

THE PSYCHOANALYTIC PROCESS AND ITS COMPONENTS

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Certain problems in defining the psychoanalytic process emerged during the five years in which a COPE study group was attempting to clarify the concept. There was agreement about the bed-rock criteria to be included in a definition: e.g., transference, resistance, a dynamic unconscious, intrapsychic conflict, defense, infantile sexuality, insight which causes change and change which brings insight. The disagreements centered on the locus of the psychoanalytic process, the best way to conceptualize change, and the methodological problem of validating whether specific interventions cause specific claimed effects. Confusion about how to account for the interactional aspect of the psychoanalytic situation in a manner consistent with a one person psychology emerged as an important source of the difficulty in arriving at a satisfactory definition of the psychoanalytic process.

THE JOURNEY, NOT THE ARRIVAL MATTERS.
MONTAIGNE

It has long been obvious that we must be able to define just how it is that we help our patients. We must be able to state this explanation in such a way that we can distinguish the advantages of psychoanalytic treatment compared to other forms of psychotherapy but also in such a way that we can decide within the domain of psychoanalysis what are the most meaningful differences between alternate theoretic models. Finally we must be able to demonstrate what clinical consequences, good or bad, follow from the use of each of the several currently rival theoretic models of psychoanalysis. For some time it has seemed to many analysts that there is one concept known by the name "psychoanalytic process" which could go a long way to answering all of these requirements.

Although Freud (1937) stated that we already knew the mechanism for the mode of therapeutic action in successfully treated cases and that we should focus our attention on the causes for our therapeutic failures, the majority of psychoanalysts no longer agree that this is so. There is in fact widespread disagreement about just what is the essential, irreducible core of the psychoanalytic process. Whatever commonalties there may be between the structural, object relations, self psychology, and developmental models there are some analysts who continue to feel that commonalties of terminology and political interest are masking substantial differences in theoretic frames of reference and clinical outcome. This was the climate in which the Committee on Psychoanalytic Education of the American Psychoanalytic Association established a study group of senior psychoanalysts in 1984 to address the problems related to ambiguity and confusion about the concept of the psychoanalytic process. The group met bi-annually for five

years; it was geographically diverse and balanced but each of the members could be described as "mainstream" in their theoretic orientation. It quickly became apparent that whatever unity of belief existed on many major issues there was substantial disagreement on a few issues which will be the topic of the major discussion in this paper. My purpose in this paper then is to give a report of some selected aspects of agreement and disagreement which emerged in this representative group of experienced psychoanalysts about the concept of the psychoanalytic process. My own bias may have caused me to have altered my reporting of some of these issues and this paper is in no way an "official" report of the proceedings of the study group. The discussions were spirited, illuminating, and highly useful. So many of these discussions exist in my memory in composite form that I may be failing in what follows to credit individual members for originating certain ideas; but the conclusions I have reached are my own responsibility and do not reflect a group consensus.

NON-PSYCHOANALYTIC DEFINITIONS OF PROCESS

The term "process" has numerous meanings in general usage. It is generally understood when used as a noun to denote a systematic series of actions directed toward some end. This is the hub meaning or point of departure for additional accretions of connotation. There are a few points about the semantic and etymological aspects of this term "process" as a general rather than as a psychoanalytic term which are relevant. The term "process" is both a transitive verb as well as a noun. One of its etymological roots is the past participle, *processus*, of the Latin verb, *procedere*, which means to advance. A ceremonial procession for example is an act of going in an orderly succession. Etymologists link the term "progress" to these definitions of process (Onions, C.T.; 1966). So process implies progression, and advancement towards a purpose. Some of the confusion about our psychoanalytic usage of the term "process" is related to the reifying consequences of using the term as a noun rather than as a verb. It is analogous to the problem we create by using the term "mind" as a noun rather than as a verb to describe our human capacity for mental functioning. The noun form introduces a powerful but concealed semantic push which thrusts us into the domain of noun things which exist in space somewhere

and away from the domain of functions which have no concrete spatial referent. The term psychoanalytic process is thus subject to the same confusion caused by inadvertent reification as is the term "structure" in the psychoanalytic lexicon. One of the consequences of using the noun form rather than the verb is the concealment of a reification.

The next point to keep in mind will be more clear if I first indicate that the psychoanalytic "process" has always shared with the general term "process" the implied meaning of an integration of whatever series of actions constitutes the process. Process is a felicitous term for any systems theory because it assumes that all the actions in any process are responsive to any change in any one of its component actions. This is certainly the shared and widely held view of many analysts regardless of their sometimes radical differences on many other substantive points. The second linguistic problem imposed on our notion of the psychoanalytic process is the unrecognized push of the singular form, in contrast to the plural, toward the loss of boundaries of all subordinate actions in the process. The singular form of "process" pushes toward a homogenization of levels of abstraction and collapses the conceptual pyramid of sub-processes into one layer: *the* psychoanalytic process instead of the psychoanalytic processes. We shall see this illustrated in the later discussion of the locus of the process. Having considered some implications of the noun/verb and singular/plural usages for the fate of our concept of the psychoanalytic process, I will mention one other point. It is not yet possible to adequately describe let alone systematically define numerous processes outside of the domain of psychoanalysis. Learning theorists would consider it a worthwhile achievement if they could *really* explain how we teach a child to tie his shoes. The sophisticated theorist of learning would blush at the immodesty and naivete of the lofty phrase "educational process". Such a vague term as psychoanalytic process doesn't seem to have troubled many of the contributors to our vast literature on this topic. We have been told that the psychoanalytic process is a "recreative growth process", or that it is "the transformation of counter-cathexis energies to participate in integrative reorganizations". These are such abstract statements that they really could just as well be applied to normal development of the mind as to the psychoanalytic treatment situation. On

the other hand, a truly systematic definition of the psychoanalytic process would require that we state all of the sub-processes required for the total process to start, continue, and to conclude. But we are by no means prepared to do that yet. As an example, let us consider the memory functions of both patient and analyst as one of the sub-processes. We expect the patient to make pattern matches and comparisons. The ability to see that two experiences are similar is disrupted by isolating defenses, enhanced by diminished anxiety and is itself a very complex process. It is a functional capacity by no means separate from psychic conflict or from affective vicissitudes. The ability to see how two things fit together is a crucially important sub-process in the psychoanalytic process. There are more unrecognized, unnamed, silently operative sub-processes essential to the vast enterprise which we simply call the psychoanalytic process than those with which we are familiar. At this time we can only provide a reasonably useful but very incomplete map of the psychoanalytic process. The major purpose of this paper will be to discuss one of these poorly mapped areas, the so-called interactional aspect of the psychoanalytic process. I will argue that it is useful to utilize a *one person psychology* to enhance our understanding of the dyadic interaction between analyst and patient.

DEFINITIONS OF PSYCHOANALYTIC PROCESS

Although the study group met under the auspices of the American Psychoanalytic Association it was never instructed nor did the group expect to arrive at an absolutist definition representing the final truth or even an official definition which would carry the imprimatur of the Association. We merely wanted to arrive at some understanding of what the agreements and disagreements about this term were about. Nor did that mean that any member of the group was free of a strong personal conviction that his or her own views were more correct. It turned out that we arrived easily and promptly at a number of agreements but that certain topics were a recurrent basis for differing views. One could categorize the dimensions of the psychoanalytic process as the changes which take place in the patient over time as a result of collaborative interaction with the analyst. That is in fact not an acceptable definition of the psychoanalytic process but it has the advantage of conveniently grouping the elements of the psychoanalytic

process so as to sharpen the description of our agreements and disagreements. One can thus speak of the psychoanalytic process in terms of the activities of the analyst, the activities of the analysand and the elements of change (Abend, 1989). We easily arrived at a list of the elements of changes which had to occur before we would determine that a "true" psychoanalytic process had developed and concluded. I shall describe this list shortly. We questioned whether to consider the psychoanalytic process as a characteristic sequence of such events or results.

Obviously one can conceptualize the psychoanalytic process in many different ways. Freud (1913) said it could only be *facilitated* by the analyst. Kris (1956) called the process change over time. Adding to the complexity of defining the term psychoanalytic process is that it overlaps with such terms as the psychoanalytic situation or psychoanalytic treatment. The term psychoanalytic process also articulates with numerous other terms such as transference, countertransference, the working alliance, the mechanism of therapeutic action, and insight (Abend, 1989). Weinshel's (1984) valuable discussion of this topic indicated that the very idea of a psychoanalytic process evolved only very gradually in our literature and has received much more attention in recent decades than it did before. Since Weinshel offered a comprehensive historic review of the concept there is no need to discuss the history of the evolution of the term here. Weinshel emphasized the point that the term "psychoanalytic process" has only gained favor in recent years. It is a matter of no small interest to consider exactly why it now seems so self evident to many analysts that we must distinguish between psychoanalytic treatment and something embedded in that treatment which we designate as its process. Evidently the proliferation of competing theoretic models has left many analysts seeking "commonalities" from which a "true process" could be distilled. But very different "data" emerge when different theories are applied. That is another reason why I am in agreement with Weinshel (1984) about the futility of arriving at a definition of *the* psychoanalytic process.

RESISTANCE

Fully aware of the serious problems with such a misleading assumption Weinshel did not attempt a definition of *the* psychoanalytic process. Instead he offered a most valuable

description of the sine qua non for the definition of a psychoanalytic process: "Resistance together with its successful negotiation by the analyst, most often by interpretation, is the clinical unit of the psychoanalytic process" (1984, p.69). In my opinion our group was unable to improve his statement. It is relevant to indicate that there is considerable historic compression embedded in this "definition" of the psychoanalytic process because it is predicated on the concept of resistance, a concept which has itself undergone radical transformation parallel to the major improvements in psychoanalytic theory since its inception (Stone,1973). Modern structural theory can be distinguished from the tripartite model of 1923 and from the earlier topographic theory by its account of resistance. In modern structural theory resistance is not seen only as a defense; it is a compromise formation of which defense is merely one component. The task which is resisted is not only remembering but understanding the nature of imaginary dangers which were the original cause of defenses and the patient who resists is viewed to be struggling with painful conflicts rather than with the analyst.

Resistance is a term which implies a conceptual unity in a deceptive manner. Resistance can be defined in various ways because the term connotes phenomena and conceptual linkages on quite different levels of abstraction, but also with very different historic definitions as psychoanalysis has evolved. To borrow an analogy used by Freud (1930, p.70) in another context resistance as a concept is like the Santa Maria Supra Minerva, a church in Rome built over the ruins of earlier Roman and Greek temples. In one definition resistance can still be defined as anything which the patient does to oppose the psychoanalytic process. Since we predicate our definition of the psychoanalytic process on resistance how do we resolve the dilemma of defining a process in terms of its anti-process.? We simply say that this is a collision of two frames of reference residing under the same name. Does insight melt resistance? It can but isn't it true that insight is sometimes necessary to enable the patient to develop and *create* necessary and subsequent resistances? An example is the resistance of a patient who wishes to impress the analyst with his insight by articulate, intellectualized discussions of his own shortcomings. The insightful understanding of his need to avoid certain dangerous feelings allows

this patient to now experience painful affects which had been avoided and therefore to struggle with new conflict and therefore to construct his next resistance. Just as history has been defined as one damned thing after another so one can define the process of successful psychoanalysis as just one damned resistance after another. Serious problems occur when the process becomes arrested and stuck with just one resistance instead of moving on so there can be one after another resistance. Modern psychoanalysis for many years has recognized that resistance is far broader than defense. Brenner (1982) more than others has systematically explicated the view that resistance should be viewed as a compromise formation of which the defensive aspect is but one component.

I referred to insight and resistance as examples of sub-processes. It is by now clear that I reject the view that the vastly complex enterprise of psychoanalysis can be aphoristically defined in a satisfactory manner. The elastic ambiguity of Freud's original criteria of transference and resistance still seem a useful solution. After all we are trying to define the effects of a complex multi-layered treatment process on a group of emotional dysfunctions each of which is itself multicausal in origin. We will have to content ourselves with approximations in any definition of the psychoanalytic process. We hope at best for a "fruitful misunderstanding". But we wish to achieve an approximation which affords the maximum current potential for establishing a methodology for validation and disconfirmation.

DEFINITIONAL REQUIREMENTS

There are formidable requirements for a *systematic* definition of the psychoanalytic process which are so complex that we have yet to fulfill them. The first is to describe the most important changes effected by the psychoanalytic treatment. The second is to explain how these changes were effected. The third requirement is not strictly speaking an aspect of the definition of the process itself but it is essential to the *integrity* of such a definition. This third requirement is a methodology for the validation of the claims that certain changes have occurred as a consequence of the interventions stipulated by the definition of the psychoanalytic process. The first task has almost been fulfilled with the close of the first century of our science of

psychoanalysis. The second is the central topic of our current controversies and the third has yet to develop beyond a rudimentary beginning.

Not all analysts would agree that the methodology for validation must be a feature of the definition of the process itself. It is my own opinion that without such a methodology any definition of the psychoanalytic process will be inadequate. Neat correspondences between these three dimensions of the psychoanalytic process and consensus or disagreement within our study group did not occur. One could say that the simplest dimension with which the group could agree more than any other was the dimension of beneficial changes. As we shall see many changes which seem merely descriptive and minimally linked to explanatory theory are actually integrally linked to complex theoretical propositions. The "resolution of a resistance" is no merely observational description. The terms "resolution" and "resistance" are each linked to embedded causal explanations. But for purposes of this discussion I will simply say that I have chosen to organize an unwieldy, complex task of exposition by speaking of change, causes of change, and proof of the change claims as three aspects of problems related to defining the psychoanalytic process. Even then I will only deal with very narrow and selected sub-topics of each of these dimensions.

CHANGE

It is not difficult to compile a list of beneficial changes which must occur in the patient before we would consent to say that a psychoanalytic process had been experienced or that a patient was ready to successfully terminate psychoanalytic treatment. These are the changes that approximate the criteria of the Certification Committee of the American Psychoanalytic Association in their scrutiny of case reports of applicants who are trying to demonstrate their eligibility for certification as a psychoanalyst. These changes were summarized by Compton (1988). I will present them in a modified form.

CHANGES WHICH DEFINE THE PSYCHOANALYTIC PROCESS

1. Gradual and progressive revealing of historic material relevant to the presenting symptoms. A convincing demonstration of the links between childhood sexual and aggressive conflicts, both pre-oedipal and post-oedipal, and adult symptoms.
2. Unfolding in the transference of this historic material together with major conflicts in a manner demonstrating these childhood sexual conflicts in the dynamically emerging transference conflicts as resistance.
3. Cooperative interest in understanding the symptoms, associations, dreams, and behavior. This is in a misleading and reductive manner referred to by some analysts as the state of being "in analysis" to contrast this "alliance" with those patients who seem excessively resistant to being curious about themselves and disinterested in introspection. In my opinion the complexity of the psychoanalytic process precludes such a simplistic test of whether or not a meaningful and useful treatment experience has developed.
4. Relatively enduring change for the better in symptoms and functioning.
5. Change in the relationship with the analyst characterized by less disguised behavior and ultimately by more realistic patterns of perception, attitude, and behavior.
6. Appearance of dynamically relevant new material.
7. Appearance of regressive symptoms, less disguised behavior, to and fro shifts in "progressive" and "regressive" phenomena.
8. Shifts in images of the self, of family members, and of the analyst.
9. Changes in predominant thematic content.
10. Increased tolerance for the expression of sexual and aggressive derivatives, together with increased coherence and clarity of the associations, behavior, dreams, and communications of the patient
11. Increased resistance to regression under stress.
12. Improved capacity to cope with unpleasant affects.
13. Diminished need for self punishment.
14. Increased capacity for realistic gratification.

This schematic list is intended as an indicator of general trends rather than as a definitive catalogue. The list has the advantage of relative freedom from highly abstract theory and jargon and of grouping observable behavior in a manner which is useful for discussion. No analyst would agree with the inclusion of every item on this list and many analysts would wish to add items of their own preference. Nevertheless this list represents an approximate core consensus by mainstream psychoanalysts in the United States at this time. What is striking is the contrast between the ease with which this outcome list was compiled and accepted and the disagreements about how to explain the process that produced these changes. Most important is the even greater uncertainty and disagreement about the methodology for proving the claimed fit between various theoretic explanations with various observable outcome changes.

THE LIMITATION OF THIS SCHEMA

We are immediately confronted with a further problem. The organizational device of using change as an observable hub for the discussion of the psychoanalytic process is convenient but it obscures the simple fact that essential elements of the psychoanalytic situation are not even included in an outcome definition of the psychoanalytic process. It is not only that the outcome list of changes makes no reference to interpretation as the major intervention by the analyst which effected all the changes in the list. It was a "given", an a priori assumption by each participant in the study group that interpretation was an indispensable component in any definition of the psychoanalytic process. But there are other fundamentally important theoretic assumptions embedded in every one of the so-called observables on this list. E.g., the list in no way indicates that we all shared the view that the most important part of the psychoanalytic process which caused these changes to occur was the development and ultimate resolution of resistance. At a more fundamental level in this less visible pyramid of minimum definitional components of the psychoanalytic process we all agreed that the phenomena observed in the psychoanalytic process were predicated on the assumptions of a dynamic unconscious, infantile sexuality, the oedipus complex, intrapsychic conflict, and psychic determinism. To further illustrate the layering of the conceptual pyramid which we designate as the psychoanalytic

process we must refer to the psychoanalytic situation. We must find some way to include in any definition of the psychoanalytic process the inescapable core matrix provided by the unique psychoanalytic situation. Here I refer not only to the couch and frequency of sessions nor only to the principle of abstinence for both patient and analyst. All of this is well known. Instead we were like lepidopterists trying to capture in our definitional net an elusive creature: the essence of the psychoanalytic process, the essential feature that captured the sine qua non of the genuine psychoanalytic treatment experience. That we could not do so very well is no surprise, because the process is so vastly complex. To give only one example: what are we really attempting to say when we pronounce the verdict that a patient is or has been "*in analysis*"? Or when we say that another patient is not yet "*in*" analysis? Some analysts have a narrow set of requirements for their definition of "*in analysis*". They would say that the patient must be productively engaged in a collaborative effort to be genuinely curious and s/he must wish to achieve insight. But some patients simulate a facsimile of such attitudes quite early and only lengthy work reveals that this was a spurious impression. Still other patients seem to have not much insight until close to the end of their analysis. Many analysts would say that a patient can be described as "*in analysis*" when and if the analysis *contains* the major conflicts of the patient and if these central conflicts ultimately become meaningfully engaged as resistance in the transference. The clinical assessment that a given patient had actually been "*in*" analysis or more modestly had experienced a useful psychoanalytic process can sometimes only be made at the successful conclusion of the work of the treatment, but often it can be made sooner. The term "*psychoanalytic process*" as used in this paper is intended to be roughly synonymous with the less rigorous term "*in analysis*".

A brief recapitulation will be useful. The psychoanalytic process cannot be defined exclusively in terms of outcome nor can it be defined without reliance on highly abstract theoretic assumptions. Second, I wish here to emphasize the view that the singular term "*process*" should really be a plural term "*processes*" because the psychoanalytic process is actually an extremely complex hierarchy of sub-processes whose adequate description requires

a diverse mixture of frames of reference, levels of abstraction, theoretic assumptions, and descriptive, observable phenomena. It is also unclear in many instances whether sub-processes in the supraordinate psychoanalytic process are lower in level of abstraction, antecedent in causal significance, or both. E.g., the memory functions of the analyst are essential to his use of metaphor, context discrimination, and the correct understanding of the relation between context and contiguity of associations. These memory functions at the service of those tasks are antecedent to the ability of the analyst to formulate an interpretation and are inseparable from his capacity to listen empathically to his patient. The activity of formulating an interpretation is itself a process, and a most complex process as we know so well. I belabor these rather obvious points because in so many polemic discussions about the psychoanalytic process one feels that the one sided insistence on the inclusion of one element and the omission of another as essential to the definition is rooted in the erroneous and simplistic view of a singular, conceptually unitary process. We should instead think of the psychoanalytic process as more akin to other heterogeneous multimodal processes such as the learning process or the democratic process.

ASPECTS OF THERAPEUTIC CHANGE

I have said that it was a simple task to compile a list of changes which must occur before we would evaluate the outcome changes as the consequence of a true psychoanalytic process. Mindful as we are of differing views in other theories than structural theory we insist that to qualify for the designation "psychoanalytic process" the changes effected must have been principally the consequence of interpretation and insight effected by the mobilization and resolution of resistance. Although it has been recognized for more than thirty years that insight is both a cause and consequence of change (Kris,1956), some analysts would still omit insight from their own list of necessary minimal changes. Some analysts today argue that it is old fashioned to speak of insight as the cause of change. But many analysts, myself included, would say that this was tendentious. The relation between insight and change is not only reciprocal; it is not only that insight is both the cause and effect of change. There is also no simple or invariant

relationship between conscious insight and the complex components and consequences of insight which are beyond consciousness and recall.

Once again we confront the problem of confusion between the global abstract and the concrete detail, between "insight" which is a composite of major sections of analytic work and insight which is minor and local. As in the case of the noun "mind", so too the noun "insight" conceals a reification. The English language does not provide a verb form "to insight", but if it did "insighting" would more accurately render the connotation of the complex mental functions of self understanding which we reductively misrepresent as the noun "insight". For those analysts who consider insight to be only the result of change, insight is epiphenomenal and should be excluded from our definition of the psychoanalytic process. A pyramidal view of the multiple levels of the psychoanalytic process describes insight as both a sub-process and as an observable behavior, but also as both a cause as well as a consequence of change. It is noteworthy that insight did not appear on the above list of minimum necessary changes, perhaps because it was assumed to be an integral, embedded feature of many or most of the changes.

THE LOCUS OF THE PSYCHOANALYTIC PROCESS

Is "the" process within the patient and merely facilitated by the analyst? Is it within both? Is it located in their interactions? Obviously all the participants in the group were in agreement that the psychoanalytic process is interactional. Obviously to believe that the interpretations of the analyst have a potentially beneficial effect is to state that the process is interactional. The disagreement which emerged was not qualitative, but it was a meaningful quantitative difference in emphasis on what mattered most. It was a disagreement about where to place the emphasis on what was mutative about the psychoanalytic process, and whether or not to stress the interactional aspect or to reemphasize Freud's original view of the process located primarily in the patient which could only be facilitated by the analyst. In the climate of present opinion this will strike many as an ancient question, long since settled and others will dismiss it as the typical anachronistic and irrelevant musings of analytic dinosaurs. My own position is strongly "interactional" and my bias may inadvertently intrude on this discussion, but I discovered that

there are some important and still quite relevant and unsettled problems related to this topic. I shall refer to the view of the process which emphasizes the importance of the patient's experience as non-interactional and the view which emphasizes the interaction between patient and analyst as interactional. This is merely a matter of expositional convenience because it cannot be emphasized too strongly that all participants in this discussion considered it misleading to insist on an overly sharp or "either-or" distinction. Here a clarification is required. My use of the term "interactional" is straightforward, but my discussion will emphasize only that aspect of the reciprocal interaction which impinges upon the analyst at work. This is in order to artificially isolate this dimension of the analyst's work in order to contrast it with two other points of view. The first is the outmoded view of the analyst as an impermeable collector of data, the second is the object relations view of a "two person psychology", an "intersubjective field" or a "we psychology". My intention is to argue that there is abundant room within the boundaries of a one person psychology to account for important aspects of the "dyadic" aspect of the interaction between the analyst and the patient. Here we would do well to distinguish between attempting to refine our understanding of the interaction between two persons in contrast to shifting from the intrapsychic to the interpersonal domain of discourse and theory. It has been too often assumed that the requirements of the former necessitate such a shift in the latter; this has led to much confusion. It is the premise of this paper that the domain of psychoanalysis is limited to the intrapsychic sphere and that this is to be understood as true for any and all observations which I offer about the interaction of the analyst and patient in the treatment situation.

The arguments for the non-interactional rather than interactional emphasis were developed during our discussion in this way. Freud's original definition of the psychoanalytic process stated (1913,p.130):

"The analyst is certainly able to do a great deal, but he cannot determine beforehand exactly what results he will effect. He sets in motion a process, that of the resolving of existing repressions. He can supervise this process, further it, remove obstacles in its way, and he can undoubtedly vitiate most of it. But on the whole, once begun, it goes its own way and does not allow either the direction it takes or the order in which it picks up its points to be prescribed for it. The analyst's power over the symptoms of the disease may thus be compared to male sexual

potency. A man can, it is true, beget a whole child, but even the strongest man cannot create in the female organism a head alone or an arm or a leg; he cannot even prescribe the child's sex. He, too, only sets in motion a highly complicated process, determined by events in the remote past, which ends with the severance of the child from its mother."

Before pursuing my main topic, it is worthwhile to consider Freud's remarkable analogy for a moment. The patient is the woman who is impregnated by the analyst's seminal interventions at the beginning of the process which commences with fertilization and concludes with birth. Freud here certainly sets the precedent for down-playing any significance for whatever further activities which the analytic father might introduce. One can only conjecture as to what possible significance this analogic fantasy might have had for Freud. What is clear is the force of Freud's insistence on the primary locus for the developing fetus of the psychoanalytic process in the impregnated patient. Nor did Freud literally intend to ignore the numerous and continuing interpretations made by the analyst throughout the entire course of the analysis, even though in those days a pregnancy lasted longer than an analysis. Instead I think he meant to emphasize that for each intervention by the analyst a dynamic equilibrium would be altered within the patient and that the nature of this disequilibrium and its complex consequences immediately and later were outside the control of the analyst. Certainly much of that notion was valid and remains believable to many analysts although many others, myself included would say that it doesn't account adequately for the complexity of the interaction between the analyst and the patient which allowed the analyst to formulate the interpretation in the first place..

To this first protest of the "interactionists", the "non-interactionists" who locate the psychoanalytic process pretty much exclusively within the analysand a la Freud's 1913 model would bring forward a rebuttal of no small significance. Since the very beginning of psychoanalysis there has been a profound misunderstanding about the true nature of transference. The controversies about the views of Melanie Klein, Harry Stack Sullivan, and Heinz Kohut, to mention some illustrative examples, share one element. In each instance the nature of transference is viewed differently than that of the original definition by Freud of transference as "ubertragung". Freud's definition of transference depended on the view of a displacement of various mental contents from one object *representation* to another object

representation. Human beings have relationships with persons and never with object representations. In fact there are no "objects" in the real world. In the mind there are no persons: there are only mental representations of "objects" who were originally the object of wishes in the mind propelled by drive derivatives in the mind. To this day there are those who mistakenly believe that the Sullivanian notion of a participant observer is no different than the "participant observer" described by some contemporary psychoanalysts. There are numerous reasons for the regular resurfacing of this basic problem and these tendentious views of transference have led to grotesque experiments in technique since the time of Ferenczi and to serious misunderstandings about transference and technique which range from the corrective emotional experience of Franz Alexander to current polemics about the relative importance of interpretation versus relationship factors as the mutative factor in successful psychoanalytic treatment.

I belabor these points to indicate that the arguments of the non-interactionists contain a highly important fact which has evidently been necessary to repeatedly rediscover. The superficial view that we can simply assume that the "actual" behavior of the analyst is correctly perceived by the patient is misleading whether or not the intervention of the analyst was an "accurate" interpretation introduced in an empathic and timely manner or an inadvertent error. We can only infer what any behavior or intervention by the analyst means to the patient by a disciplined study of the patient's behavior, associations, dreams and actions outside the sessions. In the current climate of casual pluralism of theory it is simply taken for granted all too often that the patient will accurately perceive the "empathic warmth" of the analyst providing curative factors via the relationship itself.

As for the significance of the analyst's lapses of technique whether due to inexperience or countertransference, the non-interactionists would say something like this. Errors or lapses in technique are universal and inevitable but are not truly important unless they are serious, cumulative, or continuing. They don't have to be given much theoretic consideration if the technique of the analyst was "good enough" and if the psychoanalytic process was not

irreversibly derailed. We know as an empirically verifiable fact that analysts can have brilliant therapeutic results in spite of these ubiquitous minor lapses. Further, it is difficult enough to attempt to describe the complexity of the patient's participation in the psychoanalytic process let alone to give a truly accurate, honest, and comprehensive account of the entirety of the subjective experience of the analyst. According to this argument, the recent trend toward public revelations of the "countertransference" are at best deceptively honest. Those revelations are said to be merely superficial and safe, edited versions of what really went on in the mind of the analyst. At worst these are dismissed as exercises in exhibitionistic masochism.

Another argument by the non-interactionists went this way. Freud's 1913 view was essentially correct. The influence of the analyst is important but only *secondary*. The earliest analysts weren't as knowledgeable as we are but their patients developed and participated in a psychoanalytic process. That's because those first patients believed that candor would help them, they believed that relating their past to the present would help them; but above all they were prepared to endow the analyst with transferential attributes. So even if the analyst was a member of the first generation of pioneers or a contemporary student who was untrained there would still be a psychoanalytic process in the patient because analysands show certain manifestations invariably which are unrelated to the nature of the "observer's" participation. It is the aggregate of these invariable phenomena which are not dependent on the interpretations or interventions of the "observer" which should be called the psychoanalytic process. This was the most radical expression of the non-interactionist view. (Even more radical was the view of Menninger and Holzman [1973] of the ideal analytic patient who could successfully traverse an entire analysis without the necessity of the analyst ever having had to utter a single word). In the less radical non-interactionist view the total influence of the analyst's interventions is considered to be highly important but still only secondary. To be sure, according to this view, one could easily compile a catalogue of the proper behaviors of the analyst required to effect a successful outcome. One could for example easily agree that if the analyst were to be critical and judgmental he could derail the treatment. But such descriptions fail to capture the elusive aspects

within the patient which lead to enduring change. In other words according to this view the analyst is making a major contribution to the psychoanalytic process in the patient by a negative act; by not obstructing or interfering with the patient's efforts to advance and progress within his own psychoanalytic process. According to this view the primary issue which defines the psychoanalytic process is the manner in which the analyst responds to his experience within the analytic situation. The inner response of the analyst according to this view is enormously important but it does not constitute valid evidence about the nature of the *patient's* experience. What is important in order to understand the patient's participation in the psychoanalytic process is what the patient experienced in the psychoanalytic situation and how the patient reacted to that experience. So in this sense it matters little whether the patient has correctly or incorrectly perceived some behavior of the analyst; e.g., whether the analyst was really smiling when he said hello. The actual behavior of the analyst from the most trivial clearing of his throat to his most important interpretations, from his most useful to his most disadvantageous behavior is profoundly important but only in a matter which is secondary to knowing what this meant for the patient. The primary factor which governs the outcome of the treatment for the patient is what the patient perceived and how he perceived it. If the analytic theorist who proposes a definition of the psychoanalytic process is naive enough to believe that therapeutically intended empathic benevolence is not only correctly perceived but also directly "metabolized" then that theorist is describing a very different psychoanalytic process such as encompassed by the corrective emotional experience.

THE INTERACTIONAL VIEW

It is still true that psychoanalysts in theoretic disagreements behave like any other human beings. Our meetings and literature illustrate the ubiquitous presence of polemics and the use of straw men. The attitude of many analysts who espouse an interactional definition of the psychoanalytic process is to dismiss the non-interactional view as the anachronistic death rattle of those same archaic analysts who still speak of metapsychology. The straw man here is the misleading equation of the "closed Freudian baby" (an organism unrelated to the real world of

persons, merely seeking discharge opportunities) with the "closed Freudian patient". Just as the closed baby could only relate to its quasi-hallucinatory object images instead of the real mother so we are told by some object relations theorists that the above arguments are all that one would expect from analysts who still adhere to the view that the analyst is a mirror whose own participation need never be considered let alone reported as part of the psychoanalytic process. A further straw man is to attribute to the non-interactionists the rigid view of the fifties and sixties in which the only permissible "proper" or "true" psychoanalytic intervention was the question or the interpretation. Even the last statement is a quite tendentious view of the literature of that era. In the study group those who espoused the non-interactionist view were the first to describe detailed case reports prepared by themselves twenty-five or thirty years ago as outdated precisely because those reports omitted any reference to the subjective reactions of the analyst. Yet for the non-interactionist the subjective experience of the analyst relative to the psychoanalytic process within the patient is rather like the relation of consciousness to underlying neurophysiologic processes within the brain. Consciousness cannot be ignored said the neurophysiologists not so long ago but it is an epiphenomenon.

In my own view there is an artificial quality to the dichotomous insistence on a primary versus secondary stratification of the importance of the patient as compared to the analyst. The fact that it is so much harder to know the subjective experience of the analyst is no argument for abandoning our interest in the antecedent events which lead to the visible intervention by the analyst. The argument that the actual intervention is so often misperceived does not prove that the ubiquitous presence of *correct* perceptions by the patient can be relegated to the secondary let alone deemed irrelevant. Why else would interpretations have any effect? Furthermore the ubiquitous incorrect perceptions of the patient are not only passively perceived; they are often urgently and actively obtained and achieved as the consequence of momentous efforts by the patient to discover whatever behavior the patient can provoke from the analyst as the "basis" for the incorrect perception which the patient seeks. There is much to be learned from the myriad of

such "incorrect" behaviors by the analyst which shed important light on the manner in which meaning is forged by the analyst in this crucible of interaction.

My own opinion is that transference and resistance remain the core of any definition of the psychoanalytic process. Furthermore I am convinced that the transference as *resistance* in any specific case is unique and would never and could never have developed in the identical manner, form, or sequence with any other analyst. *In fact the manifest form of a resistance is even sometimes unconsciously negotiated by both patient and analyst.* I am suggesting here a type of adaptive or benign iatrogenic resistance. The analyst in such cases is almost always the first to recognize the presence of the resistance as well as his own participation in it. I am not referring here to cases in which the analyst acknowledges some shortcoming or some lapse in objectivity. Instead I have in mind complex and lengthy sequences of interaction which only gradually become evident to the analyst as a resistance in the patient to which the analyst has in some more or less subtle way contributed by his own behavior. The phenomenon to which I refer seems to me to include countertransference but transcends that concept. I am proposing that certain "countertransference lapses" can be viewed as compromise formations utilized creatively but without initial conscious awareness by the analyst in the psychoanalytic situation. My distinction here is again about frames of reference. Countertransference is exactly like transference in that it connotes the link between the childhood conflicts of the analyst with his behavior toward his patient. Analogously, sublimations can be viewed as linked to drive derivatives. But in a different frame of reference they are viewed as culturally valued behavior. And in this analogous other frame of reference it is useful to view certain behaviors of the analyst which actually joined in the creation of a "useful" resistance as a creative contribution by the analyst which was necessary only for him and would not have been necessary for another analyst. I do not see how we can dispense with a better way to account for the sense of struggle that every analyst must go through in every analysis with every patient than is afforded by our present simple views of countertransference. If there can be no analysis without resistance by the

patient then it is equally true that there can be no treatment conducted by any analyst without counterresistance or countertransference sooner or later.

From a different perspective it has been said (Baranger, M. et al, 1983; p.10): " 'He who doesn't cry doesn't get cured' and even, thinking of the analyst, that he who doesn't cry doesn't cure." The analyst must be emotionally engaged with his patient in an equidistant manner across many fronts. A respected colleague once put it this way: "the analyst must have a tough mind but a soft heart". It is in this sense that I propose that we view resistance as the joint creation of patient and analyst in a number of instances that are not necessarily a manifestation of a disadvantageous countertransference. I do not refer to all resistances nor do I suggest that the analyst creates the transference. I am referring to certain forms of resistance to which the analyst inadvertently contributes in every successful analysis as an unavoidable expression of the essential emotional participation of the analyst in the interactional definition of the psychoanalytic process which I favor. I consider the "purity" of a theoretic analytic treatment in which all of the resistances were created only by the patient to be a fiction. If the analyst doesn't get emotionally involved sooner or later in a matter that he hadn't intended the analysis won't proceed to a successful conclusion and countertransference is too vague and abstract a concept to account for the myriad of interventions by the analyst which I am here indicating. It is not enough to say that lapses in technique are unavoidable. These lapses are highly valuable glimpses into the nature of the psychoanalytic process itself. Serious countertransference can destroy an analysis or stalemate it. Every analyst will have to monitor his work throughout his career with this in mind. But it makes little sense to refer to the ubiquitous minor intrusions of the analyst's unconscious as mere "lapses" of technique. There must be important reasons *why* these so-called minor lapses are universal and inevitable. It is time that they be removed from the category of forgivable but regrettable "countertransferences" and studied in careful and extensive detail to see what light they shed on the nature of the psychoanalytic process as the expression of an interactional experience.

When we undertake to begin a psychoanalytic treatment we engage in two dialectically entwined aspirations both of which are fortunately doomed to fail. The first is the task of the patient. We convey to the patient sooner or later that he should be trying to achieve the greatest candor during the treatment. Few analysts still announce to the patient the fundamental rule, but in one way or another we let the patient know that he should be trying to say whatever he is thinking and we direct his attention to topics which he omits from the analysis. All of this time we knew the patient was doomed to fail and when he does we label the manner in which he fails a resistance. The paradox imposed by this term which indicates opposition is that it is not only a desirable but an essential failure because without resistance to analyze there could be no psychoanalytic process. It is not resistance *per se* which is the enemy of analysis; it is the wrong kind or wrong quantity of resistance which can destroy analysis. We hope that the patient will have analyzable resistances. We maintain an equidistant attitude toward resistance and help our patients to understand that they are not uncooperative if they "resist".

The second impossible task is assigned to the analyst. He is expected to adopt an analytic attitude. He must maintain the equidistant posture *vis a vis* the present and the past; the wish and the defense; the need for punishment and the craving for absolution. He must maintain this equidistant posture with enlightened compassion and disciplined observation. He must respond to any and all behavior of the patient solely as material to be valued, respected and understood. He must help the patient by his own example to endure the intimacy and abstinence of the psychoanalytic process and he must at all times think only of the therapeutic requirements of the patient. It is no surprise that the analyst too will inevitably fail in his effort to maintain his analytic attitude. Indeed the analyst knows that all too well, just as he knows that the patient will also fail to communicate without enactments and resistances of all sorts. This mutual, inevitable failure was discussed from a rather different angle by Calef as quoted by Weinshel (1984;p.69). The analyst who bemoans this failure is like the obsessional who fills the hour with "cooperative" but meaningless content. No one can accuse the patient of silence but he is nevertheless hiding something. The analyst who ignores these inevitable failures of his own does so at his peril

because it is at the point of failure in his effort to remain objective that the analyst will be able to make valuable new discoveries about the patient and sometimes himself. There is a dialectic relation between these two noble efforts, each doomed to "failure". The true success is the understanding of the interaction between the failures. This interaction is not by any means all of the psychoanalytic process but those who relegate it to the sphere of the by-product of the psychoanalytic process or worse yet as the forgivable by-product behave as though this was psychoanalytic perspiration; a sure sign that the analyst is working hard is that he is sweating but he merely needs to mop his brow, perfect his technique, do some more self analysis and hopefully he won't have to strain and sweat next time. Those who ignore this interaction between the two failures give too narrow a view of the complexity of the psychoanalytic process.

By now it will be clear that my own view of the interactional definition of the psychoanalytic process is very different from that of object relations theorists or self psychologists. I am not imputing mutative factors to the relationship with the analyst as compared to interpretations. I am instead addressing the problem of how to improve our understanding of the subjectivity of the analyst. I wish to direct attention to the subjectivity of the analyst *within* what is coming to be called (ambiguously) the intersubjectivity of the psychoanalytic situation, and *within* the domain of a one person psychology. Finally, I wish to place this question of clarifying the subjectivity of the analyst squarely in the center of the problem of how best to understand the manner in which the analyst organizes his or her experience with the patient in order to achieve "meaning" on the path toward formulating interventions to help the patient. Further, these issues are in a very different frame of reference than the polemic argument that the analyst must do many things in addition to interpreting, such as providing encouragement, sympathy, or hope. I address the problem of interaction solely as the locus of the psychoanalytic process so as to clarify the antecedents of the analyst's interpretation and of the patient's insight. It is also necessary to distinguish such a focus from the confusing revival of the notion of the corrective emotional experience (Cooper, 1989), and from

Gill's (1979; 1984) views about the origins of the transference in relation to the patient's plausible perceptions of the analyst's behavior.

My emphasis here, in contrast to Gill, is on the subjective experience of the analyst as an aspect of his inadvertent contribution to resistance rather than on the "plausible" perception of the patient as a contribution to the transference. A brief example will illustrate the distinction I have in mind. A patient told his analyst who was a candidate that he was cancelling several hours for a business trip. At that moment the candidate remembered that he had not yet notified the patient about some sessions which he himself had to cancel. The candidate immediately interrupted the patient and told him that he too had to cancel some sessions. What then ensued is the type of interaction which Gill has discussed. My disagreement with certain of his conclusions is not relevant here. To complete my illustration I raise the contrasting alternative in which the analyst remembers only *privately* at the very moment when the patient cancels that he had forgotten his earlier intention to tell the patient that he would have to cancel some sessions himself. In my contrasting example the analyst has created an opportunity to realize that he is experiencing an intrusion of unconscious mental activity of which he had been unaware. It is predominantly "countertransference" reactions of this magnitude to which I am referring in this distinction. To call this *only* by the name "countertransference" is to correct an "error"; to view it as an aspect of the subjectivity of the analyst places it less judgementally and apologetically in my intended context. But to *ignore* the countertransferential dimension is to omit crucially important conflicts within the analyst. More succinctly I suggest that we view the countertransference as a smaller component of the totality which constitutes the subjectivity of the analyst.

Every intervention made by the analyst has attached to it the implied question to the patient: "Is this what you are trying to say that you feel?" To date our literature, especially the older literature has usually reported only the successful final results out of thousands of partially failed attempts to understand the patient. The older papers merely report the conclusions at which the analyst arrived. But the patient actually benefits not only from the correct final

answers. The patient benefits from the process of the mutually attempted partly successful and partly failed efforts to understand. The way in which the analyst misunderstands, and he always misunderstands a lot, is highly communicative to the patient and this misunderstanding is by no means only or always regrettable. We have since the dawn of our science learned so painfully that we must guard against the serious errors introduced by the countertransference that we have failed to appreciate that the conflict of the analyst can lead to adaptive and useful outcomes as well. As in any matter of conflict it is a matter of degree and the quantitative aspect will determine whether pathological countertransference or creative subjectivity will be the outcome. The misunderstanding of the analyst when it is not a gross intrusion of countertransference is something from which the patient as well as the analyst learns just as the misunderstanding by the patient of the intervention by the analyst is instructive to the patient as well as to the analyst. This is the sense in which I mean that certain resistances are negotiated in the interactional relationship.

STRUCTURAL CHANGE

Structural change as a concept has been criticized by many analysts as an overly abstract shibboleth which was too difficult to explicate or demonstrate (Weinshel, 1984). J. Erle (1989) raised the following questions. Does "structural" change imply that we are dealing with phenomena which are habitual, automatic, and embedded in the personality to the extent that any change would require a "change in structure"? Is "structural change" so related to the structural theory that any meaningful change would of necessity correspond to or be explained by a change in the relationship of the structures id, ego, and superego to each other? Are these changes (whatever we conjecture to be their cause) temporary or sustained; rigid or flexible; constricted or available? Finally, can access to these changes be related to the elaboration and exploration of the transference expressed as resistance?

These questions raised are in keeping with my own view that one important cause of the confusion about the concept of structural change is that it is overly abstract. As I have indicated elsewhere (Boesky, 1988) the term "structural change" fails to distinguish changes which occur

as a consequence of normal psychological development, successful psychoanalytic treatment, successful psychotherapy, spontaneous remission of symptoms, and even symptom formation or pathogenesis. Each of the above is possible to describe as an enduring alteration in the relation between the structures of id, ego, and superego. If we insist on one term to describe all of those diverse phenomena we can conclude that it is used in a manner so overarching, so globally inclusive that its level of abstraction is an interference. In modern structural theory there has been an increasing and useful tendency to use "observables" or at least far less abstract notions to account for numerous phenomena within the psychoanalytic domain. E.g., Brenner (1982) refers to alteration in specific compromise formations rather than to structural change when he described the mode of therapeutic action. The notion of alteration in compromise formations points us far more forcefully to clinical observations and away from the globally abstract notions of the 1923 tripartite model. But even this improvement hasn't resolved the problem of clearly distinguishing in a specific and exclusive matter between the five categories of structural change which I have list above. E.g., one can achieve beneficial changes in pathological compromise formations as a result of successful psychotherapy. A change in compromise formations can certainly also be described as a structural change if the context is to focus on the interrelationships of the macrostructures of id, ego, and superego. The term structural change should not be discarded but it should be used in a manner which clearly fits its level of abstraction.

METHODOLOGY OF VALIDATION

The last area of disagreement which arose in our group discussions which I will discuss concerned the problems of proving that the changes effected as a consequence of successful participation in the psychoanalytic process were due to the specific interventions claimed by the treating analyst to have been mutative. This is obviously the problem which is most difficult to solve and the problem which perpetuates the controversies between competing schools or

theories of psychoanalysis each with their own definition of the psychoanalytic process and each equally plausible to its adherents and implausible to its opponents. Whatever common ground might exist between some of these theoretic schools it is my own opinion that political considerations have led not only to splintering but to expedient smoothing over of fundamental incompatibilities. Within our group of supposedly united structural theorists there was another disagreement about the methodology of validation which included one problem which isn't so familiar as the other problems concerning validation about which so much has been already said. I refer to the problem of using a group of entire hours as an evidential basis in addition to the conventional data presented in our literature. Case reports usually consist of an anamnesis together with arbitrarily selected excerpts of details from certain sessions coordinated with summaries of the progress of the analysis. The arguments against using individual hours include the following. The reader is deprived of essential data if provided only with certain hours. Sooner or later the reporting analyst must summarize. In fact the psychoanalytic process is regularly manifested by characteristic sequences and events which confirm its presence. Further, the conclusions to be drawn from a single session are related to aspects of meaning and identifying thematic content. One could only arrive at trivial ideas about process from one small group of hours in an analysis which occupied 1500 hours. I think this is a one-sided view. The problem is once again a failure to fit the level of abstraction (to summarize trends is to abstract) with the data to be evaluated and the hypothesis to be validated. Major trends in the analysis require summarizing, abstracting, and integrating massive amounts of data in an accurate but wieldy manner. Otherwise the reader would be drowned in meaningless details. Circumscribed assertions about sub-processes and sub-sub-processes within the supraordinate psychoanalytic process require microscopically focused data. It is one thing to say that the defense organization of the patient underwent meaningful change, and it is another thing to say that the cause of this change was due to certain interventions by the analyst. It is still another thing to demonstrate that the defense organization and its change were related to a unique unconscious fantasy. Each of those assertions requires a different form of selection and that selection implies a different level

of focus and a different specificity of data. It is necessary to use an appropriate group of entire sessions to persuade a group of experienced analysts that a certain unconscious fantasy was the basis for certain phenomena emerging at a specific time in the treatment. But it is also necessary to provide a considerable amount of prior history of the patient in summarized form in order to make a different kind of sense out of the detailed data from the individual hours. Proving that something the analyst said about the fantasy had a certain effect is difficult but possible. At least it is often possible to arrive at such a consensus within small groups of psychoanalysts who are by and large by no means as gullible or methodologically naive as many critics of the scientific basis for psychoanalysis claim. But there is an inherent problem in the selection of data which has yet to be solved. The "history" of the patient is obtained very slowly and in small pieces. It is a mosaic of which each piece has emerged in a specific context and arose from a different source in the course of the psychoanalytic work. When we summarize in order to describe the history we destroy the surrounding context in which each piece was located. Thus we find that many experienced analysts don't want to hear lengthy historical summaries about a patient in a consultation or supervision, or in study groups. Instead, it is often preferable to hear a few sessions in detail so as to observe the dynamic unfolding of the communications of the patient in a manner which allows the essential emergence of context, contiguity, and metaphor which epitomize the data we require for an evaluation of the psychoanalytic process. So we have a problem and an anomaly. The problem is that we have yet to develop an adequate methodology for reporting clinical material. The anomaly is that in our literature and our discussions about the literature, most analysts are content to rely on arbitrary summaries and to shrug their shoulders about the limitations of this method. They say we know it's inadequate but it's the best that we can do. Either you have to report hundreds of individual sessions or you have to summarize in some way. In the end you'll believe certain authors and not others on grounds which are extraneous to the actual material reported. But on the other hand many of these same analysts insist on hearing entire hours in their effort to discuss a case presentation.

We will benefit from improving our understanding of the methodology of fitting the selection of the data we study to the hypothesis under consideration. Our literature for the most part merely assumes that this "fit" is present when in fact it is not. I am advocating that we should not continue to neglect the use of microscopic data gathered in clusters of well selected analytic hours. The proper question is not simply how detailed the data presented must be. The real question is to decide how to *fit* the theoretic assertion in any paper to the optimum type of data for that specific hypothesis. This remains a neglected area among psychoanalytic clinicians who wish to refine the methodology of validation by using psychoanalytic data.

CONCLUSION

At the conclusion of our study group discussions we agreed that the enormous complexity of the psychoanalytic treatment situation defies any effort we could make to achieve a satisfactory systematic definition. We also felt that this was not surprising in light of the discoveries of recent decades which have revealed the psychoanalytic treatment situation to be vastly more complex than had been realized by the early generations of psychoanalysts. At this point in the evolution of our science we are more aware of what we don't know and we include in what we don't know any coherent or systematic definition of the psychoanalytic process in contrast to a loosely acceptable group of definitional considerations. Of the numerous problems which await future research the nature of the manner in which the analyst participates in the psychoanalytic process especially deserves intensive further clarification. The fragile and overburdened concept of countertransference is one specific source of the current confusion about the nature of the psychoanalytic process. Finally, disagreements about "commonalities" among various alternative theoretic models will continue until our methodology for validation is refined and improved.

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