CHANGES IN PSYCHOANALYTIC TECHNIQUE: PROGRESSIVE OR RETROGRESSIVE?

Manuel Furer, M.D.

Tonight I shall talk to you about psychoanalytic technique in new and old dress. I shall ask you to direct your attention to a remarkable congruence in the technical writings of Sandor Ferenczi and those of our present day revisionists of what we may still call standard technique. The title of my lecture, Changes in Psychoanalytic Technique: Progressive or Retrogressive is adapted from a paper by Ferenczi delivered in 1929 as Progress in Technique and published in 1930 as The Principle of Relaxation and Neocatharsis. Perhaps, Ferenczi said, the term progress is a misnomer; perhaps the title should be Retrogressive or Reactionary. But, backward can be forward. Ferenczi advocated a return to Freud's early theory when the pathogenesis of neurosis was thought to be the traumatic impact on the child of seduction by the adult, and the remedy was recovery of memory, catharsis, and the use of the personality of the analyst to influence the patient. On this position, undeservedly abandoned, Ferenczi constructed an alteration of the early technique with emphasis, enhancement, and expansion of the role of the analyst which would bring about not only a reliving of the trauma but in addition, a corrective experience, and thus a neocatharsis that would heal in a way that other techniques had failed to do.

Ferenczi's new technique of 1930 was also a significant alteration of what was at that time already very close to the standard technique of today. The role of transference had by 1930 almost reached its current preeminence, and a greater understanding of transference and countertransference was available. Ferenczi added to the trauma of sexual seduction, the powerful, malevolent force of the hypocrisy of the parent as a major pathogenic agent and of the hypocrisy of the analysts an obstacle to cure.

I am indicating as is evident in my title, that the current the current technical changes as recommended and practiced are retrogressive in the sense of returning to an earlier tradition, namely Ferenczi's technical procedures of the early 1930s. I exclude the more radical experiments of the dying Ferenczi as disclosed in the recently published Clinical Diary.

In tracing the influence of ideas one can point to a direct connection between Ferenczi and the school of Sullivanian psychiatry in that many of his pupils and analysands gravitated to this interpersonal theory and method, and several became influential teachers. In the writing of the adherents of this school then and now, what is considered pathogenic are the maladaptive solutions to the child s conflict with the external world of caretakers that persists into adulthood, without however a focus on sexuality. In this school, as with Ferenczi, cure lies in the interaction between patient and analyst; and the behavior of the analyst is paramount. For many decades the beliefs and practices of the Sullivanian school seemed to remain encapsulated, that is not integrated into conflict theory. There does not seem to be the same acknowledged intellectual heritage by other schools of revisionist thought. Among Freudian analysts, that is those for whom intrapsychic conflict remains basic for pathogenesis, the source for this retrogressive movement is even less clear. There now seems to be a spillage or seepage from one school to the other. However, like Ferenczi, all share the belief that in the here-and-now of the analytic experience, the interaction of the psychic manifestations of the analyst with those of the patient have the major part in determining the psychoanalytic process. This interaction is not only considered a more accurate observation of what happens, but like Ferenczi, a coming together of technique and a theory of cure.

My interest tonight is in what I believe to be Ferenczi s influence on contemporary revisionist thought. I will not address most of the contributions to what, as you know, is a very wide-ranging debate over data and

procedure, but instead will choose what seems to me most useful to illustrate that influence. As a practicing analyst, of course, I cannot avoid joining the debate.

Both for Ferenczi in his day, and for his contemporary heirs, what is considered to be new is a more sophisticated understanding of the analytic relationship. Ultimately, the source of these additions to standard technique rest on Freud s description in 1914 of transference as the past alive in the present: The patient does not remember anything of what he has forgotten, but acts it out; he reproduces it not as memory, but as action; he repeats it without of course knowing he is repeating it. We must treat his illness as a present-day force. We have only to add that what set Freud on this road was his discovery that the wishes and desires of this force are directed at the analyst, making for a complex and formidable detour in the Freudian psychoanalytic endeavor to recover the past.

In the papers on technique, the analyst was an objective observer, unless countertransference resulted in a blind spot. Freud did not articulate the existence of a constant interaction as Ferenczi did. To me, that continuous interaction is part of any human relationship that is of any intensity. I agree with Brenner that there is no model in life for the relationship in the psychoanalytic situation in that in the mind of the analyst, and increasingly one hopes, in the mind of the patient, the purpose is to understand the operation of the patient s mind both within the analytic situation and outside it in life.

SECTION I: FERENCZI'S CONTRIBUTIONS

I turn now to those precepts of Ferenczi's that reveal the therapeutic capacities for which Freud had commended him, and which are still in use in our contemporary standard technique. The intensity and persistence with which Ferenczi sought a better therapy reminds one that he was often referred patients who had failed with other analysts. He emphasized, as in much of contemporary writing, the need for sensitivity of the analyst to himself at work, to his countertransference and to his subjectivity. He wrote in 1919, the doctor is always a human being, and as a such liable to have sympathies and antipathies, as well as impulses; without such susceptibilities he would of course have no understanding for the patients psychic conflicts.

In contrast to Freud, he thought that an excessive degree of antipathy is no reason to turn the patient away, because the unconscious aim of intolerable behavior is often to be sent away. In our time this world be described as an actualization, as for example by Boesky, or as the role thrust on the analysts as Sandler described it. To me as to Ferenczi the response can be potential and not inevitably interactive.

The following composite quote from Ferenczi, anticipated Ernst Kris conceptualization of creative thinking and includes Hartmann's construct of autonomous functioning of the ego, emphasizing what Freud called the small quiet voice of reason.

On the one hand analytic therapy requires of the analyst a free play of association and fantasy, with full indulgence of his own unconscious. We know from Freud that only in this way is it possible to grasp intuitively the expressions of the patient s unconscious that are concealed in the manifest material and in manner of speech and behavior. On the other hand, the doctor must subject the material submitted to him by the patient to a logical scrutiny and may only let himself be guided by the result of this mental effort. This constant alteration between the free play of fantasy and critical scrutiny, presupposes a freedom, an uninhibited motility of psychic excitation on the doctor's part. However, he adds, not for one moment must we relax the vigilance and criticism made necessary by our own subjective trends.

Ten years later, as we shall see, Ferenczi found that certain subjective trends in the analyst supplied both traumatic and corrective experiences which would become particularly useful in cure. In 1919, he described the development of the countertransference in the career of the analyst, as a simple straight-forward evolution. In the first stage, the new analyst, having very recently been a patient himself unconsciously identifies with his patients, becomes their champion, and wants their wishes fulfilled. Subsequently he resists this attitude, represses it, and enters the second stage of counter-resistance, overcoming the earlier identifications by setting up the contrary attitudes of over-detachment and losing thereby the intimate contact with his patient's unconscious. Finally, he strikes a balance between these two polarities, a sublimated countertransference: the analyst identifies or detaches himself to the degree and in the manner required for his rational purposes. The mature analyst is now able to let himself go, that is to give full indulgence to his own unconscious, and

also to listen to his preconscious signals so as to know when to put his critical scrutiny into operation. It is this oscillation between the free play of fantasy and critical scrutiny that characterizes the experienced analyst. What has been added recently is that the patient intends his fantasies to be responded to by the analysts, so-called actualized. That there is an aim and an object of these drive derivatives to me describes the usual burden on the analyst or as Freud called it a temptation for countertransference. In current theories of technique these responses are thought to be particularly useful. I would emphasize the quantitative factors in both patient and analyst which result in variations in response as in variations of free play and critical scrutiny. This makes for differences among individual analysts and differences in the same analysis at different times. However, the idea that enactment or actualized responses by the analyst takes precedence over the oscillation of free play and reflection and conscious judgement is what I must question.

The problem as seen by me in discussion with various colleagues, is that these interactions, often more subtle in standard technique fosters a resistance to self-awareness. The work required of the patient is subverted in the acting out of infantile wishes, of course, with the analyst as object of this aim. To try to alter the analyst's response, or to try to establish one, is also sought by the resistance. The illusion that the transference wish is being partially fulfilled is inevitable as Boesky maintains, but as Nunberg and Tarashow pointed out, the closer that wish fulfillment is a reality in the patient s mind, the less likely it is that the patient can be analyzed.

Self-reflection and insight diminish the resistance and also those elements of repetition in the transference that are addressed. Without abstinence, that is not fulfilling transference wishes, the need of the patient to understand is diminished. I should add that in practice the analyst on reflection may have to alter his behavior with certain patients when it is apparent that he is aiding the resistance; for example, Brian Bird found he had to speak less in order for his patient to recognize that it was his fantasy that the analyst was nagging him as his mother had.

To return to Ferenczi: the best explication of Freud s maxims about the surgeon and the mirror as understood at that time is contained in Ferenczi s admonition. He says, before the physician decides to tell the patient something, he must temporarily withdraw his libido from the latter, and weigh the situation coolly; he must under no circumstances allow himself to be guided by his feelings alone. The analyst like the surgeon must acquire the capacity for this temporary detachment; he does not come equipped with it. This is in contrast to some contemporary advocates of a technique that finds spontaneous emotional responses authentic, and hence especially useful. For Ferenczi, understanding the patient is a function of the natural capacity for identification and it is the refinement of this capacity that he concluded is foremost in psychoanalytic technique. As in the countertransference of the third stage, despite sublimation or the receding wishes, the latter remain unconsciously active.

Some contemporary analysts criticize the psychoanalytic technique of the 1950's, occasionally to the point of caricature, as authoritarian, arrogant, over-confident and presumptuous in regard to the knowledge of the patient. Some revisionist thinkers explain this harmful detachment as the unavoidable behavioral manifestations of the principles of abstinence and neutrality. Ferenczi in his kinder way, cautions his colleagues, Nothing is more harmful to the analysis than a school-masterish and even an evaluative attitude on the physician s part; anything we say to the patient should be put to him in the form of a tentative suggestion and not a confidently held opinion, not only to avoid irritating him, but there is always the possibility that we may be mistaken. One must never be ashamed, to confess unreservedly one s mistakes. It must never be forgotten that analysis is no suggestive process, primarily dependent on the physician s reputation and infallibility. All that it calls for is confidence in the physician s frankness and honesty, which does not suffer from the frank confessions of mistakes.

In this cautionary lecture Ferenczi then reminds his colleagues, Every patient without exception, notices the smallest peculiarities in the analyst s behavior, external appearance or way of speaking, but without prior encouragement not one of them will tell him about them, although failure to do so constitutes a crude infringement of the primary rule of analysis . The patient's reluctance to make personal comments seems to have been rediscovered in the contemporary literature, but now, the recommendation is that the analyst ask the patient to focus his mind on what is assumed to be his correct observation, both to foster interaction

and to learn about ourselves. Ferenczi advises that we have no alternative but to detect ourselves from the patient's associations, for example, when we have offended by a sneeze, the shape of our face, or a comparison physically or mentally to others who are more impressive. One must contrast Ferenczi's ideas of continuous involvement and awareness of his own subjectivity with Freud's position and that of others who felt free to advise patients and to participate with them in what they felt to be harmless interactions. Perhaps, as Lipton suggested, Freud considered such action to be outside of technique and presumably a benign use of the knowledge of the patient. Overt self-disclosure as currently recommended is felt to be essential for equality and authenticity. Then and now, such disclosure may not be harmless in distorting the transference or in influencing the life of the patient.

Another precept by Ferenczi is to the point here: A special form of this work of revision appears to occur in every case; I mean the revision of the emotional experience which happened in the course of the analysis. The analysis itself gradually becomes a piece of the patient s life history, which he passes in review before bidding us farewell. In the course of this revision it is from a certain distance and with much greater objectivity that he looks at the experiences through which he went during his acquaintanceship with us.

SECTION II: FERENCZI'S EXPERIMENTATION

I will be brief about his early experimentation which began to bring to his recognition the meaning and effect of his behavior. His first experiment he called active therapy in which he tried to produce and accentuation of tension by forbidding covert discharge of libido in the analytic situation and sometimes outside in order to concentrate the libido and focus it on discharge in free association and in affective expression in the session. However, this method failed and subsequently he followed Freud's character and ego analysis, which left him with the impression that the relation between physician and patient had become too much like that between teacher and pupil and that the patient did not dare rebel against this didactic attitude. Consequently he exhorted analyst and himself to encourage the patients to give freer expression to their aggressive feeling. Nonetheless, he noted that his inflexibility about such matters as time produced a resistance that he felt was not only excessive but a literal repetition of traumatic incidents in the patient's childhood. The use of this strictness by obsessional patients as resistance led him to knock this weapon out of his hand by indulgence. These cases, whom he had at first thought of as exceptional, became so numerous that it led him to propound a new principle, the principle of indulgence. He came to believe that in the standard analytic procedure there were two opposed elements; one produced a heightening of tension by the frustration it imposes, for example, immobility, and the other, relaxation, by the freedom it allows in speech and emotion. This experience Ferenczi pointed out corresponds to the training of children; tenderness and love, at the same time imposing the requirement to adapt to painful reality by renunciation. By giving into the wishes and demands of his patients, he found that they developed a new confidence. They also developed hysterical symptoms which represented memories. What was special was that the reconstructed past had the feeling of reality and concreteness, recollection occurred in actions and affects. These reactions represented confirmation from the unconscious of a childhood trauma that followed the toilsome analytic work recommended by Freud. Behind the structure of the neurosis as expressed in the transference was always a real psychic trauma resulting from conflict with the environment.

At that time he still gave importance to the Oedipus complex, but found of much greater significance the repressed incestuous affection of the adults for children. The child, he said, wants even in his sexual life, play and tenderness, not the passion brought to him by traumatic seductions.

Ferenczi reported, with pleasure, Ann Freud's remark to him; you really treat your patients as I treat the children whom I analyze. He was referring in part to Anna Freud s preparatory period to win the patient s confidence, but in addition it was the activity of play by both participants that he felt was technically decisive.

In 1929 he came to the conclusion that it was the similarity of the analytic procedure to the infantile situation that added to the compulsion to repeat and to the distortions in the patient. It was particularly the hypocrisy of the parent who both seduced and projected the guilt of that seduction into the child by denying their transgression and at the same time prohibiting sexual behavior in the child that was the ultimate

pathogenic factor. The meaningful conflict, the original conflict was between the individual and the outside world and not within the individual.

In urging his patients to deeper relaxation and more complete surrender to impressions and emotions, he found the patients becoming more childlike in their speech and in other modes of expression, more non-verbal than verbal; expressive movement and visual ideas appeared as in children's play. The analyst's cool expectant silence and his failure to manifest any reaction had the effect of disturbing the freedom of association. The same manner might result in the disruption of the play of children in which the analyst is assigned a part. It is in the famous grandfather vignette that he illustrates this. The patient addressed the analysts as grandpa presumably half in belief and half in play. The analyst responded with the assigned role as though he was in fact the grandfather entering into the game akin to that reported in child analysis. As with certain children, at the intensification of the family play, the patient attacked Ferenczi for not taking the game seriously enough, as if to say, don t you understand that this is real and you are denying it? This was the beginning of Ferenczi's final theory of pathogenesis and cure. The experience of the hidden tendencies to act out had to be relived fully in the present, but ultimately with the sincere analyst outside the transference as a new and different object.

He concluded that the friendly affectionate attitude of the patient was originally derived from the tender relations between mother and child. The fits of passion, naughtiness and neurotic distortions were the later results of tactless treatment by those around the child.

Ferenczi now found that the patients were all too ready to express their aggression. In response he felt it was better to admit honestly that he found the patient s behavior unpleasant, interpreting as well the attempt to put the analyst in the role of the punishing parent. His final conclusion was that what is most traumatic is the insincerity and hypocrisy of the parents who profess to love the child unambiguously. The eventual purpose of his technique is the reconciliation between the new parent, the sincere analyst and the mistreated child in this interpersonal theory. The patient knowing himself to be safe from the situation of his childhood allows himself to repeat in affect and action, the painful past.

Ferenczi observed that there is a split in the personality of the patient in which the child in him feels deserted and adopts the role of father or mother in relation to himself, undoing the fact of being deserted. The result under repression is the splitting of the self into a suffering, brutally destroyed, guilty part, and a part which knows everything but feels nothing. The latter is the unfeeling analyst in the standard technique who is idealized by the patient in order to spare him.

A condensed summary of what is curative is as follows: After the analyst's interpretation and encouragement to the patient, the latter enacts more and more threatening behavior to compel the analyst to an act of punishment which the analyst delays. The child in the patient feels abandoned and must turn his aggression against himself, particularly if the adult s guilt is projected. The whole matter had been made worse because the adult had denied the existence of the child's experience, that is to say that nothing had hurt the child. To recover in the course of childhood is rare, because in addition to the mother having to be present with understanding and tenderness, she must also be completely sincere. The second part of this analytic work is the traumatic effect of the moment when the analyst finally puts an end to the unrestrained license. This reproduces the infantile situation, the helpless rage which requires tactful understanding, and a reconciliation by the analyst, instead of what Ferenczi called the lasting alienation in response to the situation in childhood.

Ferenczi also observed the patient's exceedingly refined sensitivity for the wishes, tendencies, whims, sympathies and antipathies of his analyst. These were defensively repressed by the identification with him, abetted by the professional hypocrisy of standard analytic procedure.

Ferenczi's method, not acknowledged, was illustrated at a recent panel at the American. A patient became angry when the analyst informed him of his underpayment by one session that the patient had not attended, and complained of the analyst's interest in money. The analyst interpreted this attack as the patient's attempt to avoid confronting his inner reasons for not paying. In the ensuing discussion the analyst honestly admitted that the patient was correct in perceiving the analyst's discomfort at concealing his greed. This brought about an interaction with the analyst that activated the patient s memory of his defensive compliance with his father's deceptions.

Ferenczi said, it almost seemed to be of advantage to commit blunders in order to admit afterwards that fault to the patient. This advice however, is superfluous since we commit blunders often enough. At present such phenomena are explained as an interplay of transference and counter transference with a greater complexity of motives, but the advice for confession is taking hold today. Another common hypocrisy of the analyst identified at the panel is one in which he seduces the patient to believe that he always wants to help him, when at times the analyst is competitive and resentful, the latter to be disclosed not as a possibility but as a fact.

Ferenczi asks, Can you really apply the term psychoanalysis to what goes on in these child analyses of adults? What of the fine dissection and reconstruction of the symptom formation? His answer was that his analyses too, proceed on the level of conflict between the intrapsychic forces which may go on for years. Sooner or later, however, the collapse of the intellectual superstructure and of the distorting lens of intrapsychic conflict occurs, and the fundamental traumatic situation breaks through the original conflict between child and his tactless caretaking environment.

To summarize Ferenczi's theory of pathogenesis; it is the precocious superimposition of the passionate, guilt-laden love of the adult on the immature guiltless child who craves tenderness that binds the child to the object, requiring a distortion of the self and a repression of this accurate knowledge of the adult. This past is relived by interaction with the analyst and is ultimately corrected by the analyst's authentic spontaneous responses.

Friend and foe alike agree that whatever the yield in delineating the human relationship in analysis, Ferenczi had spent his last years attempting to cure himself with only a partial understanding. He said, in my case, infantile aggressiveness and the refusal of love towards my mother became displaced onto the patient. Instead of feeling with my heart, I feel with my head. Head and thought replace heart and libido.

SECTION III: CONTEMPORARY EXAMPLES

Anton Kris found a problem similar to Ferenczi s in a group of narcissistic patients who had also had previous failures in analysis. Their primitive unconscious self-criticism was projected on to the analyst who was then sadistically attacked: the syndrome was a vicious cycle of self-deprivation and narcissistic entitlements. Interpretation of all this was not sufficient and they required what Kris called support, an affirmative stance to prevent the return of the externalization of punishing criticism. This seeming contradiction of the principle of abstinence, he calls functional abstinence , in other words, not playing the role assigned to him. He also believes that this externalization tests the analyst s sincerity.

In another paper Kris uses Freud s supportive efforts in treating Mrs. Riviere as an illustration of an intuitive response to what she needed. He points out the contrast between Freud s behavior and his insistence on objectivity and abstinence. Kris believes these principles arose from Freud's commitment to establish the scientific respectability of psychoanalysis and led to the minimalist austerity of classical technique. This impression of an ideal of a cold, detached and silent observer is shared by many who were analyzed in the 1950s. James McLaughlin wrote a stinging caricature of that analyst and Shelley Orgel gave a paper supporting that caricature with the facts of his own experience.

The contemporary classical approach that I consider a reply to this criticism, is given by Paul Gray who makes the point that the fantasy of the affectionate authority of the analyst provides a formidable resistance. He called this a maternalistic influence on resistance, superego permission as a defense, and quotes Ferenczi, What such neurotics need is really to be adopted and to partake for the first time in their lives, of the advantages of a normal nursery. According to Gray, the wider-scope patients, probably Ferenczi s as well, cannot develop a capacity for relative autonomy and acceptance of reality, so that they require protective measures that shelters them from some of the anguish of the core psychoanalytic methodology. The patient is allowed to retain unconscious internalized superego defenses of a permissive approving form, what Anton Kris I believe would define as support. This may also be the end result of Ferenczi s procedure but as you will recall, the patients could not be spared the anguish of reliving the past.

Other revisionist writers insist that some stance dictated by intersubjectivity is inevitable. In this I tend to agree, but how it is experienced by the patient depends on his psychic reality including the state of the

transference at the time. In the paper on technique by Ernst Kris in 1950, you remember that he points out that the interpretation to the child that he was identifying with the aggression of the dentists as he breaks off tips of pencils, could be taken by the child as an interpretation of his feminine desire to be castrated and penetrated. In regard to the analyst, these questions are raised by Ernst Kris other example when without being aware, he changed his words in making an oft repeated observation, saying to his patient, your need for love rather than your demand for love. Only when the patient returned the next day to report that he had been moved to tears by the phrase need for love did the analyst recall his words. Was Kris preconscious intuition at work as he said, changing the emphasis to the passivity of the patient's wishes or also countertransference, the giving of permission, or the result of a response to a role thrust on the analyst to actively love? Standard technique indicates that only subsequent free association will elucidate the matter. However, for revisionists, where interaction is primary and corrective to past interpersonal maladaptive distortions, particularly in Sullivanian theory, it is not meaningful to ask for confirmation from the data of intrapsychic conflict as revealed by associations. There is a basic difference in the theory of how the mind works.

SECTION IV: TRANSFERENCE

Something odd has happened on the way to the forum; the concept of the transference, the powerful conveyor of the patient s neurosis, but most simply, the putting of the analyst in the role of the parent and the analysands in the role of the child is now considered an authoritarian bias, inaccurate and misleading. Owen Renik states, it is hard to see how that distinction, analyst and patient, can be made on the basis of either party s actual involvement, that is, the extent to which either one expresses emotional responses in action. Since this is not yet the quality of mutual analysis, as in Ferenczi s very last experiment, the ground rules of the analytic construct that defines it as a psychoanalysis of the patient, remains. We now however no longer need to worry about the unequal power gradient in the analytic situation.

That the data of psychoanalysis is determined by mutual interaction is confirmed, in the thinking of revisionists, is seems to me, by their observation that awareness of countertransference can only occur after its enactment. Dale Boesky combining both ideas, states, if the analyst does not get emotionally involved, sooner or later in a way he had not intended, the analysis will not proceed to a successful conclusion.

The power of the analyst as therapist seems to be ever present at the same time that his place as a transference figure is diminished, and furthermore, can be disregarded so that responses become natural and beneficial. Renik, in a similar vein says, many of the most useful things we do, we do for reasons we cannot be aware of at the time.

The above descriptions of portions of the analytic work may well be correct and should be carefully examined, as in the example of Ernst Kris slip. However, if they are thought of, following Ferenczi, as in themselves curative because of the spontaneity and authenticity of a corrective experience, a great deal may be lost, particularly the patient's autonomous understanding of how his mind works.

For example, Renik's patient's therapeutic optimism reproduced a relationship he had with an aunt that activated in Renik the following fantasy; as an idealization of himself, the analyst felt he could succeed with this patient where others had failed. There followed mutual disappointment and in the analyst anger as well, which put him back, he said, into the image of the patient's depressed mother. The patient s response to this unconscious but genuine competitive attack by the analyst as to who would be pitied more, analyst or patient, led to the memory of the patient's guilt at his sadism towards his mother and his expectation of punishment. The argument given is that only the genuine emotional content of the countertransference, part of an interaction, led to the repetition and the correction of this childhood conflict. The final result, which seems to me to be based on the idea of a new experience with a new object is, Renik states, "Two imperfect people who care about each other can manage to sustain their relationship in the face of mutual disappointment."

Renik speaks of the analytic conscience, putting the patient s welfare first which becomes crucial in the negotiation, to paraphrase Ferenczi, of a reconciliation in the present in contrast to the alienation in the past. The understanding of intrapsychic conflict in Renik s case remains significant in regard to the therapeutic effect, but seems to me to have become secondary. Ferenczi carries the goal of reconciliation perhaps a

bit further. The final result of analysis of the transference is the establishment of a benevolent, passionless atmosphere such as existed before the trauma.

In pure interpersonalist technique without consideration of intrapsychic conflict, the analyst would say to his patient, What makes you think I would not be angry and want to hurt you? , with the intent of bringing the here-and-now experience and eventually the reliving and correction of the past into the work. Maintaining the autonomous observing function of the ego and enlarging it as a goal, as emphasized by Paul Gray, would seem to me to be a daunting task after either such procedure.

SECTION V: PARTIAL RECONCILIATION

Boesky states that since the patient s mind is dealing with object representations, the assumption that the actual behavior of the analyst is perceived correctly is unlikely, and consequently, the recent trend toward revelations of countertransference are deceptively honest.

This is not to say that the patient s correct perceptions of the analyst are irrelevant. The behavior of the analyst can override the transference although as I have indicated I believe that this can happen, because the patient can include that behavior in his particular resistance. However, that this means that the communication has reached the patient and has become significant in the analytic work does not necessarily follow. I agree with Gitelson that it is persistent countertransference that has problematic effect, and that these emergency responses are easily dealt with.

That resistances are created solely by the patient Boesky believes, is a fiction; to me it is a useful fiction for the purpose of discourse. Analytic experience is of course more complex, but fixed resistances although strictly speaking compromise formation, do represent the patient s particular defensive organization. To say, as Boesky does, True success is the understanding of failures that both parties participate in, I would understand as the collusion or if you wish, interaction of resistances that may or may not be analyzed. Boesky s conclusion that resistances are negotiated between patient and analyst, I believe, like many statements of some contemporary Freudians, is probably meant to emphasize what they feel has been neglected; that is Ferenczi's observations that interaction in the broadest sense as part of the human relationship is continuous in analysis.

The most crucial discovery by Freud for the practice of analysis, is that transference is on the one hand the urge to repeat the past in action in order to gratify unconscious instinctual wishes, and on the other, from a technical point of view, is the substitution of enactments as it is now called, for thought, reflection, and conscious awareness as a resistance to memory. The ego psychology of the 1950's added the detailed consideration of the capacities and incapacities of the ego of the analysands in the process of psychoanalytic work. There is no difficulty of course, in extending these same considerations to an examination of the mind of the analyst. However, when the distinction between introspection, reflection, self-awareness and enactment is dissolved, the role of insight is being revived today, is in danger of being lost. As Ferenczi asked, can the procedure he created in 1930 that, I believe is being revived today, of course altered in regard to content, elucidate the structure of the neurosis?

There is maturation and development from childhood on of the capacity for self- observation and self-awareness that is necessary for insight. I agree with Paul Gray that they are inevitably involved in conflict, the analysis of which is an important part of our work. If this approach led to the cold detachment of the analyst, the pendulum at present has swung too far in the other direction. My knowledge of the analytic procedure of the decade of the 1950's when I was being trained, does not confirm this portrait of the analyst, although what is now called the subjectivity of the analyst and its effects on the patient was certainly not given the same scrutiny as it is today.

In the 1950's, the understanding of the psychic reality of the patient was our exclusive concern, unless an obvious countertransference interfered, that countertransference being considered in those days as obstacle to understanding and not an illumination. At present, I should like to make a distinction between the recommendation to view interaction as an additional source of data about the patient and analyst, the injunction to put the emphasis on interaction as the data, and even more sharply, the recommendation to use the interaction as therapy in psychoanalysis.

An illustration of these different orientations appeared at the panel on the analyst's influence in 1994. Dr. McLaughlin reported that he was worried and perhaps exasperated: he burst out emotionally to his patient that her drug taking was self-destructive and that he was very concerned. In the discussion from the floor, Dr. Brenner said one can agree with stating to the patient that her drug-taking is self-destructive, but why not then return to the patient's psyche and ask her for her own views? Why not pursue the interaction?

An illustration of these different orientations appeared at the panel on the analyst's influence in 1994. Dr. McLaughlin reported that he was worried and perhaps exasperated: he burst out emotionally to his patient that her drug taking was self-destructive and that he was very concerned. In the discussion from the floor, Dr. Brenner said one can agree with stating to the patient that her drug-taking is self-destructive, but why not then return to the patient's psyche and ask her for her own views? Why not pursue the interaction?

Dr. McLaughlin replied that his spontaneous outburst had stimulated more material from the patient than had been forthcoming for some time in this somewhat stalemated period of her analysis and that he had addressed her psychic reality. Discussants on the panel made the argument that Dr. McLaughlin's procedure showed the proper respect for the equality of the participants, rather than the assumption of authority implicit in Dr. Brenner s question. Given the interaction having occurred this one not of a subtle nature, I would have to observe carefully in her associations either immediately or perhaps months later the meaning and effect of the interaction both inside the analysis, that is transference, as well as outside, where the effect is often displaced.

Proponents of the new technical ideal tend to caricature standard procedure. Boesky states, The pursuit of maximal objectivity by limiting the influence of individual psychology departs entirely from the true nature of clinical events, just as the related efforts to be aware of personal motivations before acting on them can never be a successful strategy. The difference of this contemporary point of view to that of the 1950's is illustrated by Boesky s recommendation that we not restrict our passionate and irrational involvement in our clinical work and Hartmann's conclusion in a previous Freud lecture that our own analysis makes us more tolerant of the passions in ourselves In the 90's and for many years the awareness of our subjectivity and the effect it has in interaction with the patient has made analysis both more burdensome and more interesting, which scarcely alters the fact that the psychic reality of the patient remains the data of analysis.

SECTION VI: DISAGREEMENT AND SOCIAL CONSTRUCTIVISM

There is another argument that ends up with similar recommendations based on the primacy of the analyst s subjectivity. It starts from what is thought to be contemporary epistemology, a post-modern set of ideas that has replaced the so-called naive positivism of Freud s day, that objective truth is obtainable by a non-participant observer.

To paraphrase Terry Eagleton, if thorough-going, this post-modern worldview would cast grave doubt upon the classical notions of truth, reality, meaning and knowledge, all of which could be exposed as resting on the naively representational theory of language. If reality is constructed by our discourse, rather than reflected by it, how could we ever know reality itself, rather than merely knowing our own discourse.

The less thorough-going derivative of post-modern thought, social constructivism, holds that reality is in the process of being constructed by the interacting parties, man and society or man and man from moment to moment. This epistemology, introduced to social science in the 1960's by Berger and Luckmann, is promulgated by Irwin Hoffman, and was adopted, late in his life, by Merton Gill, as follows: Hoffman writes, Although the sense of the possible value of the relatively detached stance is retained, there is also a sense of uncertainty as to its meaning to one's self as well as to the patient at any given moment, along with recognition that other kinds of interaction might be possible and useful. What is not possible in this point of view is the total transcendence by analytic therapists of their own subjectivity. Hoffman believes that the above contradicts the positivist paradigm of classical analysis as follows: The view of the process in which the analysts are thought to be capable of standing outside the interaction with the patients so that they can generate rather confident hypotheses and judgments about the patient's history, dynamics and transference and about what they themselves can do from moment to moment. This criticism of analysts in the past seems to state that they were not only objectivists but also absolutists. The search for the ever-

changing, incomplete and imperfect truth by a participant observer is probably sufficient for unsophisticated investigators.

The new paradigm contends that the data from the analytic situation is concreted by transference and resistance from both parties interacting. This being the case, the argument goes, the analyst is less bound by a priori theories, more open to the individuality of himself and the patient, and free to be spontaneous, emotional and authentic. Particularly important is the assumption that the patient is actively interested in exploring the analyst s personal qualities, and is often accurate in his perceptions.

Hoffman believes that curiosity or I presume any other drive derivative is not only the expression of a forbidden or unrealistic wish, but also a relatively healthy search for a meaningful contact with the analyst. In this, to me, interpersonal theory, curiosity is considered to be a basic tendency of human beings with its roots in the infant s interest in the subjectivity of the mother. It is a short step to a variation of Ferenczi's theory of the original conflict of the child and the inauthentic caretaker and the analyst as open and honest in undoing the trauma of tactlessness and hypocrisy.

The contradiction is apparent, if we share the idea of complexity and ambiguity of human responses that arises out of intrapsychic conflict. To ask for agreement on what is authentic becomes a very difficult question, if at all a meaningful question. The following is an example given by Hoffman of a purported standard technique opposed to one of his own. The traditional idea that it is always better to explore the patient s wishes in this regard under conditions of abstinence and deprivation is another reflection of positivist thinking. The implication is that the true nature of the wish or need will be exposed if the analyst does not contaminate the field by yielding to the patient s pressures, meaning that a positivist will believe in such a true nature of the wish or need, in contrast to the constructivist model, in that whatever way the analyst responds is likely to effect what is then found out about the intensity and quality of the patient's desire.

One further example will illustrate my disagreement with the direction of these trends: Renik argues for the recognition of the irreducible subjectivity of the analyst, stating that it is liberating for both patient and analyst and also guards against the negative effect of making the analyst an ideal mother who understands perfectly. It seems to me that what is being downgraded is not only the power of the transference but also the validity of the analytic method. The analyst cannot liberate the patient much less himself from idealization. This is a transference and a countertransference distortion, not an acceptance or rejection of the analyst's influence, of his blunders or his correct interpretations. The subjectivity of the analyst can effect idealization or disillusionment, depending on the patient's fantasies that prevail, whatever the analyst's intentions, both conscious and unconscious, if one listens carefully.

The implied caricature of the traditional analyst may bring out some of our salient features, but what is even more striking are the prejudices coloring the caricatures. The patient is thought by the interpersonalist to know his parents, but does not attend to what he knows. To me, what he knows of his parents and of the analyst is a caricature through the lens of his drive motivated intrapsychic conflict.

Finally, as far as I can see, there is as yet no explicit theory of pathogenesis by many contemporary revisionists that corresponds to the purported new paradigm in technique. For others, the so-called new paradigm is made up of what has been the interpersonalist method of treatment retaining the intrapsychic theory of pathogenesis of classical Freudian theory, an attempt at common ground neither possible nor scientifically productive. Another group has continued the Sullivanian tradition with acknowledgement of Ferenczi s influence. Some revisionist thinkers have added the rationalization of a recently fashionable epistemology to interpersonal theory.

One can understand and one must value the efforts of contemporary analytic thinkers to find a better way to heal. But I will conclude with a debater s question: If we assume that our patient comes to the analyst given that he has the belief rooted in our culture, of the analyst s greater knowledge, and in that sense greater authority, and what we know to be regressive transference that begins immediately, what would be the result of correcting this view at the outset? That is, indicating to the patient that there are different theories and different hypotheses, the analyst is not sure about any of them, certainly the analyst cannot be expected to have answers, and collaborative work of two equal partners is to be undertaken. Would that be a recommended enactment? Would it lead to a better understanding of the patient?

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