It would be difficult to imagine a psychoanalytic experience more stimulating or thought-provoking than re-reading Freud's "Analysis Terminable and Interminable" (1937a) and examining from our current perspective the many important issues it raises. The questions Freud posed then are fundamental to controversies in psychoanalysis to this very day. Some of the answers he proposed seem outdated and patently incorrect, while others are penetratingly perceptive, anticipating major lines of development for psychoanalytic technique.

It should be recalled that, only a few years before he wrote this paper, Freud had revised his concept of the psychic apparatus in a radical way. He had shifted from trying to understand mental phenomena from a predominantly topographic point of view in favor of a structural approach, an approach which emphasized the interplay of persistent, organized forces in the mind. The topographic model emphasized the pathogenic significance of what was repressed into the system Ucs. The
structural model emphasized the role of intrapsychic conflict and compromise formation. Obviously, it was not easy for Freud, at the end of his days, to make a clean and decisive break with a model of conceptualization which for so many years he had found so fruitful. In "The Ego and the Id" (1923), for example, he stated that henceforth he would be using the terms conscious and unconscious in a purely descriptive, rather than systematic, way. Nevertheless, in "An Outline of Psychoanalysis" (1938), he reverted to discussions of the characteristics of the system Ucs, Pcs, Pcpt-Cs. On re-examining "Analysis Terminable and Interminable," it is both interesting and instructive to observe how concepts from the two different frames of reference are used side by side, sometimes in a contradictory fashion.

Basically, "Analysis Terminable and Interminable" is an essay on psychoanalytic technique. Freud asks: How can we make the process of analysis shorter? How can we make it more effective? Should we be able to protect the analysand against recurrence of his illness? Would it be possible to make an analysand immune to psychological illness in general? Obviously, before these questions can be addressed, one must confront the issue of the nature of the pathological process. Clearly,
the rationale of any technique must relate to correcting the pathological process and its effects. It is at this point that the conceptual model becomes important. In the topographic theory, the system $Ucs$ is the great reservoir or container of the instinctual drives. According to this theory, when discharge of the instinctual drives is blocked by repression, psychological illness supervenes. We can recognize in this formulation the lingering effects of an "actual" theory of pathogenesis. The implications for technique follow quite logically. The goal of technique becomes one of overcoming repression. Its tangible result is the recollection of an event that had been forgotten.

Freud states this quite explicitly. In discussing the possibility of a person becoming "completely analyzed," Freud says, "It is as though it were possible by means of analysis to attain to a level of absolute psychical normality -- a level, moreover, which we would feel confident would be able to remain stable, as though perhaps we had succeeded in resolving every one of the patient's repressions and filling in all the gaps in his memory." (p. 220, emphasis added) Elsewhere, Freud says, "The real achievement of analytic therapy would be the subsequent correction of the original process of repression,
a correction which puts an end to the dominance of the quantitative factor." (p. 227) In actual practice, as Freud noted in "Constructions in Analysis" (1937b), this hardly ever happens, and it becomes necessary to conjecture or to "reconstruct" missing links in the personal history. Several authors (Esman, 1973; Arlow, 1978; Blum, 1979) have noted that patients who have had long and repeated exposure to the primal scene, for example, do not recover the memory, even after convincing reconstruction and excellent therapeutic results. In other words, undoing repression, as exemplified by recollection of forgotten memories, is not in itself the sumnum bonum of psychoanalytic technique.

Concentrating on undoing repression during therapy, Freud reached certain conclusions about the role of the defense mechanisms that in many respects run counter to our current views. He says, "The adult ego continues to defend itself against dangers which no longer exist in reality, and it finds itself compelled to seek out those situations in reality which can serve as an approximate substitute for the original danger, so as to be able to justify, in relation to them, its maintaining its habitual modes of reaction. Thus, we can easily understand how the defensive mechanisms, by bringing
about an evermore extensive alienation from the external world and a permanent weakening of the ego, pave the way for and encourage the outbreak of neurosis." (p. 238) Later in the same section, Freud adds, "The crux of the matter is that the defense mechanisms directed against former danger recur in the treatment as resistances against recovery. It follows that from this the ego treats recovery itself as a new danger." (p. 238, emphasis in the original)

To begin with, it runs counter to the entire concept of the ego as an agency of adaptation (Hartmann, 1939) for the ego to seek out new situations as approximate substitutes for the original danger, in order to rationalize its maintaining pathogenic defense mechanisms. It is much more in keeping with clinical experience to view the situation in a different light. Because of the persistent effect of unconscious fantasy wishes, reality tends to be misperceived, misinterpreted and "misresponded to" in terms of these unconscious fantasies. The patient responds to an external situation in terms that would be appropriate in response to his unconscious fantasy. For example, some phobic patients behave as if entering a tunnel was something dangerous to do, because unconsciously they are responding to a fantasy of entering the mother's body, within
which a dangerous rival lurks, ready to destroy him.

Situations in reality that are in some way comparable to or reminiscent of unconscious fantasies and traumatic incidents tend to evoke and reactivate such fantasies and the conflictual wishes associated with them, and thereby also evoke the need to fend off the dangers connected with them (Arlow, 1969). Only from the most superficial, phenomenological point of view can it be said that the ego treats recovery itself as a new danger. In the unconscious portion of the ego, it is the threatened confrontation with the derivatives of the id impulses that signals the need for defensive activity.

These ideas, of course, are Freud's very own, subordinated at the time to his own emphasis on the importance of recollection in the therapeutic process. In much the same way, Freud referred to transference as a resistance. Insofar as transference substitutes repetition for recollection, this is correct. Transference is a resistance to remembering. At the same time, however, transference does advance the analytic effort. Actually, transference is an example of compromise formation. It represents a dynamically determined derivative of the unconscious, instinctual conflict. Transference allows for a certain amount of instinctual discharge and gratification,
but it does so through a process of displacement from the primary object onto the analyst, from the past onto the present. Like a symptom, a dream or a parapraxis, transference is a 
distorted representation of a persistent, conflictual, unconscious fantasy. The analysis of the transference, like the analysis of defenses, serves the purpose of bringing into clear expression the hierarchically layered derivatives of the unconscious wish.

From the perspective of structural theory, the central technical issue resides not in the uncovering of the repressed nor in the pathogenic role of defense mechanisms, but rather in the analysis of the compromise formations the ego has been able to effect (Brenner, 1976). Some compromise formations are adaptive and effective; others are ineffective and pathogenic. The issue is the successful or adequate resolution of conflict, rather than the recovery of the repressed memory. Analyzing the id wish and the ego defense are of equal importance during therapy. The latter is not subordinate to the former in significance. Freud's metaphor, comparing psychoanalytic technique to the swinging of the pendulum, i.e., first the analysis of a bit of the id, then the analysis of a bit of the ego's defenses, demonstrates the increasing attention he was
paying to the role of conflict and to the importance of appropriate compromise formation as the key to improvement. He makes the point, for example, that only when the etiology of the case is predominantly traumatic will analysis succeed in doing what it is so superlatively able to do: "Only then will it, thanks to having strengthened the patient's ego, succeed in replacing by a correct solution the inadequate decision made in his early life." (p. 222, emphasis added)

He says, in effect, that analytic therapy endeavors "to replace repressions that are insecure by reliable egosyntonic controls, although we do not always achieve our aim to its full extent." (p. 229)

Throughout his discussion of why analysis takes so long and why the results frequently fail to come up to our expectations, Freud repeatedly emphasizes the quantitative factor, i.e., the strength of the instinctual drives and the strength of the resistance to ego modification. In both instances, he emphasizes the factor of congenital endowment. Concerning the defenses, he advances the idea of primary congenital variations of the ego. He says that every individual selects only certain of the possible defensive mechanisms and invariably employs those which he has selected.
Actually, this is not the case. It is true that, in the process of symptom formation, hysterics selectively favor repression, conversion, displacement and avoidance. Similarly, in the process of symptom formation, patients with obsessive-compulsive neurosis preferentially employ isolation, reaction formation, undoing and rationalization. However, as Brenner (1981) has made clear, in all patients and in all individuals, one may observe that they use a wide range of mental mechanisms in the various compromise formations that the ego effects. Nor are these mechanisms utilized exclusively for purposes of defense; they may be employed to facilitate drive gratification as well as self-punitive trends. As a result, Brenner has suggested that it would be more accurate to refer to these psychological phenomena as "mental mechanisms," rather than mechanisms of defense. Furthermore, there is considerable clinical evidence demonstrating how the preferential utilization of a particular mechanism of defense may be the consequence of specific object relations and identifications (Arlow, 1952; Hartmann, 1953; Wangh, 1959), an outgrowth of experience rather than a congenital predisposition.

In trying to explain why so often analysis fails to achieve its therapeutic goals, Freud uses several different
levels of theoretical conceptualization. Explanations such as "the stickiness of the libido" or "the amount of free aggression" belong to the realm of metapsychological formulation (Waelder, 1962). Other explanations, such as the effect of an unconscious sense of guilt leading to a need for punishment, constitute explanations at the level of clinical theory. It is very difficult to establish the validity of metapsychological interpretations when applied to an individual case. This is not, however, the situation with explanations based on clinical theory. Since the publication of "Analysis Terminable and Interminable," much has been learned about those factors, especially in the transference, that serve to prolong the length of treatment and to undermine its therapeutic effects.

The termination phase, in itself, frequently represents to the patient the last opportunity to fulfill his repressed unconscious wishes that form part of the hidden agenda with which he entered analysis (Nunberg, 1925). Many analysts, for example, feel that the termination phase, of necessity, is characterized by a period of mourning, because it represents a recapitulation of the basic transference, which reflects the vicissitudes of childhood separation experiences. While this
is often true, it is not always the case. Unresolved instinctual and narcissistic aspirations from all levels of development may quietly frustrate the therapeutic process. There is a class of patients, for example, who enter treatment, usually in the mid- or late 30's, slightly depressed and with vague complaints that do not conform to any readily recognizable syndrome. They may mention in passing that they feel disappointed in themselves for not having attained their full potential or that perhaps there is some hidden gift or talent within them that has to be unblocked by treatment. It frequently turns out that these patients entertain grandiose self images, to which they aspire, and analysis represents to them the last, magical instrument whereby the wish for transformation can be achieved (Reich, 1953). If they fail to achieve their goals, they feel it is because the analysis has not gone deep enough or the particular analyst may not be capable. Another one might be better.

There are certain grandiose expectations that some patients have from analysis, which they stubbornly refuse to surrender. It is not just that some women -- and men too -- wish to acquire the paternal phallus. What they want is the biggest, the grandest one in the whole world. Nothing less,
not even outstanding success in real life, will satisfy them. Sometimes such fantasies bear a specific relationship to the analytic situation. Orens (1955) described a patient who had no inclination to leave treatment, in spite of the fact that she had made excellent progress in overcoming her difficulties. It turned out that the patient really wanted to stay in analysis forever, because being in analysis to her was comparable to being pregnant. The analytic chamber constituted the womb and she was the baby-penis contained therein. She had a fantasy of a perpetual pregnancy; unconsciously, so long as she was in analysis she remained phallic.

Schmideberg (1938) has described how analyst and analysand may be guided unconsciously by omnipotent anticipations of how the individual should be at the end of the treatment. The "fully analyzed" person" is expected never to have conflicts, to be immune from anxiety, always to be in control, never susceptible to humiliation, etc., et cetera. These, Schmideberg points out, represent later-day articulations of what a child feels it means to be grown-up. This was illustrated to me dramatically by a patient who became depressed when I made a slip of the tongue. If I, a supposedly "fully analyzed" person, was not in complete control, how could
I ever help her to achieve that goal? It made her think of how she wet the bed when she was a child and how humiliated she felt at a recent elegant dinner party, where she was asked to pour the tea and, because of a broken spout, the tea ran all over the place.

Mention should also be made of a whole range of specific transference fantasies that are often kept in abeyance and appear either during the termination phase or shortly after the analysis is over. The patient may feel some discomfort and return for consultation or treatment, as part of an unanalyzed transference residue, unconsciously sequestered for the end of the analysis. One patient, for example, the son of a surgeon, who grew up as the only Jew in a small New England town, had been teased and made to feel humiliated by his friends and classmates, who mocked his circumcised penis. Shortly after the analysis, he returned, complaining of some depression and a sense of disappointment that the analysis had not given him what he had expected. Further analysis disclosed an interesting fantasy. He imagined that, throughout the analysis, I had put into a strongbox in my office all the money that he had paid me. He expected that, at the end of the analysis, I would take the money out of its hiding place
and give it back to him. Behind this was an unconscious fantasy that the analyst would restore his foreskin.

Even the most mundane expressions of what may happen after the analysis deserve the closest attention during the termination phase. Patients frequently conjecture on the nature of the final leave-taking and raise the question as to whether they can establish a friendly or personal relationship with the analyst: Perhaps they will run into him on the street or at some social gathering; would the analyst accept an invitation to dinner?, et cetera. A full chapter on analytic technique could be written about patients' fantasies concerning "after the analysis." Many hidden transference wishes surface in this seemingly innocent context because, after the analysis, the taboos that pertain to the professional relationship presumably no longer hold. They resemble the ideas of certain religious believers who hope to attain in the afterlife what was not possible for them during their terrestrial existence. Before one facilely accepts the patient's unwillingness to separate or clinging to the analyst because he is a "new object" as the reason why patients are not ready to leave treatment, it is always advisable to examine carefully what lies behind the patient's notions of what life will be like after the analysis.
Finally, of course, there are those realistic disappointments and unjust blows of fate that the analysis is supposed to correct -- persons with physical defects who want to be reborn whole, dead parents to be restored, absent parents to be avenged on -- the whole range of the "exceptions" as described by Freud (1916). In other words, before resorting to such concepts as the stickiness of the libido or congenital weakness of the ego, more attention should be paid to the experiential factors in the individual's life that influence the vicissitudes of instinctual development and the growth of the ego as they affect the nature of the neurotic process and the character of the transference.

The limits of what treatment can achieve are inherent not only in psychoanalysis, but in the nature of the human condition as well. Psychoanalysis cannot create a "perfect" human being, nor can it render one immune to possible neurotic illness, nor even assure a successfully analyzed person that his neurosis will never recur. Conflict is an inevitable, unavoidable dimension of existence. As Freud said, fate may be kind to an individual and spare him ordeals too severe to master. There are, in fact, limits to the capacity for adaptation. The ego capacity of the human evolved in the
context of an "expectable environment" (Hartmann, 1950) and operates in consonance with such a setting.

The psychoanalytic situation, which is the basic research and therapeutic instrument of psychoanalysis, was devised specifically for eliciting a continuing, dynamic record of intrapsychic conflict (Freud, 1925). Whatever one can interpret concerning the influence of unconscious elements of the mind is an inference sustained by the nature and the pattern of the patient's associations, conceptualized in terms of the interplay of conflicting forces. By the very nature of its methodology, psychoanalysis can only deal with active conflicts as evidenced by the derivative manifestations that appear in consciousness. A latent conflict is a hypothetical possibility, which we extrapolate from our knowledge of the vicissitudes of development. External events, among other factors, of sufficiently severe intensity or of a special nature may have the capacity to disrupt a previously effective compromise formation that had proved satisfactory in mastering an earlier conflict. In this way, beneficial results of a successful analysis might be undone, or a new form of neurotic illness may supervene, based on the evocation of a conflict that had been in the past spontaneously mastered in the course
of normal development. (It is to such problems that Hartmann [1955] directed his concepts of instinctual neutralization and deneutralization and of ego strength, as measured by the resistance to the reinstinctualization of ego functions.)

Behind the notion of a prophylactic immunization against future neurotic illness is the illusory, magical quest for eternal happiness and perfection, a fragment of childhood narcissism which we never completely surrender. Some schools of psychoanalytic thought seem to suggest that such a goal may be attainable. This would seem to be the case for those who play down the role of conflict in pathogenesis in favor of the vicissitudes of development and object relations. If only the mother had done things properly and the object relations had been truly empathic, how differently things would have turned out! Such considerations quite logically influence the way the analyst treats his patient during psychoanalysis. Friedman (1978) has characterized these techniques as representing a form of replacement therapy, that is, an attempt to recreate and improve, during the analytic treatment, the mother-child relationship of the first years of life. Treatment is effected as a recapitulation of development but under more favorable conditions, with the analyst serving as
an appropriate mother surrogate. In this new developmental experience, the bad mother is replaced by the good analyst and the persistent structures from faulty development can be undone. Supposedly this leads to a restructuring of the psychic apparatus in a new process of development under the aegis of an appropriate, empathic, affective relationship with the therapist. According to Friedman, one of the concepts implicit in this approach is the notion that growth is a non-structured phenomenon that happens automatically if not interfered with by the noxious intrusions of the less-than-adequate, unempathic mother. Such thinking may lead to therapeutic goals that are quite illusory in nature, for example, the functioning of a superego that is completely rational and dominated totally by secondary process thinking, or the belief that a mature, truly loving object relationship is totally unambivalent.

As Freud pointed out, there are limits to the prophylactic contribution to mental hygiene that psychoanalysis can make. Life makes it impossible to raise any child in a perfect manner and, even under the best of circumstances, there is no guaranty against future psychoneurotic difficulties. Until now we have been emphasizing how external events undo
the psychological equilibrium achieved through appropriate compromise formations. We must, at the same time, take note of the role of each individual's personal contribution to the process of pathogenesis. In the normal range of experience, the contribution of the individual, particularly the role played by his fantasy life, is of equal importance in the process of pathogenesis. This touches on the psychoanalytic concept of trauma. Except for extreme cases of abuse far beyond the average expectable environment, trauma does not reside in the external event alone. Whether an experience proves traumatic or not depends upon the ability of the individual to effect a satisfactory compromise formation out of the conflicts that experience generates. Not all children who lose a parent in the first or second year of life respond in the same way. While such an event, like other events, represents an adaptational challenge, it is not in and of itself pathogenic. Whether an experience proves traumatic or not depends upon the individual's ability to effect a satisfactory adaptation, one that integrates into a successful compromise the elements of the conflict that the experience generates.

I believe that those analysts who center their view of human nature on the inexorable and ubiquitous nature of
conflict tend to take a more realistic view as to what can be expected from analysis. They are willing to settle for less. It seems that, in the end, in "Analysis Terminable and Interminable," this is the conclusion that Freud finally reached, when he said, "Our aim will not be to rub off every peculiarity of human character for the sake of a schematic 'normality,' nor yet to demand that the person who has been 'thoroughly analyzed' shall feel no passions and develop no internal conflicts. The business of the analysis is to secure the best possible psychological conditions for the functions of the ego; with that, it has discharged its task." (p. 250)

In other words, the goal of analysis is to effect the most workable compromise amongst the various forces in conflict in the human mind.

In certain respects, present-day views on technique diverge sharply from those that Freud held in this 1937 paper. This is particularly true in regard to the part played by the attitude of the analysand towards the analyst, that is, by whether the transference feeling towards the analyst is positive or negative. Freud says here that, when the patient is confronted with the unpleasurable feelings that arise as a result of the fresh activation of his conflicts, negative
transference supervenes and tends to annul the cooperation from the patient which is necessary to maintain the psychoanalytic situation. The patient refuses to listen and interpretations have no effect upon him. Freud revives here an earlier concept of his concerning the relationship between positive and negative transference and therapeutic technique. In his technical papers, he urged that interpretations be given only during the phase of positive transference, because then the patient would be prone to accept them. On the other hand, the patient would reject interpretations offered during phases of negative transference.

This has not been borne out by actual experience. To begin with, as Freud himself had said on other occasions, whether the patient accepts or rejects the interpretation given by the analyst is of little consequence. What is important is the dynamic effect of the interpretation. The patient may reject some insight offered by the analyst but then come up with confirmatory material. Shall we say, in such an instance, that the initial rejection is negative transference and the subsequent production of confirmatory material constitutes positive transference? If we view transferences as vehicles of specific unconscious fantasy
wishes, if they represent derivative compromises of persistent unconscious fantasy, then the whole concept of positive or negative transference is irrelevant. In fact, it seems that the terms positive and negative transference are outmoded and should be dropped. Material that emerges during the period when the patient feels unfriendly or hostile to the analyst may, nonetheless, serve as the basis for deepening one's insight into the patient's conflicts and for advancing the therapeutic work. So-called positive transferences may be quite beguiling and serve the purposes of resistance even more effectively than certain so-called negative transferences. Labeling the patient's productions in terms of the conscious, affective tone that permeates them skews the analysis of their meaning in favor of surface phenomena which, on examination, may turn out to serve primarily the purposes of defense. In his study, "On the Vicissitudes of Insight in Psychoanalysis," Kris (1956) has demonstrated the great range of variation of meaning that may pertain to the patient's behavior vis-à-vis the analyst.

In closing, I would like to comment on an aspect of re-reading this paper that I am sure I share with many colleagues. No matter how often one returns to these sources,
one always comes upon something new and striking, as well as something which has influenced our analytic thinking even when we were not aware of it. Freud notes that, in order to sustain the analytic situation, it is necessary for the analyst to ally himself with the ego of the person under treatment, in order to subdue portions of his id which are uncontrolled. This, of course, is not possible in the case of psychotics. They do not have a normal ego. Freud then goes on to say, "The ego, if we are able to make such a pact with it, must be a normal one, but a normal ego of this sort is, like normality in general, an ideal fiction. The abnormal ego, which is unserviceable for our purposes, is unfortunately no fiction. Every person, in fact, is only normal on the average. His ego approximates to that of the psychotic in some part or other and to a greater or lesser extent; and the degree of its remoteness from one end of the series and of its proximity to the other will furnish us with a provisional measure of what we have indefinitely termed an 'alteration of the ego'." (p. 235, emphasis added)

In a previous communication, Brenner and I (1969) proposed that, instead of having two separate theories in psychoanalysis, one for the neuroses and another for the
psychoses, the structural theory may be used to encompass the psychopathology of the psychoses. Symptoms of the psychoses could be understood in terms of conflict, defense and compromise formation. We suggested that there is a complementary series, a range of disturbance reflecting the ego's inability to effect adequate resolution of conflicts, from the severe pathology observed in the case of the psychoses to the relatively mild disturbances observed in neurotics and the so-called normal. The problem in the psychopathology -- not the etiology -- of the psychosis resides in the failure of the weak ego vis-à-vis the overpowering force of the drives. The etiological considerations, namely, how the ego came to be so weak and the drives so powerful, remain elusive. Our ideas extend the views Freud expressed in the section of "Analysis Terminable and Interminable" quoted in the previous paragraph.

Freud raises many issues in this paper concerning the role of the analyst, his personality and technique, as they relate to the outcome of therapeutic work. Issues of countertransference, empathy, psychoanalytic education, and the analyst as a model for identification must be reserved for later consideration. The wealth of ideas contained in this paper is inexhaustible and their pursuit interminable.
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