THE COUCH AS ICON

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The couch has always been an integral part of psychoanalytic practice. It has even become a cultural icon representing psychoanalysis itself. However, minimal evidence exists in the psychoanalytic literature that using the couch is necessary or even necessarily helpful to establish a psychoanalytic process and conduct an analysis. Furthermore, it can potentially be harmful to patients such as those who have experienced early loss and trauma or who have significant ego organizational problems. Therefore, the use of the couch per se does not seem well suited as a defining criterion of psychoanalysis. To the extent that it may be clinically valuable, the use of the couch should be more carefully considered and critically examined.

INTRODUCTION

Psychoanalysis as a Clinical Treatment

Broadly, psychoanalysis is a system of psychology that emphasizes the overriding power of developmental experiences in early childhood for better and for worse. In the majority of cases, people grow up with distinctive personality structures that mirror, or reflect in part, along with constitutional factors, those early experiences. The result is often compatible with reasonable happiness and fulfillment. However, in some instances, there may be such discordance between the misconceptions ingrained in childhood

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This paper is based on a presentation that Dr. Linn gave at Mount Sinai Medical Center. Dr. Friedberg presented a version of this paper at a meeting of the New Jersey Psychoanalytic Society. Some revisions to the submitted version have been made, given editorial feedback.

The authors wish to thank Dr. Glenn Gabbard, Dr. Arnold Richards, Dr. Eugene Friedberg, and Dr. Zvi Lothane, among others, for their helpful comments and feedback on earlier versions of this paper.

and the experiences of adult life that they significantly conflict with the demands of reality. This conflict may lead to symptom formation or other issues and require treatment.

One way to view psychoanalysis is as a treatment that focuses on these misconceptions of childhood with the idea of making them conscious, working them through, and replacing them with more mature views that can be more effective in dealing with the difficulties of everyday life. At its core, psychoanalysis involves "analyzing" in the literal sense of the word (from the Greek *analusis,* meaning "to examine"): to separate into constituent parts or elements; to examine critically so as to bring out the essential elements; to examine carefully so as to identify causes, key factors, possible results (*Random House Unabridged Dictionary*, 2006). By doing so successfully, aspects of an analysand become resynthesized in more adaptive ways.

There is general agreement about many of the essential characteristics of psychoanalysis. Most of us would say that listening, empathy, and understanding are three such elements to help a patient to speak freely and gain more insight and self-awareness. Considerably less accord is present about how this process is best carried out. Lable and colleagues (Lable, Kelley, Ackerman, Levy, & Ablon, 2010) point out that no empirical study has investigated the effect of the couch on the psychoanalytic process or outcome. Lingiardi and De Bei (2011) question the utility of the couch in terms of therapeutic action, bolstered by recent contributions from affective neuroscience, infant research, and other psychotherapy research. Schacter and Kächele (2010) observe that there is no empirical foundation for putting all analytic patients on the couch. They note the relationship between the patient's position, free association, and therapeutic outcome is inconsistent and not well studied. Regarding the couch, they recommend using clinical judgment, considering the patient's diagnosis and personality characteristics.

So, even after more than a century of psychoanalytic practice, there is little scientifically verifiable evidence for the efficacy of the couch. Therefore, it is relevant and important to inquire if using the couch to conduct an analysis is necessary or even necessarily helpful. Provocatively, we might even ask the question, is it

ever necessary or absolutely indicated? It is remarkable that our literature, which is based on inquiry, has rarely asked such simple, challenging questions. Rather, it tends to take as a given that it is or is not.

Freud's Couch as Icon

The word "icon" refers to a picture, image, or other representation. It is derived from the Greek *eikon,* meaning "likeness, image, or figure" (*Random House Unabridged Dictionary*, 2006). Historically, an icon was a device employed by devotees of Russian Orthodox Catholicism. It was introduced into their ceremonies around the sixth century, and consists of figures of Jesus and Mary, largely in small paintings but sometimes as statuettes. In Russian ritual, the idea promulgated was that prayers directed at the icon would have a more facilitated passage in reaching the religious figures themselves or God.

The couch of psychoanalysis has received and still maintains iconic status among many in the psychoanalytic community and people more generally. In our literature, it is used at times to mean psychoanalysis itself. The request or recommendation to lie down on the couch often initiates psychoanalysis in a traditional sense (Frank, 1995). Without it, many traditional psychoanalytic institutes and associations still posit that there can be no analysis (Jacobson, 1995). To many psychoanalysts, the couch remains sine qua non for analysis.

However, this view is a vestige of Freud's personal predilection rather than a position that has been clinically and scientifically well established. It is well known that Freud himself had a more relaxed relationship with psychoanalytic technique. His usage of the couch—if he is to be taken at his word—was primarily for his own comfort and convenience. His classic case studies demonstrate a psychoanalytic process that occurred on and off the couch. Indeed, in his study of "Little Hans" (Freud, 1909), an analytic cure occurred without the patient being in his presence. Freud considered his own choice to use the couch as based at least partly in his not wanting to be looked at by patients throughout the working hours of his day rather than as dictated by clinical

necessity or technique. He referred to it as "ceremonial" and "the remnant of the hypnotic method" (Freud, 1913, p. 133).

As Freud (1913) put it in "On Beginning the Treatment":

> Before I wind up these remarks on beginning analytic treatment, I must say a word about a certain ceremonial which concerns the position in which the treatment is carried out. I hold to the plan of getting the patient to lie on a sofa while I sit behind him out of his sight. This arrangement has a historical basis; it is the remnant of the hypnotic method out of which psycho-analysis was evolved. But it deserves to be maintained for many reasons. The first is a personal motive, but one which others may share with me. I cannot put up with being stared at by other people for eight hours a day (or more). (pp. 133–134)

Ostensibly, Freud recommended the couch for patients because—at least in part and perhaps primarily—he did not like to be looked at. Perhaps he may have had some unresolved scoptophilic conflicts. To be fair, as he suggested later in that passage, it may also have been a way of giving himself over to the current of his unconscious thoughts (p. 134). Still, surprisingly, Freud's compromise solution to his apparent conflict became embedded in psychoanalytic technique. Freud's solution was followed by an even more particular response by his faithful followers. His approach, with its own conflicts about looking and being looked at, might have been viewed matter-of-factly as having elements of a compromise formation or defense. Instead, they standardized a therapeutic situation where analyst and patient do not look at one another (Freud, 1912).

It is, of course, possible that Freud's sitting behind the couch because he did not like to be looked at throughout the working hours of his day was a fortuitous and monumental discovery. Freud may have adopted an approach that he took in part for his own comfort that benefited his patients even more. For example, in not being looked at by his patients, an analyst may feel freer to restrain from responding to the patient from moment to moment and to turn his attention toward subjects and places within himself (Ross, 1999). This approach may allow the patient deeper insight and emotional connection. However, as we will consider and discuss, the visual aspect of the treatment—looking at a patient

and being looked at by him or her—may often be an important, even essential, aspect of the therapeutic process.

Codification of the Couch in Psychoanalytic Technique

In traditional psychoanalytic circles such as Institutes of the American Psychoanalytic Association, it is still emphasized, if not taken as a given, that the couch is an important and even necessary tool for conducting a psychoanalysis. Ironically, a treatment that is meant to address the needs of individuals became codified and dogmatically defined in traditional institutes and training programs.

In their contemporary textbook on psychoanalysis, Nersessian and Kopff (1996) introduce the section on treatment with the following statement: "The two principal conditions [for psychoanalysis] are that (1) the patient is seen four or five times a week for 50 minutes each time, and (2) he or she lies on a couch, with the psychoanalyst sitting behind" (p. 419). The editors attributed these conditions to Freud but, as mentioned, he famously conducted analyses that did not follow this supposed prescription throughout his career. Furthermore, these uniform parameters with couch and frequency are not used by the International Psychoanalytic Association (IPA, 2009).

But here, in a standard textbook on psychoanalysis, the attitude is clearly "no couch, no analysis." The traditional psychoanalytic community (e.g., the American Psychoanalytic Association and its Institutes) has tended to emphasize, if not adhere to, this belief that the couch is essential to the psychoanalytic situation and to conducting analysis. Given its centrality in psychoanalytic teaching and practice, one might consider the necessity of structuring the procedure in this manner to be scientifically proven or rigorously, clinically studied. However, a literature review of over four hundred papers on the usage of the couch in analysis demonstrated to us that such carefulness and thoroughness is not the case.[1] Instead, it is generally taken as a given by some analysts that the couch is necessary for conducting analysis, and as a given by other analysts that it is not. No real consensus is reached between schools of thought. In fact, the literature of each side of this de-

bate is often published in journals whose philosophy and affiliation are in accordance with one point of view or the other.

The classical psychoanalytic community also tends to hold the attitude that a couch-based analysis is the treatment of choice—the "gold standard" of treatment—for patients who are neurotic. Rothstein (1999) goes so far as to find it the best treatment overall for nonpsychotic patients. In *Psychoanalytic Technique and the Creation of Analytic Patients*, he states that "analysts who lack sufficient conviction and who have few or no cases in analysis may have an unconscious bias against analysis" (p. xii). He believes that a couch-based analysis is the best treatment for patients who seek help for complaints about their personal and professional lives or who have specific symptoms.

This attitude is problematic for two reasons: (1) Not all patients who are nonpsychotic are analyzable using the techniques of classical psychoanalysis, and (2) even for patients who are analyzable, it is not necessarily the treatment of choice to help relieve suffering and foster personal growth. The literature about the limits and limitations of psychoanalysis is extensive, even in the classical psychoanalytic literature. The idea that any patient who comes for treatment and can be analyzed should be could seem self-serving. Although, of course, sometimes the patient's best interest may be served by the analyst's as well.

THE ROLE OF THE COUCH IN PSYCHOANALYTIC PRACTICE

We will now consider the psychoanalytic literature on the usage of the couch along with several rationales and rationalizations regarding it that have emerged. We find that the iconic status of the couch and other factors rather than its clinical efficacy have led to its powerful hold on the psychoanalytic practice of many colleagues.

The Classical Psychoanalytic Situation

Freud's idea was that a situation can be created in analysis that encourages the patient to speak freely and spontaneously about whatever mental productions come to mind. From this ori-

entation, a Freudian model arose of the analyst as a nonjudgmental and neutral figure, who offers minimal verbal and visual feedback. The theory in classical psychoanalysis is that this attitude allows for the analyst to be like a blank screen for the mental projections of the analysand.

The basic rationale for the classical psychoanalytic situation seems to be that placing the patient in a recumbent position and not looking at each other, or at least the patient not looking at the analyst, allows and facilitates the work of analysis. Otherwise, what is the point of it therapeutically? From a classical perspective, this situation promotes a regressive experience in which the patient's childhood world, fantasies, and unconscious mental life emerge in the context of a relationship with the analyst based in transference. Through interpretation and clinical observation, the analyst helps the patient to more freely associate and gain insight and understanding into his or her mental life, symptoms, and himself or herself in the world. Various psychoanalytic practitioners and theoreticians have postulated different mechanisms of action for the efficacy of the couch in psychoanalysis. Spitz (1956), for example, considered the parallel to the infantile situation with the infant "speaking into the emptiness of space" (p. 382). There seems to be some general sense that losing visual cues promotes introspection (Trad, 1993). Drawing on his extensive personal experience as a psychoanalyst, Lichtenberg (1995) feels that the couch may help patients achieve a cognitive-affective state of mind that promotes successful analysis by fostering a more free-associative and reflective process (p. 287).

Whatever the therapeutic mechanism, the patient recumbent on the couch with the analyst out of sight tends to be seen as the "ideal state" to conduct a classical analysis. The idea is that the classical psychoanalytic situation allows the patient to more freely associate, which most authors agree is essential for a psychoanalytic process to occur. However, even the notion of free association is not "free" from its own misconceptions. Hoffman (2006) considers how the patient is never actually free in his or her associations because the patient and analyst always necessarily influence one another. In his intersubjective view, the analytic relationship is co-constructed. Furthermore, he argues that the

therapeutic action of psychoanalysis involves "dialectal interplay of self-expression" and "caring relational engagement" (p. 187). Accordingly in this view, even the ideal of free association in a classical setting is a myth. Free association is never liberated from its intersubjective context, and the centrality to the psychoanalytic process of achieving it is questionable.

Variables: Recumbent Position and Eye Contact

Two variables that arise frequently in discussions about usage of the couch in analysis are recumbent position and eye contact. The two are, of course, related in the setup of the classical psychoanalytic situation in which a patient lies recumbent on a couch with the analyst out of sight.

First, the recumbent position of the patient is worthy of consideration in itself. Ross (1999) finds that a hypnagogic state is induced in the supine analysand. It also, in his view, allows for a kind of empathic reverie in the unseen analyst. He considers how these states of mind interplay in the psychoanalytic situation. He quotes George Klein (1970), the cognitive psychologist, who said "posture is perception." The basic idea is that being in a supine position allows the analysand to focus less on perceptions of the external world and more on apperceptions of inner life. Freud (1900) called these apperceptions the "descriptive unconscious," which then fall within the purview of the analysand. In this view the recumbent position of the patient allows for a kind of altered, dreamlike state that facilitates the psychoanalytic process. Furthermore, in this situation, the analysand can be seen as lying like an infant on his or her back, thus promoting a regressive state in which thoughts, feelings, visual images, and bodily sensations can be differently, and perhaps better, examined. In this context, with the technique of free association, a patient's psychic reality is opened up for examination.

According to Ross (1999), the use of the couch allows this freeing up of imagination and psychic reality for the analyst as well (p. 95). He finds, as have numerous other psychoanalysts, that the classical psychoanalytic situation allows greater accessibility to unconscious mental life for both the analyst and analysand, which

can be used in the service of analyzing the patient. But as is commonly described by analyst and analysand, the recumbent position may also place the patient in a state that he or she experiences as helpless and regressive.[2]

Second, eye contact is an essential part of human communication and interaction. From early contact with a parent to other connections, we form attachments significantly through eye contact (Stern, 1985). It is well established that at about nine months infants begin to scan their mother's face for affective expressions that signal safety, caring, and other emotions. Eye contact provides visual cues that are an essential part of communication. The lack of eye contact in the psychoanalytic situation challenges a patient's capacity for trust, object constancy, reality processing, and other developmental achievements. Therefore, the use of the couch decreases the cues available to a patient.

Still, it is not obvious that losing this connection is helpful to patients. In fact, it is often a source of distress to some patients. Examining mental productions that emerge in this context, such as fears about loss of attention and disapproval based on childhood experience can be a useful part of psychoanalytic work (Schlessinger, 1990). Typically, clinicians use such instances as confirmation of one approach over another, as reflected in the literature.

What is not clear, of course, is if such subjects might also be well addressed and analyzed face to face in such patients. They would probably come up over time in the context of a patient's treatment regarding some other issue such as frequency of sessions or payment, or in an area of his or her life outside the analysis. Even if an issue has not arisen directly, the analyst might bring it up at some appropriate moment by observing that the patient is always compliant.

Advantages and Disadvantages to Patients in Using the Couch

Obviously, psychoanalysis is still evolving as a field in psychology, with some core aspects in dispute. It is possible that questions about certain central tenets or beliefs may never be resolved. Given the lack of scientific rigor and limited outcome research at this

point, it might help to take a pragmatic approach in considering the usefulness of the couch in psychoanalytic treatment.

The most significant aspect of the psychoanalytic process is generally accepted as the verbal dimension of communication. Some psychoanalysts go further in their point of view to say that the presence of visual inputs during an analytic hour represent intrusions, which detract from the effectiveness of the procedure. By eliminating the emphasis on visual aspects of the psychoanalytic relationship, classical psychoanalysis may bring into more focus and greater clarity what is said and heard—the "talking cure," so to speak. Sadow (1995) offers some anecdotal evidence about how analysts experience listening differently in the two situations, although he does not try to formally distinguish the different modalities of treatment. He suggests that in a couch-based psychoanalysis the analyst has less data to process. This focus may help him or her to concentrate on a more generative mode of listening, in contrast to a more logical and cognitive one (pp. 389–390). The notion may resonate with Freud's expressed preference for the couch in part because it made him more comfortable. As Sadow posits, when we look at one another, we may be more apt to limit ourselves to patterns of social discourse and ordinary communication and not to probe with the other person how his or her mind and affective states are organized (p. 394). However, these visual cues and facial expressions are often reported as essential grist for the proverbial psychoanalytic mill. They may be more easily and readily observed in a face-to-face situation.

Another consideration is that by eliminating eye contact, the couch may help to decrease a patient's shame, embarrassment, and other emotions that can inhibit his or her free association (Broucek, 1991). Presumably, this approach helps make those emotions more accessible to analysis. However, if analyzing shame or some other important affect is central to analysis, one could equally argue that an analyst might not want to minimize those emotions but examine them in whatever context they arise. Furthermore, for most patients, being an object of examination on or off the couch would inevitably stir up shameful and other affective states.

Kogan (1996) describes a case in which the patient experiences the loss of eye contact as a greater loss resonating with oth-

er losses from her past, which is not uncommon. She found that by the patient's losing the analyst's face, the patient could reveal her own face. This visage included angry and destructive feelings toward Kogan herself. Eventually the patient worked through these disturbing feelings and came to see the analyst as nicer and more caring than she had experienced her earlier in treatment. However, again, one also finds such good work being conducted analytically in a face-to-face setting if the analyst can tolerate the patient's anger and negative emotions toward him or her—and, perhaps, vice versa.

Goldberger (1995) gives several vignettes about patients in which the couch served as a defense against particular thoughts and feelings such as shame, conflicts around autonomy and compliance, privacy, safety, and so on. She notes that "discussion with analysts from various institutes have made me aware that insistence on the use of the couch sometimes has more to do with the interest of the analyst than that of the patient" (p. 32). Still, she finds that the couch is generally the best environment for the patient to express the fullest range of thoughts and feelings. However, she also finds that analysis can take place without the use of the couch and that it does not define psychoanalysis.

Thus, clinical technique depends to some degree on how the data are viewed and interpreted. It would be unlikely, if not impossible, to come to any definitive conclusion about usage of the couch given the diverse approaches and techniques of individual practitioners and variation of patient symptomatology and personality.

Attachment Theory and Psychoanalytic Research

A potentially useful line of research stems from Attachment Theory. Increasingly, John Bowlby's work is being operationalized in a clinical setting. Patients have certain types of attachment patterns, which have implications for clinical work (Harris, 2004). It is not surprising that eye contact and facial expressions can aid in the crucial phase of building a working alliance. They can also be an integral and at times essential part of the therapeutic connection between doctor and patient.

A brief reminder in this regard is the important work report-

ed by Spitz several decades ago. He studied a group of abandoned children in a foundling home who were fed without or with minimal contact from caregivers. These infants stopped feeding and went on to develop a wasting disorder, which was called at that time "marasmus." It resulted in increased rates of morbidity and mortality in infants if not remedied by tender, loving care by the provider (Spitz, 1945, 1946). Furthermore, obviously, significant communication and learning takes place during the preverbal months. Work by Isakower (1938), Lewin (1946), and other colleagues has suggested that nonverbal data are recorded during that preverbal period and become part of specific phenomena, like mystical experiences involving religion and sensory experiences suggesting memories of nursing at the mother's breast. Therefore, as psychoanalytic clinicians, we would want to consider the relevance and usefulness to treatment of this early phase of communication in infant development through facial contact and other nonverbal connections.

Winnicott embraced the visual with his concept of "mirroring" (Reis, 2004). He saw mirroring as present in the loving gaze of the mother (Winnicott, 1967). It reflected her responsiveness to the infant rather than her own defenses. It had a visual nurturance and positive acceptance of the child that helped instill in him or her a sense of being loved and cared for. This idea seems relevant for patients who have not had good-enough mother experiences or have been traumatized by early loses of one sort or another—the patients who are often considered for a classical analysis. Using the couch may further deprive such patients of an important, even vital, therapeutic means of helping them to heal.

Stern (2004) describes the importance of the authentic presence of the analyst for therapeutic change. He finds that an analyst opening himself or herself up to a patient to be more a source of real change than are verbal interpretations. This intersubjective perspective is underscored by the work of D W. Winnicott, Heinz Kohut, and Christopher Bollas, among others. It does not devalue verbal understanding and interpretive work but focuses on how best to create and utilize opportune moments of contact—"kairos" as Stern calls them—that utilize the real relationship between analyst and analysand. No doubt there is a balance

for each patient (or each analyst–analysand dyad) between work that can be characterized as intersubjective and intrapsychic. Finding a right balance between the two is integral to the psychoanalytic process. It may be that for many patients the authentic presence of the analyst is fostered by a face-to-face psychoanalytic experience.

Verbal and Nonverbal Psychoanalytic Communications

The psychoanalytic situation emphasizes ways in which we communicate with each other, implicitly and explicitly. Explicit communication refers for the most part to verbal communication, much of which is conscious. Implicit communication refers to nonverbal levels of communication—facial expressions, movements, posture, and the like. Implicit communication often carries information that is out of awareness. Psychoanalysis is considered a "talking cure," which is to say, a treatment based in words. This aspect of communication has traditionally been its purview. However, talking and listening are only part of psychoanalytic communication; it can be helpful to emphasize the nonverbal, visual, and bodily communications as well (Altman, 2002).

These nonverbal considerations also have their correlates in infant research. Stern and colleagues (1998), Beebe and Lachmann (1996), and others have tried to draw connections between their research in parent–infant interaction and the psychoanalytic situation. As discussed, eye contact, facial expressions, and other forms of nonverbal communication are a healthy, and even essential, part of this dyadic relationship and of childhood development. Freud spoke of catching the drift of the patient's unconscious, which seems to speak to an aspect of nonverbal communication that he recognized.

It probably is fair to say that the classical psychoanalytic situation emphasizes the verbal aspect of communication. If this aspect of treatment is considered paramount, one could also use the couch in a psychoanalytic psychotherapy that differed from classical psychoanalysis in terms of frequency or technique. At the same time, the use of the couch may also allow for some unconscious aspects of a patient's psyche to come into play in nonverbal

as well as verbal forms of communication with the analyst. Whether or not the couch facilitates unconscious communication is a question, as is whether or not such communication deepens psychotherapeutic healing.

Some analysts claim that they listen and attend better when the patient is on the couch. There may be different modes of listening that are enhanced by the couch. Using the couch may help the analyst enter a state in which he or she can connect better with the patient's conscious and unconscious mental life (Bass, 2001). The idea is that if the analyst is free from the patient's gaze, he or she will be better able to tune into his or her own inner life.

However, face-to-face contact promotes a mental alertness and readiness that may also be helpful for analytic work. Furthermore, few if any analysts would argue that analysis by telephone is a treatment of choice, even if it has become more prevalent (Leffert, 2003). While analysis by phone may be a necessary compromise, the in-person quality of the interaction is lost. So some acknowledgment of the importance of the visual interchange and nonverbal communication is recognized even in a couch-based psychoanalysis.

The issue of which mode of analysis may suit the analyst's personality better is also a consideration. But such a concern is, obviously, secondary to the patient and his or her needs. If a face-to-face analysis is a better treatment for the patient, an analyst who works in a couch-based mode can refer the patient to an analyst who favors the other mode.

Differences between Psychoanalysis and Psychoanalytic Psychotherapy

A further way to discuss the relevance of the couch is to consider differences between psychoanalysis and other forms of psychotherapy. There is an extensive psychoanalytic literature comparing psychoanalysis and psychoanalytic psychotherapy, dealing with various aspects of the analytic experience both on and off the couch and considering what defines the parameters and structure of an analysis. In 2001 an IPA panel took up the subject (Adams-Silvan, 2002). Some agreement was found that, at least with regard to psychoanalytic listening and treatment approach, there is no

difference between psychoanalysis and psychotherapy conducted by a psychoanalyst working psychoanalytically. Nevertheless, there is a psychoanalytic literature that concerns itself specifically with "converting" psychotherapy patients to psychoanalysis (Beland & Bergman, 2002; Schlessinger, 1990).

Gill (1984) usefully distinguished between extrinsic criteria for psychoanalysis such as frequency, duration, and use of couch, and intrinsic criteria such as free association, interpretation, transference, and so on. Kernberg (1999) has tried to subdivide psychoanalysis into standard psychoanalysis, psychoanalytic psychotherapy, and psychoanalytically based supportive therapy. He believes that three essential features of the psychoanalytic method are interpretation, transference analysis, and technical neutrality (p. 1079). In his view, neither the use of the couch nor frequency of sessions is a conceptually significant defining feature of psychoanalysis (p.1080). However, he finds that face-to face psychotherapy is not conducive to regression, and this aspect may limit the treatment as an analysis. The general consensus in contemporary psychoanalytic literature is that psychoanalysis is a process and that the setting does not define or determine the nature of the treatment.

In theory, there is no difference whatsoever in treating a patient psychoanalytically on or off the couch. All the principles that apply in a couch-based analysis are applicable to a chair-based analysis—whatever approaches one takes to conduct an analysis. The theory of analysis does not change based on the position of the patient. Analysts can still argue about the necessity of regression, a transference neurosis, interpretation of unconscious mental life, and the like.

On the other hand, the technique of analysis may vary, depending on how one applies that theory. The notion of defining psychoanalysis in terms of an "analytic process" may be useful (Vaughn & Roose, 1995). This concept is often defined in terms of free association, resistance, interpretation, and working through. According to Vaughn and Roose, such a process develops only in forty percent of patients in analysis, and fifty percent of patients who do not establish this process receive good therapeutic benefit (p. 343). This research supports the idea that the analytic process

is not necessarily dependent on the classical psychoanalytic situation (p. 353). To complicate matters further, there is no clear consensus on what defines an analytic process (Pires, Dos Santos, Tiellet Nunes, & Freitas Ceitlin, 2006). Given the current pluralism of psychoanalytic models, there is reason to doubt if psychoanalytic psychotherapy and psychoanalysis in a traditional sense can be meaningfully distinguished (Fosshage, 1997).

It may be worth noting that Freud himself never distinguished between psychoanalysis and psychoanalytic psychotherapy. The distinction that he made was between psychoanalysis and consciousness-based treatments such as cognitive and behavioral therapies (Zusman, Cheniaux, & De Freitas, 2007). Clearly, psychoanalysis is not an all-or-none proposition. Positive therapeutic results can be obtained with various techniques and situations.

Types of Patients

One could consider that couch-based analysis is the treatment of choice for certain types of patients. Robbins (1996) discusses the mental organization of borderline patients and other primitive personalities. He describes how the classical psychoanalytic situation presumes that the patient and analyst are both "self-contained" systems. In his view, the analyst serves a mirroring and organizing function for primitive patients. He uses the analogy of mother and infant in terms of patient development. Eye contact between mother and infant facilitates the infant's development. Analogously, he finds that eye contact between an analyst and analysand facilitates the therapeutic process of patients with primitive personalities. He believes that their difficulties are exacerbated by using the couch because it impedes recognizing affect. The couch deprives them of the self-organizing tool of visual feedback from another person. Therefore, he finds the couch is not useful in treating such patients.

Accordingly, far from being a positive therapeutic force, the couch can in some instances function in a negative or even destructive role. A common example might be a depressed patient who has limited social support in his world. He may come to an analytic hour and find his loneliness reinforced. In other in-

stances, such as in patients with histories of psychosis, analysands can be precipitated into acute psychotic states. Other types of patients with fragile or inflexible defenses may be vulnerable as well. In short, it would seem best that we have at least a clear picture of the patient's personal history, defenses, and strengths before subjecting him or her to classical analysis. Putting a patient on the couch without having a clear history of the patient and the clinical facts, so as to know the person's vulnerabilities, would be considered a questionable practice in this day and age. In analytic work, it is especially important with certain types of patients to keep in mind the role of the face, such as in early feedings, in the stranger-fear reactions, and in other childhood experiences. Various kinds of patients may suffer a depressive response to beginning or being in a couch-based analysis.

One unfortunate consequence of diagnostic categorization is that some schools of psychoanalysis then tend to divide patients into those people who are "analyzable" in their sense of the word and those who are not. Those people who do not or cannot benefit from using a couch are seen as "more disturbed," "unanalyzable," and the like. Furthermore, clinicians who are flexible in their approach to analysis in terms of not using the couch to conduct treatment may be criticized for "not doing analysis" and their work less valued in that regard. Such views would appear to be more biased than reasonable. Common sense would dictate that an individual's overall picture—symptoms, character, life factors, and so forth—rather than some particular diagnostic entity would be most relevant in treatment.

One consideration for further discussion and research might be to consider if there are certain personality types or mental disorders that tend to do better in a couch-based treatment. In such study and deliberation, treatment goals may be important as well. For example, in treating narcissistic patients, the main therapeutic task may not be in analyzing resistances to their free associating but in helping such patients communicate better with other people. A neurotic patient may need to focus on dealing better with real life problems rather than repeatedly examining the basis of inhibitions in his or her past.

Of note, the scientific literature has not established that clas-

sical analysis is the treatment of choice for any psychiatric or psychological condition. Even if it were found to be so for a given diagnosis, one would need to distinguish between classical psychoanalysis and the use of the couch. A psychoanalytic clinician can conduct a classical analysis on or off the couch. The couch can be used in treatments that are not classical psychoanalyses.

Regression, Free Association, and other Psychoanalytic Notions of Therapeutic Action

The classical therapeutic model is based in re-creating a transferential relationship (transference neurosis) in which the analyst is experienced as a problematic parent, sibling, or significant other, and aspects of that relationship are reexamined. This can potentially aid in insight and understanding about that earlier experience. But like other treatments, it can also retraumatize a patient, making what might have been a therapeutic experience into an even more damaging one.

The couch is also potentially important in psychoanalytic work because it promotes regression. The issue of the role of regression in analysis is a complex one. In a general way, the entire procedure of analytic treatment is geared toward overcoming the evidences of regressive thinking and behavior in our adult patients in relation to the realities of their world today. To some degree, our task as analysts is to work with patients to uproot these regressive tendencies and to encourage not simply the abandonment of regressive points of view and behavior but to replace them with more mature points of view and behavior. Regression may be a temporary step toward ultimate goals of treatment. However, despite ideas about regression in the service of the ego, the couch may also at times push the patient in a direction contrary to our goals of treatment (Neubauer, 2003).

The couch may encourage greater freedom for free association. Rosegrant (2005) finds that free association increases subjective awareness and disregard for reality. It can help the patient better integrate reality and subjective self-awareness. There is general agreement that free association is integral to a psychoanalytic process, but most psychoanalysts agree that the couch is not nec-

essary to establish an associational process. In fact, the consensus even in traditional psychoanalytic circles is that a process of free association can be established and utilized in a face-to-face situation (Kernberg, 1999).

Furthermore, the concept of free association is not as clear-cut in reality as a dictionary definition might suggest. Most analysts do not consider it possible that we might ever associate with complete or true freedom. The presence of the analyst and the situation necessarily influences the patient's associations. The thoughts that an analyst permits to flow through consciousness and articulates tend, at least in a general way, to be directed by the main issues of the moment. If the patient drifts into a regressive state, the analyst too may find himself or herself drifting regressively. The analyst may then respond without keeping whatever concerns are present for the patient in mind. In short, it is easy for both parties to lose sight of the main point of the free-associative process. Namely, one tries to help the patient recognize, accept, and understand his or her own inner reality and, ultimately, deal more effectively in his or her life.

Various ideas in contemporary psychoanalytic research and thinking can also be useful in considering the basis of therapeutic action in analysis. Dan Stern has discussed the importance of the "authentic presence" of the analyst (Ramberg, 2006). He believes that if the analyst opens up to the patient in appropriate ways, rather than striving for anonymity, it can result in more profound changes in the patient's implicit knowing of himself or herself. In a sense, his work underscores the value of intersubjectivity rather than a more narrative focus for the psychoanalytic work. Winnicott's ideas about "good-enough" mothering may be useful in considering the psychoanalytic situation. Presumably, there is a need for psychoanalysis because the patient is symptomatic in some way, even if the indicator is simply that the patient is not functioning up to his or her potential. To some degree the psychoanalyst acts as a parent, in terms of making up for a developmental deficit. Obviously, the overarching aim is to find an approach that allows the analyst and analysand to work most productively together in a way that suits both.

The Meaning of the Couch to Patients

Given its iconic status in analysis, whether one is on or off the couch in the course of an analysis is likely to be a meaningful subject in the course of treatment. Certainly, lying or not lying on the couch during an analysis has a multitude of meanings to analysand as well as analyst. Dialectics of privacy versus intimacy, inside versus outside, subject versus object, and submission versus dominance are just a few. Greenacre (1954) discussed what she finds is the inherently sexual nature of the situation, especially when the analyst and patient are of different sexes. Byerly (1992) focused on the dominant and submissive dynamics intrinsic to the situation. Other universal or generalizable meanings include to phobic or danger situations (Fenichel, 1941; Glover 1955; Lewin, 1954). Of course, the classical psychoanalytic situation may also be experienced more positively in terms of freedom and opportunity. The psychoanalytic literature tends to focus on not using the couch as being a resistance to analysis, and analyzing that resistance can be an opportunity for further treatment (Frank, 1995). Either position may be used to maintain safety or defend against perceived danger (Celenza, 2005). Additionally, each patient will find his or her own individual experience on or off the couch as meaningful in personal and even idiosyncratic ways. As we say, referring the process of psychoanalysis, "It's all grist for the mill."

FINAL CONSIDERATIONS AND CONCLUSION

The use of the couch is integral to most candidate's psychoanalyst training (Cooper, 1985). In a well-known vignette, Hoffman (1994) describes an interesting incident with a control case during his psychoanalytic training. The patient, who is lying on the couch, turns toward Hoffman and says, "Are you sure the couch is necessary for the process. I think the eye contact is more important for me." Hoffman playfully replies, "Well, I don't know about the process but it might be necessary for me to graduate" (p. 200). This situation underscores an attitude among certain analytic institutes, societies, and organizations, namely, that at the very least for the purposes of training candidates, analyses should be conducted to some extent on the couch. This is true for both candi-

dates and the patients they treat. Thus, using the couch becomes integral to the identity of an analyst in training, whether or not it is most useful therapeutically for the trainee or his or her patients. As a treatment, psychoanalysis is a humanist discipline with scientific underpinnings, but psychoanalytic training is organized more like a religious belief or social system with its authoritarianism, genealogy, and politics (Kirsner, 2001).

Notions like "psychoanalytic psychotherapy" and "applied psychoanalysis" may contribute to a restrictive view of psychoanalysis. For example, there is a tendency to consider such a treatment not an actual psychoanalysis and therefore not constituting valid psychoanalytic work. This notion may lead to the odd situation where the patient clearly gets better through all the techniques of analysis, but the treatment is not considered "an analysis." Of even greater concern, the treatment may be considered an analysis in the most classical sense, but the patient may derive little or no therapeutic benefit—or even worse, be harmed by the treatment as narrowly defined and rigidly applied. The annals of medicine are full of treatments that were employed in this way and no longer exist. Indeed, if bloodletting, mercury potions, and enemas were used today as they had been employed "therapeutically" in the past, they would be considered forms of malpractice or abuse. Certainly, using classical psychoanalysis today for the treatment of schizophrenia, bipolar disorder (type I), and other psychotic conditions as had been done in the not so distant past might constitute unprofessional conduct, except in exceptional circumstances. So while one cannot simply judge the appropriateness of the couch according to a patient's diagnosis, certain major psychiatric disorders may rule out its usage.

No doubt the politics of the psychoanalytic community come into play when considering issues involving the couch. Clinicians become invested in clinical approaches that they themselves were trained in or, alternately, may respond or rebel against them. Each school tries to legitimize its position and techniques by referring back to the ways of the founding father, who famously did not always practice what he preached. Richard's (2003) important "Plea for a Measure of Humility" underscores the complex motivations that each of us brings to our work as individual prac-

titioners who are part of a larger professional community. His notion about a "politics of exclusion" that exists in the psychoanalytic community is useful and relevant (Richards, 1999). The psychoanalytic debate is well summarized by Eisold (2003). Perhaps humility is too much to ask for. But what about common sense? As physicians, we especially know the timeless Hippocratic aphorism, "First, do no harm" (*Primum non nocere*).

Developments in cognitive neuroscience and other areas of research can inform our approach to psychoanalysis both in terms of psychoanalytic theory and technique. Westen and Gabbard (2002) identify several such areas, including the nature of representations, the interaction of cognition and affect, and the mechanisms that the mind uses to find compromise solutions (p. 53). Recently, Lable and colleagues (2010) proposed a number of research designs for investigating the effect of the couch on the psychoanalytic process and outcome. They offer some preliminary empirical data based on archived audiotapes from two psychoanalyses. Such research-oriented approaches aim to investigate concepts underlying the use of the couch.

Clearly, more research is necessary for making a determination about the tools and techniques of analysis. However, the approaches of evidence-based medicine and the standards of randomized clinical trials are not easily applied to psychoanalytic work—and may not be the best methodologies for studying the psychoanalytic process. Furthermore, when clinical material is presented or written up, it undoubtedly is influenced by the analyst's theoretical orientation and professional biases (Bohm, 1999).

What can reasonably be said is that using the couch emphasizes some aspects of the analysis (auditory) and deemphasizes others (visual). Intimacy and emotional closeness are necessary for the process in whatever ways and means this is achieved. In each patient the real relationship with the psychoanalyst may be as therapeutically important as the transferentially based one (Couch, 1999). This aspect of the therapeutic relationship may be more apparent when the patient has the analyst in sight. Real relationships are basic to personal well-being. In the analytic setting, this aspect of a relationship is better viewed as an aid than an impediment to psychoanalytic work. Human connection is an es-

sential aspect of psychological health and healing. "No man is an island," as John Donne's "XVII Meditation" begins.

For some patients the couch is a facilitating tool for psychoanalysis. It may help a patient get in better touch with his or her inner life, such as affective experiences and fantasies, and more effectively adapt to the world. But there is ample evidence that for many patients, the couch is not advantageous and can even be therapeutically problematic. It may deprive a patient of the very therapeutic modalities he or she needs to get better. It is not just that such a patient may feel more comfortable and safe in a face-to-face setting in order to proceed with the analytic work; rather, the visual experience and other kinds of connections can be the therapeutic pathways of his or her analytic experience.

For the most part, the way analysts arrange the classical psychoanalytic situation deprives both participants of the opportunity to view each other. It is not evident from reviewing the psychoanalytic literature that such an arrangement generally benefits the therapeutic work which psychoanalysis is meant to foster. However, rather than take up the issue as a subject of serious concern and study, the traditional psychoanalytic community has tended to take it as a given—an assumption—that a couch-based approach is best, at least partly because of historic precedence. Such is the kind of received wisdom that has been problematic for medicine in the past. It smacks of belief systems that tend to hamper new learning. To the extent that using the couch may retraumatize certain types of patients, then obviously it should not be used for them, especially if other efficacious treatments are available. At least some such patients are those who have experienced early losses and deprivations. However, from various case studies in the literature, these patients are often considered suitable candidates for couch-based analysis. Yet for such patients, face-to-face contact may be an integral and even essential part of a psychoanalytic relationship.

Psychoanalysts have a long history of misapplying theory and technique to patients with schizophrenia, autism, obsessive–compulsive disorder, severe depression, and other psychiatric conditions. Generations of clinicians were convinced that major psychiatric conditions arose directly from dysfunctional families and

were best treated with psychological interventions. Our profession remains full of ideas for which there is little tangible evidence but which have become entrenched because of historical precedent, charismatic personality, politics, self-interest, lack of better alternatives, and so on. One wonders how many of our current practices will stand the test of time in terms of therapeutic efficacy.

Clearly, psychotherapy therapy can be a useful and important part of the overall approach to treating even major psychiatric disorders. However, given the integral place of the couch historically as a modality in psychoanalytic work, its usage should be more critically examined. From the standpoint of psychoanalytic theory, nothing is requisite about use of the couch in psychoanalysis. In fact, it is potentially harmful to patients and trainees to define psychoanalysis in such terms. It plays into positions and attitudes that have little relationship to clinical efficacy. As Kernberg (2004b) points out, the psychoanalytic community is deeply ambivalent about research because it may interfere with cherished beliefs and traditional theories. However, to remain a vital and vibrant treatment, psychoanalysis needs to further question and examine the very tools and assumptions it is based in. No doubt scientific knowledge and more rigorous studies will shed light on the subject in years to come.

An analytic approach to treating patients can be invaluable. Each analysis is individual and unique. Accordingly, a reasonable view regarding the use of the couch in analysis would seem to be that it depends on the patient and the analyst and how they relate to one another—their "fit," so to speak. Until clearer criteria can be established for its indications, the use of the couch for psychoanalytic work should be more flexible, circumscribed, and circumspect (Hirsch, 2002).

Clearly, the debate about the use of the couch—and what defines analysis—has been misplaced. As Glen Gabbard (2003) and others have pointed out, the analytic community should be primarily concerned with what is psychotherapeutic. Whether or not a treatment is "psychoanalytic" is secondary, although in part because of political and historical reasons it has often become a central issue in a treatment. Any psychotherapeutic treatment is best tailored to meet the needs of each individual patient to the extent possible. Nowadays, there is more awareness in the analytic

community of the relevance of cognitive-behavioral therapy, psychopharmacology, and other treatment modalities.

In order to remain a useful treatment, psychoanalysis needs to adapt and evolve in ways that are true to its essential, therapeutic principles but relevant to the times in which we live and practice. Examining and reexamining ourselves as a profession and inviting others to do so—putting psychoanalysis on the couch so to speak—can only help increase our own awareness of the benefits as well as the limits and limitations of our work.

NOTES

1. For this paper, the authors reviewed over four hundred papers of the PEP CD-ROM database cross referencing the word "couch" and "psychoanalysis." This database includes the major journals of psychoanalysis.
2. In a personal communication, Glen Gabbard highlighted this useful aspect of the classical psychoanalytic situation. He cited the work of Ogden and others that the couch allows the analyst to achieve a state of mind most conducive to psychoanalysis.

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