The Analyst's Role in Healing:

Psychoanalysis-*Plus*

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"A Hungry Heart," in addition to being a testimony to [Gordon] Park's wit, sensitivities and vast armory of talents, is a treatise on the value of encouragement. The miracle of his life is what he's achieved with the opportunities he was given. (J. Wranovics, 2006).

Abstract

Over millennia the healer-sufferer relationship reveals ubiquitous use of suggestion, persuasion, consolation and insight, techniques widely used

currently by parents, mentors, teachers and relational analysts to facilitate individual development. While the classical analyst may utilize these techniques, he may do so implicitly and not openly, suggesting he may be troubled by some discomfort or guilt about utilizing non-prescribed techniques. The analyst's discomfort may interfere with exploring the impact upon, and meaning to the patient, of these implicit interventions.

We conclude that the bases for classical psychoanalysis's earlier proscription of these techniques fail to justify continuing to exclude these ancient modalities. Becoming comfortable using these techniques explicitly and openly may enable examination and analysis of these salient interactions.

Psychoanalytic theory of praxis, Origin of psychoanalytic theory, Healer, Suggestion, Consolation

Introduction

We describe the common techniques in healer-sufferer relationships over the ages and hypothesize that Freud rejected them to try to prevent the analyst's use of suggestion from threatening the scientific status of psychoanalysis. Ferenczi objected to Freud's prescribed objectivity, and included the time honored healing techniques that Freud had interdicted. Examples of classical approaches to support and consolation demonstrate that their use was proscribed. Despite this, it is our impressions that contemporary analysts may utilize implicit caring, support and consolation, but do not acknowledge doing so publicly and may fail to focus analytic attention on its occurrence.

Classical psychoanalysis has used the presumed validity of psychoanalytic theory and of free association as well as the presumed therapeutic superiority of classical treatment to justify rejecting these techniques. We conclude that there is no sound basis for excluding the use of any of these techniques explicitly and publicly. Analysts who become comfortable with these techniques may become able to examine and analyze a broader range of patient-analyst interactions, which, in turn, may enhance therapeutic effectiveness.

The History of Healing

The healer-sufferer relationship extending over thousands of years and across societies and cultures has been examined by Jackson (1999), who extracts the following commonalties: influence is brought to bear by suggestion and persuasion; there is consoling and bringing of comfort; there is also a search for insight and self-understanding – of 'knowing' what all the suffering has been about. He noted that with the advent of psychotherapeutics that "[c]omfort and consolation tended no longer to be cited as elements in clinical work" (p. 197). He concludes that "The evidence leaves me wondering whether human nature might have some limiting influences on the number and nature of such elements. There is a bedrock to healing that is related to our shared human nature" (p.384).

Why Did Freud Proscribe Time Honored Healing Techniques?

Freud, who was well-read, knew many 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, in part because he was a Jew, entered private practice to 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. (In Freud's 23-volume oeuvre there are only six detailed case studies.) 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, 1896, p.203).

To achieve this, he developed psychoanalysis within the context of a (nineteenth century) scientific enterprise: Psychoanalysis, Freud wrote, "[i]s a part of science and can adhere to the scientific *Weltanschauung*) (1933, 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 …" (1914-1916, p.59); "But scientific work is the only road which can lead us to a knowledge of reality outside ourselves" (1927, p.31). "[*o]ur* science has as its object that [psychical] apparatus itself" (1940, p.159).

Suggestion was the greatest threat to the scientific status of psychoanalysis because it was clearly associated with hypnosis, then in bad repute. We hypothesize that Freud proposed neutrality, abstinence and

anonymity to try to assure the analyst's objectivity, thus walling off 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 ..." (1913, 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" (1912, p. 115); "The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him" (p1912, 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" (1913, p. 143). Freud remained concerned throughout his life about analytic objectivity, about the scientific status of psychoanalysis and about the possibility that the role of suggestion might undermine that status (Fogel, 1993).

Prior to this torrent of references urging objectivity, Freud (1893-1895) had recommended that "One works … as a teacher, as the representative of a freer or superior view of the world … One tries to give

the patient human assistance …" (p. 282). He also wrote in 1928 (quoted in Jones, 1955) regarding his Recommendations on Technique that "I considered the most important thing was to emphasize what one should *not* do, and to point out the temptations in directions contrary to analysis. Almost everything positive that one *should* do I have left to 'tact' … The result is that the docile analysts did not perceive the elasticity of the rules I had laid down, and submitted to them as if they were taboos…" (p. 241). Much later, in the twilight of his career (1940), (quoted by Greenberg, 1981), he harkened back to his earliest explicit prescription: "We serve the patient in various functions, as an authority and a substitute for his parents, as a teacher and educator …" (p181).

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. Patients's difficulties come in an infinite variety of shapes and sizes; one size won't fit all.

Ferenczi, who focused on therapy, not science, after many years began to disagree with Freud's emphasis on neutrality, abstinence and anonymity (Thompson, 1943). He became convinced that the cause of neurosis was the parents's failure to provide the child with needed love.

Treatment, therefore, had to take the form of a human relationship in which the analyst provided the love that was missing in childhood. Thus, Ferenczi expanded analytic treatment to include those same time honored healing techniques that Freud at first had acknowledged and then had interdicted. This brief, oversimplified, dichotomous picture of the Freud-Ferenczi debate seems to delineate important still current dimensions in the evolution of analytic treatment.

The Classical Psychoanalytic View of Explicit Support in Treatment

Freud (1909) 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 these 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). The PEP-CD-ROM contains only one paper with a title dealing with support as an analytic technique (De Jonghe, Rijinierse and Janssen, 1992) and this support was specifically implicit support. Although described as an element of "postclassical" analytic theory, these authors conceptualized support as drive based: "[s]upport that deserves to be called psychoanalytic means the providing of adequate gratification of preoedipal (archaic) needs and/or the fostering of their repression" (p.483). They believe that: "Deficient structuralized adults have an age-inadequate need for what infants have an age-adequate need for; external support can either consist of need gratification, thus reducing drive tension, or of defense strengthening, thus enhancing drive control" (p. 482). We believe, to the contrary, that many analysts now recognize the adult need for support as a ubiquitous aspect of the human condition.

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."

The Classical Psychoanalytic View of Consolation

Freud himself comfortably consoled Frau Elisabeth von R.; "that we are not responsible for our feelings, and that her behavior, the fact that she had fallen ill in these circumstances, was sufficient evidence of her moral character – it was a long time before these consolations of mine made any impression on her" (1893-1895, p. 157).

In contrast, Weinshel (1989) described, from the classical point of view, a syndrome entitled "inconsolability" in which the wish to be consoled is conceived solely as a resistance to being analyzed, and thus not to be gratified. The patient "hangs on" to misery and does not accept consolation: "This clinical material throws some light on the role of penis envy (or other loss) in inconsolability (p. 133). … The best known examples are those related to the loss of a beloved person … (p. 134). I have tried to demonstrate that the analytic work can best be maintained by dealing with the inconsolability as a resistance and dealing with those factors that at least appear to contribute to the interference with the process of consolation" (p.135).

Weinshel's first encounter with Mrs. D's "inconsolability" occurred during the first months of analysis when she related a series of failures in her

life and then alluded to her concerns about her performance in analysis. Weinshel writes "I told her that just as she felt she had failed to do as well as she had expected in various aspects of her life outside the analysis, she was now concerned that she might also fail to do well in the analytic work" (p. 123). She became angry, deflated, discouraged, sad and hurt.

Weinshel characterized her response as reflecting "inconsolability." In contrast to Freud's response to Dr. Lorenz, Weinshel responded to Mrs. D's battered feelings with an interpretation (probably correct) which may have validated her fear that she was, indeed, doing poorly at her treatment. Recognizing her reaction, Weinshel acknowledged to himself and us that he didn't feel very good about his interpretation. Providing an interpretation alone rather than empathy/consolation is consistent with a neutral classical psychoanalytic position in which consolation is seen as vitiating understanding.

Some patients, writes Peltz (1992) "[b]ecome resistant to the analysis of the wish to be soothed" (p. 371 in order to avoid the analysis of conflict. Classical analysts had assumed that the patient's wish to be consoled by the analyst was always a defense against analyzing the neurotic, conflicted elements in the wish to be consoled. Peltz adds, "Once these patients achieve

a tranquil frame of mind, they may cling to it tenaciously, imbuing the analyst and the analytic situation with near magical power to console and comfort" (p. 337). In the treatment of his patient, Mr. C, the "[t]ransference fantasy proved to be an intractable resistance to the analysis of the man's hatred of and sadism toward women and his fears of homosexual surrender" (p. 379). During a childhood with parents who fought and a depressed mother, the lack of parental 'presence' was compensated only by the solace of his three-year older sister. Despite this grim description, Mr. C's wish to be consoled is examined solely as a defense against neurotic impulses. When Mr. C terminated treatment prematurely to move to a distant city, the analyst wondered to what extent Mr. C's decision to move was motivated by the need to flee from the conflictual transference. The authors empathize with this patient's wish to be comforted and believe its depth lies beyond defensive functions.

To Jackson consolation has always been prominent in the care of the bereaved; "[s]uffering is a form of need for another person – a need for a relationship with another," a helpful alternative view. We now know that consolation is prevalent not only in humans; consolation is present in chimpanzees and their motivation to console has been shown to be stronger than the desire for food (De Waal, 2005).

Assessment of the Analyst's Behavior is Problematic

Although we can assess what technique is prescribed, it is difficult to determine the analyst's actual feelings and behavior with the patient. Friedman (1988) (quoted by Lhulier, 2005) describes the actuality of the analyst's behavior as the "[p]ersonal push and pull, nameless, theory-less, shapeless, swarming interaction" (p. 12). Case histories seldom accurately reveal the analyst's feelings and behavior since they are necessarily condensed and selective, and designed to fill some purpose for the author. In addition, forces that remain unconscious in the analyst when writing the report will shape the analyst's portrayal as well as the impact on the patient.

When the analyst's actual behavior with the patient is inconsistent with prescribed technique, it is unlikely to be described in the case report. Freud himself in the late 1920's deviated from recommended technique when he advised his patient, David Brunswick, to go to medical school and to become an analyst. Brunswick obediently began medical school in Vienna, only to drop out shortly (Roazen, p. 44).

The following anecdote about Eissler's behavior provides another example of deviation from the analyst's own publication on technique. Eissler's widely-read paper (1953) asserts that "[t]he baseline of

psychoanalytic techniques is one which uses a single treatment tool, to wit, interpretation" (p. 126); only when there is a "structural defect in the ego" (p. 126) is the introduction of a parameter appropriate, and it should be used only temporarily, being abolished by interpretation. An analysand of Eissler's in the 1950's described to one author (J.S.), how she'd expressed her concern to him that, pregnant with her fourth child, she'd been unable to locate a nanny who could help her postpartum. As she left the session Eissler silently handed her a card on which he had written the name and phone number of a nanny he recommended. The patient gratefully accepted his explicit help.

A case presentation (Smollen, 2006) seems to illustrate covert deviation from prescribed neutrality. The patient described had improved significantly during an eleven-year analysis. The analyst, who seemed to embrace classical technique, refused to tell the patient where she vacationed, and would not agree to avoid attending a wedding to which the patient had been invited. This material sounded as if the analyst's classical stance resulted in keeping the patient at emotional arm's length. However, at one point during her presentation the analyst became tearful as she described the appreciation the patient expressed for being accepted as her patient and for the help she'd received. This spontaneous display of feelings by the analyst

suggests that the analyst had covertly expressed feelings of caring and love for the patient throughout this long and difficult analysis.

The fact that in her presentation the analyst did not openly acknowledge her caring, loving feelings for the patient suggests that the analyst regarded such expression as inconsistent with prescribed neutrality – a term alternatively translated as "indifference." The analyst did not report either discussing the meaning of her loving feelings to the patient, or the impact on the analyst of the patient's appreciation. The analyst's presumed discomfort with her own implicit expression of loving feelings makes it seem likely, with termination pending, that these salient interactions will never be examined.

Whether the analyst will experience his feeling or action as a deviation from prescribed technique will vary with the way neutrality is interpreted by that analyst. 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; for him, the analyst's affirmative attitude is a departure from neutrality. Akhtar (2004) 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) believe that neutrality encompasses the analyst being accepting and compassionate.

Despite the difficulties determining how analysts actually behave in their office, it is our impression that many analysts utilize implicit caring, support and consolation, but few are comfortable doing so explicitly or describing it in public. Unfortunately, when, either consciously or unconsciously, an analyst feels that his own feeling or action deviates from prescribed technique, some discomfort and guilt is stirred, and, as a consequence, the analyst is unlikely ever to examine its meaning to the patient with the patient.

The Classical Psychoanalytic Theory of Healing

In the past, classical psychoanalysis has emphasized that understanding (albeit augmented understanding), and insight *alone* are more effective than understanding *plus* explicit suggestion, persuasion, consolation, support and advice. Freud, 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). While creating understanding may provide implicit support for the sufferer, it is not, however, the same as

explicit support, and inevitably excludes suggestion, persuasion and other elements. Therefore, contemporary classical analysts who acknowledge that experiences in the patient-analyst relationship contribute mutative effects through a variety of mechanisms (Gabbard and Westen, 2003), do not refer to any of the above techniques in their publications.

Classical Psychoanalysis's Justification for Excluding These Techniques

To turn to our argument, the banning of explicit and open use of these modalities must rest on the validity of classical analytic theory of praxis, which is itself based on Freud's etiological theory of neurosis. Although contemporary theory may be independent of that origin, the absence of current empirical validation of analytic theory increases the importance of scrutinizing the original theory. Additionally, the validity of free association, a fundamental of analytic praxis, falters when examined with our more sophisticated, contemporary understanding of the role of suggestion and of placebo effect. Further, since justification for excluding these modalities requires that classical treatment be more effective than those comparable treatments that include those humanistic modes, we review the comparative therapeutic effectiveness of classical analytic treatment. Finally, the question of whether support, consolation and suggestion may be especially relevant for certain diagnostic groups will be examined.

A Brief History of the Origin of Psychoanalysis

Freud created his etiological theory of neurosis in 1892; in December of that year he wrote to Fliess that his theory was going to be published (Masson, 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. 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.

In 1892 Freud largely dispensed with hypnosis, first treating Frau Elizabeth v R mainly without it, and therefore, 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" (1983-1985, p. 154). Prior to that, however Freud had already formulated his etiological theory of neurosis. On what had it been based? Analysts generally believe that Freud derived it inductively from his patients' productions, failing to recognize that the productions were of those hypnotized patients he treated *before* he developed his new technique of free association. Stated conversely, to the degree his 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.*

We focus on this historical fact because it is acknowledged that hypnotized patients are extremely suggestible, and, evidence suggests that Freud made covert suggestions to his patients of which he himself was unaware. Consider Freud's (1896) 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). Such finding in eighteen cases is unlikely to have occurred by chance; we assume that its occurrence 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 of putative childhood sexual experiences. To the degree that Freud's theory originated from the productions of highly suggestible hypnotized patients compounded by his failure to recognize that his own covert suggestions to these patients, we consider that the foundation of psychoanalysis is far from sturdy.

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 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 (1993) noted 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 by suggestion (Freud, 1954, pp. 334, 337). 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 (1897), an observation subsequently confirmed empirically (Dywan, J and Bowers. K., 1983). These early doubts support our question of why elucidating the cause became entrenched in praxis and was expected to relieve neurotic symptoms.

Given Freud's genius, even if we accept the shaky foundation of his etiological theory of neurosis we recognize that this criticism does invalidate his hypotheses. However, later conceptions and theories shown to be either

clearly mistaken or questionable include the libido theory, the concept of infantile omnipotence, the theory of the phylogenetic inheritance of the Oedipus complex, the conception of women and their penis envy, the theory of paranoia, the belief that homosexuality was intrinsically psychopathological, the theory of the infantile wish formation of dreams, the belief that sexuality was the core etiology of all neuroses and the theory of the death instinct, all of which were fashioned by the consilience that Freud argued protected against error.

Holt (1985), in some disbelief, pondered that "It is hard to admit how little *proof* there is for any psychoanalytic hypothesis after all these years of use, when the theory seems so clinically valuable and when such a large part of the intellectual world has adopted great hunks of the clinical theory and treats it not as a set of interesting hypotheses but as received knowledge" (p. 306). Strenger (1986) adds 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,

reiterated that conclusion.This all adds to the lack of evidence for the validity of the analytic theory that has opposed the open, explicit use of these techniques in praxis.

Free Association: The Basic Rule of Psychoanalytic Treatment

We have described how Freud's etiological theory of neurosis antedated his use of free association, but free association itself soon became the fundamental rule of analytic treatment (A. Kris, 1982); and remains so in contemporary psychoanalysis (Gabbard and Westen, 2003). Grünbaum (1984) 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), however, 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).

Surprisingly, although free association remains the fundamental focus of analysis, we have not examined either its reliability or validity. Searching the PEP CD-ROM for titles that include, "free association, reliability" or "free association, validity" fails to identify a single published paper among the 35,000 articles. Since the data of free association are used to interpret causal connections to 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).

We believe that the patient's free associations were never *entirely* the patient's creation; they are always co-constructed by patient and analyst, with the patient's contribution exquisitely context dependent. Grünbaum quotes Marmor's striking illustration:

> Depending on the point of view of the analyst, 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 analysts! Thus each theory tends to be self-validating. Freudians elicit material about the Oedipus complex and castration anxiety, Jungians about archetypes, Rankians about separation anxiety, Adlerians about masculine strivings and feelings of inferiority, Horneyites about idealized images, Sullivanians about disturbed interpersonal relationships, etc. (1962, p.289).

Glover (1955), in discussing different analytic views of patients and inexact interpretation, concludes, like Marmor, 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. 381,382) – or possibly both.

Masling and Cohen (1987) concur both with with Marmor and Glover about the analyst's influence in the co-construction of patient's productions, concluding that "all psychotherapies generate clinical evidence that supports their theoretical positions – [and] can be understood as instances of therapists systematically rewarding and extinguishing client behaviors" (p. 65).

The analyst's profound influences on the patient's associations can be conceived of as a function of two related concepts, suggestion and placebo effect. Today, many analysts acknowledge that suggestion is ubiquitous in treatment. The sources of the analyst's implicit suggestions are manifold, certainly in part derived from the analyst's subjectivity which encompasses the analyst's personal values, the analyst's realistic reactions to the patient, the analyst's transference responses to the patient, the analyst's theoretical orientation, and the analyst's current, personal concerns about his own life. Renik (1993, 1998, 2004) asserts that many of these 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 will inevitably have only limited success.

The other, related potent influence we've paired with suggestion is the placebo effect (Shapiro and Shapiro, 1997; Mosher, 1999). The effectiveness of a set of factors to be therapeutic for some disorder despite its assumed irrelevance, such as a pharmacologically inert drug, is at the heart of the notion of a placebo effect. Consider the prospective longitudinal-naturalistic study by Puschner et al. (2006) using repeated measurements along the course of treatment; 144 patients received psychoanalytic treatment (2-3 sessions/week) and 472 patients received psychodynamic psychotherapy (1 session/week). 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 more quickly in the interval from acceptance for treatment to the start of treatment, than during the treatment*

itself: "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; alternatively, patients may grow increasingly anxious anticipating the start of treatment. 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, 1994). Puschner et al. 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. Inferences about this pretreatment effect must be viewed with caution because of the small number of observations.

In sum, the failure to establish the validity of free association means that the rule of free association does not provide warrant for excluding the open, explicit use of these techniques.

Contrary to the classical analytic conception, suggestion and placebo effect should not be considered to be 'noise' in the treatment situation

requiring minimization, but, rather, ‘signal’ which deserves its own scientific study. 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). Understanding the dynamics of these powerful forces should indeed enhance knowledge of the mutative factors in analytic treatment.

The Comparative Therapeutic Effectiveness of Classical Treatment

To justify classical theory’s minimalization of the described additional techniques, outcome studies of classical treatment should show greater effectiveness than those achieved by those comparable treatments that utilize them, such as relational treatments.

The Menninger study (Wallerstein, 1986) 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. This surprising result should be qualified since all the patients 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.

The next pertinent report is the study of Grant and Sandell (2004) of 331 psychotherapy patients and 74 analytic patients. The psychoanalyses

were with members of one of the psychoanalytic societies in Sweden and the psychotherapies with psychotherapists licensed by the National Board of Health and Welfare. Therapist's orientation was assessed by the Therapeutic Attitude Scale. Patients in psychotherapy (which were indeed sometimes conducted by people with psychoanalytic training) were treated in a therapeutic milieu (eclectic milieu) that was more similar to what had been found characteristic of behavioral and cognitive therapists. The psychotherapy providers put greater value than psychoanalytic providers on life adjustment, while showing kindness, supportiveness and self-disclosure. Thus, eclectic referred to a constellation of the therapists's more sociable attitudes plus positive valuation of insight and neutrality. Among the psychoanalytic treatments, 30% were by eclectically oriented psychoanalysts and 70% by classically oriented psychoanalysts. Among the psychotherapies, 43% were conducted in an orthodox psychoanalytic vein and 57% in a more eclectic way.

Results indicated that psychotherapy provided in an orthodox psychoanalytic milieu failed to show significant therapeutic benefit, and was significantly less effective than psychotherapy in an eclectic milieu. Psychoanalytic cases showed no significant difference in therapeutic gain between those treated in an orthodox psychoanalytic milieu and those treated

in an eclectic milieu. We conclude from this study that there is no evidence that classical treatment is more effective than eclectic treatment in psychoanalysis, and is actually less effective in psychotherapy.

Indications For These Additional Techniques

Studies of analytic treatment outcome examining different diagnostic groups are rare, although various analysts, starting with Rank, considered personality styles which require techniques other than classical. Blatt (2004) and Blatt and Shahar (2004) have developed a psychodynamic, dichotomous characterization of patients' 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.

We wondered if these findings imply that the use of the additional techniques of explicit support, suggestion, consolation and persuasion should be minimized with introjective patients who appear to do better with classical treatment and queried Blatt. He (2005, personal communication) replied 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…" Thus, Blatt, himself, despite his findings, does not suggest that these additional techniques should be minimized with introjective patients.

Discussion

The techniques of explicit support, suggestion, consolation, persuasion and advice have been employed throughout the ages to help sufferers. Currently they are widely used to foster development by parents, mentors and teachers, and, most recently, by relational analysts. Although classical analytic treatment has evolved substantially since the analyst strove ideally to be neutral, anonymous, objective and non-gratifying, the open acknowledgement of the explicit use of these techniques is still not widespread.

The bases of classical psychoanalysis upon which repudiation of these explicit techniques stand are not sound. Contemporary validation of classical theory is not available, and the origins of classical theory can best be described as shaky. Recognizing that the theory of analytic practice may have broadened and increased in complexity, may have shifted focus from reconstruction of infantile traumas to include analyzing unconscious conflict, transference, and transference-countertransference interaction in no

way eliminates the question of validity. Nor, argues Eagle (1993) is the problem avoided by the varied contemporary schools of psychoanalysis: “There is no evidence that contemporary psychoanalytic theories have remedied the epistemological and methodological difficulties that are associated with Freudian theory" (p. 404). In conclusion, lacking validation, analytic theory provides no basis for excluding the open, explicit use of these techniques.

The next basis for excluding the analyst’s explicit use of suggestion and other techniques is that they contaminate the patient’s free associations. We aver that the data of free association upon which causal interpretations are based are so influenced by the analyst’s implicit suggestions and unconscious reactions, as well as by the potent placebo effect, that their validity is necessarily already questionable.

Lastly, classical analysis should be able to demonstrate superior effectiveness to justify excluding these techniques. While specific comparative studies have not been conducted, there is no evidence that, overall, classical treatment is more effective for the general patient population than comparable non-classical analytic treatment. In sum, none of these three bases for continued rejection of the open and explicit use of these additional techniques can stand.

Given that the rationale for continued rejection is judged not viable, we can shift our attention to the goals of analytic treatment. It is noteworthy that "to heal" has two primary meanings. One is to cure or restore to a healthy condition a disease or wound, and the second is to make a person hale and whole, to restore to health. Freud's goal initially was to cure neurosis, but as this goal was recognized to be unattainable, the goal has gradually shifted towards making a person hale or whole, i.e., towards fostering the patient's development, including realizing their potential. This has not, however, included the open explicit use of those techniques that over the ages have fostered this broader goal of healing. We know of no evidence that these techniques will interfere with the more specific treatment of neurosis. Indeed, a priori, it seems likely they would operate synergistically by enhancing the patient-analyst relationship and facilitating the therapeutic alliance, thereby fostering resolution of neurosis.

We see no reasons why these age-old, widely used, presumably helpful explicit techniques should not now be openly recognized as valuable parts of the analyst's armamentarium and incorporated into classical treatment as a plausible next step in the decades-old evolution of that treatment. Whether and when these techniques should be employed will require the same nuanced judgment as is used to determine whether and

when an interpretation is presented; it will depend on the interactions in the particular dyad. If analysts can be convinced that using these techniques explicitly and openly is no longer proscribed by classical theory, they may be able to utilize them comfortably, and that, in turn, may enlarge the domain of patient-analyst interactions subject to examination and analysis, and thereby enhance the effectiveness of analytic treatment.

Will the treatment still be psychoanalysis? The analyst will continue to interpret the patient's unconscious feelings, conflicts and fantasies and explore transference-countertransference interactions. Westen (2002) refers to "a way of working clinically that is kinder, gentler, and [he adds] I suspect more effective" (p. 916); but, he is concerned that this will move us toward theoretical nihilism. We believe it need not since any increased effectiveness of these techniques can be researched and understood. Gabbard and Westen suggest that we defer "[t]he question of whether these principles or techniques are analytic and focus[ing] instead on whether they are *therapeutic*" (p. 826). We, the authors, call incorporating these modalities "psychoanalysis-*plus*."

If adding these modalities proves to enhance effectiveness of classical analytic treatment even in a specific population, then psychoanalytic theory as well as praxis may be advanced. Freud had been concerned that the

treatment would destroy the "science" (1926). 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). We think that enhancing treatment effectiveness may revitalize the science by generating empirically-based modifications in psychoanalytic theory which will increase the respect for and interest in it by other scientific disciplines, and perhaps by the public at large as well.

References

Akhtar, S. (2004). Diversity without fanfare. Some reflections on contemporary psychoanalytic technique. Presented as a discussion at the

Panel on "Theoretical and technical approaches to the clinical case: Advantages and disadvantages of present day pluralism" held at the 43rd IPA Congress, New Orleans, March 11.

Blatt, S. (2004). *Experiences of depression. Theoretical, clinical and research perspectives.* Washington, DC: American Psychological Association.

Blatt, S. & Behrends, R.S. (1987). Internalization, separation-individuation, and the nature of therapeutic action. *International Journal of Psychoanalysis,* 68, 279-297.

Blatt, S.& Shahar, G. (2004). Psychoanalysis – With whom, for what, and how? Comparisons with psychotherapy. *Journal of the American Psychoanalytic Association,* 52, 393-447.

Breuer, J. (1893-1895). Case I. Fräulein Anna O. In Studies on hysteria. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2, pp. 21-47). London: Hogarth Press.

Collins, S. (1980). Freud and 'The riddle of suggestion.' *International Review of Psychoanalysis,* 7, 429-437.

De Jonghe, F., Rijnierse, P. & Janssen, R. (1992). The role of support in psychoanalysis. *Journal of the American Psychoanalytic Association,* 40, 475-499.

De Waal, P. (2005). Our inner ape – what primate behavior tells us about human nature. Presentation, American Museum of Natural History, New York, December 15.

Dywan, J. & Bowers, K. (1983). The use of hypnosis to enhance recall. *Science,* 222, Oct.14, 184-185.

Eagle, M. (1993). The dynamics of theory change in psychoanalysis. In Eds. J. Earman, A.I. Janis, G.J. Massey, N. Rescher. *Philosophical problems of the internal and external worlds: Essays on the philosophy of Adolf Grünbaum.* Pittsburgh, PA/Konstanz, Germany: University of Pittsburgh Press/University of Konstanz Press, pp. 373-408.

Eissler, K.R. (1953). The effect of the structure of the ego on psychoanalytic technique. *Journal of the American Psychoanalytic Association,* 1, 104-143.

Eissler, K.R. (1969). Irreverent remarks about the present and future of psychoanalysis. *International Journal of Psychoanalysis,* 50, 461-471.

Ellenberger, H.F. (1970). *The discovery of the unconscious. The history and evolution of dynamic psychiatry.* New York: Basic Books.

Fogel, G.I. (1993). A transitional phase in our understanding of the psychoanalytic process: A new look at Ferenczi and Rank. *Journal of the American Psychoanalytic Association,* 41, 582-602.

Freud, S. (1896). The aetiology of hysteria. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 3, pp. 189-221). London: Hogarth Press.

Freud, S. (1909). Notes upon a case of obsessional neurosis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 10, pp. 153-318). London: Hogarth Press.

Freud, S. (1913). On beginning the treatment. (Further recommendations on the technique of psychoanalysis I). In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 121-144). London: Hogarth Press.

Freud, S. (1914-1916). On the history of the psychoanalytic movement. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 1-66). London: Hogarth Press.

Freud , S. (1926). The question of lay analysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 179-258). London: Hogarth Press.

Freud, S. (1927). The future of an illusion. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 21, pp. 3-56). London: Hogarth Press.

Freud, S. (1933). New introductory lectures on psychoanalysis. Lecture 35, The question of a *Welltanschauung.* In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of sigmund Freud* (Vol. 22, pp. 1-182), (Original work published 1932).

Freud, S. (1954). *The origins of psychoanalysis.* New York: Basic Books.

Gabbard, G.O. (2004) *Long-term psychodynamic psychotherapy.* Washington, D.C.: American Psychiatric Publishing.

Gabbard, G.O. & Westen, D. (2003) Rethinking therapeutic action. *International Journal of Psychoanalysis,* 84, 823-841.

Glover, E. (1955). *The technique of psychoanalysis.* New York: International Universities Press, 1958.

Grant, J. & Sandell, R. (2004). Close family or mere neighbors? Some empirical data on the differences between psychoanalysis and psychotherapy. In Eds. P. Richardson, H. Kächele, C. Redlund. *Research on psychoanalytic psychotherapy with adults.* London: Karnac, pp. 81-108.

Greenberg, J.R. (1981). Prescription or description: The therapeutic action of psychoanalysis. *Contemporary Psychoanalysis,* 17, 239-257.

Grünbaum, A. (1993). *Validation in the Clinical Theory of psychoanalysis. A study in the philosophy of psychoanalysis. Psychological Issues, Monograph 61.* Madison, CT: International Universities Press.

Gunderson, J.G., Gabbard, G.O. (1999). Making the case for psychoanalytic therapies in the current psychiatric environment. *Journal of the American Psychoanalytic Association,* 47, 679-704).

Holt, R.R. (1981). The death and transfiguration of metapsychology. *International Review of Psychoanalysis,* 8, 129-143.

Holt, R.R. (1985). The current status of psychoanalytic theory. *Psychoanalytic Psychology,* 2, 289-315.

Holzman, P. (1985). Psychoanalysis: Is the therapy destroying the science? *Journal of the American Psychoanalytic Association,* 33, 725-770.

Jackson, S.W. (1999). *Care of the psyche. A history of psychological healing.* New Haven, CT: Yale University Press.

Jones, E. (1955). *Sigmund Freud: Life and work. Vol. II, 1901-1919 Years of maturity.* New York: Basic Books.

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

Kris, A.O. (1982). *Free association. Method and Process.* New Haven, CT: Yale university Press.

Kris, A.O. (1990). Helping patients by analyzing self-criticism. *Journal of the American Psychoanalytic Association,* 38, 605-636.

Leichsenring, F. (2005). Are psychodynamic and psychoanalytic therapies effective? A review of empirical data. *International Journal of Psychoanalysis,* 86, 841-868.

Levenson, E.A. (2001). Freud's dilemma. *Contemporary Psychoanalysis,* 37, 375-390.

Lhulier, J. (2005). Learning in an increasingly multitheoretical psychoanalytic culture: Impact on the development of analytic identity. *Psychoanalytic Psychology,* 22, 459-472.

Mahoney, P.J. (1986). *Freud and the Rat Man.* New Haven CT: Yale University Press.

Marmor, J. (1962). Psychoanalytic therapy as an educational process. In Ed. J Masserman, *Psychoanalytic Education.* New York: Grune and Stratton, pp.286-299.

Masling, J & Cohen, I.S. (1987). Psychotherapy, clinical evidence and the self-fulfilling prophecy. *Psychoanalytic psychology,* 4, 65-79.

Masson, J.M. (1985). Ed. And Trans. J.M. Masson. *The complete letters of Sigmund Freud to Wilhelm Fliess, 1887-1904.* Cambridge MA: The Belknap Press of Harvard University Press.

Mosher, P. (1999). Suggestion and the placebo effect. American Psychoanalytic Association Members List, September 23.

Peltz, M.L. (1992). The wish to be soothed as resistance. *Psychoanalytic Quarterly,* 61, 370-399.

Puschner, B., Kraft, S., Kächele, H. & Kordy, H. (2006). Course of improvement during two years in psychoanalytic and psychodynamic outpatient psychotherapy. *Psychology and Psychotherapy,* in press.

Renik, O. (1993). Analytic interaction: Conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly,* 62, 553-571.

Renik, O. (1998). The analyst's subjectivity and the analyst's objectivity. *International Journal of psychoanalysis,* 79, 487-497.

Renik, O. (2004). Intersubjectivity in psychoanalysis. *International Journal of psychoanalysis,* 85, 1053-1056.

Roazen, P. (1995). *How Freud worked. First-hand accounts of patients.* Northvale, NJ: Jason Aronson.

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

Shapiro, A.K & Shapiro, E. (1997). *The powerful placebo from ancient priest to modern physician.* Baltimore MD: Johns hopkins University Press.

Strenger, C. (1986). The foundations o0f psychoanalysis. A critique. *International Joiurnal of psychoanalysis,* 67, 255-260.

Thomä, H. & Kächele, H. (1992). *Psychoanalytic Practice,* Vol. 2: *Clinical Studies.* Berlin, Heidelberg, New York, Tokyo: Springer.

Thompson, C.M. (1943). 'The therapeutic technique of Sándor Ferenczi': A comment. *International Journal of Psychoanalysis,* 24, 182-195.

Von Krafft-Ebing, R. (1896). Zur suggestions behandlung der hysteria gravis. *Zeitschrift für hypnotismus,* 4, No.1, 27-31.

Von Kraffet-Ebing, R. (1897). *Arbeiten aus dem Gesamtybiet der Psychiatrie und Neuropathologie* Leipzig: Barth, III, 193-211.

Wallerstein, R.S. (1989). The psychotherapy research project of the Menninger Foundation: An overview. *Journal of Consulting and Clinical Psychology,* 57, 195-205.

Weinshel, E.M. (1989). On inconsolability. In Ed. R.S. Wallerstein, *Commitment and compassion in psychoanalysis.* Hillsdale, NJ: The Analytic Press, pp. 118-139.

Westen, D. (2002). The search for objectivity in the study of subjectivity. Reply to commentary. *Psychoanalytic Dialogues,* 12, 915-920.

Wranovics, J. (2006). *A hungry heart. A memoir.* By Gordon Parks. The New York Times Book Review, January 8, p. 15.

Wurmser, L. (1989). "Either – or": Some comments on Professor's Grünbaum's critique of psychoanalysis. *Psychoanalytic Inquiry,* 9, 220-248.