Psychoanalysis

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Why is Sigmund Freud important to contemporary life? 2
The listening cure: understanding the subjectivity of the patient 2
Dora 2
The interpretation of dreams 3
Freud as neurologist and sexologist 3
Psychosexual stages of development 3
From the topographical to the structural model: two theories of anxiety 3
Defense mechanisms 4
Intrapsychic conflict (wish, defense, compromise formation) 4
Development of morality in groups and individuals 4
Unconscious fantasy/unformulated experience 4
After Freud 4
Earliest theorists 5
Drive/ego theorists: mainstream psychoanalysts through most of the 20th century 5
The primacy of relationships and social forces 5
Attachment theory and psychoanalysis 5
Pluralism vs. multiple orthodoxies 6
Intrapsychic vs. interpersonal conceptions and approaches 6
Modern conflict theory 6
The past is never dead. it's not even past 7
Two persons are in psychological contact 7
Unconscious fantasy vs. unformulated experience 7
Rapprochement 8
Systematic research and neuropsychoanalysis 8
Systematic research 8
Neuroscience and neuropsychoanalysis 9
Summary and outlook 9
References 9

Key points

- *The Interpretation of Dreams* was a key publication at the start of the 20th century by Sigmund Freud which remains a foundational text of psychoanalytic thought.
- The *Psychosexual Stages of Development*, developed in a publication by Freud 5 years later, set a foundation for developmental theory.
- In *The Ego and the Id* of 1923, Freud introduced the structural model which remains the core of one branch of psychoanalysis termed *ego psychology*.
- Ego psychology makes use of the interpretation of *Defense Mechanisms*, or unconscious (nonexperience) processes which protect us from tensions between wishes, internalized prohibitions, and the constraints of reality. Ego psychology psychoanalysts help patients to better understand their rigid, maladaptive, and self-defeating use of defenses in the service of building self-awareness and freeing the patient for greater range of choice in resolving the inherent conflicts encountered in day-to-day life.
- The *Interpersonal/Relational School*, focuses on the matrix of meanings as it unfolds within the dyad created by the therapist and the patient. The therapist assumes less a position of an objective observer of defenses and instead focuses on areas of *enactments*, or areas where the therapeutic dyad can together discover new meanings through their collective actions in the service of building reflection and understanding in the patient.
- Both schools make use of *transference*, or the interactions between the patient and therapist that are modeled on former relationships including those of the patient and their parents, to create emotional mediacy and work through problems as they occur within the treatment.

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Glossary

Countertransference The therapist's reaction to the patient's transference (narrowly) or the therapist's emotional feelings about the patient (broadly), initially seen as a destructive force, later understood as a valuable tool for understanding the work of the treatment

Free Association The method of speaking freely without omitting, restraining, or refraining from mentioning thoughts or contents which on the surface seem initially trivial, objectionable, or not worth mentioning

Repression A defense mechanism which places objectionable material out of awareness of the consciousness to reduce conflict or tension in our awareness in day-to-day life

Slip of the tongue Trivial or happenstance occurrences which the therapist marks to help the patient understand their importance in understanding repressed material

Talking cure Sigmund Freud's early formulation of the manner in which recovery from illness is achieved; the individual freely associates without restraint in order to bring with the help of the therapist disavowed or minimized material to light in its importance

Unconscious Aspects of the individual of which the person is not immediately aware but which define the authenticity of the person

Abstract

Psychoanalysis is a term coined by Sigmund Freud describing the various forces working on the mind, mainly of our consciousness and its connection to early childhood experiences. In contemporary mental health treatment both psychoanalysis and psychodynamic psychotherapy follow the same principle, with the former being a more intense treatment and the latter less intense. Currently, the two main psychoanalytic theories are the *interpersonal/relational model*, which focuses on the actual relationship between analyst and patient, and the *intrapsychic model*, which focuses on how the actual relationship is influenced by *mental representations* of early relationships, which persist as *unconscious fantasies*. In recent years, there have been many empirical studies of *psychodynamic psychotherapy* and the field of *neuro-psychoanalysis* has attempted to integrate basic psychoanalytic concepts with modern cognitive/affective neuroscience.

Why is Sigmund Freud important to contemporary life?

Psychoanalysis remains an important field of mental health care. Additionally, it has informed fields from the humanities to the quantum sciences in its ability to consider ambiguity, uncertainty, and overdetermination of meanings. In this article, we explore the historical roots of the field, its persisting contemporary relevance, and its promise for the future.

The listening cure: understanding the subjectivity of the patient

Sigmund Freud was born over 150 years ago. This was a very different time. Living a long life, his earliest thoughts were formulated within the very different landscape of the Victorian Era and *fin-de-siecle* Europe, and he lived through the damages of the First World War, and the terrors of the start of the Second World War. In some quarters, it is considered a given that Freud's constructions are outdated, wrong, or irrelevant to contemporary psychological treatment. From today's perspective, flaws in Freud's technique are obvious, especially his ultimate conception of femininity. However, Freud's patriarchal approach was consistent with the tenor of the times. It is important to bear in mind Freud's revolutionary innovation at the turn of the 20th-century. Freud learned that in order to effectively treat patients, doctors had to *listen* to them, a quantum leap in psychological treatment, far outweighing the impact of technical errors.

Dora

Freud's treatment of the adolescent *Dora* is an example of the dramatic change in the history of mental health treatment. After listening to Dora's father's disparaging complaints about his daughter, Freud insisted that he had to hear *Dora*'s side of the events that transpired. Few from that era would have thought to take into consideration the young woman's subjective experience and would simply have believed the father's version of events.

Freud himself wished to be remembered as an heir to those who triggered disillusionment in humanity. Copernicus discovered that the earth is not the center of the universe and Darwin that humans were not at the center of creation. Freud discovered that humanity is not the master of its own house because of the power of the unconscious mind.

Freud's idea of *unconscious* mental activity has always been controversial. There is evidence that many of Freud's ideas are consistent with the findings of modern cognitive neuroscience (Solms, 2021). Two of Freud's most important discoveries which retain clinical relevance are that an individual's development, actions, thoughts and feelings are influenced by an individual's past, especially *childhood experiences* and that these factors are *unconscious*.

Much of the language of Freud still is common parlance in the 21st century: *unconscious*, *repression*, *talking cure*, *slip of the tongue*, and *free association*. The rubric, *talk therapy*, is the common phrase utilized in therapies where a patient speaks and the therapist *listens.* The term *listening therapy* is more appropriate because patients in need seek help from professionals who listen and respond in appropriate ways. Can therapy be efficacious if the person talks without anyone listening?

The interpretation of dreams

Much of the work in the *Dora* case was set out in this well-known work. This publication in 1900 marked Freud's turn from neurology to psychology as an explanatory model of the mind. Several major mental mechanisms were postulated, including *displacement* and *condensation*. Displacement is the substitution of a less objectional image or content for another, while condensation is the signification in one form of many ideas or associations. These two original ideas of Freud were shown to have later parallels in linguistics with simile and metaphor and proved that the mind was structured like a language. Understanding the meaning of dreams was the *royal road to the unconscious*, by which we could read the speech of our dreams to better understand our personhoods. And, making the unconscious conscious would lead to cure.

Freud began his clinical career as a neurologist, whose staple of practice included nervous (hysteria, neurasthenia, and obsessions) and psychotic disorders. By 1895, Freud attempted to develop a comprehensive neurological theory, however, the limited knowledge of the day led Freud to developing a purely psychological theory, resulting in *The Interpretation of Dreams* (1900), mainly based on Freud's self-analysis following his father's death in 1896.

Freud as neurologist and sexologist

At the end of the 19th and the beginning of the 20th century, sexologists actively studied human behavior. They conceptualized sharp demarcations between normal and abnormal sexual behavior. Freud's (1905) work demonstrated that the distinction between normal and abnormal was not clearly delineated, and that adult sexual fantasies and activities were derived from childhood passionate states. With his revolutionary method of *listening* to patients via *free associations* of what came to their mind, Freud heard about childhood experiences, particularly sexual feelings and fantasies. He compared patients' fantasies with the reports of sexologists, understanding that bodily areas other than the genitals provided sexual-like pleasurable experiences (*oral* and *anal* stimulations, *erotogenic* zones). This led to the conclusion that there was an association between those pleasures and the pleasure from *genital* sexuality. The focus on psychological explorations promoted a sense of hope in the treatment instead of pessimism, as individuals with abnormal sexual behaviors were not all so different from those with so called normative sexual behavior.

Psychosexual stages of development

In the *Three Essays on the Theory of Sexuality* (1905), Freud postulated *erotogenic zones* (other than the genitals) as the source of childhood sexual feelings and fantasies into: *oral*, *anal*, and *phallic.* The oral phase related to pleasure derived from feeding and the mouth, while the anal phase derived from the control and mastery of expulsion. The phallic phase implying the primacy of the penis for both boys and girls was one of the most controversial Freudian concepts. As the concept of *penis envy* was seen to overlook primary femininity, the term, *phallic phase* for both boys and girls came to be questioned because of its patriarchal assumption. The concept *genital phase* is more consistent with development, which refers to a period in which childhood psychosexual conflicts are predominantly resolved and in which matters of intimacy in love relationships reign as the predominant source of gratification.

The height of the pre-school period, around ages 4–5, is the *Oedipal Phase* where children experience intense passions toward parents (intense love and hate). Since these passions cannot be fulfilled in reality, children develop a variety of *defense mechanisms* to moderate their wishes. At the same time (at the age of 7 ± 1) there is great cognitive leap and a period of *latency* (middle childhood) follows with a diminution of passionate feelings and more focus on learning and activities. *Pre-adolescence* and *Adolescence* occur during tweens and early teens with the upsurge in hormones and bodily changes. Recently a stage of *emerging adulthood* has been conceptualized (late teens to mid-twenties).

From the topographical to the structural model: two theories of anxiety

Freud's first conception of the mind was a *topographical model,* with a *conscious, pre-conscious* (not immediately conscious but capable of drawing to consciousness), and *unconscious. Libido* (or sexual energy) was the driving force, "residing" as a reservoir in the *unconscious.* If there weren't sufficient release, libido would be dammed up and converted to *anxiety.* This model fostered the technique of making the unconscious conscious, bypassing or barreling through patients' *defenses* which worked to keep content within the unconscious.

Recognizing the need to *respect defenses,* the *structural model* was developed. The *id* represents the person's innate drive for pleasure, while the *ego,* the master agent, erects barriers (*defense mechanisms)* to keep forbidden wishes in check. The concept of *signal*

anxiety, as a function of the *ego*, was developed: If forbidden wishes come too close to consciousness, signal anxiety functions adaptively to warn that punishment may ensue. The new adage of analyzing the *defenses* was "Where *id* was, *ego* shall be" instead of "making what was unconscious conscious." A third agency was conceptualized: the *superego*–or that aspect of the mind which is defined as an internalization of a moral system, discussed by Freud (1900) in *Civilization and its Discontents*.

Defense mechanisms

Defense Mechanisms are Freud's (1926) most validated constructs. *Defenses* had to be respected and addressed in analysis rather than forcibly overcome. Anna Freud (1936) began the first systematic study of *defenses* and *defense mechanisms*. S. Freud had delineated *repression* (see glossary). In addition, Anna Freud and others, described many other defense mechanisms. Vaillant (1992) developed a hierarchy of maturity of *defense mechanisms*; Cramer (2006) identified three broad categories of defenses, while Bornstein (1945) demonstrated the clinical value of addressing *defenses against painful emotions* in children. Gray (1996) systematized focusing on *defenses in adult analyses*, and work on defense mechanisms will certainly continue in decades to come.

Intrapsychic conflict (wish, defense, compromise formation)

The model of *intrapsychic conflict* proposes that all human activity entails a *compromise formation* among *wishes (unconscious)* and *defense mechanisms* (Brenner, 2006). If *compromise formations* are adaptive, one may not discern the presence of conflict. If an imbalance between *wishes, defense mechanisms,* and *superego demands* develops, *compromise formations* can become maladaptive and treatment may be sought.

Development of morality in groups and individuals

Freud was often disillusioned by civilized countries acting immorally and individuals acting brutally. Freud (1900) discussed the irremediable antagonism between the demands of primitive instincts and the restrictions of civilization, attained through renouncing or controlling these impulses. In social interactions, people have mixed feelings toward others, including conflicts between love and aggression. Many falsely think that the solution to life's problems is to eliminate *guilt* and to lead "guilt-free" lives. However, it is impossible and unwise to totally eliminate *guilt*, which is normal and necessary in order to allow social interactions: thinking not just of oneself but of the other person too. Thus, the source of the commandment "Love thy neighbor as thyself."

One of the major problems for humanity is reaching a balance and reconciliation between the desires of one individual and their group or one group and other groups. For example, a group may be cohesive and caring for its members but may direct its aggression toward members outside the group or toward another nation.

Child-rearing always involves teaching a balance between frustration and gratification. If children were allowed limitless gratification, progressive development toward autonomy within the social environment would be greatly compromised. The ability to reflect upon thoughts and feelings in oneself and others (*mentalization)* provides children with a fuller range of responses to their own and others' perceived aggression.

The key factor for the control of aggression is the development of the conscience (*superego*). Young children identify with their caretakers, *incorporating* their conceptions of right and wrong, gradually *internalizing* caretakers' authority to limit and control actions (Freud, 1900). External experiences of violence, abuse, and deprivation influence children's experience of their own and others' aggression and prevent them from modulating their aggression.

Unconscious fantasy/unformulated experience

Unconscious fantasies are considered *mental representations*, particularly of important persons in one's life. These *memory images* are organized from childhood as a result of sensory-motor experiences and are imbued with pleasurable and unpleasurable feelings. With development, the child has more interactions and, thus, more pleasurable/unpleasurable images, which become organized as persistent *unconscious fantasies*.

In *interpersonal/relational theory, unconscious fantasy* is considered an impediment to analytic work because it implies that mentation already exists (made conscious as a result of the analyst's interpretations). *Unformulated/unmentalized experience,* which is symbolized during the analytic process, is a more valuable construction.

After Freud

Young-Bruehl et al. (2009), in *One Hundred Years of Psychoanalysis, a Timeline: 1900–2000*, depict the various strands of psychoanalysis during its 1st century, from the *Interpretation of Dreams* (1900) to the turn of the 21st century, the beginning of *neuropsychoanalysis*. The bands include a large central thread representing the Freudian mainstream; other bands include the French school, cultural theorists, Kleinians and British Independents, the Budapest school, interpersonalism and relationalism, and Jungians and existentialists. Each band is highlighted by significant books on each theoretical perspective.

The list highlights the diversity in psychoanalysis, all of which have had a significant impact on mental health treatment and society. The impact reached a zenith in the middle of the 20th century, when about 30% of chairs of psychiatry in the United States were psychoanalysts. The ideas of Emil Kraepelin, a leading German psychiatrist from the end of the 19th and beginning of the 20th Century whose thinking promoted concepts of categorical diagnosis and neurobiological bases to psychopathology, resurfaced in the latter part of the 20th Century and the prominence of psychoanalysis diminished. Over the last 2–3 decades, neurobiology caught up with psychoanalysis and the field of *neuro-psychoanalysis* developed promoting a meaningful integration between modern cognitive science and neuroscience, as well as an increase in empirical evaluation of psychodynamic treatments.

Earliest theorists

Alfred Adler and Carl Jung were Freud's most important early adherents. Eventually both were forced to leave Freud's circle because they diminished the centrality of infantile sexuality. Freud and several colleagues, including Jung (before his split), visited America in 1909 to lecture. This visit was instrumental for the development of psychoanalysis in America with the New York Psychoanalytic Society and American Psychoanalytic Association founded within the next 2 years.

Anna Freud, Freud's daughter, and Melanie Klein, both child psychoanalysts were leaders of the second generation of psychoanalysts. In the 1920s, a dispute arose about the role of *parental involvement* in the psychoanalysis of children and its impact on children's *transference*. This was one of several disagreements that led to the development of two schools (Anna Freudian and Kleinian).

Drive/ego theorists: mainstream psychoanalysts through most of the 20th century

The basic premise of this group, followers of Anna Freud, was the importance of the internal life of individuals generated by the *drives* or the *libido* and modified by the *ego* (*defense mechanisms*). Heinz Hartmann, Rudolph Loewenstein, and Ernst Kris were the principal representatives of *ego psychology*. Peter Blos pioneered the study and treatment of adolescents. Charles Brenner developed what came to be called *Modern Conflict Theory*, Jacob Arlow expanded the concept of *unconscious fantasy*, and Heinz Kohut developed *self-psychology*.

The primacy of relationships and social forces

A separate group of theorists focused on the impact on mental development of inter-personal relationships and social forces. The aforementioned group did not deny the importance of relationships but focused on what can be called *mental representations of relationships*. (Fairbairn, 1941) was the earliest to discuss the *primacy of relationships* in contrast to the primacy of *drives* or *libido: Object-relationships* became primary. Donald Winnicott has been, arguably, one of the most influential, not only in the promotion of *object relations theory*, but in child development and treatment. He is among the most popular theoretician and clinician among contemporary psychoanalysts. *Transitional Objects and Transitional Phenomena—A Study of the First Not-Me Possession* (1953) and *The Theory of the Parent-Infant* Relationship (1960), are the most read literature by contemporary psychoanalysts (*Psychoanalytic Electronic Publishing* data base).

In the middle of the 20th century, a group of analysts, *neo-Freudians* or *neo-Adlerians* stressed relationships among people, the importance of social forces, and focused on the relationship between analyst and patient in the therapeutic situation. These included Karen Horney, who early in her career argued with Freud about the nature of female sexuality and whose early theories about women were later validated. Other neo-Freudian psychoanalysts included Clara Thompson, Harry Stack Sullivan, and Erich Fromm.

Many in this group were followers of Ferenczi (1949). Ferenczi, in contrast to Freud's abandonment of the *seduction theory*, stressed the important role of traumatic factors in the origins of psychopathology and in countertransference reactions as the traumatic event was repeated in the psychoanalytic situation.

Erik Erikson's contributions were legion, and during his lifetime, beginning with *Childhood and Society* (1993, 1950), had a large effect on the general intellectual public, particularly college students and young adults. He stressed the importance of *social forces* in the development of the *ego*.

Kernberg's (2006) study of borderline phenomena integrated *object relations theory*, the role of *reality* such as a history of sexual abuse, *classical theory* (Edith Jacobson), and *Eriksonian* and *Kleinian theory*. And, in the last two decades, Kernberg has been one of the few analysts to become fully immersed in empirical research of clinical approaches.

An important publication within the last 40 years is *Object Relations in Psychoanalytic Theory* by Greenberg and Mitchell (1983). It has been cited over 50,000 times, comparable to the number of citations of Erikson's *Childhood and Society*. Its publication spurred the further development of the *Interpersonal/Relational* approach.

Attachment theory and psychoanalysis

Bowlby (1982) noted that attachment was a fundamental form of behavior with its own internal motivation distinct from feeding and sex. He contrasted the term *attachment* from *dependency* and *dependency need* because the latter have a pejorative flavor, do not imply an emotionally charged relationship, and have no valuable biological function. This theory was based on many observations

by many researchers in many fields, including ethology. Studies by Ainsworth et al. (1978), Main et al. (2011), and many students and colleagues, especially the *Strange Situation* and the *Adult Attachment Interview*, promoted the field.

Fonagy and Campbell (2015) review the decades old antagonism between psychoanalytic ideas and its focus on *internal meaning* in contrast to attachment's focus on *behaviors*, avoidance of *sexuality*, and consideration of *aggression* as secondary *motivation*. Psychoanalysts critiqued the reductionist focus on a handful of empirical paradigms. The re-connection between attachment theory and psychoanalysis has been promoted by Fonagy and colleagues, fostering the development of the internalized concepts of *mentalization* and *epistemic trust and distrust*, or the willingness to consider new information as credible or misleading, concepts useful in understanding effective parenting and psychotherapy.

Pluralism vs. multiple orthodoxies

Contemporary psychoanalysis is a pluralistic scene where analysts have a preferred theory and way of working psychotherapeutically. Bernardi (2005) stressed that pluralism allows each analyst to recognize that there is no ideal model. Unfortunately, particular models are favored without sufficient critical comparisons to others. Some have warned of the dangers of multiple co-existing theories.

Intrapsychic vs. interpersonal conceptions and approaches

In all psychologic interventions, the development of a *therapeutic alliance* (Greenson, 1965, 2008), originally called by Freud as the *unobjectionable* part of the *transference* (Freud, 1912), is crucial for the maintenance of treatment.

Psychodynamic interventions fall within a broad spectrum: supportive and expressive. At one end are supportive interventions, promoting the *therapeutic alliance* and an attempt to keep emotional expression within certain bounds. The therapist/analyst uses encouragement, reassurance, promotion of logical thoughts and reasoning, clarification and reframing of internal and external dangers, promotion of autonomy, and management, such as setting limits with explanations, education, and facilitation of understanding of cause and effect. These all promote a more realistic appraisal of realistic aspects of life.

Expressive interventions advance an elaboration of personal thoughts, memories, and feelings, and they foster the patient's immersion in emotional expression. Within such an in-depth experience, both patient and therapist are emotionally engaged. Therapists maintain clinical boundaries. The intensity facilitates the patient's understanding of their motives, their defenses, and of how examining the transference/countertransference contributes to a greater understanding of the patient's life leading to a more coherent sense of oneself, sense of one's history, and sense of the nature of one's intimate relationships.

Treatment can be open-ended or one that is time limited, whether explicitly stated or implicitly motivated by either patient or therapist. In a technique where one wants to promote mainly a remission of symptoms, fostering expressive exploration may be contra-indicated. In some patients one may not want to promote too much emotional expression because "too much emotionality" may cause difficulties for the patient. However, when in-depth exploration is warranted, psychoanalysis can achieve greater *personality modification.*

Two paradigms predominate in contemporary American psychoanalysis, both interacting and communicating and not isolated from one another: *Modern Conflict Theory (MCT*), an offshoot on ego psychology, and *Interpersonal/Relational Theory*. In addition, there are significant contributions from object relations theory, contemporary Kleinian theory, self-psychology, and other conceptions, such as contributions from Bion (2013).

Modern conflict theory

Brenner (2006) has been the major theorist in the development of MCT, which is derived from the psychoanalytic situation where one observes the *mind in conflict* (opposing mental forces). Mental conflict is ubiquitous—in health as well as in disease. In fact, all human activity when considered from this point of view can be seen to have elements of conflict. For example, there are many factors that contribute to life choices: native endowment, intelligence, socio-economic status, ethnic identifications, familial interactions, and the many accidental fortunes and misfortunes of life. When these forces work in concert toward the achievement of an *adaptive* goal, they are not observed.

For example, two people may become attracted to one another and marry because their respective partners are in some way *unconsciously* reminiscent of their *Oedipal* figures, their parents. This *compromise formation* is adaptive. At some point, one member of the couple may become disillusioned in the relationship (the *compromise formation* becomes maladaptive) and seek treatment with an analytic therapist. The therapist may help to uncover a degree of rising *signal anxiety* as a result of some old forbidden *Oedipal* wishes beginning to emerge into consciousness and directed toward the partner. As a result, the person utilizes the *defense mechanism* of reversal, and love turns into disillusionment. In a psychoanalytic therapy, understanding and working on the nature of the conflict can help the person understand that the disillusionment is not a result of actual limitations in the partner. The actual work can involve addressing (*analyzing)* the *transference* in the therapy and understanding how the patient *transferred* feelings and conflicts *unconsciously* from the past onto the present.

The past is never dead. it's not even past[1]

Milton Horowitz (cited in Richards, 1997) maintains that the analytic process "consists in the shifts of points of view and in alterations of symptoms associated with changes in *transference* and *resistance/defense*" (p. 1242). Among analysts who valorize the intrapsychic process, Abend (1990) notes that the "optimum analytic technique demands that the analyst attempt, insofar as possible, to limit his or her activities to observing and analyzing patients' mental functioning," while Jacobs (2002) maintains that the analysts' awareness of their own *countertransference* experiences, or the reactions in the therapist to the content of the patient, be they in direct relation to the therapist or by virtue of the therapists' own past and psychology, improves the capacity for the appropriate interpretation to the patient about the nature of the patient's intrapsychic conflicts (Jacobs, 2002). Arlow (1979), in *The Genesis of Interpretation,* notes that the analyst responds unconsciously to the patient's associations. The analyst's empathy and trial identification with the patient promotes their introspection and formulation of an interpretation.

Two persons are in psychological contact[2]

Within the *Interpersonal/Relational model* the analyst's primary focus is predominantly on relationships, particularly between analyst/therapist and patient. Of course, every therapeutic situation involves an admixture of the two approaches, even though one avenue may be stressed in preference to the other.

In contrast to analysts whose primary focus is on interpretation of *meaning* of the *conflicted* issues within the *intrapsychic* world, Levenson (1979) notes, for example, that "change is not as a consequence of the communication of meaning alone, although that may be a large part of it. The linguistically alert therapist, by paying attention to the concordance of *spoken and acted language*, facilitates the process even if he doesn't know exactly what it is he is doing" (p. 281). These ideas are similar to the Boston Change Process Study Group (2007), that with the two participants, action is occurring implicitly and continuously. (Levenson, 2003) goes on to suggest that analytic work is "organized more around pictures than words, more around interactions than explanations" (p. 233). He highlights how the analytic data is organized around visual-spatial lines, regardless of one's theoretical perspective.

Bromberg (cited in Richards, 1997) maintains that within an interpersonal-relational model, the transferential intensity that leads to genuine analytic experience is co-created through the real, not *implied*, interaction between the participants, and that it is the analyst's ability to observe his or her contribution to an enactment, or a process which unfolds outside of either parties' awareness and which under reflection and discussion yields meanings for both parties to understand better the unconscious processes between the pair, which is the critical element in enabling patients to see themselves through the analyst's eyes and make use of interpretations.

In the vignette described above, concerning the disillusioned partner of a couple, the *Interpersonal/relational* analyst and patient would discuss the nature of their relationship with one another. The analytic work would succeed as analyst and patient process the *emotions* in the actual *relationship in the present with the analyst* in contrast to a focus on the *transference* in which the analyst is a representation of a past figure.

Unconscious fantasy vs. unformulated experience

There is an ongoing interaction between sensory perceptions from the outside world and the *unconscious fantasies* and associated affects. It is important to note that when external perceptions are ambiguous, such as an analytic situation, the expectations derived from one's unconscious fantasy will dominate the perception of the real person. Thus, understanding transference reactions to an analyst allows patients to experience the influence of past relationships on perceptions of the present (Arlow, 1979).

From the perspective of *interpersonal/relational theory*, Bromberg (2008) and Stern (2013) argue against the construct of unconscious fantasy and prefer the construction of *unformulated.* They maintain that the construct of unconscious fantasy is an impediment to analytic work because it implies that mentation already exists, which is made conscious as a result of the analyst's interpretations. They feel that the construct of *unformulated/unmentalized experience,* which is symbolized during the analytic process, is a more valuable construction.

Bromberg (2008) states that "What looks like the uncovering of a *hidden fantasy* (i.e., unconscious cognition) is the inch-by-inch development of self-reflectiveness in areas of experience that previously foreclosed reflection and permitted only affective, subsymbolic enactment" (p. 138). "It is what the patient does with the therapist that allows the unsymbolized *affect, not fantasy*, of each participant to engage in a cocreated process through which the patient's self-narrative is expanded" Bromberg (2008, p. 138).

In the example of the patient who became disillusioned with the partner, from an *intrapsychic* perspective the patient would become aware of the connection between the partner and the analyst and, ultimately, the partner and the parent. This realization would allow the patient to differentiate old feelings imbued on the partner with the partner's real attributes. Within an *interpersonal/relational theory* perspective both analyst and patient would engage in an interaction with powerful unsymbolized affect (an *unformulated/unsymbolized experience*). In this interaction, the *affect* is experienced in the present so that *unformulated/unsymbolized experience* can be symbolized. This allows the patient to modify their self-narrative (about the relationship to the partner, for example).

[1]William Faulkner in Requiem for a Nun.
[2]Rogers (2007, p. 241).

Rapprochement

On the surface, it seems as if the two different approaches reflect what has been called a *one-person psychology* (a primary focus the *mental representations* in the patient) in contrast to a *two-person psychology* (a primary focus on the relationship between two people). The differences highlight the prominence, in an *intrapsychic* model, of a cognitive focus with limitations of powerful affective engagement between analyst and patient. And a limitation of cognitive focus in the *interpersonal/relational* model. In reality these dramatic distinctions are caricatures.

Freud (1937) likened the curative mechanism of the analytic process to an archeological dig with the analyst perceiving a variety of clues in the patient's life and associations. This fosters the analyst's ability to *construct or reconstruct* important memories and their accompanying affects from the patient's past which have been repressed, promoting further work by the patient. Freud notes that the patient may not retrieve a memory of the actual constructed event but instead develops an "assured conviction of the truth of the construction which achieves the same therapeutic result as a recaptured memory" (p. 266). Freud's description is of a classic *one-person model*, where the analyst is an observer of what is transpiring within the patient. Freud, however, notes that *trying to understand how cure happens despite a lack of conscious recollection* "is matter for a later enquiry" (p. 266). This profound question by Freud has, either explicitly or implicitly, been a stimulus to try to understand the mutative actions of psychoanalysis and psychotherapy.

Gottlieb (2017) notes that inevitably there are unconscious entanglements between patients and analysts. Thus, he conjectures that a *reconstruction* proposed by an analyst says more about the present interaction between analyst and patient than about the patient's past. This can help the analyst understand the nature of the interaction between analyst and patient in the present.

Lane (2018) has described a model for change in all psychoanalyzes and psychotherapies consistent with the neuroscientific understanding of memory, affect, and memory reconsolidation. He integrates neuroscience findings with clinical findings. He notes that instead of being fixed, unconscious mental contents can be transformed. Problematic memories, which are recalled explicitly or implicitly though reminders are malleable when they are remembered in a setting of intense affect (as a result of the presence of neurotransmitters and hormones). Analysts' responses are different from patients' expectations and a corrective emotional experience occurs. Analysts' responses in the arena of malleability of memories promote the *updating* of old memories which are then *reconsolidated*. The analyst reconstructs the nature of the patient's earlier and more recent life experiences and converts *implicit* experiences in themselves to "*explicit* constructed emotional feelings that provide clues to what the patient needs. [This] sets the stage for providing corrective experiences in the patient that can bring about lasting change" (p. 514). In other words, through analysts' interventions "the process of change evolves from *implicit* (problematic patterns) to *explicit* (corrective experiences) to *implicit* (better adapted) patterns" (pp. 513–514). In the therapeutic situation problematic *memories* accompanied by intense *affect* are malleable and in the context of a safe relationship with the analyst can be *reconsolidated*. The mutative factors in the analytic situation seem to involve both *implicit* and *explicit communications* between analyst and patient (Boston Change Process Study Group, 2007).

Erreich (2015) reviews developmental and cognitive studies. She proposes that *priming* is a useful concept to examine the impact of *unconscious fantasies* (a class of *mental representations*). *Priming* occurs when one is subliminally exposed to a stimulus and that exposure influences how one would respond to subsequent related stimuli. For example, if one is *primed* subliminally by a picture of a dog, one would respond more quickly to a picture of a cat than to a picture of a chair. *Unconscious fantasies,* as a category of *mental representations* may be encoded as *narrative* memories (*implicit* or *explicit*, *unconscious* or *conscious*) or as *procedural* memories (implicit). They evolve as the person develops. Most notably, they serve as *primes (unconscious or non-conscious)* for new experiences. "We are *primed* to respond to some situations in predetermined ways; past experiences which have been mentally represented in or out of awareness *prime* us to respond to the present in often unique and personal ways" (p. 195). *Unconscious fantasies prime* us to respond, in our own individual ways, to events and people.

In a therapeutic relationship, each participant's *unconscious fantasies* can serve as a *prime* for the other. One person's communication (*explicit* or *implicit)* can serve as a trigger if it touches the *unconscious fantasy* of the other. The treatment can thus be conceptualized as alternating sequences between analyst and patient (each stimulating a *prime* in the other) with gradual evolution in the patient and analyst, a *co-construction*, during the analysis. In an *interpersonal/relational* model, words or actions can serve as external stimuli leading to the recollection of memories that, until that moment, have been *unformulated* (un-verbalized, remained *unconscious* or *pre-conscious*). This can lead to a more integrated sense of self in the patient because the previously barely-recognized memories from the past are more fully appreciated.

In a treatment which focuses on the *intrapsychic*, the alternating sequences between analyst and patient also occur. However, the analyst does not focus so much on the mutual influences on both members of the dyad. Instead, the analyst focuses mainly on the vicissitudes of the patient's responses to the external stimuli (the analyst's interventions), and not so much on the analyst's *primes* which are touched by the patient's communications (Hoffman, 2019). The jury is still out as to how to compare the direct impact of *implicit* and *explicit communications.* The contributions from Erreich (2015) on *priming* and Lane's (2018) on *memory, affect, and memory reconsolidation* can promote a systematic comparison between the two perspectives.

Systematic research and neuropsychoanalysis

Systematic research

There have been many *Randomized Control Trials* (RCTs) which demonstrate the efficacy of psychodynamic psychotherapies. A selected list of manualized treatment include: *Transference Focused Psychotherapy* (Kernberg et al., 2008); *Panic Focused Psychotherapy*

(Milrod, 1997; and further developments), the only NIMH funded study for a *psychodynamic treatment*; *Mentalization Based Therapy* (Allen and Fonagy, 2006); and more recently manuals for the psychodynamic treatment of children, *Mentalization based Therapy for Children* (Midgley and Vrouva, 2013) and *Regulation Focused Psychotherapy for Children* (Hoffman et al., 2016). In addition, the International Psychoanalytic Association has developed a series of *Comparative Clinical Methods* (CCM) groups. Consistent with the discussion above, one compares addressing transference or the relationship in psychoanalytic sessions, Rudden and Bronstein (2015) studied 17 cases presented by North American psychoanalysts: 8/17 focused only on transference; 4 managed the therapeutic relationship; and 5 used mixed models.

Neuroscience and neuropsychoanalysis

Solms (2021) and Panksepp and Biven (2012) have been the leaders in studying the comparisons between psychoanalytic theories and *affective neuroscience*. Along with other colleagues they provide a potential of an overarching theoretical frame of reference for psychoanalysis and psychotherapy. Finally, Rice and Hoffman (2014) have proposed a way to integrate the concept of *defense mechanisms* with the neuropsychological construct of *implicit emotion regulation*. A criticism of psychoanalysis has been its distance from psychological materialism, in the sense of the neurobiological underpinnings of health and pathology. Contemporary empirical studies consistently demonstrate genetic, molecular, cellular, structural, and physiologic signatures to common unwellness; certain problems of living, such as schizophrenia, attention-deficit/hyperactivity disorder or autism spectrum disorders, have today been understood as highly biologic and best addressed through pharmacotherapeutic options. Links between Freud's fundamental concepts and those of contemporary neuroscience provides a pathway to open available models for understanding and treatment and to enrich both psychoanalysis and medical science with opportunities for the future. In short, findings from neuroscience can help address the multiple theoretical perspectives that beset the field, not only of psychoanalysis, but all psychotherapies.

Summary and outlook

In this article we described many of the salient features of psychoanalysis, particularly the integration of intrapsychic conceptualizations with interpersonal approaches. We conclude highlighting the need for continued systematic research in the field and continued attempts to integrate the findings of psychoanalysis and neuroscience.

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