What Makes Psychoanalysts Tick? A Model and the Method of Audio-Recorded Retroreports*

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1. Introduction

Among the unsurpassed virtues of audiorecordings are their incorruptibility and their completeness. Word for word, laughters or sighs, stutters or stammers, irritated or soothing tone of voice, the duration of silences, all is faithfully and completely stored, to be studied and restudied at will. Although in use for over 50 years, audiorecordings of psychoanalyses or psychotherapies are not generally accepted by the analytic community. A recent exchange of arguments may be found in Frick (1985) and in Gill's (1985) response to it (for a more recent review see Kächele et al., this volume).

Nonetheless, such audiorecordings present at least two problems for the researcher:

The Problem of Dual Self-Selection

Dual means that both analysts and patients who agree to record are not representative of the population of analysts and patients. The only analysts who volunteer are those willing to reveal themselves unguardedly with all their uncertainties, hesitancies, clumsy formulations and blunders to their colleagues' perhaps not always benevolent scrutiny. Moreover only those analysts truly committed to rigorous empirical study of the analytic process are likely to even seek their patients' consent

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to recording. In addition patients whose anonymity might be compromised have to be omitted.

The Gap in Audio-Recordings

A significant problem with audiorecordings of therapeutic sessions is that they include only what the therapist actually said, thus omitting the very processes that led him to formulate his interventions. Heimann (1969, 1977) has described that an analyst, listening to a patient, conducts an inner, silent "running commentary," searching for hidden meanings, constructing "working models" of the patient, etc. The nature of this inner running commentary is hardly known and rarely studied systematically. The central goals of this study were (1) to propose a method for studying these cognitive and affective processes in the analyst and (2) to offer a preliminary model of what makes the analyst tick.

Although we did the empirical study first and then constructed the model, here I will describe the model first in order to make it easier for the reader to assimilate a very unfamiliar kind of clinical material.

2. The Schematic Model

Figure 1 is a schematic model of the psychoanalytic interaction as seen from the analyst's point of view.

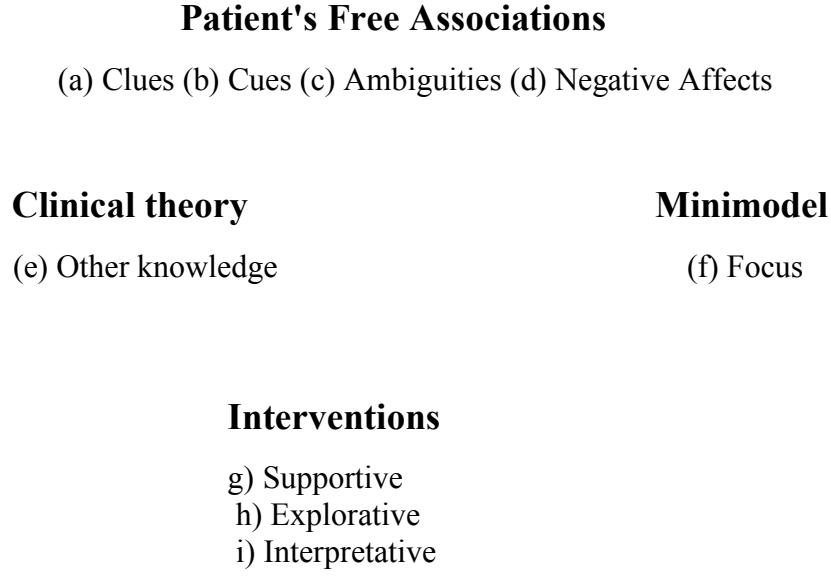

Figure 1 A Flow Chart of the Interaction in the Analytic Process

Classification of the Information from the Patient's Free Associations (a, b, c, d)

The model stipulates that the analyst classifies the free associations into four broad categories: (a) clues, (b) cues, (c) ambiguities and (d) negative affects. Clues are patient statements that the analyst classifies provisionally as an example of certain clinical concepts, which function as prototypical minimodels, e.g. "The patient has a distorted cognition that there are only rulers and slaves," might be classified as sadomasochism. Cues are statements that the analyst classifies as new instances of the same minimodel, e.g. "Making the strong leader even stronger by overlooking his weakness." Ambiguities are statements that the analyst has not yet clearly categorized, e.g. B 3.6: "... I could not make very much of this dream, therefore I ... asked her to associate to this and that detail... ." Negative affects include such feelings as anxiety, discomfort, helplessness, feeling rejected, sadness and worry, which are clear examples of Dahl's (1978) negative ME emotions, whose function is feed-back information about the status of the patient's important wishes.

Clinical Theories and other Knowledge (e)

Ramzy (1974) has argued that a psychoanalyst follows "general principles of reasoning" and hence is "a therapeutic logician or a logical physician." Our data point to the contrary: psychoanalysts employ a highly special set of conceptualizations, quite different from Ramzy's "general principles of reasoning." Their competence seems to lie both in their special theories about the nature of human conflict and in their detailed knowledge about specific patients. It is in this domain of clinical theory where most of the battles among schools of analysts originate.

Minimodels and Focus (f)

"Minimodels" is a substitute expression for Greenson's (1960) "working model" of the patient. However, in agreement with Bowlby (1969) and Peterfreund (1975) the use of the plural is deliberate and meant to convey that an analyst does not employ a single conceptualization, but rather a set of different models to organize his understanding at any given moment. "Mini" indicates that the models actually identified in our retroreports are rather small and circumscribed.

If and when the analyst believes that a certain minimodel has therapeutic potential it becomes a "focus" (see Fig. 1). Such a focus is then given preference for cognition and intervention. Once a focus has been formed the analyst scans the patient's report for "cues" for his focus (see Fig. 1). Hence there is an implicit strong tendency in this model for the analyst, once he has constructed any focus, to perceive what were formerly clues as cues, thus reinforcing his prior theories. To a lesser degree this applies equally to a minimodel and tends to lead to making interpretations based on that particular minimodel (Bowlby 1979).

Interventions (g, h, i)

Three types of interventions are stipulated in the model: (g) supportive, (h) explorative, (i) interpretative. The implicit theory claims that: (1) negative affects tend to evoke supportive interventions, (2) ambiguous statements give raise to exploratory activity such as asking for clarification and (3) successful classification of clues and cues into minimodels or foci leads to interpretations to expand the patient's knowledge.

3. The Empirical Study - Method

Because we wanted to find out what the analyst was thinking during the sessions that was not reflected in his interventions, we asked analysts to dictate a two-part *retroreport* immediately after each session at the end of the same tape that recorded the hour. Both of these were transcribed.

Free Part: In this portion the analyst was asked to free associate, with the hope that his wishes, frustrations, therapeutic plans, personal problems aroused by the patient's remarks, etc., would show up .

Structured Part: In the second part, called the *"explanation of the intervention*," the analyst's task was to identify three interventions (among all those that he made during the hour) which he thought were most important. "Important" was loosely operationalized as "inducing change," in the topic or affect or leading to fresh material. For each of these he was asked to state: (1) the source, (2) the aim and (3) the actual time during the session when it occurred. By "source" we meant a wide range of the analyst's knowledge including theory and his own and the patient's past and present associations. By "aim" we meant what he wanted to accomplish with the intervention at that very moment.

Our sample of psychoanalysts was derived from twenty German analysts, all known for their research interests, who were asked to participate. Only three agreed to do so. In Table 1 the total number of sessions recorded, the number of hours retroreported, the number of retroreports missed (for various reasons), and the numbers of the recorded sessions are listed.

Table 1

Analyst	No of sessions	Hours reported	Hours skipped	Hour Nos.
A	21	14	7	436 - 457
B	630	620	10	1 - 630
C	12	10	2	1 - 12

For obvious reasons the initial twelve sessions of one patient cannot be compared with sessions 430 to 460 of another. Our study was designed to compare separately the first ten retroreports of analyst B and C with each other and sessions 430 to 460 of A with the same numbered sessions of B; and within B to compare early versus late hours. However, here I will only report some selected comparisons of the first ten hours of analysts B and C.

4. Data Analysis

The first step in the data analysis consisted of marking homogenous topics[1] in the retroreports and grouping them into similar topic categories. This yielded nine topics which, though not exhaustive, included the intuitively satisfying categories shown in Table 2.

[1]Each topic was numbered according to session number and its sequence in the session; for example, B10.9 designates analyst B, hour 10 and the 9th topic within the retroreport of this hour.

Table 2 Topic Categories in the Retroreports of Analysts B and C

Impact of the study situation
Minimodels
Sources for interventions
Aims of interventions
Transference
Registering changes in the patient
Counterreactions
General descriptions of the session
Reflections on technique

The raw number of these topics reported by analysts B and C is shown in Table 3. The obvious differences in the frequency of the topics is a likely result of the difference in the length of their retroreports. B's retroreports were 3 to 6 pages long, while C's were only one page on the average. Time and space do not allow a complete presentation. In order to illustrate the method and the usefulness of the information gained by means of our retroreports I will only present the results of the first four categories of Table 2.

Impact of the Study Situation

The conditions imposed by our study design obviously had their impact on the participating analysts. However, the two analysts, B and C, differed markedly in the way they reacted to and fulfilled the instructions. B indicated the many ways in which the experimental procedure was stressful for him, while C' s reports did not offer a single clue about how he was influenced by the situation. In contrast, B's actual interventions in the session were well-formed prose, while C's were often ungrammatical and filled with false starts, etc.

Table 3 Number of "Topics" Discussed in each of B's and C's first available 10 Retroreports

	Main topics		Sub-topics	
	B	**C**	**B**	**C**
Session				
1	4	rm	1	rm
2	11	3	0	0
3	9	7	1	0
4	12	4	2	1
5	7	4	4	1
6	8	rm	4	rm
7	10	3	0	4
8	11	6	2	0
9	6	5	2	0
10	11	5	5	1
11	na	11	na	0
12	na	5	na	0
Sum	89	53	21	7

Key: A sub-topic is a topic embedded in another topic
rm = recorder malfunctioned; na = not analyzed

Minimodels

Analyst B, in his first two retroreports, made three psychodynamic formulations, which he classified as an hysterical wish for acceptance:

B 1.4 She intends to make herself smaller than she is; . . . It's important for her that the analyst likes her and she believes that the analyst expects more from her than she can offer.

B 2.4 We are in the middle of a hysterical need to be accepted, and only at its surface . . . In the intervals I pondered about . . . Hoffmann's . . . guidelines of the hysterical character. This frenetic, "I want to be loved – if I am not loved, I am nothing." Or "because I am nothing, I must be loved to prove to me and the world that precisely I am not nothing." Some formula of this sort that I cannot get together.
B 2.11 You believed you had lost your mother's love.

A new minimodel, sadomasochism, began to emerge in session 4:

B 4.5 The patient has a distorted idea that there are only rulers and slaves.

B 4.9 I suddenly have the feeling the patient is saying something like: "There are only masters and slaves, and there are brutal rulers and mild rulers. I (patient) am a mild ruler so that others can not rule brutally over me."

B 4.12 To cajole men is dangerous. They may start manipulating you.

B 5.6 Because there are only rulers and subjects, there is a constant struggle for power . . . The focus is not right; it leaves out that the patient enjoys being raped in daydreams.

B 6.6 Initially you make yourself helpless and ask for guidance; only later this irritates you and you rebel.

B 6.7 "Making the strong leader even stronger by overlooking his weakness."

B 7.1 So there are two Lisa's, one who wants to be led and for this makes herself weak; another Lisa says: "My ideal is the opposite. I myself want to be leading."

B 8.9 The patient believed her father unswervingly, that an adult's life consists only of trouble and punishment, and this blind faith has to do with master and slave and being led.

Looking at the repetitions of these two minimodels reported for the first 8 sessions we observe a shift from a mini-hysterical model to a mini-sadomasochistic model. In B's retroreports he did not explain how he explained the shift to himself (cf. with the CCRTs in Luborsky, this volume). However there is circumstantial evidence: B retroreported in 3.7 ". . . this is an intervention which somehow pulls in the known problem structure of the patient . . . masochistic fantasies and also the sexual defense . . .". And in 4.12 B reported, "Thus I have combined the need for acceptance of the patient with the fear of men who might rape her." Since there were no sadomasochistic cues in the first two sessions B must have known about these from his intake interviews, which, very probably, made him formulate a sadomaochistic model. However in the first two sessions acceptance needs predominated. Accordingly B formulated such a minimodel. In session 3 (and more strongly in session 4) sadomasochistic clues appeared, and could soon be combined (in B 4.12) with the acceptance model.

Two other minimodels were referred to in the material; the first pertained to a completely different kind of concept, namely, the patient's

resistance because she did not want to tell a dream (B 9.5). The other, ambivalence, could as well be classified as an example of sado-masochism, as in the following two examples:

B 7.6 and ***B 10.5*** The analyst assumes an ambivalence minimodel for the phobic anxiety of the patient, that her husband could have had an accident. She wants to be rid of him to be free to develop, but she is afraid she is too weak to succeed without his protection. Even this could be seen as: the slave wants to dethrone her master and be independent, but is afraid she will be lost without a patron.

Analyst C's minimodels appear far more diverse with much less repetition than B's, as illustrated in the following sequences:

C 2.2 The patient's defense against needs for exhibition and being liked.
C 3.3 The patient's wholesale confession to his wife of his own adultery served two purposes, (a) to relieve himself, and (b) to pressure his wife.
C 3.4 An aggression inhibition and its reversal into passive submissiveness.
C 4.1 The patient's not asserting himself, so as to make himself liked, stems from his childhood experiences as a refugee.
C 5.2 My fee regulation is perceived by the patient as anally castrative and the patient's body schema is an expression of castration anxiety: nose = penis.
C 5.3 The patient has to intensify this to remain a victim.
C 5.4 A very impressive connection between symptom formation and unconscious fantasies, which are related to activity of the right arm and the anxiety that others perceive this and despise him.

Retroreport C 5.4 is highly condensed. The transcript showed that patient C reported two dreams of automobile accidents where he was severely wounded. The analyst then recalled that the patient reported earlier of feeling physically deficient. The patient described at some length the alleged malformation of his nose and then complained of pains in his right arm which usually preceded a torticollis attack.

C 7.3 Analyst C speaks of the masochism of the patient, neither going to a doctor nor taking a pill to alleviate his backache.
C 9.4 An ongoing oscillation between masochism and rebellion.

C 8.5 As he is very superego determined (see his remarks concerning belief and his religious attitude) I am afraid that after such an outburst he would have to suffer additionally under the pressure of his self reproaches.

C 8.6 The patient could not stand separation (informal or legal) from his wife.

We may raise the question of whether it is possible to construct a more encompassing and coherent model from the given elements? Indeed I think any experienced analyst could, e.g. castration inferiority engenders submission (one form of masochism) and inhibition of exhibition (because of anxieties to be found out being deficient). Both are reinforced as a reaction formation against aggressivity by the social fact of being a refugee. Submission is secondarily ideologized (more precisely christianized) as the victim being morally superior to the aggressor. All this is embodied in a strong superego.

However, there is no evidence from C's retroreports that he consciously formulated such a coherent integration (or another) of these minimodels, which then would be an example of a Greenson "working model."

Another minimodel seems to be an example of Mitscherlich's "two phasic defense operation":

C 11.6 There is a remarkable resurfacing of blushing anxiety, which had for the time being completely disappeared after the development of torticollis.

B's and C's reported psychodynamic patterns were of uniformly low complexity. Neither analyst spelled out a larger working model (gestalt) in a single coherent formulation. Frankly, it surprised me that minimodels appear to be all that these analysts reported under the conditions of this experiment.

The question then is, since we know - as shown above - that analysts do indeed construct larger models, when and under what conditions is this done? I presume that such more encompassing working models of a patient remain preconscious until in what Heimann (1977) called a third "ego configuration," such as a candidate reporting to his supervisor, the supervisor instructing his candidate, an analyst preparing a paper or presenting it to a case conference, or filing a health insurance claim.

In the preceding paragraph I used the term "preconscious." Indeed it is highly plausible that composite larger models like <hysteric-phobic-acceptance needs with a sadomasochistic pattern> or <reaction formation against castration inferiority with symptom formation and an inhibition of exhibitionistic wishes>, are part and parcel of analysts' everyday thinking. Although such composites may well have influenced our two analysts, remarkably, they were not consciously verbalized. I surmise that minimodels are both necessary and sufficient in the here-and-now situation of therapy - and more would potentially be harmful - because all encompassing conceptualizations would risk overtaxing the patient.

Sources of and Aims for Interventions

Sources and aims will be discussed together because they relate to the same intervention, thus allowing a more integrated and parsimonious description. Both analysts were rather lax in respect to the "explanation part" of their retroreports, as illustrated by B's comment:

B 5.5 Yes – oh no – . . . I have not read . . . the instruction for the homework . . . Thought I had them in my head . . . And today I read them through . . . I should also explain my interventions, not only label them . . . Yesterday I did do it in a way. Today I will try to make amends.

In contrast to B, C, in his brief reports, did not clearly distinguish between the two tasks.

Analyst B's comments about sources reflected an impressive variety:

B 4.2 Another patient who had this mechanism
B 4.5 The image of the raging and terrorizing father
B 4.8 The patient's description of how she controls men
B 5.7 The transference concept
B 6.7 The patient described overlooking her strong girl friend's weaknesses.
B 9.2 The resistance concept
B 10.6 Learning theory
B 10.7 Pornography

A similar variety seemed to exist for aims:

B 4.11 Counteracting the negative transference
B 8.10 Show her that sex is a topic
B 10.7 To make her feel better and support her
B 10.8 To reduce anxieties

Let us now examine B's retroreports about sources and aims in detail through the ten sessions. In the first two sessions B was clearly anxious that his patient might flee, as she had several times before.

B 1.1 Although, I must say, I said more than I usually would say in a first hour, simply not to let the patient wait too long for a response. I must say that in other cases I would allow a bit more frustration.

B 2.2 . . . I made . . . perhaps half a dozen supportive interventions. But much less than in the first session, where I had the feeling that I had to carry her along.

These examples suggest both an aim and a source. Manifestly his aim was to support, comfort and protect her so that she would stay in treatment. We might speculate that the source of these anxieties were related to B's investment in the patient as a research case.[2]

In session 3 the patient reported a dream in which three dangers appeared: (1) F. J. Strauß,[3] (2) men from the local red light district, and (3) a spider. B then reported:

B 3.6 Beyond this I could not make very much of this dream, therefore I asked a lot of questions and asked her to associate to this and that detail.

When B asked for the patient's impression of Strauß he referred to him as "Landesvater (father of the country) Strauß," which prompted the patient to reminisce about her own father. To the spider the patient associated to her brother. B then made an interpretation and retroreported:

B 3.7 "Then all the dangers in the dream seem to be men." This is the most important intervention, not because the patient reacted to it or that I was quite sure of the meaning. But I believe this is an intervention which somehow pulls in the known problem structure of the patient. The feeling and these – yes – masochistic fantasies and also the sexual defense against the husband and all these things. She needs two men. Her husband must not look at another woman and all these (inaudible) and masochistic things. Yes, this thus would be the most important intervention.

In this passage it seems clear that B used a minimodel, <hysteric sadomasochism>, that he arrived at during the intake interviews; the aim was to help her see that all her fears were of men.

[2]As a matter of fact, patients (i) with a classical neurosis, (ii) with marked impairment, (iii) a reasonable prognosis for psychoanalysis, and (iv) no previous psychotherapy, who were also willing to consent to tape-recording and research were few and far between.

[3]The well-known Bavarian prime minister.

In the fourth session B, perhaps reflecting his uncertainty about the meaning of the dream in 3.7, recalled the fact that the patient associated to her own father after the analyst had referred to Strauß as the Landesvater and then reported:

B 4.5 I thought of the patient's father as the archetypical beer-drinking Bavarian. I think I have produced a bit of a Rosenthal effect.

Later the following exchange took place:

B: The brutal tyranny, that you fear from men, you react to by becoming the victim.
P: I am not a victim; instead I am pretty aggressive.
B: So, you meet force with force.
P: (14 s pause) Hmm. (12 s pause).
B: So men do not rape you. You rape men.
P: (14 s pause) Mmhmm, but not sexually.

As a source for this B mentioned :

B 4.8 The patient's description of how she controls men.

Then he described his third important intervention and gave the source for it:

B 4.12 "The dangerous men have to be cajoled, so that they become kind and approving." Thus I have combined the need for acceptance of the patient with the fear of men who might rape her. I then continued, "This procedure has its drawbacks. If one cajoles men, they might easily get the idea that one is a victim, inviting manipulation or domination." This is also an interpretation, I would say, which stems from clinical experience. There was another patient I once had with her relentless begging for love, who was often understood sexually or abused sexually, when she only wanted to be cuddled and rocked. I believe she was a kind of model, or played a role, for this interpretation.

The following exchange took place in session 5:

P: (Daydreams that one of her girl friends is raped and she catches this man and beats him until he gives up.) It must be pretty hard for me, since I dislike and am so afraid of men, to have any kind relationship with them. (2 minute, 24 second pause punctuated by several sighs)
B: Right now it seems that you're also having trouble with me.
P: I, no, I don't know, I don't think so . . . One – some men one sees only as professional colleagues or so. And I certainly do not see you as a man right now, but as a doctor or –

In his retroreport of this exchange B stated:

B 5.7 With this I wanted to point out to her that I too am a man. It struck me that she was silent today much more than usual. Or was she hiding something? . . . The interpretation did not bear fruit. In effect she said: "For me you are only a doctor and not a man." Still I believe it will have a sort of educational effect that I point out to her to that thoughts about me – or everything which happens – has to be seen on the basis of her relationship to me.

It seems clear that this is an example of the patient's resistance to the experience of the relationship with the therapist (see Hoffmann and Gill, this volume).

The minimodel, <negative father transference>, continues to evolve in each of the following sessions:

B 6.7 I told her, "You believe that anybody who dominates you has to be strong. And if you don't find someone, you simply make her stronger." This occurred to me (6 minutes earlier) when she denied the weaknesses of her strong girl friend.

And in session 7:

P: I still blame my mother that my father turned out like he did.
B: Yes, you think your mother is the real villain.

As a source for this B reported:
B 7.7 Said this mainly from theoretical considerations.

B 8.7 Came to my mind, "You look for a mild form of slavery" but this seemed too negative, so 1-2 minutes later I put it positively, "You are looking for a better father who doesn't drink and is not so domineering."

In the ninth session B retroreported:
B 9.2 Already in my mind: Is there something she consciously keeps secret? So when she said, "Don't you believe me?" (that her mind is blank), I was silent for awhile, let her fret and said: "A part of you must know something, otherwise you would not be so anxious. You think that what you don't know won't hurt you." Then she admitted that she had had a dream.

B continued to work with the PERT minimodel: <resistance to the experience of the relationship with the therapist> and he tentatively confronted the patient – and succeeded.

In the 10th session the patient reported that for the first time in her marriage of 8 years that she, instead of her husband, went out to buy breakfast rolls. B intervened: "It almost looks as if this was a result of yesterday's session that you got the rolls today." The patient acquiesced and suggested that freedom probably begins with little things. B made her repeat this and then emphatically said, "Exactly."

B 10.6 Here I am obviously somewhat infected by learning theory when I find this to be the most important intervention.

It may come as a surprise that in the midst of a resistance situation as portrayed by the quotations and retroreports of the previous sessions, the analyst was "infected" with a well-known hobby horse of his. Whatever the merit of his <learning> minimodel for the understanding of this situation is, it underscores the patient's concept that this is a process of many small steps.

In contrast to B, analyst C's brevity in reporting is illustrated by his complete retroreports of session 2:

C 2.1 My interventions had two aims. For one I tried to help the patient familiarize himself with the analytic situation. This aim was served by my initial encouraging remarks.

C 2.2 It was above all about focusing on his defense against his need for recognition and exhibition. The patient acknowledged these interpretations positively. I believe that his repeated confirmations were correct – correct – altogether emotionally authentic and I see in it the relevant interpretations of this second hour.

C 2.3 The later questions served to orient me about his work situation and furthermore they also naturally had the aim of pointing out to the patient that I am also interested in this area. End of the retroreport.

C mentioned four aims, but no sources. Nonetheless when I examined the transcript it was easy to find plausible candidates for sources. However I will abstain from speculation. From the retroreport of session 3 I quote only those passages that related to sources or aims.

C 3.2 In the beginning of the hour I focused on the working alliance.

C 3.3 Theoretically the topic of his general confession to his wife was probably the most important. From this I deduced that the patient couldn't stand it any more and therefore unburdened himself on his wife, evidently quite permanently, even though the relationship had eased in between.

However, if we look at the actual interventions, C took a different line:

C: Uhm, you had also connected your somewhat specific confession with your general confession that, uhm you – that this is, uhm, will give up the other relationship – that you –
P: Yes, uhm.
C: With this, uhm, through the with the, confession, uhm, you wanted to control yourself in this way.
P: Correct.
C: Is it?
P: Yes, yes, yes, yes.
C: So that no one else will attract you.

Thus C actually interpreted that P informed his wife in order to erect a barrier against his own adultery. The discrepancy between transcript and retroreport lies in the fact that the actual intervention stressed the patient's need to control himself with the confession, whereas the retroreport emphasized the unburdening and aggressive function of the confession.

This is one of several examples found in the present investigation that a psychoanalyst's dictated report - even immediately after a session - may be prone to serious distortion. There is ample evidence that this is unfortunately equally valid for reports made during the session (see Meyer 1981).

Later in the same session, as the following sequence of paraphrases of C's interventions shows, the sources and aims of a new topic emerged:

C – Repeats selectively that the patient feels entitled to ask for a raise because of costs of his illness. Then explores the reasons for and amounts of these costs. Subsequently points out that it is easier for the patient to beg for support than to demand reward for work, and reminds him of concrete examples of his extra efforts at work. Then explores the amount the patient wants, how much it is relative to his basic salary and what the chances are of getting it; learns that the raise is very small and there is a very good chance of getting it. Finally C said, "Thus, what I mean is that it is easier for you – yes, perhaps I exaggerate a bit – to act like a beggar than to, uhm, fight for something you've earned, isn't it, with, uhm, uh or uhm?"

And C concluded that this problem had existed before, but that the illness made it worse. He then retroreported:

C 3.5 His inhibition of aggression and the reversal into passive submissivity became distinct in connection with his inability to argue for a wage increase for his extra work. He has an idea that he can argue with his superiors using his illness and what it costs him. My references in the middle of the hour were addressed to this.

The sources seemed to lie in the clinical material itself and the minimodel of <passive aggression> is everywhere. C's aim was to try to help the patient understand this.

After session 4 he reported:

C 4.1 The theme of the hour culminates at the end in P's insight that his trying to make himself generally popular has its roots in his experiences as a refugee child. My interpretations led to this development, which I had intended. In the middle there was the topic of making oneself popular, not being able to be direct because this is too closely associated with being aggressive. Right at the beginning of the hour I made some references to this which I repeated during the hour.

C 4.2 Also it was important to me to make him aware that – for his own relief – he has to become forceful, because when he feels under pressure he relieves it by getting angry.

Up to this point C's strategy seems to have been to actively analyze the patient's conflicts based on the here-and-now transference manifestations and his prior clinical theory. But in the next report there was another aim:

C 4.4 Also important to me was – and my questions were aimed at this – to collect genetic material, because as of now I still know very little of the patient's history and his – and the vicissitudes of some of his typical behaviors.

In session 5 the topic of money entered into the transference in C's retroreport:

C 5.1 Especially important are those transference interpretations, which I made, of a small detail, namely the patient's concerns about the fee. The fact that he has to pay his own money for the treatment was quite certainly experienced as anally castrative by the patient. Another topic was also important in the hour – especially his disturbances of his body schema as an expression of his castration anxiety: nose = penis. I felt it was important to make an interpretation about this equation. In addition, these feelings are so strong for the reason that he could not argue with me and had to remain a victim.

C 5.2 These interpretations naturally had the aim of mobilizing his aggression.

From the last two retroreports I now offer a reconstruction of what made C tick. He took his patient's reaction to having to pay the fee himself as an example of the minimodel <anal assault>. In the transcript there are many other instances of a variant of this model. These refer to hypochondrical preoccupations with the size of his nose and his penis, classifiable into a minimodel of <castration anxiety>. The aim of C's interpretations was to point out to P the defensive strategy of remaining a victim, e.g. <if I submit, he won't attack>.

Editors' Coda:

It seems to us that this reconstruction is an excellent example of the fact that Meyer's model has captured the pervasive tendency in the analysts' mental processes to represent free associations as *cues* rather than *clues*. It thus highlights Bowlby's (1979) claim that the task of the clinician lies in maximizing the value of positive evidence, whereas the task of the researcher lies in maximizing the value of negative evidence.

Author's Coda:

I am deeply obliged to the three contributing psychoanalysts for their courage in submitting to the novel conditions of this investigation – conditions not generally accepted in the psychoanalytic community – and for their dedication in spending additional time and effort for research. I can only hope that they will feel that the findings constitute a reasonable, or even a good result. Equal thanks are due to the patients for their willingness to share their intimate secrets with unknown observers in the name of science. Even if they could not foresee the full extent of their commitment when they consented, none of them withdrew as they became aware of it.

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