6 The Initial Interview and the Latent Presence of Third Parties

6.1 The Problem

Patient and analyst usually meet for the first time in the waiting room, but each has already formed some kind of image of the other. Consider a patient who has arranged his appointment on the telephone or in writing. He has outlined his problems in brief or has written a detailed account of his life and current situation to emphasize the urgent need for a consultation. He may also have expressed his doubts and his hopes that this analyst, whom he has heard of through the grapevine, will take him on as a patient and that his long-postponed decision to undergo analysis will now lead swiftly to successful treatment of his chronic symptoms. For his part, the analyst has already learned or inferred much about the patient's life and current situation from the way in which the patient has come or been referred to him and from the content and form of the letter or telephone call. Thus even before the first encounter, processes of transference, countertransference, and resistance have been set in motion. In anticipation of the first meeting our imaginary patient may even have dreamed of a house whose similarity to the building where the analyst's office is located was obvious to him on waking. For his part, the analyst may have noticed in himself signs of positive countertransference in the more comprehensive sense of this term. Since the patient has described his work situation in a way which permits the analyst to assume that he has considerable flexibility with regard to appointments, the analyst has checked his appointments schedule to see what he can offer.

Two things can be gathered from this brief account of an imaginary typical case. First, transference, countertransference, and resistance begin before the first encounter between patient and analyst. Second, the patient's hopes also start to affect his dream thinking before the initial interview. It is for these reasons that this chapter comes after the chapters dealing with those aspects. With regard to transference, countertransference, and resistance, we would like to underline the vital importance of the analyst's attitude for the first meeting and all subsequent encounters. We emphasize this particularly for those who have chosen to read this chapter first because it offers an introduction to psychoanalytic practice. The somewhat more experienced reader will see from our outline of the preliminaries that the outcome of the initial interview with this imaginary model patient can be predicted with some certainty even on the basis of this small amount of information. In such cases no great diagnostic acuity is needed, and the decision to commence an analysis has almost been made before the analyst has racked his brain over specific indications. In a few cases an initial interview or a lengthy phase of clarification can be dispensed with. It is then clear to both participants — patient and analyst alike — that the initial interview may mark the

commencement of treatment. Every analyst is familiar with such swift decision-making processes which have nothing to do with the fascinations of mutual attraction; quite the opposite, they lead so smoothly to four or five sessions of treatment per week because the expectations on each side complement each other well. Everything fits, so to speak: age, level of education, severity of symptoms, a successful professional career which gives the patient financial independence and flexibility with regard to appointments.

It comes as no surprise that the psychoanalytic literature contains many more discussions of the opening phase of treatment than of the initial interview. We would also prefer to skip discussion of the initial interview and proceed directly to treatment rules and the commencement of treatment itself. However, we cannot act as though we deal principally with ideal patients whose motivation for seeking treatment is good and who are aware of the connection between their symptoms and the problems and conflicts in their lives i.e., who already have the psychoanalytically desirable insight into their illness. Such patients do exist, but are few and far between; in reality things are quite different. As soon as an analyst's patients have a wide range of psychic and physical problems (i.e., cover a broad nosologic spectrum) and are not all financially independent and well-educated, the initial interview assumes decisive importance. Once the initial interview is no longer ascribed the dubious alibi function of allegedly identifying the patient who is suitable for psychoanalysis, it is possible to share Freud's pioneer spirit and the pleasure he took in experimentation.

We regard the initial interview as the first opportunity for the psychoanalytic method to be adapted to the particular circumstances of the individual patient. The first encounters carry a heavy burden of responsibility. The information which must be gained in just a few meetings will be incomplete and unreliable. On principle, only in absolutely clear-cut cases may it be stated with certainty that a given patient *cannot* be helped by psychoanalysis, as the psychoanalytic method is based on the establishment by the analyst of a special interpersonal relationship with the patient as an individual in order to be able to exercise a beneficial therapeutic influence on disturbances, symptoms, and illnesses which are partly or wholly *psychic* in origin. Thus we employ a somewhat pretentious word and speak of an *encounter* in which all technical rules and specialized terms are embodied.

Plainly one must go beyond mere generalization. The further therapeutic methods and techniques are developed and refined, the more clearly they are related to the theory of the origin of the given illness and the more precisely their efficiency can be predicted. And the better the circumstances surrounding the origin of the condition are known and the more exactly the mechanisms of the remedy have been clarified, the greater is the accuracy of prognostic statements. Thus, in medicine, standardization and generalizability of a technique — its applicability to the typical case, but with the flexibility to allow for adaptation to the individual patient represents the scientific and practical ideal. In this way, errors in treatment technique can be described as deviations from an established norm. The full relevance of this emerges in the identification of instances of malpractice.

Can this ideal be applied to psychoanalysis, and can we expect the initial interview to yield the information we need to establish a positive indication for treatment? This would mean that indication and prognosis are interrelated, as is plain in the questions every patient asks: "What are my chances of improvement or cure from analysis? Is the treatment less likely to be successful if I can only come twice a week?" Such questions are awkward for every analyst. This is the reason that we have openly admitted that we too are happy to work under standardized conditions, under the proviso that the diagnosis implies a clear psychogenesis, so that indication and prognosis can be grounded.

If the selection of patients suitable for the standard psychoanalytic technique were the only issue of importance in the initial interview, it might seem that we could proceed directly to therapy, i.e., to the psychoanalytic process, the course of which determines the prognosis. But appearances are deceiving; the technical standards designed for the so-called suitable case are formal criteria, and as such remain outside the essence and substance of the process and possibly even interfere with it. It is for this reason that we must take so many different factors into account in talking about the initial interview, and this multiplicity must be viewed in the context of the comprehensive tasks that have to be achieved. By tracing a few lines of development, we would like to widen the perspective and use the psychoanalytic attitude to shed light on the initial interview from various angles. We emphasize the importance of the analyst's *attitude,* for example in the attention he pays to transference, countertransference, and resistance. Frequently the psychoanalytic tools, in the strict sense, cannot be utilized, so that the analyst's attitude and the way he handles the patient's communications are essential. Thus a specific psychoanalytic interview technique was late to develop, although psychoanalysis soon influenced the psychiatric interview in the USA and history-taking in German psychosomatic medicine.

Our aim in this chapter is to do justice to both the general requirements of interviewing and the special characteristics of the psychoanalytic interview. We therefore have to familiarize the reader with a broad range of views, because although the medical model for the establishment of positive indications was adopted in the standard technique of psychoanalysis, hardly any analyst — except in the rare clear-cut cases mentioned above — is in the position to form a definite opinion on the basis of just a few meetings with the patient.

It is not surprising that in those cases in which it seems to the analyst that the very first meeting can be conducted in a way approximating the basic model technique, the patients turn to be suitable for an analysis under standard conditions. It is indeed important how, for example, the patient reacts to trial interpretations, since for obvious reasons this may provide useful pointers to his capacity for insight and awareness of conflicts. Even more important is the experience that patients' reactions to trial interpretations and to other special tools of psychoanalytic technique depend on a multitude of determinants, for example timing. Many factors are involved in determining how long a patient needs to become so familiar with the psychoanalytic dialogue as conducted by the individual analyst — and the spectrum is wide — that he can grasp the meaning of trial interpretations. All things being equal, the same holds true for all criteria.

Finally, our conviction that the form taken by the initial interview should be adapted to the particular circumstances of the individual patient influences our description.

6.2 Diagnosis

Freud's diagnostic explorations served to exclude somatic illness or psychosis. The limitations of the psychoanalytic method seemed to be defined much more by the constraints of outpatient as opposed to inpatient treatment than by restrictions of technique. Freud, who in any case never hesitated to take on seriously ill patients, saw temporary inpatient treatment in emergencies as a means of considerably extending the applicability of the psychoanalytic method (Freud 1905 a). As soon as the elementary preconditions had been satisfied and questions of payment and appointments settled, the fundamental rule was explained and the analysis began. Then as now, general psychosocial factors such as education, age, and motivation were highly relevant. Freud did not take a detailed history until the first phase of treatment; his preliminary interview was brief, as can be seen in the case of the Rat Man (1909d, p. 158).

Freud's patients were all "in analysis"; after he had discontinued hypnosis he made no distinction between various forms of psychoanalytic therapy — there was just his psychoanalytic method. He principally treated serious cases, patients who could not cope with life, i.e., those with whom and for whom psychoanalytic therapy was developed (Freud 1905a, p.263).

The problem of selection first arose when demand began to outstrip supply, as Fenichel reported about the clinic of the Berlin Institute:

> The difference between the total number of consultations and the number of analyses it was possible to undertake necessitated a disagreeable sifting-out process. It goes without saying that the primary criteria were those of indication for analysis, but in addition the Institute imposed two conditions for the acceptance of a patient for psychoanalytic treatment: the case had to lend itself to scientific research and to teaching. (Fenichel 1930, p. 13)

The ratio of consultations to treatments initiated was at that time about 2.5:1. The prevailing climate at the Berlin Institute with regard to initiating psychoanalytic treatment was one of enthusiasm for experimentation, and this is underlined by the high proportion of analyses (241 of 721) which were broken *off*

> The breaking off of a relatively large number of analyses after only a short time can be explained. In most of these cases, the patients' accessibility to analysis was doubtful from the outset but they nevertheless underwent a "trial analysis," at the end of which the analyst had to recommend termination. (Fenichel 1930, p. 14)

Trial analysis served to establish indications more definitely, and was plagued from the outset by the patient asking: "If it turns out at the end of the trial analysis that I'm not suitable for psychoanalysis, what kind of treatment am I suitable for?" This obvious question rocks the very foundations of the patient's existence. It would seem that the problem could be avoided by not expressly agreeing on a trial analysis, i.e., the analyst could decide on a trial period without telling the patient, but this would be irreconcilable with the psychoanalytic

attitude. Moreover, the trial analysis can only be valid as a test of suitability in the context of a standardized technique which the same analyst would also use later. The patient's behavior during the trial analysis would thus be seen from the viewpoint of one particular understanding of the rule. Not many of the patients now seeking consultations at psychoanalytic outpatient clinics would be judged suitable in a trial analysis conducted according to the basic model technique. It is plain why the trial analysis was dropped; the rejection at the end can be very painful for the patient if he is simply branded "unsuitable for psychoanalysis" and not given any suggestions as to alternative treatment.

Of course, dropping the trial analysis did not solve the problem, but just shifted it to the initial interview. As we will show later, this burden will not be reduced to a level which is bearable for both participants, or constructively soluble, until an adaptive establishment of indications has become a fundamental aspect of diagnosis and therapy. First, however, we would like to stress that the problems which had to be solved in the initial interview in the clinic of the old Berlin Psychoanalytic Institute are still encountered in all large clinics; private practice is not affected as strongly. For this reason, most publications on the subject of the initial interview stem from experience authors have gathered in institutions. In addition, few psychoanalytic training centers expressly teach interview technique. The following major lines of development can be discerned: In general diagnostics, psychoanalysis has over the years adopted the nosologic system from psychiatry. The diagnostic models of psychosomatic medicine were and are oriented around physical symptomatology. The psychoanalytic initial interview is a relatively late achievement and was developed in large outpatient clinics.

The psychoanalytic attitude and psychoanalytic thinking exerted a great influence on psychiatric exploration technique. Here, as anywhere in history, there may be asynchronous phases lasting decades, and interdisciplinary influence may long go unrecognized, but there can be no doubt that psychiatric diagnostics underwent a change with Bleuler's (1910) assimilation of psychoanalytic thinking. Brill, Putnam, and other psychiatrists acquainted themselves with the psychoanalytic technique through Bleuler's Burgholzli school and helped to diffuse it among psychiatrists in the USA, where the way had already been paved by Meyer's ideas on social hygiene and psychotherapy. The influences of psychodynamic thinking were perceptible as early as the 1930s. The individual steps have been traced by Gill et al. (1954), whose important contribution is the definition of the psychodynamic interview technique. They contrast the traditional psychiatric exploration with the "dynamic interview," which has three aims:

> The first aim is to establish *rapport* between two strangers, a professional person and a human being who suffers psychologically and often makes others suffer. A serious attempt to understand the patient, a warm human contact and some mutual appreciation have to be established regardless of who therapist and patient are. All writers on interviewing have stressed this and we are in basic agreement on this point. The second aim is *appraisal* of the patient's psychological status. The third aim is *reinforcement* of the patient's wish to continue with therapy whenever this is indicated, and to plan with him the next step in this direction. (Gill et al . 1954, pp. 87-88)

The psychiatric diagnosis is rooted in the appraisal of the total situation and

corresponds to Balint's concept of total diagnosis. Gill et al.'s inclusion of the development and support of a patient among the tasks of the initial interview marks in our opinion a significant step away from the purely diagnostic interview in the direction of therapeutic action.

Sullivan's "interpersonal theory of psychiatry" (1953) put great emphasis on the relationship aspect. Unresolved is whether Sullivan really founded a truly interpersonal psychotherapy, as Greenberg and Mitchell (1983) claim, or returned to a largely intrapsychically oriented approach (Wachtel 1982). The clarification of this issue depends on how the analyst's role as participant observer is realized in practice.

In the course of the 1950s, numerous different psychodynamically oriented interview strategies were developed by psychoanalysts working within dynamic psychiatry. It was during this period that Deutsch described the "associative anamnesis" in the context of his teaching activities:

> The method called "associative anamnesis" consists in recording not only what the patient said, but also how he gave the information. It is of consequence not only that the patient tells his complaints, but also in what phase of the interview, and in which connection he introduces his ideas, complaints and recollections of his somatic and emotional disturbances. (Deutsch and Murphy 1955, vol. 1, p. 19)

An approach centered on exploration and description of the psychopathology was replaced by observation of the dynamic of what takes place, without putting too much stress on the relationship component, but rather using it to create a situation conducive to investigation. It is rewarding to look at this integration of psychiatry and psychoanalysis — as sought, for example, by Redlich and Freedman (1966) — from the point of view of the various blends of descriptive psychopathology and recognition of the relationship which have emerged.

Kernberg's "structural interview" (1977, 1981) is a good example of the second generation of psychoanalytically oriented psychiatric initial interviews following in the tradition of the dynamic interview. He attempts to relate the history of the patient's personal illness and his general psychic functioning directly to his interaction with the diagnostician. Kernberg's technical guidelines recommend a circular process. On the one hand, returning continually to the patient's problems and symptoms defines the psychopathological status; on the other, attention is focussed on the interaction between patient and therapist in the psychoanalytic sense, and interpretations, including interpretations of transference, are given in the here-and-now. The main goal is clarification of the integration of ego identity or identity diffusion, the quality of the defense mechanisms, and the presence or absence of the capacity for reality testing. This permits the differentiation of personality structure into neuroses, borderline personalities, functional (endogenous) psychoses, and organically determined psychoses. The interviewer mobilizes clarification, confrontation, and interpretation in the effort to gather material which will yield important prognostic and therapeutic information. He is particularly concerned to appraise the patient's motivation, his capacity for introspection, his ability to work together with the therapist, his potential for acting out, and the danger of psychotic decompensation. Occasionally, unconscious connections are offered as interpretations to a neurotic

patient, or a borderline patient is told about splits in his self-representations. From the patient's reactions, conclusions can be drawn which help the therapist decide on further diagnostic and therapeutic measures.

The structured classification of differential diagnosis follows the nosologic system of psychiatry in the division into three main categories — endogenous and exogenous psychoses and neuroses. Kernberg adds borderline disturbances as a fourth category. Despite the circular form of the dialogue, the main theme of Kernberg's interview, which he makes more concrete by means of particular questions in the beginning, middle, and end phases, follows the psychiatric phenomenological concept of looking first for psychoses resulting from cerebral disorders, next for functional psychoses, and only then for borderline disturbances and neuroses. Through his use of terms like "diagnostics," "exploration," and "cardinal symptoms," Kernberg shows that he stands with one foot planted firmly in descriptive psychiatry. The interviewer's structuring activity naturally affects the interaction. A certain restriction of freedom in the way the relationship between patient and therapist begins to form is accepted in order to gain the information necessary for differential diagnosis. The structural interview is nevertheless a balanced blend of psychopathologic description and relationship analysis, and meets the diagnostic, therapeutic, and prognostic demands placed on the initial consultation. It also covers a broad spectrum of illnesses which are only encountered, whether in private practice or in institutions, in the absence of restrictive preselection processes ensuring that the analyst almost exclusively treats neuroses. In our opinion, Kernberg has achieved a good synthesis of the various functions of the first meeting. If one considers that almost all American psychoanalysts have had psychiatric training, it becomes more comprehensible why no great emphasis is placed on the initial interview in the curricula of American psychoanalytic institutions (Redlich and Freedman 1966).

Greatly simplified, one could say that the psychoanalytic attitude and psychoanalytic thinking influenced the psychodynamic interview technique and that this in turn affected psychoanalytic practice. In the framework of these reciprocal influences there are particular nodal points which characterize the main tasks of the initial interview. In the following description, we are aware that our emphasis on certain aspects exaggerates the differences.

First we will deal with biographical anamnesis, because the question of the connection between the patient's life history and his current symptoms comes up in every initial interview. If one is to proceed from the precipitating situation — in psychoanalytic terms, from the situation of temptation and frustration — to explanation of the psychogenesis in the sense of Freud's complementary series, it is indispensable to learn something about the patient's childhood. In order to grasp the potential emotional relevance of this information, however, it is essential to incorporate it into the psychopathology of the conflict, and thus in the wider sense into a theory of personality. It must therefore be noted even at this juncture that the psychoanalytic initial interview is rooted partly in the attempts made in the 1920s and 1930s to systematize the theory of therapy. Finally, we come to the interactional interview model which Balint developed at the Tavistock Clinic, influenced by object relationship psychology and the significance of the

interchange between doctor and patient in the here-and-now.

The beginnings of psychosomatic medicine in Heidelberg after the war were strongly influenced by von Weizsacker's (1943) question: "Why does a disease appear *now,* and why does it appear precisely *here* in this organ or system?" The development of the associated interview technique of "biographical anamnesis," and its evolution into "systematic history-taking" have been described by Thomä:

> The central aim of "biographical anamnesis" (see Ruffler 1957) is to use questions to throw light on the patient's life situation at the time of the onset of the symptoms and then to describe this situation precisely .... Biographical anamnesis was not primarily concerned with a psychotherapeutic goal, i.e., with achieving change, but with the diagnosis of the past. No special consideration was given to the doctor-patient relationship or to its specific expression in transference and countertransference. (Thomä 1978, p.254)

The temporal associations between the patient's current situation, previous events in his life, the origin of his symptoms, and their variable intensity naturally form the starting point for many more or less systematized interview techniques. The triad of "object loss, hopelessness, and helplessness" (Engel and Schmale 1967), which can be observed in many different illnesses, forms the theoretical background for the mode of dialogue recommended by Engel (1962). Adler (1979, p. 329) describes Engel's method as a technique of history-taking which puts the doctor in a position, by virtue of his knowledge of developmental psychology and the theory of neurosis, to integrate psychic, social, and somatic data and recognize their significance.

It is generally true that the therapeutic appropriateness of these information-seeking and insight-providing techniques for structuring interviews is largely determined by the way they are applied. If the analyst succeeds in using typical conflicts in the patient's life to show him *ad oculos* something of the latent dynamics and the connections, this method facilitates access particularly to those patients who would otherwise have no direct, unhindered insight into the psychogenesis of their symptoms.

In this technique, diagnosis drew on a more or less well consolidated theory of neurosis, and the conducting of the dialogue in practice was oriented on the psychoanalytic treatment technique as systematized in the 1920s and 1930s. Experience gained in psychoanalytic outpatient clinics was decisive in this respect. Particularly great emphasis was placed on diagnostic ability at the outpatient clinic of the old Berlin Psychoanalytic Institute, and it became necessary to make the findings comparable. Teaching and research thus promoted systematization. Alexander's early work provides an excellent example; his later research on specificity in psychosomatic medicine, at the Chicago Psychoanalytic Institute, would not have been possible without a diagnostic interview model (Alexander 1950).

Schultz-Hencke's (1951) "goal-directed anamnesis," which served the purpose of diagnosing the symptom-precipitating situations of temptation and frustration, neglected the relationship and transference aspect of the initial interview. Schultz-Hencke related these situations, which Freud had introduced into psychoanalytic terminology and practice, to his own theory of conflict and structure. The later extension of this interview technique was termed "biographical anamnesis" and

described in detail by Duhrssen (1972, 1981).

In recent years, the expectation has decreased that we will be able to identify typical, highly characteristic constellations of conflicts as discussed by Alexander and French (1946) under the heading of specific hypotheses. The variability of psychodynamic conflict patterns, and their no more than loose connection to the clinical picture, i.e., their "nonspecificity" (Thomä 1980), has relativized the diagnostic component of the initial interview.

The Tavistock model, which is closely associated with Balint's work, stresses the therapeutic relationship in the here-and-now, i.e., the functional unit of transference and countertransference. In the late 1950s, Mitscherlich introduced this model in the Psychosomatic Clinic of the University of Heidelberg, where it proved extremely productive in that from the very beginning of the dialogue it drew the analyst's attention to the current processes of exchange between him and the patient (Kunzler and Zimmermann 1965). Some important points which invite special consideration when making a written summary of the dialogue are as follows:

Development of the Doctor-Patient Relationship

1. How does the patient treat the doctor? Are there any changes in this respect? Does this point to habits of behavior or to his relationship to the illness?
2. How does the doctor treat the patient? Are there any changes in the course of the interview?
   a) Was the doctor interested in the patient's problems?
   b) Did he have the feeling he could do something for him?
   c) Did he notice any human qualities on the part of the patient which he liked in spite of all the patient's faults?

Important Moments in the Interview

The focus of attention here is the development of events within the interview, i.e., the results of transference and countertransference.

1. Surprising statements or expressions of emotion by the patient, parapraxes etc., obvious exclusion of specific periods of his life or particular people in his environment, and so on.
2. What interpretations were offered in the course of the interview, and what were the patient's reactions?

Findings and Assessment

1. How is the disturbance expressed in the patient's life (listing of the symptoms revealed in the interview, including those the analyst vaguely suspects at this juncture)?
2. Presumed significance of the disturbance, expressed in psychodynamic terms.
3 Choice of therapy:
   a) Suitability for a short therapy (focal psychotherapy); reasons
   b) Potential arguments against

c) Suitability for psychoanalysis; reason
d) Refusal of any form of psychotherapy; reasons
e) Other possibly suitable forms of treatment

4. Next goals: What does the doctor consider the essential symptom, the one he wants to tackle first? How might the treatment of this symptom affect other symptoms? Thoughts on the frequency and duration of treatment.

In the next section it will be made even clearer how the spirit of Balint's model influenced the understanding of the therapeutic aspects of the initial interview. Although many are unaware of its origin, this model — whether in its original form (Balint and Balint 1961, pp.69-70; Balint et al. 1972, pp. 19-20) or modified — has in many places become a guide for the therapeutic conception of the initial interview.

6.3 Therapeutic Aspects

The introduction of the Tavistock model changed the conception of the initial interview: psychoanalysis was incorporated into the interview as a therapeutic method, and diagnosis was subordinated to therapy. Or perhaps we should be more cautious and say that the diagnostic and therapeutic functions of the first consultation were now seen as equal in importance. We base our discussion of this qualitative change on Balint's work. Although many other analysts have of course contributed to the therapeutic function of the initial interview being given its rightful place in the first encounter between analyst and patient, we have good reason to concentrate on Balint, as it is precisely with regard to the structure of the interview that his influence on German psychoanalysts is particularly strong. The emphasis put on the therapeutic task creates just that flexibility which we consider essential if one is to achieve an adaptive assessment of indications. The fact that this interview style was originally developed for a special form of therapy, i.e., focal therapy, does not reduce its utility for psychoanalysis in general. On the contrary, obtaining genuine solutions to problems in such a short time is the strongest indication that broader and deeper conflicts might also be reached in a therapeutically useful manner in the course of a longer analysis.

Indeed, hardly any other factor has had as great an influence on the way the analytic dialogue is conducted as the interview technique developed within the framework of focal therapy. Balint's considerations often apply in the same way to the physician and to the psychoanalyst. This emphasizes the widereaching interactional nature of the interview; it can be extended to cover many different situations. Central, however, is the observation of the bipersonal process, which Balint stressed as important for the comprehension of the patient's life history. The conception of two-person psychology means that the analyst creates a relationship between what the patient says and how he behaves in the analytic situation, and then uses this relationship diagnostically and therapeutically. Accordingly, the result of the investigation depends on how the analyst behaves in this professional relationship and what he learns from it. Ultimately only what

the patient contributes can be used in diagnosis, but his contributions must be understood as "the sum total of the patient's reactions to a particular doctor, at a particular moment, in a particular setting" (Balint and Balint 1961, p. 167). This puts the doctor or psychoanalyst in a situation which is theoretically interesting, but in practice hard to solve. The differentiation of function and tasks leads to this one-sided version of interaction. As regards treatment technique, the object relationship which develops is considered to be determined principally by the patient's inner need for such a relationship (see Beckmann 1974).

The general message that psychoanalysts have also received from Balint's writings for physicians in general is that the attempt should be made to use "the patient's potentiality for developing and maintaining human relationships" (Balint and Balint 1961, p. 183) as a criterion for decisions. The acceptance of Balint's ideas enabled the initial interview to be varied widely within psychoanalysis and applied in many different fields (Junker and Waßner 1984). The renewed reflection on the parameters of the interview which is necessary in each individual case simultaneously permitted innovations that played a part in the development of various types and configurations of the initial meeting (home visit, consultation with family doctor, psychoanalytic counseling, etc.). Interviews without previous appointment, as introduced at the Sigmund Freud Institute originally for purely practical reasons, create unforeseen new forms which demonstrate just how much the content of an interview is determined by the conditions under which it takes place (Argelander et al. 1973). This kind of interview meets the expectations of a patient in acute distress. The analyst, for his part, sees the patient at a time of crisis in which the therapeutic possibilities are circumscribed and limited. Unaccustomed for the analyst, but perhaps therefore important, is the opportunity — analogous to the general practitioner — to lend immediate short-term therapeutic support and thereby possibly create an atmosphere of trust conducive to a subsequent analysis. Wherever analysts reserve time for consultations at short notice — whether in their own practices or, as is more usually the case, in institutions a wealth of new possibilities emerge. The patients who avail themselves of this opportunity are mostly those who do not fit into the rigid framework of analytic practice and thus enrich the analyst's store of experience.

The longer patients must wait for the psychoanalytic initial interview, the greater the selection among the patients the analyst eventually sees. There are two psychodynamic factors at work here. On the one hand, the patient who has taken the step of making an appointment is already in a therapeutic situation. In conscious and unconscious fantasies, he is trying out preexisting patterns of transference to the analyst, although they have not yet met. On the other hand, his unconscious resistance is inevitably reinforced by the frustration of waiting.

Questionnaires and tests before the initial interview place the patient under stress and also, understandably, awake expectations in him. He is then tense when the interview comes and often expects more than the analyst is in a position to give. The different expectations aroused by the differing settings in institutions and in private analysts' offices must be made a topic of discussion at an early stage.

Additional differences in the expectations toward the initial interview arise from the range of treatment available, which differs from place to place and is usually not completely familiar to the patient. To avoid disappointments, suitable preparation concerning the goals of the interview is an important first step in the introductory phase *(recommendation 1).* The interview is an unaccustomed situation for patients, and most errors in the consequences drawn from their behavior stem from inadequate preparation. Cremerius gives one clear example of this in his criticism of the situational structure of the interview technique employed by the French psychosomatic-psychoanalytic school (Cremerius 1977a).

Educated and uneducated patients vary so widely in their prior knowledge of psychoanalysis (Cremerius 1977a) that the way the dialogue is conducted must be adjusted accordingly. A striking example of the patient's prior understanding and the analyst's erroneous interpretations of it is provided — probably unintentionally — by Schröter (1980) in his essay on specific reactions to the treatment process and the social distance to the therapist: "It nevertheless seems that lower-class patients are typically irritated to a greater degree than others by the special features of the psychoanalytic dialogue" (p.60).

It irritates us that a sociologically trained author here postulates a form of the psychoanalytic dialogue which seems to make no allowances for variation in the conditions under which the patient's everyday communication takes place. We cannot let this rigidity — as though the unconscious were accessible only via a form of psychoanalytic dialogue oriented toward an upper middle class standard — go uncriticized, particularly since we have good models for conducting the interview according to the patient's potentialities (Deutsch and Murphy 1955).

It would seem more profitable to study the Balints' recommendations concerning the necessary conditions for a successful interview (Balint and Balint 1961, pp. 187-188), which we would now like to summarize. *Recommendation* I (see above) stresses the importance of proper and adequate introduction to the encounter — particularly relevant with regard to the social component of the differences in patients' expectations. Recommendation 2 is the creation and maintenance of an appropriate atmosphere, in which the patient can open up enough for the therapist to be able to understand him. This is a test of the interviewer's capacity for active empathy, and thus of his ability to adjust himself to every new patient. Difficulties are inevitable here as well, necessitating continuous examination of the analyst's contribution to the dialogue. The Balints emphasize this by pointing out that a doctor who always reassures the patient as soon as he notices the latter is under stress will gain material different in nature to that gathered by a doctor who only listens passively and lets the patient "stew" or steer the interview himself.

Statements about a patient should therefore always include information on the situational parameters created by the interviewer which have acted as "stimuli" — in the Balints' sense of the word — on the patient *(recommendation 3).*

It is very important that the psychoanalyst have some idea of the future direction of the relationship before he begins to mold it in the interview. The concrete interview plan *(recommendation 4)* depends on whether the analyst can

anticipate that the interview relationship will develop into a therapeutic relationship, or whether it is certain from the outset that the relationship will end at least provisionally after this one encounter because the patient will be either placed on the waiting list or referred to a colleague.

The duration of the interview is another of the parameters determined both by practical external considerations and by the complexities of the interaction. On the one hand the therapist is emotionally and scientifically curious, on the other his need for security leads to great differences in the form the interview takes.

One practical problem which is often overlooked is the patient's lack of information as to the duration of the interview. After all, the initial interview frequently follows a series of mostly disappointing and often short consultations with doctors. How should the patient know that he can now count on a duration of at least 45 minutes and on the security which this gives? Another matter which must be considered is the question of whether the patient should be informed of the possibility of a second meeting directly at the beginning of the interview, or whether this should be decided at the end on the basis of what the interview has revealed.

Conversely, we believe it is vital that novice analysts, in particular, set themselves a definite framework for the configuration of the initial interview, but avoid having an unlimited number of sessions depending on their own personal degree of insecurity *(recommendation 5).*

These passionately debated details of technique all belong to the area which the Balints seek to embrace in the concept of *elastic interview technique.* The analyst must react differently to different patients and not allow himself to be restricted by stereotypes such as the traditional understanding of countertransference *(recommendation 6).* We can speak of a capacity for countertransference when the analyst recognizes countertransference and can use it to good diagnostic effect (see Dantlgraber 1982). The decisive question is: In which respect does this flexibility have to prove its value? Here too, the Balints go straight to the problems for which there are no universally applicable answers, but which must be solved on an individual basis: "Is it advisable or desirable that a consultation should amount to nothing more than a diagnostic examination, or should it include some sort of therapy, e.g. some highly mitigated form of psycho-analysis?" (Balint and Balint 1961, p. 195). We are of the opinion that the patient should experience in the initial interview what the treatment can mean for him; this is therapeutic in itself. But viewing the initial interview as a model of therapy raises a demand which cannot be satisfied. The interview should be conducted in a manner that gives the patient a basis on which to decide for himself whether he wants to undergo psychotherapeutic treatment and is capable of tackling the problems inevitably associated with its realization. This approach releases the patient from his passive role. Although a certain amount of exploratory diagnostic work is essential and should not be phobically avoided, the goal of the psychoanalytic interview is to find what is going on or has gone on within the patient and how he himself has contributed to his fate. This goal can be reached by means of an appropriate technique, as described clearly and empathically by Rosenkötter:

When a patient visits a psychotherapist on account of neurotic symptoms or other problems of psychic origin, the first contact between the two is in principle no different from that in other medical consultations. The patient reports his problems, and the therapist tries to find out as much as possible about their occurrence and history and about the life history of the patient in general, in order to gain material on which to base a verdict as to indication and prognosis. An important role is played by the therapist's experience and gift for empathy. The therapist must allow sufficient time to enable the patient to enter the dialogue spontaneously and of his own free will; any questions he needs to ask should accompany and supplement the patient's report in a cautious manner, and he should take care to maintain a beneficent neutral, reserved attitude. He should avoid specific questioning, definitive statements, and instructions, which tend to lead patients in general to adopt an attitude of passive, magic expectation toward doctors. (1973, p.989)

The Balints' comments on the initial interview, which are relevant for the analyst as well as for psychotherapy in medical practice, were taken up by Argelander, who in a series of publications (Argelander 1966, 1967, 1970; Argelander et al. 1973) devoted himself to the interaction between patient and investigator:

For the experienced psychotherapist, Balint's statement says that every interview is also grasped as an analytic situation and features specific moments of transference to the given interviewer and the given surroundings at the given time. The patient's very varied communications verbal information, proffered behavior, ideas induced in the interviewer, and so on are grouped or, more accurately, crystallized around this interpersonal relationship, the heart of the examination as Balint called it. They receive from this action center a directive which leads to the patient's problems unfolding in characteristic fashion before the eyes of the given examiner. (1966, p.40)

Argelander varies and elaborates these themes in the later publications. Taking Balint's theses to their conclusion, he describes the interview as "an analytic situation in which we use our psychoanalytic instrument also for diagnostic purposes" (1966, p.42). Even though it is taken for granted that the analyst adapts the psychoanalytic instrument to the special external structure of this initially restricted analytic situation — it must remain in harmony with the current reality and the ego-related process — this interview technique often demands more than analyst and patient are in a position to deliver. Argelander (1966, 1967) distinguishes between two areas of experience which he tries to relate in the interview: the registering of objective facts and the development of subjective experiencing.

The fusion of these two areas of experience (with the objective subordinated to the subjective) constitutes the specific psychoanalytic access. In this concept, the three essential working steps are characterized by observation of behavior, questioning for "objective" information, and a specific kind of perception which takes the form of empathic understanding of the unconscious object relationship. This third function is precisely that understanding of process activity which occurs in long analyses:

We know from psychoanalytic experience that in an object relationship internal psychic processes are projected externally and can be perceived and experienced subjectively. For this reason we give the patient the chance to initiate an object relationship in the initial interview, leaving the form, content, and dynamic of the relationship to be determined by his own individual personality. His spontaneity is fully safeguarded. Our appearance, age, sex, character, temperament, etc. are concrete situational factors which stimulate the examinee to transfer preexisting inner feelings, expectations, conflicts, ideas, and fantasies to the examiner. (Argelander 1967, p.431)

This "transference theory" of the initial interview owes its indisputable

attractiveness to the fact that the painstaking, slowly developing processes of mutual understanding and communication in the psychoanalytic process are apparently comprehended at the very first attempt, during the first encounter.

In his further elaboration of this position (1970), Argelander separated the three sources of information, which he termed objective, subjective, and scenic. This is somewhat arbitrary, as he himself says, but useful in practice. "Scenic information is dominated by the experiencing of the situation, with all its emotional stimuli and ideational processes" (1970, p. 14). The specific understanding achieved in scenic cognition was developed and structured in Balint group work and in case discussions (Argelander et al. 1973). The accumulated experience of Argelander and his colleagues underlines the fact that in an interview material is usually gathered relatively rapidly "in order to put analytic perception and thinking on an operational basis" (Argelander et al. 1973, p. 1004). The Balint group experience was confirmed in this setting, which (although different) shared a similar structure by virtue of the brevity of the interviews. Despite the very positive response among German-speaking analysts to Argelander's model of the initial interview, his own admonitions and self-critical comments have not received corresponding attention: "The exercises in scenic understanding should thus serve to accentuate the preconscious perception and thought processes more strongly and in this way mobilize the analyst's natural creative potential" (Argelander et al. 1973, p. 1009). The capacity to perceive preconscious processes can be improved through training.

> Without this training nothing more than extravagant fantasies and wild speculation can be expected .... This fact cannot be stated often enough, as our speciality is particularly guilty of ignoring it. The failures are then swiftly blamed on the hopelessly overstressed subjective factor, and eventually the whole method is discredited. (Argelander et al. 1973, p. 1010)

Our assessment of this interview style can be related to Argelander's own reservations. It is one thing for a group led by a specially gifted psychoanalyst to dedicate itself to developing a highly differentiated interview style, but quite another to evaluate how well such a procedure can be taught and learned. In addition, we doubt whether this method, when applied in too purist a fashion, achieves the special results it was designed to achieve, i.e., to enable the selection of a specific therapeutic procedure "oriented toward the patient's present inner conflict situation (e.g., short therapy) or his current transference disposition and its needs, conflicts, and forms of expression (e.g., group therapy)" (Argelander 1966, p.41). Indications for particular treatment procedures cannot be established entirely from the diagnosis of unconscious conflict constellations, as the following discussion of the problems regarding indications will show.

In recent years it has become increasingly clear that although the initial interview is adequate for a subjective appraisal (Dantlgraber 1982), a more differentiated establishment of indications requires consideration of additional factors. The purely subjective impression of a patient's suitability for analysis is not sufficient.

6.4 Decision Process

So far we have concentrated on a critical account of past and present conceptions of the initial interview as an event which is simultaneously diagnostic and therapeutic. At the end of the last section we were confronted with the question of what conclusions regarding indications can be drawn from any one technique. As we will now show, the misgivings we mentioned are borne out by the almost complete lack of substance displayed by the results in the copious clinical literature.

Freud's indication criteria were essentially criteria of exclusion: to be excluded are those who do not have a certain degree of education and a fairly reliable character, and also those who themselves feel no necessity to undergo treatment for their problems but are pressured into doing so by their families. "To be quite safe, one should limit one's choice of patients to those who possess a normal mental condition, since in the psycho-analytic method this is used as a foothold from which to obtain control of the morbid manifestations" (1905a, p.264). Further restrictive criteria which Freud applied were age and the necessity for swift elimination of threatening symptoms, for example in anorexia nervosa.

We attach greater importance to Freud's positive criterion of indication which is much less widely known: "Psycho-analytic therapy was created through and *for* the treatment of patients permanently unfit for existence" (1905 a, p. 263, emphasis added). With the proviso of the existence of a "normal mental condition" as described above, Freud attaches no restrictive significance to the severity of an illness. This viewpoint differs radically from the conclusion reached in numerous round table discussions of analyzability (e.g., Waldhorn 1960); the description of the suitable patient can be summed up as "sick enough to need it and healthy enough to stand it." This shows how far the neoclassical style of treatment technique has departed from Freud's original conception.

We must today still proceed from the assumption that the indication for psychoanalysis can only rarely, if ever, be derived from the nature of the illness. Although a distinction was long made between transference neuroses — considered treatable — and narcissistic neuroses, the fact could not be disguised that the diagnosis of a transference neurosis actually says relatively little about treatability. Before we continue the tangled story of the development of indication criteria, characterized over the decades by the introduction of various terms such as suitability, accessibility, and analyzability, we would like to point out that in doing so we are describing a line of thought which did not originate in Freud's practice.

We believe that to discuss the problem complex from the perspective outlined by Tyson and Sandler (1971) — that of the problems involved in selection of patients *for* analysis — is to start from a false position, one which originated in a legitimate central idea but has become a dance around the golden calf of the basic model technique (see Chap. 1).

The nucleus of many discussions concerning the selection of patients for psychoanalytic treatment is represented by the high demands in terms of personal commitment, money, and time which an intensive analysis places on both patient

and analyst. Not for nothing has psychoanalysis been compared to an expedition whose members must be chosen with care. It thus seems that the method may in fact not be successful in all the "patients permanently unfit for existence" for whom Freud originally said psychoanalysis was created, and therefore it is in the interests of both doctor and patient to appraise its applicability in advance in each individual case. This must be borne in mind in reading the following discussion of the problematic nature of indications for psychoanalysis in the standard technique with its high frequency of sessions.

Freud enthusiastically regarded patients with all variants of severe and complex neuroses who could not be treated by more convenient methods (1905a, p.262) as potential candidates for his new method. Jones (1920), however, introduced the connection between diagnosis and prognosis. His catalogue of indications includes the following diagnoses: (I) hysteria, (2) anxiety hysteria, (3) compulsion neurosis, (4) hypochondria, (5) fixation hysteria. Groups 4 and 5 were considered to have worse prognoses.

Fenichel (1945) took up the idea of connecting the prognosis to the severity of the neurosis:

> In general, therefore, the difficulty of an analysis corresponds to the depth of the pathogenic regression. Thus using analytic knowledge about the depth of the decisive fixation points in the respective neuroses, the neuroses may generally be classified, according to their accessibility to analysis ... (p. 574)

The method, by this time established, is embodied in the words "accessibility to analysis." Fenichel stresses, however, that:

> Many other circumstances must be considered in making the prognosis: the general dynamic relationship between resistances and the wish for recovery, the secondary gains, the general flexibility of the person. (p. 575)

Glover (1955) takes up the concept of responsiveness and assigns diagnoses to one of three categories, "accessible," "moderately accessible," and "intractable. "

Tyson and Sandler (1971) state that the symposium "The Widening Scope of Psychoanalysis" shifted the emphasis from diagnostic criteria to criteria of suitability. As A. Freud (1954b) commented, there is no guarantee that two people with the same symptoms will react identically to the same technical intervention. This fact cuts the ground from under the feet of any nosologically oriented discussion of indications. Yet it took a long time before the knowledge that it is impossible to predict the result of treatment for a given patient led to the conclusion that analysts should seek those factors which have a positive effect on the development of a psychoanalytic process. The problem continued to be reduced to the familiar formula "insight into the structure of the neurosis." Freud's (1913c) concept of a trial analysis was elaborated by Fenichel (1945) but has never really been widely adopted. Instead, the initial interview increasingly contains elements of the trial analysis, the intention being to test the patient's ability to handle interpretations (Alexander and French 1946, p. 98). Although the results are sometimes impressive, the fear remains that this situation could create excessive stress, with potentially negative consequences on the decision regarding indication.

Mitscherlich (1967) formulated a minimal requirement which ought to give a greater number of patients access to psychoanalytic treatment: "The ability [of the patient] to react affectively to an understanding offer seems to us the most certain prognostic indicator that ... the symptom does not represent the best outcome which the patient could achieve" (p. 149). Also implied here is the "ability" of the therapist to make an "understanding offer." The problem of the initial interview and the associated problems of indication is complicated by the technical issue of how we can convince patients to cooperate with our "direction of questioning" (Mitscherlich 1967, p. 141). However, since we do not want our portrayal of the problems to end up following the traditional dichotomy between the standard technique and analytically oriented psychotherapies, the simple statement that the patient's cooperation in the initial interview should be won by means of an understanding offer does not suffice. For which goals should it be won? In this light we can now examine more closely the criteria of suitability put forward by Tyson and Sandler (1971), which in our opinion imply processes to reach consensus on goals.

We suggest speaking in terms of a wide range of treatment goals. Psychoanalysis can only fully live up to its ambitious claim of being a path to improved self-knowledge if the self-knowledge which is gained results in a decrease of anxiety and thus in a change in viewpoint and a modification of behavior toward a freer choice of goals. Freud's statement (1909b, p. 121) that "therapeutic success, however, is not our primary aim; we endeavour rather to enable the patient to obtain a conscious grasp of his unconscious wishes" implies a postulate of change that can only be artificially distinguished from narrowly defined medical criteria of success. Psychoanalytic theory postulates that the elimination of repression and the conscious recognition of previously unconscious wishes necessarily bring about a change in psychic processes. The discussion of indications for various forms of psychoanalytic treatment is thus actually a discussion of various goals. The decision to suggest that a patient have several sessions of analysis a week implies the assumption that he can in all probability achieve profound changes in his psychic processes which will affect very different areas of his life in various ways. When setting the goals, it is legitimate to make the necessary preconditions for such a process of change the object of critical discussion. The patient's motivation, his personal orientation, his curiosity about psychology, and his ability to utilize object relationships are among the factors which play a decisive role in the current discussion of indications for classical psychoanalysis.

Kuiper (1968) professes a restrictive approach to the establishment of indications and points out, quite rightly, that young analysts' enthusiasm for the standard technique leads them to apply it uncritically. There can, for example, be highly unfavorable consequences if the analyst treats silence and stereotyped nonanswering of questions as indispensable components of the standard technique and employs them with patients for whom this technique is not suitable. Note that we designate the technique unsuitable, not the patient. We thus agree with Kuiper that the standard technique is very limited in its applicability, but accentuate the necessity of modification and adaptation to fit each individual patient. Kuiper even

puts forward a motive for the tendency toward excessive application of the standard technique: Analysts have invested a lot of energy, time, and money in learning it, and now they want to try it out exclusively and intensively with as many patients as possible. The inevitable disappointments then lead, via reaction formation, to dismissal of other, "nonanalytic" aids (Kuiper 1968, p.261). At the same time, idealization of the standard technique removes the analyst's own doubts about it; instead of thinking about modifying his technique, he blames the patient for turning out to be unsuitable after all.

All too often, it emerges that the characteristics described as necessary or adequate for the acceptance of the responsive or analyzable patient for classical psychoanalytic treatment simultaneously form goals of the treatment process:

> The patient must have a sufficient degree of intelligence, an ability to tolerate painful affects and be capable of sublimation. His object relationships will be relatively mature and his capacity for reality-testing will be more-or-less well established. His life will not be centred around his analysis so that he becomes unduly dependent on it, and his moral character and educational achievements will have assured him of a good position in life with adequate rewards. It would seem that we may be in the paradoxical position of finding that the patient who is ideally suited for analysis is in no need of it! (Tyson and Sandler 1971, p.225)

Rather than drawing the conclusion that minor deviations from this ideal must be tolerated, we prefer to examine the interactional quality of those characteristics. "Healthy enough to stand it" refers after all to the psychoanalytic situation which patient and analyst must create and maintain. Kuiper believes that the question of who analyzes whom in what way and to what end cannot be taken seriously enough. Defining what the analyst must and can do in every individual case to make an analytic process possible should bring to an end the persistent debate concerning analyzability. In a review of the difficulties regarding analyzability, Bachrach (1983, pp. 199-200) reduced the problem to three groups of patients:

1. "Reflective persons of basically reliable ego who are able to adapt to the expected range of differences among analysts and make the most productive use of their analytic opportunities"
2. Ego-weak patients who display an infantile character and are "unable to participate in the work of analysis"
3. Patients described by Bachrach as "borderline" cases (not in the diagnostic sense), "for whom the fate of the analytic work often more heavily depends upon the person and special talents of the analyst"

Although it is plain what Bachrach is trying to express in the words "basically reliable egos," we consider it more advantageous and strategically more appropriate to examine the interactional configuration in every therapeutic situation. The basic reliability of which Bachrach speaks is as much a fiction as Hartmann's "average expectable environment," which led the theory of ego psychology up a blind alley (Fürstenau 1964). The importance of the psychoanalyst's ability to vary his approach in response to each individual patient's needs and conflicts has grown by the same extent to which the main symptoms have been shifted from circumscribed disturbances to more diffuse personality problems (Thomä and Kächele 1976). The existence of two complementary techniques, which Cremerius (1979) described for solely didactic

reasons as opposing poles, is an expression of the fact that "the boundaries of analyzability are not the boundaries of the patient and his psychopathology, as claimed by Freud (1937c), but the boundaries of the analyst" (Cremerius 1979, p.587). We believe that the concept of "analyzability" has lost every last scrap of specificity and could be beneficially replaced by "treatability." If "analyzable" comes to refer to what a psychoanalyst can do and endure, then indications can become the object of discussion and research only within the framework of the bipersonal foundation of the therapeutic process.

The conception of indication in the initial interview thus changes from *prognostic* (static) to *adaptive* (dynamic), expressly referring patient and analyst to one another (Baumann and von Wedel 1981). A successful example of this thinking is given by S.H. Shapiro (1984), who proposes a genuinely psychoanalytic approach to ascertaining the most suitable treatment method. Instead of a trial analysis — which we also consider no longer appropriate, for many reasons — Shapiro has an exploratory phase in the course of which he tells the patient about the method of free association. We agree with his assessment of the potential of a *diagnostic phase of therapy,* which is not a trial analysis in the conventional sense followed by the decision regarding suitability, but rather has the purpose of finding out what changes can be achieved under what therapeutic conditions. The wide scope of the current forms of psychoanalytic therapy allows room for many ideas, which do not even have to be restricted to the field of psychoanalysis in the stricter sense.

If we apply Balint's recommendations to general practitioners to the psychoanalytic initial interview, and develop the conception of a longer relationship to the patient extending beyond one single meeting, the many possibilities offered by patient-oriented indications open up various paths to change which the patient can follow immediately or at a later date (Hohage et al. 1 9 8 1).

Analysis of the many aspects of the problem of indication must include both the recognition of the subjective elements in the decision (Leuzinger 1981, 1984; Dantlgraber 1982) and consideration of institutional factors affecting psychoanalytic activity. The interaction of the two is often very difficult to discern, as they are easily concealed by the strategies the analyst employs to justify his procedure.

The influence of theoretical assumptions on the decision is great, but still greater is the effect of practical circumstances, which influence the determination of indications now just as they did in Freud's time. Alteration of such circumstances such as the inclusion of psychodynamically oriented and analytic psychotherapy in the services covered by health insurance — enlarges the circle of patients who can undergo treatment. Class-specific factors nevertheless continue to play a significant role in decisions on indications, as is shown by all empirical studies on this topic. The bias in selection is concealed behind criteria of suitability which thus in many places impose iatrogenic restrictions on the range of psychoanalysis.

Social changes and the covering of costs by health insurance have brought us nearer to the goal of attracting patients from a broad range of social and

nosologic backgrounds by means of flexibility in the structuring of the initial interview. It is easy enough to start an analysis with a highly motivated individual, even if the treatment turns out to be difficult; the art of the initial interview lies in awakening a hesitant patient's interest in the therapy he urgently needs. The development of many different forms of psychoanalytic therapy which can be tailored to the individual patient means that Freud's metaphor of gold and copper has to be revised. Today therapy can be planned and structured to meet the individual patient's needs. This perhaps brings us to the central problem concerning the initial interview: We are in a situation where we must make decisions relating to the patient that are no longer defined by the old familiar dichotomy of psychoanalysis vs. analytic psychotherapy. We have to consider how the most favorable conditions for the patient's development can be created and which psychoanalyst is the best for this task. At the end of the first meeting, if not before, the analyst must face the questions: What happens now? Which external conditions have to be satisfied if treatment is to take place? How can a therapy be harmonized with the patient's personal and professional life?

The adaptive approach to indications — the one we regard as commensurate with our present state of knowledge — does not reduce the great responsibility which goes along with the acceptance of a patient for therapy, regardless of frequency and duration. It avoids, however, the particular strains which arise when far-reaching temporal and financial commitments have to be made simultaneously with the assessment of analyzability. We also believe that when discussing the arrangements for the analysis, stress should be laid right from the outset on defining the duration of therapy in terms of the desired and achievable goals, rather than in terms of years or number of sessions. This robs the information concerning the duration of analysis of its depressing effect, and the patient can hope for improvement or cure in less than 1, 2, or X years. Since deterioration, improvement, and cure — the analytic process in its entirety — also depend on the analyst's professional competence, the duration of treatment is also a dyadically determined quantity depending on many factors.

The analyst must always take into consideration the fact that the patient is at liberty to interrupt or terminate the treatment at any time. Attention must therefore be paid to suggestive undertones in remarks about frequency and duration. On the other hand, both participants know that the patient's ideal freedom of choice is in reality restricted — by external circumstances, by self-deceptions based on unconscious motivations, and by the relationship and transference conflicts of the analytic process. Thus there are many factors determining how long treatment should ideally continue and how long it actually lasts.

In the transition from initial interview to therapy, it is important to leave as much room for flexibility as possible and to create an atmosphere of freedom which arouses hope (Luborsky 1984). At the same time, a framework must be established which ensures good working conditions. There is no simple solution to this problem. However, our seemingly banal experience is that patients generally continue to attend as long as there is a positive balance between investment and return. There are good reasons for attaching central significance to the patient's

personal assessment of investment and return and thus for according his decisions the consideration they deserve. In this way an ideal scope for development is at least envisaged, however many restrictions actually emerge in its realization. The matter never rests at purely subjective weighing up of pros and cons. Even a multimillionaire who retreats to a desert island like a modern Robinson Crusoe with his analyst Dr. Friday in order to undergo interminable analysis will have to reckon on his analyst assessing the relationship of investment to return differently than he does. There is no need to let this fictive situation spur us on to further fantasies, as nowhere in the world does the patient have sole control of investment and return, of frequency and duration of treatment. The analyst also has a say, and the latently present third parties express their opinions too, directly or indirectly — the effect being particularly incisive in the case of third-party payment.

Enormous differences are possible in the assessment of what we have for the sake of brevity referred to as investment and return. Too many combinations are conceivable for us to be able to discuss them individually here. Our choice of economic terminology is quite deliberate, although we realize it may well alienate the reader. We must not allow the enthusiasm over the frequently liberating effect of psychoanalysis to divert us from the involvement of the patient's family and the investment in terms of time and money. Klauber (1972b, p.99) placed particular emphasis on the great influence of the cost in time and money and the involvement of the latently present third parties, the patient's family. In West Germany and West Berlin the great majority of analyses are paid for in full by the public health insurance companies. Even most so-called private patients (i.e., those not in public health insurance schemes) receive third-party support from private health insurance companies or the state. The only analysands who genuinely pay out of their own pockets are future analysts undergoing training analyses. Since over 90% of the population are compulsorily insured by public health insurance companies, most patients undergoing analytic psychotherapy suffer no financial privation as a result. Patients come to the initial interview with a certificate for treatment guaranteeing that the costs will be borne by their insurance company. We will return to this theme later (Sect. 6.6), but first we will discuss the patient's relatives, who are always latently present in the initial interview and are not infrequently really present. The analyst's attitude to the patient's family colors the way the dialogue is conducted, and is another factor which can have an often totally unnoticed influence on the direction of the analysis.

6.5 The Patient's Family

Freud (1940a, p. 145) described the earliest endeavors in psychoanalysis as the study of "the individual development of human beings." In the Enlightenment tradition, he strove to explore the connections between a patient's widely varying actions and his inner afflictions, and to achieve a cure through self-recognition. Freud sought to effect the expansion of an individual's consciousness by enabling him to gain insight into his unconscious psychic life, seeing in this an essential

contribution of psychoanalysis to enlightenment.

The request for psychoanalytic treatment must come from the patient alone. Any agreement between therapist and patient has ethical and legal implications. Discretion and professional confidentiality contribute to a basis of trust between the two parties. In considering whether and when to consult members of the family, we must have the patient's well-being in mind. Only in emergencies may we contact them without the patient's permission, for instance if the patient is not in a position to supply reliable anamnestic information to enable the doctor to make a diagnosis and decide on the appropriate form of treatment. An example of such an emergency is a psychotic or suicidal patient, i.e., one who is not in control of himself. Otherwise the analyst must follow the rule of giving the family no information about the patient.

Generally the psychoanalytic method makes it unnecessary to involve the patient's family. The psychoanalyst relies on what he observes in the sessions with the patient. It is assumed that a patient in analysis has relationship conflicts with the analyst similar to those with his spouse and closest friends and relatives. The analyst needs no direct contact with the patient's family because with the development of the transference neurosis, if not before, he can experience for himself how the patient behaves toward those close to him and unconsciously provokes actions and attitudes for or against himself.

An analyst with an interactional understanding of transference and countertransference can on the one hand gain insight into the way the patient sees things, and on the other, understand the behavior of the relatives, whose reactions may bear similarities to his own countertransference. To these two dimensions can be added at least one more, i.e., the analyst's professional knowledge of human interaction.

The psychoanalytic method raises specific questions concerning the way the analyst deals with the patient's relatives. The method is dependent on the dyadic relationship. In comparison with a surgical operation, the situation is complicated by the real presence of a third person. The commitment to a two-person relationship entails differentiation between internal and external relationships. The psychoanalytic method is a dyad, but could more correctly be termed a "triad minus one," as a third party is always present in some sense, even when no member of the family actually takes part in the treatment. This real absence but latent presence of the third party has major consequences for all concerned.

Glover's survey of 29 British psychoanalysts (Glover 1955) included questions on how they saw and dealt with the problem of patients' relatives. He asked, for instance, whether they had contact with relatives, and if so, with or without their patients' knowledge: "All speak to members of the family, most unwillingly, and at the patient's request. With few exceptions (severe psychoses, children), interviews are arranged with the knowledge of the patient" (Glover 1955, p.322).

The subsequent literature contains scant reference to the technical management of this problem, although it has broad clinical relevance; indeed, it plays an important role in every therapy. This includes training analyses, where in most cases the analysand's families have no direct contact with the training

analyst or institution, although both inwardly and outwardly they are deeply involved. It is not uncommon for the partners to enter therapy themselves or form their own discussion groups.

Freud wrote that he was "utterly at a loss" in face of the problem of how to treat the patient's relatives. His advice runs as follows:

I must give a most earnest warning against any attempt to gain the confidence or support of parents or relatives by giving them psycho-analytic books to read, whether of an introductory or an advanced kind. This well-meant step usually has the effect of bringing on prematurely the natural opposition of the relatives to the treatment — an opposition which is bound to appear sooner or later — so that the treatment is never even begun.

Let me express a hope that the increasing experience of psycho-analysts will soon lead to agreement on questions of technique and on the most effective method of treating neurotic patients. As regards the treatment of their relatives I must confess myself utterly at a loss, and I have in general little faith in any individual treatment of them. (1912e, p. 120)

As we know, Freud later expected his analysands to have read his works, but did not wish to give their relatives access to the same information. He resigned himself to "the natural opposition of the relatives to the treatment." His optimism had hardly increased by 1917:

Psycho-analytic treatment may be compared with a surgical operation and may similarly claim to be carried out under arrangements that will be the most favourable for its success. You know the precautionary measures adopted by a surgeon: a suitable room, good lighting assistants, exclusion of the patient's relatives, and so on. Ask yourselves now how many of these operations would turn out successfully if they had to take place in the presence of all members of the patient's family, who would stick their noses into the field of the operation and exclaim aloud at every incision. In psycho-analytic treatments the intervention of relatives is a positive danger and a danger one does not know how to meet. (1916/17, p.459)

These remarks have to be seen in part against the background of Freud's technique at that time, which was concentrated on the exploration of the unconscious and of infantile sexuality. The comparison of the psychoanalytic situation with a clean, aseptic operative field leads logically to descriptions of relatives as a source of danger. The ideal of the clean field is expressed explicitly in Eissler's (1953) description of parameters. For him, the intrusion of a family member into the dyadic situation represents a deviation from the basic model technique. This technique views relatives as a confusing and disturbing factor in an otherwise apparently ideal space between doctor and patient.

In an earlier discussion of the problem of the patient's relatives (Thomä and Thomä 1968), we took the view that there are two reasons for analysts' "unwillingness" to involve them, one general and one specific. We see the *general* reason in the wish to protect the "working alliance" (Greenson 1967) with the patient. The "working team" of doctor and patient (Heimann 1966, pp. 333334) can only function if interference by relatives remains limited. In the effort to ensure discretion and gain the patient's trust, the analyst pushes the family too far out toward the periphery. Richter (1970) mentions further aspects of excessively rigid adherence to the two-person relationship:

Psychotherapists know that treating an individual is generally less arduous than working with the clustered problems of the whole family group. It is easier to comprehend the difficulties of a single patient than the knot of interactional conflicts involving several members of a family. In addition, it is easier to bear, and work on, the

transference of a single patient than the complex tangle of emotions of a whole group of people in the grip of neurotic tensions. (p. 122)

Patients feel the analyst's unwillingness to change the setting, and this leads to specific manifestations of transference/countertransference. The relatives then feel all the more excluded, and their mistrust grows. They tend to react by either idealizing or totally rejecting the analyst. This again depends on what the patient reports about the analysis and what he keeps to himself. Since the development of the transference neurosis depends to a high degree on the analytic technique, it is very likely that the patient will act out intensively outside the analytic relationship and that the persons affected will react with counteroffensives. The consequent professional attitude distances the analyst from the patient's relatives and can be viewed as the specific reason for his reluctance to deal with them.

6.5.1 The Burden on the Family

Hans Thomae (1968, p.89) stressed that for Freud and his followers, the way an individual acts and feels is determined above all by the conjunction of a need and a specific constellation of environmental factors within a more or less circumscribed critical phase. The connection between the patient's *individual* rate and its impact on the environment characterizes the tension between the patient and his family. Psychoanalytic treatment affects the relatives as well as the patient, and these consequences of the psychoanalytic process cannot be taken too seriously.

The family has a correspondingly strong interest in the patient's treatment. Nothing could be more natural than the desire to see the analyst and get to know him, or at least learn something about him. In the early phase of analysis some patients will bring a close relative (usually the spouse) with them, unannounced and with noticeable hesitation, in order to bring about at least a superficial acquaintance. Probably many more relatives than we suppose have seen the therapist or heard something about him.

The relatives' interest in the analyst and the treatment arises from their realization that not only the patient's life will be changed, but theirs too. Some try to escape these changes by claiming that the problem lies wholly with the patient, whom they "hand over for therapy." Mostly, however, they notice that an individual's development processes also affect the people around him, changing the relationships between them. Grunberger (1958) illustrated the links between the lines of development with the example of the restructuring of the patient's superego. The inevitable structural modifications of the superego in the course of the psychoanalytic process disturb the existing arrangements regulating life within the family.

Lidz et al. (1965; Lidz and Fleck 1985) provided a striking account of how closely the psychic conflicts of severely disturbed patients are interwoven with the psychic problems of their relatives. It is precisely when the patient's relatives are emotionally disturbed themselves, or at least contribute to maintaining the patient's neurosis, that unconscious motives can lead them to lend only partial

support to the treatment. In such a case the analyst should consider whether the interpersonal conflict should be made a goal of therapy, although then the question arises of whether the members of the family should be included only during one certain phase of therapy, or whether treatment of a couple or of a whole family seems to be indicated and the two-person therapeutic setting should be abandoned.

Patients often base important decisions concerning their professional and private lives on what they have discovered about themselves in the course of analysis. When this happens, it is essential that the analyst give the patient's relatives the feeling that he is aware of the burden on them and recognizes that the psychoanalytic process has repercussions on them too. In our view, this means not just thinking about the intrapsychic conflicts but also considering the patient's relationships with other people, in order to achieve a balance between the external and the internal, between interpersonal relationships and intrapsychic object relationships. The positive change in the psychoanalyst's attitude to the patient's family and environmental situation has modified the management of this problem in the way we have described.

Few empirical studies have been published on how partners or other family members change during or after psychotherapeutic treatment. In a study on 39 hospital inpatients with severe psychic disturbances, Kohl (1962) wrote that all the partners also suffered some form or another of mental illness and endangered the success of the therapy. Bolk-Weischedel (1978) relativized this statement. In a semistructured follow-up study of the spouses (15 women and 35 men) of 50 patients treated on an outpatient basis, she found that 13 previously symptomatic individuals became symptom-free and experienced positive structural change during their partners' treatment. Eleven previously symptom-free spouses became symptomatic, six of them with subsequent positive structural development. Ten spouses suffered so much during the treatment that they sought advice or therapy for themselves. Ten patients decided on separation or divorce during the course of the treatment; this corresponds to the figures on the divorce rate during psychotherapeutic treatment given by Sager et al. (1968). The majority did not regret taking this step. Bolk-Weischedel interprets this appearance or alteration of symptoms as an indicator of a lability, induced by the treatment, which first makes progressive development possible.

6. 5. 2 Typical Situations

Great sensitivity is needed in dealing with the patient's relatives. The keynote is always the creation of a therapeutic situation which gives the patient faith in the therapy and in the analyst. In other words, the principle we follow when making our decisions is that whatever we do, the vital point is to create for the patient "the best possible psychological conditions for the functions of the ego" (Freud 1937c, p.250). In occasional cases the inclusion of one or more members of the patient's family can promote the psychoanalytic process by combating stagnation. It is not merely a matter of expanding the basis of observation to gain more

information; the presence of the relatives enables added concentration on the interpersonal relationships between them and the patient. The observation of this interaction serves diagnostic purposes (for example, the degree of real dependence must be evaluated), but therapeutic influence can also be exerted.

There are basically three situations in which we have to decide whether or not to take up direct contact with a patient's family: (I) during the initial interview; (2) in an emergency (accident, suicide risk, committal to hospital); (3) in the course of the treatment.

It is well known that the *initial interview* can take many forms. One essential element in the assessment of the patient's condition is the behavior of the relatives — whether they do not appear at all, stay in the background (outside the house, in the waiting room, etc.), or arrange it so that they come into the office with the patient. Depending on the analyst's approach, various things can happen. Relatives who remain in the background and hesitate to approach the analyst are unconsciously reinforced in their reserve; those who appear unexpectedly are rebuffed with analytic neutrality and distance. The opportunity to recognize the interpersonal dynamic and analyze it with an expert eye can then be lost. For various reasons, it is difficult to behave in a natural way (Heimann t978).

It is common knowledge that some patients decide on separation or divorce from their partners during the course of psychoanalytic treatment. Because prospective patients and their partners know their marriage might be endangered, they often seek a therapist whose own marriage is said to be stable by the friends who recommend him. Conversely, would-be patients with extramarital relationships tend to choose therapists with similar life styles, because they believe that such therapists will understand them particularly well. Patient and partner may raise urgent questions on this topic at the time of the initial interview.

In the initial interview we inquire about the patient's relationships, distinguishing between present and past ones. At the beginning of therapy it is useful to note how the persons close to the patient react. Reports by friends and relatives on their past treatment have a decisive influence on the patient's initial attitude to his own therapy. The analyst can answer many urgent questions by tendering information about psychoanalytic treatment.

Emergency situations form an exception to the normal rule that every contact with a relative must be discussed with the patient. Such situations may be uncovered in the initial interview or may first reveal themselves during the course of treatment; for instance, suicidal tendencies in a psychotic episode demand swift action which often necessitates the cooperation of the patient's family. It is very unusual to have to commit a patient to a psychiatric hospital against his will; usually we can obtain his consent, though often only with the help of his family.

The patient's partner can enter the *treatment situation* at the wish of the patient or the analyst, but also at his or her own request. The question of what (apart from emergencies) precipitates interaction with relatives leads to the definition of the ideal patient: someone able and willing to include the neurotic element of his relationship disturbances in his transference in such a way that his conflicts are renewed and can be resolved — in other words, someone who is suffering but who works through his conflicts in the analysis. The reaction of the

patient's family obviously depends on how he reports his experiences in the analysis. The psychoanalytic method demands a high capacity for introspection on the part of the patient and his family. Often, however, not all the parties involved initially possess this. The progress of a treatment may even set something in motion in the patient's partner with which neither of them can come to terms; one or the other then requests the analyst's assistance in mastering this problem.

In all considerations of what help the psychoanalyst can offer, it must be remembered that the therapeutic situation revives infantile behavior patterns in both the patient and his relatives. This forces us to weigh up very carefully just what and how much we say to any family member who is brought in. If one talks to a relative alone, every word and every scrap of information will be passed on to the patient in a subjective manner. If for particular reasons a joint session with both patient and relative does not seem advisable, we recommend telling the patient what has been said to the relative. Menninger and Holzman (1958) favor telling the patient in advance what will be said to the relative, but this probably has no decisive effect on the patient's reaction. More important is the decision whether one can talk to the two of them together. One then reduces the risk of the information being distorted, but may succumb to the temptation of regarding the descriptions of the patient's relationships as objective. Greenacre made the following comment on this subject:

> While it is undoubtedly true that an analyst's vision of the total situation may at certain points be seriously impaired by his need to stick to the microscopy of his work or by an overidentification with the patient, still it seems that this is in the long run less distorting ... than if the analyst succumbs to the pressure of outside information, which is sometimes not in the least objective. (1954, p.682)

Greenacre never gives or requests specific information concerning the patient without the latter's knowledge and consent, and only does so at all at the patient's request.

We will now discuss ways of looking at this issue. Dealing with relatives raises two types of complications for the psychoanalytic technique: those from inside to outside, and those from outside to inside.

If the patient's conflicts are not included in his transference, they manifest themselves outside the transference in all his activities and relationships. This compulsion toward repetition outside the therapeutic situation takes the place of the impulse to remember, and is acted out mainly within the family. The analyst must then try to ascertain whether the patient who behaves in this way is avoiding working through his conflicts in the doctor-patient relationship by using his relatives as substitutes, or whether his acting out is so egosyntonic that he cannot include his suffering in the transference relationship; whichever is the case, therapeutic influence is obstructed. It is often difficult to achieve clarity on this point. Even if we define acting out simply as those forms of behavior outside the treatment sessions which take the place of remembering and working through within the analysis — repetition in actions — the kind of relationship the patient has with his partner will in part determine, for example, how much he tells his relatives about the analysis. Provision of adequate information to the partner

guarantees confidentiality of the patient's relationship to the analyst, but also reinforces his loyality to his partner. If patients talk too much about the analysis, their relatives may become anxious and be tempted to intervene. On the other hand, relatives who are told little about the therapy feel excluded, and any pre-existing skepticism concerning the analyst is reinforced. This acting out must be interpreted if a change in the patient's behavior is to be induced.

The patient's anxiety that he will change but that his partner will not is often so strong that no progress can be made. In this case, the analyst must accede to the patient's wish and arrange to have an explanatory talk with the partner. Such a talk can be very effective in a situation where the patient is placed under strain by the partner's feeling of being excluded.

Here too, it is important to distinguish whether a relative is brought in at the wish of the patient or is driven by his own anxieties to seek contact with the analyst. If a patient withdraws into the analysis and tells his family little about it, this behavior may strengthen their justifiable sense of exclusion, and they tend to counterreact. These complications are particularly delicate; on the one hand we have to preserve the patient's regression, but on the other, too great a retreat into an infantile dyad may indicate an exaggerated regressive tendency. The analyst must carefully elucidate the patient's degree of readiness to exclude external reality, and must sometimes head off exaggerated regressive tendencies by means of technical intervention (for example by confronting the patient with reality). If this fails and a relative intervenes from outside in the therapeutic process, a joint discussion may release the tension. In some cases though, it may be important to preserve the two-person relationship, in which event the tension that arises must be endured.

Special attention must be paid to the wish or demand, from partner and/or patient, that the partner should also undergo therapy. Coming from the patient it may arise from guilt feelings, coming from the partner it may be an expression of jealousy, helplessness, or the desire for revenge. However, it is also possible for the patient's progress in the course of the treatment to awaken the partner's own previously suppressed wishes for therapeutic help, and such wishes must be taken very seriously. Occasionally, the analyst has to consider enlarging the therapy to include the partner. In such a case the interpersonal relationship will relegate the individual intrapsychic conflicts to the background. A large proportion of such therapies are indeed direct continuations of individual therapies (Bolk-Weischedel 1978). It may also seem appropriate to offer the partner separate treatment or even to refer him or her to another analyst. The latter is preferable if the couple is considering a separation.

Although the problem of relatives seems to have been neglected in the literature, we believe we can discern a trend toward *inclusion* of members of the patient's family in the therapy plan. This certainly results in part from the broadening of the spectrum of indications for psychoanalysis. A higher proportion of those seeking treatment are people with developmental problems or narcissistic personalities, borderline cases, or psychotics. Among these, some also have alcohol and drug problems, and many have marital difficulties, with all the consequences. Correspondingly, the 1976 survey by the American

Psychoanalytic Association revealed an increasing number of psychoanalytically oriented psychotherapies which include partners and other family members.

The inclusion of relatives is necessary not only in treatment of children psychotics, and patients with inadequate ego structures, but also with some compulsive neurotics. A friend or partner, for instance, can serve as "auxiliary ego" (see Freud 1909d, p.175).

The attitude of analysts has also changed in recent years, becoming increasingly more patient- than method-oriented; they now pay more attention to family and environment. Pulver's (1978) overview contains hints of greater flexibility. The change in the clientele demands changes in the methods of treatment thus more emphasis is being placed upon interpersonal relationships.

6.6 Third-Party Payment

6.6.1 Psychoanalysis and the German Health Insurance System

Nearly all patients consulting a psychoanalyst in the Federal Republic of Germany (FRG) have medical insurance. Over 90% of the population are members of compulsory insurance programs. Persons earning more than about DM 50 000 (ca. $20 000) annually are no longer compelled by law to insure themselves against illness, but are free to do so voluntarily. At the time of the initial interview, most patients have no clear idea of whether, or to what extent, their insurance company will agree to cover the costs. Only the cautious few who plan long-term and have been considering the possibility of a psychoanalysis for some time have inquired in advance and have a realistic payment plan. Those who are members of the various public health insurance organizations have mostly been officially referred by their family doctors and assume this means they will not have to pay. They know that they have the basic right to treatment free of charge by the doctor of their choice, but the majority have extremely vague conceptions of psychotherapy and psychoanalysis.

Many patients do not know that psychodynamically oriented and analytic psychotherapy are recognized by the insurance companies and that the analyst is thus remunerated for his services according to a fixed scale. Their insecurity is correspondingly great, with a very broad spectrum of attendant reactions. Depressives tend to assume that analytic psychotherapy is not covered by their insurance and that they will not be able to afford the fees themselves. Others take it for granted that they will receive free treatment for their marital and other problems, even if these cannot be construed as illnesses. Patients referred to a psychoanalytic outpatient clinic ask the receptionist about payment by the insurance company. As all people with public health insurance know from previous visits to the doctor, the official referral guarantees treatment free of charge. The doctor is not entitled to charge these patients any additional fee on top of his remuneration from the insurance company.

When agreeing on the therapy, if not before, the patient should be informed of the regulations covering psychoanalysis, including payment in the context of

public or private health insurance. Because the subject matter is so complex and is immediately complicated further by the subjective and unconscious meanings which the patient attaches to it, the analyst should not confine himself to giving only limited information. Above all, he must himself be acquainted with the way in which psychotherapeutic care fits into the German health insurance system. We regard it as essential to inform the reader about the current regulations, although they form only the external framework of therapy. In cases of third-party payment, it is extremely important that analyst *and* patient be fully informed about the part played by the third parties, in order to be able to grasp both the unconscious meaning of this arrangement and the interaction between inside and outside. Neglecting to provide information *and* to supply continual interpretations brings about confusion which endangers the analytic process.

We have to familiarize the reader with the banal facts of the mode of payment and with the regulations for the use of analytic psychotherapy within the German insurance system. The less patient and analyst know about the legal framework and its historical development, the more difficult it is to analyze the many and varied unconscious meanings attached to third-party payment.

Every third-party payment, whether by the health insurance company or by the patient's family, brings problems which have both external and internal — material and psychic — aspects. We are clearly talking primarily about the situation in West Germany, but we are not addressing ourselves exclusively to the German reader. The recognition of psychoanalysis as a valid form of treatment for mental illnesses has led in many countries to a situation in which health insurance companies cover the expenses. This is reflected in the international currency of English terms such as "third-party payment" and "peer report." The arrangements for payment via health insurance, involving an application by the treating analyst and peer review by a second analyst on behalf of the insurance company, vary greatly from country to country, but we believe that some typical problems are universal and thus that readers of all nationalities can pick up some ideas on treatment technique from this section. Our knowledge of the situation in many other countries has also convinced us that Germany — a country whose history has not often been characterized by successful compromises — has arrived at a system of third-party payment for analytic therapy through health insurance which is not only effective but leaves a great degree of flexibility for the individual case. Third-party payment and the peer report system, which have proved successful in West Germany over the past decade, are now attracting interest in many other countries, and for this reason our experience merits international attention.

Critics from other countries, such as Parin (1978), Parin and Parin-Matthey (1983b), and Mannoni (1979), have not taken the trouble to examine the West German system in detail before condemning it. Lohmann (1980) — by no means a lover of institutionalized psychoanalysis — repudiated the assertion made by Mannoni (of the Lacan school) that there is a connection between socialization and payment, and described many of Mannoni's invectives as ignorant and grotesque. Ironically, Lohmann's arguments also apply to Parin's (1978) ideological prejudice against psychoanalysis as conducted in the context of the

West German health insurance system. De Boor and Moersch (1978) have also advanced pertinent arguments to counter Parin's view. The discussions between representatives of the various European associations of psychoanalysis in recent years show how difficult it is to absorb information and dismantle prejudices. Groen-Prakken (1984) has summarized the debate. She stresses the undeniable advantage of patients in some countries now being able to obtain psychoanalytic treatment independent of their means, but overall this is outweighed by the fear of interference on the part of those providing the financing. "Interference," not "assistance," is the word most frequently used in these discussions. Since third-party payment can be provided by various agencies — insurance companies, the state, or a national health service — there are different contractual partners in different countries; in the western world, however, one can assume that democratic governments and insurance companies which exist to serve the common good, are not interested in invading the private sphere and will respect the statutory and professional ethical provisions on confidentiality. The important thing is thus to find solutions which on the one hand guarantee the rights of the individual, and on the other are compatible with the statutory responsibilities of the insurance companies. The current international debate on third-party payment reminds us vividly of the controversies preceding the introduction of the present system in West Germany. Thanks to the efforts of certain doctors, including some analysts, it was possible to establish a set of agreements between the *Kassenärztliche Bundesvereinigung* (KBV; the national corporate organization of physicians regulating matters of public health and the payment of medical care) and the health insurance companies. These contain lucid guidelines that exclude manipulative interference and make analytic psychotherapy available to the insured to an extent which was previously unthinkable. Up to the 1960s, following the example set at the Berlin Psychoanalytic Institute (1920-1933), psychoanalysts had treated quite a few of their patients on a low-fee basis out of a sense of social responsibility (de Boor and Künzler 1963).

We will first discuss the external framework of the system of third-party payment by the public health insurance companies. The insured patient makes no direct payment; the analyst receives his fee via his branch of the KBV. However, the patient does have a substantial monetary interest in this transaction, since he pays a fair proportion of his earnings to his health insurance company as cover for general health care, including the eventuality of an illness whose costs would be too great for the average individual to pay alone. A typical person insured with one of these public companies pays about DM 5000 (approximately $2000) annually. There are no further charges at time of use. It should be emphasized that the patient's right of legal redress is directed not at the state but at the health insurance company, an arrangement dating back to insurance regulations implemented by Bismarck. The West German social insurance system is supervised by the state, but it is not a national health service in the sense of, for example, the system in the United Kingdom.

The patient knows how much is deducted from his salary or wages as his health insurance contribution, and he can calculate how much he has paid in over the years and how often he has availed himself of services. He has a free choice

of doctor. Just as the public health insurance companies together form a corporate entity, nearly all doctors are members of the KBV.

The fees for doctors' services are negotiated between these two corporate organizations. Expressed simply, this means the following: The insurance companies have a duty of payment toward the regional physicians' organizations, which together comprise the KBV. The physicians, in return, have a duty to provide medical care for the members of the public insurance companies, i.e., for over 90% of the population. The regional sections of the KBV represent the interests of the doctors in the financial negotiations with the insurance companies. Obviously, the agreements on the fee rates for medical services involve compromises in which political factors play a part and the general economic situation must be considered. And indeed, in many respects, the specific regulations covering psychodynamically oriented and analytic psychotherapy, including the guidelines on payment, represent such a compromise.

Most analysts are reluctant to concern themselves with the topic of payment by insurance, and naturally, the less one goes into them the more complicated they seem. The latent presence of the third party financing the treatment is seen as a source of interference in the ideally purely dyadic psychoanalytic process. It is thus no wonder that nostalgia for the good old days, when settling the fees was a purely private matter, grows with third-party financing.

The advantages of the old system are, however, exaggerated. The true state of affairs can be seen by looking at the situation in countries where analytic psychotherapy is still not covered by health insurance. As far as psychoanalytic care is concerned, the good old days were only good for a very small proportion of the mentally ill. For the majority they were very bad old days. And in countries where the health insurance companies contribute nothing or not enough to the costs of psychoanalytic treatment, it is still true today that only the well-off can afford an analysis. The same conditions prevail which Freud bemoaned in his famous speech in Budapest at the end of the First World War: broad strata of the population suffer from severe neuroses without anything being done about it. At the same time, he predicted, "at some time or other the conscience of society will awake and remind it that the poor man should have just as much right to assistance for his mind as he now has to the life-saving help offered by surgery" (Freud 1919a, p. 167).

In some western countries Freud's prediction has been at least partially fulfilled, and third-party payment, as shown by the controversies of recent decades, has become a hotly debated aspect of treatment technique. Surprising, though, is that third-party payment has only now become a problem- the severely ill, married women, adolescents, and children without inherited wealth or a high income were always reliant on third parties. The biggest such group, and the most dependent on third parties for payment, are children and adolescents. In this section, as in this book in general, we restrict ourselves to the treatment of adults, but at this juncture we would like to stress the great importance of the fact that analytic psychotherapy of children and adolescents is included in the agreements between West German health insurance companies and doctors' organizations. Provision of the necessary funds ensures the treatment of financially dependent

children. The early treatment of crises typical for particular phases of development and of neurotic manifestations was made possible by the inclusion of psychodynamically oriented and analytic psychotherapy in the medical treatment covered by health insurance. It is plain that the treatment of infantile neuroses at the time they arise is of tremendous psychosocial significance.

The complications which can arise from dependence on a spouse, other relatives, or wealthy acquaintances, even if they are required by law to provide financial support, are discussed in Sect. 6.6.2. Other problems of treatment technique can arise when financially independent patients pay out of their own pockets with money they have not earned themselves. Freud's Wolf Man is a good example. Originally very rich, he was impoverished by the Russian Revolution; nevertheless, Freud continued his treatment free of charge and even indirectly supported him. It is our belief that most patients, and thus also their analysts, were always dependent on direct or indirect financing by third parties.

For obvious reasons the self-payment by the minority was idealized. Those who genuinely finance their own therapy avoid many complications that inevitably accompany financial dependence on a third party. Therefore the ideal (interminable) analytic process was conceived of as one with a patient whose success in professional life demonstrated good — though neurotically limited — ego functions and who was in a position to remunerate the analyst adequately from his own resources. Even the financially independent patient nowadays usually claims, as a matter of course, the (partial) third-party payment to which he is entitled. The problems which occur in the psychoanalytic treatment of the rich and powerful are, as is made plain by Cremerius et al. (1979), much greater than the idealization of the self-payer would indicate. Even the very wealthy almost always have private health insurance, and expect — realistically — that their application for at least partial payment of the costs, accompanied by a report from the analyst, will be successful. The medical treatment of civil servants is subsidized to the extent of approximately 60%.

About 50 years after Freud's Budapest address (1919a), neuroses were at last recognized as diseases by West German public insurance companies. Far too little attention has been paid to the fact that the road leading to broad application of psychoanalysis was paved by the work in the 1920s at the outpatient clinic of the Berlin Psychoanalytic Institute, where poor patients were treated for very low fees, which did not even cover costs and were paid to the clinic, not to the therapist. The Institute, the first of its kind in the world, was thus kept going not only by the generosity of its benefactor, Max Eitingon, but also by the idealism of its members and trainees, who gave much of their time free of charge. The clinic was not very large, but the treatment of a relatively small number of patients sufficed to allay one anxiety which Freud had expressed in the Budapest address. Although he believed that the most important and effective elements of strict, disinterested psychoanalysis would be adopted in psychotherapy for the masses, he feared that "the pure gold of analysis" would have to be freely alloyed with "the copper of direct suggestion" (1919a, p. 168). Hypnosis and even an integration of psychic and material support would have a place in this future broad-based psychotherapy.

Freud's clear distinction between strict, disinterested psychoanalysis and the mass application of the method, expressed in his metaphor by the stark contrast between the pure gold of analysis and the copper of suggestion, has made a lasting impression right down to the present day. This makes it all the more important to repeat the finding of the report on 10 years work at the Berlin Psychoanalytic Institute (Rado et al. 1930): that the broad — though by no means mass — application of psychoanalysis did not lead to a relapse into simple suggestion. Freud's foreword for this report (1930b) underlined the threefold importance of the Institute as a center for teaching, research, and treatment. Simmel (1930, p. 11) stressed that the *outpatient* treatment of working-class and insured patients differed in no way from that of well-off, selfpaying patients.

In 1946, amid the ruins of postwar Berlin, Kemper and Schultz-Hencke broke new ground by founding the Central Institute for Psychogenic Illnesses, which was financially sponsored by the local insurance society, the later General Communal Health Insurance *(Allgemeine Ortskrankenkasse).* Baumeyer (1971) and Dräger (1971) rightly emphasize the great social significance of this pioneering advance: "This was the first step in the recognition of neurosis as illness by a German public institution. For the first time one of the institutions in the social insurance system paid the costs of psychoanalysis and other psychotherapeutic treatment" (Dräger 1971, p.267). For the first time, insured patients were able to receive psychodynamically oriented therapy at no direct cost, and this on a far greater scale than in the outpatient clinic at the old Berlin Psychoanalytic Institute. Great credit is due to Dührssen (1962) for her pioneering analysis of the follow-up of 1004 patients who had received analytic psychotherapy at the Central Institute, in which she showed the effectiveness and efficiency of the treatment.

Baumeyer (1971) correctly stressed that the work of the Central Institute for Psychogenic Illnesses made a significant contribution to overcoming the resistance of the social insurance system to psychodynamic treatment: "The Central Institute for Psychogenic Illnesses provided the German Society for Psychotherapy and Depth Psychology with many of the arguments which after long and weary years of negotiations finally led to success" (i.e., to recognition of psychoanalysis by the health insurance companies) (p.231).

The recognition of neuroses as illnesses was a precondition for the inclusion of the so-called standard psychotherapy in the program of the major health insurance companies in 1967, followed by the other public organizations in 1971 (Haarstrick 1976; Faber 1981). Some limitations were imposed by the obligations of the public and private health companies. The health insurance system exists to enable the necessary outpatient or inpatient medical treatment at the time of need for people from all strata of society, regardless of their financial situation. Apart from a few special circumstances, the patient pays no more than his regular insurance premium (approximately 14% of his income). The legal constraints thus do not permit the health insurance companies to demand from the patient any direct contribution toward the costs of analytic therapy. Whether this will change in view of the explosive growth in the cost of providing health care remains to be seen. In passing, we would like to state that a socially just regulation of the degree

to which each patient should bear the costs directly would entail practical problems that could be exceedingly difficult to solve. For the time being, at least, the present legal framework will remain in force, and psychotherapy will continue to be available free of charge to members of public health insurance organizations whose illnesses fit the existing guidelines. It is to these guidelines that we now turn our attention.

In the latest version (March 1984) of the guidelines for the use of psychodynamically oriented and analytic psychotherapy, the methods of the two forms of therapy are defined and the indications for them laid down. The most important passages are as follows:

Psychodynamically oriented and analytic psychotherapy, as defined herein, are types of etiologically oriented psychotherapy in which the unconscious psychodynamics of neurotic disturbances with psychic and/or somatic manifestations is made the object of treatment. Techniques of psychotherapy which are not in accordance with the following descriptions of psychodynamically oriented and analytic psychotherapy will not be funded.
a) *Psychodynamically oriented psychotherapy* includes forms of therapy which treat currently active neurotic conflicts but strive for a concentration of the therapeutic process by means of restriction of the aims of treatment, use of a conflict-oriented procedure, and limitation of regressive tendencies.
b) *Analytic psychotherapy* includes the forms of therapy which treat not only the symptoms of the neurosis, but also the neurotic conflict material and the patient's underlying neurotic structure, in the course of which the therapeutic process is set in motion and continued with the help of the analysis of transference and resistance, involving the exploitation of regressive processes.

Psychodynamically oriented psychotherapy encompasses the short-term focal therapies and the dynamic psychotherapies which expose and work on conflicts. These short therapies, which originated from the psychodynamic derivatives from psychoanalysis, have proved their worth (Malan 1976; Luborsky 1984; Strupp and Binder 1984). Kernberg's (1984) expressive psychotherapy, based on the Menninger Foundation's follow-up study (Kernberg et al. 1972; Wallerstein 1986), is the equivalent of what is known in Germany as the psychodynamically oriented, conflict-revealing techniques of treatment.

The definition of the method of *analytic psychotherapy* fully incorporates the factors Freud regarded as the cornerstones of psychoanalysis, i.e., resistance, transference, and the therapeutic use of regression.

The application of the two forms of therapy in the framework of the health insurance system is restricted in principle to illnesses whose course can be influenced for the better. The therapist must satisfy the analyst acting as peer reviewer that the intended therapy has the potential to alleviate, improve, or cure the neurotic or psychosomatic disease in question. In the application form (from which we quote below), a conditional prognosis has to be stated and supported. The conditions which give the symptoms the status of an illness and the factors maintaining the symptoms must be set out. The decisive factor as regards prognosis is constituted by the *conditions for change* which the two parties, patient and analyst, must bring about. The analyst must in each individual case assess what he and the patient can achieve after he has aroused the patient's hopes by accepting him for therapy and taking on the responsibilities involved. In the situation we are concerned with here he must explain the prognostic criteria to a fellow analyst acting as peer reviewer, i.e., specify why he expects an

improvement to occur.
In the above-mentioned guidelines the indications for the two forms of therapy are laid down as follows:

1. Psychoreactive psychic disturbances (e.g., anxiety neuroses, phobias, neurotic depression)
2. Conversion neuroses, organ neuroses
3. Autonomic functional disturbances with established psychic etiology
4. Psychic disturbances consequent on emotional deficiencies in early childhood; exceptionally, psychic disturbances related to physical injuries in early childhood or to malformations
5. Psychic disturbances resulting from severe chronic illness, as long as they offer a basis for the application of psychodynamically oriented or analytic psychotherapy (e g., chronic rheumatic conditions, particular forms of psychosis)
6. Psychic disturbances due to extreme situations which evoke grave personality disturbances (e.g., a long prison sentence, severe psychic trauma)

The indications are further defined by a list of circumstances under which the health insurance organizations will *not* cover the costs of psychotherapy:

Psychodynamically oriented and analytic psychotherapy are not covered by public health insurance if they do not have the potential to bring about cure or amelioration of a disease or lead to medical rehabilitation. This applies especially to measures intended exclusively for professional or social adjustment, to child-rearing guidance, and other similar measures.

In the area of rehabilitation the following points have to be observed:

If indicated exclusively as a means to medical rehabilitation, psychodynamically oriented or analytic psychotherapy can only be applied under the condition that psychodynamic factors play an essential part in the psychic disturbance or in its effects and that with the help or psychodynamically oriented or analytic psychotherapy the patient can be integrated, if at all possible long term, into the working situation or into society.

The use of psychodynamically oriented and analytic psychotherapy is thus limited in a variety of ways. The range of application is defined in terms of method and nosologic orientation (indications), but at the same time is very adaptive. Each individual patient's motivation and adaptability must be assessed with regard to the possibility or probability of treatment being successful. Here we run up against the triad of necessity, effectiveness, and economy which governs a doctor's diagnostic and therapeutic action in Germany; he is obliged to review his chosen therapy and to justify it, in terms of the triad, to the insurance company.

The treating analyst argues the case for his therapy plan in an application in which the patient's personal data are encoded. This application is checked for form and content by an independent peer reviewer, also an analyst, who has to judge whether the above-mentioned preconditions (type of illness, indications) are fulfilled. The reviewer thus has no personal influence on the treatment process or the way treatment is conducted, but his very function means that he may have a significant effect on the patient's transference, especially at the time of applications for extension of therapy. The fact can then no longer be overlooked that the analytic dyad is in this sense a triad including a latent third party.

Complications inevitably ensue if analyst and analysand forget that they are in many respects only two sides of a triangle. The less the role of the peer reviewer

in the therapy is clarified and interpreted, the better he serves as a projection screen. One cannot behave as if the reviewer were not there; whether therapy is extended or not depends on his assessment. In making his decision, he has to heed what the guidelines have to say on the subject of treatment duration: "Analytic psychotherapy should as a rule achieve a satisfactory result in 160 sessions, in special cases up to 240 sessions." Extension to 300 sessions is possible in exceptional circumstances, but must be supported by detailed arguments. Even 300 sessions is no absolute limit, and in the discussion of applications for extension we will present the conditions which have to be met in order for treatment to be continued within the guidelines. The compromise in the guidelines on psychodynamically oriented and analytic psychotherapy obviously has many different aspects. Our positive evaluation of this compromise will become still clearer in Sect. 6.6.2, in which we examine the consequences of the contractual agreements on the psychoanalytic process.

At this point, however, we would like to draw attention to an aspect of professional politics. The introduction of analytic psychotherapy as a form of treatment covered by the public health insurance system means that appropriately qualified doctors can be authorized to provide the specific psychotherapeutic services set out in the guidelines. It is thus unusual for doctors who offer psychoanalysis to be fully active in other areas (general practice or specialities). Their contract with the KBV — their authorization — is limited to psychoanalysis and psychodynamically oriented psychotherapy. Also involved in providing psychoanalytic care to the members of the public health insurance organizations are nonmedical psychoanalysts, who, after completion of a course of academic study (nowadays a degree in psychology is a prerequisite), spend several years in psychoanalytic training at an accredited institution. It is misleading to describe these nonmedical analysts as lay analysts. Sixty years ago, the prosecution of Reik, himself a psychologist trained as a psychoanalyst, on a charge of quackery led Freud to publish *The Question of Lay Analysis* (1926 e). The charge against Reik was dropped, but nonmedical psychoanalysts were not licensed to practice within the Austrian health insurance system (Leupold-Löwenthal 1984). The incorporation of nonmedical analysts into the network of services covered by health insurance in West Germany is exemplary in the history of psychoanalysis.

A consequence of the recognition of neuroses as diseases was that the psychoanalytic treatment goal had to be guided by the medical concept of illness. The health insurance companies are obliged to take over the costs only when the symptoms constitute an illness and the triad of necessity, effectiveness, and economy is also satisfied. Both in diagnosis and in treatment, the West German doctor must have these criteria in mind. He must also remember that neuroses are on a continuum with characterologically determined disturbances, which are not covered by health insurance, and that a smooth transition from one to other may occur.

6.6.2 The Impact on the Psychoanalytic Process

The psychoanalytic process is determined by a multitude of factors, which we will discuss in detail in Chaps. 8 and 9. At this juncture we will restrict ourselves to presenting a few typical consequences of third-party payment by insurance companies. We would like to begin by putting forward a thesis derived from our experience with the guidelines from the point of view of the patient, the treating analyst, and the peer reviewer. *Every* third-party payment affects the course of the therapy in a typical way, leading to problems which do not crop up when the analysand alone finances the treatment. These typical complications can, however, be solved by analytic means, i.e., by means of interpretation. Our experience confirms Eissler's (1974) expectation; the classical technique can also be applied when treatment is financed by health insurance.

Working through oral and anal themes is more complicated when payment is indirect, but not impossible. Ehebald (1978) and Cremerius (1981 a) have provided well-grounded refutations of the widespread view, most clearly expressed by Kemper (1950, p.213), that direct payment is nothing less than the moving force of analysis.

Obviously the guidelines also involve restrictions, and it is vital that the social parameters be incorporated into the interpretive work. It can then be seen that the financing of treatment by health insurance, despite its limitations, creates most of all a great degree of freedom for patient and analyst, in that for a period they are relieved of all financial constraints. Their dependence on third-party payment grants them the *freedom* without which neither the necessary conditions for the psychoanalytic cure nor the material existence of the analyst would be assured. Without payment by the public health insurance organizations, the majority of those in need of analytic psychotherapy would have no access to it, and the psychoanalyst would depend on a small number of self-financing patients. We would like to stress once more that since 1967 every publicly insured person in West Germany who has neurotic symptoms constituting an illness has a *right* to etiologically oriented psychotherapy. The patient without means of his own is no longer dependent on the generosity of a well-off friend or relative. Analysis thus no longer depends on the economic factors which used inevitably to exert an unduly great influence on the decision-making process. Less than appropriate remuneration of the analyst for the time-consuming and highly skilled service he provides brings significant difficulties for both parties. These problems vary in degree, for a wide range of reasons. Freud reported unfavorable experience of gratis treatment, but on the other hand stated that "one does occasionally come across deserving people who are helpless from no fault of their own, in whom unpaid treatment does not meet with any of the obstacles that I have mentioned and in whom it leads to results" (1913c, p.133).

Payment by the insurance company makes the patient independent of the benevolence of the analyst. Many countries still rely on self-sacrifice on the part of analysts. There, the social responsibility is borne by outpatient psychoanalytic institutions, where young analysts or trainees treat patients for fees so low they do not even cover their own costs. In many places, experienced analysts earning their living from private practice act as unpaid supervisors. In countries where no solution resembling the West German system has been found, the situation

remains similar to that at the old Berlin Psychoanalytic Institute.

The contrast between the current situation in West Germany and the position in countries with no such provision for financing by insurance companies is striking. A West German analyst presently receives DM 70-80 per hour and thus has an income which, although secure, is limited, especially considering that the training is long and costly.

In general, the regulations on fees still undervalue the personal service that doctors provide; this is particularly true for the psychoanalyst, whose work is highly specialized and time-consuming. This reflects, among other things, a widespread idealization that goes hand in hand with a simultaneous devaluation. Psychotherapy is raised to a higher, nonmaterial level and glorified. It may not be defiled by worldly things, certainly not by anything so tainted as money, and should therefore not be practiced on a professional basis. On the other hand, both laymen and doctors dismiss psychotherapy in the same terms: "They don't do anything but talk; that can't do any good, so it shouldn't cost anything."

Idealization and devaluation take their toll on the patient. If he does not pay the analyst out of his own pocket, he loses the experience of an immediate symbolic reward. Thus it is essential to remember, and to interpret, the indirect compensation of the analyst by the patient's insurance company. The function of the third party has a great bearing on the interaction between patient and analyst, and must be elucidated continuously throughout the analysis in order for the analyst to be able to reverse any disappointments and projections of components of his own self. The association of idealization and devaluation and the role of payment form but one example among many we could give. Cremerius (1981 a) carried out a systematic investigation of many aspects of the influence that payment by health insurance companies exerts on the relationship between patient and analyst and on the development and configuration of the transference neurosis. Of course, the acceptance of psychoanalysis as a recognized treatment also increased the profession's social standing. Without a doubt, this had a favorable effect on the patient as well as the analyst, even though the trusting therapeutic relationship is actually established principally in other dimensions.

The financing of analytic therapy by health insurance companies has made the analyst independent of self-financing patients who pay punctually. He can now conduct initial interviews (up to six sessions as a basis for the application) in a purely patient-oriented manner, because his decision as to which form of psychotherapy to employ is no longer influenced by how much money the patient has (Ehebald 1978). The analyst practicing in West Germany today also no longer has to strike a balance between the number of patients he treats free of charge, or for reduced fees, and his desired standard of living. Freud had this to say on the subject: "It must be remembered ... that a gratuitous treatment means far more for the psychoanalyst than to any other medical man; it means the sacrifice of a considerable portion ... of the working time available to him for earning his living over a period of many months." A second free treatment has a detrimental effect on the analyst's earning power "comparable to the damage inflicted by a severe accident." Freud then asks "whether the advantage gained by the patient would not to some extent counterbalance the sacrifice made by the

physician" (1913c, p.132).

We interpret this as meaning that it is important to find a solution which is acceptable to both parties. For this reason, we have stressed that the patient partly finances the treatment himself through his health insurance contributions, and that payment of the balance by the insurance reinforces his sense of being part of society. In contrast to the problems which arise in treatment conducted free of charge or for very low fees in outpatient clinics, and which are extremely difficult to solve analytically, the complications emerging from the fact that the patient need pay nothing directly out of his own pocket can be overcome interpretively. The analyst's countertransference is disturbed much less if his services are adequately recompensed, and in this respect the source of the payment is irrelevant.

The situation is different, however, for the trainees and young analysts carrying out treatment practically free of charge in the outpatient clinics of psychoanalytic institutions, who sometimes even have to pay their own supervision fees. The severe problems to which they are exposed often become apparent at the conclusion of their period of training, which is frequently followed swiftly by the termination of such analyses. Despite the serious difficulties in treatment technique which may occur, we share Cremerius' (1981 a) view that indirect payment represents no grave obstacle to the psychoanalytic process. The complications inherent in the psychotherapy guidelines lie in another area, as we will now demonstrate.

The difficulties arise in connection with the binding of psychotherapy to the medical *concept of illness* and with the fixing of *time limits* for the financing of the treatment, defined in terms of necessity, effectiveness, and economy. The guidelines reflect a compromise between the exigencies of psychoanalytic therapy and the statutory norms. Let us first examine the area of *agreement* between the guidelines and psychoanalytic practice. Sections 6 and 9 of the application form for the financing of therapy require the following:

6. Psychodynamics of neurotic condition. An account of the development of the neurosis and the intrapsychic conflicts, including the resulting neurotic compromises and symptoms. The time of onset of the symptoms, the precipitating factors, and the psychodynamic development are to be described.
9. Prognosis of psychotherapy. Assessment of the patient‘s motivation, and awareness of the problem, capacity for forming a therapeutic relationship, reliability, and partial coping with life. In particular, assessment of the capacity or tendency for regression, degree of fixation flexibility. potential for development, and insight into the illness ....

The guidelines demand from the analyst nothing other than a rational justification of his therapy plan according to the principles of the etiologic theory of psychoanalysis. The peer reviewer refers to the general level of knowledge within psychoanalysis and to his own experiences in deciding on the *plausibility* of the psychodynamic connections described by the analyst. His principal task is to determine whether the symptoms constitute an illness. He can also form an idea of the persuasiveness of the connections between the neurotic compromise and symptoms and the analyst's treatment priorities. The peer reviewer cannot, of course, determine whether the descriptions correspond with reality or whether the treating analyst is orienting himself on his outline in conducting his treatment.

Nonetheless, he does form a certain impression of the course of the therapy, because the analyst is obliged, in every application for extension of the financing for the further 80 sessions, to summarize the course so far and to describe the change in the symptoms in relation to transference and resistance. The revised prognosis with regard to regression and fixation is one of the most important items in the application for continuation of treatment.

It will have become apparent that fundamental principles of psychoanalytic theory are contained in the scheme of indications and course within which the treating and reviewing analysts interact. Without this common basis, no peer report system could function. Even Beland (1978), in an otherwise critical paper, conceded that the peer report system has proved its worth. The reviewer's clearly defined function does not permit him to intervene in his colleague's treatment. His position becomes more difficult if he cannot follow the processes described in the application. Every application is expected to display a certain persuasiveness and coherence, and an application for continuation must state how the transference neurosis is developing and what changes in the symptoms (improvement or deterioration) are resulting. The peer system has led to reviewers talking to their treating colleagues in cases of doubt, and thus to an intensification of the dialogue between analysts.

These observations concerning an important aspect of the guidelines may already suffice to support the following view: In the application for the initiation or continuation of psychodynamically oriented or analytic psychotherapy, like in every seminar on technique, it is important to demonstrate that the psychodynamic appraisal and the treatment steps undertaken are in accord. The patient's reaction to the therapy so far must also be described, as the correctness of the treatment as a whole is shown by his progress.

Thus it is advisable not just for legal reasons, but also on grounds of technique, to write every application in such a way that the patient can, if he wishes, read and understand it. It is probably not harmful for a mature patient to share in the analyst's reflections unless these deviate considerably from the insights conveyed in interpretations. If the discrepancy between the content of an application and the patient's experience of the therapy cannot be bridged in the dialogue about the application, the chances of gaining knowledge in the dyad are poor. According to psychoanalytic theory, the prospects for achieving a cure are then also very low.

The guidelines demand from the treating analyst a kind of self-supervision. Most analysts agree that it is essential occasionally to reflect intensively on the development of the therapy in the light of analytic criteria. In the case of the peer review procedure, a second analyst with a precise, narrowly defined function gives his opinion on the result of this relection — incidentally, with the right of veto on the part of the analyst making the application. If the self-supervision can be seen as the beginning of scientific work in practice, the review procedure can even be regarded as an extended form of self-supervision. In many respects, applications for continuation represent a store of knowledge which is far from exhausted. The descriptions they contain mirror the treating analyst's view of psychoanalytic practice in the framework of the psychoanalytic scheme

formulated in the guidelines.

It is a truism that the psychoanalytic process takes time, but it is for just this reason that applications for continuation and the imposition of a limit on the number of sessions throw up such great problems of principle and of treatment technique. We would like to go into this topic at some length.

The components of the compromise are as follows:

1. On one hand, since the first, methodologically inadequate statistics were gathered at the old Berlin Psychoanalytic Institute, it has been demonstrated that satisfactory results can also be achieved with psychodynamically oriented and analytic psychotherapy of limited duration.
2. On the other hand, analyses have been growing in length since the early 1950s. The forerunners of the "supertherapy" (Balint 1954, p. 158) are the ever longer training analyses.
3. The goals of these analyses are moving ever further away from the treatment of symptoms amounting to illness as defined in medical terms, and from the proof of necessity, effectiveness, and economy.

An improvement in the symptoms on the basis of partial structural changes is as a rule accompanied by a change from neurotic distress to a state of general happiness, albeit not entirely free from unhappiness and tragedy (Freud 1895d, p.305). When this state has been reached is a matter of judgement.

Despite the limitations applied, the guidelines impose no absolute upper limit. However, as one of us (H.T.) has been able to establish in his capacity as peer reviewer, it relatively rarely happens that applications for confirmation beyond the standard duration are supported in the way Freud recommended for particularly deep analysis (see Chap. 10). More often, the argumentation employed shows that it is not easy to achieve a balance between the time frame and the therapeutic utilization of regressive processes. We will go into this utilization of regressions in detail in Chap. 8, contenting ourselves here with saying that in analytic psychotherapy within the framework of the guidelines it is very important always to bear the social and economic realities in mind. These permit no regression for its own sake. The situation of the insurance companies and their members plays a role. This brings us to a further component of the compromise:

4. Financial considerations on the part of the health insurance organizations played a part in the limitation of the duration of treatment because the insurers foresaw numerous insoluble dilemmas, including financial problems, in the extent of deviation from the medical definition of illness and the extension of responsibility to cover financial assistance in the relief of social and domestic problems or the raising of the so-called quality of life in general.

Beland has this to say on the matter:

> Every patient, every analyst, and every reviewer can understand and accept such a restriction — it is honest and needs no justification based on neurosis theory. The dilemma facing this system of insurance, namely having to legitimize the limitation of the service provided by means of a theory of treatment, rather than by a lack of money, is a miserable state of affairs with harmful consequences for the reviewer, the therapist, and above all the patient. It is therefore desirable for reviewers to free themselves from the responsibility of having to justify the termination of the service after 240 or 300 hours. (Beland 1978, p.9)

It emerges from what we have said that the theory of treatment underlying the guidelines sets no absolute limit. This theory is established in a strictly psychoanalytic manner, and thus empirical proof is necessary, as laid down by Freud (see Chap. 10). As we have already stated, however, the limited means (among other factors) have played a role in the restriction of services. First, it has been shown that in many cases a lasting improvement in symptoms can be achieved within 300 sessions, which may well indicate an at least partial alteration in structure. We do not want at this juncture to go into the difficulty of proving this to be the case. Second, it has also been demonstrated that a good number of the analyses which are continued further lead to an enrichment of the quality of life going beyond the medical concepts of "healthy" and "ill." We would recommend that both the treating analyst and the peer reviewer give serious thought to Beland's criticisms and our reflections; it is essential that the social reality be considered in interpreting the transference neurosis, and the flexibility of the guidelines should not be forgotten.

There is little point in talking about the duration of the treatment in the initial sessions, whether with regard to the limitations embodied in the guidelines or in respect of the utopian vision of interminable analysis. It can even be

antitherapeutic to do so. However, it is indispensable to include time and money — and thus the role of the peer reviewer — into the interpretation of transference in the context of applications for extension. If there is the risk of suicide at the expiry of the treatment period financed by the health insurance company, the analyst should reflect on how he has conducted the treatment before criticizing the restrictions imposed by the guidelines. Fortunately, our experience is that the majority of patients treated within the framework of the guidelines experience a favorable alteration in the symptoms and that the emphasis shifts away from the illness and toward difficulties in coping with life, which Freud did not count as neuroses. The guidelines even allow for long analyses for severely ill patients, provided the prognosis is reasonable.

In summary, most psychodynamically oriented and analytic psychotherapies can be terminated within the limits set out in the guidelines, i.e., after 50 (sometimes extended to 80) sessions or 240 (300) sessions respectively. It would of course be very useful to know the results of therapy, and with regard to third-party payment it would be interesting to learn the reasons why patients finance extension of the therapy themselves; however, in both cases we have to rely on estimates. The findings of research indicate the probability that about two-thirds of patients leave psychotherapy cured or with a considerable improvement in their symptoms, the remaining third showing no improvement.

It remains unsolved whether these latter patients could be improved or cured by further therapy under the same conditions (same analyst, third-party payment) or altered conditions (e.g., self-payment) without variation or modification of the method or a change of analyst. Nevertheless, we believe it is possible to specify fairly reliably the circumstances under which patients are prepared to continue the therapy at their own expense after third-party payment has been discontinued. It is necessary to go back to the beginning of the therapy and examine the general influence the psychoanalytic process has on thinking and experiencing. Initially, all patients hope and expect to become healthy and lead productive lives, and thus take an interest in the efficacy of analytic therapy. The growing insight into relationship conflicts and their association with fluctuations in the symptoms can, of course, lead to expectations which have little to do with the medical concept of health and illness or with the guidelines based on this concept.

The difficulties in coping and the expectations which analysands develop in the course of treatment often agree only marginally with the medical concept of illness and health. Faber (1981) points out, with all respect to the utopian element of the wish for self-discovery with the aid of analysis, that illusionary utopian elements in analytic goals must be grasped as transference and countertransference phenomena. He argues that one should work toward justified psychoanalytic utopias soberly and steadily: "It is a work of culture — not unlike the draining of the Zuider Zee" (Freud 1933a, p. 80).

We estimate that 10%-20% of the patients in the average psychoanalytic practice finance a continuation of the analysis out of their own pockets after discontinuation of third-party payment. This group is very heterogeneous, and the patients' goals are extremely varied. One category in this group is formed by those who have sought analysis because of the severity of their symptoms.

In the light of what we have said above, we believe that scientifically grounded applications could secure approval for continuation of treatment in many of these cases.

Another category of these secondary self-financers includes those who expect continuation of analysis to give their life a deeper meaning, independent of medical considerations. Some can only endure their work or their life with the help of their relationship to the analyst. How much this deeper meaning is worth to the analysand is related to his material means. On balance, a wealthy patient and his analyst can reach the decision to continue with the analysis much more easily than, for example, a middle-ranking civil servant who lives entirely off his salary.

Therefore the switch to self-financing often means having to reduce either the frequency of sessions or the analyst's fee. In case of the latter, the issue is not only how much the patient can afford, but also what level of payment is still acceptable to the analyst without the inevitable restrictions and sacrifices placing so much stress on the analytic relationship that the therapeutic work suffers. Any significant reduction in fees for a patient who has four sessions weekly, for example, involves a not inconsiderable decrease in the analyst's earnings. On the other hand, private financing of further therapy can affect the living standard of the patient and his family. Additional conflicts with the latently present third parties can be expected, and ultimately some sort of balance must be struck with them.

Thus many factors must be taken into account in order to reach a productive arrangement with the third parties — family, health insurance company and reviewer — and achieve a reconciliation with oneself.