Psychoanalytic Psychology, *34: 429-444,* 2007

# The Analyst's Role in Healing:
# Psychoanalysis-*Plus*[1]

Joseph Schachter, M.D., PhD., Horst Kächele, M.D.

160 West 66th Street
New York, N.Y. 10023

212 787 4270
jschachter2@nyc.rr.com

"In the absence of clear-cut evidence, doctors must work in the realm of instinct and faith, and these intangibles necessarily have

[1] We would like to thank Judith S. Schachter, M.D. for her thoughtful suggestions and skillful editing.

personal roots. This sort of situation comes up daily, even in cardiology, the font of evidence-based medicine. It is rare that incontrovertible evidence exists for our medical decisions. So you intuit, make a judgment, and hope that your hunch will serve your patient well" (Jauhar, 2005).

Abstract

We argue that the original structuring of psychoanalytic treatment is based upon an unsound foundation. The questions we raise about the bases of early treatment make understandable the subsequent evolution of substantial changes, and make plausible our recommendation of still further changes. We propose that the nuanced use of techniques of explicit support, consolation, suggestion, persuasion and advice, all used in healing across many ages and societies, be added to traditional psychoanalytic treatment. These techniques are inconsistent with the analyst's neutrality, a fundamental characteristic of the analyst's stance in the original model. The demonstration that the analyst's own values, beliefs, expectations and theories profoundly influence all of the analyst's interventions, leads us to reconsider the concept of neutrality. The possible risks associated with using these recommended explicit techniques mandate that their use requires the same discriminating judgment as is used to determine whether and when an interpretation is presented. Whether use of these additional techniques, which we have termed "psychoanalysis-*plus*," will enhance treatment effectiveness is an empirical, not a theoretical, question.

Psychoanalytic praxis, Neutrality, Healer, Suggestion, Consolation

## Classical Psychoanalysis's Exclusion of the Proposed Techniques

In the past, classical psychoanalysis has emphasized that understanding and insight *alone* are more effective than understanding *plus* explicit suggestion, persuasion, consolation, support and advice. Freud warned about diluting the pure gold of psychoanalysis with the dross of suggestion, and in 1933, (quoted by Collins, 1980) believed that "[u]nderstanding and cure almost coincide, that a traversible road leads from the one to the other" (p. 145)..

We propose adding to the analyst's armamentarium the use of explicit support, consolation, persuasion and advice. The banning of these techniques by classical theory is based on the validity of the classical analytic theory of praxis, itself based on Freud's etiological theory of neurosis. We will briefly review the early history of analytic treatment. If there are questions about the roots of the original structure of treatment, then it is plausible to consider changes and additions to that treatment. In addition, the validity of classical theory of treatment assumes the independence of free association, a fundamental of that analytic praxis. We explore this assumption in terms of more recent, sophisticated understanding of the roles of suggestion and of placebo effect. Further, since justification for excluding these modalities rests on proof that classical treatment is more effective than comparable treatments that include those humanistic modes, we review studies of the comparative therapeutic effectiveness of classical analytic treatment. Finally, we examine the

question of whether support, consolation and suggestion may be contraindicated or especially relevant for certain diagnostic groups.

## A Brief History of the Origin of Psychoanalytic Praxis

Freud created his etiological theory of neurosis in 1892, writing to Fliess in December that his theory was going to be published (Masson, p. 36). When Freud started his private practice six years earlier, he used the standard neurological treatments of rest and massage as well as hypnosis, but in 1889 he modified his hypnotic treatment by adopting Breuer's cathartic method, consisting of interrogating a hypnotized patient about thoughts and experiences related to their symptoms.

By 1892 Freud had largely dispensed with hypnosis, treating Frau Elizabeth v R mainly without it, relying on what became the new technique of free association. He pressed on her forehead to bring out new pictures and ideas; "I brought it about that from that time forward my pressure on her head never failed in its effect" (1893-1895, p. 154). Prior to that change in technique, however, Freud had formulated his etiological theory of neurosis. Analysts commonly believe that it was derived inductively from Freud's patients's productions, but they fail to recognize that the pre-1892 productions were of hypnotized patients treated *prior* to his use of free association. Stated conversely, to the degree his etiological theory was based on patient material, it was not based on patients who free associated but rather *it was entirely derived from those earlier hypnotized patients with whom he was using the cathartic method.*

Freud initially structured analytic technique and theory on the basis of his etiological theory.

We focus on this historical fact both because it is acknowledged that hypnotized patients are extremely suggestible, and, because evidence suggests that Freud was unaware of making covert suggestions to his patients. Consider Freud's (1896) claim that "In some eighteen cases of hysteria I have been able to discover this connection [to a childhood sexual trauma] in every single symptom, and, where the circumstances allowed, confirm it by therapeutic success" (p. 199). This finding in eighteen consecutive cases is unlikely to occur by chance; we instead assume that it was due to Freud's covert suggestions. Supportive evidence is found in Freud's later painful decision to abandon his seduction hypothesis. There is no indication that Freud ever considered that the reason for his mistaken belief about childhood sexual traumas might have been his own covert suggestions to patients of putative traumatic childhood sexual experiences. To the degree that Freud's etiological theory was developed from the productions of highly suggestible hypnotized patients, plus his failure to recognize his own covert suggestions to patients, raises question about his theory and the structure of treatment derived from it.

Freud's contemporaries were explicit about their belief that suggestion was involved in his presented cases. Breuer himself (1893-1895) was among the early contemporary critics of Freud, writing about his own treatment of Anna O that "As regards the symptoms disappearing after being 'talked away,' I cannot use this as evidence; it may very well be explained by suggestion" (Studies in

Hysteria, p.43). Grünbaum (1993) notes that Freud was stung and indignant when his friend Fliess charged him with projecting his own thoughts into those of his patients instead of reading their thoughts and abstaining from tailoring them to his expectations (Freud, 1954, pp. 334, 337). Von Krafft-Ebing (quoted by Ellenberger, 1970) tried the Breuer-Freud method on a few hysterical patients and found that bringing the causal trauma to light did not suffice to cure the symptom (1896). He also emphasized that the memory of the repressed trauma could emerge into consciousness in a fantastic and distorted fashion (1897), an observation subsequently confirmed empirically (Dywan, J and Bowers. K., 1983).

These early doubts of Breuer, Fliess and Von Krafft-Ebing support our question of why elucidating the cause became entrenched in praxis and was expected to relieve neurotic symptoms. Strenger (1986) notes that even if classical treatment was superior, that “This would still not mean that the original repression of this specific content was causally responsible for the onset of the neurosis. All we could claim is that the maintenance of the repression was causally responsible for the *maintenance* of the symptom. We can thus not infer from processes occurring during therapy any causal connection between childhood events and the present neurosis” (p. 257). Schachter (2002), in a detailed review, reiterates that conclusion. These criticisms point to the lack of evidence for the theory of treatment that opposes the open use of the proposed explicit techniques.

## Why Freud Proscribed Time Honored Healing Techniques

Freud, who was well-read, knew of ancient healing techniques. Why did he prohibit their use in analytic treatment? Freud had wanted to pursue a scientific career but, unable to get an academic appointment in Vienna entered private practice to marry and earn a living. Nevertheless, his continuing drive to engage in science led him to shape his theory of practice into a scientific enterprise. As he told his American patient Abram Kardiner (1977), he was interested in theory, not therapy. He structured his treatment to produce documentary evidence of his etiological theory of neurosis. Freud hoped that developing treatment as a scientific endeavor would lead to the outstanding scientific discovery of the cause of neurosis, equivalent to discovering the *caput Nili* (the source of the Nile) (Freud, 1896, p.203).

To achieve this, he developed psychoanalysis within the context of a (nineteenth century) scientific enterprise: Psychoanalysis, Freud (1932, 1933) wrote, "[i]s a part of science and can adhere to the scientific *Weltanschauung*) (p. 181); "The stress on arbitrary personal views in scientific matters is bad; it is clearly an attempt to dispute the right of psychoanalysis to be valued as a science … Anyone who sets a high value on scientific thought will rather seek every possible means and method of circumscribing the factor of fanciful personal predilections as far as possible …" (1914-1916, p.59); "But scientific work is the only road which can lead us to a knowledge of reality outside ourselves" (1927, p.31). "[*o]ur* science has as its object that [psychical] apparatus itself" (1940, p.159).

Suggestion was the greatest threat to the scientific status of psychoanalysis because of its association with hypnosis, then in bad repute. We hypothesize that Freud proposed neutrality, abstinence and anonymity to try to assure the analyst's objectivity, and insulate psychoanalysis's scientific status from the contamination of suggestion: "The analyst who wishes the treatment to owe its success as little as possible to its elements of suggestion (i.e. to the transference) will do well to refrain from making use of even the trace of selective influence upon the results of the therapy ..." (1913, p.131); "I cannot advise my colleagues too urgently to model themselves during psychoanalytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible" (1912, p. 115); "The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him" (p1912, p.118); If the transference is able to remove the symptoms of the disease by itself, "In this case the treatment is a treatment by suggestion, and not a psychoanalysis at all" (1913, p. 143). To assure the scientific status of psychoanalysis Freud urged that all patients be treated under standard conditions, appropriate for research, but, as we have learned, inappropriate for psychotherapeutic treatment. Freud's lifelong concern about analytic objectivity, about the scientific status of psychoanalysis, focussed particularly on the role of suggestion in undermining that status (Fogel, 1993).

The analyst's neutrality and abstinence served an additional unstated function for Freud and his colleagues; it codified a self-

imposed inhibition against troublesome erotic feelings toward women patients (Stone, 1961; Anzieu, 1986; Glenn, 1986; Moi, 1990). Later, Freud described neutrality and abstinence as barriers to the analyst's interventions impinging on the patient's independence (1912, 1923, 1940).

Ferenczi, focused on therapy, not science, disagreed with Freud's emphasis on neutrality, abstinence and anonymity (Thompson, 1943). Since he was convinced that the cause of neurosis was the parents's failure to provide the child with needed love, he believed treatment had to take the form of a human relationship in which the analyst provided the missing childhood love. Ferenczi, therefore, expanded analytic technique to include those time honored healing techniques that Freud had recognized and then rejected. We know that Freud never gave up the theoretical ideal of the analyst's objectivity (Fogel, 1993), but he was actually warm and friendly with his patients, on occasion providing food and loaning money (Lipton, 1977, 1983), though not considering such acts as part of technique.

This early Freud-Ferenczi debate has continued throughout the history of analytic treatment. So many analysts have contributed to the evolution of treatment that a list will necessarily be incomplete: Harry Sullivan, Clara Thompson, Erich Fromm, Freda Fromm-Reichman, Winfred Fairbairn, Donald Winnicott, Karen Horney, Franz Alexander, Otto Will, George Groddeck, Harry Guntrip, Hans Loewald, John Bowlby, Leo Stone, Heinz Kohut, Merton Gill, Irwin Hoffman, Robert Stolorow, Anton Kris, Arnold Modell, Benjamin Wolstein, Edgar Levinson, Lewis Bromberg, Stephen Mitchell, Jay

Greenberg, Stuart Pizer, Jessica Benjamin, Owen Renik, Lewis Aron, Theodore Jacobs, Irving Hirsch and Mark Blechsner.

## The History of Healing

Frank (1973) reviews psychotherapy, primarily in America, and concludes that much of the effectiveness of different forms of psychotherapy may be due to features that all have in common rather than those that distinguish one from another. Although he believes that failures of adaptation arise from early life experiences, psychotherapy aims to help the patient correct current problematic attitudes. He refers to Whitehorn's (1947) contention that the cause of a symptom should not be confused with its current meanings, which often can be changed regardless of their cause. Strupp et al. (1969) characterizes the patient's image of a "good therapist" as a "keenly attentive, interested, benign and concerned listener – a friend who is warm and natural, is not averse to giving advice, who speaks one's language, makes sense and rarely arouses intense anger" (p. 117). Frank, building on Strupp's earlier paper, notes that directive therapies seem at least as effective as evocative (analytic) ones for many types of patients, and for some produce improvement more rapidly. Success in therapy depends in large part on the analyst's ability to combat the patient's demoralization and heighten his hopes of relief. Success also depends on the patient's conviction that the therapist cares about him/her and is competent to help him/her – that the analyst has confidence in his/her theory.

The history of the healer-sufferer relationship, extending over thousands of years and across societies and cultures, was examined

by Jackson (1999), who extracts commonalties similar to Frank's: influence is brought to bear by suggestion and persuasion plus consoling and bringing of comfort as well as a search for insight and self-understanding – of 'knowing' what all the suffering has been about.

## Classical Views of Neutrality

Whether the analyst will experience his feeling or action as a deviation from prescribed technique will vary with the analyst's own interpretation of "neutrality." Stone (1981), for example, characterizes the true analytic attitude as compatible with human friendliness and warmth, but the analyst "[g]ives no affective response to the patient's material or evident state of mind, nor opinions, nor direction, not to speak of active interest, advice or other allied communications" (p. 99). Kris (1990) believes that analysts need to depart from neutrality by expressing an affirmative attitude toward the patient in order to help the patient overcome punitive unconscious self-criticism. Akhtar (2004) describes Thomä's analytic work as "unabashedly therapeutic, flexible yet firm, supportive yet interpretive and deliberate yet spontaneous" all within a classical theoretical frame. Blatt and Behrends (1987) and Blatt and Shahar (2004), unlike Kris, expand neutrality to encompass the analyst being accepting and compassionate.

Rothstein (2005), a classical analyst, acknowledges how intersubjectivity limits the objectivity of neutrality: "[t]he best anyone can do is be more or less able to subjectively reflect on his or her

experience, while simultaneously being more or less influenced by the subjectivity of the collaborating analysand" (p. 419). Aron (2005), commenting on Rothstein's paper points out that: "under the guise of neutrality, analysts encouraged their patients to renounce their [infantile] impulses, once they had become conscious" (p. 492). … So much for neutrality!" (p. 443). Benjamin (2005) takes another tack; intersubjectivity should encompass the capacity to identify, to get inside the other's mind and let the other inside us – in Winnicott's sense, to use the object. Ideals of objectivity, she feels, are not only unrealizable but may well create deep impediments to empathy. She conceives of neutrality as a nonjudgmental acceptance, a loving attitude that allows us to incorporate within our understanding even our mistakes and failures.

## The Classical Psychoanalytic View of Explicit Support in Treatment

Freud (1909) himself used explicit support treating the Rat Man (Dr. Lorenz). Mahoney (1986) characterized Freud's role in that treatment as that of a "befriending educator." At one point Dr. Lorenz expressed doubts to Freud that treatment would be able to help him modify the obsessions which had plagued him since childhood. Freud's response to this expression of anxious hopelessness was that "[h]is youth was very much in his favor as well as the intactness of his personality. In this connection I said a word or two upon the good opinion I had formed of him, and this gave him visible pleasure"

(p. 178). Clearly, Freud as practitioner had no qualms about the utility of explicit verbal support.

Contemporary classical analysts have diverse views about support. “Psychoanalytic therapy,” cites Leichsenring (2005) “operates on an interpretive-supportive continuum, and the use of more interpretive or more supportive interventions depends on the patient’s needs (Wallerstein, 1989; Gunderson and Gabbard, 1999; Gabbard, 2004)” (p.844). Blatt (2005, personal communication) writes about support: “With any patient I prefer that the patient struggle to manage their difficulties themselves. But I would offer support only if I thought the patient could not manage the difficulties alone.”

**Free Association: The Basic Rule of Psychoanalytic Treatment**

Although Freud’s etiological theory of neurosis antedated his use of free association, free association soon became the fundamental rule of analytic treatment (A. Kris, 1982); and remains so in contemporary psychoanalysis (Gabbard and Westen, 2003). Not all agree about its centrality; Grünbaum (1984) critically quotes Eissler’s (1969) hyperbolic statement that free association “[i]s one of those glorious inventions that can hold its own with Galileo’s telescope” (p. 461). Levenson (2001) remembers Clara Thompson’s less glowing view; she gave up free association with some regret, largely because no one seemed to be able to do it. Mostly, she said, they “just natted on” (p. 380).

Since the data of free association are used to interpret causal connections between the patient’s thoughts, feelings and symptoms from which a personal narrative is constructed, Grünbaum argues

that these causal interpretations must be evaluated by “modes of inquiry that were refined from time-honored canons of causal inference pioneered by Francis Bacon and John Stuart Mill” (1984, p. 47). Holt (1981) concurs: “[s]cience is defined by its methods, not its subject matter” (p. 133).

A more clinical criticism comes from many analysts recognizing, when reviewing patient material, that the analyst has substantially shaped the patient’s associations (Marmor, 1962; Gill and Hoffman, 1982). Glover (1955) early on asserted that: “When therefore any two analysts or groups of analysts hold diametrically opposed views on mental mechanisms and content, it is clear that one of them must be practicing suggestion” (pp. 381,382) – (or possibly both). The power of such influence has been confirmed empirically (Greenspoon, 1955; Murray, 1956; Murray and Jacobson, 1971; Truax, 1966). Haley (1959) argues that the very subtlety and unobtrusiveness of the therapist’s influence, coupled with his/her explicit disclaimer that he/she is exerting an influence, may increase his/her influencing power. It appears, concludes Frank (1973), that a therapist cannot avoid biasing his patient’s performance in accordance with his/her own expectations. Thomä and Kächele (1987) assert similarly that “The analyst who approaches his object, the analytic process, with a specific conception of a model, *influences, by means of his expectations, the occurrence of events* which agree with his model. … He may thus actually determine the direction the process takes, although he believes that he has only observed it” (p. 333).

Masling and Cohen (1987), citing several clinical examples, replicate this conclusion: all psychotherapies generate clinical

evidence that support their theoretical positions and so can be understood “[a]s instances of therapists systematically rewarding and extinguishing various client behaviors” (p. 65).

It follows that, due to the analyst’s powerful influences upon free association, interpretations based on them will also reflect the analyst’s influences. Glover (1952), quoted by Wallerstein (2006, p. 304) had declared that there is “[n]o effective control of conclusions based on interpretation, [and this fact] is the Achilles heel of psychoanalytic research” (p. 405).

“[w]e cannot exclude or have not excluded the transference effect of ‘suggestion through interpretation” (p. 405). Spence (1992) observes that “The clinician … tends to listen to the clinical material with a favorite set of theoretical predispositions” (p. 562), and concludes that “Interpretations in a clinical setting have an unfortunate tendency to reflect the therapist’s expectations rather than the underlying facts of the matter” (p. 559).

The sources of the analyst’s implicit influences and suggestions are manifold, in part derived from the analyst’s subjectivity which encompasses the analyst’s realistic reactions to the patient, the analyst’s transference responses to the patient, the analyst’s theoretical orientation, the analyst’s current, personal concerns about his/her own life, and the analyst’s personal values; the influences of the latter have been widely discussed (Menninger, 1958; Roazen, 1972; Lichtenberg, 1983; Lytton, 1983; Meissner, 1983; Michels and Oldham, 1983; Person, 1983; Ramzy, 1983; Gabler Gockman, 1992). Strenger (2005) asserts that “[i]t is unrealistic to believe that a therapist’s personal predilection, her sense of what constitutes the

central dimension of meaning in life, does not crucially influence each and every one of her interventions" (p. 92).

Renik (1993, 1998, 2004) asserts that many elements of the analyst's subjectivity are unconscious at the moment of interaction, and therefore can only be understood retrospectively. Further, this retrospective understanding becomes accessible only through the analyst's limited and restricted self-analysis or through consultation. In any event, whatever the implicit suggestion expressed by the analyst, once out, it has already influenced the patient, though retrospective acknowledgement and understanding may modify that influence. An analyst striving consciously to minimize the influence of his own unconscious subjectivity in the service of neutrality, will inevitably have only limited success.

## The Influence of Placebo Effect

In addition to suggestion, the placebo effect (Shapiro and Shapiro, 1997; Mosher, 1999) shapes associations. Frank et al. (1963) studied reactions of psychiatric patients to placebos in pill form and found that most of the drop in mean discomfort occurred *before* the administration of the placebo pill. They speculated that some patients may exaggerate their complaints initially to dramatize their desire for help and minimize them later in response to the demand character of the therapeutic situation. Alternatively, the patient's symptoms may be exaggerated by the evaluation apprehension in relation to a first visit to a psychiatric clinic.

In another study Puschner et al. (2006) provide evidence that a waiting period before treatment may involve an expectancy or

placebo effect. Psychoanalytic treatment was provided to 144 patients (2-3 sessions/week) and 472 patients received psychodynamic psychotherapy (1 session/week); repeated measurements were obtained along the course of treatment; At the end of the two years, outcome results were analyzed via hierarchical linear models. During the pretreatment period, a small number of observations indicate that, *surprisingly, psychological distress (measured by SCL-90 GSI) declined more quickly in the interval from acceptance for treatment to the start of treatment, than during the treatment itself:* "More than one-third of the expected improvement over the full two-year observation period was achieved during this first phase." (No information is available whether probatory sessions were used before starting treatment). A pre-treatment waiting period is not generally considered an effective treatment for psychiatric disorder; it may even be assumed that patients may grow increasingly anxious anticipating the start of treatment. However, it is noteworthy that child analysts frequently observe that child-centered complaints ameliorate after the parents call for an appointment but before anyone is seen. Since the waiting period in this study is associated with a therapeutic effect, it can be characterized as an unintentional placebo (Grünbaum, 1993). Puschner et al. hypothesize that the prospect of starting "possibly long awaited treatment raises hope and entails swift initial symptom improvement" - in other words, an inadvertent, empirically assessed expectancy effect which will influence early associations.

In sum, these factors indicate that true independence for free association has not been established, and, therefore, that the rule of

free association does not provide warrant for excluding the open, explicit use of the proposed techniques. More importantly, contrary to the classical analytic conception, complex suggestion and placebo effects should not be considered to be ‘noise’ in the treatment situation requiring minimization, but, rather, ‘signal’ and deserving of scientific study. No study of the effectiveness of analytic treatment has ever controlled for the possibility of a placebo effect (Imber, 1990). Wurmser (1989) notes ruefully: “If anybody knows how to use suggestion with such healing impact, I will gladly learn it; it surely would immensely abbreviate my work” (p. 237).

## The Comparative Therapeutic Effectiveness of Classical Treatment

To return to our basic argument, we believe that outcome studies of classical treatment should show greater effectiveness than, for example, relational treatments, to justify excluding the proposed explicit techniques. The Menninger study (Wallerstein, 1989) was one of the first to report that patients treated primarily with supportive interventions showed therapeutic gains that were as extensive and long-lasting as those treated with classical, interpretive interventions. Wallerstein (2006) elaborated: "2) across the whole spectrum of treatment courses, the treatments carried more supportive elements than originally projected, and these elements accounted for substantially more of the changes achieved than had been originally anticipated; 3) the supportive aspects of analytic treatments deserve far more respectful consideration than they have usually been accorded in the analytic literature" (p. 318). This surprising result should be qualified since all the patients studied were generally sicker

than in the usual outpatient analytic practice, and the therapists using supportive techniques were more experienced analysts than those using classical techniques.

A Swedish controlled study by Grant and Sandell (2004) evaluated 331 psychotherapy patients treated by psychotherapists licensed by the National Board of Health and Welfare, and 74 analytic patients treated by members of one of the psychoanalytic societies in Sweden. Therapist's theoretical framework was assessed by the Therapeutic Attitude Scale. Patients in psychotherapy (sometimes conducted by people with psychoanalytic training) were treated by therapists whose stance was comparable to that characteristic of behavioral and cognitive therapists. In general, the psychotherapy providers put greater value than the psychoanalytic providers upon life adjustment, additionally showing kindness, supportiveness and self-disclosure, combined with valuing insight and neutrality. Of the psychoanalytic treatments, 30% were by these more eclectically oriented psychoanalysts and 70% by classically oriented psychoanalysts.

Results indicated that those 43% of psychotherapy patients treated in an orthodox psychoanalytic milieu failed to show significant therapeutic benefit while the 57% treated more eclecticly showed more progress. Psychoanalytic cases showed no significant difference in therapeutic gain between those treated in an orthodox psychoanalytic milieu and those treated in an eclectic milieu. This study therefore provides no evidence that classical treatment is more effective than eclectic treatment in psychoanalysis, and is actually less effective in psychotherapy.

## Contraindications or Indications For These Additional Techniques

Studies of analytic treatment outcome examining different diagnostic groups are few, although various analysts, starting with Rank, considered personality styles which require techniques other than classical. Blatt (2004) and Blatt and Shahar (2004), originally using a depressed patient population, developed a psychodynamic, dichotomous characterization of patients's personality styles: "introjective," patients are concerned about their sense of self, including self-worth, while "anaclitic," patients are concerned about maintaining harmonious relations with others. These researchers re-analyzed the original Menninger data set and found that introjective patients did better with classical analytic treatment whereas anaclitic patients improved more with supportive-expressive treatment.

This finding led us to question whether the use of the additional techniques of explicit support, suggestion, consolation and persuasion should be minimized with those introjective patients who appear to do better with classical treatment. Blatt (2005, personal communication) responded that he does not believe that "[t]hese findings lend themselves to conclusions about varying treatment technique. Rather, I think these findings strongly suggest that we should be aware that we offer our patients two primary factors – a therapeutic relationship and interpretation and insight…"

## Utilizing Additional Explicit Techniques

We propose utilizing these additional explicit, as distinct from implicit, techniques of support, consolation, suggestion, persuasion and advice, which we term, psychoanalysis-*plus*. It is difficult to determine how analysts actually behave in their office, but it is our impression that many analysts utilize implicit caring, support and consolation, while few are comfortable doing so explicitly, verbally, or exposing these interventions in public reports. Caring may be communicated implicitly by the analyst's expression or tone of voice, of which the analyst may or may not be conscious. An unfortunate consequence of deviating from prescribed neutrality, either consciously or unconsciously, may be discomfort and guilt, which may therefore deprive the analyst of comfortably examining its occurrence and meaning with the patient.

Implicit, nonverbal expression by gesture, tone or facial expression may imply, both to patient and to analyst, that these communications are somehow illicit. When the analyst doesn't openly "own" the expression, then the patient may not feel entitled to explore and express his/her reactions. This analyst-patient interaction, therefore, may not be analyzed. Explicitness, on the other hand, facilitates the patient identifying and responding to the interventions. If the patient explores his/her reaction, is there then risk that the intervention's effect, itself, may be vitiated? For example, if the analyst was explicitly supportive or encouraging, would identifying and analyzing the patient's reaction undermine the intervention's effect? If so, that, in turn, could be explored.

The patient's acceptance of the analyst's explicit interventions constitutes, in Winnicott's terms, making use of the object. By

strengthening the patient's conviction that the analyst genuinely is trying to be helpful, it may also enhance the patient's capacity to explore resistance, and to examine feelings and experiences that feel shameful or humiliating. Further, these affirmative, helpful interventions may also facilitate the patient's identification with these authentic attributes of the analyst (Skolnick, 2006), which hopefully become actively integrated into the patient's internal schemas.

Two examples of such explicit interventions follow. One, from a recent case report (Schachter, 2005) combines the analyst's suggestion and advice. An analytic candidate's patient, George, announced after three-and-a-half years, that he was terminating analysis. The candidate felt strongly that this would be a premature termination, and, despite anticipating criticism from his supervisor, said to the patient: "I really think you're making a big mistake to leave me at this time. I think you should stay until our work is finished." The patient was surprised and moved and continued analysis for another year, deepening the analytic work.

A second example involves consolation and helping a patient deal with mourning (Frommer, 2005). Paul, a 38-year-old writer was in analysis for several years when his mother became ill and unexpectedly died. He claimed he had already mourned his depressed mother long before her actual death, and attempted to forestall missing or longing for her by a primitive introjection of her. Seven months later the analyst's own mother, died. Frommer told Paul he would be out of the office for a week because of a death in the family. Paul asked directly who had died and was told it was the analyst's mother; Frommer did not want his own grief to be off limits

to Paul. In a detached, vaguely contemptuous way, Paul raised many questions about Frommer's relationship with his mother. Months later, Paul asked if Frommer was over his grief, yet? Frommer replied that his mother's death had affected him deeply, that he'd be grieving for her for the rest of his life, and that it fueled his desire to live the rest of his life as fully as he could. Paul slowly began to identify with the analyst's mourning, resolve and revitalization; "there's so much you want to do in your life , and you can only do so much … she's really dead, but in some way it makes me joyful!"

**Possible Risks Associated with Using These Explicit Techniques**

Masling expresses concern about "possible misuse of support, suggestion, consolation and persuasion … relational psychoanalysis presents potential problems, some of them quite dangerous." One of us (J.S.) determined that a majority of the faculty at the William Alanson White Institute regularly use these explicit techniques. On the other hand, a continuous case seminar at the Columbia Psychoanalytic Center and other described cases indicate that some traditional analysts proscribe such interventions. J.S. asked Gabbard, an acknowledged expert on analysts's ethical violations, whether violations occurred more frequently with relational analysts. Gabbard replied: "I have seen well over 150 cases of boundary violations, and I do not have the impression that these problems are more common in relational analysts. I think the ... violations have much more to do with the analyst's personal characteristics and life stressors than their theory.""(Personal communication, 2006).

Several clinical risks should be considered. The analyst's healing gestures may augment idealization to the detriment of the patient's assessment of himself/herself, and also make it more difficult for the patient to express anger towards the analyst. When the analyst's suggestion for real life action is ill conceived, as we've learned some of Freud's proved to be, the application may prove disastrous. Additionally, while a patient may accept a well meaning suggestion or advice out of compliance, unconscious forces may assure a negative outcome. The focus on the patient-analyst interaction may itself overlook the importance of other relationships, while attention to the analyst's conscious interventions may minimize exploration of the patient's dynamic unconscious (Wilson, 1995). Wilson also warns that the analyst's helpfulness may shackle patient and analyst to an environmental position which entails blaming the other and avoiding understanding how the patient may have influenced or used the other.

In addition to these clinical issues, there is also the theoretical question, will the treatment still be psychoanalysis? We believe, as do Gabbard and Westen (2003), that as long as the analyst continues to interpret the patient's unconscious feelings, conflicts and fantasies and explore transference-countertransference interactions, that we should defer "[t]he question of whether these principles or techniques are analytic and focus instead on whether they are *therapeutic*" (p. 826). Wolstein (1992) asserts, similarly, "[p]sychoanalysis, Ferenczi made far clearer than did Freud, stands or falls as the therapeutic experience of clinical psychoanalytic inquiry" (p. 177). Westen (2002) refers to "a way of working clinically that is kinder, gentler, and [he

adds] *I suspect more effective*" (p. 916, italics added); but, he is concerned that this moves us toward theoretical nihilism, by which he means undermining the rules of traditional technique.

Rather than proposing another model of treatment to incorporate these explicit techniques, we urge a reassessment of the "standard model" which aimed at neutrality, privileged free association and provided interpretations. Given the widespread recognition that the analyst's subjectivity limits neutrality and influences associations and interpretations, a reconceptualization of the standard model is needed.

Naso (2005) shares Westen's concern about vitiating the directives of standard technique. He argues, like Eagle (1993), that postmodern psychoanalysis is no more successful in dealing with the epistemological problems of influence and inadvertent suggestion than traditional or modern psychoanalysis – and we agree. He adds that the implications of the postmodern position would be that "[i]nterpretations enjoy no hegemony over nonpsychoanalytic ones and that their therapeutic results may be indistinguishable from the effects of suggestion and influence that they ambivalently embrace" (p. 382).

Failing to solve the epistemological problems of contemporary psychoanalysis, however, does not mean that postmodern techniques may not enhance the therapeutic effectiveness of treatment. This translates, then, into an empirical, not a theoretical question.

Freud had been concerned that the treatment would destroy the "science" (1926). On the contrary, "It is not the therapy that is

destroying the science," writes Holzman (1985), "for it is the therapy that has given us the science" (p. 765). Enhancing treatment effectiveness may revitalize the science by generating empirically-based improvements in psychoanalytic praxis which will increase the respect for and interest in it by other scientific disciplines, and, perhaps, by the public at large.

## References


Akhtar, S. (2004). Diversity without fanfare. Some reflections on contemporary psychoanalytic technique. *Psychoanalytic Inquiry, in press*

Anzieu, D. (1986). *Freud's Self-Analysis.* Ed S.C.B. Yorke (Trans. P. Graham). London: Hogarth Press.

Aron, L. (2005). Acceptance, compassion, and an affirmative analytic attitude in both intersubjectivity and compromise formation theory. Commentary on paper by Arnold Rothstein. *Psychoanalytic Dialogues,* 15, 433-446.

Benjamin, J. (2005). Creating an intersubjective reality: Commentary on paper by Arnold Rothstein. *Psychoanalytic Dialogues,* 15, 447-458.

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

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

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

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

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

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

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

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

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

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

Frank, J.D. (1973). *Persuasion and Healing*. *A Comparative Study of Psychotherapy.* Baltimore, MD: Johns Hopkins University Press.

Frank, J.D., Nash, E.h., Stone, A.R., and Imber, S.D. (1963). Immediate and long-term symptomatic course of psychiatric outpatients. *American Journal of Psychiatry,* 120, 429-439.

Freud, S. (1893-1895). Case 5. Fräulein Elisabeth von R. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2, pp. 135-181). London: Hogarth Press.

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

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

Freud, S. (1912). Recommendations to physicians practising psychoanalysis. In J. Strachey (Edf. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 109-120). London: Hogarth Press.

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

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

Freud, S. (1923). The ego and the id. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol.19, pp. 3-66).

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

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

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

Freud, S. (1940). An outline of psychoanalysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works*

*of Sigmund Freud* (Vol. 23, pp. 140-207) (Original work published 1938). London: Hogarth Press. `

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

Frommer, M.S. (2005). Living in the liminal spaces of mortality. *Psychoanalytic Dialogues*, 15, 479-498.

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

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

Gabler Gockman, E.R. (1992). A note on deep-seated social values in countertransference in mother-infant dyadic psychotherapy. *Psychoanalytic Psychotherapy,* 9, 405-408.

Gill, M.M. & Hoffman, I.Z. (1982) *Analysis of Transference,* Vol.2. Psychological Issues, Monograph 54.

Glenn, J. (1986). Freud, Dora and the maid: A study of countertransference. *Journal of the American Psychoanalytic Association,* 34, 591-606.

Glover, E. (1952). Research methods in psychoanalysis. *International Journal of Psychoanalysis,* 33, 403-409.

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

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

Greenspoon, J. (1955). The reinforcing effect of two spoken sounds on the frequency of two responses. *American Journal of Psychology,* 68, 409-416.

Grünbaum, A. (1984). *The Foundations of Psychoanalysis.* Berkeley: University of California Press.

Grünbaum, A. (1993). *Validation in the Clinical Theory of psychoanalysis. A study in the philosophy of psychoanalysis.*

*Psychological Issues, Monograph 61.* Madison, CT: International Universities Press.

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

Haley, J. (1959). Control in psychoanalytic psychotherapy. Eds. J.L. Moreno, J. Masserman, In *Progress in Psychotherapy.* New York: Grune and Stratton, 4, 48-65.

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

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

Imber, S. D. (1990). The future of psychiatry. Council on Long Range Planning and Development. *Journal of the American Medical Association,* 264, 2542-2548.

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

Jauhar, S. (2005). A doctor brings his family to the delivery room. Health and Fitness, The New York Times, Tueday, March 15, p. F5.

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

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

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

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

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

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

Lichtenberg, J. D. (1983). The influence of values and value judgments on the psychoanalytic encounter. *Psychoanalytic Inquiry,* 3, 647-664.

Lipton, S.D. (1977). The advantages of Freud's technique as shown in his analysis of the Rat Man. *International Journal of Psychoanalysis,* 58, 255-273.

Lipton, S.D. (1983). A critique of the so-called standard psychoanalytic technique. *Contemporary Psychoanalysis,* 19, 35-52.

Lytton, S.M. (1983). A brief historical survey on the influence of value judgments on psychoanalytic theory and practice. *Psychoanalytic Inquiry,* 3, 573-576.

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

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

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

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

Meissner, W.W. (1983). Value in the psychoanalytic situation. *Psychoanalytic Inquiry,* 3, 577-598.

Menninger, K. (1958). *The Theory of Psychoanalytic Technique.* New York: Basic Books.

Michels, R. & Oldham, J.M. (1983).Value judgments in psychoanalytic theory and practice. *Psychoanalytic Inquiry,* 3, 599-608.

Moi, T. (1990). Representations of patriarchy: Sexuality and epistemology in Freud's Dora. Eds. C. Bernheimer, C. Kahane. In *In Dora's Case*: Freud-Hysteria-Feminism, 2nd ed., New York: Columbia University Press, pp. 181-199.

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

Murray, E.J. (1956). A content-analysis method for studying psychotherapy. *Psychological Monographs,* 70, 420.

Murray, E.J. & Jacobson, L.I. (1971). The nature of learning in traditional and behavioral psychotherapy. Eds. A.E. Bergin, S.L. Garfield. In *Handbook of Psychotherapy and Behavior Change: An Empirical Analysis.* New York: John Wiley and Sons, pp. 909-950.

Naso, R.C. (2005). Which way in psychoanalysis? The problem of suggestion in the postmodern world. *Psychoanalytic Psychology,* 22, 382-394.

Person, E.S. (1983). The influence of values in psychoanalysis: The case of female psychology. *Psychoanalytic Inquiry,* 3, 623-646.

Puschner, B., Kraft, S., Kächele, H. & Kordy, H. (2006). Course of improvement during two years in psychoanalytic and psychodynamic outpatient psychotherapy. *Psychology and Psychotherapy* 80: 51-68

Ramzy, I. (1974). Editor's Foreword to *The Piggle*, an account of the psychoanalytic treatment of a little girl. Ed. I. Ramzy. Madison, CT: International Universities Press, pp.xi-xvi.

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

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

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

Roazen, P. (1972). The impact of psychoanalysis on values. In Ed. S.C. Post, *Moral Values and the Superego Concept in Psychoanalysis.* New York" International Universities Press, pp. 197-204.

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

Rothstein, A. (2005). Compromise formation theory: An intersubjective dimension. *Psychoanalytic Dialogues,* 15, 415-431.

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

Schachter, J. (2005). *Transforming Lives. Analyst and Patient View the Power of Psychoanalytic Treatment.* Ed., Lanham MD: Rowman and Littlefield.

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

Skolnick, N.J. (2006). What's a good object to do? *Psychoanalytic Dialogues,* 16, 1-27.

Spence, D.P. (1992). Interpretation: A critical perspective. In Eds. J.W. Barron, M.N. Eagle, D.L. Wolitzky. *Interface of Psychoanalysis and Psychology.* Washington, DC: American Psychological Association, pp. 558-572.

Stone, L. (1961). *The Psychoanalytic Situation.* New York: International Universities Press.

Stone, L. (1981). Notes on the noninterpretive elements in the psychoanalytic situation and process. *Journal of the American Psychoanalytic Association, 29, 89-118.*

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

Strenger, C. (2005). *The Designed Self. Psychoanalysis and Contemporary Identities.* Hillsdale, NJ: Analytic Press.

Strupp, H. H., Fox, R.E., & Lessler, K. (1969). *Patients View Teir Psychotherapy.* Baltimore: Johns Hopkins Press.

Thomä, H., & Kächele, H. (1987). *Psychoanalytic Practice,* Vol. 1: *Principles [1985],* Wilson, M., Roseveares, D. Trans. Berlin, Heidelberg, New York, Paris, Tokyo: Springer.

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

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

Truax, C.B. (1966). Reinforcement and nonreinforcement in Rogerian psychotherapy. *Journal of Abnormal Psychology,* 71, 1-9.

Von Krafft-Ebing, R. (1896). Zur Suggestions-Behandlung der Hysteria gravis. *Zeitschrift für Hypnotismus,* 4, No.1, 27-31.

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

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

Wallerstein, R.S. (2006). The relevance of Freud's psychoanalysis in the 21st century. *Psychoanalytic Psychology,* 23, 302-326.

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

Whitehorn, J.C. (1947). The concepts of "meaning" and "cause" in psychodynamics. *American Journal of Psychiatry,* 104, 289-292.

Wilson, A. (1995). Mapping the mind in relational analysis. Some critiques, questions and conjectures. *Psychoanalytic Psychology,* 12, 9-29.

Wolstein, B. (1992). Resistance interlocked with countertransference – R.N. and Ferenczi, and American interpersonal relations. *Contemporary Psychoanalysis,* 28, 172-189.

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