

Common Analytic Process goals: A Clinical Model of Analytic Change
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Introduction

In this paper I will present a model of common clinical goals in the analytic change process in order to highlight the similarity of different analytic approaches. The fact that the different approaches differ in their assumptions about what people are like, what they need, what motivates them, and what constitutes psychopathology makes it difficult to find extensive common ground at the theoretical level. However, Goldfried (1980) has written of the possibility and usefulness of relating psychotherapy theories at the level of clinical strategies or principles of change, reflecting the fact that different approaches can have similar clinical goals. I believe this is true for the different analytic approaches. Although there continues to be debate about the merit of having multiple analytic approaches, in this paper I take plurality as a fact of life in current psychoanalysis and explore how to learn the most from it.

With the development of multiple orientations the tendency has been to focus on the differences between them. This makes sense in terms of clarifying what each one has to offer and what constitutes its unique place in psychoanalysis. However, the strong emphasis on the differences has created problems for the field. Firstly, it has made meaningful discussion between analytic schools difficult. Even when there is genuine interest about different approaches it has been difficult to constructively relate them to each other because of their different meta-theories. Secondly, although traditionally analytic change has been described in terms of both process and outcome goals (Wallerstein, 1969), the focus on differences has led to a focus on process goals as an end in their own right, since it is process goals, couched in terms of a particular theory, that usually characterize an approach.

Traditional process goals have included making the unconscious conscious, undoing repression and recovering memories, "where id was there ego shall be" (Freud, 1933), the development and resolution of a transference neurosis, the resolution of unconscious conflict, and the development of a self analyzing function. Different schools, and different analysts within schools, have delineated additional, and often alternative, process goals. For Kleinians the process goal can be a greater integration of the parts of the self with increased access to the defenses of the depressive position (Joseph, 1992). For self psychologists it can be the creation of a stable self-object transference leading to a more resilient and cohesive self (Kohut, 1971). For Winnicott (1969) and his followers it can be the development of the capacity to use the object and thereby reactivate and live the true self. For Sampson and Weiss (1986) it can be the modification of pathogenic beliefs. For Gray (1973) it can be the ability to recognize one's own changes of voice and learn how one's defenses operate. For Schwaber (1990) it can be the full articulation of the analysand's subjective reality. For hermeneuticists and inter-subjectivists it can be the creation of a new narrative with new meanings which constitutes a new self experience (Frank, 1991). For Meissner (1981) it can be the reworking of introjects into new identifications. For Loewald (1960) it can be the resumption of development through the free and flexible communication between the unconscious and preconscious. For Kris (1996), in a similar vein, it can be the development of the capacity to effectively free associate. For Fonagy (2000) it can be the development of the capacity for mentalization. For Hoffman (1994) it can be the development of the ability to see the analyst

differently than the patient had before. For Mitchell (1988), similarly, it can be the development of new possibilities in relationships.

The outcome goals, what patients come to us looking for, i.e. symptom relief, better adaptation, more fulfilling relationships, a change in how they feel about themselves, a fuller life, are assumed by each of the different approaches to follow more or less automatically from the achievement of their process goals. Some analysts have even denied any interest in outcome goals (Schwaber, 1990). This is particularly problematic as empirical research (Kantrowitz (1990) and Wallerstein (1986)) has called into question the relationship between the degree of achievement of process goals and the successful achievement of outcome goals. According to this research, good outcomes do not seem to depend upon the achievement of the process goals, and the achievement of the process goals does not correlate well with better outcomes. Although these studies are not definitive, they demonstrate that it is dangerous to assume that the desired process leads to the desired outcome in all situations, and the evaluation of an analysis needs to consider outcome as well as process changes.

In this paper I will present a model of the similarity between approaches that exists at the clinical level, including similar outcome goals. I will discuss the model by relating the similarity to the differences that are generally acknowledged, and use the model to organize the differences into a coherent framework. I will use this framework to highlight the clinical assumptions which the different approaches bring to similar clinical needs. I will demonstrate the usefulness of this framework and the clearer recognition of different clinical assumptions in creating a more meaningful dialogue between different orientations in relation to individual interventions and current clinical and technical controversies.

Clinical Model of Process and Outcome Goals

Phenomenologically, we start an analysis by asking the patient to lie down and say whatever comes to mind, while we, the analyst, listen with evenly hovering attention, which is basically an open mind about what is most relevant in the communication and a simultaneous awareness of our own internal thoughts and reactions. What happens then is that the analyst hears certain things, the patient and the analyst experience things, a relationship develops, and patterns of thinking and relating emerge. The analyst chooses to make the patient aware of some of what is occurring, and interacts in ways to 'deepen the process'; that is to facilitate and enhance the experience of certain things. What the analyst should focus on, what experiences he/she is trying to elaborate and enhance, and how best to do it, are the questions addressed by precepts of technique, and different analytic approaches answer the questions in somewhat different ways. However, in general, I believe the following seven common functions describe the goals of psychoanalytic technique (the analytic change process), regardless of how particular process goals are articulated.

1. To create an atmosphere conducive for self exploration, where patients experience safety and develop the trust needed to begin to talk about and experience thoughts, feelings, expectations, motivations, and meanings, which they have previously been unable to experience.

2. To use this trust to develop patients' motivation for exploration; their curiosity about how their internal world operates and how they relate to themselves and to others. This is done by demonstrating that thoughts and feelings have a meaning and a relationship to each other that the analysand did not previously recognize and that these previously unrecognized elements are relevant.
3. To use this safety and curiosity to help the analysand experience and explore thoughts, feelings (including anger, depression, guilt, shame, and anxiety), meanings, expectations and motivations which they have previously been unable to experience or recognize, even though this expanded experiencing creates anxiety and confusion.
4. To provide an atmosphere that enables patients to tolerate this new experience, to maintain their exposure and motivation in the face of anxiety, depression, guilt, shame and confusion, thereby enabling them to experience and reflect at the same time.
5. To provide integration by establishing new meanings, new perspectives, and new ways of processing these new experiences which enable them to become owned and integrated into a fuller and thereby more complex sense of self, including an understanding of the origin of the old meanings, perspectives, expectations, motives, and defenses. This also involves a greater acceptance by patients of these different aspects of themselves.
6. To enable this new awareness and capacity to experience more to lead to new actions, new experiences, and new relationships in life which alter and consolidate the new, more complex, and more realistic views of the self and the world.
7. To enable these new perspectives, experiences, and relationships to lead to the amelioration of the symptomatic behavior and experience which necessitated the analysis.

Let me summarize these goals which all analytic schools are trying to achieve in different terms and by various means. All analytic schools are interested in creating a safe enough atmosphere for the patient to develop trust in the analyst and all want to use this trust to bring into affective awareness patterns of interaction with the analyst which have not been recognized, and a wide range of psychological phenomena not previously experienced or recognized, i.e. feelings, motives, beliefs, fantasies, thoughts, wishes, fears, and needs, which have not fit in with the patient's conscious view of themselves and others. The patient is encouraged to stay with and elaborate these experiences, become less afraid of these aspects of themselves, to reflect upon them while experiencing them, and by so doing to develop new perspectives on the patterns and experiences and integrate them into a fuller sense of self and other. This new awareness and capacity to experience more should lead to new actions and experiences in life and outside relationships which, in turn, should consolidate and enhance the changes, including ameliorating the symptomatic and characterologic behavior which necessitated the analysis, and enabling the patient to function more effectively in their life.

Discussion

This clinical model describes an underlying similarity of purpose of interventions from different schools. I do not mean to imply that any analyst pursues these goals in an orderly or systematic way, or that the order in which they arise in an analysis follows in a linear sequence. But I do believe that the pursuit of these clinical goals constitutes an underlying unity which makes different analytic approaches all psychoanalytic. However, because of their different assumptions about people and pathology, their way of picturing these goals and their ideas about how to most effectively pursue them differ. This can be demonstrated by looking more closely at each of the steps.

The first priorities for an analyst of any analytic school are to create an atmosphere of safety, to engage the patient affectively in the treatment, and to achieve a position of influence in order to promote a loosening of the limited, habitual ways the patient has of experiencing their life, their inner world, and their relationships. Freud (1911-1915) was referring to this priority when he said that the first task was to attach the patient to the treatment.¹ Early interventions of all approaches are aimed at promoting an attachment to the analyst, making the patient aware that more is going on than they have been aware of, and demonstrating that the more that is going on is relevant. The classical view was that sufficient safety, attachment, and trust would be experienced if the analyst adopted the traditional stance of genuinely interested, nonjudgmental, neutrality. Many analysts, while agreeing with that stance, have viewed different aspects of it as being crucial for establishing safety and attachment. Strachey (1934) wrote that it is by virtue of the analytic stance of being a benign interpreter that the analyst was automatically internalized differently than any other object. Gittleson (1962) focused on the diatrophic function provided by the way analysts listen. Loewald (1960) articulated aspects of a new relationship, not just the analyst as neutral interpreter, that he believed were essential for safety. The analyst's view of who the patient can be, seeing the core of the patient, having love and respect for the patient, and functioning as a mature object are all aspects of the analytic relationship that he saw as essential for safety and trust. Kohut (1971) saw an actively empathic milieu as the crucial aspect of the analytic stance which provided necessary "oxygen" for the relationship.

In addition to highlighting different aspects of the traditional stance as crucial for the provision of safety and promotion of attachment, some analysts believe that a different stance may be necessary to achieve this goal with some patients. They believe for some patients the traditional analytic set up does not provide a safe situation, and that the analyst must actively seek ways to be experienced as safe enough to be usable. Bacal (1985) has referred to this as providing optimal responsiveness. This topic has also been addressed in the extensive literature on the importance of the therapeutic alliance and the need, at times, to promote its development. Providing ego support, providing empathic understanding, functioning as a container of affects, recognizing the capacities a patient brings to analysis, recognizing the depth of problems, being willing to enter into an enactment, avoiding entering into an enactment, refraining from interpretation, and making deep interpretations, have all been advocated by different analysts as useful and at times necessary ways of creating a safe enough environment. Although these different ideas have led to intense controversies, which I will explore below, it is important to recognize that these very different interventions can all have the same analytic purpose; creating safety and attachment.

¹ The central role in this endeavor of creating a safe atmosphere has been highlighted by Schafer (1983) in his discussion of Freud's papers on technique.

This is not to say that anything goes, that if the patient feels safe that is an end in itself and how the safety was achieved doesn't matter. The purpose, and therefore the ultimate gauge, of adequate safety in analysis is the analysis and engaging in genuine and meaningful self exploration (step three), and eventually self reflection and self integration (step five). It is in attempting to create a very broad experiencing of previously unrecognized phenomena and a wide ranging integration within the treatment relationship itself, that psychoanalysis has differentiated itself from other psychotherapeutic approaches.² Every analytic school is aiming for this even though the different analytic approaches have different phenomena they look for (differences in the content of step 3) and different ideas about how best to elicit those phenomena (differences in how to pursue step 3). For Freud these phenomena were looked for in the form of infantile drive conflicts, expressed as wishes and fantasies in the transference. For other schools unconscious phenomena have been packaged not only as drive conflicts but as innate fantasies, pathogenic beliefs, relationship conflicts, pathogenic internal object relationships, early self object needs, distorted views of the self and the world, preoedipal concerns, the unthought known, patterns of attachment, difficulties in affect regulation, other deficits and apraxias, and the list goes on. The focus on different phenomena, which are based on different views of the most important determiners of development, behavior, and pathology, does represent a genuine difference between approaches (Levey, 1984-85). At a clinical level, however, all of these phenomena take the form of thoughts, affects, motives, expectations, meanings, and self states which have not been previously experienced and/or effectively integrated. At this phenomenological level there is a similarity of content. So, although different approaches will focus on different specific thoughts, affects, self states, etc., eliciting these sorts of phenomena is a unifying similarity of analytic purpose which is articulated in step 3.

In addition to differences in the content of important unconscious phenomena, there are also differences in ideas about how best to elicit unconscious phenomena in a constructive way. These differences have been referred to as different analytic surfaces by Levy & Inderblitzen (1990). They give examples of four surfaces, each associated with, and in an important way defining, the approach of a given analyst. One surface is a focus on sequence, the changes in affect or association, and what is going on in those transitions and what that means. This can be within a session, such as listening for changes of voice or breaks in associations, or between sessions such as a change in affect or the patient's focus. The second surface is a focus on the relationship, what the patient is feeling to the analyst as they are talking about whatever they are talking about. The third surface is a focus on underlying affect, affect that is being warded off and not directly experienced, but which the analyst feels the patient could experience if it were pointed out. This may become apparent to the analyst through a discrepancy between words and affect. The fourth surface is a focus on the actual experience of the patient, the surface affect; trying to further elaborate, articulate and understand the subjectivity of the patient in depth. There are additional analytic surfaces that they don't mention. For example, the neo-Kleinians look to their own countertransference experience as their analytic surface. Some analysts, like Fred Pine (1998), suggest using multiple surfaces. The underlying similarity in these different approaches lies in their clinical goal. They are all used in the service of bringing up new material in a way that it can be felt, thought about, and eventually integrated and owned.

² Friedman (personal communication) has referred to this as forcing full freedom.

The fourth step underlines the fact that as the patient gets deeper into the process new anxieties arise and there is an ongoing need to keep the new experiences alive and help the patient stay in touch with them. I include it as a separate step because many of the differences and disagreements between approaches center on how much one believes that the analyst needs to actively focus on this step with their interventions. With step four, as with step one, any active focus on making it safe enough for the patient to stay in touch with the new affects and motivations represents a departure from classical technique. However, although there is debate about how much of this to do, how best to do it, and what its role is in the analysis, there is no question that all analysts do address this step. Freud spoke of the importance of the love for the analyst to motivate the patient to stay with their discomfort, although he did not advocate actively encouraging it. Some analysts characterize their effort to keep this step in mind as analytic tact. One of the clear findings in Wallerstein's (1986) long term Menninger project was that all treatments, whether analysis or long term psychotherapy, had many supportive interventions; interventions which helped the patient tolerate and stay with uncomfortable experiences, i.e., were aimed at promoting step four.

However an analyst chooses to intervene here, the goal is to help the analysand stay with, take seriously, and begin to integrate the new experiences. The clinical goal is for the analysand to feel strongly and to reflect on the experience at the same time. The analyst intervenes to enable the patient to maintain contact with new feelings or persist with new experiences in spite of discomfort. However, there are a wide range of very different interventions which can all have this aim. One analyst may make a direct statement acknowledging the difficulty the patient is having in staying with the experience. Another may interpret a conflict activated by the patient's feeling and acting differently. A third might empathize with the difficulty of the new experience. A fourth might simply ask the analysand to expand on his or her own experience of themselves in changing. A fifth might emphasize the value of what the patient is experiencing. A sixth might speak to the analyst's experience of what the patient is experiencing. A seventh might even be silent as his or her way of holding the patient and the new affective experience. There are also significant differences in the degree to which this step becomes an active focus of technique which I will discuss below.

Step five, the integration of new experiences and new information, is the step in all approaches where the process actually results in structural change. Most of the process goals of different schools are different visions of what this new integration will look like. But, as with steps 1,2, and 4, there are significant differences about how much to actively focus interventions on this step. Classical analysts assumed an intact ego, where patients were seen as able to integrate their experience autonomously. So, in the analytic literature, the eliciting of new phenomena, step 3, was seen as the central focus of analytic technique. However, with many regressed or more primitive patients, developing the capacity to integrate their experience, as opposed to bringing new phenomena into awareness, is now often seen as the core of the analytic task. Neo-Kleinians, for example, see the promotion of integration, and not the promotion of regression, as the analyst's main concern. Peter Fonagy (2000) speaks of the central task of helping the patient to "mentalize." This is both an end in its own right and also, at times, a necessary preliminary step in making it possible for the patient to open themselves to the experience of new unconscious material from a position where it can be constructively used and integrated. So, although this step is, and always has been, the essential step in analytic change for all approaches, there are now important differences about whether, when, and how to directly promote it.

Steps 6 & 7, the promotion of new actions and experiences in life, are even more controversial as a focus of direct intervention. The assumption has been that promoting action will make the analyst seem partisan, no longer safe, and thereby limit the phenomena that emerge. Suggestions are also assumed to render patient's transference reactions unresolvable because they would then be based on the 'reality' of the analyst's actions. For these reasons steps six and seven, our outcome goals, have often been prohibited from being a direct focus of technique. Although Freud (1919) wrote that at times the phobic patient has to be pushed to enter the phobic situation, his idea has been viewed by some analysts as unanalytic and unnecessary.³

Yet, new actions are recognized as a crucial part of the process. New actions are essential for new self integration, as many analysts since Freud have recognized. Although he writes about this in terms of language, Schafer (1976) views the patient's ownership of new actions as the essence of the entire analytic endeavor. Michael Basch (1988) has also underlined the importance of action, viewing competence as the most reliable builder of self esteem. Anton Kris (1988), has written that divergent conflicts, the sense of either/or, yield to gradual insight as a result of actions, both within and outside the transference, that demonstrate that the feared dichotomy is illusory. In his paper Kris indirectly suggests that those actions are necessary for insight. Paul Wachtel (1992) has made the point that old patterns tend to be strengthened by current reality, and that altering the pattern requires new behavior, not just insight. Westen (1999) has written that insight does not necessarily weaken implicit connections between representations and affective responses. To change the affective response the patient needs new experiences in order to associate the representation with a different affective state. So, insight may make new actions possible and it can enable them to be experienced differently, but new behavior is also required for patterns to change. Thus, whether or not promoting new action is an active focus, all analysts are looking for it as an important aspect of evaluating and consolidating analytic change.

What I have tried to show is that different analytic orientations are different ways to promote a common analytic process of change. This examination of the common clinical goals highlights how very different interventions can serve similar functions. It also highlights the underlying similarity of different process goals and different views of the analytic process, in that they are all looking to activate and integrate new psychological experiences (i.e. thoughts, feelings, meanings, etc.). In addition to clarifying these similarities the model also enables the differences between orientations to be organized in a more useful way. Each approach has particular content it explores and particular suggestions for the most effective way to explore it. The usefulness of the model comes from the juxtaposition of the similarity of purpose with these differences in approach. This juxtaposition highlights the purpose of different technical suggestions and the clinical assumptions behind them. In the next section I will demonstrate

³ Freud wrote that insight is curative for hysterics, but phobic patients have to enter the phobic situation for more associations to arise. Brenner (1969) wrote that even if that were the case, the analyst shouldn't use personal influence to get the patient to enter the situation, but instead should keep analyzing (i.e. interpreting) what is blocking the new 'spontaneous' actions. However, if the analyst is sure that there is more to analyze as long as the patient isn't taking new action, then the analyst is beginning, at this point, to look for the patient to enter the phobic situation. In so far as that is being communicated through the interpretation, the interpretation is functionally an indirect suggestion in this situation. Interpreting may be an effective tactic but it does not avoid influence, it simply manifests it in a different form. Also, Brenner is indirectly confirming that new actions are an important goal of the process and their absence is an indicator of the necessity for more analytic work.

the usefulness of the model in promoting constructive dialogue around current controversies in technique and also in comparing individual interventions from different orientations with each other.

Uses of the Model

An Approach to Issues of Technique

It is easy to see how different views of development, pathology, and change have led to intense controversy about technique, since they result in interventions which are, on the surface, very different. I have previously given examples of different ways to promote safety in steps one and four, and different ideas about how best to elicit strong experiences in step three. In fact, there are many suggested interventions that are seemingly polar opposites. For example, Freud believed that the way to make the relationship safe was to be neutral, interested, and nonjudgmental. Winnicott (1992), in contrast, felt that for some patients to feel safe enough to “regress to dependency,” the analyst had to be available at all times. Brenner (1969) believes that an interpretive stance is the most effective way to explore the unconscious. Hoffman, Newman, Mitchell and others believe that many patients have to change aspects of themselves before they can utilize interpretations, and that different kinds of action by the analyst are often necessary to enable fruitful exploration of the unconscious. Gray (1973) believed that the best way to maximize access to unconscious content was to take the stance of an observer of the patient’s associations, pointing out changes of voice. Schwaber (1990) and some self psychologists believe that the way to maximize access to unconscious content is to empathize with and communicate understanding of the patient’s experience; to share it rather than observe it. Schwaber believes that every intervention from the analyst should arise from a question, while Racker (1962) believes that analysts now have the knowledge to make many inferences which can usefully be conveyed to the patient. Strachey (1934) felt that the best way to promote resolution of the transference was to withhold reality from the patient. Gill (1979) wrote that the best way to promote resolution of the transference was to actively locate the reality base or trigger. From a more global perspective, Levy & Inderblitzen (1990) have written that many different analytic surfaces can be effective, but they need to be followed consistently, while Pine (1998) believes that shifting between surfaces as the material suggests is most effective.

When these different stances are discussed in theoretical terms there is a tendency to fall into an ideological argument, since each approach is best in the context of its own theoretical assumptions. However, the different technical recommendations can usefully be thought of as predictions of what will be clinically effective in achieving the common goals. The predictions are based upon explicit or implicit clinical assumptions deriving from the different theoretical orientations. Freud’s technical recommendations are a case in point. His approach to analysis was developed in the context of the topographic and structural models. In topographic theory psychopathology is the result of unconscious conflicts between wishes and fears, or between incompatible wishes, or between drives and defenses, and the anxiety and depression which these create which lead them to be repressed. As a result of repression patients present with symptoms, but they are not in touch with the motives and wishes which the symptoms partially fulfill and partially protect them from experiencing. With the addition of the structural model he highlighted the fact that patients are also not aware of the ways in

which they ward off more direct recognition of their conflicts, wishes, fears, and affects. So, the goal is to analyze conflict: first make it safe for the conflict to be experienced, then demonstrate the existence of conflict, then experience, tolerate, and manage the affect associated with it, and finally resolve it. Analytic technique, in this model, is designed to enable patients to learn how they have protected themselves from recognizing the repressed in the past, to remember what they have repressed, and to tolerate the anxiety and depression that may accompany that awareness, all of which undoes the repression and leaves them able to resolve conflict and manage affect in more adaptive ways, which they have available as adults but did not have available earlier in development. In this view of analysis, therapeutic action flows linearly from affective experience to insight to intrapsychic change to new actions.

Freud's (1911-1915) papers on technique detail how to accomplish these tasks. The analyst attaches the patient to the treatment by being genuinely interested in what they are saying, being neutral, and nonjudgmental. Then free association automatically starts to activate old longings. Then the characteristic defenses come up as resistances and these are interpreted by the analyst. The patient is initially not conscious of the repetition, the defensive function, and the genetic origin of the defensive patterns of relating, and making the patient aware of this is what the interpretations are designed to do. Effective interpretations gradually interfere with the avoidance of infantile wishes and fears, and the analyst then, again automatically, becomes the target for these wishes in the transference, a new and final defense before awareness and ownership of them. The infantile wishes are then frustrated in the transference to build up their intensity, and are eventually interpreted. When this is effectively done it leads to the undoing of the repression and the coming into conscious awareness of the pathogenic childhood experiences and fantasies. The content of the reexperience is the transference neurosis, what the patient fantasized at the Oedipal period, and this is what the classical analyst listens for and then reconstructs, to help the patient's ego integrate this aspect of themselves. This widens the scope of the ego both by increasing awareness and by providing access to the energy of the infantile drives.

This brief summary of the expectations of the analytic process by classical analysts includes all of the seven steps listed above. However, in this model not all of the steps are the active focus of technique. The only foci of active technique are step three (through defense and transference interpretations), and step five (through transference interpretations, genetic interpretations and reconstructions). The assumption is that safety, trust, and therefore influence, the focus of steps one, two, and four, will be taken care of through the structure of the analytic situation and the analytic stance of being interested, neutral in regard to the patient's internal and external life, nonjudgmental, and encouraging of free association. So, the patient does not need active help with steps one, two, and four, because it is believed that the analytic atmosphere provides the needed safety. In fact, the provision of the safety needed for maximum exploration is the rationale for the traditional analytic stance, and it is believed that actively creating a supporting atmosphere will undermine safety and trust and will lead to aspects of unconscious conflicts not fully emerging, as the patient will feel that the analyst can't tolerate them and does not want to hear them. When step three (bringing into awareness warded off affects, motives, expectations, and meanings) is pursued effectively, it is assumed that the transference neurosis will emerge, be tolerated, and eventually understood. The integration of these experiences, step five, also called working through, is accomplished for the most part autonomously by the patient, with the analyst assisting through further transference interpretations, genetic interpretations and reconstructions. Steps six and seven, the outcome

goals, are taken by the patient automatically without the intervention of the analyst. In fact, any intervention here by the analyst is assumed to jeopardize the full development of step three, because revealing oneself as an interested party in the patient's life destroys neutrality and jeopardizes the sense of safety. In this view of analysis, any failure of effective intrapsychic change and new adaptation is theoretically attributable to a lack of adequate insight.

In terms of my model subsequent approaches have differed from Freud's and from each other in three main ways. The three differences that characterize approaches are different phenomena looked for in step three, different ideas about how best to promote each of the steps, and the active targeting of different steps with technical interventions. These differences, as I indicated earlier, reflect different clinical assumptions derived from different theories. For example, both Gray (1973) and Goldberger (1996) adopt many of Freud's assumptions in their approach of close process monitoring. They look for similar content, unconscious conflicts, especially around aggression. In their writings they emphasize their method for doing this, which they believe is most effective for many patients. They advocate the stance of being an observer who stays out of the patient's life and focuses on changes of voice in the room in order to show the patient how his mind works. They have articulated many of the clinical assumptions that lead them to recommend this stance. They see this as the stance that will make the analytic space safe enough for the patient to risk the greatest exposure. Focusing on the anxiety in the room and any conflict about speaking will make it safe for the patient to experience impulses. Working through the conflicts about expressing everything in the analysis will lead to the patient experiencing affects and drive derivatives in their full intensity, while talking of subjects outside the room will lead to the patient being more controlled and less affectively intense. When the patient fully experiences the transference fantasy it will get so far from reality that the patient will recognize the distortion and associate to it. So, their clinical goals are the provision of safety for the experiencing of impulses in their full intensity in a context that maximizes the potential for the patient to recognize and subsequently integrate these impulses into an expanded sense of self. Their technique is based on the empirical prediction that it will lead to this clinical result.

They also follow Freud in aiming their interventions at step three, the elicitation of unconscious content. This is based on the assumption that integration will automatically follow from this process as the patient experiences and observes at the same time. Patients are also expected to spontaneously use self understanding to regulate affect, and when patients realize that thoughts can always be free in analysis they are expected to generalize that realization to their outside life. The outcome will be increased freedom of thought, increased creativity, and freedom to use their talents in their life.

Fosshage (1992) makes different assumptions about the most effective way to achieve similar outcomes. He looks for different content, the use the patient makes of the analyst in regulating a narcissistic equilibrium. Because his theory assumes a greater inherent push towards health in patients, he tends to focus more of his interventions on step 4, helping the patient tolerate new experience, since he anticipates that new affects and needs will emerge spontaneously when given a chance. He also views the empathic stance as an important new experience which, in addition to insight, is important for therapeutic action. That assumption also leads to his preferred way of eliciting change, illuminating the analyst's subjective experience. He believes that this is what will deepen the process and lead to the most intense affective experience. He looks for the deeper affect, in the context of an empathic relationship, to lead to insight and increased self cohesion: the ability to more effectively regulate affect. He

looks for similar outcomes to Gray and Goldberger, but couches his expectations in terms of expanding associations, the ability to withstand increased emotional intensity without fragmenting, and a symbolic reorganization of the self.

Some other analysts are not as explicit about their clinical assumptions. Schwaber (1990), for example, denies any agenda, which makes her assumptions implicit. She writes that she is only looking for patients to articulate their subjectivity, not to recognize their distortions. However, denying an agenda is actually a tactic rather than a full portrayal of the complexity of her position. In all her vignettes she is looking to help patients develop additional perspectives to their habitual ones and to enable them to have new reactions in addition to their old ones. Her implicit assumption is that her stance of clarifying the patient's experience of themselves, both trying to understand it and underlining its validity, will make the analytic space safe and promote the full articulation of the patient's experience, enabling it to be integrated in a way that is both enlightening and freeing. Her stance of not having an agenda is what she feels most effectively promotes this agenda.

Thinking about issues of technique in terms of clinical assumptions can be useful in shifting discussions about technical approaches onto a more empirical plane. When analysts are aware of their assumptions and the common goals, they are in a position to evaluate whether their approach is having its expected effect. For example, in an analysis being conducted with close process monitoring the analyst is evaluating whether, for this particular patient, recognizing how his or her mind works is actually leading to a fuller affective experience, or whether it is becoming intellectualized. Similarly, an analyst who is withholding reality from a patient is evaluating whether this stance is leading to the patient becoming more clearly aware of his or her own projections and internal reality. Although all analytic approaches that have endured make clinical assumptions that are often valid and useful, we need to remember the relativity of these predictions. Psychoanalysis, which has done so much to enrich our understanding of the importance of non-normative assumptions about people's behavior and responses, has repeatedly demonstrated that we cannot consistently and accurately predict how any particular analytic stance or intervention will be experienced by the patient population in general, and, therefore, what it will accomplish with a given patient. When a technical stance is evaluated based upon its effectiveness in producing adequate safety and trust to promote self exploration and effective integration in any given patient, rather than on its achieving this in a particular way, then current clinical controversies can be framed in a way that has the potential to further develop our understanding of the complexity of promoting change.

A Fresh Look at Clinical Controversies

We can use the model and the clinical assumptions of different approaches to understand more fully both the effectiveness and limitations of our current techniques. For example, interpretation in the transference has traditionally been taught as the most effective focus of interpretations. What clinical assumptions lie behind this assertion? What is interpretation in the transference designed to accomplish in terms of the goals of analysis? The transference to the analyst is often where the patient is most affectively alive and where a pattern of interaction can be most clearly recognized. Thus, interpretations in the transference are often effective because they enable a patient to experience a reaction or an aspect of the relationship with the analyst intensely and reflect on it at the same time. This combination of

intense affective experience and reflection is what we hope will happen as the result of a well timed transference interpretation. However, this is a clinical assumption, which holds true for many patients, but it remains an empirical question in any analysis whether or not this intervention has the desired effect. It is the effect that we are looking for.

Similarly free association and lying down are two aspects of technique which are so fundamental that they have, at times, been used to define analysis. However, they, too, are employed because of assumptions about the effects they will have in promoting the analytic goals. Free association, lying down, and the frequency of meetings are all designed to promote access to affects, thoughts, and feelings that are not generally experienced. Free association can also promote a sense of authenticity and genuineness of the experience which can foster integration. Lying down, avoiding face to face contact, can often make the analytic space safer and associations more clearly felt as one's own. The usefulness of these aspects of technique depends on their actually promoting these effects in any given analysis.

On the other hand, any deviation from these central precepts brings up understandable fears about what might be lost. This has been couched in terms of the treatment no longer being analysis, but here, too, it is more useful to delineate the potential compromises of the treatment. The first danger is that the analysis will be truncated, and that not enough of the affects, thoughts, motives, and self states will be activated and worked with. There will be limitations on how the analyst can be experienced; the transference possibilities will be limited and skewed. Another danger is that experience and insight will not develop in a form that can be recognized as authentic by the patient and effectively integrated into a new, fuller, and more authentic sense of self. The experiences may be felt by the patient to be created by the analyst and not integral to the patient's self. Alternatively, the patient may respond with premature acceptance, compliance, in a way which is not truly owned, authentic, and therefore not stable. These are dangers to be aware of and to look for. But, these are potential dangers in every analysis. Being able to judge the scope and authenticity of the patient's experience and integration is an essential part of being an effective analyst, and there is no technical stance that can safeguard an analyst from blind spots. We are constantly monitoring the increasing depth and breadth of the associations and affective experience of the analysand (Erikson, 1964).

Once it is clear that these dangers cannot be avoided by any particular analytic stance, then it becomes an empirical question in any analysis, whether conducted in a traditional manner or with modifications, whether the analytic goals are being met. In fact, it has been the recognition that the traditional stance does not always lead to a deepening, useful process that has led to questioning of universality of the traditional assumptions of which steps to target and how best to promote them. In previous sections I mentioned some of the various suggestions for creating a safe atmosphere and attachment to the analyst (steps 1 & 2), as well as different ideas about how to most effectively access unconscious phenomena (step 3). In fact, each subsequent step in the model has also become a suggested focus of active technique by various analysts.

In terms of step 4, helping the analysand stay in contact with new experiences, there are different views not only about the most effective ways to promote it, but also about the extent to which interventions should focus here. Analysts who see these interventions as not simply supporting new insights but as an important part of therapeutic action itself (in that they actually give the patient the experience of a new object responding in a different way to their self development) will tend to be more active here. Analysts like Schwaber, some self

psychologists, and Sampson & Weiss, all of whom postulate a strong innate push for growth in patients, and view patients as actively (albeit unconsciously) seeking new experiences, tend to focus many of their interventions on making the analytic space safe enough for the new experiences to occur. They see patients as intrinsically motivated to stay with their new experiences, and they view their own encouraging response as providing a needed developmental experience and also as the most effective way to elicit deeper material. Paul Wachtel (1997) emphasizes to the patient what is new in the experience in the transference as an important way to reinforce its emergence. As a patient becomes less defended Wachtel will remark on that, rather than on the defenses that are still being employed. He views the focus on the movement forward as an important intervention to enable the patient to stay with and fully recognize new experiences which may still be conflicted. Marion Tolpin (2002) has also emphasized the importance of the analyst recognizing what is new; what she calls forward edge interpretations. This is in contrast to Gray, for example, who is more focused on the ingrained nature of the defenses and would, therefore, tend to be more active in interpreting and interfering with the remaining defenses and engaging the patient actively in that process as his way of most effectively promoting the patient's staying with new experiences. The 'rightness' of these different interventions can be judged empirically on their effectiveness in helping a given analysand to go further with new experiences.

As I mentioned earlier, there have been many analysts who have written of active interventions to promote step five, structural change, the integration of new experiences. This expanded technical focus on step five has led to changes in thinking about interventions in steps three and six, as well as technical changes related to promoting step five, itself. The aim of technique in step three has always been to elicit new psychological material in such a way as to maximize its potential for being owned by the patient and effectively integrated. So, the technical approach to step three has always kept step five in mind. The classical assumption, most clearly stated by Strachey (1934), was that when the affective experience emerged in the transference relationship to the analyst, and in the context of the analyst being neutral and withholding reality as much as possible, then there would be the maximum possibility of the experience being recognized by the patient as a product of his or her own transference and projection.

Now, however, there are sharp differences of opinion about what stance by the analyst in working with the transference is actually most conducive to achieving this self awareness. Gill (1979) has suggested that actually focusing on reality, identifying the kernel of reality in the distortion or projection, is the best way to help patients see their role in how they created their idiosyncratic experience of that reality. Others suggest that a focus on the inter-subjective context for the patient's reaction will highlight the patient's own subjectivity. Still others believe that acting as a new object in ways other than being a benign, neutral interpreter (which Strachey felt was the essence of the new, unique, object relationship to the analyst) is the most effective way to promote Strachey's second half of the mutative interpretation: the patient's recognition of his or her distortion. Mitchell (1996), for example, talks of responding to the transference differently than the old objects did, and being uninvolved or neutral may not necessarily be different. Hoffman (1994) talks of being willing to throw away the book in a constant struggle to figure out what would really be in the patient's best interest, as the position of the analyst that is most likely to promote the ownership and integration of new recognitions and understandings. There has been a good deal of controversy over these stances. But, whichever stance the analyst takes, the goal remains to try to help patients recognize, own,

and integrate their new experiences. Which stance will best achieve this in a given case is fundamentally an empirical question.

In addition to suggesting adjustments in the stance within which new insight and experience occur, many analysts have also found it necessary to intervene directly in step 5 to help patients own and use their insights and new experiences; to more directly promote internal structural change. Although in theory the classical model assumed that these changes would automatically follow from insight, Freud was aware of this as a problem in clinical practice. The fact that these changes took time and required repeated interpretations he explained as the need for working through (Levey 2002). Attributing structural change to working through implied that repeated interpretations of conflict, along with identification with the analyst, were sufficient to promote integration. The fact that at times these changes did not follow even with extensive working through he attributed to the adhesiveness of the libido, a biological explanation which does not suggest an intervention (Freud, 1937).

Modern analysts have several different ways of understanding why structural change may not follow from insight, and their different interventions are determined by their understanding. When the problem is seen as the patient lacking the capacity to effectively integrate (what Fonagy has called mentalize), then interventions other than interpretation have been suggested to promote this step. Interventions which directly help patients to integrate are intended to help build psychological capacities and develop psychological skills such as the ability to regulate emotional tension, the ability to recognize affect, the ability to tolerate shame and frustration, the ability to self observe, and the capacity to mourn and leave old identifications, introjects, and self organizations behind. With patients who need active help in developing the capacity to integrate, interventions such as reflection, reframing, modeling, and communicating the analyst's experience of the patient, have been recognized as central to, rather than ancillary to, technique.⁴ This is a situation where interpreting, uncovering latent meaning, is not the intervention of choice, since its use implies that the patient already has the necessary capacity to use the information constructively once he or she has it.

Even for patients who do demonstrate the requisite psychological capacity, the recognition of affects, motives, and meanings that they avoided in the past does not always lead to a new sense of themselves and new actions. Some analysts attribute the failure to truly own and use new insights to conflict about change, the fear of the loss of old attachments, and the fear of the loss of a sense of self. When conflicts are seen as the problem then interpretation of these conflicts is the usual intervention. However, other analysts have taken the fact that change does not consistently follow insight as a basis for questioning the assumption that insight alone is responsible for structural and behavioral change.

The idea that insight is only a part of change has led to a range of technical suggestions to address the clinical problem of promoting integration with patients who do not seem to be able to use interpretations effectively for this step. Neo-Kleinians, for example, will directly address the patient's relationship to the interpretation and insight. Here the actual intervention is still in the form of an interpretation (Mitchell, 1996). Other kinds of interventions

⁴ Gedo & Goldberg (1973) made a similar point in Models of the Mind. They viewed the immediate self organizational state in which the patient was functioning as the prime indicator for the kind of intervention which would be most helpful in deepening the process, with interpretations of latent meaning being the appropriate intervention when patients were functioning in mode 4 of their model. John Gedo (1979) has continued to write about the necessity for developing interventions which can provide belated psychological learning and help patients modify and overcome their apraxias.

have also been proposed. Merton Gill (1982) has addressed this as the resistance to the resolution of the transference, and has suggested confronting the patient with the reality that they now know, but do not wish to acknowledge. Another suggestion by some analysts is that actively encouraging new actions, making step six also a focus for technique, may be useful for some patients. Ken Frank (1992), Prudy Leib (2001), and Drew Westen (1999) have convincingly demonstrated that new actions, whether spontaneously undertaken by the patient, or encouraged by the analyst, can often be powerful ways to promote integration and, at times, even bring in new material. In Westen's example his patient was encouraged to remember moments of praise and to sit with his affective response. This opened up new associations which only arose when the avoidance of the affect was interrupted. This stance furthered insight into the patient's central dynamics. So, new actions may be the best way of deepening the analytic process at certain points, as well as being essential to consolidate change. The empirical test of the appropriateness of encouraging new actions, as with any other intervention, is whether the actions enhance new integration and/ or new awareness. The encouragement will itself have a meaning (as lack of encouragement can as well) that may be important to understand. But we cannot accurately predict what that meaning will necessarily be, or whether it will promote or curtail the analytic process.

It follows from the preceding discussion that, when different interventions are recognized as implementing similar functions, many of the theoretical controversies around technique can be translated into empirical discussions about what effectively promotes a given step in the analytic process. For example, the debate about how neutral to be can be translated into a question of what different analytic stances and interventions can most effectively promote safety for, authentic recognition of, and subsequent integration of a broad range of new affective experiences for a given patient. However, just as different interventions can target the same step, serve the same function, it is also true that the same intervention can be used at different times for different purposes. For example, an interpretation can be used to promote any of the steps in the analytic process. It can be used to convey empathy and enhance a feeling of being safe and understood, or it can be designed to interfere with the functioning of a defense, or it can be an attempt to bring an aspect of the unconscious into awareness, or it can be used to summarize and help integrate disparate awareness, or it can be an indirect suggestion for a kind of action or experience (as with the Brenner example previously cited). Keeping this in mind can help to create constructive dialogue around technical controversies that cut across the steps in the model.

For example, the debate about whether an enactment promotes or interferes with the analytic process can be brought into sharper focus when the purpose of the particular enactment is clarified. When Mitchell (1996) discusses entering into enactments early in the analysis, taking the role the patient gives you in the relationship, he is explicitly describing this as a way to promote engagement and safety. When Hoffman (1994) describes his enactment with a patient who demanded that he call her internist to get her medication, he is using it as the most effective way to uncover the wishes and fears behind the demand. Once the function of the enactment is clarified, then being able to look at whether and how the enactment fulfilled its function, and being able to think further about why it did or didn't work, can lead to empirical comparisons of enactments with more traditional ways of performing the same analytic task.

The same argument holds true for the question of whether self disclosure is helpful to analysis. This intervention can also be used with different ends in mind, e.g. promoting safety and attachment, helping the patient stay with new feelings, or promoting integration. This issue

is actually related to the broader question of the role of personal influence in analytic change. Freud was very aware of the importance of influence and referred to it as the unobjectionable positive transference, or love for the analyst, which he saw as the necessary engine for analysis. So, his idea of neutrality or non influence was a stance, a way to influence; to promote engagement in the process and attachment to the analyst. Strachey (1934) said that the analyst was automatically introjected (experienced) differently from any other object because of the analytic stance of being a benign interpreter, so a special influence was assured. However, although we now know that a traditional stance may not lead automatically to a position of influence (that, in fact, actually gaining a position of influence may be the most taxing aspect of some analyses) analysts have traditionally been uncomfortable actively promoting their influence in any other way.

The reasons include the fears cited earlier that the transference will be curtailed or become unresolvable, thus interfering with the development of full freedom. Because of this we have been more willing to own the use of influence early in the analysis to encourage the patient to engage in the analytic process; to explore and tolerate new aspects of themselves. That influence is explicitly in the service of forcing full freedom. We have been less comfortable and clear on the uses of influence in helping patients with later parts of the process which involve integration and change. Thinking of self disclosure and personal influence and as dimensions of the analytic relationship which may be useful in promoting the common goals provides a way to see influence as not inherently unanalytic. We can evaluate whether any given form of influence actually promotes the analytic goal it is being used to achieve, and also whether it promotes the analytic process as a whole or interferes with some aspect of it. An increased openness to evaluate the analytic effects of personal influence is important because our discomfort with acknowledging influence has interfered with our being able to effectively conceptualize it as part of the analytic change process.

This is an old issue in psychoanalysis. The idea of an experience in the relationship being potentially curative, for example, actually goes back a long way even in traditional analytic circles.⁵ Strachey (1934) wrote that sometimes the analyst's not responding as the patient expects in the transference can have the effect of creating the new perspective that is usually achieved through interpretation. Lucia Tower (1956) wrote a paper on countertransference where she asserted that it was the experience her patient had of bending her to his will, getting her to side with him against his wife, that was actually curative of the defect in his sense of masculinity, and that the interpretations and understanding which followed that event were also important, but could not have been effective without the experience of having affected her. In this case, which was analyzed from a classical stance, the shift in the man's fundamental sense of himself seemed to be the result of unanalyzed interactions, not of increased understanding. Many other analysts, such as Gittleson (1962) and Loewald (1960) have also cited aspects of the relationship as crucial for change, not just for safety. Self psychologists have spoken of the experience of empathic responsiveness as a developmental need, the provision of which in the analytic relationship, in addition to understanding the effects of its previous lack, is seen as an important aspect of creating change through a new experience (Terman, 1988). Pine (1992) has taken this a step further by asserting that other experiences in the relationship, not just being understood, may be curative.

⁵ The contributions of Ferenczi (1928), Rank (1923), and Alexander (1958) are particularly pertinent to this issue, but discussing them would take me too far afield.

Jay Greenberg (2002), in a recent article, highlights the difficulty we have had in integrating these observations into our understanding of analytic change. He wrote that the analytic goal was clear, it was a commitment to self understanding and self exploration. This goal is what differentiates us from other therapies. However, he said, it is also the interactions that occur in implementing the goal that contribute to, and may even be the most important part of, the therapeutic action of the analytic experience. He wrote that there is an inevitable tension between what we aim for in what we do, our goals (self exploration and self understanding), and how what we do actually works. I believe that being freer to conceptualize when and how influence promotes the analytic change process and when it interferes, can position us for a more complete understanding of how the analytic process actually leads to change. Thinking of technique in terms of its functions and the clinical assumptions on which it is based can help free us to do this.

Comparing Interventions and Stances From Different Orientations

Recognizing the common clinical functions of technique and the clinical assumptions behind technical interventions provides a basis for viewing different approaches as complementary to each other, not just competitive. This has the potential to create a more constructive dialogue between different analytic orientations. Clinical case discussions tend to highlight the differences between approaches. Clinicians from one school will see phenomena that those from a different school aren't addressing, and will often suggest addressing different phenomena from a different stance. Since every analytic school can always find material that, based on its clinical assumptions, isn't being adequately addressed by another, it is hard to constructively move past the question of what material to address and in what way. However, when the purpose of addressing the different material is explored (the clinical assumptions of what each approach expects to happen as a result of their interventions), the potential complementarity of the approaches can come into focus. The focus on common goals suggests many questions analysts from different orientations could ask each other which could shed useful light on the analytic enterprise. What are the different clinical assumptions behind different approaches to the same material? What would different analysts expect to happen as a result of their interventions; what would they be looking for? Would they expect a different intervention from the one they propose to be effective? Why or why not? What differences would they expect to occur as a result of the difference in approach, and how do they understand those differences as being important for outcome? Questions such as these create the potential for mutual enrichment from different approaches and clarification of their underlying assumptions.

This perspective allows an approach to be evaluated on its own terms and at the same time compared to others. Two questions can usefully be asked of any intervention; what did the analyst hope to accomplish by the intervention, and why did the analyst want to accomplish this (what did he/she hope/expect would ensue). I realize that it is unusual for most analysts to be consciously thinking about what they are trying to accomplish with a particular intervention. In fact, many analysts think of themselves as simply responding to the patient in the moment in ways to deepen the process. The idea of the analyst hoping to accomplish something with an intervention may even seem to be incompatible with evenly hovering attention and the need to lack therapeutic ambition. However, evenly hovering attention is an information gathering

stance, and when an analyst decides to make an intervention he or she has something in mind, even if it isn't fully conscious. These thoughts are more clearly conscious for a discussant or supervisor responding to a presentation of a case. Discussants and supervisors usually describe what they might have said and why they would have said it. When the discussion also addresses the analyst's intent then there is an empirical basis for evaluating the immediate effectiveness of the analytic intervention on its own terms, and also a basis for clarifying areas of disagreement in a useful way.

For example, if an analyst makes an intervention designed to reduce shame and make the analytic space safer for the patient to experience emerging infantile rage, a discussant with a different orientation may question the intervention in a number of different ways. There are at least four different clinical assumptions which can form the basis for a disagreement. Firstly, the discussant may believe that the intervention the analyst used would not reduce shame. Alternatively, the discussant may believe that the shame may be reduced, but that reducing shame at this time would not effectively make the analytic space safer; that, for example, addressing anxiety would be more effective. A third possible objection could be that the discussant did not believe that increasing safety would enhance the experience of infantile rage at this point; that the intervention would not deepen the process. Once the analyst's intentions are explicitly recognized, and the specific nature of the disagreement expressed, subsequent material can clarify whether or not the analyst's clinical assumption is borne out. Finally, the discussant may see the intervention as effectively reducing shame and enhancing the experience of infantile rage, but may believe that promoting the experience of infantile rage was not the best way to deepen the process at this time; that it would not lead to the desired outcomes. This is a question which the material immediately following the intervention may not answer, but it is also, fundamentally, an empirical question which can be addressed by material later in the analysis demonstrating whether steps five, six, and seven are, in fact, occurring.

Clarifying clinical assumptions is useful for comparing different responses to the same material. At the same time, comparing the different responses is a useful way to clarify clinical assumptions. An example could be a patient who comes into a session feeling "flat", associates to the previous session where the analyst raised her voice, and realizes he felt that the analyst believed he was stupid. Depending on where in the analysis this occurred the analyst might have very different reactions. Early on she might wonder with the patient about his interpretation of the previous session. Later in the analysis, when this kind of reaction had often been explored, the analyst might look to encourage the patient to work with the reaction. One possible goal would be to try to enable the analysand to see that he is creating that belief; that it was not an accurate view of what the analyst was thinking and experiencing. One possible intervention designed to do that might be a genetic interpretation such as, "It sounds as if you experienced me as you used to experience your father when he would yell at you and call you stupid." In this case the genetic interpretation would be aimed at step five, and, by pointing out the source of the patient's expectation, the analyst would also be implying that she did not see the patient that way. The hope would be that the patient would hear it that way and then take the step himself of questioning his readiness to read the analyst as disparaging him.

A different potential goal in that situation would be to try to help the patient become more aware of his affective experience. A different analyst might see this as an occasion to promote step three, helping the patient to recognize and experience more fully affects such as anger or sadness, that might be truncated in the experience of "flatness." This analyst might

believe that bringing up the father would be counterproductive because it would take the affect out of the room. Although that may well be true, the intent of the first analyst at this point was not to heighten the affective experience. There can be arguments made for choosing one focus or the other (or for the belief that knowing which is more useful at any given point is part of the art of analysis), but the differences can be usefully compared in terms of different clinical assumptions.

The hypothetical analyst who made the genetic interpretation in my example, might be operating with the following assumptions. She might see the patient as being quite competent but lacking in confidence at this point. The genetic experiences which had led to this may have been uncovered in the analysis. The analyst may see the patient as now trying things he hadn't tried before and relating in new ways. The analyst may also feel that although these new experiences are objectively successful, the patient's tendency to experience the other as negative is preventing him from subjectively feeling consistently successful enough to have his experience solidify a more confident sense of self. The genetic interpretation was designed to help the patient recognize his ongoing tendency to negatively distort the analyst's view of him. The hope is that this will lead the patient to be more clearly aware of his negative bias. The therapeutic hope in this case is that as he questions this bias and recognizes it, he will then be able to experience his successes more consistently, and have that, in turn, shift his sense of self. The assumption might be that new, successful experiences are important in consolidating change at this point, and that the patient's negative bias is what is limiting his capacity to recognize new experiences as consistently different.

The analyst who wants the patient to have a clearer and fuller experience of the affects that are avoided by the experience of "flatness" would have a different view of the therapeutic need at this point. She might, for example, see the patient as unable to tolerate a feeling of anger, and as needing to avoid and pull out of any experience or relationship that activates anger. In her view it may be the inability to tolerate anger and deal with it effectively that is interfering with the patient being able to experience consistent success in developing more fulfilling relationships. Her expectation would be that as the patient is able to feel his anger more fully and express it directly to the analyst, he will become more comfortable with that aspect of himself. He will then be able to successfully negotiate deeper relationships which inevitably activate anger. Her working assumption might be that it is the inability to tolerate anger, and the need to avoid situations that activate it, that is limiting the patient's capacity for new experience at this time. So, having to tolerate the affect is implicitly viewed as a necessary (although not necessarily sufficient) step in effecting a deeper engagement in relationships, an outcome goal.

Usually the choices in an analysis aren't this clear or absolute. The analyst isn't consciously thinking about all this. In fact, there is usually no active awareness of this, but there is an implicit view of therapeutic action that manifests itself through expectations about the effects these analytic interventions and experiences will have on a person's sense of self, relationships, capacity for fulfillment, and ability to effectively resolve symptoms. If an intervention is successful in terms of the immediate process (that is, has the immediate effect the analyst hoped for), then it becomes an empirical question, to be answered as the analysis continues to unfold, whether the intervention effectively addressed what was needed to help the patient actually move forward in analysis and in life. In terms of this example, both a perspective on one's tendency to distort other people's reactions and a fuller connection to one's own affectivity can be important for therapeutic change. Interventions addressing either

one can ultimately be compared based on their effectiveness in achieving the therapeutic end, which is the same even when the immediate process goal is different.

Analysts can also ask themselves the same two questions (what they hoped to accomplish with an intervention or stance, and why they wanted to accomplish it) in their own work to clarify their assumptions and continue to develop their clinical theories. When analysts are explicitly aware of their assumptions they can recognize when their interventions are not accomplishing what they anticipated. In these situations it is useful to think of analysis as a scientific experiment (which Freud certainly did), and treat the failure as an opportunity to reassess the clinical assumptions, which can lead to modifications of the procedure, the underlying theory, or both. Finding an intervention which does work for that patient is not only useful clinically, but when the different clinical assumptions behind that intervention are recognized, it can potentially be used to expand the analyst's underlying theory of development and pathology, making it more complete by dealing with a reaction it did not previously account for.

Judy Kantrowitz (1992) gives a nice example in her description of an effective shift in her stance to overcome a patient-analyst stalemate. She had taken an empathic stance with the patient which had been very helpful over a seven year analysis. He had developed genuine insight into his conflicts, had a new self understanding, and had had a new relational experience in response to her empathic presence. These experiences had been helpful in many ways, but he was still unable to tolerate reality frustration or to genuinely accept his limitations while still feeling good about himself. He felt he just couldn't do that; he didn't know how. For this patient the expected shift to greater genuine self acceptance was not happening, and she was at a loss as to how else to promote it. Her ability to understand the therapeutic need in terms different from the ones she usually used, in this case in terms of what he wasn't learning, proved helpful in developing a strategy that uncovered an avoidance which had been masked by his helplessness.

As a result of a consultation she adjusted her stance to one that was akin to close process monitoring, but with a focus not on drive derivatives in the room, but rather on the patient's shifts from starting to deal with reality and frustration to his giving up in despair and recruiting others. With this focus he realized that accepting limitations was not a task which he didn't know how to do, but rather that he would actually start to do it but then stop himself. When he saw his volitional (although unconscious) role he was able to recognize that he was reluctant to test himself, and became aware that he had to test reality before he could even know what he could or couldn't do. She was able to help the patient confront what he had been avoiding, challenge his expectations of himself, and eventually learn and develop new psychological abilities.

This example also demonstrates the usefulness of this sort of clinical self inquiry in further developing clinical theory. In dealing with the impasse Dr. Kantrowitz also made a contribution to a further articulation of the steps that go into working through at a clinical level. Working through encompasses the steps from new experience and insight to enduring change, and articulating the steps involved and understanding how to promote them when they don't automatically follow from the work of insight and new experience can lead to a more complete psychoanalytic learning theory.⁶ Some of the steps included in working through are the development of new coping skills (such as tension regulation and self control), a developing

⁶ Working through has virtually constituted the learning theory of psychoanalysis, although some analysts, like French (1970) and Rapaport (1959), have expressed the need for a more general learning theory.

sense of effectance (which can come from success experiences with new behaviors, providing they are felt as such, owned, and valued), having new experiences matter to the extent that they lead to an internal reorganization of priorities, values, and identity, and developing an awareness of and acceptance of change. This kind of microanalysis can be helpful in recognizing what is not happening when change doesn't occur as the analyst expects. What aspect of new learning is not taking place? Is the patient not developing a feeling of mastery? Is she not having success experiences? Is she having them but not recognizing them? Is she recognizing them but discounting their importance? New techniques and different stances that may help to accomplish these goals can be empirically evaluated in terms of their effects on the analytic enterprise as a whole. In fact, one of the advantages of defining analysis operationally at the clinical process level is that it enables our clinical data to be organized by theories other than analytic theories when that is helpful. The related disciplines of cognitive science, neuroscience, linguistics, child observation, and attachment research all have information relevant to understanding development, learning, and change. Along with concepts from other psychotherapeutic approaches they can provide new perspectives on our current techniques, suggestions for developing new techniques, and further clarification of the impact of the relationship on the process of change.

None of this means the loss of the unique place of psychoanalysis. The analytic approach will continue to be characterized by its aim of a wide ranging integration of unconscious aspects of the analysis and through the development of insight in an intensive relationship with the analyst. A clinical level description of the analytic process, however, makes analysis more amenable to a fruitful dialogue between analytic approaches, to effective adaptation of concepts from other sources, and to further development of our own research paradigms. All of these factors should enable us to address more effectively questions such as when and why change through a specifically analytic process would be most appropriate, precisely what is the importance and role of insight in change and self integration, and what aspects of the analytic relationship are crucial in effecting change. This knowledge should enhance analytic practice, enabling us to be more precise in explaining when, with whom, and for what analytic change is most useful and appropriate.

Conclusion

I have presented a clinical model of common goals in the analytic change process which different analytic approaches all share. I have used that model to clarify some of the explicit and implicit assumptions of different approaches which form the basis for their different technical recommendations. I have suggested that recognizing the similar goals underlying different approaches makes it possible for different analytic schools to enrich each other's understanding and clinical effectiveness without having one school supplant another. This approach of relating different analytic schools at a clinical level is more promising than attempting to relate them at a more abstract theoretical level. Both technique and our understanding of therapeutic action could be enhanced by such a dialogue.

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