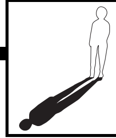

Psychoanalysis

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Abstinence The analyst avoids nonessential advice and reassurance, waiting to hear the patient's usually unspoken wishes and fears.
Dream Interpretation Explaining symbolic meanings behind dream images.
Dynamic Interpretation Explaining the wish-fear-and-defense configurations involved in forming maladaptive patterns of experience and behavior.
Genetic Interpretation Interpretation about situations, memories, and fantasies of infancy, childhood, and adolescence that lead to an understanding of the patient's present patterns.
Interpretation The main tool of the analyst.
Neutrality The analyst does not react as emotionally as he or she might in a personal social situation.
Reconstructive Interpretation Piecing together different topics and inferences to form a plausible story about how possibly significant early experiences account for current beliefs, attitudes, and behaviors.
Resistance Defensive operations that work against authentic emotional expressions and memory recovery thereby obstructing the progress of analysis.
Transference Interpretation Explaining the meaningful configurations of ideas and feelings about the relationship with the analyst.
Transference Neuroses A substitute pathology that reiterates fundamental developmental conflicts based on unconscious schematizations and motives concerning self and other roles in a relationship. In forming such transference-based reactions, the patient regresses to early stages of development, returning to the conceptual source of problems.

PSYCHOANALYSIS is a treatment that aims at a comprehensive exploration and understanding of unconscious conflicts, character, and personality development. Meetings are frequent and often go on for years. The aim of therapy is to alter the interaction of conscious and unconscious processes in the direction of better integration of identity leading to improved adaptation, maturity, and health. The central concepts of theory provide the basis for the treatment. These concepts focus on the interactions of wishes, fears, and defenses against threat, and the influence of enduring but often unconscious motives upon personality structure.

Personality is viewed as a knowledge and procedural structure that is the result of repeated behaviors and decisions for how to reduce or avoid dangerous manifestations of raw wishes, exposures to dreaded situations, and the experience of problems, symptoms, and uncontrolled moods. Thus, a psychoanalytic formulation of personality may include hypotheses about developmental antecedents in terms of how wishes, fears, and immediate defenses lead to more adaptive but still defensive compromises. Although relatively more adaptive compromises may be preferable to problem-filled or symptomatic compromises,

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they are not seen as substitutes for new, more optimal solutions that may be achieved through treatment.

I. THE BEGINNING OF PSYCHOANALYSIS: SIGMUND FREUD

Sigmund Freud established psychoanalysis as a combination of theory, mode of investigation, and technique of treatment. Dream work, multiple subpersonalities theory, recognition of unconscious determinants of behavioral patterns, hypnosis, and suggestive techniques were islands of fragmentary knowledge before Freud integrated them, added a developmental approach, described unconscious defensive mechanisms, and recognized transference and resistance.

In initial work, Josef Breuer and Freud emphasized the importance of psychic traumas. Repressed but dynamically active, memories of such traumas might affect conscious thoughts, feelings, and behaviors. Later, Freud added theories of repressed wishes and fears and their elaborations into unconscious but active fantasies.

In his early model, Freud viewed therapy as making the unconscious conscious. He developed one of the most important techniques in psychoanalysis, *free association,* as he gave up hypnosis and yet retained the attention-altering properties of trance and suggestion-induced reveries. No association is, of course, entirely free. The patient is encouraged not to suppress or edit what comes to mind and not to always focus only on one specific topic, instead saying in words all thoughts, images, feelings, and bodily sensations as they occur in the stream-of-conscious representations. Free association has been useful in counteracting unconscious defensiveness in general, in finding linkages between ideas in particular, and in understanding the power of certain symbols.

In order to associate freely, the patient must try to set aside restrictions on thought and reporting that occur because of feelings of embarrassment, shame, guilt, or fear that these emotions bring. A patient can experience such a process as confusing and anxiety provoking, which is why psychoanalysis is not always useful for persons who are vulnerable to conceptual disorganization.

Studying the flow of a patient's associations, therapists look not only at contents but at the sequences that indicate efforts to avoid or distort the communication of meanings. Together, the patient and therapist can observe the derailment of clear expression and elaboration of a topic. Thus, by developing free association as a rule in psychoanalysis, Freud was in a position to describe defense mechanisms.

Early theory dealt with repression as a defense against the repetition of emotionally distressing traumatic memories. Paradoxically, both intrusions into consciousness and omissions from consciousness were seen as the result of defense mechanisms. Omissions of traumatic memories were due to inhibitions; intrusions were due to sudden conscious representation in spite of efforts to inhibit the mental contents. Freud's early observations of both amnesia and excessive intrusion of traumatic memories have stood the test of time. Nonetheless, subsequent research has shown that the repressed memory theory of psychopathology was too limited.

After trauma psychology, Freud began to work on repressed wishes and then on how personality comes to be formed. He proposed that personality developed from the action of two basic drives or instincts, libido and aggression. From biological determinants these drives evolved into structures of learned knowledge during infancy, childhood, and adolescence. Social experiences in interactions with significant others affected the direction and linkages of such drives. Each individual was a complex result of nature and nurture. This was called id psychology.

Freud described the evolution of character in what was one of the first attempts to put psychology into a developmental sequence. He said the libidinal drives proceed in stepwise fashion to invest the oral, anal, and genital zones of evolving sensation, interpersonal communication, and erotism. This is the psychosexual theory of development within id psychology. Some observations of character traits that tended to occur together have been confirmed by subsequent investigations, but the general theory of id psychology has since been modified.

In altering his therapeutic technique from suggestion, hypnosis, and catharsis to free association, Freud simultaneously realized that a "different though not contradictory conception of the therapeutic process" was warranted. With the new emphasis on removal of amnesia and recovery of repressed memories, he observed that the same instinctive forces that brought about repression in order to obliterate pathogenic material from consciousness continued to exert a force—

resistance—against full disclosure through free association; moreover, unexpected feelings toward the analyst—*transference*—was noted.

Freud's view of transference was of ideas and feelings that arose from the past and recapitulated earlier ties with significant persons from childhood. In the case of Dora in 1905, he believed her hostile feelings resulted in her breaking off treatment, which he called "acting out." Just as Fraulein von R. had been the first pivotal failure with hypnosis leading to Freud's major technical shift away from its use, so the case of Dora was the turning point in psychoanalytic technique that highlighted for Freud the necessity to interpret feelings transferred onto the analyst.

II. POST-FREUD: EARLY TWENTIETH CENTURY TO PRESENT

The history and growth of the psychoanalytic movement from classical psychoanalysis to current practices has been marked by repeated revisions by Freud himself, as well as reappraisals and additions by others. From its beginnings, some analysts have argued against nearly all of Freud's basic conceptual premises, from the strictly sexual etiology of the neuroses to his views on feminine psychology. Reacting more directly to their clinical concerns that too few patients are amenable to the rigorous requirements associated with orthodox psychoanalysis, others have attempted to make the treatment more extensively applicable, affordable, and terminable.

Early efforts in the 1920s and 1930s by such analysts as Sandor Ferenczi, Otto Rank, and Wilhelm Stekel were aimed at increasing the applicability of psychoanalyses to a larger clinical spectrum by shortening treatment time (Rank was the first to propose an "endsetting" time limit) and emphasizing a more active, affective, and caretaking approach, particularly the use of the therapist as a substitute primary object in the treatment of young children. However, these therapists soon sparked a major controversy over whether their supportive therapy additions, a departure from a totally neutral-interpretive technique, would compromise treatment.

Karen Horney's rejection of Freud's libido theory of neurosis in favor of a more interpersonal approach in the analysis of neurotic patients also made less distinction between analysis and psychotherapy in that the analyst played a more active role, and dispensed with free association and the couch. Similarly, Harry Stack Sullivan's pioneering work with a population of schizophrenic patients drew attention to their distorted thinking and action patterns in adult interpersonal relationships, and influenced treatment techniques by defining the face-to-face psychiatric interview that examined the role of the analyst as a participant as well as an observer.

Within the framework of existential analysis (e.g., Medard Boss' *Daseinanalysis*), the role of the analyst was further altered by emphasizing the real, here-and-now encounter, as recently updated by Irving Yalom. Others who were engaged in the treatment of patients with character problems began to acknowledge the increasing need to enlarge the scope of treatment by introducing "parameters" (Kurt Eissler's term) that would help such patients in analysis. This technical direction was influenced by the growing effects of ego psychology on the understanding of ego defects and problems wrought by their presence.

Wilhelm Reich's analysis of character armor, as well as Otto Fenichel's investigations of problems of psychoanalytic technique, expanded the analysis of resistances in the form of pathological character traits. As analysts like Merton Gill, Leo Stone, Kurt Eissler, and Wilfred Bibring attempted to define and expand the horizons of psychoanalysis, Anna Freud's delineation of defense mechanisms also placed new emphasis on both their adaptive function and their characterological nature, and George Vaillant has brought this theory into the present.

At the same time, the European influence of the British object relations school, and the theories of Melanie Klein, Wilfred Bion, Donald Winnicott, and Michael Balint, led to modifications in technique to accommodate patients with impoverished or distorted early childhood learning patterns, as embodied in concepts of therapy as a "holding environment," the therapist as "container," and "healing the basic fault."

Elizabeth Zetzel, and later Ralph Greenson, followed Anna Freud's (and others') interests in the real relationship between analyst and patient by developing the now accepted notions of the therapeutic or working alliance that recognized the need to incorporate nontransferential elements into analysis; simultaneously advances were being made on a more theoretical front of interpersonal subjectivities and unconscious resonances as brought up to date by

Evelyne Schwaber, Robert Stolorow, Alan Skolnikoff, Owen Renick, and Morton and Estelle Shane.

Amplifications of ego functions' influence on adaptation were advanced by Heinz Hartmann, Ernst Kris, and Hans Lowenthal. Hartmann especially postulated the existence of a "conflict-free sphere" of the ego, and further defined the concepts of the self as a separate structure within the ego. Edith Jacobson's developmental model as a foundation of comprehensive psychoanalytic theory, which integrated drive theory with ego psychology and object relations theory, was supported by Renee Spitz's and Margaret Mahler's research that directly studied infants and their mothers during development. This work has been brought into current focus by Robert Emde, Fred Pine, and Daniel Stern.

Since the 1970s there has been an increased interest in narcissistic and borderline character disturbances. Heinz Kohut's psychology of the self in the understanding of narcissism and Otto Kernberg's application of psychoanalytic object relations theory to the development of psychoanalytic techniques in the treatment of borderline patients gained center stage. Their observations have profoundly influenced notions of the nature and kind of transference manifestations that appear in treatment.

John Bowlby added new theories having to do with how wishes and fears were incorporated into enduring, usually intrapsychic working models and schematizations of self and other. Like Edith Jacobson, Otto Kernberg, Heinz Kohut, and Mardi Horowitz, he attempted to integrate object relations theory and advances in developmental, cognitive, or ego psychologies. These object relations theorists described a variety of new ways people distort their views of self and others due to discomfort and trauma, including defenses of splitting, projection, and projective identification. Kohut then rejected many aspects of the original Freudian id-ego-superego theory in favor of what he called self-psychology.

Self-psychologists added views of others as extensions of self or self-objects, and of maladaptive patterns of idealization and devaluation to support fragile self-conceptualizations. Rather than real loved personas, with separate wishes and responses to the patient, self-objects are projections onto the other person of what the patient wishes them to be. Of course, these views often are quite at odds with reality and lead to relationship problems.

The control mastery theory of Joseph Weiss and Hal Sampson expanded on previous views of unconscious mental processes. They inferred that each person had unconscious plans at mastery of life. Unconscious calculations appraised the degree of safety or threat in trials of whether or not actions based on these plans could be successfully implemented. If unconscious assessments, based on past and perhaps outmoded developmental experiences nonetheless predicted danger, then processes of control inhibited the plans or led to distorted versions of them.

People like Arnold Cooper and Robert Wallerstein found ways to encompass the divergences in modern theory. Morton Reiser and Mardi Horowitz made efforts to develop a general psychodynamic theory that used modern cognitive neuroscience languages while integrating ego psychological and object relations theories into information processing terminologies. Horowitz developed formulation methods that identified states of mind, each with different schemas of self and models of relationship with other, and differing defensive control processes in each state. He suggested that shifts in control, memories, and person schemas, led to the state cycles of personality based patterns of repetitive but maladaptive interpersonal behaviors.

Table I contrasts the evolving differences between psychoanalysis and psychoanalytic psychotherapy, and Table II outlines the historical development of psychoanalytic psychotherapy.

III. MAJOR METAPSYCHOLOGICAL CONCEPTS

The *dynamic* perspective reflects the notion that all mental phenomena are the result of a continual interaction of forces that oppose one another. It implies that human behavior and motivation are active, goal and plan directed, and slowly changing at all times. It is the basis for such fundamental concepts as *conflict.*

The *topographical* perspective refers to the premise that mental phenomena reveal themselves at different levels of manifestation, from unconscious to the border of awareness or accessibility (preconscious) to conscious representation. This general orientation recognizes a human being's pervasive avoidance of painful feelings or experiences by keeping unpleasant thoughts, wishes, and affect from awareness. It also

Table I Psychoanalysis and Psychoanalytic Psychotherapy Contrasted

Feature	Psychoanalysis	Psychoanalytic psychotherapy	
		Expressive mode	Supportive mode
Frequency	Up to five times per week.	Regular one to three times per week.	Flexible.
Duration	Long term; usually 3 to 5 or more years.	Short or long term; several sessions to months or years.	Short or intermittent long term: single session or lifetime.
Modus operandi	Systematic analysis of all (positive and negative) transference and resistance: primary focus on analyst and intrasession events; transference neurosis facilitated; regression encouraged.	Focus on conflictual topics, interpersonal patterns and transference.	Focus on topics of current concern and increasing skills, reducing tendencies to transference by early interpretations of irrational beliefs.
Sample patient populations	Personality problems and psychosomatic disorders.	Symptom neuroses; personality problems; pathological responses to stressor life events.	Immaturity; severe personality disorders; latent or manifest psychoses; physical illness; ongoing stressor events.
Usual patient requisites	High motivation; psychological-mindedness; good previous relationships; good tolerance for ambiguity.	High to moderate motivation and psychological-mindedness; ability to form therapeutic alliance; frustration tolerance.	Modest degree of motivation and ability to contemplate.
Goals	Reschematization of knowledge structure; resolution of unconscious conflicts; insight into intrapsychic events; improved developmental level and new capacities.	Partial reorganization of personality and defenses; resolution of preconscious and conscious derivatives of conflicts; insight into current interpersonal events; improved relations; symptom relief.	Reintegration of ability to cope; stabilization or restoration of preexisting equilibrium; learning new skills; better adjustment or acceptance of pathology; symptom relief.
Major techniques	Reduced eye contact; free association; full interpretation (including confrontation, clarification, and working through) with emphasis on developmental reconstruction.	Limited free association; confrontation, clarification, working-through, and interpretation.	Expression of feelings and ideas, suggestion, clarification and logical views in the here-and-now, providing a safe relationship.
Treatment with medication	Usually avoided; if used, all negative and positive meanings and implications thoroughly analyzed.	May be used. If applied, negative implications explored and diffused.	May be used. If applied, negative implications explored and diffused.

acknowledges the persistence, resilience, and inaccessibility of underlying conflicts that remain alive and active, but may appear in diverse and disguised forms often unrecognizable by their recipient.

The *structural* perspective refers to the idea that the mental apparatus is organized into functional units of a tripartite nature—the it-like functions of id, the self-like functions of ego, and the over-self-like functions of superego. This basic personality organization forms the theoretical structure of intrapsychic conflict among instincts (*id*), a set of functions integrating identity with external reality demands (*ego*), and one's ideals, moral precepts or standards (*superego*).

The *economic* perspective relates to how psychic intentions are distributed, discharged, and transformed. It has implications for how ideas and affect are expressed (e.g., verbally or somatically), and for how the individual fends off psychic threat through a variety of defense mechanisms (e.g., *sublimation,* whereby unacceptable drives are diverted into socially acceptable forms; *reaction formation,* which turns an impulse into its opposite; or *displacement,* in which feelings belonging to one object are transferred to

Table II Historical Development of Psychoanalytic Psychotherapy

Theorist	Major contributions to psychoanalytic psychotherapy
1920s–1940s	
Rank, Ferenczi	Emphasized supportive as well as expressive technique with emphasis on affective experience: end-setting time limit.
Stekel	Psychoanalytically based brief psychotherapy.
Reich, Fenichel	Expanded analysis of character.
A. Freud, Spitz	Application of ego psychology to psychoanalytic treatment and child analysis, with emphasis on the adaptive function of defense mechanisms.
Alexander, French	Role of analyst to provide corrective emotional experience by being different from parents and offering alternative to early developmental experiences; short-term duration; emphasis on face-to-face interviews.
Horney, Fromm, Sullivan	Closed distinction between analysis and therapy; free association and couch not essential; active therapist role; short-term goals focused on patterns of interpersonal relationships.
1950s–1960s	
Eissler, Bibring, Stone, Gill	Expanded definition, indications, and scope (parameters) of psychoanalysis (Eissler, Bibring, Stone), including broadened analysis of transference (Gill).
Klein, Winnicott, Bion, Balint	Influence of British object relations school on psychoanalytic theory and technique (Klein): concepts of holding environment, good-enough mothering (Winnicott), therapist as container (Bion), healing the basic fault (Balint) addressed patients without adequate mothering in early months of life.
Zetzel, Greenson	Extension of therapeutic relationship to nontransferential aspects: concepts of therapeutic alliance (Zetzel) and working alliance (Greenson) advanced idea that analysis incorporate aspects of reality or real relationship into treatment, utilizing both observing and experiencing ego of patient.
Hartmann, Kris, Lowenstein	Advanced ego psychology in adaptation; postulated conflict-free sphere of ego and defined concept of self as separate structure: concept of regression in the service of the ego emphasized ego's participation in the analytic process.
Jacobson	Developmental model as basis of comprehensive psychoanalytic theory, integrating ego psychology, object relations, and drive theories in terms of multiple layered representations of self and others.
Mahler	Direct observation and research on infants and mothers; delineated separation-individuation subphases of child development, with impact on adult personality and pathology and implications for analytic treatment process.
Arlow, Brenner, Sandler, Stone, Rangell, Wallerstein	Clarified issues of unconscious fantasy and conflicted structures in relation to appraisals of reality. Studied expressive and supportive dimensions of therapy.
Edelson, Peterfreund, Klein, Rosenblatt, Thickstun, Schaeffer	Clarified need for a new theoretical language closer to observation.
1970s–1990s	
Kernberg, Ogden	Extension of object relations theory to psychoanalytic psychotherapy techniques in treatment of borderline disorders; delineation of expressive techniques for analyzing primitive transferences and defenses.
Kohut, Gedo, Goldberg, Basch, Ornstein	Development of self-theory in analytic treatment of narcissistic disorder; delineation of self-object (mirroring and idealizing) transferences; emphasis on empathic atmosphere to facilitate insight and transmuting internalization to crystallize self.
Weiss, Sampson	Developed, in control mastery theory, an enlarged view of unconscious processes as calculating whether life plans could be implemented to achieve mastery or needed to be held in check by processes of control because of dreaded consequences such as harming others.
Horowitz, Luborsky, Singer, Strupp	Integration of ego psychology and object relations theory with cognitive theory to develop coherent case formulations in terms of states of mind, schemas of persons, and habitual processes of control; added research methods.

another). Displacement has direct treatment implications for the phenomenon of *transference,* in which affect meant for early significant figures in the patient's life is placed onto the analyst or therapist.

The *genetic* perspective concerns the historical aspects of personality and its subsequent development. In this view, early experiences are repeated (*repetition compulsion*) until they can be neutralized through consciousness; that regression to infantile modes of behavior is both a manifestation of illness and a technical process facilitated to recreate within analysis the patient's original conflict (*transference neurosis*), whose resolution is the essence of classic analytic cure. It has broader implications for the idea of *psychic determinism,* which illuminates the crucial notion that present behavior is meaningfully related to one's past, and for developmental stages through which the individual evolves from infancy to adult maturity.

IV. FUNDAMENTAL TREATMENT CONCEPTS

A. Transference

Transference is broadly defined as the experience of feelings toward a person that do not befit the intended individual but belong to another person from the past. Intensive analysis of transference is the modus operandi that technically distinguishes psychoanalysis from all other forms of psychotherapy. Since Freud's original serendipitous discovery of the "strange phenomenon" of transference in the psychoanalytic treatment of every neurotic patient, its vicissitudes have been conceptualized in various related ways: (1) as a distinct type of therapeutic relationship, which has since been distinguished from nontransferential therapist–patient bonds (i.e., therapeutic alliance or real relationship); (2) as substitute pathology, expressed in the formation and resolution of a so-called transference neurosis; and (3) as a general phenomenon that transcends the boundaries of analysis into all human relationships.

B. Transference as a Therapeutic Relationship

The typical transference relationship is one in which the patient directs toward the analyst an unusual degree of attachment and affection that is not a realistic response to the relationship between them but can only be traced to wishful fantasies and idealizations that have remained unconscious. These fantasies are repeated in analysis as unresolved childhood attitudes and affects that are anachronistic and inappropriate, in part because repressed material necessarily contains infantile strivings and in part because the analyst may promote their appearance through special methods and analytic rules that intensify reactivation.

The peculiarity of the transference relationship to the analyst lies in its excess, in both character and degree, over what is rational and justifiable. Its major manifestation may include overendowment of the analyst as an idealized image, often including overestimation of the analyst's qualities, adoption of similar interests, and intense jealousy of other persons in the analyst's life. As the transference relationship is based on projection and fantasy on the part of the patient, and the analyst neither responds to the cravings of the patient nor reacts in a reciprocal or personal fashion, it is characterized (and often criticized) as being an artificial and asymmetrical bond. These qualities have been amended in later nontransferential concepts of the therapeutic relationship (e.g., working alliance, real relationship) that have been incorporated into theory and treatment.

Often, what distinguishes a transference from a nontransference reaction is not its content per se, but a group of qualities that tend to characterize transference responses and that may be used as signals to the analyst to denote their occurrence: inappropriateness (which refers to the largely irrational character of the transference response); intensity (which applies to the unusual strength of emotionality); ambivalence (which relates to the contradictions and shifts in affect that occurs toward the therapist); tenacity (which reflects the resilience with which such feelings tend to persist despite the analyst's actual behavior); and capriciousness (which describes the erratic, and sometimes trivial events that evoke the responses).

As transference distortions develop, their manifestations can be either positive or negative, paralleling the ambivalence that underlies all feelings that are in part unconscious. *Positive transference* refers to the expression of good feelings toward the analyst, of love and its many variations, manifested in (albeit excessive) interest, trust, admiration, respect, sympathy,

and so on, that can predominate as the motive force behind the wish to change and receive the analyst's approval. In a state of positive transference, the patient overvalues and endows the analyst with some of the same magical powers attributed during infancy to the patient's parents. These feelings may be the basis for benign dependency, utilized by the analyst in gaining the patient's trust and establishing rapport insofar as the patient is well motivated and receptive to the analyst's influence. At the other end of the affective spectrum, *negative transference* refers to equally intense bad feelings toward the analyst—including hate, anger, hostility, mistrust, and rebelliousness—in which the patient undervalues the analyst in ways that also repeat comparable feelings toward parent or parent substitutes of the past. Both types are inevitable aspects of psychoanalysis and must be interpreted. Some analysts have considered positive transference to be libidinal, based on sexual drives, whereas negative transference is regarded predominantly as a function of unresolved aggressive strivings.

For the most part, however, it is negative transference that becomes most problematic and requires analysis if treatment is to proceed because it manifests itself in ways that interrupt treatment, whether through direct attacks on the analyst or by acting out negative feelings instead of exploring them. Nonetheless, very intense positive transference, often expressed in the patient's excessive passionate demands on the analyst, can be misleading in that it too may be manifestation of resistance as the patient defends against further probing into unresolved conflicts. Another obstacle to analytic progress may be the analyst's own strong reactions to the patient, *countertransference,* which can inappropriately enter the treatment if the analyst is not sufficiently aware of personal feelings.

As traditionally understood, transference refers primarily to unrealistic distortions from the past, whether positive or negative; it does not pertain to reactions resulting from reality factors, as when the patient may be legitimately angry. However, transference responses are increasingly recognized as having objective as well as subjective components, relating to significant figures of the past and to real responses of the analyst: "new editions" of old conflicts are exact replicas that are total projections, whereas "revised editions" attach themselves to actual characteristics of the therapist.

C. Transference Neurosis

The most vivid expression of transference is the formation of a *transference neurosis,* a substitute pathology that reiterates fundamental pathology, in which the patient psychologically regresses to early stages of development and returns to the source of personality problems in the past in order to transcend them. Manifestations of the transference neurosis do not arise immediately, but emerge in the so-called middle phase of analysis, when the patient is most subject to the regressive forces induced by the analytic situation and the emergence of infantile needs for gratification. Its appearance may be episodic, or it may never truly appear, although much of the work of the middle phase is spent removing resistances in order to allow the transference neurosis to surface. The transference neurosis was originally regarded as a serious obstacle to analytic work, but it also allows the analyst to observe directly the recapitulation of the patient's childhood responses.

D. Resistance

Resistance is defined as the forces or defensive operations of the mental apparatus that work against the recovery of memories and that obstruct the progress of analysis by opposing the analytic procedure, the analyst, and the patient's reasonable ego. Comparable to transference, analyzing or managing resistances is also central to analytic work, and functions in counterpoint to transference in two ways: (1) as resistance to the transference, which means that the patient fights against the development of a transference and thus prevents the analyst from being able to tap the source of intrapsychic conflict, and (2) as transference resistance, which means that the transference itself is used as a resistance by stubbornly adhering to irrational transference manifestations instead of utilizing the transference as a path to earlier experiences and memories.

Conscious resistance refers to the deliberate withholding of information from the analyst, or the like. Such resistance is transient and usually easily rectified by pointing it out to the patient. Unconscious resistance, however, refers to a much more significant and resilient phenomenon that arises as a defense against emotionality and memory.

The clinical signs and manifestations of resistance

are manifold. Any persistent, stereotyped, or inappropriate interruption of the treatment process may be a clue to resistance. Common examples include the silent patient, who impedes the progress by failure to verbalize, and, at the other end of the spectrum, the compulsive talker, who is ostensibly obeying the fundamental rule to say whatever comes to mind, but whose verbal productions are unconscious barriers to insight. Specific variations of resistant behavior may be undue focus on the past (fixation on a particular point in time) or incessant inclusion of trivia or external events in order to avoid painful or emotionally laden topics. Typical forms of resistance also include lateness, missed hours, and delaying (forgetting) to pay one's bill.

Managing resistances means that the defensive maneuvers of the patient are to be addressed before the material that is fended off can be approached. The analyst must discover how the patient resists, what is being resisted, and why. The immediate cause of resistance (e.g., anxiety, guilt, or shame) may be a superficial or surface indication of what is going on in the patient; repeated uncovering and confronting of resistances should reveal the underlying affects that are unconsciously behind such behaviors.

E. Countertransference

As previously mentioned, and as the name suggests, *countertransference* is transference in the reverse direction—from analyst to patient. It generally refers to unconscious emotional needs, wishes, or conflicts of the analyst evoked by the patient, which are brought into the analytic situation and thus influence the analyst's objective judgment and reason.

Countertransference manifests itself in many ways; it is commonly acute, temporary, superficial, and easily recognized and managed; but it can also be chronic, permanent, deeply rooted, largely unconscious, and out of the analyst's control. The former may occur in response to very specific content that arises or in identification with some concrete aspect of the patient's personality. The latter involves more generalized and ingrained patterns of behavior, often pathological, that pervade the analysis in a way that is untherapeutic and to which the analyst remains blind without external intervention.

The former type of countertransference, fortunately, is more typical and occurs in every analysis. Comparable to the patient's acting out, the analyst brings into the analysis feelings, thoughts, or behavior that do not belong there. Classic countertransferences may manifest themselves in special consideration for an attractive patient, like eagerly making an unavailable hour available, or failing to remember the changed hour of an uninteresting patient. The following are considered common warnings of countertransference in analysis: experiencing uneasy feelings during or after sessions with certain patients; persistently feeling drowsy or actually falling asleep; altering sessions or showing carelessness regarding scheduling (e.g., extending hours or forgetting about them); making special financial arrangements (e.g., overly strict with some patients and underassiduous with others); wishing to help the patient outside the session; dreaming about one's patients or being preoccupied with them in one's leisure time; using the patient as an example to impress a colleague or having the urge to lecture or write about a particular patient; reacting strongly to what the patient thinks of the analyst (i.e., needing a particular patient's approval); not wanting the patient to terminate or wanting the patient to terminate; finding oneself unable to explore certain material or to understand what is going on with the patient; and evincing sudden or excessive feelings, such as anxiety, depression, or boredom.

Countertransference is presumed to relate primarily to unresolved and irrational responses; yet it may also refer to an analyst's relatively reasonable reactions to a patient's behavior, as when feeling aroused by a seductive patient, paternal to a deprived patient, frightened by an aggressive patient, burdened by a demanding patient, or jealous of a successful patient. As such, countertransference feelings are an inevitable part of any treatment. However, when these feelings are not simply situation-specific and evoke strong reactions that belong to former events or persons in the analyst's life, they can become problematic because the analyst is in danger of bringing these unconscious feelings into the analysis in the form of unnecessary, if not actually untherapeutic, behaviors.

Of more serious implication are those forms of countertransference reflecting chronic problems left unsettled in the analyst's own analysis. Some examples may be the analyst with an underlying masochism who accepts abuse from patients without adequately analyzing its reasons; the grandiose analyst who takes on the most difficult patients with promises of cure

without recognizing the need for help if the treatment is not going well; the analyst who allows a seductive patient to act out, or reciprocates sexual advances instead of examining the patient's wish to arouse; or the lonely analyst who encourages the patient's dependency and will not terminate treatment for fear of abandonment. When the analysis becomes a source of narcissistic gratification for the analyst who encourages the love or idolatry of the patient without introducing a more realistic appraisal, or prematurely terminates patients who do not improve sufficiently, the analyst's own return to therapy may be indicated.

V. CHARACTEROLOGICAL FORMULATION

The theories of psychoanalysis are an aid to explaining characterological aspects of personality problems and to planning how they may be changed. Therapists combine theory with observation in order to develop a patient-specific set of hypotheses. Typically, in psychoanalytic case formulation, it is assumed that symptoms and problems in living are caused by the interaction of multiple processes at biological, social, and psychological levels. At the level of the individual's psychology, the symptoms and problems might be caused not only by deficits in normal capacity but by conflicts. Active conflicts may lead to the formation of compromises between or among wishes, and their feared consequences. In psychodynamics these compromises are often regarded as defensive mental strategies.

The formation of symptomatic traits is often understood as a compromise between expressive aims and the wish to avoid the threatening consequences of expression. Some traits are learned from identification with others. Because symptomatic character traits are seen as complexly rooted in such multiple causations, psychoanalysts use the term overdetermination or pluralistic determination in making formulations.

For example, an individual may want to both transgress a moral value and also express feelings of guilt over the transgression. He or she fears the distress that could occur and inhibits both the wish and the guilt. Because of the unresolved topic he or she may nonetheless experience anxiety that something dreadful is about to happen. For such a person, anxiety would be a presenting symptom. The topic of the type of transgression might be conflictual or emotionally evocative, but unclear. The warded-off wishes, guilt, and fear can be formulated as the unconscious reasons for forming anxious experiences. The symptoms of anxiety are viewed as the result of the conflict between the impulse to express the guilt and the defensive avoidance of such expressions. Social and biological factors might influence the manner in which the anxiety symptoms are experienced and communicated.

A patient may mysteriously have anxiety symptoms during encounters that are meant to be lovingly erotic. The patient may add descriptions that indicate fears of phenomena that are even worse than the anxiety symptoms, such as horror of becoming enraged upon sexual frustration, guilt about potentially acting on the hostility felt toward a spouse, and/or a warded-off despair on feeling rejected. Avoidance of erotic situations may reduce the frequency or intensity of anxiety symptoms at the expense of diminished opportunities for the satisfaction of sexual wishes. The person might report substitute behaviors such as becoming so interested in morality that he or she is investigating pornography because it is socially bad and ought to be banned.

A patient may present a set of signs and symptoms that are part of a problematic state of mind, but not necessarily the most dreaded. For example, the person may present with moods of tension in which there is preoccupation, diddling with peripheral details, and blockage of work on central aspects of a project. This may be a surface indicator of approach and avoidance conflicts about collaborating on a project or about competing to win a role in a project. The desired state might be one of working well, enjoying mutual effort and, when necessary, competing in a realistic way. A related dreaded state of mind with a work supervisor or rival peer might be guilt over doing so well that the other is harmed or defeated, or doing so poorly that the self is humiliated. Approach and avoidance conflicts can lead to a problematic compromise state, one presenting with symptoms of anxiety and work block. A relatively less symptomatic and so relatively more adaptive compromise state defends against dreaded consequences of working too well by taking a stance of aloofness in regard to work. By procrastinating and isolating the interests of the self from the project, the risks of being one-up or one-down are reduced, but the satisfactions cannot be obtained.

Similarly, on a sexual topic, the presenting state may be a problematic compromise state containing

anxiety symptoms and a tense mood. The desire might be for states of sensuous pleasure and closeness. The patient may have even more dreaded states of mind such as a mood of despair over being used and then abandoned. A relatively more adaptive compromise state that the problematic state of anxious tension might be clowning around to ward off states of closeness and intimacy. Just as one does not take the surface symptoms as the whole picture, in making a psychodynamic formulation at the level of observing the states of mind that bring phenomena together into coherent patterns, one does not take the presenting or problematic states of mind as the whole picture.

Psychoanalytic formulations of why states of mind occur focus on unconscious aspects of identity of self and on internalized object relationships. Interpersonal experiences during development leave an enduring inner set of models, comprised of views of self and others, that can cause the styles, moods, and organizations of any particular state of mind. Moreover, these inner schemas about self and the surrounding world may have sequences that can lead to cycles of shifting from one state to another. These sequences can be a part of not only conscious but, very importantly to psychodynamic formulations, unconscious fantasies, plans, or scripts. Once again, the developmental antecedents of various schemas, plans, and scripts are important aspects of formulations, and dynamic formulations change with increased understanding—formed during explorations in treatment sessions—of how the past is influencing, perhaps very irrationally, the present and near future.

Personality is in part a repertoire of schemas of self and others, and of values and plans for how to handle wishes, fears, defenses, and coping. Self-organization is a set of schemas that leads to a conscious sense of identity, of an "I" or "me" that continues over time. Each person's experience of the self varies; this stems from the activity of multiple self-schemas that can lead to different self-images and styles in different states of mind.

Some self-schemas can be activated to ward off the effects of others. An inferior self-schema may organize a potential state of shame. If less inferior and more realistic self-schemas cannot be activated, then grandiose and unrealistic ones might be primed in order to avoid shame by bolstering pride.

Activation of ideal schemas of self, when matched to and discrepant from real or devalued schemas of self, can lead to emotional experiences of shame or guilt. Whether or not such self discrepancies lead to deflation of self-esteem or can be accepted while maintaining emotional equilibrium depends on an individual's level of personality maturity. One way to view maturity is in terms of degree of supraordinate integration of multiple schemas of self. People vary in the degree to which they have or have developed the capacity to develop schemas of schemas. Those who can manage this are said to have an integrated self-conceptualization because they can accept various types of self-discrepancies.

The technique of interpretation and working-through in treatment might differ for patients who do and do not have supraordinate self-schemas to integrate and control subordinate self-schemas. The existence of supraordinate schemas allows a patient to contain in a given state of mind the information relevant to the self-schemas that organized a different state of mind. Patients without this capacity are more vulnerable than others to explosive shifts in state and in how they can view the therapist. These aspects of a formulation can be understood using a tool of inference called *role-relationship models*. Such models contain views of self and other, and self with other, and how transactions may unfold. A role–relationship model, in its simplest diadic form, includes a set of characteristics of self, a set of attributes and roles of others vis à vis the self, and a script of automatically expected transactions between self and other. One example of such a script begins with a wish, goes on to a response of the other, and then to reactions of the self, which may include self-appraisals. This is the aspect that Lester Luborsky called a Core Conflictual Relationship Theme.

Any person may have multiple role–relationship models for internally interpreting any topic, for any relationship, and for any traumatic event. Theories about such unconscious beliefs separate psychoanalytic points of view from cognitive and behavioral approaches to therapy because they add these components to case formulations: (1) there are immature schemas that can influence behavior in some states of mind but not others; (2) there are more mature schemas that can inhibit activity of less mature schemas in some states but not others; and (3) there are defensive layerings so that some schemas may be activated in order to ward off dreaded states of mind that might be organized by other schemas. Psychoanalytic therapies

explore this structure of knowledge about self and others, its lack of concordance with real interpersonal opportunities, and its developmental sources. Such insight seeks to achieve a process of working through in order to arrive at new behaviors that can be learned and practiced until new schemas function automatically in organizing behavior and states of mind.

Psychoanalytic formulations include control processes that act beyond full conscious awareness to reduce the expression of ideas and feelings. By uncovering and analyzing such processes the therapist and patient can act to change them if they are resulting in symptoms or obstructions to the patient's life. The idea is not only to increase work on warded-off topics but to modify in an adaptive direction the person's habitual and nonadaptive forms of defensiveness.

Inhibitions of conflicted and potentially emotional topics can lead to the defensive maneuvers known as suppression (conscious avoidance), repression (unconscious avoidance), denial (reducing the impact of the real implications of external stressors), and disavowal or negation (obscuring what has been revealed).

Inhibitions of schemas and facilitations of other schemas, as well as dislocations of roles and attributes, can lead to defensive maneuvers that distort views of self and others. These include such operations as projection (attributing something from self to other), displacement (putting something from one person onto a less dangerous person), and role reversal (exchanging positions to take the role of lesser danger to the self).

Another class of control processes, one that affect the form of expression, can be added to these controls of the topics of thought and communication and their schematic organizers. These are also important to understand because of their implications for technique. A patient may discourse on a conflictual topic in a flat, hyperlogical, or intellectualized, unengaged, or generalized manner. There may be communication only of ideas, without emotion, a defensive mechanism called isolation.

VI. THE GROUND RULES AND CONTEXT OF PSYCHOANALYTIC TREATMENTS

The goal of therapy is to improve the future for the patient. Each party to the treatment has tasks in relation to this goal. The patient is asked to speak truthfully and completely about memories, fantasies, associations, images, dreams, bodily feelings, wishes, and fears that are usually not told to others. The therapist and the patient together observe what it feels like to do this, how it is done, what is communicated, and what the process does to their relationship. The therapist puts this understanding into words in the form of interpretations, which are intended to connect the patient's present feelings with his or her past, giving a broader picture about meanings, including those that have never before been verbalized.

In psychoanalysis, the two people explore private themes, personal dilemmas, conflictual memories, and unsettling feelings of one of them. Most people are not used to speaking openly on such matters. The analyst describes what can be done in the sessions to create this unusual environment of very frank discourse and interpretation. The therapy hour will begin on time and end on time. The patient's feelings about this are often one of the first topics relating to the therapy itself that comes up. Despite the fixed ending of each hour, the patient is not rushed to premature closures. An hour may end but a conflictual topic can be held over until the next session begins. As no one can be sure about interpretations, ambiguity as to meanings will have to be tolerated.

The analyst offers a relationship in which there is respect for the personal attitudes and feelings of the patient. The values of the therapist may be different from the patient and are not imposed on the patient. Clarification of the patient's values and how they may conflict with social norms is, however, an aspect of the dialogue. The therapist also displays more equidistance, abstinence, and neutrality, than one would expect of other relationships as with friends, teachers, parents, or religious counselors.

Equidistance means the therapist is "there" not just for the adult, poised, competent self-schema of the patient, and the states of mind organized by that set of concepts and images, but also "there" for the patient's ideals and values, and also "there" for the childlike self-schemas and immature passions of the patient. The patient may have a conflict among wishes to be taken care of, dangerous wishes to take over the lovers and careers of others, moral injunctions against ruthlessness or dependence, and adult concerns over how to appraise current dangers in the social, political, spiritual, and environmental worlds. The therapist does not side with any sector or any of a variety of

self-schematizations of the patient, but remains available as a container for all facets of conflict.

For the therapist, the term abstinence means, at its best, avoiding unessential advice and reassurance while waiting to hear the unspoken and the hitherto unspeakable. The therapist is not there to gratify the patient's wishes but to foster adaptation to life so that the patient can seek constructive gratification in life outside the therapy. A related concept is neutrality, which means that the therapist does not react emotionally as he or she would in a social situation according to his or her own wishes, ideals, and moral standards. Neutrality is not coldness or indifference: warmth, compassion, concern, sympathy, empathy, and understanding are not deflections from neutrality but absolute requirements for the therapist if the treatment is to achieve its full goal.

The major general techniques of psychodynamic treatments are fostering expression, suggestion, clarification, interpretation, and repetition in order to facilitate working through. Working through means the process of revising knowledge structures so that warded-off topics can be confronted, traumatic memories integrated, and conflicts and contradictions resolved or accepted; working through is also the process by which deficiencies are reduced and unconscious fantasies are modified by conscious choices.

A. Fostering Expression

Fostering expression includes helping the patient to assume most of the responsibility for bringing up topics of importance. He or she is encouraged to broaden the topics of discussion beyond the scope of original complaints. The fundamental rule is to try to say everything that comes to mind or is felt in the body.

This fundamental rule of complete disclosure can be expanded to helping the patient to use free associative reveries and to report peripheral and fleeting thoughts and visual images. At times drawings, paintings, poems, letters, and discussions of bodily postures or impulses to move during the hour may be used to widen the modes of representation for initial expression of inchoate feeling states and ambiguous ideas. But while pictures in the mind's eye and bodily enactions are utilized as carriers of meaning, translation into words is emphasized as the clearest form of communication and the beginning of the possibilities for logical and psychological understanding of nonverbal impulses and behavior and through that, the ability to change, if change is desirable.

B. Suggestion

The therapist may suggest that the patient attend to certain topics, follow certain principles of disclosure, or try out certain alternative modes of perceiving, thinking, feeling, or acting. The therapist may ask, for example, "What do you imagine you would feel if it were to happen that . . ." to suggest focusing in a specific direction. The choice about whether or not to follow such suggestions is left to the patient. Firm directions are seldom if ever given, and any type of manipulative or covert suggestion is avoided. This means giving up the use of certain positive effects of suggestion, as in the placebo effect, in favor of fostering a sense of joint exploration in the search for insight and understanding as vehicles to change.

C. Clarification

Clarification includes techniques of questioning or repeating what the patient has told the therapist. Even when the therapist repeats exactly a bit of dialogue spoken by the patient, it sounds different when the patient hears the remark. When the therapist reorganizes information reported by the patient it is usually to convey cause and effect sequences and to show the patient the meaningful relatedness of sequences that have seemed, to the patient, unrelated.

For example, the patient might tell a story like this:

"He really made me mad, implying I had not done my work. I'd like to quit that job. While I hadn't gotten the inventory together, I would have eventually."

The therapist might qualify:

"While you had intended to do it, you had not yet gotten the inventory together. He criticized you for that. Then you got mad and now want to quit."

This intervention is very minor, but it puts the sequence into a temporal order and gives the patient a chance to listen to that and then comment further.

It can be helpful to say how the discourse of the patient is being received. The therapist may say:

"I don't understand this story too well, maybe I haven't got the sequence of events in my mind yet."

Such remarks not only encourage the patient to elaborate on the sequence of events, they clarify the manner in which the patient is telling the story in question.

D. Interpretation

Interpretation is the central tool of the psychoanalyst and dynamic therapist. In an interpretation the therapist says what is important, why it is important, and/or how it comes about. Interpretations are so crucial to psychodynamic techniques that they can be categorized as follows.

Genetic interpretations link current patterns to their developmental antecedents, going back to adolescence, childhood, and infancy as necessary to understand the present. (The word "genetic" here is used to refer to the original or developmental source of current patterns, not to direct action of the genes.) A special form of genetic interpretations is the reconstruction. In a reconstruction the dynamic therapist pieces together different topics and offers a story about what significant early experiences might have been like in order to account for current, clear, important, and maladaptive beliefs, attitudes, wishes, or behavioral problems.

Transference interpretations explain to the patient the meaning of distortions in the relationship with the therapist. A transference interpretation may involve a contrast between the role–relationship models described as transference and the role–relationship model that might describe the current therapeutic alliance of the patient, or the potential for relationship in the treatment setting that takes into account the real opportunities of that setting.

Dynamic interpretations explain to the patient the forces involved in a conflictual constellation. Wishes, fears, and defenses on a given topic are described, and their interaction leading to experiences is also described. The advantage of working with levels of formulation that address phenomena, states of mind, person schemas, and processes of control is that the language of the formulation itself can be used directly in discourse with the patient about desires, threats, and defensiveness.

Dream interpretations explain to the patient the concerns and symbolic meanings that may lie behind the formation of dream images. Some schools of dynamic treatments rely partly on assumed general inclinations such as archetypes or mythic symbols, but most often dream interpretation is delivered in terms of what the therapist actually knows about this specific patient's schemas and role–relationship models. Accurate interpretation of a dream usually requires more knowledge than the description of the manifest content of the dream, and so the patient's free associations to elements in the dream are requested. They suggest the antecedent moods, schemas, and recent experiences that contribute to the dream elements.

Interpretations are tentative and may change over time as understanding deepens. That is why in technique the wording is often put in a tentative way, leading to some jokes about analysts who too invariably repeat "I wonder if perhaps you might be feeling. . . ." Interpretation is not enough to induce psychic change. The change process beyond interpretation is called working through.

E. Repetition and Working Through

The working-through process involves repeated examination of the same topic. If the treatment is progressing, each repetition is perhaps a bit different and contributes to the overall decrease in repression and increase in understanding. Some new aspect of conflict may be identified, and new linkages between topics are established. Realization of developmental antecedents of current conflicts helps the task of differentiating current reality from past fantasy.

Previously warded-off ideas and feelings may be allowed expression and modification during repetitions. Linkages to other domains of meaning may be established. In each repetition there may be a shift in the interaction of wishes, fears, defenses, and beliefs about reality. Should the whole topic again fall under repression, as it characteristically does after the treatment hour, it is in this revised form and can come up again, each time more easily, for further revision until it is completely analyzed.

F. Complications

It has been observed in exploratory psychoanalysis that some patients have an initial period of effective work and then have a deterioration in their condition. This has been called a negative therapeutic reaction. Sometimes character traits of self-punitiveness have been noted in such instances. It is important in such instances for the therapist to be self-observant for feelings of helplessness, guilt, and anger, and to aim instead for understanding with the patient why the condition has gotten worse.

Not to be confused with negative therapeutic reactions are negative transference phenomena. These are a common aspect of treatment. In developmentally immature patients, ones who have unintegrated self-schemas and who are vulnerable to feeling fragmented, empty, worthless, or bad, negative transference reactions can occur and seem to the patient "the whole picture." That is, they are not mitigated by simultaneous schemas of a therapeutic alliance. Early interpretation of the negative transferences and/or very early emphasis on signs of the therapist being helpful in a therapeutic alliance may be needed to prevent the patient from dropping out prematurely in the midst of a negative transference reaction.

VII. RESEARCH AND EVALUATION

Henry Bachrach, Robert Galatzer-Levy, Alan Skolnikoff, and Sherwood Waldron report the following in their review of psychoanalytic efficacy studies: Robert Knight reviewed analytic case outcome research before the late 1930s. The results indicate much improvement or better in 63% of neurotic cases, 57% of character disorder, 78% of psychosomatic conditions, and 25% of psychoses. In a study led by Weber of persons who applied for psychoanalysis and then received either analysis or time-unlimited analytic psychotherapy, the patients in different modalities had a 90% or greater report of being satisfied, and 75 to 90% were rated as improved. In a separate study Jerome Sashin, Stanley Eldred, and Suzanne van Amerowgen reported a 69% agreed-upon completion rather than breaking off of therapy, and a 75% level of achieving at least moderate improvement.

Brief forms of dynamic psychotherapy have been found to be effective in many empirical studies as summarized by Mary Lee Smith, Gene Glass, and Thomas Miller. At outcome the average patient is better than 72% (effect size .59) of subjects in waiting-list control groups. The current questions for research concern which therapy for which type of patient and with what type of emphasis on therapist action.

Different studies led by Robert Wallerstein and by Mardi Horowitz have indicated that therapist actions that are more probing for warded-off contents and more confrontational with respect to control processes may be more helpful for neurotic level cases and less helpful for narcissistically vulnerable, borderline, or psychotic levels of self-organization.

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