysts who rarely thought about their own analyst. Overall, clearly, the analyst's characteristics and behavior substantially influence the likelihood that the patient will initiate post-termination follow-up contact.

In a different study, Schachter et al. (1997) studied the impact of analyst-initiated follow-up interviews by three different treating analysts of their own former patients to discern if there were deleterious effects of the follow-ups. The treating analysts presumed that these follow-up visits would not have a deleterious effect on the patients. In one case the meetings facilitated the patient's re-entering treatment, leading to significant further growth. In the second and third patients, the meetings re-ignited mourning for the analyst and furthered analytic gains. In this small sample there was no evidence of harm; the contacts were helpful for all three patients, and appeared to provide an opportunity to extend the mutually caring relationship that had developed in treatment. They also indicate that follow-up meetings may result in a patient returning for additional treatment that might not have occurred had the follow-up not taken place.

In another follow-up study (Leuzinger-Bohleber et al., 2003) one patient at the end of a second interview told the interviewer, "I was very glad of the opportunity to talk to you. I have just realized that something in me now has come to an end – I think these interviews have helped me to finally complete my analysis. I no longer have the feeling of having left my analysis too early. Talking to you I realized that I am in good contact with my unconscious and can continue the dialogue with the hidden parts of my soul without my analyst now …" (p. 278). The authors of the study reported that "many of our colleagues have told us how valuable it has been for them to listen to former patients and what they have to tell us, consciously and unconsciously, about their positive and negative experiences with their psychoanalytical treatments" (p. 285).

Empirical Study of the Post-Termination Mourning Response

Contrary to the concerns about continued contact with the analyst attenuating the patient's mourning, Craige's (2002) empirical study demonstrated that contact with the analyst after the end of treatment did *not* vitiate the response of mourning. Her survey of 121 analytic candidates who had completed their training analysis, reported that 76% of the respondents experienced a mourning process that lasted on the average between six months and one year, even though almost all of them expected to continue to see their training analysts in the course of professional activities. Craige also was surprised to find that neither the [candidate's] *sense of painful loss ... nor loss of the unique analytic relationship* ...was significantly correlated with *significant emotional loss in childhood* (p. 518). She

concluded that "the loss of the actual, present-day relationship with the analyst is, in itself, the loss most keenly and commonly felt after termination" (Craige, 2006, p. 587). This conception is consistent with the relational/interpersonal view of patient-analyst relations described later in this paper. Pedder (1988) contrasted the post-treatment experience of non-psychoanalyst patients who have little opportunity for contact with their former analyst, with most analyst/patients who seek out contact with their *own* training analyst. He questioned whether "then are we not asking patients to face something that we analysts may never, or seldom, have to face? (p. 500).

A Case Report of an Analyst-initiated Follow-up

The description of one post-termination experience is summarized by J.S., and the description of the post-termination phase is in the patient's analysts' words (not J.S.) from the original published article Schachter et al., 1997). We appreciate this analyst's permission to report his work.

Summary of Charlie's Psychoanalytic Treatment

Charlie, a 27-year-old single musician sought help in 1982 with his sexual and competitive wishes and his harsh self-punitive reactions to them "I am a perennial 21-year-old"; he added, "People consider me a warm, outgoing clown." He reported many early arguments with his mother, and subsequently felt responsible for her drinking and her death from cancer when he was 21.

In analysis he made himself a gentle, entertaining submissive clown. The analyst interpreted his fear of discovering his hostility toward his analyst, and over the next few years clarification of his aggressively charged sexual and competitive wishes and harsh self-punitive reactions to them enabled him to experience more freedom to develop his considerable musical talents. Oedipal guilt was discussed as reflecting a frightening fantasy of competition with father, influenced by an unmodified early sense of omnipotence. He developed more confidence in himself, began a career as a professional musician, and married an attractive, capable woman.

Charlie brought up the possibility of terminating and once a date was set, many of his prior symptoms surfaced again. This was interpreted as resistance to the fear of losing his analyst and was followed by three sessions in which he cried and the analyst, too, felt tearful. He told the analyst he loved him, and they were able to terminate as scheduled.

Follow-up Contact with Charlie

"Five years later, while I [the analyst] was making plans to visit the city in which I had lived during his analysis, I contacted Charlie. I did this only after considerable soul-searching. I was well aware of my wish to see him. I decided that meeting again was unlikely to hurt my patient and would probably help him to re-examine his feelings for me. I felt it was important that I remain in an analytic role; this visit would be a part of the analysis. In thinking this way I was defending myself against the imagined accusation that I was 'acting out' with my former patient. I contacted the original referring psychiatrist to ask him to let Charlie know I would be returning to town for a visit and to enquire whether he would be interested in meeting with me. I wanted to give him the chance to decline without awkwardness. Charlie replied through the psychiatrist that he was delighted to hear from me, and he would be eager to see me again. Since I conceived of this session at the time as an extension of the analysis, despite my having taken the initiative, I charged my previous fee. My views have evolved since then, and today I would not charge for such a meeting. We met in the referring psychiatrist's office for one fifty-minute session. When our eyes first met, he suddenly broke into tears. I felt tearful, too, and excited. Then he quickly suppressed his tears and began by

telling me a funny story, the entertaining clown defense. Within moments we fell into the easy, mutual familiarity we had enjoyed before termination. I continued to feel excitement, and I realized how much I had missed him. I asked about his life and, in particular, his current handling of the issues that had been so troublesome before and during the analysis: work, relationships with women, and tolerance of his own aggression. He told me of his considerable professional success, with only a trace of the previous guilt. Sadly, he described his father's recent death and mourning for him. He went on to describe his marital difficulties and the likely failure of his marriage in the near future. I asked him if he wanted me to let him know if I would return again. He said, 'Yes, absolutely'. The mutual pleasure at being together was evident. During this hour he recalled many details of the analysis and referred to them repeatedly. I was astonished at how much the meeting brought back to me also the experience of working with him years ago. The meeting was deeply satisfying, not unlike periodic visits with my own adult children.

Two years later, in 1994, I telephoned Charlie to ask permission to publish our experience of the above visit. He was again delighted to hear from me and readily agreed to my request. He told me that he had realized precisely at the time of our meeting that his marriage had failed, and he had since ended it, 'the hardest thing I ever did'. Three months later he met a new woman. They were now living together quite happily and planned to marry. He added, 'This is the first time I have been in a relationship where I felt this kind of commitment, where it really works'. He recalled having dreams of being in my old office both before and after we met two years ago. 'There was a real warmth between us in those dreams. I took them as confirming that I was on the right track. After meeting with you I realized once again that I can make decisions and live my life as an adult man. It took me a long time to realize [during the analysis] that you didn't have all the answers.' I asked if there had been anything unhelpful about our meeting again. He replied that he didn't think so. 'It would have been artificial if you had come to town and I had *not* seen you. It was a reminder of the genuine search for truth which we had done together.' I also asked if he still thought much about his mother. 'That's the relationship I have the most figured out. If not, I couldn't have married A, and that led to B [with whom he is happy]. I don't think about Mom much any more. That was twenty years ago [that she died]. I'm at peace with her. Now I'm mostly dealing with myself as my father's son. Seeing you again was important to me. It was like seeing my father as a human being."

Discussion—Charlie

Charlie's initial response to meeting his analyst five years after termination was a tearful re-awakening of mourning for the loss of his analyst, a brief reprise of the week-long crying period during termination. Contact with his analyst also appeared to have re-vitalized the sense of self-worth that he had developed during the analysis. That helped him to accept his realization that his marriage was failing and to move ahead with his life.

Traditional Theory's Conceptions and Alternative Conceptions of Termination and Follow-up

Since the 1950's the literature on termination has expanded, based almost entirely on traditional psychoanalytic theory. We propose that these earlier conceptions of termination and follow-up contact are extensions of those fundamental theoretical and technical conceptions of traditional psychoanalytic theory. Basic traditional theoretical conceptions of termination consist of the following beliefs: 1. Termination requires complete separation of patient and analyst in order to provide the patient with the opportunity fully to resolve the mourning response to the loss of the

analyst; this experience is necessary for the full development of the patient's autonomy. 2. Follow-up patient-analyst contacts may involve risks of deleterious effects upon the patient. 3. Follow-up contacts may foster the patient's continued dependency upon the analyst. Unquestioning acceptance of these assumptions failed to stimulate empirical studies that would support any of the three elements of the traditional conceptions of termination and follow-up listed above.

Why did traditional analysts so readily and uniformly maintain that medically-traditional follow-up would be deleterious to the patient despite their limited experience with follow-up contact other than their own often very different positive personal experiences with their own analysts? We speculate as follows. Although opportunities for extra-analytic patient-analyst contact vary widely, we have observed that many analysts appear ill at ease with informal contact outside their office with current or former patients. We hypothesize that in casual extra-analytic contact, analysts may experience a loss of the emotional support of their professional persona. The power and prestige of the analyst's role with its accompanying office rituals, may be reassuring to the analyst and none of these protections are available in extra-analytic contacts. Possibly, analysts' concern that follow-up contact may be deleterious to the patient may serve the analyst's own need to avoid such follow-up contact in which the analyst's role is undefined and the analyst may be potentially uncomfortable. Moreover, if the analyst, additionally, has concerns about the degree to which treatment had helped the former patient, he/she may feel uneasy about the revelations in such subsequent contact.

Although there are numerous contemporary analytic theories, we have limited our focus to the relational/interpersonal and their variations. We highlight these significant differences from traditional analytic theory's conceptions of analytic treatment as viewed by us from a general interpersonal/relational point of view. Traditional theory regards interpretation of unconscious transferences as the fundamental mutative factor. "It is interpretation – leading to insight and awareness – that is viewed as *the* primary carrier of therapeutic action in the classical conception of treatment,' writes Eagle (2011a, p. 90), as a faithful yet critical reporter of that position. He adds, "There also appears to be widespread agreement that it is the interpretation of these new editions of old conflicts, that is, transference interpretations, that are especially conducive to therapeutic change" (2011a, p. 217). Traditional theory recognizes that the real patient-analyst relationship also contributes to therapeutic benefit and that conscious and unconscious identification with the analyst plays a mutative role, but this identification is not assumed to be with the *person* of the analyst, but, rather, with the analyst's *analytic activity* (Olds, 2006; Geller and Freedman, 2011). This more abstract formulation is conceptually necessary for traditional theory because, if the patient appeared to identify with the *person* of the analyst, that would signify that the analyst had influenced the patient. Such influence might reflect suggestion and hark back to and resonate with Freud´s fear that the analyst's influence might undermine the scientific status of psychoanalysis. Some alternative theories of analytic treatment, particularly relational/ interpersonal, articulate different conceptions in which aspects of the real patient-analyst relationship are considered to be the fundamental mutative factor. Transference interpretations are regarded as therapeutically useful tools, and identification with the person of the analyst is accepted as playing a positive mutative role.

The Real Relationship in Psychoanalytic Treatment

Anna Freud (1954a) had written, "somewhere we should leave room for the realization that patient and analyst are two real people, of equal status, in a real personal relationship to each other" (p. 619). Subsequently acknowledgment of the significance of the real relationship was explicated by Gill and Hoffman's (1982) recognition and insistence that the patient's transferences are distorted only in part; they also reflect the patient's perceptions of actual, realistic attributes of the analyst.

They believed that psychoanalysts should acknowledge and accept the patient's capacity for intuitive, accurate perception of the therapist's character. The patient's accurate perceptions of the analyst are intertwined with those historically-created templates of authority figures that Mitchell characterized as "pre-designed categories", as well as with idealized images of the analyst and other authority figures. Despite this complexity which requires exploration, the accurate perception plays a significant role in influencing the patient's inter-actions with the analyst and development of an appropriate relationship with the real analyst. Summers (2012) comments "I told him [patient] what in his criticisms I found to be accurate and what critical remarks I regarded as exaggerated expression of my foibles" (p. 158). Although the attributes of the real analyst are probably differentially influenced by interactions with different patients, we assume that there are a core set of attributes that are common to the analyst with all patients. The analyst's participation in characterizing these core attributes will help in the development of an appropriate relationship with the real analyst – how the analyst actually is – one of the central tasks of treatment. Hurn (1971) maintains that "the entire analytic process leads inevitably to the patient's perception of 'the analyst as he is' "(p.340).

The real person of the analyst is multi-faceted, and only some of these attributes are likely to be shared with a particular patient - different facets for example, than are likely to be shared with the analyst's spouse. However, there is a core to our sense of who the analyst is as a real person which is probably what we have in mind when we decide whether or not to refer a patient to him/her.

The patient may also correctly perceive the analyst's genuine concern and caring, thus contributing to the patient's feeling that a good "fit" exists between the patient and the real analyst. Numerous empirical studies have reported a strong association between "fit" and subsequent satisfaction with treatment (see Schachter et al. 2014).

The Role of Mutual Caring in the Real Relationship

Based on extensive research of once/weekly psychotherapy, the real relationship is considered to consist of two key elements: a) genuineness and b) realism. Genuineness may necessitate some self-disclosure by the analyst, always constrained by considerations of the impact on the patient. "Strong and effective real relationships require that the patient and therapist have basically positive feelings toward the realistically perceived and experienced other. … These positive feelings may be termed liking, caring … or even a kind of loving" (Gelso, 2011, p. 155). Couch (1999) has reviewed the psychoanalytic picture of the real relationship, and concluded that "the quality of genuineness and naturalness is evident in all of Freud's published cases, as well as in the numerous reports by patients about their analysis with him …" (p. 141*)*. This awareness of the role of Freud's character in treatment led Nacht (1962) to make the point, similar to the later view of Levenson (2005a, 2005b), that in many fundamental respects, who the analyst *is* has more importance than what the analyst says. Couch added, "many of the analyst's reactions are best seen and conveyed in a clinically appropriate form as genuine reactions to important aspects of the patient's life as a fellow human being" (p. 151). Couch quoted Stone (1961) "whereas purely technical or intellectual errors can, in most instances, be corrected, a failure in a critical junction to show the reasonable human response which any person inevitably expects from another on whom he depends can invalidate years of patient and largely skillful work" (p. 55). Couch (1999) agrees, "it is quite natural for the analyst to feel some sadness and concern over failures or tragic losses in the patient's life, some anger over the patient's cruelty to others, and some pleasure and satisfaction in the patient's successes and happiness. These are reactions that stem from and reflect the genuine human qualities of the real relationship …"(p. 159).

Levenson's focus on the real analyst may be derived from Sullivan's conviction that "You [analyst] had to be a person" (Kerr, 2012). More explicitly, writes Levenson, "the therapist is required to be real, "to have reactions and to be able to use them without shame or guilt" (2005a, p. 201); "the most loving act of the therapist is to be real, to be there and to permit himself the discomfort of engaging the patient's system" (2005a, p. 214). Presumably, this includes the analyst's expressing either angry feelings or affectionate feelings to the patient, as well as acknowledging being scared of the patient, all constrained by consideration of these expressions' impact on the patient. Levenson adds, "the interpersonal therapist must grapple with the *real* matrix of events and personalities in which every therapy is embedded. It is not a question of what the patient has projected "onto" or "into" the therapist, but of really *who* the therapist is and *what* he brings to the therapy encounter" (2005b, p.21). To explore this, Levenson raises his famous question, "What's going on around here?" which may have been influenced by Sullivan's conception that an interpretation was always a question (Kerr, 2012). Levenson considers the analyst a "real" partner who will grieve if something bad happens to the patient and who will feel sadness at the end of regular sessions together.

Traditional as well as revisionist analysts recognize that by the closing months of a reasonably successful, helpful analytic treatment, the treatment has included the development of an intimate, mutually caring, patient-analyst relationship (Stone, 1961). Breger (2012) observed that it is "impossible to work at a deep emotional level with people over long periods of time without developing real affection for them" (p. 113). In support of this assumption are the numerous reports that analysts themselves react to "termination" with feelings of loss, sadness and mourning, suggesting that they had developed caring feelings toward the patient (for moving reports see Salberg, 2010). Granels, writing in the New York Times, noted that the model physician has difficulty expressing grief: "Our study indicated that grief in the medical context is considered shameful and unprofessional. Even though participants wrestled with feelings of grief [when patients die], they hid them from others because showing emotion was considered a sign of weakness" (2012, p. 12).

Friedman (2005a), however, a traditional analyst, refers to "a peculiar intimacy that can be experienced only by someone who [analyst] is in many respects a merely *virtual* partner" (p.373; (italics added). Levenson, contrariwise, conceives of the analyst as a *real* partner, not a *virtual* one, and Nussbaum (2005) agrees, challenging Friedman: "Will you grieve if something bad happens to me, or will you just go merrily on your professional way? (p. 380). She comments that Friedman avoids this question …"(p. 380). Friedman (2005b) concludes that the analyst cannot have "real" loving feelings for the patient; "the classical analyst could never report to work without assuming that his self-reflective distillation of feelings can somehow moderate his response" (p. 387). Eagle (2011b), certainly not a classicist, joins Friedman and says that: "I believe that the claim of loving the patient is a kind of deceit, one that can be quite intimidating to analysts who do not feel they love their patients" (p.1108). For a dyad with an intimate, mutually-caring patient-analyst relationship, a total end of all contact at termination might feel inappropriate. Following Eagle we have elected to substitute "deeply caring" for "loving" in the hope of a less controversial description. While recognizing that some patients may be so problematic, demanding and exasperating, that "deeply caring" may not be easy to maintain, and the analyst may, instead, be faced with regulating his/her hostile feelings to avoid a rupture of the relationship.

The Mutative Role of Identification in the Real Relationship

Identifications begin in infants and children and then progress to emulations of the admired and desired attributes of others throughout life. Lyons-Ruth (2006) describes how "the infant internalizes affectively charged distortions and deletions as they occur in the two-person dialogue and makes these distortions his own" (p.612). Litowitz (2012) notes similarly, "we know that (the child's) focused attention becomes joint attention, through which intentionality can be shared; and that shared intentionality continues processes of identification that began earlier in imitation" (p.270). Beebe et al. (2012) agree: "the recurrent nature of the infant's experiences leads to the development of internal representations or "working models" of self and others, generalized representations of events, that influence the infant's emotional expectations and create internal working models of attachment" (p.264).

Deutsch (1959) described the central role her female patients' identification with her female analyst [played] in the success of her analytic treatment. Edelson (1963) states "the problem of termination is not how to get therapy stopped, or when to stop it, but how to terminate it so that what has been happening keeps on 'going' inside the patient. … Most basically, it is a problem of facilitating achievement by the patient of the ability to 'hang on' to the therapist or the experience of the relationship with the therapist) in the form of a realistic intra-psychic representation (memories, identification associated with altered functioning) which is conserved … making mastery of this experience possible" (p.23). Marmor (1979), based on observation of analytic sessions through a one-way mirror, noted similarly "another unexpected finding … was the surprising degree to which patients tended unconsciously, after awhile, to adopt certain of the analyst's patterns of thought and behavior. This process occurs without the analyst's consciously intending it or fostering it. It is often described as a form of identification" (p. 351). A patient's mature identifications may include attributes of the analyst, often modified for integration with pre-existing templates. Geller (2005) identified therapists "who conceive of the processes of internalization as making an independent and positive contribution to the outcome of therapy (p.383): (see also Blatt and Behrends, 1987; Dorpat, 1974; Kohut, 1971; Loewald, 1962; Mitchell, 1988). Brubach and O'Brien (1999) generalize the outcome of this process: "Each and everyone of us is a walking catalogue of allusions to the movies we've seen, the stories we've taken to heart, the people we've known; we appropriate an actor's gesture, a character's fate, a friend's expression. In the aggregate of these little impersonations and the mutations we bring to them lies our identity" (pp. 161, 162). Our questionnaire study of analyst's attitudes toward training analysis (Schachter et al. 2014) reported that graduate analysts practiced the way his/her own training analyst had practiced with him/her. Imitating the training analyst's way of practicing is a form of identification with the training analyst, which in these satisfactory training analyses was facilitatory for the analyst-patient's subsequent function as an analyst. There was a significant positive association between the degree to which the graduate analyst emulated his/her own analyst's style of practice and the degree of satisfaction with their training analysis reported by the respondent graduate analyst.

To Terminate or Not – Is this a Question?

A large German sample of analytic treatments resulted in a medium length of about 600 sessions (approximately four years), at 1-2 or 3-4 times/week (Leuzinger-Bohleber et al., 2003). Dewald's (1972) published case runs for 600 sessions, and Mrs. C., treated by H. Dahl, under the supervision of J. Arlow, went for 1200 session. Experiences with such therapist-patient dyads shaped our views about termination in long-term analyses. Wallerstein's (1986) report on the long-term fate of patients

treated in the Menninger study showed that some had become "lifers", patients who were permanent users of psychotherapy. Anzieu (1987) has hypothesized that some patients need a constant auxiliary ego in the analyst. We conclude that there may be certain patients who, like a blind person who can never "outgrow" the need for a relationship with a seeing-eye dog, can never outgrow the need for a continuing relationship with an analyst. In some, as yet undefined way, that relationship provides an essential, stabilizing element in their lives. In addition, we accept that the question of treatment intensity (sessions/week) remains controversial. Thomä and Kächele (1994b) have described a 20-year-long treatment totaling 600 sessions, six-times/week for four years, followed by another 700 sessions during 13 years of low frequency, once/week or once/month meetings that consisted of ongoing and fruitful work. For such long-term therapeutic encounters, we believe that it is quite inappropriate and often very counter-therapeutic, for the analyst unilaterally to set termination itself as a goal. Surely, whether termination is an appropriate goal should be determined by shared decision making between patient and analyst.

One definition of long analyses in a Canadian report is directly in opposition to this position. Arvanitakis et al. (2000) defines long analyses as those with the same analyst lasting ten years or more at a minimum frequency of three times per week. In borderline cases, they write, "the internalization of the analyst as a good, alive, containing object, becomes seriously compromised. The imperative to maintain the analyst as an *external* real object interferes quite seriously with such internalization. … Essentially what we observe is that the analytic process is arrested, and free association as well as true regression cannot take place" (p.32). These comments are direct representations of traditional psychoanalytic theory, and no illustrative clinical material is provided, let alone any empirical data. Contemporary psychoanalysis (especially relational/interpersonal theory) regards the patient's view of the analyst as an "*external* real*"* person critical and positive to therapeutic work, not a phenomenon that "interferes quite seriously with … internalization". "True regression" is not regarded as desirable, particularly in borderline patients. In contemporary theory the patient's capacity to see the analyst as a real person results in many therapeutic internalizations of the analyst.These basic and conflicting conceptions of long analyses of traditional compared to contemporary (relational/interpersonal) analytic theory cannot be evaluated in the absence of both clinical and empirical data.

In regard to cases of very long term treatment the issues of allocation of public resources should be raised in relation to the ethical principle of fairness. Psychoanalysts, due to their high qualification, are public goods, even when patients pay privately (Beauchamp et al., 1994).

Conclusion

Contemporary clinical psychoanalytic theories indicate how unlikely it would be for all analytic dyads to be best served by the single conception of termination prescribed earlier by traditional Freudian analytic theory. Mendenhall (2009) agrees and concludes, that "a new understanding emerges that moves beyond the concept of termination to the idea that analytic relationships may evolve over time in many ways that are determined uniquely in each dyad" (p. 130). The widespread theoretically-based conviction that follow-up may constitute serious risks for the patient is not substantiated by a single empirical study and is probably incorrect. Alternative conceptions of termination and follow-up have been developed by relational/interpersonal and other analytic theories and may be most appropriate for some analytic dyads. The patient's development does not end with termination but continues, willy nilly, with or without the analyst's participation in the post-analytic phase of development. Following a successful analysis Freud (1937c) wrote, "the stimuli that he has received in his own analysis not ceasing when it ends and on the processes of

remodeling the ego continuing spontaneously in the analysed subject" (p.249). Freud (1937c) also commented that after a successful analysis "we have no means of predicting what the later history of the recovery will be." (p. 223). Deutsch (1959) observed "in many cases, patients … experience shortly after the end of treatment, without external provocation, a recurrence of their old neurosis. They declare in despair, that 'everything is like it was before analysis" (p. 446). During this post-treatment period, the patient may lose some of the therapeutic benefits gained during treatment, or, conversely, may resolve some problems treatment had been unable to help.

At least a dozen analysts have documented cases in which substantial and even dramatic changes occurred after "termination" (Milner, 1950; Nunberg, 1954; Saul, 1958; Eissler, 1963; Holtzman, 1964; Hoffs, 1972; Firestein, 1978). Both Macalpine (1950) and Ackerman (Panel, 1955) reported that marked improvement may occur following termination. Further, Kantrowitz et al. (1990), in her follow-up research of 17 patients concluded "neither analysts' assessments at the time of termination nor patients' assessments of themselves or assessments based on psychological tests one year after 'termination' predicted which patients would improve or retain psychological change" (p. 471). Szecsödy (1999) wrote "follow-up studies not only provide external legitimation of psychoanalysis, but also represent a fruitful method of studying psychoanalytic change" (p. 64). Sandell (2012) commented that "the finding that outcome is a process, changing after termination in ways that are not always predictable, is another argument for the vital importance of extended follow-up in outcome research" (p. 397). Follow-up, by providing the analyst with information about post-termination changes, both positive and negative, in the former patient's life may give the analyst the opportunity to reassess his/her assumptions and understanding of the patient's course and outcome at termination. If the analyst is considering that follow-up may be mutually beneficial, and if the patient has not raised this possibility, the analyst has the option of introducing the issue by noting that both analyst and patient are likely to have feelings about the upcoming ending of regular sessions, and that they should consider and discuss how they feel about the possibility of follow-up. How does a former patient understand a prior analyst's apparent disinterest in further contact with the patient if nothing has been said about it? Possible fears, risks and advantages may then be considered. Such meetings should be considered thoughtfully in order to avoid any harmful enactment of wishes by the patient or the analyst and to maintain the focus on the patient's well-being. Holmes (2010) observes that "the attachment implication [of termination] is that one can only leave home if there is a secure base to return to … including, if need be, a continuing relationship with a therapist" (p. 80). He adds that "the meaning of such arrangements must always be thought about and discussed in therapy – in other words, mentalized" (p.69). Decisions about post-termination follow-up should preferentially weight the patient's feelings and be mutually-agreed by patient and analyst. Since follow-up meetings are not continuations of analytic treatment, and may benefit both patient and analyst, we suggest leaving whether to propose a fee for such contacts to the discretion of the analyst. Certainly, some unresolved issues may become stirred up during a follow-up meeting, and become disturbing to the patient. At that time the patient has the option of returning for additional treatment to try to deal with this discomfort.

In sum**,** post-termination follow-up may demonstrate the analyst's continued deep caring about the former patient's welfare. Follow-up may also provide the former patient with reinvigoration of positive, internal representations of the analyst that facilitate the patient's continued development and emotional adaptation. Interviews with former analysands have identified a group of patients who continue to rely after termination on analyst introjective fantasies for the purposes of self-soothing (Dorpat, 1974; Kantrowitz et al., 1990; Pfeffer, 1993; Schlesinger and Robbins, 1974; Falkenström et al. 2007). In addition, follow-up contact may provide the patient with a further opportunity to

modify persistent idealization of the analyst (Buxbaum, 1950; Reich, 1950). The analyst may also benefit by learning about the post-treatment course of the patient's life, which may enable the analyst to improve his/her understanding of the course and outcome of the treatment.

Chapter Nine

Peer Group Consultation, "Intervision", Can Help with Troublesome Analyst-Transference[11]

Abstract

The fate of the lonely analyst is the topic of this chapter. How can he or she master the problems that arise when the analyst is caught up in the hard to solve issues of countertransference. We report in experiences of German colleagues that feel that continuous lifelong peer intervision may help to alleviate the burden of daily work. A survey of the use of consultation by American psychoanalysts gives good reasns to initiate a debate on the issue of intervision.

The Need for Consultation with Analytic Colleagues

The assumption that graduate analysts do not need to continue in supervision is, Mander (1993) asserts, a naïve and potentially dangerous self-deception. In agreement with many, Zysman (2012) notes that unconscious interactions between patient and analyst during a session "are beyond the sphere of conscious recognition by the analyst while at work and often also afterwards, so that they call for detailed investigation between sessions and with colleagues as recommended by both Bion and David Liberman" (p. 2). Zysman adds, "caught up in the transference relationship and compelled to struggle with his counter-transference, the valiant analyst clings to his knowledge and to the theories with which he identifies. Although he applies them honestly to the best of his knowledge and belief, this is apparently not all that is taking place, but seems to be just the tip of the iceberg that must be explored" (p. 2). The German analyst, Wegner (2012), commenting upon Zysman's paper, agrees: "If we are to continue to exist as psychoanalysts, we need a psychoanalyst, a patient and a colleague… that is, ongoing exchanges with colleagues concerning our clinical work." (p. 1).

Disturbing Analyst-Transference

The awareness of troublesome analyst-transference as an analytic issue is ubiquitous and has been well examined in the literature. This paper focuses and describes a form of regular peer group consultation, called "intervision" in Germany – to distinguish it from supervision. What distinguishes intervision groups from supervision groups is the circumstance that there is no official leader; we acknowledge that senior analysts may have a stronger voice in the group but formal equality is the basic principle. The advantage is that junior participants have a chance to experience senior colleagues in their work. It is widely used by German psychoanalysts who mainly practice in an insurance system/professional organization collaboration in which the patient makes no direct payment for psychoanalytic treatment and the analyst's fee is paid by the state insurance company, Kassenärztliche Bundesvereinigung (see Thomä & Kächele 1994a, chap.6). The patient pays for all kind if medical treatment indirectly by paying approximately $3000 annually to the state insurance company.

We believe that one source of troublesome analyst-transference is the analyst's prior exposure to the training analysts, and, to a lesser extent, to supervisors, who serve as authority figures whose "correct interventions" may be internalized and subsequently utilized with patients. Rado's (1956, [1934-1937]) prescient observation 80 years ago, that analytic training "hastened to patronize and overawe the student rather than to foster his intellectual independence … it has not impressed upon him the fact that only by means of his own independent thinking can he properly assimilate what he is taught … That training is a failure which accomplishes no more than to make the student believe that his role is blind belief" (p. 125).

An analyst seeking help with an individual consultant or with a leader-run consultation group risks being taught, and thus integrating, techniques that work for the consultant or for the group leader but do not help the analyst to understand and deal with the analyst's own interfering transference. For example, Kantrowitz (1999) sought help with a consultant because she had ended a session with a patient prematurely. The consultant suggested an interpretation for her to make with the patient, but failed to help her understand and deal with her distressing counter-transference.

Self-analysis has been widely used for help with problematic transference (Kramer, 1959) but its value is limited by the analyst's own unconscious and spontaneous dissociation. This is epitomized by the well-known comment that "a doctor who treats himself has a fool for a patient."

Peer Group Consultation, Called Intervision, in Germany

Leaderless peer group supervision developed in Germany from the early nineties. Stehle (2000) reported that 85% of German psychoanalysts in private practice regularly take part in some form of continuing clinical education. Those who participate regularly register on average for 23 intervision sessions per year. Intervision thus is a commonly accepted part of private practice in Germany.

A personal description of participating in an "intervision" group is provided by a participating German analyst, Schunter, from the Ulm group (Hansjoerg.Schunter@bn-ulm.de) which has been translated and edited freely: "The topic of 'intervision' has kept me in its grips for the last 30 years and I have participated in my recent group, composed of experienced colleagues, for more than ten years. Let me extract from this experience the conclusions I have reached: Ideally group size should be 4-6 with fairly regular attendance leading to the liveliest case discussions. Voluntary continuity of participation provides benefits to all participants in their professional as well as private lives. While the composition of the group is optimal when most of the colleagues share similar years of experience, younger colleagues can be integrated and will absorb the culture of the group. Personal vanities and narcissistic vulnerabilities decrease in the longer exchanges; however, occasionally a member disappears as a result of feeling too criticized. We are aware that working together for long times in such groups may create a danger that the critical potential is reduced if everyone becomes too accustomed to the others' ways of thinking; then at those times it has been useful to invite an outside guest from time to time.

To meet in a study group constellation with colleagues well known to each other and to feel well in a critical discourse puts narcissistic issues in the background. In this way, subtle counter-transference attitudes and response sets, diagnostic errors, blind spots, enactments, technical errors, but also reaction about negative courses of treatments, etc., can be handled easier".

A personal supplementary statement is provided by the former president of the German Psychoanalytic Association (2012),Walker (christoph.walker@t-online.de), a member of the Tübingen group:

"Basically I couldn´t imagine my work as psychoanalyst without the collegial exchange in 'intervision' groups. The group I am most committed to consists of four members, two women and two men and has met weekly in the early afternoon for the last 22 years.

I consider that the most relevant aspects are a stable, reliable frame which supports the growth of confidence among us. In this atmosphere we can cultivate a readiness to talk about what is really difficult in spite of all the associated negative affects. This enables members to be confronted with "one´s blind eye" without shame and devaluation. Members are encouraged to remain curious and the change from presenting one's own case material to listening to others' cases increases awareness of both knowing and not knowing, and enables the communication of the uncomfortable. The group is a container which enables exploration of the analyst's frustration, of what has changed, and also of what was not present in analysand or analyst. The collegial relationships enable explorations and changes of clinical and theoretical concepts".

The authors personally know of at least four ongoing leaderless peer groups in the United States; one such group of six analysts has been meeting weekly for 32 years and one, apparently, for 30 years. One American leaderless consultation group (Hunt & Issacharoff, 1975) ended with an unsatisfactory outcome.

A Survey of the Use of Consultation by American Psychoanalysts

In order to assess the proportion of American analysts who utilize either no psychoanalytic consultation, individual consultation or peer group consultation, we conducted two surveys. The first was a telephone survey of 200 members of the American Psychoanalytic Association; the other was an email survey of the members of four New York City psychoanalytic societies, two of whom would be considered "traditional" while the other two predominantly "relational". Individual societies were not identified to maintain anonymity of the society.

For the first survey, two hundred members' names were selected at random from the Roster of the American Psychoanalytic Association; of these 20 phone numbers were not responsive. Each of the remaining 180 were queried by phone by J.S. using a script: "(1) Are you in active practice? (2) During the last six months have you utilized either no consultation, or a formal individual consultation and/or peer group consultation. Please call at 212.787.4270 and leave an anonymous response. For a representative result, it is important that, whether or not you are in active practice, you respond". In the second, later survey, that same script was distributed as an email message to the members of four New York City Societies by their own offices. An additional email request was sent one week after the first email request, thus a total of 1,354 analysts were contacted.

Results are presented in Table 1.

Table 1

Survey of Analysts' Use of Consultations

	APsaA	NYC Analytic Societies			
		1.	2.	3.	4.
Contact Medium	Phone	Email	Email	Email	Email
Number Contacted	180	262	178	242	492
Number Responses	70	12	29	31	106
Response Rate	39%	5%	16%	13%	21%
% Indiv. Consult.	46%	58%	24%	16%	43%
% Peer Group Cons.	41%	75%	72%	39%	69%

Discussion of Consultation Survey

As the table indicates, two different survey mechanisms were used; personal phone calls and email requests. Clearly, the survey response rate was much higher when personal contact was made by telephone (39%) than by email (5-21%). Analysts apparently feel less pressure or motivation to respond to email than to phone. Further, we speculate - though we have no evidence - that under reduced pressure or motivation to respond, analysts who can report neither individual consultation nor peer group consultation, may be more reluctant to respond at all, just as it has been assumed, that analysts with few or no patients in analytic treatment to report, were less likely to respond to APsA's organizational practice survey. If this latter hypothesis is valid, the percent of analysts reporting no consultation, 12% - 55%, is an underestimation, and, consequently, the percent reporting individual and peer group consultation may be somewhat exaggerated. Results indicate that Individual Consultations range from 16% to 58%, and Peer Group Consultations range from 39% to 75%, thus suggesting that peer group consultation may be used somewhat more frequently than individual consultation.

The Psychoanalyst's Need for Help with Difficult Analyst-Transference

Several analysts have acknowledged this need for help which "intervision" may provide. Lacan (1959-1960) had proposed the institutionalization of a "third" as a reviewer and interlocutor in routine analytic practice. Frayn (1996), while valuing self analysis, reached a similar conclusion: "It is important that analysts make arrangements to candidly discuss personal and professional concerns with trusted colleagues, as well as engage in a deeper exploration of themselves within a reflective frame of reference." (p. 305). Kirschner´s (2012a) stance is closest to ours, since he suggested that "it may be time, at this moment in the evolution of the analytic discipline, to find new ways to involve others as witnesses to analytic practice" (p. 1239). Although not articulating why he believes this is an appropriate time, he suggests that "it would not be onerous to involve others as witnesses

to analytic practice" (p. 1239). "The step of incorporating others into the role of psychoanalyst would recognize the uniqueness of psychoanalytic work and its fundamental rootedness in an ethical position" (p. 1240). He elaborates, that "it would not be onerous, for example, to require candidates to share their work in small groups and practitioners to maintain regular contact with peers as part of membership in a society" (p. 1239), thus, coming close to the "intervision" model. He adds, "perhaps analysts should also consider adopting a formalized practice … which might take the form of periodic meetings during retreats or of institutionalized encounters within regional groupings." (p. 1240). He commenting on the discussion with his peers Kirschner (2012b) concludes, that this is a good time for institutes to try some experiments and invent new procedures…" (p. 1286).

Conclusion

The most striking finding is that a significant proportion of American analysts, perhaps 25-35% - virtually one third - do not reach outside the solo practitioner model for any help with analyst-transference difficulties, thus missing the critical possibility of assistance, in contrast to German analysts almost all of whom utilize some form of consultation. This is especially noteworthy since many analysts acknowledge that consultation is essential for effective psychoanalytic practice. We suggest that probably all analysts should obtain some external help in dealing with their troublesome analyst-transferences, and that "intervision" is suggested as a particularly effective tool. We do recognize that individual supervision, despite some concerns, as well as a return to personal analytic work, may also be helpful.

During analytic education all candidates participate in supervision, so all have had the experience that individual consultation may be helpful. We suggest, as Kirschner had proposed, that "intervision" should also be supported and included in the analytic curriculum so that candidates experience how such consultation works, how helpful it can be, and will recognize its usefulness after graduation. To enhance the future psychoanalytic practice of graduates, psychoanalytic education could thus begin to supplement Freud's solo practitioner model of the psychoanalyst with experience with intervision.

Chapter Ten

Comparison of Vignette-based Ratings of Satisfaction with Treatment by Training Analysts and by Non-Training Analysts[12]

Abstract

This study provides data about vignettes of individual interviews with 13 American Psychoanalytic Association (APsaA) psychoanalyst-patients who had both a training analysis and an analysis by a non-training analyst (non-T.A.). Individual ratings of treatment satisfaction based on interview vignettes by each of two senior psychoanalysts corroborate questionnaire ratings of satisfaction indicating that in this study the training analysis was reported to be *less* satisfactory than analysis by a non-T.A. in these 13 analysts; the difference was especially marked when the training analysis preceded the analysis by the non-T.A..

All psychoanalytic organizations that require that candidates be treated only by T.A.'s, presume that analysis by a qualified T.A. will be *more* satisfactory than analysis by a non-T.A.. To date, the empirical data in two studies fail to support that presumption.

Introduction

At the Nurnberg Congress in 1910, Freud said "It seems that the pre-requisite for a successful application of psychoanalytical technique is that the physician should begin his analytical training by being analyzed himself" (Quoted by Kovács, 1936, from the Report of the Nurnberg Congress by Otto Rank). At the Budapest Congress of the International Psychoanalytic Association in 1918, Nunberg remarked similarly in a private conversation, "no one should henceforth be allowed to analyze who himself has not been analyzed previously" (Szasz, 1958, p. 599; Sandler, 1982). The Berlin institute was founded in 1920, and many of its members felt the need for a personal analysis. During the winter of 1923-1924, Hanns Sachs was invited to move from Vienna to Berlin to specialize in the analysis of psychoanalysts; he thus became the first training analyst (Bernfeld, 1962).

In contrast, at the same time, in 1922 Bernfeld (1962) discussed with Freud his intention to establish himself as a practicing analyst and asked Freud if it was desirable for him to have a didactic analysis. Freud responded "Nonsense. Go right ahead. You certainly will have difficulties. When you get into trouble, we will see what we can do about it." (p. 463). Apparently Freud was not in favor of dictating a training analysis, at least not for everyone aspiring to become an analyst.

However, that same year at the Berlin Congress it was agreed that authorization to practice psychoanalysis would be limited to those taking theoretical courses, and submitted to a training analysis by an approved analyst (Kovács, 1936). Three years later, at the Ninth International Congress in *Bad Homburg* in 1925, Eitingon suggested the establishment in each country of institutes to take full responsibility for the training of prospective analysts, including supervision as well as training analysis (Sandler, 1982). Thus, Freud and Nunberg's original suggestion proceeded

within seven years to complete institutionalization of psychoanalysis without leaving any record of the discussion of possible problematic aspects in this major transformation. Balint (1954) recognized this absence and commented during a symposium about training analysis, "This symposium will then stand to our credit, that at least we were conscious that there were problems to be faced" (p.157). "In psychoanalysis, as elsewhere," Bernfeld noted, "institutionalization does not encourage thinking" (p.468), and "the laying down of laws is a hobby of psychoanalysts everywhere" (p. 479). As if to fulfill this insight, at the Innsbruck Congress in 1927 the International Training Commission adopted an additional standard, namely, that analysts should be more fully analyzed than their patients (Kovács, 1936).

"The training analysis," writes Wallerstein (2010), "has been the central problematic of our entire institutionalized educational structure" (p. 903). A variety of difficulties and problems have been identified by many well-known authors. Kernberg (2000), a repeated, preeminent critic, identified "a tendency to infantilize psychoanalytic candidates, a persisting trend towards isolation from the scientific community, a lack of consistent concern for the total educational experience of candidates, authoritarian management and a denial of the effects of external, social reality" (p. 97). He added, "the inhibition of the creativity of psychoanalytic candidates … is one of the major problems of present-day psychoanalytic education …" (p. 116).

The collected and extensive criticisms of training analysis imply that a training analysis will be *less* satisfactory than analysis by a non-T.A.. An interview study by Tessman (2003) found no difference in satisfaction with T.A. compared to satisfaction with non-T.A.

The present report will attempt to validate the questionnaire ratings of satisfaction with analysis both by a T.A. and by a non-T.A. by comparing subsequent vignette-based ratings with the earlier questionnaire ratings of each. In addition, satisfaction with a T.A. will be compared with satisfaction with analysis by non-T.A.'s on the basis of vignette-based ratings alone.

Method

Thirty-one graduate analyst APsaA respondents in a questionnaire/ interview study experienced both a training analysis and analysis by a non-training (non –T.A.) analyst, and the 13 of these who participated in the individual interview about their analyses with J.S. were selected for this study; the remaining 18 respondents had not volunteered to be interviewed, so we lack vignettes for them. Two senior analysts, Rater A and Rater B, who were blind with regard to the respondent's questionnaire ratings, individually rated for satisfaction both the vignettes about training analyses and those about analyses by non-T.A.'s of these 13 interviewees. We determined that it was not feasible to disguise the vignettes about training analyses so that it would not be possible to identify them as training analyses. Therefore, we separated and scrambled the 13 training analyses and the 13 analyses by non-T.A.'s, so that Rater A and Rater B would not be able to recognize that a T.A. vignette and a non-T.A. vignette both came from the same interviewee. Each rater dealt with a population of 13 T.A. vignettes, and, separately, 13 vignettes of analyses by non-T.A.'s. Then, these 13 respondents' questionnaire ratings of satisfaction and interview vignette-based ratings of satisfaction were compared separately for training analysis and for analysis by a non-T.A. . Vignette-based ratings employed the same Likert-scale format used for questionnaire ratings*: (5) Very satisfied; (4) Moderately satisfied;(3) Partially satisfied/partially dissatisfied; (2) Moderately dissatisfied; and (1) Very dissatisfied.* In order to further anchor the ratings of the participants, J.S. had provided brief prompts about each of the five points on the scale of satisfaction for rating vignettes.

Interviews were voluntary, exploratory and relatively unstructured; they prioritized developing emotional contact with the interviewee to provide more illumination of emotionally-charged views

of their training analysis rather than the cataloguing possible in a structured interview. A limited number of themes were consistently explored in the interviews: interviewees were regularly asked how they'd selected their analyst, how they felt about the "fit" with their analyst, and about post-termination contact issues. The full transcribed interviews by J.S. have been reviewed and approved by the interviewee, and permission granted to publish vignettes.

The vignettes were selected by J.S. to separate interview material about the T.A. from that about the non-T.A.

Results

Relationship of Questionnaire Ratings to Vignette Ratings

The first analysis of ratings of vignettes will examine whether there is a close association between the two analysts' blind vignette ratings of satisfaction and the questionnaire ratings of the analyst-patients satisfaction of which the raters were unaware, separately for training analyses and for analyses by non-T.A.'s. Each rater assessed each vignette. The two raters agreed substantially in evaluating the 26 vignettes ($r = .75$, $p < .001$). This agreement was consistently high for the two groups of 13 considered separately as well. We next assessed the closeness in agreement between the average of the two raters and the analyst-patients' questionnaire scores: the correlation was ($r = .65$, $p < .001$), confirming a central hypothesis of this study, that vignette ratings were significantly correlated with questionnaire ratings. A further check on the reliability of these ratings was made by comparing the vignette scores of each of the two raters to the questionnaire rating by the analyst-patients: Cronbach's alpha = .83 for all 26 sets of ratings.

Next, the relationship between vignette ratings and questionnaire ratings was examined separately for those who had the non-TA analysis before the TA analysis, and for those who had the reverse in Table 1.

Table 1

Table of Satisfaction Ratings*

Subject Code	Questionnaire Rating		Average Vignette Rating	
	Non-T.A.	T.A.	Non-T.A.	T.A.
Non-T.A. *Before* T.A.				
6014	4	5	3	3
3064	5	4	4.5	4
1023	5	3	4	1
1500	3	3	4	3
1741	4	4	3	4.5
3005	3	5	2	5
1761	5	5	4.5	5
2097	3	5	4	2.5
5007	5	5	4	4.5
8002	4	2	3	3
3061	5	4	4.5	4
Mean	3.8	3.9	3.5	3.5
T.A. *before* Non-T.A.				
1310	5	1	4	1.5
8024	5	3	4	2
Mean	5	2	4	1.8
Overall Mean (n=13)	3.7	3.8	3.7	3.3

*The larger the number the *more* the satisfaction.

Five of the total of 26 questionnaire ratings for these 13 respondents indicated levels of dissatisfaction (ratings of 1 or 2); four were for training analysis. Four of the total of 26 vignette ratings indicated levels of dissatisfaction; three were for training analysis.

Questionnaire Ratings

The questionnaire satisfaction data for 13 S's in Table 1 was subjected to a two-factor analysis of variance, consisting of a between subject factor, Group (non-T.A. *before* training analysis vs.

training analysis *before* non-T.A.) and a within subjects factor, Treatment Type (non-T.A. vs. training analysis). There was no statistically significant main effect for Group membership (F (1, 11) = 1.49, p= .25, beta-squared = .12); indicating that overall levels of satisfaction for both types of analysis combined did not differ by the sequence in which participants had experienced their analyses. However, there was a statistically significant main effect for the Treatment Type factor (F (1, 11) = 8.51, p < .014, beta-squared = .44); indicating that training analysis generally was rated as *less* satisfactory than non-T.A.. Further, a statistically significant interaction effect between Treatment type and Group membership was found (F (1, 11) =7.16, p < .02, beta-squared = .41). The interaction plot, displayed in Figure 1 and a series of simple main effects contrasts indicated that satisfaction levels for training analysis were significantly lower than ratings of analysis by non-T.A.'s for those participants who had training analyses before their analyses by non-T.A.'s.

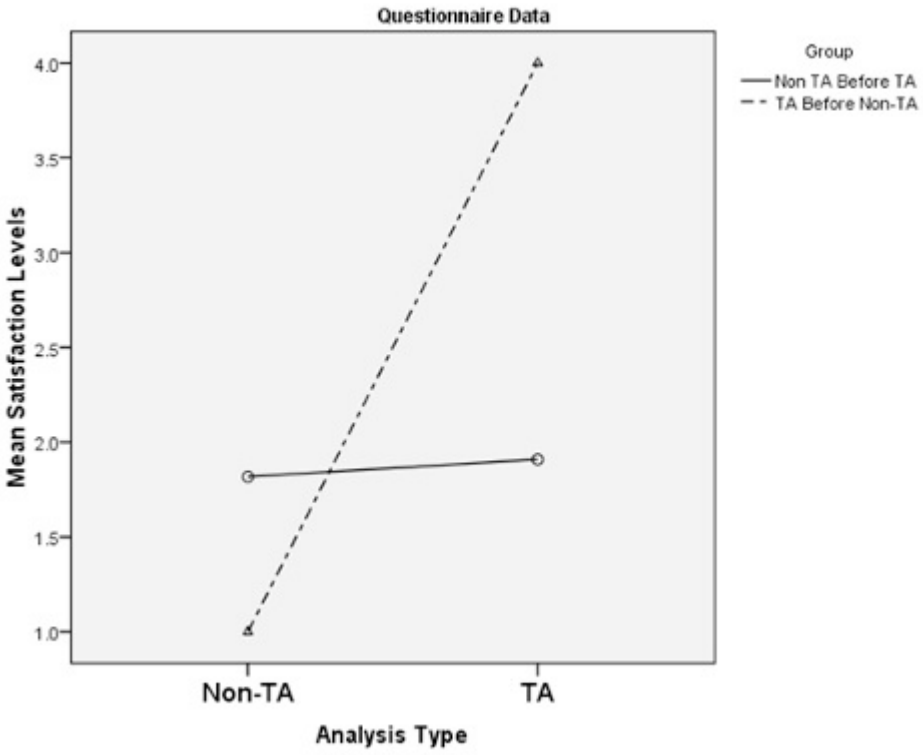

Figure 1. Mean questionnaire ratings of satisfaction levels by type of analysis and the order in which analysts experienced their personal and training analyses.

The vignette ratings of satisfaction data in Table 1 was subjected to the same two-factor analysis of variance procedure as the questionnaire data. There was no statistically significant main effect for Group membership (F (1, 11) =1.86, p= .20, eta-squared= .15); indicating that overall levels of satisfaction for both types of analysis combined did not differ by the sequence by in which participants had experienced their analyses. However, as in the questionnaire data, there was a moderate-sized (eta-squared = .25) main effect for the Therapy Type factor. However, due to small sample size, the effect was non-statistically significant at the traditional 0.05 level (F (1, 11) = 5.00, p <.08); indicating that training analysis was generally rated as *less* satisfactory than analysis by non-T.A.'s. Here too, there was a moderate-sized interaction effect between Therapy Type and Group

membership (eta-squared = .19) but not statistically significant at the traditional .05 level (F (1, 11) =2.63, p<.13). The interaction plot is displayed in Figure 2 and a series of simple main effects contrasts indicated that satisfaction levels for training analysis were significantly *lower* than ratings of analysis by non-T.A.'s for those participants who had training analyses before their analyses by non-T.A.'s.

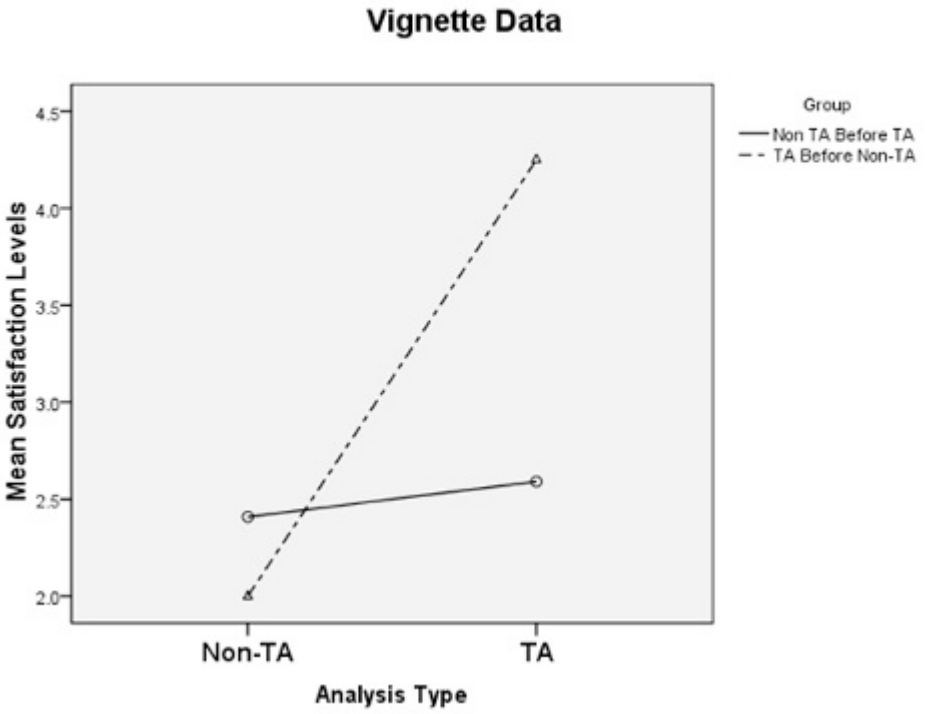

Figure 2. Mean vignette ratings of satisfaction levels by type of analysis and the order in which analysts experienced their personal and training analyses.

Transcribed Vignettes

Transcribed vignettes of the 13 interviewed S's will be presented next**.** We present interview vignettes of the 11 S's who had analysis by a non-T.A. before the training analysis first. Honoring chronology, for each of these respondents, the first vignette will refer to the analysis by a non-T.A., and the second vignette will refer to the training analysis. After each vignette, the questionnaire's satisfaction rating will be presented, followed by the ratings by Rater A and Rater B for comparison.

Analysis by non-T.A.'s *Before* Training Analysis

Analysis by non-T.A.: Dr. Jepson (Questionnaire # 6014)
Dr. Jepson likes to participate in any analytic research she can because she doesn't actually do any research, and feels the least she can do is participate in some research. Additionally, she is particularly interested in the training analyst system. In her twenties Dr. Jepson had had some psychotherapy in Europe, and later, when she was having marital problems, she began analytic treatment in the United States. Her analyst, Dr. Phillips, focused on her narcissism and the guilt that

lay behind it, resulting in her working on childhood issues. He challenged her presenting herself as dumb, and encouraged her to go to graduate school and move on with her life. Dr. Jepson, however, felt that the way he worked remained mysterious to her.
Analysis by non-T.A.: Questionaire: Moderately satisfied =4; Rater A =3; Rater B =3. .

Training Analysis: **Dr. Jepson** (Questionnaire #6014)
Years later she again struggled with difficulties in her relationship with a man who was an analyst and who urged her to seek further analytic treatment. When choosing an analyst she reviewed several who were bright, but felt they had character problems, and then selected a male analyst, Dr. Carter, who was very smart, and was analyzing a good friend of hers. He also offered a fee she felt she could afford. Her analysis with Dr. Carter, who was a training analyst, led her to decide to become an analyst. During this treatment, however, she was so consumed by her personal problems that she didn't directly make use of this analysis as a "training analysis"; she didn't talk about her treatment of patients or supervision. From him she learned the value of abstinence, and of regression in working with early experiences and memories.

She sees herself as fairly compliant and was unable to express anger towards him. An example she provided focused on her not coming to a session on a May 31. She had assumed he did not work on the holiday; since she had never missed a session she was angry that he charged for that session. She paid for the session but was unable to express her anger. Another time, when he was leaving for a trip, she asked where he was going. He didn't answer, and, again, she was angry but couldn't express her anger. She accepted his "rule" and never again asked him a similar question

Dr. Jepson had written several papers critical of the training analyst system, but Dr. Carter never explored whether her writing these papers involved her transference feelings, and neither did she. Dr. Carter was always supportive of her progression at the institute
Training analysis: Questionnaire: Very satisfied: = 5; Rater A = 3; Rater B = 3.

Analysis by non-T.A.: **Dr. Peterson** (Questionnaire #3064)
Asked why he was interested in being interviewed, Dr. Peterson replied that he wanted to be of some help, and the study sounded interesting and valuable. Dr. Peterson reported that when he was in college he was unhappy and disillusioned. A teacher/friend who was in analysis realized he needed treatment, and asked his analyst for a referral. Dr. Peterson began analysis with Dr. Paul and soon went five sessions per week and used the couch. His teacher/friend was gay and tried to seduce him, which disturbed him but he didn't even think of telling his analyst about it, until it sort-of erupted. Dr. Paul was British trained and allowed him to get connected to his own feelings. Dr. Paul didn't say much; Dr. Peterson sort-of did it himself, which was important to his self-esteem. Dr. Paul did do a lot of dream interpreting which Dr. Peterson loved. It was a fairly regressive experience; Dr. Peterson dropped out of college for a couple years. His whole life was devoted to analysis. He thinks his transference was displaced onto his teacher/friend, and Dr. Paul just let that happen. Near the end of treatment Dr. Paul suggested that Dr. Peterson should read Winnicott, of whom he had never heard. Dr. Peterson emerged from analysis with his own identity, graduated college, was accepted in medical school and got married.

When Dr. Peterson left for medical school Dr. Paul gave him the name of an analyst in the city in which he would be going to medical school, which Dr. Peterson felt was the first time he had broken the frame. Dr. Peterson wrote to him a few times, and Dr. Paul wrote back, and mentioned that he had published an article about Dr. Peterson's treatment which disturbed Dr. Peterson because it referred to a specific possibly identifiable attribute of Dr. Peterson.
Analysis by non-T.A.: Questionnaire: Very satisfied =5; Rater A =4; Rater B = 3.

Training analysis Dr. Peterson (Questionnaire #3064)
When Dr. Peterson began his residency he felt he still had work he needed to do analytically, and wanted to process his residency experience. He asked one of his supervisors for analysts' names and started analysis with a Dr. Flemming, a self psychologist, with whom he felt comfortable. When he began analytic training Dr. Flemming became his training analyst.

Like Dr. Paul, Dr. Flemming never imposed anything on him; sometimes he wished they would have imposed more. He feels he was able to distance himself from his family in a healthy way, though he is still pretty involved with them. Although he had been his father's least favored child, his relationship with his father improved enormously. This analysis, too, helped him to carve out his own identity. His two analyses were not that different from each other, which may say more about him than about the analyses.

Then Dr. Flemming and several other analysts left to form a new analytic group, and asked him to join them. Dr. Peterson felt abandoned and hurt by that, and did not join them. This precipitated his terminating his analysis with Dr. Flemming.

J.S. asked if he could have Dr. Peterson's permission to contact his analysts. Dr. Peterson responded that he thinks Dr. Paul is not alive any more, but it would be fine to contact Dr. Flemming. Dr. Peterson added that he had read J.S.'s book on transference and really loved it. Perhaps that had influenced him to want to be interviewed.
Training analysis Questionnaire; Moderately satisfied = 4; Rater A =4; Rater B =4.

Analysis by non-T.A.: Dr. Dolphin (Questionnaire # 1023)
Dr. Dolphin had gone into personal analysis when she was a psychiatric resident with an analyst she had previously seen for a short period of psychotherapy as an undergraduate. She had been very suspicious about lying on the couch; she had been watching the analyst's reactions the way she used to watch her mother to see if the latter was O.K. However, the treatment was very helpful, and she became more and more interested in doing analysis. The institute told her she could apply for analytic training after she finished her personal analysis which lasted four years.
Analysis by non-T.A. Questionnaire: Very satisfied = 5; Rater A =4; Rater B =4.

Training Analysis: **Dr. Dolphin** (Questionnaire #1023)
Dr. Dolphin had had a choice of only two training analysts. One seemed a very cold kind of person, so she chose the other who was at least kind of warm. The training analysis was terrible; it was a little due to herself, but a lot due to him. She didn't feel he understood her, didn't feel that he was empathic. He asked if she had ever had an abortion, which made her feel very misunderstood, though the truth was she had had an abortion. She never had an alliance with him as she had had with her first analyst; she felt he was unfair. He thought she idealized her first analyst, which was true. He was "a kind of a crazy guy" who ended up having a psychotic break and being hospitalized. She consulted a liaison analyst about ending her training analysis, and did terminate it. She objected to rules about how long a training analysis had to be.

After her training analysis ended, she went back to her first analyst for a short time. She then moved into an office across the hall from him, and began having lunch with him and developed a personal relationship with him. Dr. Dolphin said that talking about this began to feel uncomfortable, so perhaps she will come back to it. Her concern about that relationship led her to join J.S.'s Clinical Discussion Group on Post-termination Patient-analyst Contact which she said was the best discussion group in which she had participated. She ended up marrying one of her analyst's patients, which was a big mistake. She then saw a woman analyst, a self-psychologist, who was really very nice and very supportive. The analyst indicated she thought it would be O.K. if she left the marriage,

and she did so. She remains in contact with this analyst by email. She commented that she's good at talking to people and intuitive, but has difficulty describing in a conceptual framework what she was doing. J.S. asked Dr. Dolphin if she would give him permission to contact this last analyst, and she replied that that would be fine.
Training Analysis: Questionnaire: Partially satisfied/partially dissatisfied = 3; Rater A =1; Rater B =1.

Analysis by non-T.A. Dr. Prentice (Questionnaire # 3061)
Dr. Prentice started participating in a psychoanalytic training group and went for a personal analysis with one of the instructors there. She had wanted to work with a woman who proved to be incredibly perceptive. She has continued to work with her, and is now seeing her twice each week. The analysts in this group feel there is a psychoanalytic reason for everything; the focus is on a one-person psychology and the unconscious, with much less interest in the relational-interpersonal. She's very happy there. The group is part of a study of psychotic patients.
Non-training analysis: Questionnaire: Very satisfied =5; Rater A =5; Rater B =4.

Training analysis: Dr. Prentice (Questionnaire #3061)
Dr. Prentice agreed to be interviewed because she was curious to see what might come out about her analytic experiences, and because she was interested in the subject of the training analysis. As a graduate student she had had a professional and personal breakdown, and obtained analytic treatment for a limited time period, which was quite helpful. She knew immediately she wanted to go into analysis. She ended treatment when she obtained a position and left.

She was accepted for analytic training, and selected Dr. Forrest who offered the lowest fee. It wasn't, she noted, "a match made in heaven," but it seemed to work. She did miss the first analyst she had seen. Her financial state became quite dire. Dr. Forrest became defensive, and suggested since she was trying to get pregnant, that she sell one of her own eggs. Dr. Prentice felt that that specific suggestion at that time of her life was problematic, and she became enraged. Although Dr. Forrest didn't agree, she terminated her analysis anyway. After a break she went back and tried to work with him, but was unable to do so. Another training analyst was willing to see her so she could reach a mutually-agreed termination of the training analysis. After she left Dr. Forrest, they did have a friendly relationship, and she purchased his collected works of Freud. In response to J.S.'s question, Dr. Prentice said she didn't think her training analyst had intervened in her progression in the institute.
Training analysis: Questionnaire: Moderately satisfied =4; Rater A =3; Rater B =1.

Analysis by a non-T.A.: **Dr. Peters** (Questionnaire # 1500)
Dr. Peters agreed to participate in the interview because psychoanalytic research was a fundamental part of the psychoanalytic world; the more information the better. He first had a personal analysis. He had previously seen the analyst he selected as a consultant, and liked him. He had very impressive credentials, and seemed empathic and down to earth. His basic understanding was extremely helpful; it enabled him to resolve a divorce and find an appropriate partner. Dr. Peters thought the analyst liked him. Certain issues, however, were not worked out – but that's O.K. Subsequently, though, he became disappointed in him as a human being.
Analysis by a non-T.A.: Questionnaire: Partially satisfied/Partially dissatisfied = 3; Rater A =4; Dr. Rater B =4.

Training Analysis: **Dr. Peters** (Questionnaire #1500)
Later, he considered going into analytic training, and went to see a training analyst, initially once/twice per week. He had the most gravitas. Although he was formal in a lot of ways, his ideas were more radical than his demeanor. I asked Dr. Peters if he thought his analyst intervened in his progression in the institute. He thought in that local psychoanalytic community that it could be done subtly, indirectly; it operates insidiously from a negative point of view.

An internal conflict developed at the institute. He and his analyst had different views. His analyst simply wasn't interested in what he had to say. His analyst interpreted Dr. Porter's disagreement as his own psychological problem. That made him decide to end his training analysis, though he wasn't honest that that was the reason he was terminating. He didn't consider switching to another analyst because of how that would upset his analyst. He was a fine man, a deep thinking man, and he had been quite helpful. Later, he died.

J.S. asked if before termination he and his analyst had discussed the possibility of post-termination contact. They had not; he commented that they conformed to pretty traditional ways. He did have professional contacts with him, especially after he, himself, became a training analyst. He came to recognize the disparity between his idealization and a realistic view of his analyst. Similarly, he doesn't encourage post-termination contact with his own patients. He doesn't see there being an analyst-patient relationship after treatment has ended.
Training analysis: Questionnaire: Partially satisfied/Partially dissatisfied = 3; Rater A =3; Rater B =3,

Analysis by non-T.A.: **Dr. Crawford** (Questionnaire # 1741)
Dr. Crawford was interested in participating in the interview because she thought it might improve her perspective, help her to reflect on her experiences. She selected her first analyst for a personal analysis because her boyfriend was in analysis with him and spoke very highly of him. She didn't begin analysis so much because she had specific symptoms or problems, but because in the 1970's many people wanted analysis to reflect on themselves. She was part of a group of leftist activists, and this analyst treated members in that group. She described positive and negative aspects to the "fit" between them. She felt very supported in her intellectual development by him; she went on to a PhD. On the other hand, he was demanding and moralistic – pushing all the time. It had the effect of enhancing her perfectionistic qualities.
Analysis by non-T.A.: Questionnaire: Moderately satisfied =4; Rater A =3; Rater B =3.

Training analysis: **Dr. Crawford** (Questionnaire #1741)
She married, went into practice, and a supervisor urged her to consider analytic training. She did decide to go back into treatment and selected a training analyst recommended by her supervisor so she would be eligible for training. She felt this analyst was a good "fit"; he was deeply compassionate, a real "mensch". He helped her fix her judgmentalism. Having that good experience fostered her decision to go into analytic training, despite the onerous waiver process as a psychologist. She didn't know many psychologists who were applying for training. Her positive transference and support from her training analyst probably influenced her decision to persevere. She terminated her analysis well before she graduated from analytic training.

J.S. asked if she had had any post-termination contact with her training analyst. They had not discussed this possibility during the analysis. They met when she graduated; he was not an analyst with rigid boundaries. Later he became ill; she wrote him a note about how much he had meant to her. She wasn't comfortable visiting him; felt it was too intimate. She has boundary concerns about that. Felt she wouldn't have known what to say if she had visited him. Later, he died.

She has not become a training analyst. Her career has taken a different path. She obtained a part-time job working with volunteers who had been working overseas and became troubled. This work became a large part of her practice. She became interested in working with PTSD patients, and learned that she had to work with them in a very different way than she had with analytic patients. She became interested in somatic approaches. She used a technique called EMDR and was quite successful with PTSD patients. Basically, she became a trauma therapist, seeing patients once per week and doing a lot of teaching about the technique. She doesn't practice psychoanalysis any more. *Training analysis: Questionnaire: Moderately satisfied = 4; Rater A =4; Rater B =5.*

Analysis by a non-T.A.: Dr. Fletcher (Questionnaire # 3005):
Dr. Fletcher said that she agreed to an interview because she was responding to J.S.'s request. Prior to her training analysis she had had a twice-weekly, face-to-face therapeutic experience with an analyst, Dr. Green. Although she free associated, she did not consider it psychoanalysis, and felt it was a problematic, conflicted experience, that was more painful than it needed to be. She now feels they were not a good match, and considers that he had narcissistic and counter-transference difficulties. She feels she was subjected to unnecessary information which was provocative and not helpful to her. She did not need to be repeatedly confronted with him "avoiding" eye contact, especially when he ended up, after her, in the adjacent check-out line in a grocery with many checkers from which to choose. When his wife died during her treatment, although he reduced his practice, he did continue to treat her; she didn't need to know he had reduced his practice. During her analytic training, in a class he taught, a classmate of hers specifically commented on Dr. Green's behavior toward her.
Analysis by a non-T.A.: Questionnaire: Partially satisfied/Partially dissatisfied = 3; Rater A =2; Rater B =2.

Training analysis: **Dr. Fletcher** (Questionnaire # 3005)
When picking her training analyst, Dr. Fletcher talked to several people and interviewed three analysts. She chose Dr. Roberts, a calm, relaxed person who didn't seem to need to prove anything. He had a maternal quality with which he seemed comfortable. Although she would have preferred a woman analyst, none seemed appealing. Although she knew he and one of the analytic teachers with whom she was having difficulty in a class were friends, she wondered, perhaps he was more rigid, arrogant and insensitive than she had imagined him to be. Dr. Roberts carefully lived up to his responsibility about confidentiality, and that was very important to her.

One weekend she became unexpectedly, intensely depressed, and had no idea what the cause was. In the Monday session, Dr. Roberts speculated that in the Friday session he had been sicker than he realized, and had been relatively absent emotionally; he thought the loss of his presence had provoked her depression. That intervention was a relief for Dr. Fletcher, who had been disturbed by her reaction. She was pleased that Dr. Roberts could look at himself and "self-reveal" in ways that were helpful to her. She became tearful, even now, as she recalled that.

J.S. asked Dr. Fletcher if she had discussed post-termination contact with Dr. Roberts, and she had not; she had assumed she would be seeing him from time-to-time at institute-related activities. She noted, apparently with some self-awareness that she had grown up in a family with no boundaries. Although she and Dr. Roberts were at the same institute, they actually didn't see that much of each other. She commented that he's retired, and she should call him and take him to lunch. Lastly, J.S. asked Dr. Fletcher if she would give him permission to contact Dr. Roberts to get his view of her treatment, and she responded, "sure".
Training analysis: Questionnaire: Very satisfied = 5; Rater A =5; Rater B =5.

Analysis by non-T.A.: **Dr. Haven** (Questionnaire #1761)
Dr. Haven's first analytic treatment was by a candidate. She had no choice in regard to selecting this analyst, but she felt he was a good "fit". He was actually quite experienced and said things that were particularly relevant to her. He encouraged her to talk about (and develop a sense of validity about) her feelings and to experience them at greater depth. After more than five years she brought up the question of termination. He didn't explore her motivation for doing so, perhaps because he needed a completed case to graduate training. She felt a particularly encrusted layer of problems had been lifted and she was able to get married. She and her analyst had not discussed the possibility of post termination contact. When they occasionally met, he was very friendly.
Analysis by non-T.A.: Questionnaire; Very satisfied =5; Rater A =5; Rater B =4.

Training Analysis: Dr. Haven (Questionnaire #1761)
Some years later she developed a life-threatening illness which required intensive treatments; chronic treatments have been required. She worked briefly with an analyst twice a week to deal with this trauma and during that time she felt her mother, about whom she had been conflicted, 'float' away; it had been an amazing experience. Later, when she entered analytic training she asked friends for recommendations for a training analyst. She met with two of them. The woman thought she should wait a year before beginning training, which she did not want to do. She chose to work with the man. Looking back, she feels that was definitely the right decision. She had periods of intense anger at him that were very uncomfortable and lasted for days. With time they were able to work through that. When she disagreed with him, or criticized him he "put up with" her; he could "deal with" her. During the treatment something fundamental about her had taken a new shape. She had always felt she had views that were in the minority, and while she expressed them she was quite aware of how anxious this made her feel. When she understood in the analysis what that was about she felt much more comfortable saying what she thought. She felt she had given her analyst a very hard time, but that her attitude and behavior had changed. She came to accept him the way he was and to understand that they were different.

After termination she had considerable contact with him in professional settings, and he was always friendly and social. He congratulated her when she graduated. She kept in touch with him, and whenever there was a change in her medical condition, she would let him know. Finally, J. S. asked for permission to contact her training analyst. She jokingly asked if she could know what he said and then said, "Sure, you can". J. S. closed by saying he had enjoyed talking to her, and she said she had enjoyed it as well.
Training analysis: Questionnaire: Very satisfied = 5; Dr. Rater A =5; Rater B =5.

Analysis by a non-T.A.: Dr. Roberts (Questionnaire # 2097)
Dr. Roberts had had a personal analysis with a male analyst of self- psychological persuasion that had been very helpful. He became involved in her life and made suggestions which at times may have been problematic. She became less suicidal working with him, and had loved him very much. Her experience with him made her decide to become an analyst. J. S. commented that her description in the interview of her first treatment sounds more positive than her questionnaire rating of "Partially satisfied/Partially dissatisfied".
Analysis by a non-T.A.: Questionnaire: Partially satisfied/Partially dissatisfied = 3; Rater A =4; Rater B =4.

Training Analysis: Dr. Roberts (Questionnaire #2097)
For her training analysis Dr. Roberts wanted a good classical analyst, and selected a woman analyst who "did it by the book" and this analysis of 18 years is still ongoing. When Dr. Roberts reminisced about her mother's death in the interview, which had occurred before her first analysis, she came to the verge of tears, as she said she wished she had done more to help her mother before she died. Dr. Roberts said that her second analysis by a woman took place at a greater emotional distance, and she added that she thought the second, traditional analysis probably wouldn't have "worked" at the time she sought help the first time; she probably would have left her. J. S. commented that she had had two very different analyses, and both had been helpful.
Training analysis: Questionnaire: Very satisfied = 5; Rater A =4; Rater B =1.

Analysis by a non-T.A.: **Dr. Thorpe** (Questionnaire # 5007)
Dr. Thorpe initially had two periods of twice-weekly psychotherapy, one in her early twenties, and a second in her latter twenties. She began a personal analysis 2-3 sessions/week with a non-training analyst when she was in her thirties which lasted seven years. There were only two senior analysts to pick from; she selected the one who was recommended by a friend, and went to the other for supervision. He was knowledgeable about people who had experienced trauma, and her own early life had been very traumatic. She trusted him, felt safe with him, and made a good connection with him. He was able to look into very gory things: seemed to be able to bear anything. He commented that her early life sounded like one of the most horrible he had heard about. He didn't work much in the transference; never invited her to talk about him. After working with him for seven years, she was accepted for analytic training; it was very difficult to leave her analyst. From May to September, when she had to make the switch, she cried every day. She and her analyst did not discuss the possibility of post-termination contact, though, as they were in a small town, they met occasionally. She thought it was odd that they hadn't discussed it. It was clear she could return to him for more treatment if she needed to. He later died suddenly, and she regretted not having gone back to meet with him. She herself, now, does planned follow-up sessions with her patients who terminate. She doesn't want them to suffer unduly about the separation. Having had a very traumatic childhood of her own, she feels she has a talent for working with those who had a terrible trauma. Eventually, though, she does terminate with her patients. She does lean toward staying available as a future therapist for former patients; she is comfortable with that. She feels patients have a legitimate need to idealize their analyst and to have someone in the wings after termination who can perform the very unique self-object function that an analyst performs. She did see her first therapist occasionally for lunch years after termination. She's only seen a few patients with whom she worked that she thought might become a friend. If she began a friendship with a former patient, that might include socializing and confiding personal issues, she feels that would interfere with the possibility of the patient returning to see her for further treatment.
Analysis by a non-T.A.: Questionnaire: Very satisfied = 5; Rater A =4; Rater B =4.

Training analysis: **Dr. Thorpe** (Questionnaire #5007)
J.S. asked how Dr. Thorpe had selected her training analyst. One friend reported that she had had a good experience with him; she had met him once or twice and really like him. He was one of seven available training analysts. She did, however, have to drive half-an-hour to get to his office. Although he was not the kind of person she would look twice at on the street, she immediately developed a major crush on him. He was an old-fashioned analyst, very proper, who didn't say much. He never put a finger on her. He smiled when she came into his office, and she always felt he liked her, and was enjoying working with her. He tended to be playful, though he only interpreted

the transference. Next, J.S. asked if her analyst had ever intervened in her progression at the institute. He had not, though he felt they should discuss whether she was ready to start her first analytic case. She never had any issues with her progression at the institute. Had Dr. Thorpe ever gotten angry with her analyst? When she learned another candidate was living in an apartment in his home, she had an incredible rage attack; she was furious!
Training analysis: Questionnaire: Very satisfied = 5; Rater A =5; Rater B =4.

Analysis by non-T.A.: Dr. Griffin (Questionnaire # 8002)
Dr. Griffin had become depressed during his first year in college and started personal psychoanalytic treatment. They were a poor "fit". The analyst was much older and was from another country. Dr. Griffin thought he couldn't understand a lot of what he, Dr. Griffin, talked about. Dr. Griffin went five sessions per week for three years. J.S. asked how it helped with his depression. His depression lifted. The analyst did get Dr. Griffin to appreciate introspection. J.S. asked if Dr. Griffin thought he identified with his analyst; he thought he did, though he didn't practice the way his analyst practiced – quite taciturn. He realized he wouldn't survive as a therapist if he tried to be somebody he was not.
Analysis by a non-T.A.: Questionnaire: Moderately satisfied = 4; Rater A =3; Rater B =3.

Training analysis: Dr. Griffin (Questionnaire # 8002)
Much later he chose a training analyst. He interviewed two analysts whose names had been suggested. He selected the analyst whose office was closer to his. He had had too much anxiety to be able to master quiet listening; he learned that from his analyst. But they were not a good "fit". He was very quiet; some sessions not saying anything; he practiced elective mutism. That was hugely frustrating to him and he complained about it bitterly. Dr. Griffin was unhappy about how unresponsive he was to Dr. Griffin's need for more engagement. It was like his father having hit him when he was a small boy. He couldn't say, "Fathers don't do that to boys". Dr. Griffin was concerned that if he switched to another training analyst that his analyst would use his power against him.

One day Dr. Griffin asked him why he wasn't listening – he was so quiet. His analyst replied, "Why do you think I'm not listening; I am listening". Dr. Griffin said that changed the whole way he listens to patients. Dr. Griffin had felt abandoned as a child, and his analyst helped him to understand that quiet listening wasn't abandoning him. Dr. Griffin then felt less pressure to respond to patients. Dr. Griffin's wife commented that he had benefited a good deal from his analysis.

Did he think his analyst had intervened in his progression at the institute? There was no talk about it; he doesn't pay attention to it. He has not become a training analyst; the option never presented itself. He would have had to offer low fees and recommend analysis; he stopped doing both since graduation. His work-a-day patients can't afford either the time or the money for analysis. He has too many expenses to offer lower fees. Also, he doesn't believe analysis is what patients need most; he does very good psychodynamic psychotherapy. His practice is so unlike his analyst's.

He's been very happy to do a lot of teaching in a psychotherapy program for residents. He's also very active on local committees. He does have identification with the institute which is his intellectual home. He has written a couple of papers. He said he's not a member of APsaA any longer; he's not that rich. J.S. asked if he had any post-termination contact with his analyst. They lived in the same section, and during analysis would see each other walking around the nearby lake. It had given him so much anxiety that he turned the other way.

After analysis ended they developed a friendly relationship. His analyst was dying of prostate cancer, and they talked about it. He reacted to his analyst's death the way he reacted to his father's

death – great sadness and great sense of triumph. He does think about him, especially when he walks around the lake. He has to remind himself that his analyst is dead.
Training analysis: Questionnaire: Moderately dissatisfied =2; Rater A =3; Rater B =3.

Training Analysis *Before* Personal Analysis

Training analysis: **Dr. Griffin (**Questionnaire # 1310)
Dr. Balter asked around who would see her for a reduced fee and selected Dr. Richmond. She was anxious about beginning treatment; when she saw him she thought it would be a good fit. He seemed to be interested and followed what she said. Subsequently he started making positive comments about her appearance, and after he returned from a separation, he said he had not wanted to separate from her. He became a training analyst, and his comments about her became more egregious, talking about his positive feelings and sexual attraction toward her. They never develop a physical relationship. She felt this was no longer an analysis and became worried about an impact on her own analytic work. He warned her not to disclose what was going on, saying that if she did she would be perceived as a borderline personality disorder and no one would refer patients to her; she was too scared to disclose this. Perhaps she wouldn't be believed and would be discharged from training. She had wondered if she had been so sick or needy that she had caused this.
Training Analysis: Questionnaire; Very dissatisfied =1; Rater A =2; Rater B = 1.

Analysis by non-T.A. **Dr. Balter** (Questionnaire # 1310)
Dr. Balter ended her very problematic training analysis and sought additional help. She selected a therapist recommended by her supervisor, and found him to be a decent person and a good clinician. He conveyed empathy, and was less reserved than her previous analyst. She was too anxious to lie on the couch, but her analyst was patient and flexible. She was so anxious about this current treatment that she asked a woman supervisor if she could consult with her about her ongoing treatment, and the supervisor agreed to do so. Dr. Balter never needed to consult the supervisor. Subsequently, she ended treatment with her second analyst, and soon thereafter he left for another city. They had not discussed the possibility of post-termination contact. She had started writing him a letter, but hadn't finished it. Currently, she plays a very active role in her institute.
Analysis by a non-TA: Questionnaire; Very satisfied =5; Rater A =4; Rater B =4.

Training Analysis Dr. Turner (Questionnaire # 8024)
Dr. Turner had agreed to participate in this interview because he wanted to help support research and develop psychoanalytic understanding. Dr. Turner had begun his first analysis as a personal analysis and later switched to a training analysis. Dr. Turner's analyst-parent suggested who he should see for treatment. His analyst, Dr. Fisher, exhibited patience, empathy, and a good appreciation of Dr. Turner's narcissistic vulnerabilities. Dr. Fisher was also very encouraging. After several years, Dr. Turner, partly from a feeling of obligation to become an analyst, was accepted for analytic training, so his treatment with Dr. Fisher became a training analysis. The switch was not reflected in any way in which they worked. Dr. Fisher remained, as before, a judicious analyst.

J.S. asked if he thought Dr. Fisher had intervened to facilitate his progression in the institute. Dr. Turner recalled that he had started his first control case before getting permission from the Progression Committee. Dr. Fisher was outraged by his grandiosity in doing so. Dr. Turner was fearful of Dr. Fisher's anger, and concerned that Dr. Fisher would have him dropped from training. Dr. Turner felt that instead of Dr. Fisher adopting a superego role, he should have helped Dr. Turner get in touch with his feelings. Although Dr. Fisher had not intervened in his own progression, Dr.

Turner recalled that he had heard once the Chair of the Progression Committee decided to accept a candidate's case to enable her to graduate. Dr. Turner also learned that Dr. Fisher had blocked the graduation of a candidate, though not one he was treating.

On one occasion, Dr. Fisher yelled at Dr. Turner who he felt was being unreasonably narcissistic. Dr. Turner consulted another analyst about this, who advised Dr. Turner that he was entitled to an apology from Dr. Fisher. In fact, Dr. Fisher did apologize, but Dr. Turner started to have a change of thinking. He began to explore the possibility of changing to another training analyst. Dr. Turner continued to try to make the treatment work, but couldn't reestablish the relationship they had had before the anger incident. They never explored why Dr. Fisher had become so angry, or, why Dr. Turner had been so hurt. Dr. Turner decided to change to another analyst who was more interested in early pre-oedipal trauma. When his treatment with Dr. Fisher ended he was so happy to get out of there, that he had no interest in the possibility of post-termination contact.
Training analysis: Questionnaire: Partially satisfied/partially dissatisfied = 3; Rater A =3; Rater B =1.

Analysis by non-T.A. **Dr. Turner** (Questionnaire #8024)
Dr. Turner selected as his new analyst a woman, Dr. Previn, who had training and interest in infantile issues. Dr. Turner felt that he and Dr. Previn were a good fit. She was empathic and they were able to deal with his maternal transference. They focused on more infantile conflicts. Dr. Turner still sees Dr. Previn, though he feels they are in the final phase of his analysis. He has had a few contacts with Dr. Previn both at conferences and at non-professional activities, which were collegial and respectful. J.S. asked if Dr. Turner would give him permission to contact Dr. Previn, and he replied that would be fine with him.
Analysis by non-T.A.: Questionnaire # 8024 Very satisfied = 5; Rater A =4; Rater B =4.

Discussion

The reviewed extensive literature is critical of training analysis and includes the tendency toward institutionalization of approved technique as well as idealization of T.A.'s with near priest-like status. This would likely interfere with the free unfolding of the candidate's point of view, and led us to hypothesize that graduate analysts would report *less* satisfaction with training analysis compared to satisfaction with analysis by a non-T.A. The most cogent test for comparing satisfaction is to examine analysts who had experienced both analysis by a T.A. and analysis by a non-T.A. Results indicated that respondents' questionnaire ratings exhibited *less satisfaction* with T.A. than with treatment by a non-T.A. Blind ratings of satisfaction of interview vignettes showed a similar tendency for *less satisfaction* with T.A. than with treatment by a non-T.A., though the differences did not quite reach statistical significance. A prior interview study (Tessman, 2003) reported no difference in satisfaction with T.A. compared to non-T.A.; she concluded that "nothing suggests that non-TA analyses were less satisfactory per se". In addition, this study's blind ratings of satisfaction based upon vignettes of individual interviews were significantly associated with the questionnaire ratings of satisfaction with training analysis and therefore support the validity of questionnaire ratings of training analysis.

Among these 13 interviewees, 61% reported questionnaire ratings of satisfaction with training analysis, a rate which is somewhat less than, though similar, to results reported in five prior published questionnaire studies and one interview study: 86% (Shapiro, 1976); 90% (Goldensohn, 1977); 72% (Craige, 2002); 77% (Tessman, 2003). Additionally, Martinez and Hoppe (1998) reported that 78% of T.A.'s reported that their own analyses were of "very much" or "tremendous

benefit", while Bush and Meehan (2011) reported that the mean satisfaction score of 3.8 of graduate analysts' ratings of training analysis falls between "Moderately satisfied" and "Very satisfied". Thus, empirical reports (both questionnaire- and interview-based studies) substantiate that a majority of analysts report satisfaction with their training analysis, apparently countering those clinical papers asserting that training analyses are intrinsically problematic to the analyst-patient. It is noteworthy that these six significant empirical studies that document satisfaction with training analysis *are not referenced* in the numerous clinical papers that are critical of training analysis.

Our reported vignettes illustrate, and further support, the finding in prior questionnaire studies, that the majority of analysts are satisfied with their training analysis. In this study vignette-based ratings of the degree of satisfaction showed satisfactory reliability between the two raters, and they correlated positively and significantly with questionnaire ratings both of training analysis and of analyses by non-T.A.'s.

Limitations of this Study

Thirteen subjects constitute a small sample and although a similar finding was reported in Tessman's prior study of 14 analysts, further replication and broadening of the demographics will be needed. Evidence that satisfaction with analysis is positively associated with therapeutic benefit is limited (Bush and Meehan, 2011), and therefore further studies are warranted to examine this connection. The present study obtained data only from the analyst-patients and not from their treating analysts. The variable, *satisfaction*, itself may be limited in its ability to encompass the many complexities of psychoanalytic treatment, but we've chosen it as a measure because of its use in prior studies, and it has added to our knowledge about training analysis.

Conclusion

This study and Tessman's found that overall either there was no difference in satisfaction with analytic treatment reported by the same analyst/patient for analysis by a T.A. compared to satisfaction with analysis by a non-T.A., or there was less satisfaction with training analysis. No reported study has found *greater* satisfaction with analysis by a T.A. than with analysis by a non-T.A.

Following the 'golden' years of the 1940's and 1950's, psychoanalysis, particularly in the United States has exhibited a slow decline and become a more precarious profession. Recent decades of increasing stress, both externally and internally, are reflected in long-term reductions in the numbers of analytic patients per graduate and of new candidates. The current diverse array of psychoanalytic theories, along with the absence of consensually-agreed definitions either of psychoanalysis or of psychoanalytic process, means that although its principal tenets are potentially falsifiable, (Grünbaum, 2008) they remain unvalidated. Thomä and Kächele wrote that there is "a fundamental crisis of the entire theoretical structure of psychoanalysis" (1994a, p. 33). Evidence of the effectiveness of psychoanalytic treatment is limited (Sandell et al., 2000; Blomberg et al., 2001) although there is growing empirical support for psychoanalytic psychotherapy (Falkenström et al., 2007; De Maat et al., 2009; Grande et al., 2009; Shedler, 2010; Leichsenring and Rabung, 2011; Zimmermann et al. 2015), including a recent resolution by the American Psychological Association affirming the effectiveness of psychotherapy.

The burden of proof clearly falls upon any psychoanalytic organization that employs a T.A. conception to present empirical evidence that treatment by a T.A. *actually is more satisfactory* to the analyst-patient than treatment by a non-T.A.

Chapter Eleven

A Questionnaire/Interview Comparison of Satisfaction with Training Analysis to Satisfaction with Analysis by a Non-Training Analyst: Implications for Training Analysis[13]

Abstract

The training analysis concept assumes that training analysts (TAs) can more effectively treat analyst/patients than non-TA's can. This study tests that assumption empirically by comparing satisfaction with analytic treatment by a TA with that by a non-TA in the *same* analyst/patients.

Extensive literature critical of training analysis led us to hypothesize that analysis of analyst/patients by TA's would actually be *less* satisfactory than personal analysis by a non-TA. The validity of the analyst's questionnaire ratings of satisfaction was supported by independent ratings by two senior analysts of transcribed individual interviews of participants. It correlated significantly with participants' questionnaire ratings of satisfaction.

Theoretically, treatment by TA's should be *more* satisfactory than treatment by non-TA's. This study, however, found no significant difference between satisfaction with analytic treatment by a TA compared to treatment by a non-TA. This same lack of difference in satisfaction had been reported in a prior, unrelated clinical interview study. Further, there was no difference between TAs and non-TAs in the proportion of analysts who reached a mutually-agreed termination and no difference in treatment duration.

Since *no* study has reported that treatment by a TA is *more* satisfactory than treatment by a non-TA, the burden of proof falls on those psychoanalytic organizations who utilize a TA conception to demonstrate that treatment by a TA is *more* satisfactory.

Introduction

"The training analysis," writes Wallerstein (2010), "has been the central problematic of our entire institutionalized educational structure" (p. 903). A variety of difficulties and problems have been identified.[14]

Lewin and Ross (1960) termed a basic problem with training analysis as "syncretism": "the two models, 'psychoanalytic patient' and 'student' complement, alternate with and oppose each other. … The institutes are unavoidably trying to exert two effects on the student: to 'educate' him and to 'cure' or 'change him" (pp.46, 47). Another critic, #Cremerius (1987), noted that "When the negative transference has not been satisfactorily worked through, analysands will introject an unrealistic image of the training analyst which will serve as the kernel both of a new super ego formation and for the organization of a pathological-narcissistic identification" (p.1074). Kernberg (2000), a repeated, preeminent critic, identified "a tendency to infantilize psychoanalytic candidates, a persisting trend towards isolation from the scientific community, a lack of consistent concern for the total educational experience of candidates, authoritarian management and a denial of the effects

of external, social reality." (p. 97). Kernberg added, "The inhibition of the creativity of psychoanalytic candidates … is one of the major problems of present-day psychoanalytic education …" (p. 116). None of these critics compared the difficulties with training analysis with the problematic aspects of analysis by non-TA's.

One clinical interview study (Tessman, 2003) did report such a comparison. She explored "how their own analyst became memorable in ways that have made themselves felt over postanalytic time" (p. 2). There were 34 analyst participants, most from the Boston Psychoanalytic Society and Institute; 8 declined to participate. Of the 34 participants, 28 had two or more analyses; they presented narratives about 64 analyses. Her taped interviews lasted between 2 and 8 hours per participant, and included both spontaneous narrative and responses to 13 lines of open-ended questions. Seventy percent were deeply or moderately satisfied; 23% were dissatisfied. The category of highly dissatisfied accounts for 22% of all analyses and 23% of training analyses, suggesting no difference in satisfaction with training analysis compared to analysis by a non-TA. She concluded that "nothing suggests that non-TA analyses were less satisfactory per se" (personal communication).

The imposing list of critics agree that training analysis suffers from a wide variety of problems and flaws which led to our first hypothesis, that training analyses will be *less* satisfactory than non-training analyses not burdened by these difficulties: analysts who had *both* a TA and a personal analysis by a non-TA would be *less* satisfied with their TA than they were with analysis by a non-TA. Although empirical studies stated that analysts report having been generally satisfied with TAs, we know of no empirical study that compared satisfaction with TA to satisfaction with non-TA. That comparison has important implications for the rationale for training analysis.

Method

This is a mixed-method quantitative and qualitative study utilizing both an anonymous questionnaire and an unstructured individual clinical interview. The variable "satisfaction" was selected for study because of its use as the central variable of prior empirical questionnaire studies of TA. In addition, Tessman's (2003) comprehensive interview study of training analysis also utilized "satisfaction". For his own questionnaire study, Bush concluded that "satisfaction is probably the most valid [measure]" (personal communication).

The questionnaire, presented in Appendix I, was limited to two pages to enhance the usual low response rate reported in prior surveys of analysts; we expected that a longer questionnaire would reduce the response rate further. The questionnaire focused on the graduate analyst's report of satisfaction with both training analysis and analysis by a non-TA if relevant. Satisfaction was rated on a five-point scale: *Very satisfied* = 5; *Moderately satisfied* = 4; *Partially satisfied/partially dissatisfied* = 3; *Moderately dissatisfied* = 2; *Very dissatisfied* = 1.

The target population of American Psychoanalytic Association (APsaA) graduate analysts selected for study were those who had graduated during 1993-2003 inclusive. This range was selected so that they all would be relatively recent graduates, but it allowed for a five-year period post-graduation to engage in additional analytic treatment. It was not possible to mail directly to members because the year of graduation could not be determined from the membership roster. At the author's request, APsaA institutes were asked to send lists of names of graduates during 1993-2003 to our research assistant, pledged to confidentiality, who emailed the questionnaire to the graduate. Respondents emailed the questionnaire back to the research assistant who removed the respondent's name and email address from the questionnaire, assigned a code number, and forwarded the

anonymized questionnaire to the author for scoring. Only respondents who requested an individual interview were identified by name to the author.

Next, this paper will illustrate the process of assessment of the validity of the questionnaire ratings of satisfaction by comparison of questionnaire ratings with ratings of satisfaction based on transcriptions of individual interviews of those volunteer respondents. The interviews were not as focused on the respondent's satisfaction with analysis as the questionnaire, but on a broad range of feelings and experiences in relation to the analysis. Since the interview material is different from and not simply redundant to the questionnaire rating, it seems appropriate to use the interview material to validate the questionnaire rating of satisfaction. Interviews were designed to obtain information about the emotional aspects of respondents' analyses which were not explored in the brief questionnaire. Interviews were voluntary, exploratory and relatively unstructured; they prioritized developing emotional contact with the interviewee to provide more illumination of emotionally-charged views of their training analysis rather than the cataloguing possible in a structured interview. Interviewees were regularly asked how they'd selected their analyst, how they felt about the "fit" with their analyst, and about post-termination contact issues. All transcribed interviews by the author have been reviewed and approved by the interviewees, who also had access to this entire paper.

The order of transcribed interviews was scrambled and sent separately to two senior psychoanalyst raters (HK and FP) who rated them individually and blindly for satisfaction using the scale of questionnaire ratings of 5 to 1, based on brief descriptive anchor points from the author about each questionnaire level.

Results

This current paper presents the results of analyses of the *overall data* for the *total population* of respondents in this study. (A second paper, already published, Schachter et al., 2013, presented analyses based on a *subset* of 13 subjects who had treatment by a TA and a non-TA, and also participated in individual interviews.)

Pilot Study

A pilot study was conducted at a non-IPA institute. Questionnaires were mailed to those who had graduated between 1992 and 2002 who were asked to complete the questionnaire and mail it, unsigned, with no return address to the author. In this group, 32 out of 65 analysts responded, giving a 48% response rate. Seventy-two percent reported being either very satisfied or moderately satisfied with their training analysis.

Main Study

Questionnaires were distributed to 409 analysts at 17 participating APsaA institutes who had graduated during 1993-2003. Ninety questionnaires were returned, resulting in a 22% response rate, and 59 of the 90 respondents requested an interview. To date, 48 have been interviewed. For all 82 training analysis respondents who supplied complete data, the mean satisfaction ratings was 4.02; 73% were "Very" or "Moderately" satisfied. Hypothesis 1 was *not* supported for the 31 analysts who had *both* a training analysis and a personal analysis *by a non-TA*. Ratings of satisfaction averaged 3.89 for training analyses and 3.75 for non-TA analyses; the difference was not significant (with $t(27)=0.53$, $p=.73$, point-biserial r=.10, d=.20). A rating of either "Very" or "Moderately" satisfied was made for 68% of these training analyses, and for 61% of these non-TA analyses.

Additional analyses indicated that there was no difference between TAs and non-TAs in the proportion that reached a mutually-agreed termination or in the duration of analysis.

Additional Findings

1. Patient perceived patient-analyst "fit" (Question #7, "How satisfied were you with the working relationship, the fit with your training analyst?") correlated highly positively with satisfaction *(r*=.81, p< .0001) for training analysis and (*r*=.83, p<. 0001) for personal analysis.

2. Fifty-two of the 82 respondents with complete TA data (63%) had two analyses. Second analyses, whether training or personal, were rated as more satisfactory than prior analyses ($t(39)=-2.541$; $p < .015$, point-biserial r=.37, d=.80).

3. Degree of satisfaction with treatment was positively associated with the degree with which the graduate analyst now works similarly to the way his/her analyst had worked with him/her both for training analysis (*r*=.60 *p*<.0001) and personal analysis (*r*=.59 *p*<.00015).

4. Length of treatment was positively correlated with satisfaction (r = .35 *p*< .021) for personal analysis but not for training analysis.

5. Ratings of either "Very dissatisfied" or "Moderately dissatisfied" were recoded as unsatisfactory; this designation applied to 15 % of training analyses and 12% of personal analyses.

The Relationship of Questionnaire Ratings to Transcribed Recordings

Forty-eight one-hour individual interviews were recorded and transcribed. Each of two senior analysts separately and blindly rated each transcribed interview for degree of interviewee's satisfaction with their training analysis using the same five-point scale used in the questionnaire. (Thirteen interviews were of analysts who had both had analyses by TAs and non-TA's and were analyzed in the previously published paper; interview ratings correlated significantly with questionnaire ratings of satisfaction.) The remaining 35 interviews comprised 18 (51%) who gave the highest positive questionnaire rating of their training analysis, "Very satisfied #5"; 10 (29%) who rated their training analysis "Moderately satisfied #4"; five (14%) who rated their training analysis "Partially satisfied/partially dissatisfied #3"; one reported "Moderately dissatisfied #2", and one reported "Very dissatisfied #1". Thus, 27 of these 35 interviewed subjects (77%) reported being either very, or moderately, satisfied with their training analysis, similar to the results for the questionnaire group as a whole. To provide the flavor of these interviews, six brief interview transcriptions were randomly selected by protocol from those 18 subjects whose questionnaire ratings were "Very satisfied"; six of the nine subjects whose ratings were "Moderately satisfied" similarly were randomly selected; all five interviewees whose ratings were "Partially satisfied/partially dissatisfied" were selected; however, to limit the length of this paper only the first two transcriptions of each of these three groups are presented here. The sole "Moderately dissatisfied" analyst as well as the one "Very dissatisfied" analyst are also presented. Thus, a total of nineteen interviews were selected from the sub-total of 35 for clinical assessment of satisfaction by the two analysts; of these, 8 are presented in this paper. Recorded interviews about training analysis are presented below using fictitious names.

Two Transcribed Recordings with "Very Satisfied" #5 Interviewee Questionnaire Ratings

Dr. Porter (Subject #1021)

Dr. Porter selected his training analyst by surveying those friends already seeing T.A.'s about available analysts and read some of their publications. He selected Dr. Felix because he thought him knowledgeable, liked his writing and a friend believed Dr. Felix would be especially good for him.

Dr. Porter has a PhD and was accepted as a research candidate. The letter of acceptance that came from a Dr. Paul, the analyst in charge of the psychoanalytic training program, told him he was to begin his analysis with Dr. Paul and specified that he call to set up an appointment. He had not liked Dr. Paul one bit, and was shocked and astounded by this turn of events. He consulted an Institute leader who assured him that he could select his own analyst, and should go ahead and do so. Thereafter, Dr. Porter believed that Dr. Paul hated his guts, and subsequently prevented him from starting classes. His training analyst, Dr. Felix, told him that he thought the grounds for postponing his starting classes were ridiculous, but that Dr. Porter should just hang in there and eventually he would get where he wanted to go.

He had a very good experience with Dr. Felix, a self psychologist, and a caring, fine, thoughtful, smart person, who was very much "present" and remembered whatever he had talked about. That was especially important to Dr. Porter because his father had not been "present", but was rather a silent, uncommunicative person. Dr. Porter got a great deal out of the analysis.

Dr. Felix didn't speak a lot but made clarifying comments and some interpretations. He tended to be quiet, not chatty or interactive. Dr. Felix's non-critical approach was conducive to increasing his understanding of his narcissistic issues and his grandiosity. However, Dr. Porter indicated he had one complaint; he wished Dr. Felix had been more interactive; had put himself out more. Dr. Porter had been troubled when the analysis was interrupted for three months due to his analyst's medical problems. He found this interruption to be a very painful period of time and he felt Dr. Felix should've kept in touch with him more during the hiatus, perhaps by offering some phone sessions. Dr. Porter also had criticized Dr. Felix for not directly giving advice about how to handle a difficult situation. His analyst responded that it wouldn't be very psychoanalytic to do so, and when Dr. Porter had gotten angry at that and said, "Who gives a damn about what is psychoanalytic; the purpose of these sessions is for you to help me"; Dr. Felix thought about it, decided Dr. Porter was right, and then did give him specific help. When Dr. Porter got turned down for progression the first time, Dr. Felix commented that sometimes the Institute gives candidates a hard time and again reassured him that if he hung in there he'd be fine in the long run.

Ratings for the above vignette are as follows: Interviewee's Questionnaire rating #5; Kächele #5; Pfäfflin #5.

Dr. Perry (Subject #1053)

Dr. Perry had had initial therapy, felt it was not going well, and terminated it. One of her colleagues suggested a consultant who might be expected to refer her on. She met with Dr. Franklin, a TA, was comfortable with him and started treatment with him. He made a point of telling her that his wife and daughter were both therapists, and they had taught him quite a lot about women; she felt it was a good sign that he could learn from others. Dr. Franklin helped her to get in touch with her own emotional life; was skilled at capturing the essence of someone else. Sometimes he would sit quietly and listen to her, though usually he was a talker. He encouraged her to confront people directly, sometimes in a playful way. She felt valued by him; didn't really become angry with him. At termination, Dr. Franklin commented that he realized she needed to idealize him so he'd left it alone.

Before graduation she ended regular sessions with him, and then met with him occasionally, especially if she was beginning or ending a relationship. Later she was invited and attended a birthday party for him. Subsequently a supervisor highlighted a personal issue of hers that her analyst had not raised. She then felt less need to idealize him; she could accept his having missed certain matters with her own emotional life.
Ratings for the above vignette are as follows: Interviewee's Questionnaire rating #5; Kächele #5; Pfäfflin #3.

Two Vignettes of "Moderately satisfied" #4 Interviewee Questionnaire Rating

Dr. Warren (Subject #1000)
Dr. Warren had been depressed and was treated twice weekly for two years. Six months after stopping that treatment she started a personal analysis with Dr. Clark, knowing that she planned to enter analytic training in about one year, and recognizing that this analysis would become a training analysis. She had little choice of training analysts in her city, and the alternative, to commute to another city did not seem desirable. She had taken a seminar with Dr. Clark, felt he was a bright, nice enough guy; there was nothing she disliked about him. She recalled one dream from her analysis in which her analyst would not let her enter a college. This dream was interpreted as probably related to her own conflict about being a woman in a man's field. She recollected that she once left the last session before a summer vacation angry, and was pleased at the thought that the analyst would be concerned about her for a whole month!

Dr. Clark was a fairly classical analyst; although not exactly rigid, he was not as flexible as she. There were times when she was extremely angry with him. He once stopped the session 15 minutes early, but she was halfway across town before she realized it. Another time she was obsessing about what a word meant, and he said "does it really matter?" And she said if it mattered to her it should matter to him.

Later, after a year of saying that she was ready to terminate the analysis, one day he agreed with her. She was astonished and immediately didn't want to terminate. Six months later she did terminate and spent those last six months grieving about the loss of the analysis. The analysis had helped her become more open and comfortable with herself personally and sexually. Dr. Warren thinks of her analyst fondly and finds herself remembering some of the things he said. Even now, she said, it's hard for her to say that she loved him - and she began to cry. She mentioned that she had given him her check in the next to last session so giving him a check wouldn't be the last thing she did with him.

She thought some of this work was accomplished after the analysis ended. Several years after termination she returned to him for once/week treatment for six months; when her father died she used that as an excuse not to pursue further treatment. While she wants to go back and have someone analyze her again, she doesn't think she can afford it.
Ratings for the above vignette are as follows: Interviewee Questionnaire rating #4; Kächele #4; Pfäfflin #3.

Dr. Black (Subject #1714)
When Dr. Black moved from university and medical settings to private practice she felt her prior training was not adequate. She wanted to learn how to be more helpful to patients, and to do more personal work for herself. She wanted to start personal psychotherapy first, and eventually transition to analysis; she wasn't ready for psychoanalysis at that time. She saw a male psychoanalyst who had been recommended to her and was fairly prominent in the local analytic group but she felt that the fit

was not right; he wanted her to start four-session per week psychoanalysis immediately. She had young children, was unable to afford either the time or the money, and was not yet ready emotionally for psychoanalysis. He said he would agree to a reduced schedule if they would use their time to examine her resistance to analysis. She had been very clear about what she wanted, but he didn't hear what she was saying. Although at that point she was not very assertive, she did not continue to see him.

She obtained other recommendations, and saw a woman analyst in once/per week psychotherapy. It would not have mattered if the analyst was male or female. The analyst's competence wasn't the issue; both analysts were competent. She needed a therapist who she believed heard her, took her subjective experience into account and whose responses she could feel so she would feel connected to the analyst. The woman analyst did not sit with a blank-screen kind-of-face. It seems as though she made the right decision. Somewhere in her analysis she realized she did want to become an analyst.

Interviewee Questionnaire rating #4; Kächele #4; Pfäfflin #4.

Two Vignettes of "Partially satisfied/Partially/dissatisfied #3 Interviewee Questionnaire Rating

Dr. Marshall (Subject #1800)

When Dr. Marshall was selecting a training analyst there were only three training analysts available. One turned her down so she went to see one of the other training analysts whose office was not far from hers. He was hesitant about seeing her because previously he had treated a family member, but they proceeded and she felt he was emotionally available. They had a good working relationship; he was "good enough". Her analysis was very helpful, but she felt his talk about his own parents' difficulties was intrusive. She imagined switching to another training analyst, and discussed it with her analyst, but never seriously considered doing so. She concluded she'd be better off working things out with him.

Ratings for the above interview vignette are as follows: Interviewee Questionnaire rating #3; Kächele #4; Pfäfflin #3.

Dr. Stuart (Subject #1205)

Dr. Stuart started once/week therapy, but she and the therapist didn't have a good fit, so she left after six months. Subsequently, she decided she wanted to be analyzed, though at that time she was not interested in becoming a psychoanalyst. She obtained the names of several analysts from an analyst she knew. One did not return her call, but another analyst she felt was kind and emotionally available accepted her after a six session evaluation. Later, she decided to enter analytic training. Her analyst was a training analyst so she continued working with him, even though she knew that he felt that individuals with her professional background should not become analysts.

She rated her evaluation of her training analysis as "partially satisfied/partially dissatisfied"; a lot of things were missing. Although it was a good relationship, it was not a good analysis. While he was real, as a person, and she needed that, he made very few interpretations, perhaps six in the entire analysis. Since she knew Dr. Forrest was not in favor of individuals from her professional background becoming analysts, she stayed away from difficult subjects. Now that she herself has become a training analyst she feels that her criticism of her analysis in retrospect is valid. Although she had been dissatisfied, she did not consider transferring to another training analyst because it was a small Institute, and she knew all the other training analysts. As Dr. Forrest aged, he appeared to suffer from the dementia that eventually caused his death.

Ratings for the above interview vignette are as follows: Interviewee Questionnaire rating #3; Kächele #2; Pfäfflin #3.

One Vignette with "Very dissatisfied #1" Interviewee Questionnaire Rating

Dr. Prentice (Subject # 3025)
Dr. Prentice reported such a lousy experience with her first training analyst that after termination she had to correct the work with someone else. She had been in training analysis for eight years, didn't know what she was doing with her own patients, did not have an analytic identity, and wasn't going anywhere. It was an uncomfortable relationship. However, her analyst's Kohutian approach of being supportive and kind made it easier for her to feel comfortable. Initially she had idealized her as a training analyst, since she felt she herself would never be able to become a training analyst. Dr. Prentice never dealt with her own transference and the analyst never brought anything into the transference. There wasn't practically any transference interpretation in eight years. Her analyst was so anti-Freud that Oedipal issues were never addressed. Her analyst wanted her to read about "unformulated experience". Dr. Prentice couldn't get her analyst to be "with her". Her own masochistic tendencies were not analyzed. It was inconvenient for her analyst to acknowledge that they weren't getting anywhere in treatment. Her analyst's devotion to theory was much greater than to understanding the patient. How could her hostile comments about her analyst go on being unrecognized?

After about four years of treatment she began to question problematic aspects of her relationship with her husband. If she called him on anything, he became abusive and either threatened divorce or having a fourth child! It was clear it was crazy for him to try to blackmail his wife. She colluded with the analyst in denying the significance of the passage of time, and in her not switching to another analyst. Dr. Prentice finally became aware that she had been in treatment for eight years and was devastated! At that point she knew nothing could stop her from terminating. She became assertive, set the date and terminated. Initially she felt jubilation that the "imprisonment" was over, but then she became depressed.

Subsequently, she decided to end the supervision she was engaged in and began twice-weekly psychotherapy with that former supervisor. She had huge Oedipal conflicts that she had to work through, which she did by an enactment with him. They worked together for approximately three years and she identified with him as a person. He was matter-of-fact and brutally honest. Occasionally he was rigid but she could call him on it. At times he was explicitly helpful; he said, for example, it was okay to give a woman patient a hug. She really loved him and that shaped her whole identity as an analyst. One time she did yell at him for not letting her talk and he interpreted her anger and traced it to a significant trauma of her past. She ultimately divorced her husband, and now regards her former supervisor/analyst, as a dear friend.

The ratings below refer to her second training analysis.
Interviewee Questionnaire rating #1; Kächele #1; Pfäfflin #1.

Statistical Assessment of Ratings

The reliability of Kächele's and Pfäfflin's ratings of recorded interviews is very satisfactory, the Cronbach's alpha coefficient of reliability among the two psychoanalysts' raters and the interviewees' questionnaire ratings was .92 (df=16, p<.001), and correlations with the respondents' questionnaire ratings are significant, r=.76 (df=16, p<.001) for Kächele and r=.77 (df=16, p<.001) for Pfäfflin. The correlations between the two psychoanalyst raters was 0.83 (df=16, p<.001). To

date, these are the only reported data assessing the validity of questionnaire ratings of satisfaction (in addition to those in our previously published study).

Discussion

Although modest, a 22% response rate in the main study is similar to response rates in other questionnaire studies: 27%, Blaya Perez, (1985); 36%, Martinez and Hoppe, (1998); 25%, Curtis et al., (2004); 39%, Ward et al., (2010). Craige (2002) reported a 9% response rate from all candidates in APsaA.

Satisfaction has been used in six other empirical studies of analysis, in a study of psychoanalysis (Beutel & Rasting, 2002) and is significantly and positively associated both with therapeutic benefit (Bush & Meehan, 2011), and with patient-analyst "fit" in the present study.

Why did our data fail to substantiate the hypothesis derived from an extensive literature that there would be decreased satisfaction with training analysis? It is unlikely to be due to sample bias since Tessman's (2003) earlier multiple interview study, with the same finding, had an 81% participation rate and six prior empirical studies plus our pilot study with a non-APsaA institute all showed that a majority of analysts were satisfied with their training analysis. Sample bias for all is unlikely.

The decision of some APsaA institutes not to participate in the study means that our sample is derived from a subset of training institutes; the basis for that possible skewing is not clear. While our 22% sample may be biased toward analysts who support analytic research, we know of no compelling reason why such an influence would affect the *comparison* of satisfaction with analysis by a TA to satisfaction with analysis by a non-TA.

We now hypothesize that our failure to find reduced satisfaction with training analysis, as we had expected, is due to the fact that published criticisms of training analysis, like those of Lewin and Ross, were primarily based upon clinical and anecdotal material. Comparable critical assessment of non-TA analysis was not considered. Moreover, these repeated and innumerable criticisms do not proffer evidence that the difficulties with training analysis are specific or unique, rather than that there may be a similar set of difficulties applicable to *all* analyses. In addition, information within an institute and its education committee may be tilted toward assessing problems with a training analysis rather than problems with a personal analysis, thus biasing conclusions about the prevalence of problems with training analysis.

Every empirical study, in addition to our pilot study and main study, has reported that a large majority of candidates are satisfied with their training analysis. Satisfaction rates for training analyses were: 86% (Shapiro, 1976), 90% (Goldensohn, 1977), 72% (Craige, 2002), 77% (Tessman, 2003). Additionally, Martinez and Hoppe (1998) reported that 78% of T.A.'s reported their own analyses were of "very much" or "tremendous benefit". Bush & Meehan (2011) reported a mean satisfaction score of 3.8 for graduate analysts' rating of training analysis which falls between "Moderately satisfied" and "Very satisfied". Empirical reports thus substantiate that a majority of analysts report being satisfied with training analysis and so counter those clinical papers asserting that training analyses are intrinsically problematic. It is noteworthy that these six empirical studies that document the satisfaction with training analysis *are not referenced* in the numerous clinical papers that are critical of training analysis.

The literature also includes arguments that our training analyses are "good enough" (Bernardi & Nieto (1992), Sachs (1992), Limentani (1992), Torras de Bey, 1992). Shapiro (1976) went further and, contrary to the critics, emphasized the positive value of training analysis and considers the criticisms without basis. Target (2001), too, concluded that the critical literature "really only

captures one side of the picture. It leaves out the imparting of profound understanding and skill, both through training analyses and teaching …". Hardt (2000) also concluded "much of the criticism directed at training analysis merely indicates that some training analyses are bad analyses".

Now that *two* studies have failed to find any evidence that treatment by a TA is *more* satisfactory, and no other study provides evidence that training analysis *is* more satisfactory, it clearly shifts the burden of proof of generating evidence of superior satisfaction of training analysis on any psychoanalytic organization that utilizes a conception of training analysis.

The lack of a difference between TAs and non-TAs in the proportion of mutually-agreed terminations may be a result of such high proportions of reported mutually-agreed terminations for *both* TAs and non-TAs that it is not possible to find a difference between them. In sharp contrast, *non-psychoanalyst* patients reach a mutually-agreed termination of analytic treatment in only approximately 50% of cases (Glover, 1955; Hamburg et al., 1967; Hendrick, 1967; Sashin et al., 1975; Erle, 1979: Erle and Goldberg, 1984; Weber et al., 1985a; Weber et al., 1985b; Novick, 1988; Kantrowitz, 1993b). This low proportion of mutually-agreed terminations for non-psychoanalyst patients is a function in part of including those who dropped out of treatment, whereas our data for psychoanalyst-patients is drawn from graduate analysts and therefore does not include those who dropped out of analytic training. We concur with Marmor's (1986) suggestion that this large reported difference in mutually-agreed termination rates of 80% for analyst patients, compared to 50% for non-analyst patients, may be due to psychoanalyst-patients' greater positive professional stake in all psychoanalytic treatment because of personal identification as psychoanalysts. This identification with psychoanalysis may also have influenced the high frequency of positive reports about the benefits of analytic treatment both by TAs and non-TAs.

We turn next to our finding of a strong positive association between patient-analyst "fit" and satisfaction in both training analysis and treatment by a non-TA. While it is possible that in our study the satisfaction with treatment influenced retrospectively the assessment of patient-analyst "fit", our finding does replicate the association between patient-analyst "fit" and satisfaction, previously reported by Shapiro (1976), Kantrowitz et al., 1989, Kantrowitz et al., 1990, Kantrowitz, (1993), Leuzinger-Bohleber (2002), Tessman (2003), Carr (2006) and Bush & Meehan (2011). Kantrowitz et al. (1989) described "fit" as "the analyst's character or style provide a beneficial effect for the patient" (p. 906) though "only in 13 of the 21 cases did match stand out as centrally relevant to outcome" (p. 915). She (1989) added that "matches of patients and analysts that appear to have facilitated the analytic process … are those in which the analyst's character style provided some quality that was inhibited, deficient or in some other way lacking for the patient. We suspect that the patient's acquisition of a formerly missing attribute may be based on the patient having internalized an identification with the analyst" (p. 918). Kantrowitz et al. (1990) concluded later that "for twelve of the seventeen patients interviewed five to ten years after termination of psychoanalysis, the researchers found that the patient-analyst match played a role in the outcome of the analysis." (p. 655). Tessman similarly noted that "the particularity of the dynamics within each analytic dyad was pivotal, because some analysts could be highly effective with one participant and damaging with another" (p. 308). Sampson (1994) referring to the theory of Weiss and Sampson, describes that when the analyst behaves differently than the patient anticipates it helps the patient to disconfirm pathogenic beliefs. He adds that "Important changes also takes place when the analyst is attuned effortlessly – because of his own sensitivity … " (p. 361). Presumably, patient-analyst "fit" facilitates this attunement. Dolinsky et al. (1998), however, assert that this association between "fit" and positive outcome does not itself prove cause and effect.

There is a substantial literature about second analyses or re-analyses which we will not attempt to review; rather, we will limit our discussion to trying to understand our finding that second analyses, whether training analyses or analysis by a non-TA, are more satisfactory than first analyses. Of the 82 TA respondents who provided complete data, 8 had the TA before the non-TA. Since 68% of training analyses and 61% of analyses by non-TAs in our study were satisfactory, it seems likely that dissatisfaction with the first analysis was *not* the motivation for the second analysis. Meyer and Debbink (2003) note "given all the variables influencing results, the definition of reanalysis does not require consideration of prior analytic adequacy" (p.62) and Tessman (2003) agrees that reanalysis implies "an affinity for analytic process and its yield, rather than dissatisfaction with a first experience" (p.5). Lyon (2008), too, considers "Later life experience and challenges may make further treatment necessary or possible; there need be no implication of a problematic lack in the initial treatment" (p.959). Numerous analysts agree that a second analysis is likely to reflect the fact of subsequent developments in the patient's life, including improvements and achievements, not present in the first analysis, that may have made a second analysis possible and necessary (A. Reich, Panel, 1985; McLaughlin and Johan, 1985; Meyer, 2007; Lyon, 2008).

A. Reich (Panel, 1985) considered that the second analyst is in a better position because he/she has learned from the first analysis; R. Eissler (Panel, 1967) mentioned that sometimes those interpretations ineffective in the first analysis become effective in the second analysis because the patient has become less defensive or less fearful due to either greater maturity or new life experiences. Jacobs acknowledged that a second analyst stands on the shoulders of the first, learning from the missed opportunities and inevitable shortcomings of the first analysis, and learning, with the patient, what remains to be done [in Lyon, 2008].

There is agreement that reanalysis is characterized by a greater regression (Meyer, 2007) perhaps because for some, resistance to the training analysis involved shielding pathology from the training analyst for the sake of career (Greenacre, 1966; Szalita, 1968; Caligor, 1985). Szalita (1968) also found frequently in her re-analytic work that losses of any kind, whether the death of grandparents, parents, siblings, friends, pets or even loss of dolls had previously been neglected. Later (1982) she added that there was similar omission of an early relationship, usually with a sibling.

Limitations of this Study

The number of subjects is modest, and we cannot be assured they are a representative sample of APsaA's institute graduates or that this was a representative time period. We cannot assess the effects on the sampling of respondents due to the absence of graduates from those institutes unwilling to participate in the study. In addition, our sample was limited to graduate analysts, and, as noted, we don't know the possible effect on the data of candidates who dropped out of training. We have only the views of the graduate analysts, not of their analysts. The failure to find significant differences in satisfaction between training analysis and non-training analysis may be a function of unknown factors.

We acknowledge that satisfaction with analysis is a much more complex phenomenon than can adequately be evaluated with the questionnaire/interview methods we used. Research sometimes involves measuring relatively delineated and specific parts of complex wholes. The scientific enterprise assumes that many efforts to make such measurements by independent investigators will add to knowledge.

Conclusion

This empirical questionnaire/interview study failed to find any evidence for the assumption that treatment by a TA is *more* satisfactory than treatment by a non-TA; no other extant study provides such evidence. Therefore, the burden of generating data to support the presumption of superior satisfaction of treatment by a TA compared to treatment by a non-TA now rests on any psychoanalytic organization that utilizes this conception of training analysis.

Addendum

Training Analysis and Personal Analysis Questionnaire

1. Your gender? Male ___; Female ___ .

2. Year of graduation from psychoanalytic training _____.

Training Analysis

3. Gender of your training analyst? Male ___; Female ___.

4. Frequency of sessions per week? ____

5. Did you lie on a couch? Not at all ____; Occasionally ___; Frequently ____; All the time ___.

6. What was the length of your training analysis in years? ___.

7. How satisfied were you with the working relationship, the fit with your training analyst? Very ___; Moderately ___; Partially satisfied/ Partially dissatisfied ___; Moderately dissatisfied ___; Very dissatisfied ___.

8. Did your analyst exert influence on your progression in analytic training at the institute either overtly or covertly ? Yes ___; No ___; Don't know ___.

9. Did you terminate your analysis unilaterally without your analyst's agreement?

Yes ___; No ___;

Reasons you terminated:

10. If your training analysis was terminated by mutual agreement was it because treatment had been satisfactory? Yes ___; No ___.

11. Did you switch to another training analyst during analytic training for reasons other than the analyst's retirement, death or change of residence? No ___; Yes ___.

12. How do you feel about the results of your training analysis? Very satisfied ___; Moderately satisfied ___; Partially satisfied/partially dissatisfied ___; Somewhat dissatisfied ___; Very dissatisfied ___.

13. Do you believe that you work with analytic patients in the same way your analyst worked with you? Almost identically ___; Very similarly ___; Moderately similarly ___; Substantially differently ___; Almost completely differently ___.

14. After termination of your training analysis and after graduation, did you engage in additional treatment, either psychotherapy or analysis, either with your prior analyst or with a different therapist? Yes ___; No ___.

If You Had A Personal Analysis, Please Answer the Following. If You Had Several Personal Analyses, Please Respond About the Last Analysis

15. Was you personal analysis Before ____ or After ____ your training analysis?

16. Reasons you engaged in a personalanalysis? ……

17. Gender of your personal analyst? Male ____; Female ___.

18. Frequency of sessions per week? ____.

19. Did you lie on a couch? Not at all ____; Occasionally ___; Frequently ____; All the time ____.

20. What was the length of your personal analysis in years? ____.

21. How satisfied were you with the working relationship, the ˜fit" with your personal analyst? Very ___; Moderately ___; Partially satisfied/ partially dissatisfied ___; Moderately dissatisfied ___; Very dissatisfied ___.

22. Did you terminate your analysis unilaterally without your analyst's agreement? Yes ____; No ____.

Reasons you terminated: ……..

23. If your personal analysis was terminated by mutual agreement, was it because treatment had been satisfactory? Yes ____; No ___.

24. How do you feel about the results of your personal analysis? Very satisfied ____; Moderately satisfied ____; Partially satisfied/partially dissatisfied ____; Somewhat dissatisfied ____; Very dissatisfied____.

25. Do you believe that you work with analytic patients in the same way your analysts worked with you? Almost identically ___; Very similarly ___; Moderately similarly ___; Substantially differently ____ Almost completely differently___

26. Would you be interested in adding a further contribution to this project by participating in a one-to-one, confidential interview with Principal Investigator Joe Schachter about your responses? That would add a depth to this study that a questionnaire is unable to provide. Yes ___ No ___.

Chapter Twelve

On Side Effects, Destructive Processes and Negative Outcomes in Psychoanalytic Therapies – Why is it Difficult for Psychoanalysts to Acknowledge and Address Treatment Failures?[15]

Abstract

Side effects, adverse treatment reactions and negative outcomes are relatively neglected topics in the vast clinical literature on psychoanalytic therapies. This paper discusses numerous contributory elements and zooms in on the contribution of therapist factors. We present definitions, briefly summarize the state of outcome research and specifically mention the high attrition rate in psychotherapy and psychoanalysis. Factors shown to contribute to negative effects include incorrect diagnoses, unfavorable external conditions, constitutional factors and modifications of the ego. We concentrate on examining the role of countertransference and other therapist factors. The paper closes with a clinical perspective that raises a question about the analyst´s ethical responsibility to inform new patients about the possibility of side effects, damaging consequences and imcomplete or negative outcomes.

Introduction

"I am invisible, understand, simply because people refuse to see me ... When they approach me they see only my surroundings, themselves, or figments of their imagination. - indeed, everything except me" (pp.3-4) wrote Ralph Ellison in 1952, a black man in a white United States. Black men were seen as threatening by many whites and appeared as invisible. At an even more graphic level, many German Jews, despite growing evidence, were unable to „see" the deadly intent of the Nazis and remained in Germany until it was too late. Indeed, Freud himself did not „see" the necessity to leave Vienna until his daughter, Anna, was arrested briefly.

Psychotherapeutic and psychoanalytic failure are largely invisible to many therapists who refuse to see them. Treatment failures may be seen as threatening by many therapists in that they may seem to undermine the effectiveness of their therapeutic role. Failure of psychotherapeutic and psychoanalytic treatment is a major clinical problem of substantial dimensions, which must be acknowledged so it can be dealt with by empirical research. Research efforts to date have been limited in part because of the lack of theoretical conception of how to define, classify and assess side effects and negative outcomes of treatment; we need cooperation of clinicians and researchers in this enterprise.

Side effects of an intervention (be it a drug or psychotherapy) may be positive or negative; in any case the main effects of a treatment have to be justified and patients have to be informed about the frequency of side effects. Empirical research on these phenomena is limited, partly because there is a lack of theoretical conception of how to define, classify and assess psychotherapy side effects and negative outcomes. Recently Linden (2012) proposed a model for the definition, classification and

assessment of psychotherapy side effects. Not all unwanted events (UE) may be regarded as adverse treatment reactions (ATR); one would have to demostrate a causal link to identify an unwanted event as side effect:

Side Effects in Psychotherapy: The UE–ATR Checklist

Table 1. Definition of side effects different from treatment failure, deterioration and malpractice

Side effects	Definition
Unwanted event (UE)	All negative events that occur parallel or in the wake of treatment
Treatment-emergent reactions (TER)	Any UE that is caused by the treatment
Adverse treatment reactions (ATR)	Any UE that is probably caused by correct treatment
Malpractice reaction (MPR)	Any UE that is probably caused by incorrect or improperly applied treatment
Treatment non-response (TNR)	Lack of improvement in spite of treatment. It is a UE; it can be or cannot be an ATR or an MPR
Deterioration of illness (DOI)	Worsening of illness during therapy or any other time in the course of illness. It is not necessarily a UE; it can be a UE and can be or cannot be an ATR or an MPR
Therapeutic risk (TR)	All ATRs that are known. Patients have the right to be informed about severe or frequent or impairing TR as this is the basis for giving their informed consent for treatment
Contraindications	Conditions of the individual case, which make severe ATR highly probable. An ATR of treatment in spite of given contraindications are one form of MPR

Linden (2012, p. 3)

Negative processes during an ongoing treatment may be due to a disorder´s autonomous course, as happens all too often in the case of severe anorexia nervosa. They also may be conceived as either consequences of patients´ incapacities to use treatment at a specific moment in time or of some patients' chronic tendencies to sabotage any treatment, as has been conceptualized in the "negative therapeutic reaction" phenomenon. Thomä and Kächele (1994a), however, have suggested that it may be most illuminating to look for therapists´ share in such developments. True destructive processes in psychotherapy and psychoanalysis do happen mainly in the context of severe transgressions of the rules of abstinence (Gabbard, 1989).

Failures in psychoanalytic psychotherapy and psychoanalysis, as in any medical enterprise, are very robust, widely occurring phenomena. However, it is striking that psychotherapists and psychoanalysts generally fail to address this critical clinical problem. For example, the electronic database PEP, covering thousands of references, reveals only four references to "psychoanalytic failure," while "psychoanalytic theory" garners 648 references. Only five, among the many hundreds of Anglo-American psychoanalytic books that have been published, focus on treatment failures: *Success and Failure in Psychoanalysis and Psychotherapy* (Wolman, Ed., 1972); *Why Psychotherapists Fail,* (Chessick, 1983); *The Prison House of Psychoanalysis* (Goldberg, 1990); *Failures in Psychoanalytic Treatment*" (Reppen & Schulman, Eds., 2002); and *The Analysis of Failure: An Investigation of Failed Cases in Psychoanalysis and Psychotherapy (*Goldberg*, 2012)*. In "*The Primordial Mind in Health and Illness*" Robbins (2011) reports on cases where he did not succeed in treatment. In terms of a comparative perspective on psychoanalytic therapies from different schools – ego psychology, relational therapy or Kleinian approaches – there are, to our knowledge, no data available. Although we think psychoanalytic psychotherapy and psychoanalysis are more than mere neighbours (see Grant & Sandell, 2004), for didactic reasons we maintain a distinction in our discussion.

The State of Outcome Research

We first look at some background about the state of outcome research in general. Based on thousands of controlled studies we are in a position to be very confident that psychotherapy is more

likely to improve patients than to harm them. The overall effect sizes – a statistical measure that allows comparing the effects of various interventions in medicine, psychology and pedagogy - are quite substantial. These effects are as large or even larger than the effects reported, for example, for anti-depressive medication, and they are larger than those produced by a variety of methods typically employed in medical and educational interventions (Lambert & Ogles, 2004).

These findings, however, represent average scores. Changes occurring in both experimental and control groups show a significant increase in the variability of criterion scores, which become manifest at post-testing in the treatment groups. This implies that some treatment cases are improved while others are deteriorated, thus causing a spreading of these scores. The phenomenon of deterioration, although quite familiar to many clinicians, has remained a neglected topic in treatment research even though it was pointed out forty years ago by Bergin (1963). So the issue is really quite dramatic; not only does psychotherapy generate significant change across groups, it also is a potent intervention that has significantly positive and negative effects beyond so-called 'spontaneous remission' factors.

Attrition in Psychotherapy and Psychoanalysis

Patient attrition in psychotherapy is a common clinical phenomenon. A review of research (Garfield, 1986) reported that more than 50% of patients withdrew before the eighth session (Straker, 1968; Bakelund & Lundwall, 1975; Reder & Tyson, 1980). Bakelund and Lundwall noted that in the long run it is the patient who leaves rather than the one who remains in treatment who is the typical patient (see Table 1). In a later meta-analysis of 125 studies on psychotherapy dropout (Wierzbicki and Pekarik, 1993), the mean attrition rate was 47%. "Remarkably . . ." noted Barrett et al. (2007), „clients continue to disengage from mental health services at a rate comparable to that found more than 50 years ago" (Rogers, 1951, p. 247). Barrett et al. add, "more than 65% of clients end therapy before the 10th session (Garfield, 1994), with most clients attending fewer than 6 or 8 sessions" (Phillips, 1985, p. 248). Variations in the definition of dropout have influenced the findings.

Barrett et al. summarized the data as follows: „Of 100 prospective clients contacting a mental health clinic, only 50 will attend the initial evaluation, 33 will atttend the first treatment session, 20 will remain by Session 3, and fewer than 17 will remain by Session 10" (p. 253).

Table 1

Psychotherapy Attrition Rate

Authors	Date	Attrition	Time Interval
Garfield	1986	50%	First 8 sessions
Lorion & Fellner	1986	47%	Indefinite
Sledge et al.	1990	32%	Time limited
Sledge et al.	1990	67%	Brief psychotherapy
Wierzbicki & Pekarik	1993	47%	Indefinite
Garfield	1994	47%	Indefinite
Elkin et al.	1999	50%	First month
Sparks et al.	2003	47%	Indefinite

Attrition was greater for African-American and other minority groups, for less-educated and for lower income patients. Piper et al. (1999) compared 22 patients who left time limited psychotherapy

with 22 matched completers; none of the pretherapy predictors significantly differentiated the two groups, though several of the therapy process variables, including the therapeutic alliance, patient exploration and focus on transference did distinguish the two groups. Barrett et al. (2007) discussed numerous strategies to reduce attrition: role induction, motivational interviewing, active involvement with the client, therapist feedback and enhancing the therapeutuc relationship.

It is not surprising that borderline patients demonstrate an inordinately high attrition rate in psychotherapy relative to other diagnostic groups. Borderline patients form intense and unstable relationships relative to other diagnostic groups. Skodol et al. (1983) reported a 67% attrition rate among borderline patients after three months of psychotherapy. Waldinger and Gunderson (1984) found a 46% attrition rate within six months; only one-third of their sample completed treatment. Similarly, Gunderson et al. reported that 52% of borderline patients left treatment by six months. Smith et al. (1993) found attrition rates of 31% and 36% at 3 and 6 months, respectively, for borderline patients. However, use of a self-psychological approach to treatment found a reduced attrition rate with borderline patients of only 16% at 3 months (Stevenson & Meares, 1992).

Less acknowledged than these data about attrition in patients in psychotherapy is the similarly high attrition among psychoanalytic patients. Published clinical examples in the available literature span more than half a century; approximately 30-60% of psychoanalytic patients leave treatment before reaching a mutually-agreed termination. (See Table 2).

Table 2
Psychoanalysis Attrition Rate

Authors	Date	Attrition	Time interval
Glover	1955	55%	Indefinite
Hamburg et al.	1967	43%	Indefinite
Hendrick	1967	40%	Indefinite
Sashin et al.	1975	31%	Indefinite
Erle	1979	38%	Indefinite
Erle and Goldberg,	1984		
Study I		27%	Indefinite
Study II		44%	Three years
Kantrowitz	1993	60%	Indefinite
Cooper et al.	2004	29%	Indefinite
Hamilton et al.	2007	31%	6 months
Cogan and Porcerelli	2008	39%	18 months

To illustrate these findings we point to the study by Cooper (2004):

„The present sample included all control cases who initiated treatment with a candidate analyst at the Columbia University Center for Psychoanalytic Training and Research from 1995 to 2000. Patients entered analysis either by applying to the center's clinic specifically for psychoanalysis, or by conversion from the private psychotherapy practices of candidates. Data were obtained by a review of the charts kept at the center. All patients signed a consent form for treatment and research. For the purposes of this study, the cases designated as "premature terminations" were ones in which the candidate analyst made a chart note indicating an abrupt or early termination.

Over a six-year span, 163 patients were accepted to begin psycho-analysis as control cases at the center. Almost one-third of the patients in this sample (n = 48) terminated treatment prematurely, indicating that this is a common experience in training. With regard to the pattern of early termination, over half the patients who left did so within the first six months (n = 25).

The origin of the referral for treatment plays the strongest role in distinguishing between those who leave and those who stay in treatment. Patients referred by the clinic were much more likely to end treatment than those converted from candidates' private practices (42.5% of clinic cases vs. 18.9% of converted cases)" (p. 1233) .

How can we understand the apparent failure of most psychoanalysts to acknowledge and address this clinical problem of widespread attrition? We offer a speculation. One observation is that many – probably most – senior analysts are reluctant or unwilling to present treatments of their own patients either to their own institute or to a conference audience. Another related observation is that, similarly, many – probably most – analysts are unwilling to give permission for the study of their treatment, either of a past patient or of a present patient. These observations suggest that many analysts have an underlying uncertainy or insecurity about the effectiveness of the treatment of their own patients. We suggest that it is this anxiety about the effectiveness of the treatment of their own patients, that, perhaps unconsciously, leads them to turn a blind eye towards widespread evidence of failed treatment.

In striking contrast, the data from *psychoanalyst-patients* indicate that approximately 80% of them remain in treatment, whether with a training analyst or a non-training analyst, until reaching a mutually-agreed termination (Schachter et al. unpublished); i.e., only 20% dropout. This investigated cohort of *psychoanalyst-patients* are all graduate analysts and therefore does not include those who dropped out of a training analysis. We do not have data about drop-outs from training analysis, though apparently very few have done so. We concur with Marmor's (1986) suggestion that this large reported difference in mutually-agreed termination of 80% for *psychoanalyst-patients* compared to 50% for non-psychoanalyst patients may be due to the *psychoanalyst-patients* greater positive professional stake in all psychoanalytic treatment based on a personal identification as psychoanalysts. For a *psychoanalyst-patient* to recognize a failed personal psychoanalytic treatment might shake the foundation of his or her chosen profession. We believe that the issues of failed psychoanalytic treatment for *psychoanalyst-patients* differ markedly from those for non-psychoanalyst patients" (Schachter et al, unpublished). Still, it is refreshing to learn what 75 psychoanalysts found helpful and hurtful in their own analyses (Curtis *et al*., 2004).

Since Bergin's (1963) paper, "The effects of psychotherapy: Negative results revisited," a number of factors have been identified that contribute to some of the negative results. Reading a conventional clinical paper on general factors leading to failures in any form of psychotherapy, one is likely to find the following list (reproduced from Stein, 1972):

a) Incorrect diagnoses and, therefore, selecting the wrong form of treatment

b) Untoward external conditions:

- where external conditions are so unfavorable that the actual gain by remaining sick seems to be of greater value than the advantages of having good health.
- where the attitude of the family supports any neurotic (or psychotic) manifestations in the patient.

- other reality factors: education, class, economic status, and the effect of trauma such as illness and loss.

c) Constitutional factors - strength of biological given (instincts) and of conflicts.

d) Unfavorable modifications of the person's ego leading to a severe characterological disturbance.

e) Transference and countertransference.

Indeed some of these factors are well-known and we shall later comment on them. However, what one misses here are the factors relating to any significant contributions from the therapist. Only the very last item in this list - countertransference - points to such factors, which are neglected in almost all forms of psychotherapy.

In his recent critical evaluation Goldberg (2012) characterizes several categories of analytic failure:

a) Cases that never get off the ground or never seem to start.
b) Cases that are interrupted and so felt to be unfinished by the therapist or analyst.
c) Cases that go bad.
d) Cases that go on and on without obvious improvement – losing one's patience.
e) Cases that disappoint.

These descriptive categories leave open the question of why the psychoanalytic treatments failed. We therefore discuss some factors that may pertain to both psychotherapy and psychoanalysis; later we will focus on the therapists' contributions to constructive and destructive processes and their relation to treatment outcomes.

Incorrect Diagnoses Leading to Incorrect Indication

The assumption is that a correct diagnosis makes a difference in selecting the proper treatment and thus leads to a better outcome. As an illustration we mention the advent of specific borderline treatments that have clearly improved the outcome for this difficult-to-treat patient group; the treatment manuals (DBT, TFP, MBT etc.) all work with careful diagnostic evaluation!! (Kächele, 2013; Sandell, 2012).

As patient diagnosis and degree of disturbance are related we should not be particularly surprised about this finding. However, particularly for borderline disorder patients some therapeutic techniques, aimed at breaking down, challenging, or undermining habitual defenses, clearly seem to contribute to a negative outcome. Studies with psychotic patients (Feighner et al., 1973), borderline patients (Horwitz, 1974; Weber et al., 1966; Fonagy et al., 1996) and studies with disturbed participants in encounter groups (Liebermann et al., 1973) demonstrate that a worsening of patients' conditions sometimes occurs and that therapeutic techniques are probably responsible for this deterioration. This is not to minimize the point that patients' characteristics also contribute to this deterioration, which we shall learn more about when discussing other factors.

Unfavorable External Conditions

a) Unfavorable external conditions might lead to what Freud had categorized as a "secondary gain from illness." In a discussion of this phenomenon Thomä and Kächele (1994a, p. 133) explore this point.

One of Freud's five forms of resistance was ego resistance, which "proceeds from the 'gain from illness' and is based upon an assimilation of the symptoms into the ego" (Freud 1926d, p. 160). In evaluating the external forces that co-determine and sustain the psychic illness, it is useful to bear in mind the distinction between primary and secondary gain from illness that Freud made in 1923 in a footnote to his account of the Dora case (1905e). Between 1905 and 1923 the ego was assigned a much greater significance in theory and technique with regard to the origin of symptoms, specifically relating to defense processes. According to the 1923 footnote: "The statement that the motives of illness are not present at the beginning of the illness, but only appear secondarily to it cannot be maintained" (Freud 1905e, p.43). Precisely a case exhibiting a stable structuring of symptoms is characterized by a course in which the primary conditions are so mixed with the secondary motives that they can hardly be distinguished. There is very little systematic research on the embedding of this internal neurotic mechanism in the context of life circumstances. The various follow-up studies on untreated patients could illustrate such considerations (Thomä and Kächele 1994a, p. 133).

The case of the Wolf Man probably would serve as a good example where a dramatic worsening of the patient's life circumstances contributed to his identifying himself as a lifelong patient (Gardiner 1971; Obholzer 1982).

b) The attitude of the family sometimes contributes to treatment failures. The Hamburg study on anorexia (Engel et al., 1992) reported that long-term recovery was significantly related to the developmentally necessary separation from the family. Long-term mortality (!) was higher in those adolescent girls that remained with the primary family environment compared with anorectic girls who left home; we do not understand why remaining at home impacted on the fatal outcome.

c) Reality factors - education, class, economic status - may also contribute to negative development of the therapeutic relationship. What is true of all somatic diseases applies also to psychological disorders: poor education and low social class, especially low economic status, have anti-therapeutic effects. One of the main effects is that these people are not even considered for treatment. Even within the German insurance-supported psychotherapy system, the percentage of the population in psychotherapy is not at all representative of the overall social strata (see Kächele et al., 1999). Caspar and Kächele (2008) have pointed out that incorrect self-exclusion of patients - patients that could profit from treatment - contributes to negative effects indirectly.

Constitutional Factors

The role of constitutional factors, like strength of instincts, goes back to Freud's (1937c) review of the factors influencing the outcomes of psychoanalytic treatment. He considered three main factors whose total impact was dependent on their interactions: *" ... the influence of traumas, the constitutional strength of the instincts and alterations of the ego"* (p. 224).

Whatever "strength of instincts" may mean, the well-known psychoanalytic researcher Luborsky has summarized a modernized understanding with the findings on the global dimension, "Psychological Health-Sickness" (PHS), as a predictor of outcome in dynamic and other psychotherapies (Luborsky, 1975).

Psychological Health-Sickness (PHS) is *"*a concept conveniently covering an extensive continuum from rosy, robust psychological health to the nadir of psychological sickness. A host of similar-sounding terms have been used for this concept: adjustment, ego strength, personality integration, emotional stability, psychiatric severity, adequacy of personality functioning, and mental health*"* (Luborsky et al. 1993, p. 542). For this concept, which, in a simplified version of the original measurement device, has been integrated into the DSM as Global Assessment of Functioning (GAF), research has demonstrated across many studies that the mean moderate predictive power displayed a correlation of 0.27 (7 % of the variance) on the outcome of psychotherapy. Freud's idea that the sicker the patient, the harder it will be to make therapeutic gains, has been well corroborated (Ibid, p. 546).

Modifications of the Ego

Examples of the impact of unfavorable modifications of the ego leading to severe characterological disturbances have been provided by Wallerstein (1986) in his report on the long-term fate of 42 patients in treatment within the famous Menninger Hospital in Topeka. Some of the patients treated became so-called lifers, permanent users of psychotherapeutic support systems (p. 561). However, one might raise the question where, if anywhere, these people might have received the proper treatment that could have changed their sad course. There are reports in the literature that some patients indeed need very long treatment to finally recover. The patient Christian Y, treated in high frequency psychoanalysis by H. Thomä, needed 600 sessions to resume his normal life as a student of law; following which the treatment took another ten years in low frequency analysis to obtain a really satisfying personal and professional outcome (Thomä and Kächele 1994b, p. 398).

Transference and Countertransference

The last item of this list invokes the central psychoanalytic technical topic: the concatenation of transference and countertransference. Ever since Freud's cases were studied in depth, we have learned that not all of these cases had a favorable outcome. Certainly the case of 'Dora' did not. For good reasons, she left the treatment with Freud enraged (Appignanesi & Forrester, 1992), and it still remains controversial whether this case should be looked at as an example of a destructive interactive process (Freud's initial view), or as a creative act of an adolescent starting to step out of a situation that she could not make good use of (Levine, 2005). She later acknowledged to Freud that the analysis had been useful, in that he had believed her, and this gave her the courage to confront her tormenting parental figures, after which the hysterical symptoms stopped. However, much too often, the clinician's countertransferentially-colored view of these negative outcomes puts the burden of responsibility on the shoulder of the patients (i.e., "they failed to respond to the therapy"), but we should learn to face that destructive (or unconstructive) processes derive often from mishandling of the therapist's role in such a drama.

What do we Know about "Therapist Factors"?

Hans H. Strupp, one of the early prominent leaders of the field of psychotherapy research, invited former "patients" to review their psychotherapy (Strupp et al., 1969). As a consequence of this pioneering study he was commissioned by the US National Institute of Mental Health to perform an empirical investigation on what constitutes a 'negative' effect and what in the view of experts were the reasons for it (Strupp et al., 1977). In this research one of the most frequent sources cited for negative effects in psychotherapy was the therapist. Many experts agree that "poor clinical

judgment" or a general "fallibility of the therapist" are significant factors in producing negative effects.

The therapist variables fall into two broad categories, the first being deficiencies in training and skill, resulting in part from poor training facilities, and the second pertain to health delivery systems that do not require adequate background in the biomedical and psychological sciences on the part of practitioners. Deficiencies in training and supervision, which result in the delivery of inadequate professional services, may produce particularly severe negative effects when dealing with borderline patients, due to the therapist inadvertently stimulating the release of primitive aggression without quite knowing how to deal with it in psychotherapy. Such negative effects may be exacerbated by the therapist who masochistically participates in the patient's acting out.

A significant contribution to such negative effects in psychotherapy resides in what can be termed a complex of ignorance and inappropriate personality. This may or may not coincide with a poorly trained or incompetent person. Sachs (1983) conducted one of the most careful empirical investigations specifically aimed at illuminating the process that leads to these negative effects in brief therapy. The most dramatic factor in identifying success and failure in psychotherapy was a measure named "Errors-in-Technique-Scale." This scale indicated that the therapist´s competence and skill in applying verbal techniques in short-term psychotherapy led directly to a positive or negative change. Strupp´s own Vanderbilt Research Program also has shown that the interpersonal process is connected to a differential psychotherapeutic outcome: good versus poor outcome was differentiated by greater levels of "helping and protecting" and "offering and understanding" and lower levels of "blaming and belittling" (Henry et al. 1986).

A therapist´s misuse of his or her position is today considered a very important factor that contributes to negative effects. Typical deleterious personality attributes, mentioned by the expert respondents in the Strupp et al. (1977) investigation, include:

- coldness, obsessionalism
- "anything goes" as long as 'analyzing' is happening
- excessive need to make people change
- excessive unconscious hostility, often disguised by diagnosing the patient as "borderline" or schizophrenic
- seductiveness, lack of interest, or warmth
- neglect, pessimism, sadism, absence of genuineness
- greed, narcissism, absence of self-scrutiny

Information on the negative consequences of therapist maladjustment, exploitiveness, and immaturity can be gathered with ease from client self-reports. Striano (1987, 1988) documented, in publications for the lay public based on her dissertation, a variety of horror stories of the type that are often privately shared among clients and professionals but are rarely published.

A German psychoanalytic candidate, Dörte von Drigalski, published her analytic training experience with three analysts under the title "Flowers on Granite - An Odyssey through German Psychoanalysis" (1979). Her first female training analyst was able to resonate reasonably well with the somewhat whimsical patterns of behavior of this still late adolescent person, until her analyst moved to Paris for personal reasons. Then von Drigalski was transferred to another (male) training analyst. From then on her analysis slipped more and more down into a devastating negative course. She felt rejected by the devaluating interpretations, especially about the very accomplishments that had helped her master her young life. She broke off analysis, moved to another town, and after some trouble found a quite young male training analyst. There things developed even worse. By her own

report she experienced borderline states with psychotic breakdowns. All this is detailed in the book, with a painful repetitive quality.

Dörte von Drigalski's book was very successful with the German public, but less so with the professional world. There was never any official echo from psychoanalytic institutes to the publication of the report; but when an English translation appeared, it was the psychotherapy researcher Hans Strupp who praised the work as a prime example demonstrating destructive experiences instigated by poor quality work in psychoanalysis (Strupp, 1982). Meanwhile a market for such therapeutic 'adventure' (or disaster) stories has developed (see Märtens and Petzold, 2002).

The most recent painful German report (Akoluth, 2004) tells the story of a 58- year-old woman who sought help to cope with issues around the disabling disease of her husband. For a number of years she got what she was looking for. After the death of her husband, her therapist unilaterally initiated body contact and the lonely woman fell open to transferential wishes for contact. The therapist, however, was not willing to give her what she wanted – although he clearly had induced these wishful states of desire. This interaction is quite typical. Many senior therapists transgress boundaries for several 'good' or 'bad' reasons. What then usually follows are protracted encounters that turn the therapy from blissful moments to chronic nightmares.

Ricks (1974) presented one of the most striking examples available in the research literature. He examined the positive and negative changes conducted by two contrasting therapists. He analyzed the adult status of a group of disturbed adolescent boys who had been seen by either of two therapists in a major child guidance clinic. Although the long-term outcomes of these two therapists were not particularly different for the less disturbed clients, there were striking differences in their therapeutic styles and (most significantly) in their outcomes with the more disturbed boys. For all the cases in the sample, 55 percent were judged to have become schizophrenic in adulthood. Only 27 percent of therapist A's cases, however, had such an outcome, whereas 88 percent of therapist B's cases deteriorated to such a state. The caseloads of the two therapists were equal in degree of disturbance and other characteristics at the beginning of therapy.

In analyzing the differences in therapist style, it was found that therapist A devoted more time to those who were most disturbed, whilst the less successful therapist B did the opposite. Therapist A also made more use of resources outside the immediate therapy situation, was firm and direct with patients, supported movement toward autonomy, and facilitated problem-solving in everyday life, all in the context of a strong therapeutic relationship. Therapist B, however, seemed to be frightened by severe pathology and emotionally withdrew from the more difficult cases. He frequently commented on the difficulties of cases and seemed to become depressed when confronted with a particularly unpromising one. He became caught up in the boys' depressed and hopeless feelings and thereby reinforced the client´s sense of self-rejection and futility.

Today this topic is discussed under the heading of "optimal match" or "fit." Incompatibility between the patient's and the therapist's personality may significantly contribute to negative effects in psychotherapy. A growing number of studies have reported a significant, positive association between "fit" and satisfaction with the outcome of treatment (Shapiro 1976; Kantrowitz, 1986, 1993; Leuzinger-Bohleber et al., 2002; Tessman, 2003; Carr, 2006; Bush and Meehan, 2011; Schachter et al., 2013).

The variety of factors discussed here may adversely influence therapy in a number of ways, including deleterious effects in the relationship with the patient and misuse of therapeutic techniques. It is also possible for a well-meaning therapist, with the unconscious motivation of enhancing his own personal and professional self-esteem, to inadvertently overemphasize his assets and create a dissonance in the therapeutic relationship.

We conclude this section with the general comment that psychopathology or deficient skills in the therapist can lead to inadequate recognition of transference manifestations, premature uncovering of unconscious conflicts without provision of concomitant support, or both. Therefore we face an open issue: Should we diagnose therapists in training and how can we do it (Pfäfflin and Kächele, 2000)? The research team around Rolf Sandell, a psychoanalyst and well-known researcher, has developed the 'Therapists Attitudes Scales' (Sandell et al., 2004) and demonstrated in the Stockholm Psychoanalysis Project that therapist attitudes influence change during treatment (Sandell et al., 2007). A latent class analysis clearly distinguished successful from unsuccesful therapists (Sandell et al., 2006).

Clinical Perspectives

Psychoanalytic clinicians rarely speak about their everyday personalities; they prefer to speak about a 'work-ego' observing their countertransferences. Ever since countertransference was transformed from a despised Cinderella into a radiant beauty (Thomä and Kächele, 1994a, p. 81), we can observe a truly enthusiastic "*the more, the better*" reception from within the psychoanalytic community: to observe this, one needs to study educational papers in the *International Journal of Psychoanalysis* (Gabbard, 1995; Hinshelwood, 1999; Jacobs, 1999).

Countertransference-induced failure is one of the denied aspects of psychoanalytic therapy (Fäh, 2002), although the substantial body of research findings that we have mentioned points to the overwhelming influence of this phenomenon. In recent years reliable measures on habitual countertransference have been published that differentiate local, circumscribed countertransference reactions from more general, pervasive attitudes of a therapist (Betan and Westen, 2009; Gelso and Hayes, 2007; for a summary see Kächele et al., 2015); as we now have these tools it might be appropriate to test out their usefulness in supervision.

Summarizing their clinical experience, Thomä and Kächele (1994b) concluded that certain therapist factors, not always identified as countertransference, are likely to contribute to a development of destructive processes:

a) Attempts to master crisis situations solely by working with transference and resistance are insufficient if they do not lead to an improvement in the patient's real life situation.

b) When a patient has no partner, focussing on unconscious transference wishes is also likely to have an antitherapeutic effect because, once again, the forced reference to transferential wishes can arouse unrealistic hopes.

c) Often a patient can employ the therapy as a weapon against her or his family members (mother/father). This may be a consequence of the therapist taking sides. As a result, the patient's aggressive impulses, the development of which was inevitable after her hopes had been disappointed, were directed onto someone outside the therapy, which paved the way for the later, unfavorable collusion.

d) Threats of committing suicide can lead to the analyst´s giving more sympathy to the patient than can be maintained in an analytic setting. This may obstructs the interpretation of aggressive impulses, especially with the patient's use of the threat to commit suicide as a way to coerce the analyst.

e) In some cases, a lonely female patient is somehow aware of the male analyst´s personal situation, being single or divorced, and this is likely to increase any illusory hopes. If an unmarried patient, who cannot cope with being alone, happens to have a therapist who is the right age, alone, and possibly even unhappy himself, then the social reality of this constellation may be so strong that it may make it difficult for them to be able to focus on the neurotic components of a patient's hopes.

f) Often a therapist, under the burden of disappointments and complications that he at least in part caused, is not able to resist the pressure of his or her own feelings of guilt, and attempts to alleviate these feelings by getting tied up in telephone conversations justifying his or her procedure. This may promote the patient's secret hopes of overcoming the limitations of the therapeutic setting.

g) Sometimes the therapeutic framework only regains its importance the moment that the therapist admits his failure and announces that this means the termination of therapy.

Ethical Responsibility to Inform Prospective Patients about Treatment

It is uniformly regarded as an ethical imperative for the provider of medical treatment to offer to the prospective patient an estimate of the probability that treatment is likely to be successful, plus an estimate of the likelihood and nature of possible complications. Failure of the medical provider to provide such information to the prospective patient may be the basis of a malpractice charge. To the best of our knowledge, such information has rarely been provided by therapists in the practice of psychoanalytic or psychotherapeutic treatment. Until recently practitioners had relatively little information they could impart to the prospective patient. There is now, however, substantial empirical data about the effectiveness of these treatments, the possibility and nature of possible complications, and the probability of successfully completing the treatment, which could be communicated to the prospective patient. The therapist could refer to the resolution of the American Psychological Association confirming the effectiveness of psychotherapeutic treatment. Yet, we are unaware of any practitioner attempting to provide such information.

Based on our long term clinical experience psychotherapeutic practitioner seldom provide such information to prospective patients. We suspect it is because such information would have to include some statement about incomplete treatment and failure of treatment, and we believe that therapists continue to have difficulty acknowledging the presence of these common, significant negative events. They may also be concerned that such information may have a negative impact on the patient´s expectations for benefit from treatment (see Kirsch, 1999).

Professional organizations of therapists, such as the International Psychoanalytic Association, American Psychoanalytic Association and the American Psychological Association have ethics committees, and we recommend that these committees consider the appropriateness of the ethical imperative of therapists informing prospective patients about the varieties of outcomes of treatment.

Conclusion

The message that runs through this report is this: Negative outcomes are likely to happen both in psychotherapy and psychoanalysis. If leaving treatment prematurely and either failing to achieve therapeutic benefit or worsening of the emotional disorder are included, this Concusions includes probably 50% of all patients who initiate treatment. Of patients who initiate psychoanalytic treatment, only parts go on to reach a mutually-agreed termination. However, as Luborsky et al. (1985), Okiishi et al. (2003), and Sandell et al. (2006, 2007) have demonstrated, therapists vary in

their competence, so the early identification of poor work-performance in therapists in training should be of great concern in terms of our professional responsibility.

We think that systematic scrutiny of side effects and negative developments of psychoanalytic therapy should receive a more attention. In medicine, monitoring for unwanted effects has lately been given a high priority for determining the standards of care. A similar effort in the field of psychoanalytic therapies would be timely. Shame for not being successful is a bad advisor. Casement`s (2002) book *Learning from our Mistakes* provides a message. Impressive examples by retro-reports from experienced clinicians about their patients and by some of their patients about their own treatment have demonstrated that we can learn a great deal (Thomä and Kächele 1994b; Schachter, 2005; Breger, 2012).

We recommend that the ethics committees of psychotherapists' professional organizations consider the appropriateness and value of the ethical imperative of therapists imparting information about the range of outcomes and possible difficulties of psychotherapeutic and psychoanalytic treatment to prospective patients, which is standard procedure in medical treatments.

Chapter Thirteen

Arbitrariness, Psychoanalytic Identity and Psychoanalytic Research[16]

Abstract

From the outset, psychoanalysis extensively utilized arbitrary convictions which subsequently generated and perpetuated an intolerance of criticism and dissent. Arbitrariness also fostered an intense investment of the individual's singular professional identity as a psychoanalyst. Defensiveness about the arbitrariness and the need to protect this professional identity engendered fear of, disinterest in, and criticism of analytic research whose findings might threaten unsubstantiated psychoanalytic tenets. For these, and other complex reasons, American psychoanalysis has generated little analytic research.

In recent decades American psychoanalysis has declined in status and prestige, due, at least in part, to societal changes. The persistent arbitrariness and the dearth of research have prevented effective responses to the external forces responsible for the decline. The only effective way to respond to the continuing decline is to develop a broad research program focused on providing empirical bases for the fundamentals of psychoanalysis, both for our own integrity and in order to restore respect for psychoanalysis within the general public and in the scientific community. *You cannot graft research onto the current psychoanalytic clinical identity; it cannot flourish.* All psychoanalytic education should be taught *jointly by researchers and clinicians* if the necessary research cadre is to be developed

"The human mind cannot grasp the causes of phenomena in the aggregate. But the need to find these causes is inherent in man's soul. And the human intellect, without investigating the multiplicity and complexity of the conditions of phenomena, any one of which taken separately may seem to be the cause, snatches at the first, the most intelligible approximation to a cause, and says: 'This is the cause!'" (L. Tolstoy, 1869, p. 1178).

A History of Arbitrariness

Arbitrariness refers to an intense conviction that lacks substantiation or supporting data. Arbitrariness, Webster's New Twentieth Century Dictionary states, is based on one's preference, notion or whim. Scrutiny of the history of psychoanalytic thinking exposes a previously unrecognized difference in the psychodynamics of *witting*, compared to *unwitting* arbitrariness.

In *witting* arbitrariness the conviction is without basis or plausibility; one example is the belief that "the eclipse of the moon means the gods are angry". Such witting arbitrariness may serve a variety of useful purposes when little or no information is available about the nature of the particular phenomenon. It is probably useful, perhaps necessary, that all fields and all individuals occasionally utilize witting arbitrariness since knowledge about the nature of many phenomena is so limited.

However, if a field or an individual relies primarily, or exclusively, on witting arbitrariness over time it is probably a sign of dysfunction.

Unwitting arbitrariness refers to a conviction whose basis is plausible though upon subsequent review we realize is erroneously conceived. For example, the ancient belief that the earth was flat was plausible given the known nature of the universe that could be seen with the naked eye. Subsequent knowledge changed the belief.

Freud's first arbitrary conviction was his initial theoretical hypothesis/ conviction that childhood traumas were the cause of adult neuroses (Freud & Breuer 1893a). He thought the plausibility of this conviction was substantiated by the clinical material provided to him by the patients that he treated with Breuer's cathartic method. He failed, however, to appreciate and to acknowledge that all these initial patients were *hypnotized* and therefore extremely susceptible to his suggestions (Schachter, 2002).

We consider that Freud was unaware that he was subtly suggesting ideas to these patients, and believe that our conclusion is supported by his report that in each of 18 consecutive hysteric patients he discovered the causative childhood trauma. Freud's treatment at that time lasted only several weeks or a few months, so from our current position we can posit that it is unlikely that he could have "discovered" this relevant childhood trauma in 18 consecutive hysteric patients, or that chance or coincidence could explain the finding. Most likely, these "findings" resulted from Freud's suggesting in some manner, to each patient, the existence of the childhood trauma that his theory had led him to expect. The fact that Freud cited these "findings" as evidence of his theory indicates that he was not aware he was making suggestions to patients, and, indeed, later, he explicitly denied doing so: "I can assert without boasting that such an abuse of suggestion [to persuade the patient to accept things which we ourselves believe] has never occurred in my practice" (1937d, p. 262). Freud (1909d) actually provides one explicit example of a suggestion he made in proposing to his patient, the "Rat Man," that the patient's father had threatened to castrate him as a child, although there was no recollection or information about such a childhood event. It is noteworthy that several of his contemporaries, Breuer, Fliess and Von Krafft-Ebing (Schachter, 2002) rejected Freud's claim that his clinical material substantiated his theory.

The most convincing evidence that Freud made covert suggestions to patients, and was unaware that he did so, was his stunned realization, from his self-analysis, that the stories patients were telling him about childhood traumas were not authentic. He adapted to this recognition by his famously reformulating his theory claiming that a childhood *fantasy* can be pathogenic. Critically, however, neither he, nor his followers, considered asking *why* all these patients told him stories of childhood traumas that were not veridical. There is no indication that either Freud or his followers ever considered that Freud might have suggested to these patients their experiences of childhood traumas which later evidence acknowledged were not genuine.

Freud's belief that his patients' reports constituted valid evidence of his etiologic theory was supported by the observation of therapeutic benefit to his patients; the "Rat Man" improved dramatically. Given Freud's conscious view and understanding of the treatment situation, his conviction that his patient's material validated his etiological theory is plausible, though, in retrospect, erroneous. Because of his limited knowledge of the treatment universe, Freud's conviction should be categorized as *unwitting arbitrariness*.

We differentiate Freud's reasons for believing his etiological theory from those of his followers. They had neither access to the detailed clinical material available to Freud, nor access to direct evidence of the patient's therapeutic improvement. Thus, their belief was based primarily on Freud's

statements, rather than on any plausible view of the universe of Freud's treatments. Therefore, we regard this acquiescence of Freud's followers as *witting arbitrariness*.

Consistent with our characterizing Freud's colleagues' belief in his etiological theory as witting arbitrariness is Eagle's (1983) assertion that "just as therapeutic success would not vouchsafe the validity or truth of Freud's etiological hypotheses*, it does not vouchsafe the validity of current etiological hypotheses"* (p. 43, italics added). Fonagy and Target (2003) concur:

> To accept clinical data as validating developmental hypotheses flies in the face not only of ferocious opposition from philosophers of science (e.g., Grünbaum, 1984, 1992) but also common sense; to accept retrospective hypotheses requires the unlikely assumption that pathological states observed in the consulting room are isomorphic in their structure and function to early stages of development (p. 8).

Further support for this critical conclusion is provided by Roth's experimental observation (personal communication, 2007) that, in animals, genetic defects and environmental defects may produce the same effects on the brain. It would not be possible, therefore, to determine the etiology of a specific effect on the brain simply from the nature of that effect. The question of what proportion of the variance can be attributed to genetic and what proportion to environmental factors is currently not answerable.

Why were Freud's followers so prone to accept witting arbitrary convictions? Conflicting answers have been proposed. Roustang (1976) suggests that Freud's disciples' beliefs were all related to their transference relationship to Freud: "At work in each case were: attachment to Freud's person, demand for privileged recognition, jealousy of the others, and conflict about the inheritance" (p. 9). Roustang also wondered whether in Freud's countertransference "the disciples were not each in turn supporting some part of the master's diffracted desire" (p. 11). In a related comment, Bergmann (1997) pictures that Freud "supported the autocratic structure of psychoanalysis and was pleased by the formation of the secret committee, safeguarding its orthodoxy" (p. 76).

Deutsch (1940) presented an alternative view: "It was never any fault of Freud's that they cast him in this role and that they … became 'yes men'" (pp. 189-190, quoted by Eisold, 1997, p. 99). Eisold concludes: "Passively, indirectly they manipulated him into the role of president for life he had sought to avoid" (p. 99). On the other hand, Freud, from whatever source, seemed intolerant of independent views; his response to a 1911 presentation by Adler was "This is not psychoanalysis" and will "do great harm to psychoanalysis" (Eisold, p. 97). These views provide a useful reminder of how difficult it is in historical reconstruction to determine which is the canonical version.

Freud was deeply concerned that analytic treatment be viewed as a scientific enterprise (Schachter and Kächele, 2007). To establish a scientific ambience in treatment Freud proposed that the analyst maintain an attitude of neutrality toward the patient to prevent the analyst from making suggestions to the patient. Given Freud's view of the treatment situation and his understanding of the nature of suggestion, his conviction about the value of neutrality is plausible and should be considered an unwitting arbitrary conviction, although subsequently we've learned that neutrality can not prevent the analyst from communicating suggestions.

To follow our distinction, absent a concern about the scientific character of analytic treatment among his followers, their adopting the analytic stance of neutrality reflects a witting arbitrary conviction on their part.

Many of Freud's later colleagues accepted many of his other convictions. Contemporary analysts still perpetuate his belief that his clinical material substantiated his etiological theory (Lothane,

2001). All they had were Freud's reports; essentially, they took him at his word, impressed by both his incisive intellect and his powerful authoritarian personality. Failure to accept Freud's convictions was dangerous; he brooked little dissent from his views, and expeditiously excommunicated critics such as Adler, Rank, Jung and others from the "Psychoanalytic Movement."

On a larger, organizational scale, there are many other examples of witting arbitrary convictions in psychoanalysis; excluding psychologists because their academic education was inadequate as a basis for psychoanalytic training; homosexuals were too psychopathological to become competent psychoanalysts. Witting arbitrary convictions in the treatment domain include: treatment should be five [or four] sessions per week; the analyst should sit behind the couch; the patient's questions must not be answered; and medications prevent meaningful analytic work.

It is noteworthy that in one area, the dynamic role of unconscious thoughts and feelings, there has been extensive empirical validation (Westen, 1999).

The Transmission of Witting Arbitrariness

The institutionalization of the "training analysis," has played a crucial role in the transmission of analysts' witting arbitrary convictions of Freud's views to subsequent generations of analysts (Reeder, 2004). After 1922 institutes were required to have each candidate complete a training or didactic analysis with a recognized psychoanalyst (a member of the International Psychoanalytic Association (IPA) in order to become a psychoanalyst.) (Mosher and Richards, 2005). We assume that, historically these "training analysts" would have acquired their own witting convictions that Freud's etiological theory had already been substantiated.

Multiple factors lead candidates to accept their "training analyst's" belief in Freud's convictions. For example, analysand's questioning or criticizing early theory, might be characterized as a "resistance" that had to be overcome for the successful completion of a "training analysis." Further, interactive forces foster a candidate's identifications with the "training analyst," identifications likely to include the analyst's fundamental belief in Freud's etiological theory. In addition, since many candidates find their "training analysis" to be personally therapeutic, they may credit Freud's etiological theory, basic to treatment, with the therapeutic gain. The "training analysis" as an educational prerequisite for the would-be analyst, thus serves as a significant and powerful institution for transmitting Freud's early unwitting arbitrary convictions, and, in the process, for squelching questioning and criticism. Psychoanalytic training is largely based on transference (Arlow, 1972; Roustang, 1980; McDougall, 1995; Kirsner, 2000). The real allegiances of analysts, Eisold observed, "are to their analysts and to the lineages of analysts that define particular schools of thought" (p. 101); the threat to psychoanalysis, he concluded, "is the unacknowledged dependencies of analysts themselves" (p. 101).

Knight (1953) stated bluntly that "our [training] regulations may have the effect of drying up the supply of research psychoanalysts" (p 215, quoted by Thomä, 1993, p. 2). Bernfeld (1962) (quoted by Lothane, 2007) believed that "the inventors of our training system" *intended* that it quash dissent, that it would be a "barrier against heterodoxy" (p. 476), but he cited a handful of dissidents as evidence that it had been unsuccessful in doing so. We consider the fact that he could only cite a handful of innovators in contrast to the thousands of non-innovative analysts, constitutes evidence that it worked all too well. Excessive authoritarianism in psychoanalytic education arises from the complete condensation of all important functions into the training analyst position, plus the lack of an agreed methodology for determining the validity of our theoretical propositions (Auchincloss and Michels, 2003).

In retrospect, it is understandable that a profession whose tenets have not been validated might attempt to prohibit criticism. Freud initiated this protectiveness and once this prohibition of criticism is relinquished, the body of work becomes exposed to serious risk. Psychoanalysis eased the prohibition of dissent – not without struggle – when it began to listen to and to tolerate the dissenting views of Melanie Klein and Heinz Kohut. Other divergent views multiplied rapidly until we have reached the widespread contemporary diversity which we regard as a sign of dysfunctional disintegration rather than of healthy vitality. A. Cooper (2008) wrote, similarly, that "pluralism alone is chaos and a plurality of authoritarian orthodoxies provides no means for selecting among them" (p. 235).

Arbitrary Convictions and the "Singularity of Identity"

A structured prevalence of arbitrary convictions is likely to have close ties to what Nobel Laureate Sen (2006) termed "singularity of identity," a distortion that occurs when one of the individual's identities far outweighs recognizing many other identities (such as man/woman, spouse, parent, friend, religious identification, political identification, etc.). Kernberg (2006) refers to a rigid role commitment to a group identity as foreclosure, a term with a pathological connotation. An analyst with arbitrary convictions may well enjoy the image of himself/herself as an infallible authority in that one domain, psychoanalysis, which then becomes that individual's most salient identity.

We speculate, and would like to research, our impression that one's professional identity as a psychoanalyst is more encompassing than comparable identifications in other professions such as law, medicine or teaching. Consistent with this hypothesis is the fact that, despite the continuing decline in the numbers of analytic patients, and the observation that the majority of graduate analysts spend most, or all, of their practice time doing analytic psychotherapy rather than traditionally defined psychoanalysis, few APsaA institutes teach psychotherapy in their educational curriculum. This policy is described by Kernberg (2007a) as "practically suicidal for psychoanalysis" (p. 191). Teaching psychotherapy to candidates would demand an exploration of the relationship of psychotherapy to psychoanalysis, thus diffusing the uniqueness of the identification of the practitioner as a psychoanalyst. A viable alternative consists in conceiving a concept of broad spectrum psychoanalytic therapy as Thomä & Kächele (1994a,b) have demonstrated in their two volumes on *Psychoanalytic Practice*.

"The illusion of singularity" writes Sen, "draws on the presumption that a person not be seen as an individual with many affiliations, nor as someone who belongs to many different groups, but just a member of one particular collectivity, which gives him or her *a uniquely important identity*" (p. 45, italics added). At one time, for example, psychoanalytic institutes criticized dual roles, e.g., of biochemical researcher *and* a psychoanalyst. One problem with a singular identity is that it demands protection from diffusion and therefore restricts inclusion in the group of those who maintain other identities. The need for singularity interferes with the capacity to make reasoned judgments utilizing the person's other identities as resources. According to social identity theory, multiple identities are useful and important (Johnson et al. 2006).

Sen adds: "An illusion [of singular identity} that can be invoked for the purpose of dividing people into uniquely hardened categories [such as non-training analyst and training analyst] can be exploited in support of fomenting inter-group strife" (p. 178). This may contribute to understanding intense internal conflicts and splits within psychoanalytic organizations large and small; reportedly, at any one time approximately one-third of the institutes of APsaA are embroiled in serious internal conflicts.

Why would analysts develop a more pronounced singularity of professional identity than other professions? The social attraction hypothesis of social identity theory suggests that individuals identify with groups that are prestigious or distinctive and enhance self-esteem (Johnson et al., 2006). Many analysts, Arlow (1972) noted have been recruited from the middle class, liberal, intellectual stratum of society and put behind them identification with family, religion or national group. The term "classical Freudian psychoanalyst" writes A. Cooper (2007) "identified one as being directly in Freud's lineage and even more importantly, it identified one as being a "true believer." This desire, not only to remain in the direct lineage of the father but to uphold every one of his beliefs is a necessity in religions and monarchies."

We speculate that this identification may increasingly be a defensive reaction to an underlying sense, perhaps largely outside of awareness, that many of the traditional tenets of psychoanalysis are unsubstantiated beliefs, characterized as witting, arbitrary convictions. Knafo, the author of a New York Times article about the New York Psychoanalytic Institute, noted that "so far, the Freudians haven't had much success in proving the validity of their master's theories." Myerson, Director of the Houston-Galveston institute, in discussing his institute's internal conflicts at the IPA Congress in Berlin in July (2007), noted that lack of agreement about what psychoanalysis is, provokes anxiety. Luyten (2007) concludes that "it would probably be most wise to say that we really do not know whether there are differences [between psychoanalysis and psychoanalytic psychotherapy], and if there would be differences, how these could be explained." Similarly, A. Cooper notes that analysts of different schools "not only disagree as to whether certain interventions represent good analysis, but cannot agree on whether they represent psychoanalysis at all." The failure to achieve a consensually-agreed definition either of psychoanalytic process or of psychoanalysis itself, or of possible differentiation of psychoanalysis from psychoanalytic psychotherapy, presents every analyst with these epistemological quandaries.

These uncertainties, we hypothesize, evoke a defensive reaction formation of intense certainty or conviction that the fundamentals of psychoanalysis are solidly based, beyond those of many other professions – which Jonathan Lear has termed "knowingness." Psychoanalysis, therefore, becomes conceived of as superior and its uniqueness supports a special professional identity. Support for this view is provided by the results of marketing surveys of views of psychoanalysts by the public and by mental health professionals. One of the prominent characterizations of analysts was "arrogance" (Zacharias, 2002).

Empirical studies demonstrate that uncertainty, particularly self-conceptual uncertainty, motivates and facilitates identification with groups that are clearly defined, distinctive entities. Hogg (2004) proposes that this group cohesiveness, called entitavity, (which includes clear boundaries, internal homogeneity, social interaction, common goals, prescribes perception, affect and behavior and structures social interaction), moderates the relationship between self-uncertainty and identification. That is, uncertainty increased identification, but only when the group was high in entitavity. Hogg et al. (2007) speculate that chronic and extreme levels of uncertainty, perhaps associated with personal or widespread life or societal crises, may motivate people to identify strongly as "true believers".

What maintains and replenishes a practitioner's identity as a psychoanalyst? One's identity can be reinforced as a result of exposure to "identity primes" that stimulate processing of identity related information (Forehand et al., 2002). Examples include participating in a psychoanalytic study group, attending a psychoanalytic meeting or reading a clinical psychoanalytic paper (not a research psychoanalytic paper).

Experiences after analytic treatment that are connected to the prior treatment may constitute identity primes as well. Freud (1937c) recognized that analytic work continues after treatment had ended. This analytic work, occurring after treatment, may include the effect of extra-therapeutic contact with the prior analyst and/or thoughts about the prior analyst which serve as identity primes and revitalize the identifications with the former analyst (Geller, 2005). In a follow-up study of ten (non-psychoanalyst) analytic patients two spontaneously mentioned that they were "able to recall the voice of the analyst as a soothing presence in times of stress or to recall the analyst's office as an inner source of support and containment" (Falkenström et al., 2007, p. 644). Further, self-analysis, which may reflect identification with the analyst, was correlated with post-termination improvement. For psychoanalysts, presumably, the absence of such identity primes as study group participation, attendance at meetings or contact with or thinking about the former analyst, may lead to a fading of the psychoanalyst's identification.

Arbitrariness, Psychoanalytic Identity and Psychoanalytic Research

Freud, deeply concerned to protect the scientific bona fides of psychoanalytic treatment, had no interest in empirical analytic research in his lifetime. When offered empirical findings that supported some of his hypotheses, he said in 1934 that they were of little consequence, and added, condescendingly, "still, they can do no harm" (quoted in Shakow and Rapaport, 1964, p. 129). (An analyst might speculate that Freud had some concern that, indeed, they might do some harm.) Freud, personifying a psychoanalytic identity that eschewed empirical research, was one of the templates for a psychoanalytic identity, which was transmitted to generations of analysts. In this context, formal psychoanalytic research first appearing in the 1950's (Kubie, 1952) and, more seriously in the 1960's, was seen as alien to the psychoanalyst's identity; it belonged to "other." Rado (1955) was a lone, dissenting voice who insisted that the future lay with an "increasingly rigorous application of the scientific method to psychoanalytic work" (p. 335) (quoted by Busch, 2006, p. 82).

Positivist and Hermeneutic Views

Hoffman (2007) criticizes Luyten et al. (2006a) for favoring a positivist view over a hermeneutic/constructivist orientation. Since our proposal reflects a positivist position, we should address Hoffman's critique, at least briefly. Most of our case-centered training, Hoffman asserts, tended to be positivist, and, therefore, he argues, the superiority of the hermeneutic/constructivist position needs to be emphasized, in part by criticizing the positivist position. One of his criticisms of positivism is that to call for "justification" of an interpretation "misrepresents the nature of the whole [psychoanalytic] enterprise;" more important than "justification" is whether what the dyad has created is "good" or not. Why, we ask, is one more valuable than the other; why are not both important? Hoffman adds that a "finding" that one form of treatment was more effective than another for a particular group of patients would be misleading for the analysts because it overlooked and obfuscated the patient's uniqueness. We believe that such a "finding" can inform the analyst and need not in any way diminish the analyst's appreciation of the patient's uniqueness. Moreover, we have no knowledge of the degree to which a patient's treatment behavior is a function of unique characteristics and of shared-group characteristics.

Each analyst's view, like each analyst's preferred psychoanalytic theory, has roots in his/her personality organization. Attempts to establish the superiority of the hermeneutic/ constructivist view over the positivist view by argument is as likely to be futile as an attempt to get an analyst to replace his/her preferred analytic theory with another one by citing clinical material.

We see these conceptions as complementary, not competitive. One approach may be more appropriate to certain psychoanalytic issues and problems than to others, e.g., delineating mutative factors or assessing treatment effectiveness. Each view has its problems and it seems more constructive to try to deal with them than to compare which are the more severe. The value of each approach should be judged in terms of its productivity for psychoanalytic theory and practice. We agree with Luyten et al. (2006b) that "much more is to be gained from dialogue than from opposition, and from complementarity rather than competition and conflict" (p. 599).

Arbitrariness and Psychoanalytic Research

Arbitrariness and the singularity of psychoanalytic identity are no friends of psychoanalytic research; indirect empirical evidence supports this view. A questionnaire study of the degree to which analysts read clinical papers rather than research papers found that those analysts with the strongest convictions about the fundamentals of analytic theory and practice were the analysts who read the fewest research papers (Schachter and Luborsky, 1998). The authors hypothesized that intense convictions about analytic beliefs were defensive reaction formations against underlying concerns that psychoanalytic theory and practice may actually rest on shaky grounds. Such analysts would have the greatest concern that analytic research might question or criticize fundamental tenets, and therefore, would have the most fear of, and avoidance of, analytic research reports. Eagle (1983) noted that "many contemporary psychoanalytic writers do not seem to be either aware of or interested in these basic issues of reliability, hypothesis testing, or elementary rules of evidence" (p. 41). Green (2000) called infant researchers to task for trying to destroy psychoanalytic theory. Luyten et al. (2006b) make a related observation: "the prospect of having to give up cherished ideas, an inevitable correlate of research and dialogue with individuals of other persuasions, may engender fear – in clinicians that research will increasingly intrude on their "old ways" …" p. 596). Probably included in their "old ways" is a conviction that psychoanalytic treatment is effective, and analysts may have a concern that research may fail to confirm that (Busch, 2006**).** Consistent with this hypothesis, Irwin Hoffman's recent plenary address to the APsaA, which was intensely critical of and ridiculed psychoanalytic research, evoked a standing ovation from the audience of analysts; Cooper (2007) suggests "that the audience was reassured in their ignorance."

A Survey of Psychoanalytic Research by American Psychoanalysts

For purposes of this review, a paper was defined as a research paper if it contained empirical data about analytic treatment or outcome, or, if it dealt with methodological or conceptual issues in analytic research; papers that reported neuroscience research were included. If the generous definition of research by Leuzinger-Bohleber and Fischman (2006) were utilized, it would appear that a great deal of analytic research is being published. Our data (presented below) documents the dearth of published psychoanalytic research. The invention of the term *conceptual research* (Dreher, 2000) appears to veil the "inconvenient truth" that little psychoanalytic research is published. Further, the recommendation from an IPA conference that "any effort for validation must be rooted in the history of psychoanalytic clinical thought" (Freedman et al., 2000) attempts to apply an inappropriate strait jacket to research formulation.

Members were divided into two groups of analysts: 1. The current members of the two leadership groups of APsaA, the Executive Council (Board of Directors) and the Board on Professional Standards (BoPS); and 2. A random sample of current members of APsaA. The PEP CD-ROM was used to identify analytic research papers published during the five year period from 1998-2003.

Results for the Executive Council are that of 56 Councilors, 10 had published a total of one or more papers, and one (2%) had published three research papers. For BoPS, of 62 Fellows, 19 had published a total of one or more papers, and three Fellows (5%) had each published one research paper.

A random sample of 165 active members (approximately a 10% sample of 1707 active members) was selected from the roster by choosing one member from the same selected position on each of the 165 pages of the roster. If the selected position contained an affiliate member, the next active member was chosen. Results were that 36 members (22%) published one or more psychoanalytic papers; thus, 78 % of this random sample of active members published no psychoanalytic papers. Seven members (4%) published one or more psychoanalytic research papers, a total of 9 papers. Thus, 96% of this random sample of active members published no research papers. Extrapolating from this 10% sample, the total active membership of 1707 would publish 90 papers over a five-year period, an average of 18 papers per year.

In order to check whether this annual number of research papers found is a reasonable estimate, we reviewed 908 papers published in one year, 2003, in 16 journals in the PEP CD-ROM. Twenty-one research papers had been published, constituting 2.3% of the total papers published. This is consistent with the estimate of 18 research papers per year from the review of members

One qualification is in order. Judgment of whether a paper should be considered a research paper was made by only one author (J.S.) so there is no assessment of the reliability of these judgments. However, the judgment did seem clear in most cases.

These results indicate how few APsaA members produce research papers: 4% of the general members and 2 - 5% of the leaders. These findings support our proposition that the identity of a contemporary APsaA psychoanalyst does not include competence in, or involvement in, psychoanalytic research.

Analytic Research and the Current Decline in American Psychoanalysis

Despite the anti-research attitude of the contemporary psychoanalytic identity, a small number of intrepid researchers have produced illuminating studies about analytic treatment. For example, Leichsenring et al. (2005), Sandell et al. (2000, 2007) and Zimermann et al. (2015) have presented empirical data (not just witting arbitrary convictions) about the effectiveness of analytic treatment for at least certain patients; Kächele, Schachter and Thomä (2009a) have reported what are probably the most intensive and comprehensive empirical studies of the analytic treatment of a single patient (for a summary see Kächele et al. 2006). Luyten et al. (2006b) mention additional empirical studies, but do acknowledge that "the empirical basis of psychoanalysis still is relatively meager compared to other forms of psychotherapy" (p. 576).

APsaA and IPA are enhancing their research efforts. Each provides an intensive research training course, and APsaA, in addition to its Fund for Psychoanalytic Research, arranges poster sessions of research projects at its meetings and has committed $100,000 over five years to a study of the effectiveness of psychoanalytic treatment. Replication and extension of these studies plus many additional studies need to be generated and their objective results presented to the public and to the scientific community.

Studying the effects of analytic treatment is extraordinarily complex for many reasons, including the risk of investigator bias because of experimenters' beliefs and expectations. Numerous independent replications are necessary to be convincing, and multi-center participation may be necessary. Four percent of members is an inadequate base for developing the extensive research programs needed. To accomplish this will require a scope and breadth of a research cadre far beyond

APsaA's current reach and conception. Even doubling the research output of American psychoanalysis in the next few years from 18 to 36 research papers per year would be inadequate to meet research demands including assessing effectiveness of psychoanalytic treatment with many different groups of patients, comparing effectiveness of psychoanalytic treatment to that of psychoanalytic psychotherapy and delineating the mutative factors in psychoanalytic treatment with many different groups of patients. Luyten et al. (2006b) refer to a growing awareness of the need for empirical evidence "to support psychoanalytic assumptions and therapies" (p. 572). If you accept the thesis that the foundations of psychoanalysis are constituted by witting, arbitrary convictions, the magnitude of the research enterprise becomes apparent.

We have detailed elsewhere evidence that American psychoanalysis is undergoing a marketing decline (Schachter and Kächele, 2007). While some analysts' psychotherapeutic practices fare well, the number of analytic patients continues to shrink, as does the number of applicants for training. For example, in Los Angeles the non-APsaA institute, ICP, has many more candidates than the new, combined APsaA New Center for Psychoanalysis. Similarly, in Boston, the non-APsaA institute, MIP, has recently had more candidates than the two APsaA institutes, BPSI and PINE, together. The awarding of the pretigious Lasker Prize to Dr. Aaron Beck for his development of cognitive behavioral therapy, acclaimed the most significant development in mental health treatment in fifty years, is another sign. A striking symptom of this decline was the publication of a section on Sleep in the New York Times (2007). In two different articles about nightmares and dreams (Angier, 2007; Carey, 2007), the only reference to Freud was: "found in their studies scant evidence to confirm that dreams were the disguised, forbidden wishes described by Freud" (p. F2). In a more recent New York Times article about Freud, Patricia Cohen concludes that an APsaA report she reviewed "underscores pressing questions about the relevance of their field and whether it will survive as a practice" (p.6); the article's illustration was of an analytic couch having been thrown out a window, discarded. Kirsner (2000) concludes "already the steep decline of institutionalized psychoanalysis is all but assured" (p. 250). We do not believe that public relations or advertising can reverse this widespread decline.

Rocha Barros (1998) warned that the essential crisis is not the "marketing crisis" but the crisis in the intellectual and scientific domain where we produce a dearth of exciting new knowledge. Stone (1975) wrote that resistance to the reexamination of our basic procedural assumptions betrays an unscientific (sometimes antiscientific) non-rational component that is "the greatest single obstacle to the progress of psychoanalysis" (p. 335-6) (quoted by Reeder, p. 189). Few institutes make any effort to teach analytic research. The much maligned New York State regulation for licensure of psychoanalysis requires at least one course in analytic research; the "standards" of APsaA have no such requirement. Pres. Lynne Moritz in her TAP article (2007) concludes that "it is clear, in evaluating the current functioning of research and science within the Association, that we have not yet found optimum structures" (p. 3). In Sweden, psychoanalytic institutes were rejected partly on the grounds that no research was being done under their auspices (Rolf Sandell, 2007, personal communication).

The required enterprise demands a fundamental change in the conception of a psychoanalyst's identity to enable the generation of the large number of skilled researchers required. Thomä (2004) hoped that the psychoanalyst's identity would be abandoned so that this identity will no longer hamper "the development to a scientific community" (p. 213). Psychoanalytic education needs to be reoriented towards open, skeptical questioning and interdisciplinary, critical research (Kernberg, 1984; Thomä and Kächele, 1999; Kirsner, 2000; Auchincloss and Michels, 2003; Levy, 2008). This change in goal and ideal requires a dramatic change in psychoanalytic education. *We believe that*

psychoanalytic research cannot be grafted onto the current psychoanalytic clinical identity; it cannot flourish. Clinically-based training programs will never generate the necessary research cadre. Psychoanalytic identity must shift to encompass *both* clinical and research knowledge and competence.

We propose, not that every analyst should become a researcher, but that every analyst should develop a *research orientation, an inquiring attitude and a tolerance for uncertainty* in order to become a *good clinical analyst.* These qualities cannot be learned from clinicians who teach the practice of our craft, which is different from educating analysts (Bartlett, 2007). Many clinicians, believing they must be confident about their knowledge about both theory and practice, are defensive about their knowledge about both. Consequently, not only do they not encourage an inquiring attitude in candidates, often they are hostile to research. For example, although most analysts have not had the experience of having either a former or current patient participate in a research project, they routinely and defensively refuse permission for a former or present patient to participate in a research study. To foster a research orientation and an inquiring attitude in candidates, some of the teachers of psychoanalytic education need to be researchers, in whom these attitudes are integral. In addition, including researchers will provide a research role model with whom candidates can identify. It is noteworthy that the Columbia University Psychoanalytic Center for Training and Research, which is located in a large research institute, generates considerable psychoanalytic research.

We propose that all psychoanalytic education be taught *jointly* by a researcher and a clinician, including all didactic courses and supervision. This provides another valuable consequence. "Clinicians and scientists function in very separate worlds," writes Roth (2007); collaboration between the two are crucial. Joint teaching by researchers and clinicians will provide each of them with familiarity of current developments in each others' fields, which is as valuable for the researcher as for the clinician.

An elective course would be provided for "Research-Participating Candidates," those willing to have their patients and analytic treatments participate in research projects. The impact of the research on patients, candidates and the treatment process, would be explored and discussed; supervisors would be invited to participate.

We believe that APsaA has the financial wherewithal to provide one full-time researcher to each of our 30 institutes for at least the next ten years. We suggest three sources of funding: 1) supervisors contribute candidates' fees for supervision to APsaA (and getting a tax contribution for doing so; this seems a reasonable request since Training and Supervising analysts who have always earned more practice income than non-training analysts have not been required to pay more institute dues than lower-earning non-training analysts); conservative estimates for 950 candidates averaging 1.5 supervisory sessions/week at an average fee of $75 per session for 40 weeks per years would generate $4,275,000; 2) increasing the proportion of the annual operating budget devoted to research from 3-4% to 15% yields $450,000; and 3) allocating 10% annually from APsaA's reserve fund or "rainy day fund" (it's raining) provides $350,000 (if the reserve fund generates a !0% annual return – it exceeded that in 2007 - the balance would remain at the same level after the first year). These monies total $5,075,000 which can provide $170,000 per year to each of 30 institutes, enough to hire one full-time researcher. Hopefully, these researchers subsequently would generate research grants.

The candidate's analysis would return to a personal analysis conducted outside the domain of an institute, with an analyst of the candidate's own choosing (Kirsner, 2000; Reeder, 2004). The fundamental re-conception of the psychoanalyst's identity would not be possible if the training analyst institution was maintained.

We realize that our proposal may seem inconceivable, but it is not because it is not feasible. We believe that the current serious decline in psychoanalysis is likely to continue unless drastic measures are taken to increase respect for psychoanalysis in the general public and in the scientific community. A. Cooper warns that "unless in the next half-century we can establish our own cadre of full time basic and clinical researchers, university supported, we will become a footnote to other intellectual disciplines" (p. 253). Are there alternative, less drastic proposals than fundamentally re-conceiving the identity of the psychoanalyst, that carry equal promise?

Chapter Fourteen

The Problems of Single Case Reports in Psychoanalysis

Abstract

The long history of discussion on research using the single case approach documents its principal significance for theory and practice. However there are more papers on the single case research approach than empirical based case studies. This chapter discusses the manifold variations on the issue and points to an example of how it can be implemented.

Introduction

Throughout the history of psychoanalysis, theories have always hinged on clinical single case reports and teaching has focused on the value of such case histories. Freud and many of his followers believed clinical case histories were critical for scientific testing of psychoanalytic theories. Freud was so convinced of the validity of this connection that when he was offered the results of empirical studies confirmatory of his theories he wrote dismissively: "I cannot put much value on these confirmations because the wealth of reliable observations on which these assertions rest make them independent of experimental verification. Still, it can do no harm."

However, the idea that clinical case histories provided scientific tests of psychoanalytic theories was criticized from the outset even by those sympathetic to psychoanalysis and certainly by its detractors because of the possible influence of suggestion (Breuer, about his own work with Anna O., in Breuer and Freud, 1893-1895, p. 43; and Fliess, in Grünbaum, 1984, pp. 32, 130). Von Krafft-Ebing (1896) tried the Breuer-Freud method on a few hysterical patients and found that bringing the causal trauma to light did not suffice to cure the symptom. The shadow of increasing doubt on the scientific value of clinical case histories has continued and later, in response to this, empirical (not experimental) studies of single cases began to be formulated. Critiques notwithstanding, traditional analysts continued to maintain that case-history-based clinical findings are "the real basis of psychoanalysis" (Jones, 1959, p 3, quoted by Grünbaum, 1984, p. 99).

Freud's Scientific Conception of Psychoanalysis

Early in his career Freud had been a neurological scientist. He had hoped to continue in his scientific career, but, because he was a Viennese Jew, he failed to get an academic appointment, and, having married and started to have children, he went into the clinical practice of neurology. He thus earned his livelihood by using hypnosis and massage, the standard armamentarium of the neurologist. He soon grew tired of hypnosis, tried Breuer's abreaction technique and developed it over time into psychoanalysis.

Freud remained ambitious and still dreamed of becoming a famous scientist like his contemporaries, Darwin and Koch, discoverer of the cause of tuberculosis. He set out to discover the cause of neurosis, and believed that psychoanalysis would be the route to this discovery, but only if

psychoanalysis was a scientific enterprise. To avoid the critique that psychoanalysis was influenced by the analyst's suggestions, which played such an obvious central role in hypnosis, he struggled to minimize or prevent suggestion which might influence the patient and shape what would emerge as the putative cause of neurosis. To rule out suggestion, Freud structured the psychoanalytic situation like a scientific observation. The analyst should be objective, anonymous and neutral, and try to keep the patient in abstinence. The analyst should behave as closely as possible like a scientist examining a specimen, and analytic treatment should be applied in a standard fashion to all patients. Although Freud himself sometimes deviated from this prescription by being both friendly and supportive toward a patient, he probably regarded this as "outside" of psychoanalytic technique. Throughout his life Freud remained concerned that suggestion might play a role in the outcome of psychoanalytic treatment. This always lurking possibility of the influence of suggestion has been a persistent theme in all criticisms of the clinical case history.

The Case of the "Rat Man"

In 1892 Freud hypothesized that the symptoms of two women patients suffering from hysteria were caused by "repression, that is, by the exclusion from consciousness of memories and feelings about a current sexual trauma," and this "represented the beginning of his fundamental discovery of the power and influence on behavior of unconscious thoughts and feelings" (Schachter, 2005a, p. 9).

Eleven years later Freud treated a twenty-nine-year-old lawyer who became famous as the "Rat Man." This case history of Freud's is unique because it is his only treatment that includes the notes he made on the day of each session. The patient, Dr. Paul Lorenz, had begun to have obsessions five years earlier, on his sudden realization that the first of his state law examinations was one month away. These obsessions consisted chiefly of fears that a dreadful torture involving rats would be inflicted on two people of whom he was very fond – a "lady" he admired, and his father (who actually had died several years previously). He had a history both of obsessional concerns dating back to childhood, as well as of compulsive impulses, such as, of cutting his throat with a razor.

After obtaining permission from his mother, who controlled his money, Dr. Lorenz began his analysis on October 1, 1907. Freud instructed Dr. Lorenz to "say anything that came into his head" (Freud, 1909d, p. 159) – to "free associate." Many of Dr. Lorenz's thoughts were about sexual matters, which led Freud to inquire what made him put such stress on his sexual life? Dr. Lorenz replied that his reading of Freud's theories made him think that this was expected. I consider that this reading of Freud's papers may constitute our first recorded example of pre-treatment, implicit suggestion. That he regarded Freud as an eminent professor with the knowledge and power to cure him may also have functioned as a positive placebo effect. We have no way to know.

In the eighth session, unrelated to any material from Dr. Lorenz, Freud constructed the following: "how before the age of six he [Dr. Lorenz] had been in the habit of masturbating and how his father had forbidden it [and used] as a threat the phrase 'it would be the death of you' and [Freud added] perhaps also threatening to cut off his penis" (p. 263). Later, when Dr. Lorenz's mother was unable to confirm the occurrence of any such incident, Freud then changed his theory; Dr. Lorenz's traumatic experience with his father had not been real, but had been a childhood fantasy.

Freud then wrote that after an interpretation, Dr. Lorenz's rat obsession disappeared, but Freud did not describe what that interpretation had been. Mahony (1986) determined that Dr. Lorenz's total treatment lasted less than nine-and-a-half months in all, while the period of frequent and regular sessions didn't exceed several months. After seven months of treatment Dr. Lorenz was able to accept work in his profession, and, approximately one year after termination, Dr. Lorenz became

engaged to his "lady," who he married in 1910, thus foiling his mother's attempt to choose his spouse. Unfortunately, Dr. Lorenz perished in World War I.

Clearly, Dr. Lorenz's treatment, although exceedingly brief by contemporary standards, was a therapeutic success. Was Dr. Lorenz's improvement caused by Freud's interpretation, by explicit and implicit suggestion, by a positive placebo effect, by some unidentified factor or some combination of all? This question, 'what was mutative?' remains central to the subsequent decades of criticism of clinical case histories.

Freud's writing, Shakow and Rapaport (1964) observe: "is characterized by subtlety and power of language rather than precision and organization of propositions. While his case histories and clinical discussions are unrivalled to this day, his theoretical formulations still leave very much for the reader to unravel" (p. 7).

The Development of Criticism of Psychoanalytic Case Histories

The American atmosphere in the first decades of the 1900's was peculiarly favorable for Freudian ideas. Shakow and Rapaport (1964) wrote:

> "The muckrakers and early realists of the last decades of the nineteenth century had already laid the foundations for breaking down the "genteel" tradition of a primarily Puritan and Victorian culture. This trend was markedly accelerated by the literary realists, the social protesters, the feminists, and the Bohemians, all of whom were influential in the period surrounding the First World War. Freudian ideas were welcomed with open arms by these rebellious forces, and relationships developed among them in which the Freudian influence became paramount.
>
> Freud, in his philosophic orientation appears to have gone back to the spirit of the Enlightenment with its integration of intellect and affect, rather than adhering to either the Romantic Period's marked overemphasis on affect, or to the later nineteenth century's emphasis on intellect alone" (p.192).

Alternative voices in psychoanalysis took issue with Freud, such as Rank, Adler and W. Reich; Freud, intolerant of dissent, ejected them from the "psychoanalytic movement." Jung, believing that Freud had exaggerated the role of sexuality, also separated from Freud. The disagreement with Freud with the longest lasting repercussions was by Ferenczi (Thompson, 1943) who believed that the lack of appropriate love during childhood was the cause of adult neurosis, and that the analyst's task was to replace this missing love. He, therefore, disagreed with Freud's technique of treatment in which the analyst remained "objective" and neutral and tried to keep the patient abstinent. Ferenczi thus presaged contemporary modifications in analytic treatment in which the focus was directed to patient-analyst interaction, in which the analyst played an active role and acknowledged knowingly influencing the patient.

Critiques of psychoanalysis proliferated. Dunlap (1920) dismissed psychoanalysis as a new band of mysticism which violated logic and the scientific canon. Jastrow (1932) wrote that "there remains a valid core of insight in the germ idea of psychoanalysis" (p. 5) but went on to assert that there are "reasons why the Freudian "Ucs" is completely unacceptable … There is no evidence that any such region or process exists …"(p. 175, quoted by Shakow and Rapaport, 1964, p. 164). Sears (1943) saliently concluded that: "Psychoanalysis relies upon techniques [clinical case histories] that do not admit of the repetition of observations, that have no self-evident or denotative validity, and that are tinctured to an unknown degree with the observer's own suggestions" (p.133, quoted by Shakow and

Rapaport, p. 170). A few years later, however, Fenichel (1945) published a significant and widely accepted authoritative text of psychoanalysis using only short clinical illustrations later called vignettes.

World War II proved to be a nodal point in the development of psychoanalysis in the US. By utilizing psychoanalytic insights and techniques, mental health professionals were very successful in treating soldiers with "battle fatigue," which greatly enhanced the status and prestige of psychoanalysis. Returning from military service, psychiatrists brought psychoanalysis into hospitals and departments of psychiatry. Professionals and academics used money from the Government Issue bill to undertake psychoanalysis not primarily because of emotional distress, but because it was believed that it might enhance their personal and career development. Most of the chairs of departments of psychiatry in the United States were filled by psychoanalysts. It was, indeed, the golden age of American psychoanalysis. The soaring expectations of the therapeutic power of psychoanalysis, however, proved to be excessive as an enlarged patient population was treated, and later the seeds of disappointment and disillusion contributed to a decline in psychoanalysis.

Grünbaum's Critique of Single Case Histories

Although the methodological basis for empirical studies of single cases had been advocated by the statistician Chassan (1960; 1979) only a few pioneer studies were conducted (Dahl, 1972; Jones & Windholz, 1990). And little attention was paid to such empirical studies in the profession. Analysts, riding the crest of the popularity of psychoanalysis, may have felt, like Freud, that they were so certain of the validity of their theories that there was little need for empirical validation. These convictions, however, were challenged by an incisive critique of psychoanalysis by Grünbaum (1984), a professor of the philosophy of science. Psychoanalysts mounted a vigorous response and defense.

Grünbaum began his rigorous examination by quoting Freud's (1916/17) earlier statement that: "After all his [the patient's] conflicts will only be successfully solved and his resistances overcome if the anticipatory ideas he is given tally with what is real in him. Whatever in the doctor's conjecture that is inaccurate drops out in the course of the analysis …" (p. 452). This statement has been termed by Grünbaum Freud's "tally" argument.

Grünbaum refutes Freud's "tally" argument by: 1). If a correct psychoanalytic

interpretation removes the cause of the patient's disturbance or symptoms, then psychoanalytic treatment should be more effective than treatments that do not use such interpretations, but there is no evidence that that is the case; 2). Contemporary psychoanalysts recognize that they do not know what factors have produced therapeutic improvement in an individual patient, and therefore the possibility that the improvement is a function of suggestion and/or a placebo effect cannot be ruled out. Marmor (1986) similarly asserts "No serious scientist today would assert that the success of any therapeutic method constitutes proof of the correctness of the theory on which the therapeutic technique was based" (p. 249). Luborsky and Spence (1978) asserted that "far more is known now [in psychoanalysis] through clinical wisdom than is known through quantitative, objective studies" (p. 350) and add the sobering caveat that psychoanalysts "literally do not know how they achieve their results" (p. 360).

Freud had also proposed a "consilience argument" that stated that if the data pieces fit together exactly, like those of a picture puzzle, they almost certainly must be correct. Grünbaum asserts that consilience is spurious because it assumes the independence of the pieces of evidence, but they cannot be independent because of a shared contaminant, the analyst's influence. In addition, the consilience itself is in part a function of the cleverness of the analyst and depends on it. The

recognition that some of Freud's views, such as his conceptions of femininity and of homosexuality, proved to be erroneous is consistent with the conclusion that putative consilience may be mistaken.

Returning to the "Rat Man" Grünbaum noted that when relying on the patient's recall, it is not possible to determine if a reported childhood experience is veridical. Further, even if the experience may be shown to have taken place, we still lack basis for claiming that that the specific childhood experience was the cause of the adult disorder.

We would add that additionally, Freud argued that with the resolution of the patient's transference, the patient's therapeutic benefits were freed of any effects of suggestion by the analyst. This is not supportable because contemporary research has shown that while the patient's transferences are often modulated, they are not resolved (Luborsky & Luborsky, 1995).

The claim that the test of a traditional analyst's interpretation is the therapeutic effect it produces, which served Freud as evidence that it tallies with what is real in the patient's mind, should then also apply to interpretations by Kleinian analysts, self-psychological analysts, relational analysts and perhaps to cognitive behavioral therapists as well. Since what each of them finds in the patient's mind differs qualitatively from what the traditional and the other schools find in the patient's mind (see f.e. Pulver 1987a), the tally argument must finally be discarded. Grünbaum cements this conclusion by quoting Marmor (1962) that "the patients of each [rival psychoanalytic] school seem to bring up precisely the kind of phenomenological data which confirm the theories and interpretations of their analyst! Thus, each theory tends to be self-validating" (p. 289, quoted in Grünbaum, 1984, p. 265). This finding suggests how pervasive the effects of the analyst's suggestions can be.

Grünbaum concludes: "insofar as the evidence for the psychoanalytic corpus is now held to derive from the production of patients in analysis, this warrant is remarkably weak" (p. 278). He carefully avoids the error of concluding that psychoanalytic tenets are invalid, which error was made by Jastrow (1932) who wrote that the concept of "the Freudian "Ucs" is completely unacceptable" (p. 175). The absence of substantiation never demonstrates that the phenomenon in question is false.

Mitchell (1998) noted that after exposure to Grünbaum's critique, psychoanalysts become afflicted with the "Grünbaum Syndrome" which included trying to "remember how analysis of variance works, perhaps even pulling a twenty-year-old statistics book of the shelf and quickly putting it back. There may also be a sleep disturbance and distractions from work" (p. 4).

Edelson's Defense of Single Case Histories

Edelson (1988) proffered the most spirited, articulate and sophisticated response to Grünbaum's critique of causative inferences based upon clinical case histories. Single subject research, he argues, has an advantage over group comparison research in that it is possible to enhance the validity and reliability of variables of interest by individualizing instruments for obtaining data, instead of employing a scattershot approach of a variety of behaviors or states that may be relevant to some members of a group and not to others. Single subject research can focus upon those behaviors which the investigator has reason to believe are especially relevant to the individual subject.

Edelson considers whether statistical tests in single subject research are justifiable since they involve the assumption that observations or measurements are independent: "One may try to justify the use of statistical methods; develop new statistical methods to deal with the kinds of dependencies which violate the independence assumption; or, eschewing statistical reasoning and methods, seek to achieve effects that are clearly clinically or theoretically significant, such large effects indeed that it can be argued … [that it] excludes as implausible the alternative hypothesis that this effect is due to chance or random fluctuations produced by extraneous variables" (1984, p. 69).

Edelson draws a parallel between psychoanalysis and Darwin's development of a methodology enabling him to make causal inferences about natural history. He cites Gould (1986) who argues "that iterated pattern, based on types of evidence so numerous and so diverse that no other coordinating interpretation could stand – even though any item, taken separately could not provide conclusive proof – must be the criterion for evolutionary inference" (Edelson, p. 65). However, he fails to recognize both Darwin's and Gould's observations are entirely independent of each other and of the observer, whereas the analyst's pervasive influence upon the patient undermines the independent nature of the patient's data. One of the fundamental ways the analyst influences the patient's "free association" is by ignoring some of the patient's associations and by selecting others for exploration or comment. Independence is crucial for consilience, and it cannot be found in the consulting room.

Edelson questions Grünbaum's claim that there is no way of assessing

contamination of the patient's material. He argues that unless there is some evidence the analysand intends consciously to deceive, his conscious feelings, thoughts and perceptions can be included as data. These data, he asserts, are theory laden, but the theory with which they are laden is not psychoanalytic theory but the patient's personal theory, and he therefore contends that with respect to psychoanalytic theory such data are non-theoretical facts. He also believes that it might be possible to reduce the adulteration of data by suggestion to such a degree that it ceases to be a plausible alternative explanatory candidate. He adds "The disciplined use of psychoanalytic technique which focuses on interpreting defense, rather than providing the analysand with suggestions about what he is defending against, also might cast doubt on a claim that suggestion is a plausible alternative explanation for an outcome observed in a particular single subject research" (1984, p. 130). In addition, he proposes that the phenomenon of suggestion itself may be studied and the extent of its influence measured. Finally, as evidence of how limited a role suggestion plays, he claims that "A psychoanalysis without surprises cannot properly be termed a psychoanalysis at all" (1984, p. 136). That is a striking statement, especially since it is our impression that it is rare to read a case history in which the analyst describes being surprised.

We believe Edelson underestimates the pervasiveness of suggestion by the analyst while the recent literature is more cognizant of it and approaches it from different directions. Levy and Inderbitzin (2000) describe "the inevitable presence and need for suggestive factors in analysis" (p. 739). Glover (1952) wrote; "we cannot exclude or have not excluded the transference effect of suggestion through interpretation" (p. 405, quoted in Wallerstein, 2006, p.304). Thomä and Kächele (1994a) assert similarly that "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 (p. 333). Schachter and Kächele (2007) write that "Spence (1992) observes that 'the clinician … tends to listen to the clinical material with a favorite set of theoretical predispositions'" (p. 562) and Spence concludes that "interpretations in a clinical setting have an unfortunate tendency to reflect the therapist's expectations rather than the underlying facts of the matter" (p. 559). Masling and Cohen (1987) reach an identical conclusion: "All psychotherapists generate clinical evidence that supports their theoretical positions – [and] can be understood as instances of therapists systematically rewarding and extinguishing various client behaviors. Therapists' belief in their theories serves as a self-fulfilling prophecy" (p. 65). Marmor (1962) (quoted earlier) extended this observation to different analytic schools.

In the same vein Schachter and Kächele (2007) write: The sources of the analyst's implicit influences and suggestions are manifold, in part derived from the analyst's subjectivity, which encompasses the analyst's realistic reactions to the patient, the analyst's transference responses to

the patient, the analyst's theoretical orientation, the analyst's current, personal concerns about his/her own life, and the analyst's personal values; the influences of the latter have been widely discussed (Menninger and Holzmann, 1958; Roazen, 1972; Lichtenberg, 1983; Ramzy, 1983). Strenger (2005) asserts that "it is unrealistic to believe that a therapist's personal predilection, her sense of what constitutes the central dimension of meaning in life, does not crucially influence each and every one of her interventions" (p. 92).

Edelson (1984) also countered another of Grünbaum's arguments that there was no warrant for concluding that an event remote in time, a childhood experience, could be causative of an adult symptom. Edelson argues: "The pathogen reappears in all its virulence, with increasing frankness and explicitness, in the transference – in a new edition, a new version, a reemergence, a repetition of the past pathogenic events or factors" (p.95). But recourse to that argument begs the question, since there is no proof that the current "transference" is a repetition of a childhood experience. An unsubstantiated psychoanalytic hypothesis cannot be used to validate psychoanalytic theory. Thus, whether a present "transference" expression is a reappearance of a childhood experience remains an hypothesis requiring independent verification (Schachter, 2002). .

Finally, Edelson cites as credible Glymour's (1980) approach to evaluating a clinical case, which is that of testing subsets of the interrelated but independent hypotheses of a theory. This process should make it possible to reject and revise a subset of hypotheses without abandoning an entire theory. However, Edelson, like Glymour, overlooks the likelihood that the interrelated hypotheses are not truly independent; they are interconnected in the analyst's mind, and as a result of the analyst's influence, they may not be independent for the patient.

Here, as a postscript to Edelson's views, is a contemporary description by Wolitzky, Director of the Ph.D Program in Clinical Psychology at New York University, that, in contra distinction to Grünbaum, utilizes the criterion of plausibility for assessing the value of a single case report:

> "I am interested in collecting a series of case studies, particularly those published in the last two decades, that offer persuasive evidence for the psychoanalytic formulation of phobias, or any other psychoanalytic propositions. The cases should be ones in which enough detail, including some verbatim material (if possible) is provided to make a compelling case. ... I want to be clear that to nominate a paper you do not have to feel that the clinical illustration "proves' something, only that the clinical evidence is persuasive … that the formulation made a good deal of clinical sense to you (i.e., that it was highly plausible, coherent, internally consistent, and not overly speculative). In other words, the formulation should lead to serious consideration for an open-minded skeptic (Wolitzy, 2007).

Notes on the Methodology of Single Case Studies

In a pivotal review of the problem of psychoanalytic treatment research some fourty years ago Wallerstein and Sampson (1971) enthusiastically recommended performing systematic single case studies to enhance the field. Three decades later Wallerstein (2002) concluded: „that we are without warrant ... to claim the greater heuristic usefulness or validity of anyone of our general theories over the others, other than by the indoctrination and allegiances built into us by the happenstance of our individual trainings, our differing personal dispositions and the explanatory predilections then carried over into our consulting rooms" (p.1251). In the same vein Gabbard and Westen (2003) urge that „we attempt to move from arguing about the therapeutic action of psychoanalysis to demonstrating and refining it" (p. 338). The best possibility for resolving these differences and for developing some consensus about the fundamental tenets of psychoanalysis rests with empirical

research generating relevant data that can provide a basis for consensual agreement about fundamental psychoanalytic principles (Schachter, 2005b).

Historically in psychoanalysis oral tradition and loosely documented case vignettes have constituted the principal means of reporting the insights originating from the therapeutic situation. Until today we encounter prominent authors underscoring that the clinical encounter is best reported via the narrative mode (Michels, 2000). When Hartvig Dahl used the term "the specimen hour" (in Dahl et al., 1988) for the session five of the completely tape recorded treatment of Mrs. C (see Malcolm, 1980), to provide for the interested public this transcript this then still anonymous presentation implied that there are not only specimen dreams in psychoanalysis, as Freud coined it, but also specimen cases that have to be studied each in its own right. However the number of papers calling for single case research (f.e. Donnellan 1978) far outnumbers the number of papers reporting on detailed single case studies (Leuzinger-Bohleber 1995). Searching through the history of psychoanalysis for true single case studies – excluding the Freud´s cases - is enlightening.

As a bibliographic exercise Kächele and Thomä (2009d) reviewed the post-Freud psychoanalytic literature for treatment reports of a certain size, searching for presentations that cover, using a rough measure, of more than 30 pages in published form. Looking at the dates of publication in this sample, its incompleteness must be emphasized once again, one is struck that from 1930 to 1959 there were 6 reports, while from 1960-1979 there were 20.

These extended clinical case reports constitute a bridge to the more formalized systematic case studies. Given their material qualities they well could have been and still can be the object of more formal empirical studies. However the introduction of tape-recording into the psychoanalytic treatment situation opened a new window onto the process that for long was ardently debated and for most analysts is still controversial. Audio-recordings of the psychoanalytic dialogue indeed do pose a number of substantial clinical and ethical problem although for scientific reasons they provide true progress (Kächele et al. 1988). They allow an independent, third – person perspective on the analytic, interpersonal transaction; with regard to the analyst´s and the patient´s internal modes of experiencing they are silent and ideally have to be completed by the participant´s testimony. The recording of these cases has opened up access to many theoretical and technical issues.

Single case studies are not confined to tape-recording; any systematic gathering of treatment relevant material can be used to document a treatment. Overviews on the methodology have been presented by Kazdin (2011), Hilliard (1993), Fonagy and Moran (1993). The latter summarized the topic succinctly:

> "Individual case studies attempt to establish the relationship between intervention and other variables through repeated systematic observation and measurement .....The observation of variability across time within a single case combines a clinical interest to respond appropriately to changes within the patient, and a research interest to find support for a causal relationship between intervention and changes in variables of theoretical interest. The attention to repeated observations, more than any other single factor, permits knowledge to be drawn from the individual case and has the power to eliminate plausible alternative explanations" (Fonagy & Moran, 1993, p. 65).

The Ulm Psychoanalytic Process Research Study Group

For many years the Ulm Psychoanalytic Process Research Study Group has implemented a program to examine the material bases of psychoanalytic therapy. We were and are convinced that only the careful exploration of the patient's interaction with the analyst can illustrate the central aspects of

psychoanalytic treatment and enable an empirically driven theory of the process. Therefore we have undertaken a sustained, multi-level, collaborative examination of what may be described as a "specimen case." Over the course of many years – even decades - studies of various kinds – in qualitative and quantitative methodology – have been made on the psychoanalytic treatment of our first specimen case named "Amalia X".[17] Clinical vignettes and a psychodynamic summary of the case have been provided in the second volume of Thomä & Kächele´s textbook "Psychoanalytic Practice" (1994b) from which we now quote the clinical description of the patient:

„Amalia X (born 1939) was in psychoanalytic treatment (517 sessions) during the early seventies with good results. Some years later she returned to her former therapist for a short period of analytic therapy because of problems with her lover, many years her junior. Twenty five years later she consulted a colleague of mine as her final separation from this partner had caused unbearable difficulties and she again asked for circumscribed help.

Amalia X came to psychoanalysis because the severe restrictions she felt on her self-esteem had made her vulnerable to depression in the last few years. Her entire life history since puberty and her social role as a woman had suffered from the severe strain resulting from her hirsutism. Although it had been possible for her to hide her stigma – the virile growth of hair all over her body – from others, the cosmetic aids she used had not raised her self-esteem or eliminated her extreme social insecurity. Her feeling of being stigmatized and her neurotic symptoms, which had already been manifest before puberty, strengthened each other in a vicious circle; scruples from a compulsion neurosis and various symptoms of anxiety neurosis impeded her personal relationships and, most importantly, kept the patient from forming closer heterosexual friendships.

This woman, who was hard-working in her career, cultivated, single and quite feminine despite her stigma, impressed me positively. The analyst was relatively sure and confident that it would be possible to change the significance she attributed to her stigma. In general terms, he proceeded from the position that our body is not our only destiny and that the attitude which significant others and we ourselves have to our bodies can also be decisive. Freud's (1912d, p. 189) paraphrase of Napoleon's expression to the effect that our anatomy is our destiny must be modified as a consequence of psychoanalytic insights into the psychogenesis of sexual identity. Sexual role and core identity originate under the influence of psychosocial factors on the basis of one's somatic sex.

The analyst´s (H.T.) previous experience warranted the following initial assumptions. A virile stigma strengthens penis-envy and reactivates oedipal conflicts. If the patient's wish to be a man had materialized, her hermaphroditic body image would have become free of conflict. The question "Am I a man or a woman?" would then have been answered; her insecurity regarding her identity, which was continuously reinforced by her stigma, would have been eliminated; and self-image and physical reality would then have been in agreement. It was impossible for her to maintain her unconscious fantasy that she was a man, however, in view of her female genital. A virile stigma does not make a man of a woman. Regressive solutions, such as reaching an inner security despite her masculine stigma by identifying herself with her mother, revitalized old mother-daughter conflicts and led to a variety of defensive processes. All of her affective and cognitive processes were marked by ambivalence, so that she had difficulty, for example, deciding between different colors when shopping because she linked them with the qualities of masculine or feminine" (Thomä & Kächele 1994b, pp. 79).

Given the prevailing paucity of systematic descriptive data on psychoanalytic cases, we have to accept that the various studies performed on the specimen case of Amalia X refer to parts and aspects of the treatment only, and must eventually be integrated so that the relationships among them, and thus the case as a whole may be appreciated. Whether general conclusions can be drawn from our efforts remains an open question. Our principle conviction ultimately leading to the start of this enterprise was the credo that psychoanalysis—like any other scientific field—requires careful descriptive work. This necessary step in research was dubbed as the "botanical phase in psychotherapy research" (Grawe, 1988).

Luborsky and Spence's (1971) statement concerning the requirements for specimen cases spells out quite succinctly what is at stake here. "Ideally, two conditions should be met: The case should be clearly defined as analytic, and the data should be recorded, transcribed and indexed so as to maximize accessibility and visibility" (p. 426). The first condition has been met as well as possible, given the existing epistemological problem that there is no consensually-agreed definition of psychoanalytic process, by virtue of the fact that a reasonable number of colleagues considered this case as being truly 'analytic'. The treating analyst had a high reputation in the professional community, although all analysts have to demonstrate the nature of their work in each and every case. Based on the results of studies, it can also be said in retrospect that the treating analyst conformed to the fundamental psychoanalytic rules extant during the seventies. Conforming to a specific method should not be confused with abiding a law. Rather, we share the view of Gabbard and Westen (2003) that the process should be conducted according to the principle of trial and error. Our stand on this issue remains exclusively within the professional community.

The second condition formulated by Luborsky and Spence (1971) is fulfilled by the utilization in our studies of the Ulm Textbank (Mergenthaler & Kächele, 1988), in which audio recordings of 517 sessions of this psychoanalytic case are stored and kept available for investigation by members of the scientific community. Through many years of work, more than half the sessions of this case have been transcribed according to the rules of the Ulm Textbank (Mergenthaler & Stinson, 1992). Most of our investigations would not have been possible without these audio recordings and verbatim transcripts of dialogue.

We would like to emphasize the value that audio recordings create for the realisation of empirical analytic studies of treatment-reports and interdisciplinary research. The accessibility of psychoanalytic dialogue, and the investigation of it by psychoanalytic researchers in collaboration with psychologists, linguists, or other independent scholars, strengthens the interdisciplinary foundation of psychoanalysis. In the past, too often scholars wrote about psychoanalysis without having access to its primary data—a situation that may be compared to discussing of the philosophical ideas of Socrates without actually having read the Platonic dialogues.

The Empirical Approach: A Multi-Level Observational Strategy

Our long-term aim has been to establish ways of systematically describing the various aspects and dimensions of the psychoanalytic processes, and to use the descriptive data obtained in this way to examine process hypotheses. This entailed the generation of general process hypotheses as well as the specification of single case process assumptions. Specifying how a psychoanalytic process should unfold must go beyond general clinical ideas by considering the kind of material brought forth by each patient and the strategic interventions most appropriate to achieving change in the dimensions of theoretical relevance specified for each particular case. Although our approach excluded the use of non-clinical measures to limit the intrusions on the clinical process[18],

independent psychometric pre-post outcome and follow-up data were used to assess the effectiveness of the psychoanalytic treatment, and have been published in the second volume of Thomä and Kächele (1994b, chap. 9.11.2).

Our methodological approach distinguishes four levels of case research, each working on different material studied at different levels of conceptualization (Kächele & Thomä, 1993). These are: clinical case study (level I); systematic clinical description (level II); guided clinical judgment procedures (level III); linguistic and computer-assisted text analysis (level IV). Following Sargent's (1961) recommendations, we chose this multi-level strategy based on our understanding that the gap between clinical understanding and objectification cannot be meaningfully bridged by using only one approach.

The account of this unique single case study has been summarized elsewhere (Kächele et al. 2006;); the details on the manifold aspects of the work can be found in Kächele et al. (2009). In view of the paucity of thorough clinical-empirical studies of psychoanalytic cases Werbart (2009) in his careful review expressed the opinion that this work represents a major step in devising a methodology of sound empirical research into the process of analytic treatments. First by demonstrating that it can be done, and then by showing how it can be done, given sufficient dedication and institutional support. Psychoanalytic treatment can be made the focus of objective and methodologically sophisticated research, leading to findings and discoveries that cannot be made by the treating analyst alone. The clinical perspective of the treating analyst is essential but is necessarily limited by his or her role as a participant observer of the analytic process. Supplementing this, formal systematic research opens the way to independent understandings of the mechanisms of change in psychoanalysis.

The studies of our specimen case not only support the notion that this analytic treatment led to considerable change in many aspects of the patient's cognitive and emotional functioning, but also demonstrate the usefulness of micro-analytic research techniques that help to identify and conceptualize change processes. The number of descriptive dimensions that are possible and necessary to describe these changes is not small. However, one conclusion can safely be drawn from the studies of our specimen case, which is that change processes exist and can be demonstrated by research methods that are reliable and valid. Both the process of change in psychoanalysis and in the patient's basic psychological capacities take place all along the way, and it is often but not always the case that they can be described in terms of linear trends along the continuum of the treatment.

The case of Amalia X is one of the most intensely studied, perhaps the most intensively studied, of all specimen cases. Almost all of the process hypotheses tested were significant, thereby providing support for the underlying conceptions of psychoanalytic treatment that guided the studies. Although this substantiation is valuable, it is also of interest to consider the limitations of the studies. Except for the hypotheses relating to Amalia X's improvement in acceptance by others, which were not confirmed, in all other instances we found what we expected to find. Whether this may be read as an expression of a investigator allegiance (Luborsky et al., 1999) remains open. Fact is the transcripts raw data are publicly available and any one is invited to check our findings. In any case the implication is that we need to develop and to address further innovative questions.

Also we did not come away from this array of studies with really new, convincing ideas of which were the most important mutative factors in her substantial improvement. Although momentary affective patient-analyst interactions may have mutative effects, we have concluded that a long-term view of the course of treatment is essential to identify structural changes in the patient. This emphasizes the extraordinary complexity of attempting to delineate the causes of mutative effects, and reinforced the need for humility in approaching such endeavors. Often the analyst's uncertainty

is defended against by compensatory feelings of knowing all about analytic treatment, or, as Jonathan Lear (1998) terms it, "Knowingness."

Having said that, we would like to assert that in the domain of examining mutative factors specifically in psychoanalytic treatment, that single case research has certain advantages compared to group studies. Conversely, in regard to assessment of therapeutic benefit, that group studies seem advantaged. Indeed, group studies seem to have solidly established the efficacy of psychoanalytic treatment (Leichsenring & Rabung, 2008; de Maat et al., 2009; Levy et al. 2012; Zimmermann et al. 2015).

Open Questions

Any attempt to study mutative factors in psychoanalytic treatment in particular must deal with the unresolved epistemological problem that there is no consensually-agreed definition of "psychoanalytic process." This is so vexing that it has been dealt with largely by denial of the existence of the problem. For example, the definition of psychoanalysis used by de Maat et al. is: "the patient lies on a couch, and there are at least three sessions a week" (p. 2). As Gill has argued, these external criteria are insufficient. It is noteworthy that although the outstanding attribute of contemporary psychoanalysis is the diversity of theory and praxis, we know of no attempt to substantiate the characterization of a treatment as psychoanalytic that included psychoanalytic reviewers who were diverse in orientation.

As we have demonstrated single case research allows for a number of research methodologies to be implemented in order to conquer the universe each individual analytic couple represents. "The careful scrutiny of the psychoanalytic process through concurrent use of multiple methodologies has created a comprehensive reference text that clinicians can use to improve their understanding of the mechanisms of change", comments Fonagy (2009) on the full length account of this research enterprise.

We would like to encourage other research groups to single out a carefully documented, tape-recorded case and zoom into the various dimensions. We want to encourage other psychoanalysts to open the privacy of their clinical work in the endeavour to improve clinical work by allowing others in the scientific community to carefully scrutinize their work. We recommend the training of researchers who are also trained as clinicians, and the training of clinicians who are also trained as researchers, so that they may learn to identify with both the clinical and research tasks. We need analysts and researchers with the ability to support long-term commitment to making slow but cumulative progress. Systematic investigations are dependent on teams supported by institutions which promote cooperation between analysts in practice and full-time researchers. Implementation of such research will help to move psychoanalysis creatively beyond its contemporary crisis.

Chapter Fifteen

Toward a Science-Based Conception of Psychoanalysis

Abstract

This chapter is courageous in its attempt to sketch a science-based conception to secure the future of psychoanalysis not only as a profession, but also as a science.

In a way it summarizes the gist of our critical outlook on many clinical issues in present-day psychoanalysis.

> "That nothing ought to be admitted as true, but that which has been proven by good and solid reasons" (Young Spinoza's maxim, Stewart (2006), p. 28).

Introduction

Our rationale for the need of a major reconceptualization of clinical psychoanalysis includes the following. Diversity of analytic views and of clinical inferences, which cannot be resolved by dialogue, reflect fragmentation of the field of clinical psychoanalysis. The absence of any consensually agreed definition of psychoanalysis creates an epistemological problem which prevents assessing the validity of clinical inferences from "analytic process." Without determining whether a treatment is psychoanalytic psychotherapy or psychoanalysis, measuring by numerous scales aspects of patient-analyst interaction remains futile. Given the uniqueness of each dyad, studies of mutative factors would best be done in each dyad separately utilizing empirical single case studies. The training analyst system, based upon a clinical conception of psychoanalysis that excludes formal analytic research, needs to be reconceptualized. We propose that the leadership of psychoanalysis be shared equally between clinicians and researchers so a cadre of researchers can be developed who can bring empirical data to bear on the many unresolved psychoanalytic questions.

Diversity of Analytic Views of Clinical Case Histories

Case histories, especially Freud's, have been the bases of psychoanalytic theory and practice for more than 100 years. Kantrowitz (1993a) noted that numerous analysts had acknowledged the effects of the analyst's transferences and character on the patient, thereby shaping case histories. Seitz (1966) demonstrated long ago that, perhaps due to the analyst's personality and/or orientation, senior analysts could not agree on formulations relevant to the conduct of a case. This was confirmed in Pulver's (1987a) demonstration that an analyst's theoretical formulation profoundly impacts on his thinking about patients and the way he works with them. Silverman, an adherent of structural theory, presented a short summary of his patient's history, the course of the analysis to date, and process notes on several consecutive sessions. The material was discussed by four original panelists and then by commentaries from additional analysts.

> Brenner, a representative of the structural viewpoint, regarded the patient's angry stance as a defense against her sexual feelings out of fear of her mother's displeasure and retaliation. Burland, a child analysts with a strong background in separation-individuation theory, saw the patient as suffering from pre-oedipal character pathology; her oedipal love for her father was undercut by her helpless rage and passive yearnings. Goldberg, a self psychologist, thought the patient felt misunderstood, reliving that feeling with the analyst who imposed a personal set of theoretical ideas upon her. Mason, a Kleinian, saw the patient demonstrating a reverse Oedipus complex in which she wishes to mate with her mother and defeat and replace her father. Levenson, representing the interpersonal viewpoint, proposed that the therapist-patient field should be the focus for the reenactment and re-experiencing of the current manifestations of the patient's cardinal issues. Lichtenberg represented the developmental perspective; he examined the patient's main problems and contrasted a variety of possible dynamic formulations of them. McDougall uses the theater as a metaphor and relies heavily on insight. Modell, reflecting the object relations viewpoint, asserted that the patient's main issue was narcissistic rather than oedipal. Gill emphasized that the patient portrays herself as misunderstood and imposed upon by others and she experiences the analyst as misunderstanding and imposing himself upon her. Finally, Schwaber urged that we need to attune to new cues from the patient that may tell us if we have unwittingly superimposed our view and used our theory to justify doing so.

This demonstration of the powerful impact of the analyst's viewpoint on the treatment was replicated in a study by Streeck (1994). Quinodoz's (2006) report also exemplifies the influence of different viewpoints.

> Quinodoz treated a single woman in her forties and inferred that the patient was unconsciously reproducing in the transference-countertransference relationship sadomasochistic impulses. Davies (2006) shared his view, agreeing that the patient was experiencing the analyst as the abuser. Schwaber (2006), however, questioned this inference; she saw the relationship differently, arguing that rather than inferring unconscious meaning toward which we try to guide the patient, it would be more fruitful to seek to learn what may not yet have been recognized.

Differences in analyst's orientation so impact upon their formulations of clinical case reports that basic inferences and tenets have not and cannot be substantiated.

Such differences in analytic viewpoints do not seem resolvable by dialogue. A recent effort by Gediman (2006a), a Contemporary Freudian, specifically to reconcile different analytic viewpoints was entirely unsuccessful.

> Gediman tried to demonstrate through her case material that apparent contradictions between Contemporary Freudian and Relational viewpoints are based on caricatures of each viewpoint and are spurious. The commentaries of the Relational analysts and Gediman's responses made abundantly clear that neither Gediman (2006b) nor any of the relational analysts showed any evidence of having modified their distinctive views as a result of the dialogue.

This example confirms Westen and Gabbard's (2002a) conviction that given the complex emotional roots of our analytic beliefs and our investments in those beliefs, intellectual discussions exert little effect: "As a method psychoanalysis provides a poor method for testing hypotheses, as is apparent to anyone who has tried to convince a Kleinian that he should be a Freudian, or vice versa, based on 'the data of clinical observation'" (p. 57). Hopefully, relevant empirical data may have a greater influence.

Is this impressive diversity of contemporary psychoanalysis a sign of vitality of psychoanalysis or of fragmentation? If it were a reflection of the former, there should be corroborating signs such as increased status and prestige of psychoanalysis, increased market share of analytic patients, increased number of applicants for psychoanalytic education, and growth in the American Psychoanalytic Association. Unfortunately, the opposite is the case, which is consistent with the notion that the diversity reflects fragmentation.

Clearly, analysts with varying viewpoints all may produce excellent therapeutic results (Pulver, 1987b). Schachter (2005a) documents this in a book he edited containing seven detailed case histories of successful analytic treatments by analysts varied in analytic persuasion, gender, nationality, and sexual orientation. The range from the traditional analyst, to the self-psychological-relational analyst, was bridged by five others exhibiting varying degrees of eclecticism. Differences in technique, especially in the use of interpretation were striking, but all patients improved impressively. These findings underscore our position that the effective ingredients of psychoanalytic therapy rarely are a function primarily of the theoretical perspectives of the individual analyst, but reside instead in aspects of their competence, proficiency and personality (Luborsky et al. 1985).

Reliability and Validity of Case History-Based Analytic Inferences

Psychoanalysis, historically based on case histories, has failed to establish the reliability of clinical analytic inferences derived from those case histories. Westen (2002a) discussed the inherent limitations of the most accurately presented case material: "lack of replicability, lack of reliability of inference, lack of control over variables that would allow causal inference, and unknown generalizability" (p. 883). In the absence of reliability, there are no agreed-upon phenomena or inferences whose validity can be assessed; reliability is a prerequisite for examining validity. Fonagy, Roth and Higgit (2005a) argue that development of analytic outcome research will require a shift in epistemology on the part of psychoanalytic therapists, including "adopting a scientific attitude that celebrates the value of the replication of observations rather than their uniqueness" (p. 45). The necessity for reliability applies equally to the empirical single case studies.

In addition, we hold that validity does matter, despite disagreement by Mitchell (1998), Michels (1999) and hermeneuticists. We believe that to understand why and how an interpretation, - or any other intervention – has a therapeutic effect, we need to understand its validity, i.e., its veridicality (Eagle and Wakefield, 2004; Friedman, 1996), complementary to its practical utility in attaining the desired effect (Thomä and Kächele 1994a, p. 364). The capacity to sense what's in the other person's mind develops in infancy with the aid of mirroring (Wolf et al. 2000) and plays an essential role throughout life in interpersonal interactions. The analyst's irreducible subjectivity (Renik, 1993a) which forms part and parcel of any intervention, however, makes any formal judgment about the truth of what was in the patient's mind or what actually went on between patient and analyst, extremely difficult and perhaps impossible for the analyst himself/herself to determine in an ongoing treatment. Therefore, [analytically] trained observers – as in other sciences – using both patient and analyst material, are best equipped to make a reasonably reliable judgment about the reality of what

was in the patient's mind or the reality of the interaction - hence the need for treatment focused research.

Eagle and Wakefield (2004) assert that "to give up any claim to truth would be to openly acknowledge that suggestion is at the core of all these "narratives" (p. 352). They add that "truth is valuable in its own right and it is unacceptable to purchase mental peace at the cost of living a lie" (p. 352). We disagree with their dichotomization that truth is the *only* acceptable form of helping patients. We are uncertain whether truthful interpretations are *necessary* for successful treatment, but we are convinced from the sophisticated field of treatment research (Lambert and Ogles, 2004) that truthful interpretations are not *sufficient* for successful treatment. We conclude from that body of research that, *in addition* to truthful interpretations, that age old healing interventions such as explicit support, consolation, suggestion and advice (Schachter and Kächele, 2007) may contribute to helping the patient.

Evaluating Whether a Causal Interpretation is Valid

Is there any evidence that an analyst's causal interpretation was correct? No, other than post hoc ergo propter hoc, which fails as evidence. The causal hypothesis is not testable. Most likely, as we shall argue, individual interpretations never are testable in the strict sense of the word. Interpretations are tools within a complex therapeutic armentarium that contains more than interpretations (Kächele 1994a). We agree with Marmor (1986): "No serious scientist today would assert that the success of any therapeutic method constitutes proof of the correctness of the theory on which the therapeutic technique was based" (p. 249). Grünbaum (2006) refers to this form of argument as the "fallacy of crude hypothetico-deductive … pseudo confirmation" (p. 270).

Consider hypertensive disease. Hypothetically, assume that hypertension is

maintained primarily by the interaction of three factors, salt sensitivity, autonomic nervous activity and vascular reactivity. Altering anyone of these - a salt-free diet, a lumbar sympathectomy, or pharmacological blocking agents - may alleviate the disease, but we can't conclude that the therapeutic factor identifies the cause of the disease. For example, even though the salt level before treatment had been normal, lowering the salt level may reduce the hypertension. Therefore, we can't conclude that because salt depletion had a therapeutic effect, we'd proved that excess salt was the cause of hypertension. Mental and emotional symptoms, like diseases, are usually a function of complex, multiple systems; a unitary therapeutic factor is unlikely to have identified their causes.

Rapaport (1960) quoted by Wallerstein, 2006) echoed the same sentiment: "There is [as now] no established canon [in psychoanalysis] for the interpretation of clinical observations" (p. 113). The problem persists to this day. Grünbaum (2006) reiterates his arguments "that the principal tenets of the Freudian corpus, which are causal, have not been validated even a century after their enunciation" (p. 258). We distinguish between validation of basic theoretical statements, (like the theory of defense, #Kline, 1981, 2004) and theories about clinical practice. Ahumada (1997) asserts that "for analysts transference is an observational fact; for Grünbaum it is not" (p. 522). Implications of the fundamental epistemological critique of much of current psychoanalytic clinical writing is the focus of this, our paper.

Confidence in the analyst's experience generates plausibility, the mainstay of clinical work; but plausibility is not enough, since throughout history many eminently plausible theories - that the earth is flat - have been abandoned after events or scrutiny reveals their lack of validity. A few well-known, specific examples of case-history-derived analytic theories and inferences that have been found wanting and discarded include: the Lamarckian inheritance of "racial memory" (Hoffer,

1992), the theory of infantile omnipotence (Stern, 1985), the centrality of penis envy (Dahl, 1996), and the conception of homosexuality as intrinsically psychopathological (Friedman, 2002).

Measurement of Psychoanalytic Process

We assert that to hunt for measures of pure *psychoanalytic process is misleading,* as numerous reliable measures of patient-analyst interaction display enormous variability about what analyst call a psychoanalytic process – it seems more sensible to accept that psychoanalytic processes are constituted by the use of core constructs (Perry and Cooper, 1986; Luborsky and Crits-Christoph, 1998; Waldron et al., 2004a,b; Ablon and Jones (2005); Porcerelli et al., 2007). As there is no *independent criterion* attesting that a given treatment is psychoanalysis, the measures of patient-therapist interaction may measure just degrees "analytic process". Empirical case studies of analytic treatment have relied solely upon the fact that the therapist was a psychoanalyst to substantiate that the treatment was psychoanalysis. Sandler´s solution that every treatment by a IPA-qualified psychoanalyst could be called psychoanalysis is not a scientific statement but rather a political one. A scientific approach could be to identify the presence or absence of core processes - like work with the transference - and measure the degree in treatment across sessions from beginning to end.

After the Certification Committee in 1977 required that applicants for certification demonstrate "analytic process" in their case write-ups, there have been numerous attempts to develop a consensually-agreed definition of "analytic process," and all have failed. In addition, an empirical study concluded that analysts could not reliably assess "analytic process," and questioned whether "analytic process" was a meaningful conception (Vaughan et al. 1997). Blatt (2005) notes that "this lack of agreement about such a central construct creates serious problems for contemporary clinical practice, training and research" (p. 569). He suggests that "the definition of a treatment as psychoanalytic … must be based on whether the interaction between patient and therapist facilitates the patient's exploration of unconscious processes" (p. 575). We don't know how many contemporary psychoanalytic schools would agree with that definition. Our failure to define psychoanalysis and to have consensually-agreed, independent criteria for psychoanalysis remains a serious, unsolved epistemological problem for psychoanalysis.

Defining Psychoanalysis: The Epistemological Problem and Its Consequences

Our climate of unsubstantiated, conflicting, fundamental theories and practices calls for an attempt to define psychoanalysis. The title of Friedman's paper "What is psychoanalysis?" implied that he would provide some definition. Instead, he ridiculed the question: "What is psychoanalysis - indeed! A tired old useless question is what it is, right?" (2006, p. 688). Instead of addressing the question, he devoted his paper to revisiting the history of psychoanalysis. However, the query, "What is psychoanalysis?" does not go away and our difficulty providing a satisfactory answer has both causes and consequences worth considering. One cause we have tried to demonstrate is the long-term reliance on case histories as the source of unsubstantiated analytic theories and inferences. One consequence is that criticism of our own analytic theories threatens our sense of personal identity as psychoanalysts and renders practitioners defensive about their own particular set of analytic beliefs and mode of clinical functioning.

Psychoanalysis, with theories and practices generating thousands of case vignettes, all lacking independent agreement among analysts, has evolved so that formerly held fundamental tenets are inconsistently applied and definitions are increasingly unclear. Consequently, its once assumed uniqueness has been blurred, leading to Wallerstein (1995c) speaking of multiple versions of psychoanalyses. More and more it is difficult to distinguish these versions from psychoanalytically

informed therapies. The editors of the "Open Door Review of the Outcome of Psychoanalysis" of the IPA Research Committee have wisely refrained from drawing distinctions (Fonagy et al., 2001). To those whose identity as a psychoanalyst is a powerful organizer of self, it may feel necessary to maintain the categorical distinction of psychoanalysis, psychoanalytic psychotherapy and supportive psychotherapy but from a researcher´s vantage point it seems appropriate to conceptualize only quantitative differences, i.e., they differ in degree not kind, and to use the term "psychoanalytic therapies "as a generic term encompassing the diverse brands (Thomä and Kächele, 1994a; Wallerstein 1995; Kächele, 2010). This approach to a definition to the broad range psychoanalytic treatments renders it unnecessary to distinguish psychoanalytic treatment from psychoanalytic psychotherapy.

Pursuing this stubborn epistemological problem leads to a surprising place. The most sophisticated approach to this problem was that of Ablon and Jones (2005) who asked 11 senior analysts to complete the Psychotherapy Process Q-set for what they conceived was an ideal psychoanalytic session. The analysts were able to do so reliably, and the factor scores calculated from their responses weighed most heavily when applied to psychoanalytic treatments, less heavily to long-term psychodynamic treatments, and least heavily to brief psychoanalytic psychotherapy. The most heavily weighted single factor was "Patient's dreams or fantasies are discussed," and the next most heavily weighted factor was "Analyst is neutral," which suggests that this group of 11 analysts may have been traditional in orientation. Analysts of different orientation might well have created different factor scores for an ideal psychoanalytic session.

Their most striking finding was that applying these factor scores to two real presumed psychoanalytic treatments *revealed different factors in each of the treatments*. They concluded that "each patient-analyst pair had a unique and distinct pattern of interaction, and that these patterns were very likely related to treatment outcome" (p. 565). Kantrowitz (1993b) had observed the uniqueness of therapeutic dyads, commenting that the uniqueness of the patient-analyst interchange is true for both the analyst and the patient. Ablon and Jones' conclusion about uniqueness was empirically-based. Thus, for treatment presumed to be psychoanalytic, not only does one size not fit all, but mutative elements in each dyad are probably unique. The Q-Sort study of the German specimen case, Amalia X, identified two different sets of typical features comparing initial and terminal phase of treatment, which speaks to the relative weight of these features depending on the state of "analytic work" during treatment (Albani et al. 2000).

This empirical observation about uniqueness raises questions about treatment. To what degree are there standard principles that are considered psychoanalytic that can be applied to all or many or some patients in unique dyads? Freud had proposed that psychoanalytic treatment should be standard for all patients because he wanted psychoanalysis to be a scientific enterprise in order to discover the cause of neurosis. To achieve scientifically acceptable conditions, he tried to use a standard format with all patients to guard against the possibility that his suggestion might influence the patient. The possibility that suggestion was operating was a concern of Freud's throughout his life; treatment must avoid anything related to the suggestion of hypnosis, an unscientific treatment. To protect the scientific nature of treatment, the scientist-analyst must be objective, neutral, and anonymous, within an atmosphere of abstinence with all patients. In 1918 he had told one of his patients, Abram Kardiner, American anthropologist/psychoanalyst, that he, Freud, was interested in theory, not therapy (Kardiner 1977). Without rancor, Kardiner reported that at the end of his six-month analysis with Freud, during which childhood experiences had been reconstructed, Freud advised him to work out the implications of these childhood experiences for his adult functioning on his own after termination. Freud's focus on the etiology of neurosis was in the service of discovery, not of therapy.

Freud, unable to obtain an academic appointment in Vienna, needed to earn a living while pursuing the etiology of neurosis. This problem was resolved when he hypothesized that identifying the etiology of a patient's neurosis would be therapeutic, a view that has been accepted for more than 100 years despite the fact that according to Grünbaum (1984) and others this has never been empirically validated. Recognition that mutative factors are most likely unique in each dyad suggests that it is unlikely that standard etiological oriented examination is therapeutically beneficial to all patients. We need to test empirically whether identifying etiological factors in neurosis is therapeutic for some patients, and, if so, which patients.

We have argued that in regard to therapeutic benefit that there was no evidential basis for the standard conditions of psychoanalytic treatment, namely, that the analyst be neutral, anonymous and to keep the patient in abstinence (Schachter and Kächele, 2007). Therefore, we have urged that the analyst be free to deviate from standard treatment by supplementing interpretations and other analytic interventions with age-old interventions in the ancient art of healing, specifically, providing explicit support, consolation, encouragement and even advice.

Empirical single case studies are the most appropriate venue for delineating mutative factors in treatment. Group studies, which lump together the varying mutative factors of the individual patients, are less likely to be useful in this particular regard. It would be possible, for example, for analyst/observers to review tape recorded material from one dyad for perhaps the first year of treatment, interview patient and analyst, and develop hypotheses about mutative factors. These hypotheses could be tested in the remainder of the treatment using a combination of existing scales plus specially designed scales.

Since different psychoanalytic schools cannot reach agreement in defining psychoanalysis and since it is likely that each dyad is unique, it becomes more understandable that Friedman dismisses the question of the definition of psychoanalysis as a useful inquiry.

Validation of Particular Psychoanalytic Hypotheses

We acknowledge that certain psychoanalytic hypotheses have been empirically confirmed. Westen (1999) concludes that there is overwhelming empirical substantiation of the psychoanalytic hypothesis that much of mental life is unconscious. Confirmation at this level of generality, however, fails to resolve conflicting theories and practices of different "schools" of psychoanalysis. Westen himself concludes that because certain thoughts and feelings can be inaccessible to consciousness that clinical work depends on the art of interpretation. Summers (2006), agrees, asserting that "If other techniques are employed without interpretation, the process remains on the psychic surface, and the analytic process is lost" (p. 336).

Opposition to Psychoanalytic Research

Before proposing a science-based conception of psychoanalysis, we want to acknowledge those philosophers and psychoanalysts who believe that psychoanalysis is not a science and cannot become a science, but is one of the humanities. Among those who feel that psychoanalysis should abandon evidential pretensions are Wittgenstein and Rorty (Ahumada, 2004, p. 584). Although acknowledging that empirical studies of psychoanalysis can be conducted, some analysts, citing the extraordinary difficulties involved, believe the results likely to be of little value to clinical psychoanalysis, (Green, 2000), or may well be damaging; Perron (2006) cites a French study of evidence based treatments (INSERM, 2004) which does "a disservice to psychoanalysis" (p. 929). Cruz Roche (1989) argues that applying the methodology of the natural sciences "confers an air of precision and rigor, but in fact what is happening is a flight from the very subject of psychoanalysis"

(p. 344). Bose (2003) urges utilization of "different discursive methods than those of scientific quantification or scientific experimentation – methods more akin to those of the humanistic disciplines and the arts" (p. 584). In the United States a questionnaire study of analysts' attitudes toward reading psychoanalytic research papers suggests some roots of these negative attitudes toward research. Results showed that analysts with the most intense convictions about their analytic beliefs were the least interested in reading about analytic research (Schachter and Luborsky, 1998). The authors hypothesized that analysts with the strongest analytic convictions had the greatest concerns that analytic research might raise questions about or criticisms of their analytic beliefs and therefore they had the least interest in analytic research.

Leupold-Loewenthal (1978) suggests that psychoanalysts feel like outsiders, excluded from the scientific community, respond with feelings of isolation and contempt for those who marginalize them and attempt to make psychoanalysis "very special" if not superior to the other sciences.

This long, intense debate will be acknowledged briefly by referring to Wallerstein's (2006) detailed criticism of those who regard psychoanalysis as one of the humanities, the hermeneuticists. He emphasizes Grünbaum's (1984) critique of Habermas' (1971) argument that only the patient has the required privileged access to the ultimate validation or refutation of psychoanalytic hypotheses (see in the same vein Thomä & Kächele 1975). If this were indeed so, Wallerstein observes, it would constitute a radically different epistemological base than that of other sciences which rest on observation by trained observers. Grünbaum disagrees with Habermas, asserting that analysts can and do interpret against the patient's judgments and in the face of his or her denials. We know that an ingratiating, compliant patient may judge as true an incorrect interpretation, and an angry, rebellious patient may reject as false a correct interpretation. Eagle (1980) argues that hermeneutics fails to provide a way to resolve differences in clinical inferences by different analysts. Wallerstein concludes that since science is not defined by its subject matter but by its method it is in no way enjoined from dealing with unconscious feelings, meanings, qualities or unique individuals. We just have to find ways to do so.

Our valuing empirical investigations of psychoanalysis is supported by the fact that it optimizes the likelihood that surprising findings may emerge. While analysts rarely report in case histories being surprised by anything that emerges in clinical treatment, the Menninger study (Wallerstein, 1986a) produced the surprising finding that supportive intervention style produced therapeutic benefits that were as extensive and long-lasting as traditional, interpretive intervention style. However, this outcome may have been influenced by the different levels of experience of the therapists treating the two groups. Nonetheless, one hundred years of clinical work failed to identify such a finding; it emerged in the Menninger study because systematic, empirical observations were made.

The Menninger conclusions, are what Kernberg (2006b) had in mind, when he noted that anti-empirical French psychoanalyst Perron "leaves aside the most important object of research, namely, the discovery of new aspects of reality, the advance of our knowledge beyond confirmation or disconfirmation of established theory" (p. 936).

Contemporary Psychoanalytic Research

To summarize the present state of formal psychoanalytic process and outcome research in greater detail is beyond the scope of this communication. However depending on one´s view the glass is half or half empty. Without question we have seen considerable progress in evoking some concerted efforts to tackle the issues that had been set out fifty years ago in Kubie´s (1952) discussion of "problems and techniques of psychoanalytic validation and progress".

The report on the Ulm conference on "Psychoanalytic process research strategies" (Dahl et al. 1988) opened the arena for systematic process studies. The continous efforts of Sandler, Wallerstein and Kernberg als IPA-presidents created the IPA research committee sponsoring systematically the transmission of research knowledge to younger colleagues. One of the outcomes were the IPA sponsored training seminars, successfully chaired by Fonagy, generating an up to then unknown degree of enthusiasm which however constantly was in danger of being financially curtailed. The most recent "firm and encouraging sign of the laudatory impact of earlier poster session" was noted by Hauser in his introduction to the fifth annual poster session (Hauser 2006b). He sees a "critical mass of contributions" and recognizes the particular relevance of such studies to psychoanalytically oriented practitioners, scholars and researchers" (p.1300). Most investigators, he writes, that the narratives reports cannot themselves systematically resolve the daunting problems as how to identify the explicit basis of clinical decisions; how to determine the processes underlying clinical phenomena, how they can modified, and the best fit of specific patients with appropriate therapies; and how to evaluate therapy outcomes and the effectiveness of particular therapies"(cit. p. 1300). This statement is a strong endorsement of the goals of the international Society for Psychotherapy Research (SPR) where all this aims have been the very reasons for establishing it many years ago.

Alas the number of senior scientist performing these kind of formal studies is small. Name a few and you have named them all: f.e. Ablon, Bateman, Blatt, Bucci, Dahl, Fonagy, JoneS, Kernberg, Krause, Leuzinger-Bohleber, Luborsky, Luyten, Sandell, Spence, Strupp, Szecsody, Target, Taylor Waldron, Werbart, Westen are the key players; hopefully a younger generation will step in and follow their examples. The salient issue resides in the question: what has the impact of these wonderful researchers on the routine practice been? They have been successful in creating innovative research paradigms; but the issues remains: not only how to close the gap between positivism and hermeneutics in psychoanalytic research? (Luyten et al. 2006). But even more relevant how the transmit, how to implement into clinical practice what has been demonstrated by research (Talley et al. 1994).

Clinical Leadership of Psychoanalysis

Despite Freud's lack of intrinsic interest in analytic treatment as therapy, his derivative interest in the service of etiological theory placed clinical analytic work at the pinnacle of psychoanalysis. Subsequently, throughout most of its development, clinicians have constituted the elite leadership of psychoanalysis. These clinical leaders promulgated guidelines for psychoanalysis on the basis of their own unsubstantiated clinical inferences from their case histories or treatments they supervised. Following Freud, these clinicians showed little interest in, or disparaged, analytic research. With treatment successes during World War II, augmented by the influx of European analysts, psychoanalysis grew dramatically in the United States and flourished during the 1950's and 1960's. There was then no reason to question the role of clinicians at the helm of psychoanalytic organizations and literature.

During the following 1970's and 1980's, however, psychotropic medications as well as competing psychotherapeutic treatments, and changing insurance coverage, all began to diminish the status and prestige of psychoanalysis, as well as its market share of patients. Diverse "schools" of psychoanalysis have developed and expanded in the past thirty years. The conflicting theoretical positions and power of new "schools" led, for the first time, to questions about the theories and practices as well as about the effectiveness of the clinicians' leadership. It's reminiscent of an earlier evolution of religious faith: "The bewildering diversity of religious faith arising out of the Reformation ... produced a crowd of new conceptions of the deity, none of which seemed to get

along particularly well with the others; and this fact in turn stimulated much theorizing concerning their similarities and differences" (Stewart, p. 157). Evidence that there were no longer consensually-agreed fundamental psychoanalytic beliefs, plus the loss of market share of patients, confronted practitioners with the possibility that psychoanalysis could no longer be categorized as a successful, vigorous profession (Schachter, 2005b).

Proposed: A Research-Oriented Core Conception of Psychoanalysis

As we share with many colleagues the belief in the intrinsic value of psychoanalysis and of psychoanalytic treatment. To aspire the status of an evidence based treatment, we propose that we need to change from a clinically-oriented to a research-oriented core conception of psychoanalysis. Teller and Dahl (1995) describe the requirements for scientific study in any discipline: "A thorough grounding in the relevant methodologies, familiarity with computational tools, and access to a standardized body of data" (p. 44). This paradigm shift would generate what Peter Galison (historian of science and Pellegrino University Professor at Harvard University) (L. Summers, 2006) calls a tools-based revolution in our science and might enable us to see things we never saw before. Many reliable research tools have been developed; we believe that the ideal psychoanalyst of the 21st century should be one who is as conversant with covariance as with countertransference, and comfortable using newly developed tools to examine the nature of the helping task.

To conduct valid studies, research minded analysts will use instruments that have been demonstrated to be reliable, and orient their efforts to develop new ones. A prime example of the fruitfulness of studying a psychoanalytic process with a multitude of instruments has recently been reported by the Ulm Study Group (Kächele et al. 2006; Kächele, Schachter & Thomä, 2009). We recognize that all instruments from Luborsky's CCRT, Bucci referential measures, Jones' and Ablon's Q-sort, Blatts scales for anaclytic and introjective personality dimensions among others, set constraints on the analyst's judgment. Apparently, the use of defined instruments selecting dimensions of the patient-analyst interaction is the necessary constraint to achieve reliability of judgments. Within those limitations, empirical tests of validity become possible. We can then examine, for example, whether the analyst's freedom to use interventions such as explicit support, consolation, suggestion and advice (Schachter and Kächele, 2007) or whether the analyst's personal spontaneity improves therapeutic outcome for certain types of patients - or fails to do so. Arguing about this and other issues on the basis of case reports without establishing the reliability of analytic inference is likely to continue to be fruitless. Case-control studies are one step and randomized control trials of treatment are feasible (Bateman & Fonagy 1999; Clarkin et al., 2007; Huber et al. 2012), though still beset by numerous problems (Westen, Morrison and Thompson-Brenner, 2004). Empirical, single case studies offer the most promise in the study of mutative factors.

We concur with Crews' (2006) assertion:

> The human race has produced only one successfully validated epistemology, characterizing all scrupulous inquiry into the real world, from quarks to poems. It is, simply, empiricism, or the submitting of propositions to the arbitration of evidence that is acknowledged to be such by all the contending parties. Ideas that claim immunity from such review, whether because of mystical faith or privileged "clinical insight" or the say-so of eminent authorities, are not to be countenanced until they can pass the same skeptical ordeal to which all other contenders are subjected.

"There can be few valid excuses for the currently thin evidence base of psychoanalytic treatment" scold Fonagy, Roth and Higgitt (2005, p. 44). Physicists, dealing with controversies about string theory, note similarly, "[n]ew ideas, some physicists complain, are a dime a dozen. What they crave is new data" (Johnson, 2006, p. 3).

Proposed: Psychoanalytic Leadership Should be Shared Equally by Researchers and Clinicians

Psychoanalytic clinician leaders have difficulty confronting much less resolving these epistemological and clinical differences or even agreeing on whether a world-wide crisis confronts psychoanalysis. Eizirik (2006), President of the International Psychoanalytic Association, avers that "the news about a so-called crisis in psychoanalysis contrasts strongly with our direct experience of dynamic reality" (p. 645). He urges that the consulting room should be given its central role "as the place where the future of our discipline will be decided" (p. 648). To whom might psychoanalysis turn for supplementary leadership? Given the need for empirical studies, we look to analytic and non-analytic researchers, collaborating with analytic clinicians, to make progress through empirical studies toward resolving some fundamental differences. This change from sole clinician leadership to an equal partnership of analytic researchers and analytic clinicians might provide each group with benefit from the ongoing interaction, and energize a focus on sound, empirically-based fundamental premises for psychoanalysis.

Assuming that learning to help patients effectively is the primary goal of psychoanalysis, then research focusing on clinical issues might attempt to delineate the critical mutative factors in treatment. As a subsidiary goal, important but still subsidiary, basic analytic research, in collaboration with other disciplines, might be directed toward exploring etiology and principles of human behavior.

This focus on therapeutic outcome identifies some fundamental, but still contentious, clinical questions amenable to empirical study. A short list includes: should the analyst adopt an essentially neutral stance vis-a-vis the patient, or should the analyst explicitly try to influence the patient? Is one approach effective with some patients defined by symptoms or character and not with others; what would determine optimal modification of approach during the course of treatment in either direction? When and with which patients is the use of the couch helpful or contraindicated, and, alternatively, when is a face-to-face model most useful? What is the role of frequency of sessions? When are non-therapeutic, post-termination patient-analyst contacts useful and when do they entail significant risk? It seems plausible that extensive, sophisticated empirical studies might provide answers leading to consensual agreement, and support positive aspects of our self-definitions.

This proposed substantial research enterprise requires a basic reorganization of our conceptions of psychoanalysis, beginning with psychoanalytic education. We need to create roughly equal opportunity for candidates to adopt either a research role model or a clinical role model. The highly controversial training analyst system, which links professional progression with the candidate's training analysis and thereby minimizes the likelihood of the candidate choosing a research role model, should be restructured. The candidate's personal analysis, widely regarded as the most influential portion of the educational program, should be de-linked to any connection with professional advancement. The candidate's personal analysis should be just that, a personal treatment with no connection with progression in the institute or with any aspect of professional advancement. The candidate's selection of a personal analyst should be entirely a personal choice not limited to designated training analysts, and, indeed, not limited to analysts associated with the candidate's institute (Thomä 1993; Thomä & Kächele 1999).

Training analysts, as a result of the requirements of the training analyst system, are almost always clinicians, who have adopted a clinical role model and personal values prioritizing the clinician. Analysis with such an analyst leaves little likelihood that a candidate will emulate a research role model rather than a clinical role model. Therefore, to provide some reasonable opportunity for the candidate to be attracted to a research role model, it will be necessary to revise the training analyst system.

The number of training analysts who have become researchers is very small. It may be fair to say that those few who have become researchers have done so despite the training analyst system rather than because of it, perhaps because of identification with an earlier research mentor, as is the case with one of the authors (J.S.).

All of the Fellows of the Board on Professional Standards (BoPS) which regulates education must be training analysts. BoPS has never required or even urged that institute curricula include courses on analytic research. (Recent New York State legislation detailing requirements for becoming a licensed psychoanalyst includes the necessity to complete a course in analytic research). It is our impression that only four of the 29 APsaA institutes include a cour5se in analytic research in their curricula.

Further, BoPS' test of "analytic competence," the certification procedure, which is prerequisite for training analyst appointment, consists of the detailed write-up of two analytic treatments. Research is not mentioned in the certification procedure, not even whether the analyst can read and understand an analytic research paper. Knowledge of analytic research has no place in BoPS' concept of "analytic competence." It is difficult to see how a cadre of researchers could be developed in such an educational system.

In addition, analytic researchers and analytic clinicians should teach *all* courses and supervision conjointly; due to the limited number of analytic researchers, psychotherapeutic researchers from allied professions might be called upon, to everyone's advantage. This transformation requires that analytic researchers receive the same respect, prestige and privileges as fellow analytic clinicians. Given an explicit rationale, candidates should learn research techniques as well as clinical techniques, while they engage in both research experience and clinical experience. Institutes should be actively engaged in research programs.[19].

In our professional organizations, too, researchers should be integrated as Directors and on various committees, especially those regulating programs and curricula. Only after overcoming the psychological and internal political impediments to these changes can we face the difficult problem in the United States of financial support for the development and maintenance of analytic careers that are completely or substantially devoted to analytic research.

Acceptance of our reconception of psychoanalysis involves acknowledging that psycho-analytic psychotherapy cannot easily be distinguished empirically from psychoanalytic treatment, and, therefore, that the teaching of psychoanalytic psychotherapy deserves to be an intrinsic part of the psychoanalytic curriculum. This modification would acknowledge the reality that currently, and indeed for the foreseeable future, most psychoanalysts will devote the bulk of their practice to psychoanalytic psychotherapy.

In conclusion, research knowledge and some research experience should be an intrinsic part of the concept of "analytic competence." If an analyst does not understand analytic research papers and therefore does not read them, how can the analyst keep up with current developments in psychoanalysis? Those developments are being created at a faster pace than ever before. As in other fields, there probably should be requirements for continuing education, and, in the public interest,

analysts should periodically be asked to demonstrate that they are keeping up with contemporary developments in psychoanalysis.

Is There a Crisis in Psychoanalysis? If So, How Shall We Respond?

Is there a crisis that calls for radical reformulation of the psychoanalytic enterprise? The number of patients in analytic treatment with APsaA analysts has been diminishing slowly but steadily for many years, and it is now estimated that the total number of analytic patients with all 3400 APsaA analysts combined is 6000. Eisold (2003a) declares that "psychoanalysis is a world in serious – perhaps terminal – trouble" (p. 558). Renik states: "The profession is in a great decline, and I predict the decline will continue" (Carey, 2006, P. f2). One reflection of the current status of psychoanalysis is indicated in this year's Lasker award, the nation's most prestigious medical prize, to Dr. Aron T. Beck for his development of cognitive therapy (Altman, 2006). Cognitive therapy "is one of the most important advances – if not the most important advance – in the treatment of mental diseases in the last 50 years," said Dr. Joseph L. Goldstein, the chairman of the Lasker jury who also noted that Dr. Beck set a new standard for determining the effectiveness of any type of psychotherapy by testing his radical new methods in clinical studies with a degree of rigor not previously applied to any form of talk therapy, including psychoanalysis. We psychoanalysts can simply continue along our present path with its downward trajectory (fewer analytic patients, fewer analytic candidates, aging analysts), hoping, like Mr. Macawber, that something will turn up.

Kernberg (2006b), who has called long and loudly for psychoanalytic educators to foster the development of psychoanalytic researchers, writes that even "if only 1-3% of all analysts in training became committed researchers, the field would be significantly better able to meet the challenges we currently face" (p. 924). We wonder whether this modest number, despite productive, creative work, would be able to deal with the magnitude of the task of assessing the fundamental tenets of psychoanalysis. A more radical re-conception of psychoanalytic education may be required to develop a full cadre of researchers who can organize teams capable of addressing the task.

We are under no illusion that our proposal to dramatically reorganize and restructure psychoanalysis has much likelihood of being implemented, although APsaA is in ferment in an intense, ongoing discussion of the training analyst system. We propose it because of our conviction *that the existing system is unable to cope with the exigencies confronting psychoanalysis and unable to reverse its diminishing status and prestige.* Some proposal is needed, and we have not yet conceived of an alternative. Perhaps the obstacles to our proposal will stimulate others to think of alternatives that are considered more feasible but equally promising.

Conclusion

We are impressed by and embrace Popper's (1962) assertion that knowledge grows by a process of falsification, that our most useful beliefs are not those that are most strongly verified, but those that have best survived criticism and refutation. We disagree, however, with his conclusion that psychoanalysis cannot be tested empirically; Grünbaum (1984) argues that in principle elements of psychoanalysis are falsifiable. We believe that there have been few serious attempts to refute the fundamental tenets of psychoanalysis and that the most compelling evidence of that failure is the fragmentation evident in the persistent diverse, conflicting views of the basic principles of psychoanalysis. The failure of dialogue to resolve these disagreements indicates that none have been falsified or rejected. We assert that only empirical research can provide an opportunity to falsify or refute axioms of psychoanalysis. Such refutation may provide optimal conditions for the growth and development of psychoanalytic knowledge.

In conclusion, we propose that if researchers and clinicians share the leadership of psychoanalysis, it increases the possibility of developing what Teller and Dahl (1993) have called for, a cadre of researchers to provide empirical studies that may lead to consensual agreement about the fundamental tenets of psychoanalysis. If this is judged not feasible, we need urgently to create an alternate, active proposal that is considered both more feasible and equally promising.

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Notes

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

We would like to thank Judith S. Schachter, M.D. for her thoughtful suggestions and skillful editing.

[2] We would like to thank Richard C. Friedman, M.D. and Judith S. Schachter, M.D. for their help and suggestions and Judith S. Schachter for her skillful editing.

[3] Leclaire (1968) analyzed all Freud's dreams from the 'Interpretation of Dreams' concluding that the pervasive use of the color yellow reflected Freud's ambitious urges.

[4] Although there were later allegations in the thirties that Jung was anti-semitic – which Jung denied – there is no evidence that this contributed to any friction between them.

[5] Kardiner (1977), an American anthropologist/psychoanalyst had a six month analysis with Freud in 1918. At its end, Freud advised Kardiner to relate the infantile fantasies they had uncovered to his current conflicts and concerns on his own! Both Ferenczi and Kardiner had probably read every word Freud had written about psychoanalysis before entering analytic treatment with him, shaping expectations of what would be found in treatment.

[6] A group of two or more people, in a workplace or other social environment, who routinely express considerable esteem and support for one another, sometimes to the point of exaggeration or pretense (Wiktionary)

[7] Schachter, J. & Kächele, H. (2010). The couch in psychoanalysis. Contemporary Psychoanalysis, 46, 439-459.

[8] We would like to express our appreciation to Judith S. Schachter, M.D. whose questions helped to shape this paper, and to Richard Friedman, M.D. whose criticisms were very helpful.

[9] Schachter J, Kächele H & Schachter J (2014) Psychoanalytic treatment of the elderly.

Psychodynamic Psychiatry 42 (1): 51-63

[10] Schachter, J., & Kächele, H. (2013). An alternative view of termination and post-termination follow-up. *Psychoanalytic Review, 100*(3), 423-452.

We are grateful to Richard C. Friedman, M.D. and Judith S. Schachter, M.D. for their helpful comments and editorial suggestions.

[11] Schachter J, Kächele H and Schachter J (2016) Peer group consultation, "Intervision" can help with troublesome analyst-transference. Psychoanalyic Dialogues, submitted

[12] Schachter J, Gorman B., Pfäfflin F. & Kächele H (2013) Comparison of vignette-based ratings of satisfaction with psychoanalytic treatment by training analysts and by non-training analysts. *Psychoanalytic Psychology 30 (1): 37-56*

This research was funded by research grant #140323 from the International Psychoanalytic Association to Joseph Schachter, M.D., PhD. We would like to thank Judith S. Schachter, M.D and Richard C. Friedman, M.D., for their thoughtful comments and editorial suggestions. We would also like to express our appreciation to Elliot Jurist, PhD., and to two anonymous reviewers whose comments and suggestions substantially improved this paper.

[13] Schachter J, Gorman BS, Pfäfflin F, Kächele H (2014) A questionaire/interview comparison of satisfaction with training analysis to satisfaction with analysis by a non-training analyst: Implications for training analysis. *Psychoanalytic Psychology 31(3): 367-374*

We would like to express our appreciation to Judith S. Schachter, M.D and Richard C. Friedman, M.D. for their thoughtful comments and editorial suggestions. Funded by a research grant #140323 from the International Psychoanalytic Association to Joseph Schachter

[14] Balint, 1954; Bibring, 1954; Nacht, 1954; Weigert, 1955; Thompson, 1958; Lewin & Ross, 1960; Szasz, 1960; Nacht et al., 1961;, Greenacre, P. 1966, Bernfeld, S. 1962, Kairys, 1964, McLaughlin, F. 1967, Arlow, 1972, McLaughlin, J.T., 1973, Friedman, L., 1974, Pfeffer, A.Z. 1974, Van der Sterren & Seidenberg, 1975; Schecter, 1979; Bruzzone et al., 1985; Hinshelwood, 1985; Kernberg, 1986; Stelzer, 1986; Lipton, 1988; Cremerius, 1990; Orgel, 1990; Thomä, 1993; Richards, 1997; Kächele & Thomä, 1998; Masur, 1998; Kächele & Thomä, 2000; Kernberg, 2000; Desmond, 2004; Reeder, 2004; Casement, 2005; Lothane, 2007; Meyer, 2007; Bezahler, 2008; Kirsner, 2009; Kernberg, 2010; Wallerstein, 1993; Wallerstein, 2010; Wilson, 2010.

[15] Updated version of Kächele, H., & Schachter, J. (2014). On side effects, destructive processes and negative outcomes in psychoanalytic therapies – Why is it difficult for psychoanalysts to acknowledge and address treatment failures? *Contemporary Psychoanalysis, 50*(1-2), 233-258.

[16] We would like to thank Judith S. Schachter, M.D., for her skillful editing and her helpful comments and suggestions.

[17] Since then we have completed a report on the second specimen case Christian Y (Kächele 2009); two more cases are to follow, Franziska X and Gustav Y.

[18] In the seventies of the last century – when this case was recorded – extra-clinical interviewing during the analytic treatment was not yet in our mind; today this strategy has been shown not to be detrimental to the analytic process (Taubner et al. 2012).

[19] Gerber has prepared a ten week Psychoanalytic Research Syllabus, Psychoanalytic Research Primer for Psychoanalytic Candidates and Faculty, available on the American Psychoanalytic Association Website).