Traditional Psychoanalytic Process:  
A Concept Ready for Retirement

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Abstract

Unresolved methodological problems concerning traditional psychoanalytic theory, including the lack of consensually-agreed definitions both of psychoanalysis and of psychoanalytic process, are among the principal factors responsible for the relative paucity and limited findings of empirical studies of traditional psychoanalytic process. Further, a current formulation of the concept of traditional psychoanalytic process is so complex and multi-dimensional that empirical assessment is not possible. The concept of psychoanalytic process should be retired.

We propose a new approach of conducting videotape studies of patient-analyst interaction with as few preconceptions as possible, modeled after extant fruitful videotape examinations of mother-infant interaction. We suggest the formation of a study group joining psychoanalytic clinicians and psychoanalytic researchers to seek a more accurate understanding of “what’s going on here” between patient and analyst.
Introduction

PEP lists 305 references to “psychoanalytic process”, but empirical studies of traditional psychoanalytic process are relatively few in number when compared to studies of the outcome of psychoanalytic treatment and to the etiological research in the attachment literature. Although Bellak and Smith (1956) studied audiotapes of psychoanalytic treatment, and Luborsky and Spence (1971 and 1978) offered some ideas, concepts and measurement approaches, in the many decades since then, the empirical literature on process has remains sparse. Even including the few studies of interpretation by those conceiving that interpretation is central to psychoanalytic process, the number remains small. Person (2000) more generally concluded that psychoanalytic research has yet to devise a research methodology to correlate change with a particular therapeutic action. Therefore it is not surprising to encounter voices such as “We would like to see,” write Finlay and Evans (2009),”future evidence-based research focusing on core therapeutic processes rather than simply on outcomes” (p. 53).

We hypothesize that the primary reason for the scarcity of studies of psychoanalytic process is unresolved fundamental methodological problems intrinsic to conceptions of traditional psychoanalytic theory. Modell (2012), discussing the scientific validation of psychoanalysis, commented, “I was thinking of the enormous difficulties encountered if one applies scientific methodology to the clinical setting, to the psychoanalytic process itself” (p.511).
We suggest that this is the time for a major reorientation of approach to the empirical assessment of how psychoanalytic treatment works utilizing as a model the successfully employed videotape studies of mother-infant interaction for the study of patient-analyst interaction.

**The Origin of the Concept of Traditional Psychoanalytic Process**

We begin with a definition: “Psychoanalysis is a method of therapy whereby conditions are brought about favorable for the development of a transference neurosis, in which the past is restored in the present, in order that, through a systematic interpretive attack on the resistances that oppose it, there occurs a resolution of that neurosis (transference and infantile) to the end of bringing about structural changes in the mental apparatus of the patient to make the latter more capable of optimum adaptation to life” (Rangell, 1954, pp. 739,740). The analyst’s neutral and objective intra-psychic position, observing and interpreting, is “the essence and the *sine qua non of the psychoanalytic process*” (Rangell, 1969, p. 72). “The analytic process can be said to begin when the patient really free associates” (Rangell, 1968, p. 22). The patient develops a transference neurosis in his/her mind which the analyst attempts to resolve by interpretations. He adds, “the analyst’s service to the patient’s ego is a limited and specialized one, to provide insight by furnishing interpretations.” (1968, p.25). The process itself, explains Rangell, “takes place within the patient” (1968, p. p.22). He defined the transference neurosis as the marker that is “pathognomonic for the analytic process” (p. 24). This description makes clear why traditional
psychoanalysis has been characterized as a one-person treatment. Everything takes place within the mind of the patient. There is no interaction between patient and the person of the analyst, except that the neutral, objective analyst provides interpretations whose content would be expected to be the same whoever the individual analyst was.

Cooper (1987) presented tightly reasoned arguments from which he concluded that it was time to retire the concept of transference neurosis, which was then regarded as central to the concept of psychoanalytic process. If the transference neurosis is, indeed, retired, and we agree that it should be, the concept of psychoanalytic process is no longer viable.

**Methodological Problems in the Traditional Theory of Psychoanalytic Treatment Resulting from Suggestion**

Freud had admired the worldwide fame of two scientists, Darwin and Koch, who made dramatic discoveries, and hoped that he too might become famous by discovering the cause of mental illness (Schachter, 2002; Breger, 2009). To achieve that fame, it was critical for Freud that psychoanalysis be a scientific enterprise accepted in the nineteenth century model. If psychoanalysts made suggestions to patients, psychoanalysis might be viewed like hypnotic treatment (which Freud had practiced earlier and given up) and psychoanalysis might suffer that same low repute. In that context, Freud’s conception of psychoanalysis as a “one-person” enterprise was not therapeutically but theoretically-based. To avoid the possibility of analytic suggestion the focus was on the patient’s unconscious and
productions. By remaining anonymous, neutral, keeping the patient in abstinence, and providing the patient only with interpretations, Freud (1919) hoped he could avoid a future in which “the large-scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion; and hypnotic influence, too, might find a place in it again…” (p. 168).

Rangell (1968) responded to questions about whether identification with the analyst constitutes suggestion by denying that the patient identifies with the “character, values or ‘style’ of the analyst”, but rather with the analytic functions of the analyst” (p. 25).

The analyst is an interpreting machine. Traditional theory conceives no interaction between the person of the patient and the person of the analyst.

Edelson (1984), however, raised a major methodological difficulty by questioning whether interpretation, the presumed mutative factor in traditional psychoanalytic treatment, is not itself influenced by suggestion. “Is there a psychoanalytic cure distinct from persuasion, a unique psychoanalytic process which is something more than, or better yet, other than, the therapist’s molding the patient to his particular view of man? Is the therapist’s vaunted system of meanings and interpretations merely a strategy to produce the change he deems necessary? … If the therapist knows where the therapy should go and what the outcome should be, it is pari passu, ideological and unavoidably persuasive.” (p.2). He adds, “If we assume that psychoanalytic change depends on the specific truth and the relevance of the therapist’s formulations or beliefs then I think we are on the razor’s edge of ideology. Therapy technique then becomes
technique for helping the patient arrive at insight which will be acceptance of the therapist’s truth. What is this if not the art of persuasion?” Despite his aim to help the patient acquire veridical insight, however, Edelson goes on to open the door to a new mutative force by suggesting, “It may not be the truth arrived at [by interpretation] as much as the manner of arriving at the truth which is the essence of therapy. … ” (p.16).

Meehl (1994) continues to examine the effects of suggestion in his exploration of Fliess’s Achensee question; Fliess had proposed that Freud engaged in suggestion by reading his own thoughts into the minds of his patients. Freud correctly perceived this as a deadly attack upon psychoanalysis, since if the analyst did indeed employ suggestion, psychoanalysis might be seen as closer to hypnosis than a scientific enterprise. Freud responded then, and throughout his life, by denying that he ever made suggestions to patients.

Despite these life-long denials, there is evidence that, from time to time, Freud did make suggestions to patients, beginning, by inference, in his observation (1896) that in every one of 18 hysterical patients he had identified the infantile sexual trauma that caused their neurosis. The probability of Freud ‘finding’ in every one of 18 patients with hysteria an infantile sexual trauma is so improbable that the parsimoneous explanation is that he suggested the occurrence of infantile sexual trauma to each of these patients.

Freud’s technique (1898) described in his chapter on “Sexuality in the Aetiology of the Neuroses” exposes what we consider pressure/suggestion from the analyst:
“Exhaustive researches during the last few years have led me to recognize that the most immediate and, for practical purposes, the most significant cause of neurotic illness are to be found in factors arising from sexual life.” (p.263).

“Having diagnosed a case of neurasthenia neurosis with certainty and having classified its symptoms correctly, we are in a position to translate the symptomatology into etiology; and we may then **boldly demand confirmation of our suspicions** (italics added) from the patient. We must not be led astray by initial denials. If we keep firmly to what we have inferred, we shall in the end conquer every resistance by emphasizing the unshakeable nature of our convictions.” (p. 269).

Meehl’s extraordinarily sophisticated and balanced exploration of this issue of suggestion that Fliess had raised, included several of his own clinical examples of interpretations which had observable clinical effects upon the patient which he thought critical analysts would agree did not involve any suggestion by the therapist. However, despite his own convincing examples Meehl, himself, remains unsatisfied: He concludes his paper, “I am ambivalently saying that Fliess’s Achensee question deserves a better answer than it has yet received” (p.79). The role of suggestion continues to raise methodological issues in traditional psychoanalytic treatment.

**The Introduction of Interpersonal/Relational Treatment Reduces Concern about the Methodological Problem of Suggestion**

The shift from the ‘one-person” to the “two-person” analytic situation “was a long time in coming in psychoanalysis, largely
because of the fear that suggestion would be seen to be the motor that drives psychoanalytic change.” (Pine, 1993, p. 202). In an interpersonal/relational psychoanalytic treatment the analyst’s acknowledged suggestion is recognized as one example of patient-analyst interaction, and therefore itself becomes a subject for study; similarly, explicitly supportive interventions may be significant, acceptable interactions (deJonghe et al., 1992; Schachter and Kächele, 2007) as they are not in traditional analytic treatment. The specific methodological problem of suggestion that Freud, Edelson and Meehl struggled with ceases to be a central methodological problem in interpersonal/relational treatment, though it remains as a matter of some concern to Foehl (2008). Diminution of concern about the problem of suggestion should facilitate the development of empirical studies of psychoanalytic process.

**Additional Methodological Problems May Contribute to the Scarcity of Empirical Studies of Traditional Psychoanalytic Process**

Crits-Christoph et al (2013) note that in classic psychoanalysis as well as brief or focal psychodynamic therapy “interpretation is the central therapist intervention designed to increase insight” (p. 43). They conclude “There is now a substantial body of research accumulating validating self-understanding … as a central change mechanism in dynamic psychotherapy” (p. 56). However, how increased understanding generates therapeutic improvement is not clear. Further, “the strongest conclusion that can be made from the large body of process-outcome studies is that the alliance (a positive
patient-analyst relationship) is an important aspect of outcome across a range of psychotherapies” (p. 67); it correlates significantly with positive outcome. However investigations on alliance in psychoanalytic cases are rare (perhaps the Jones & Windholz study 1990 is an example).

A further methodological outcome issue raised by Josephs and Bornstein (2011) is the commonly accepted knowledge that suggestion may effect a temporary improvement: “a decrease in maladaptive responding following treatment may sometimes reflect illusory structural change, with the patient remaining vulnerable to relapse in situations that activate the underlying pathogenic structure. Genuine structural change would be assessed by deliberately seeking and failing to find evidence of the enduring presence of a pathogenic structure that typically activate that structure …” (p.420).

The Lack of Agreement Regarding Conceptions of Psychoanalytic Process

Even if all the previous methodological problems are put aside, all attempts to study psychoanalytic process founder because psychoanalytic process cannot be defined in the absence of a consensually-agreed definition of psychoanalysis. Without proper definition, treatment cannot be identified as psychoanalytic; research is stymied from the outset. New York State licenses psychoanalysts and defined psychoanalysis, but this definition was not accepted or adopted by psychoanalytic organizations such as the American Psychoanalytic Association (APsaA) or the International
Psychoanalytic Association (IPA). Moreover, while some studies rely on the fact that a treatment conducted by a senior psychoanalyst is by definition psychoanalysis, this is not acceptable for research purposes. Not every treatment by a senior psychoanalyst is necessarily psychoanalysis, and, often a senior analyst’s case presentation may be met by categorical comments from the analyst audience that “That’s not analysis!”

That same response echoes about other attempts to define psychoanalytic process. Wallerstein (1988, 1990) proposed a common ground conception of psychoanalysis, but received little support. Frank, (1998) cited 19 references with little common ground of agreement. APsaA carefully selected five analysts who shared a view of traditional psychoanalysis and charged them with defining psychoanalytic process. Compton, who was one of the five, starts his contribution by short definitions: “By “psychoanalytic process” some mean the alterations (actual or hypothetical) which occur in the mind of the patient in the course of undergoing analysis (Abrams, 1987; Rangell, 1968). Others are referring to the means by which such changes are brought about, that is, to the interaction of the patient and the analyst (Dewald, 1978; Weinshel, 1984). Still others have in mind a "process model" (Thomä and Kächele, 1987), an idea in the mind of a given analyst of a sequence of expectable events derived from a general understanding of treatment or of human psychology. A fourth meaning, and the simplest (though not so simple as it would appear), is: all of the steps along the way from the start of a patient/analyst contact to its termination” (p. 585).
The relation of the "process model" concept at least four usages is complex. Thomä and Kächele themselves distinguished two general types of process models (1987, pp. 331-352). In one, the process of treatment is viewed as a naturally occurring event; the role of the analyst is hardly specified; the transference arises and is eventually resolved by the patient with the analyst as a more or less silent observer-companion. They designate this view as a "fiction of a psychoanalytic process purified of the real person of the analyst …" (p. 337).

The second kind of process model that Thomä and Kächele describe envisons the psychoanalytic process as something that "is constituted and develops interactively" (p. 348). In these models the analyst's idea of psychoanalytic process, as well as his or her personality, is seen to exert an influence on the course of events. They much prefer this kind of model.(p.568)

Compton adds another "first kind" of model, the "natural emergence process model" and the second kind the "interactive process model." Each may be regarded as a polar concept. The interactive process model might be said to purify the treatment of the real personhood of both analyst and patient, by removing the personal continuity that each brings to the interaction. Comptom´s conclusion are clear: Rangell and Abrams de-emphasize the role of the analyst: what is essential happens in the mind of the patient. The analyst´s activity falls under the rubric of "technique," his role is seen as "analyzing." Meanwhile, Dewald and Weinshel prefer an interactive type of process model: Two people are required for
analysis to take place.

Boesky (1990), another of the five analysts, concluded in his paper that “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” (p. 550).


Some years later Vaughan et al (1997) again examined psychoanalytic process, and noted that the analytic process “has been used to define psychoanalysis such that if an analytic process does not develop, a ‘real’ analysis has not taken place regardless of the benefit to the patient” (p. 959). In a fresh effort, they developed the Columbia Analytic Process Scale to measure analytic process. As result of their combined efforts they concluded that “there is no meaningful consensual definition of the term AP (analytic process) among a group of training and supervising analysts from the Columbia Center for Psychoanalytic Training and Research. This is especially striking since we’d expect that a sample of analysts from the same generation and the same institute would bias the study towards finding agreement in the definition of AP …(p.964).
Gray (2002) asks cogently “How can we investigate psychoanalytic process if we cannot define it?” (p. 13). Zepf (2008) notes “that in studies attempting to relate the outcome of treatments to an analytic process, no two studies of outcomes have used the same definition of analytic process” (p. 53). Tuckett, in 2004, asserted that psychoanalytic process still eludes definition and now, fifteen years after Vaughan’s study, despite a good deal of psychoanalytic research, we too cannot identify substantial progress in empirically validating the concept of analytic process.

**Empirical Studies of Traditional Psychoanalytic Process**

The earliest study on actual multiple-session psychoanalytic treatment was by Bellak and Smith (1956) who tape-recorded two psychoanalytic treatments. Later, the case of Mrs. C analyzed by H. Dahl under the supervision of J. Arlow. was audio-taped. Several studies have used this material (e.g. Reynes et al. 1984; Dahl, 1988; Bucci, 1988; Jones and Windholz, 1991; Weiss, 1993; Spence et al. 1994; Bucci, 1997; Sammons and Siegel, 1999).

Ablon and Jones’ (2005) Psychotherapy Process Q-set is an increasingly used measure of patient-therapist relationship. Based on a fairly limited data base they concluded that the degree to which a treatment approximated traditional ego-psychology psychoanalytic treatment was positively associated with therapeutic outcome, and they assert that the Q-set is able to differentiate analytic from psychodynamic and cognitive-behavioral treatment processes. However, no attempt was made to determine whether this new
instrument when identifying a Kohutian, Kleinian, interpersonal/relational psychoanalytic treatment style might not also have correlated positively with treatment outcome.

In a German specimen case the Ulm Process Study Group descriptively examined a number of treatment dimensions like emotional insight (Hohage and Kübler, 1988), change of self-esteem (Neudert et al., 1987), change of suffering (Neudert and Hohage 1988); change of dreams (Leuzinger-Bohleber & Kächele, 1988) and the Core Conflictual Relationship Theme (CCRT) (Albani et al., 2003). These studies have been summarized in Kächele et al. (2006 and 2009).

Two cases – Mrs. C and Amalia X – generated demonstrations of what could be accomplished in terms of process measurements of change. Beenen and Stoker developed the Psychoanalytic Process Rating Scale which rated the cooperation between patient and analyst, the tension between them, the analyst’s explicit interventions, the patient’s disillusion and the mutual satisfaction with treatment.

Current Formulation of a Concept of Traditional Psychoanalytic Process

These empirical studies are presumed to measure aspects of treatment process, and most of them do demonstrate correlations with positive outcome. Although it may be suggestive that these measures represent elements of analytic process, since they are based on correlations causation cannot be assumed. Causation needs randomized controlled design! So far the only study worldwide
that has subjected psychoanalytic treatments to a rigorous randomized controlled trial is the Munich study by Huber et al. (2012). Using Wallerstein’s measure of psychological capacities (DeWitt et al., 1991) as a process change instrument, they demonstrated clear superiority of psychoanalytic treatment compared to psychodynamic treatment.

Boesky (1990), Levine (1994), Ablon and Jones (2005) and Bacal (2011) have all concluded that there is no one correct analytic process; rather there are many processes each unique to a particular analytic dyad. Marmor (1979) wrote based upon observations of psychoanalytic sessions through one-way mirrors, what emerged “was a recognition of the subtlety, multiplicity and complexity of the interacting variables, both verbal and non-verbal, that enter into the psychoanalytic process”. (p.348). Thus, we see that there are many different measures each of which purport to assess aspects of analytic process, that analytic process differs in each analytic dyad and, in addition, it seems likely that the nature of analytic process also changes over time in treatment.

We propose, therefore, the following conception: analytic process is a function of : 1) Measure 1, Measure 2, ….Measure N; 2) Dyad 1; Dyad 2, … Dyad N; 3) Time in treatment 1, Time in Treatment 2, … Time in treatment N. Simultaneous measurement of all these variables is not feasible. This formulation indicates why it has not been possible either to define or to measure the traditional concept, “psychoanalytic process”, and we propose, therefore, that the concept be retired. Consequently, we propose a new conceptual
approach to the empirical assessment of how psychoanalytic treatment works.

**An Approach to the Empirical Study of Psychoanalytic Treatment**

We suggest modelling approaches to the empirical study of analytic process on the videotape studies of mother-infant interaction by Stern (1977, 1983, 1985, 1988, Stern and Sander, 1980, and the Boston Change Process Study Group (2007). This is consistent with the increased focus in recent decades on the importance of patient-analyst interaction in the outcome of psychoanalytic treatment. By deliberately trying to abandon preconceptions in examining these videotapes of mother-infant interaction, Stern and colleagues have been able to recognize and formulate factors that now inform our knowledge of the ongoing mother-infant relationship. Stern (1977) notes that “interactions between patient and analyst instantiate the defensive exclusions or contradictions of the patient’s implicit procedural knowings, including the resort to defensive distortion or exclusion of affective information” (p. 853). These implicit procedural knowings are probably what constitute, in other terms, a variety of mental representations and their modification.

We propose that observations of videotapes of analytic treatment sessions should **not** attempt to focus upon analytic process. Instead, the observer should try to take a fresh look at what was going on between these two persons; ideally, the observer should try to approach the task “without memory or desire”. Instead of trying to look for “analytic process”, investigators should explore
Levenson’s well-known question, “what’s going on here” between the two persons in the videotape. Stern (1977) referring to mother-infant interaction urges: “Experimental situations would not do, not alone. They capture too small a slice of life and lack the context needed for full understanding. Before experiments, we needed (and need) descriptive observations. Second, we needed new methods for these observations, methods scaled down and adjusted to the split-second and nonverbal world of mother-infant interaction” (p.1). He adds, “When you have the wonderful opportunity to be among the first people to see a new world, many of its surprising features are striking enough that they force you to reevaluate your preconceptions. You quickly grasp a new perspective and new realities such as the fact that nonverbal behaviors observed in animal ethology – a head pushed forward or tilted up, or turned away rapidly to the side and down – need to be starting points for observing human social behavior” (p. 2). Further, “This new approach taught me that the important actions occurred in seconds and split seconds … As a psychiatrist, I had been taught to identify behavioral (clinical) “units’ such as “intrusiveness,” “sensitivity,” and “rejection.” These were too large, too global, too vague for what my colleagues and I were doing now” (Stern, p.3)

Both audio-taping of sessions for supervision and research and videotaping have a long history. Interviewing a patient after an analytic session by a research group has been demonstrated not to negatively influence the process (Grande et al., 2004; Huber and Klug, 2004). Objections that videotaping psychoanalytic sessions will modify the psychoanalytic procedure need testing of their own.
Retzinger (1985) noted that “video technology … enables investigators to observe and capture even very fleeting observations and to identify their association with specific emotions. Videotaping of facial behavior thus allows analysis of behaviors that would otherwise be impossible to examine” (p. 138). Olds (2000) commented about “the incredible teaching value of videotapes. There are now many tapes derived from attachment experiments, infant observation work, and parent-infant research, all of which show what cannot be fully described in words. One sees psychodynamics happening” (p. 110, italics added). If shared with the treatment dyad, these videotape data may prove to be a therapeutically useful adjunct enabling both patient and analyst to observe interactions of which they were unaware. We hope that the proposed innovative videotape studies will inform our knowledge of patient-analyst interaction as videotaping enhanced our understanding of mother-infant interaction.

**Discussion**

Whatever contributions the concept of traditional psychoanalytic process may have provided in the past, it is no longer a viable or useful construct, and should be retired. Attempts to assess psychoanalytic process have been complicated by the lack of a consensually-agreed definition of psychoanalysis, and by the obfuscating effects of suggestion by the analyst. Although empirical studies have demonstrated correlational connection with limited aspects of psychoanalytic process, the concept is incapable of making substantial contributions to psychoanalytic knowledge for several reasons. Theoretically, resolution of the transference neurosis
is the core of psychoanalytic process. There is wide agreement that the concept of transference neurosis lacks validity and it has been retired. On that basis alone, that the core construct of psychoanalytic process has been discarded, the concept of psychoanalytic process cannot be considered a viable concept.

In addition, however, the development of a complex, multidimensional formulation of psychoanalytic process makes clear that it will be impossible to empirically assess psychoanalytic process. Since there is no possibility of ever conducting an empirical assessment of psychoanalytic process, the concept of traditional psychoanalytic process should be retired.

A fresh approach to empirical study of how psychoanalytic treatment works should be developed. Videotape study of patient-analyst interaction, which had been used so fruitfully in the study of mother-infant interaction, offers promise of delineating new constructs for assessing how psychoanalytic treatment works. Following the lead of the Boston study group, we would like to see the formation of a study group joining clinicians and researchers seeking a more accurate understanding of “what’s going on here?”.
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