Beginning a Psychoanalytic Treatment: Establishing an Analytic Frame

The opening phase of analysis has received scant attention. Freud initially included, as essential, the establishment of an analytic process via the method of free association in the opening phase. However, his stance in relation to this process we can now characterize as authoritarian, and as influenced by suggestion and manipulation. Recent literature, while contributing to the understanding of the range of dynamics possible when beginning an analysis, continues to ignore the manner in which the method of free association may be used by both participants in establishing an analytic frame. Two clinical examples of how this latter process may be inaugurated are given, and reasons for the drift away from it are suggested.

One of Freud's most cited similes (1913) is his likening of psychoanalysis to chess, where only the beginning and ending moves are open to a definite plan, while the middle defies any such delineation. History has shown him to be correct about the middle phase, while the beginning has proven equally unyielding to prescriptive portrayals. While Freud's clinical predilections led him to understand that beginning a psychoanalysis had to do with the patient's introduction to a unique *process*—the method of free association—his prestructural theory led him to focus on the analyst's tasks at the expense of the analysand's. The limited literature on this topic seems to have maintained this tilt toward what the *analyst* needs to do in beginning an analysis. It is the contention of this paper that we have continued to neglect the significance of the method of free association in the opening phase. This is especially so in relation to how free associations become the basic data of

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analysis. It is primarily through this method that what has increasingly become clear as the goals of an ego psychological approach—i.e., increasing freedom of associations and self-analysis—are most effectively attainable. Weinshel's description (1984) of "the elevation of the not-so-good hour" captures this perspective in an anecdotal fashion. In the same article he makes a plea for the "increased recognition of and attention to the less glamorous and exciting exchanges that take place daily at the interface of the analyst-analysand interaction, the more prosaic and 'quiet' elements of that interaction, and how the analyst and his interventions assist the patient's analytic efforts—instead of so much attention to those frames in the analytic work which feature the analyst in a starring role" (pp. 89–90).

Freud's seminal article (1913) on beginning an analysis is launched with some practical ground rules. These include advice on such matters as why one avoids extensive discussions with patients before the analysis; how to deal with questions about the length of the analysis; and handling issues of appointment times and money. While the issues he raises are significant ones for any analysis, and were especially significant at the time, given that no other written guidelines for beginning an analysis then existed, reading them today gives one the impression one might get from an introductory work on basketball that described the size of the court, the height of the basket, and the number of men on each side, while omitting any mention of the intricacies of team play, dribbling and shooting the ball, and the ultimate purpose of putting the ball in the basket to score points. In the second half of the article Freud elaborates the technique of beginning an analysis, and the reasons for it. Though he introduces free association as necessary for a psychoanalysis to take place, his instructions to the patient make it clear that he saw a need to overcome resistances, a view influenced by the topographic model and its primary emphasis on making the unconscious conscious (Busch, 1994). He consistently makes a familiar error (Busch, 1992; Gray, 1982), that of seeing that one must take into account resistances when dealing with unconscious wishes, while not yet seeing the necessity of taking similar precautions with unconscious resistances. Of course, it was not until the introduction of the structural theory that Freud at all recognized resistances as unconscious, the result of a threat to the ego. However, even at this point

the method of free association was used more to overcome than to understand resistances.

Freud's view of the beginning of treatment (1913) can be summarized in the following manner. One begins by introducing the patient to the method of free association and then delivering an exhortation to overcome resistances: "You will be tempted to say to yourself that this or that is irrelevant here, or is quite unimportant, or nonsensical, so that there is no need to say it. You must never give in to these criticisms, but must say it in spite of them—indeed, you must say it precisely *because* you feel an aversion to doing so" (p. 135). One then waits for the positive transference to become established, which occurs through the analyst's showing sincere interest in what the patient is saying, and through the avoidance of mistakes. Once the positive transference is established, it is used to overcome resistances. In fact, the treatment counts as psychoanalysis only "if the intensity of the transference has been utilized for the overcoming of resistances" (p. 143). Thus, Freud's initial view of the opening phase focused on the establishment of an analytic process based on the method of free association. However, the topographic theory limited his view of this process and how it might best be used, and he consequently emphasized the picture of a compliant patient and an authoritative analyst. This model still exerts a subtle influence on technique, while we have drifted away from the significance of the establishment of an analytic process in the opening phase.

A notable attempt to correct the paucity of literature on beginning an analysis can be found in Jacobs and Rothstein's (1990) book on the topic. Their focus is the opening phase from the perspective of unique issues the analyst might face in a variety of clinical situations. This is captured in the titles of the chapters, which are in fact separately authored articles: "On Beginning an Analysis with a Young Adult," "On Beginning a Reanalysis," "On Beginning with Candidates," "On Beginning with a Reluctant Patient," "On Beginning with a Borderline Patient," "On Beginning with Patients who Require Medication," etc. While a useful collection chock full of insights, the book as a whole drifts away from Freud's notion that there is an underlying psychoanalytic process that must be established from the beginning of the analysis. The book thus continues a perspective, initially advanced by Glover (1955), in which the opening phase of analysis is viewed as "determined less by the conditions

of analysis than by the spontaneous reactions of the patient" (p. 19). The establishment of a psychoanalytic process has been exchanged for the more ambiguous model of creating an atmosphere, via understanding, in which analysis can take place. Thus, in describing the stance of the "modern analyst" toward the beginning phase, Jacobs (1990a) writes that

> what he has come to understand is that technique cannot be made rigid or formalized in rules but must be adaptable and responsive to the needs of the patient. This is particularly so in the opening phase when the analyst's capacity to grasp and respond to the communications and metacommunications being transmitted between himself and the patient is so critical a factor in the establishment of the kind of rapport that fosters the unfolding of an analytic process [p. xv].

One cannot disagree with Jacobs's eschewal of bad technique in favor of better atmosphere. However, his assumption seems to be that by paying attention to the technique of beginning an analysis, the analyst will be led away from providing a good atmosphere. I would maintain that empathic understanding, without a demonstration of its contextual framework within the analytic process, is not necessarily helpful. It can encourage a regressive atmosphere, while doing little to aid the analysand in his understanding of how the use of the analytic process will be of help. To make a point I shall return to many times, we have tended to focus on the analytic atmosphere and the analyst's understanding as the primary energizer of the process, while tending to underestimate the importance of the analysand's understanding and use of the process. What Jacobs says analysts have traditionally been taught as proper technique in the beginning phase—"analyzing from the surface downward, interpretation of fluid defenses before those embedded in character, and interpretation of affects before content" (p. xv)—has proven to be inconsistently applied and misunderstood (Apfelbaum and Gill, 1989; Busch, 1992; Gray, 1982). Until recently, ego analysis has not been a particularly strong suit in our psychoanalytic armamentarium. Brenner's suggestions (1990) for beginning an analysis suffers from similar problems. The analyst's role, he writes,

> is to be analytic, nothing more. An analyst tries to understand the motives for a patient's thoughts and behavior, the nature

> and origin of the patient's conflicts, and to communicate that understanding to the patient in the best way at the best time [i.e., to offer correct and timely interpretations]. That's what an analyst should do, or try to do, from the first to the last day of every analysis [p. 55].

In one sense it is an unassailable position. Who could argue against the importance of the analyst's understanding for the success of the analysis? Yet this perspective ignores the differences among analysts over what it means to be analytic. Further, what we consider to be correct and timely has been infrequently articulated, is often subtly affected by prestructural notions (Busch, 1992, 1993, 1994), and overlooks the ego's detailed role in initiating resistances as part of the compromise formations. Most important, Brenner's position subtly moves the frame of the opening phase toward the analyst and his understanding, and away from the establishment of an analytic process. This has significant consequences for how the opening phase of analysis is conducted, while also influencing the goals and purpose of an analysis. It is a demonstration of Gray's astute observation (1982) of the distinction, between analysts, of their *forms of attention,* during analysis.

There is a framework,[1] using the process of analysis, within which most analyses take place, no matter what the theoretical orientation of the analyst. The process is the method of free association. As Kris (1990) has stated, "free association is the hallmark of psychoanalytic treatment conducted by analysts of every stripe" (p. 26). The framework we as analysts all use is that the analysand's free associations are the basic raw data of the analysis. Thus, while there are differences among analysts in what they understand from the patient's associations, the basic frame, accepted by all analysts, can be summarized by the principle that *the analysand's free associations are the primary data upon which the two participants base their understanding.* It is my contention that from the beginning of an analysis it is necessary to establish an analytic frame, which clearly delineates what the data of analysis will be. This frame is what gives shape and structure to the analysis. The frame I believe it is necessary to establish is

[1]Throughout this paper I will be describing analysis from a particular point of view. While obviously many factors go into an analysis, I believe this model helps define psychoanalysis as different from other forms of treatment, and thus serves as a useful standard to evaluate our methods of intervention. However, it is never usable in pure form throughout a treatment.

that it is the patient's free associations we will be analyzing, for the purpose of increasing freedom of thought and the capacity to see these thoughts as psychologically meaningful.[2] While empathic attunement or an appreciation of developmental concerns, just to name two factors, may play an important role in the patient's feeling understood and in the possible internalization of more benign introjects, there can be no self-analysis without the nature of analytic data being clear. If analysands do not know that what is being analyzed are their thoughts, the purpose of the analysis can become quite obscure. Further, establishing the frame of the analytic process as described above tends to make interpretations more grounded, less reliant on an omniscient analyst who intensifies patients' regressive transferences and puts them in a passive position in relation to understanding their own fantasy life. In the words of N. M. Searl (1936), "that which is important is not the extent to which *we* may be able to impart to the patient our knowledge of his life and psyche, *but it is the extent to which we can clear the patient's own way to it and give him freedom of access to his own mind*" (p. 487; italics added).

It is surprising to see how, in many second analyses, patients have little idea of what the data of analysis is. Speculation, only tangentially related to their thoughts, seems their primary method of theory building. This is more understandable when one frequently hears colleagues interpreting in a similar manner. That is, the data that have led to the analyst's conclusions are too infrequently articulated. For example, in noticing that a patient turns away after expressing angry thoughts toward the analyst, the analyst might say, "Do you feel like looks could kill?" or "I noticed that right after you expressed your anger you turned away from me. I wonder if this is an indication that you get afraid that looking at me, when you're angry, could be dangerous." This has been a dilemma in psychoanalysis since its beginning, and it is a tension that still runs through our interpretive strategies (Apfelbaum and Gill, 1989; Busch, 1992, 1993; Gray, 1982).

[2]As pointed out elsewhere (Busch, 1994), the "freedom" of free associations is "more or less" free. This will vary, dependent on the degree of resistances. However, this is one point of this essay. All we can deal with at any one point is what the patient can be aware of in the face of ongoing resistances. We analyze, in part, to increase the freedom of associations.

As I have pointed out elsewhere (Busch, 1995a), an analysand's thought processes throughout much of an analysis, but especially in the opening phase, are very concrete. This is due to certain qualities of cognition that remain through early latency, resulting in thinking about conflicts that never advances beyond a concrete stage (Sandler, 1975), or that remains as a regressive flashpoint. The same is true of the capacity to reflect back upon thoughts as a stable component of one's core cognitive processes. Within this context, the analytic frame I have described, using the patient's free associations as the basic data of analysis, serves as an ideal method for analyzing thinking that is concrete and nonreflective. Put most succinctly, it concretizes the analytic task at a time when the patient's thinking is most concrete. When looked at in its essentials, the analytic process can be conceived as following what the patient admits to consciousness, what is allowed to be connected with what, when there are interferences with this, and what is done with thoughts as the patient talks (i.e., thoughts as gifts, questions, demands, etc.). This gives a view of the process quite different from picturing the analyst as the interpreter of "absent content" (Searl, 1936); on the latter view, the primary function of the analysis becomes the analyst's search for meaning in the figure of the patient's ground, a method far less congruent with an analysand's cognitive capacities, especially in the beginning of an analysis. For the analysand, feeling that the analyst is in empathic attunement may be an important component of the initial phase, but knowing how the analyst got to that point, in a concrete way, does much to establish the process as important to the future of the analytic work. What psychoanalysis has to offer, in contrast to other forms of treatment, is self-analysis. Its cornerstone is the ability to allow thoughts to come to mind, and then using these thoughts as data that can be reflected back upon to glean whatever insights they might afford the patient in the ongoing task of self-understanding. This deceptively modest goal requires the establishment of a framework for processing thoughts, a process that can and must begin in the opening phase. The danger this averts was pointed out by Searl (1936) in her "unknown classic" on the application of ego psychological principles to the analytic task. "We are taking away the patient's accepted and reasonable responsibility," she wrote, "if we in any way shift the importance away from the

only, though very difficult, technique which analysis asks of him; and we encourage belief in magic, which is independent of conditions, if we do not evince our belief in the conditions in which analysis can be carried on" (p. 489; see Busch, 1995b).

CASE MATERIAL

In the first case the reader will see what I am striving for in setting the analytic frame. It is not new or unique. It is one aspect of what has always been part of the "talking cure." However, the specifics of the method, and especially its importance for the opening phase, has not sufficiently been emphasized. Essentially what I am trying to convey to the patient is the notion that "if we listen carefully to your associations in a variety of ways, we can learn about the conflicts that brought you into analysis." I try to stay closely tied to the patient's associations and to bring them back in as the basis for my interpretation. To the extent possible, the method eschews the investigative, interrogational mode that questions the patient, and shuns interpretations based on "special" knowledge of dynamics or development.

Case I

In his first analytic session Dr. A began with the realization that during the consultation he had forgotten to tell me of a weeklong convention, about a month away, that he had registered for several months prior to our initial meeting. At this point he wasn't sure if he should go or not. Although his wife wanted to go, he was uneasy about leaving because of a recent bout of acting out by his adolescent daughter. He thought they should stay home to prevent her from doing something self-destructive. He then recalled a time in college when he felt like he was out of control, and no one seemed to notice. Mostly he described some drinking incidents that led to reckless driving. He also alluded to having impregnated his future wife, which led to their getting married and the birth of their daughter. Yet, when he was younger, there were times when his parents tried to put controls on him, which he resented. I pointed out that he had come in talking about whether to go to the convention. This was then followed by his sense that maybe he should be home to stop

his daughter from possibly doing something harmful, and this reminded him of how he had no one to help him with his own potentially harmful behavior. I told him that it seemed he was saying there was a part of him that might wish I would stop him from going to the convention. To not have controls put on him is to feel uncared for. Yet the dilemma he is in is that he then resents the very controls he desires. Dr. A responded that this was a familiar feeling. He then described how glad he was to get going in the analysis. It was clear to him that a lot was getting stirred up. Yet he was surprised at how easily he was talking about things.

Dr. A began the second session by commenting that he was aware of feeling more anxious. He then went on to describe a number of experiences where, unable to let his feelings emerge, he stayed in control. On a recent ski trip when he and some friends, flying in a small plane, were caught in a violent storm, he showed no feelings, and indeed was scarcely aware of any. As an adolescent, he went with some friends to a prostitute but was unable to get an erection. He still has this problem intermittently with his wife, but overall he felt they had a pretty good relationship. Now that they were both starting treatment, however, he worried what this might do to their relationship. His mother-in-law had been married numerous times, and so had both his brothers. His next older brother had been mean to him when they were growing up, and he used to get very mad at him. Dr. A then described a hunting trip he went on with this same brother when they were in their teens. Dr. A heard some rustling in the tall grass, saw some movement, and then saw a bird take flight. He wheeled and shot at the bird, and immediately was stricken by a feeling of horror at the possibility he had not shot high enough and might have hit someone kneeling in the grass where, of course, he had last seen his brother. The brother was not hurt, but the experience was still a vivid one that scared him to think about. I reminded him of how he had started the session by describing situations in which he kept his emotions in check. After describing his worries over the effect that analysis might have on his marital relationship, he had told of fearing that, while acting spontaneously on the hunting trip, he had shot his brother. This suggested that his anxiety upon coming in today had to do with his fear that the analysis would lessen his controls and lead him to hurt someone. I wondered

whether one component of his question of the previous day (i.e., whether he should be "allowed" to go to the convention) was based on his feeling that he needed to be kept in check. This led him first to remember temper tantrums he had thrown as a child, and then to recall a persistent childhood image—a desolate landscape with no one else in it. It was a depressing and scary memory. I suggested that in his thoughts we could see he was fearful that the emergence of his anger would leave him totally alone—hence the feeling of needing to be kept in control. He then remembered how when he and his brother would squabble, his mother would threaten to leave and never come back if they didn't stop.

The remainder of the week the theme was similar. In the next session, after talking about sexual feelings he had toward one of his patients, he went on to describe his medical specialty as being like a time bomb waiting to go off, as they had no data on long-term results. He limited his practice to a very small area so that he would not be in competition with other doctors. He ended with a concern that he was trying to go too fast in the analysis and needed to be slowed down. This was the major theme throughout the analysis—his feeling that he needed to be slowed down or else his destructive sexual and aggressive feelings would emerge and he would be left alone. At the same time, he would become irritated whenever he felt that others were attempting to place limits on him. The result was that he lived a semireclusive life in which much of the decision making, both in his private life and in his practice, was left to his wife. His medical specialty was one in which caution and control were at a premium.

I have tried to indicate here how I establish an analytic frame from the very beginning of treatment. By staying closely tied to what the patient is saying, I try to convey that analysis is a process of listening to one's thoughts. The content, form, and sequencing of thoughts become the primary basis of forming interpretations of the patient's conflicts. Within this framework I hope to convey that the data is there for understanding, but that it needs to be listened to.[3]

[3]Another analyst might put together the associations in a different form. The reasons for this go far beyond the scope of this paper. All I am trying to convey is the importance, for the development of an analytic process, of focusing from the beginning on the data of analysis (i.e., free associations). Further, I am not suggesting there can be a direction-free analysis. As soon as the analyst proposes the method of analysis, he is directing the analysis. However, what I am advocating is that there

A primary factor that emerges, of course, is that there are dangers associated both with saying what is on one's mind and with the act of listening to oneself, as they are mirrors of the conflicts that brought the patient into analysis. Important, also, is my assumption that during the opening phase we will be dealing with a patient who, in areas of conflict, will evince concrete thinking and show a limited capacity for self-reflection. Gearing one's interpretations to this type of thinking, in a way that is useful and meaningful for the analysand, is a constant strain on the analyst's ability to integrate various levels of communication in the patient's thoughts, while reflecting this back in a usable, concrete fashion that takes into account which of these thoughts and levels the patient can admit to consciousness. If this is done well, analysands are impressed more with their own thoughts than with the analyst's ability to read or understand them.

Case 2

The following case was presented to me by a candidate. Mr. B, a lawyer, had been in psychotherapy for about a year, because of feelings that he was unable to reach his potential. He was making the transition to psychoanalysis after a summer vacation, and this was his first session using the couch. He started out by saying that he would probably fall asleep. He was back at work, he reported, and had had an anxiety attack the previous night. He got a call from a woman with whom he had had a brief affair early in his marriage. She wanted to know if he was going to an upcoming meeting, and hinted that she would be available for a fling. He said he didn't think it would be a good idea. He then started talking about a woman in his firm whom the partners had decided to let go. She was very bright, but he said, terribly neurotic, and they decided they had to do what was best for the firm. Speaking to a friend at another firm recently, he was told they were hiring someone they didn't think would work out, simply because they needed another body to do the work. "They don't give a shit he'll piss away a year of his life." Mr. B then remembered that his insurance form for the therapy had come to the office manager, and she had asked him about it. He was upset that anyone would know about this. He didn't know how

are ways of conducting and thinking about analysis from the beginning which put the patient's thoughts at the forefront of the analysis.

comfortable he would be going into the office late after his current Wednesday appointment. "Then I thought of coming in today and I got anxious." The candidate then said, "So there is anxiety, discomfort, about starting." Mr. B agreed but said he was also concerned about his loss of privacy; he was concerned that people at work would find out about his being in psychoanalysis. Therapy was one thing, but analysis was something else. He then started talking about the possibility of taking a yearlong fellowship in Washington, D.C.

While the candidate picked up on what I too would regard as a significant affect (anxiety) that needed to be addressed, he did so in a manner that requires the analysand to accept his view as an authority, thereby missing an opportunity to begin showing him how his use of the method of free association can help him understand his feelings. Mr. B comes in describing himself as having been anxious the previous evening, and then associates to a secret affair. His experienced anxiety later in the session is again associated with a clandestine relationship (i.e., analysis). He further elaborates on this when he expresses concern over use of the couch, which he sees as placing him in a passive position (his remark about falling asleep). In the background also are feelings associated with someone's being dumped after a year (the very length of time he was in psychotherapy before going on vacation and beginning analysis), suggesting defended-against feelings regarding his absence from the analyst. How I would pick up on these various associations depends on where the patient had gotten to at this point in his therapy. At the very least, I would suggest that his anxiety over beginning the analysis had to do with his fear that he would become more passive, and that it was like starting a clandestine relationship that would not be good for him. The anxiety over his association of passivity with becoming a woman (the mention of a female colleague fired for being "terribly neurotic") and the fears associated with longings stirred up by the vacation could be brought in, depending on the work that had been done to that point.

In the next session, his second, the patient started out talking about how chaotic it was, getting to his session in the early morning when he had to get his daughter ready for school. He didn't know how he was going to do this. He then wondered briefly if in a previous treatment he had ever used the couch, and then talked of the

passivity in waiting to see if certain job offers come in. He felt he wasn't used to being so passive. His thoughts then turned to a great ruling he had obtained for a client that he felt was unappreciated by the other lawyers in his firm. His daughter had been wonderful (i.e., perfectly quiet) when examined by her pediatrician. This led him to complain about his law practice. He wanted to be a lawyer, not a businessman. Everything is so competitive in this town, he said. Some people are wildly competitive, while he felt he has only competed with himself. He went on to describe various triumphs, after which there was some misfortune. He was valedictorian of his class, but he got sick and missed graduation. It didn't really matter, though, since he had really wanted to be on the football team, not the one with the best grades. When he got into a prestigious university, it was a bigger deal to others than to him. He ended the session complaining that his parents never said much to him.[4]

In this session there are mounting concerns about the feelings stirred up, with the analysand feeling uncomfortable enough that thoughts of ending treatment are in the background, as they were in the first session. Again I would reiterate the connection he makes between heightened passivity and being on the couch. Feeling unappreciated leads to thoughts of someone (his daughter) who is appreciated for her passivity. I would then point out how he associates this with being "good," like a girl. Finally, success (being named valedictorian) is followed by misfortune (falling ill), a minimizing of that success (he didn't want to be valedictorian anyway, or to get into a prestigious university), and a seeming lack of interest in competing with others (he just competes with himself). His fears about being in analysis seem a result of his view that he will have to become passive (his view of what it means to be a woman). While this seems to be making the beginning of his analysis increasingly uncomfortable, it is a position he seems to feel he must take in order to be appreciated. Further, he links it with difficulty feeling good about his successes and being competitive. It seems possible that his feelings about competition are affected by his concern that one cannot do this and remain valued.

[4]This seems to be a reference to the analyst's silence, which was intensifying the conflicts to be described. Since I would probably be saying more to this analysand, I will not attempt to integrate this association with what I would say.

As in the first case, I would be striving here to make my interventions as concrete, and as experience-near, to the analysand's associations as possible. Again, this not only matches a way of thinking characteristic of patients in the midst of conflict, but also promotes the analytic process. We are trying to convey to this patient that by listening carefully to his thoughts we will be able to understand his conflicts in an immediate way, and this will be a reflection of the issues that brought him into treatment in the first place. Thus, in both cases we can demonstrate that associations are directly linked to core conflicts, while establishing the basis of self-analysis. To paraphrase Gray (1973), when this different way of perceiving thought processes is taken for granted by the analyst and left unarticulated, the resulting interpretations may fail to take into account how fully the psychic conflict can be observed via the patient's associations. "When this is the case," writes Gray (1973), "how can the patient come to gain a maximum grasp of this part of his own self-observing capacities?" (p. 475).

Inevitably the use of free association becomes part of a transference repetition. Thus, the associations themselves become a gift to the analyst, part of sadomasochistic battle, a way to keep thoughts in control—the varieties are endless. But when the method of free association is firmly established as a basis for analytic understanding, it becomes easier to highlight these things that patients do with their thoughts.

CONCLUDING THOUGHTS

Stone's perceptive remarks on the analytic situation (1954, 1961) presaged many changes in psychoanalysis. For example, one can see a direct link between Jacobs's emphasis on the importance of the analytic atmosphere (1990b), and comments made by Stone (1961) some thirty years earlier:

> . . . I must state my conviction that a nuance of the analyst's attitude can determine the difference between a lonely vacuum and a controlled but warm situation. . . . The rigors of the analytic situation are subtle and cumulative, importantly operative, *whether evident or not.* It is one of the burdens of this presentation

> to suggest that the intrinsic formal stringencies of the situation are sufficient to contraindicate superfluous deprivations in the analyst's personal attitude [pp. 21–22].

However, Stone pointed to yet another component of the analyst's stance that still lingers, what he called the "patient-as cadaver" paradigm. "Our prototypical model," he argued, "preserved intact, indeed in some respects exaggeratedly, the traditional features of the physician-patient personal relationship: ostensibly omniscient, authoritarian, helpful on one side; ignorant, utterly submissive, requiring help, on the other" (p. 13).

What is seldom recognized, though, is that this model continues as a silent archetype in current psychoanalytic practice. The method of free association, as initially elaborated by Freud (1900), put the analysand in the position of a conduit. The prototypical example was the passenger on a train having a variety of thoughts drifting into his mind, with the added requirement that these should now be verbalized for the analyst. The patient was *admonished* to keep critical thoughts from interfering with this task, with the warning that the whole enterprise would become "impossible" if these exhortations were not heeded. Self-reflection was discouraged. The model I am describing is well captured in the passage from Freud (1913) cited earlier, in which he instructs patients in the method of free association, exhorting them never to give in to their critical faculties, commanding them to overcome their resistances.

This tone of analytic exhortation is not a thing of the past; it creeps subtly into current methods of establishing free association (Busch, 1994). Further, the cornerstone of the initial phase, resistance analysis, remained an authoritarian, noncollaborative model throughout Freud's writings. What Freud called working through resistances was in reality an attempt by the analyst, mobilizing the positive transference and using influence, education, and force of argument, to induce the analysand to give up the resistances. Again, this is a model not confined to our distant past (Busch, 1992; Gray, 1982).

Jacobs and Rothstein's book on beginning an analysis (1990) conveys much of this same attitude. The emphasis is on what the *analyst* needs to be thinking to further the process of, to paraphrase Brenner, the *analyst's* being more analytic. That is, in order for the

analysis to begin well, it is the analyst's understanding that needs to be upgraded. The patient's role is passive, being limited to being well understood. Any notion that a process needs to be articulated to analysands, to help them be participants, is secondary or absent. The model these authors are working out of is that of analyst as expert, the conveyer of understanding. It fits in with certain omnipotent and passive needs of patients to be understood, with little participation on their parts. Taken to an extreme, the model transforms the analyst into a kind of psychological detective, looking for hidden motives, obscure fantasies, missing data—the entire plethora of events Searl (1936) classified under the inspired phrase, "absent content." It is not that the analyst shouldn't look for such data, but as a primary technical stance it sets a tone antithetical to what seems to me one of the most important goals of analysis—the capacity for self-analysis and an understanding of the resistances to it.

The idealized epiphany of my own analytic education was when a senior training analyst stunned an audience at a national meeting by correctly guessing an obscure fact about a patient from the clinical data. This was further reinforced by the reverence shown for Ernst Kris's reconstruction (1956) of the omissions and distortions frequently screened by a richly elaborated family history. In this model the analyst and his knowledge is at the center of the analytic task. It was Searl (1936) who almost sixty years ago pointed out a problem with this perspective:

> If on the other hand we say to a patient, 'You are thinking so and so,' 'You have had such and such a phantasy,' and so on, we give him no help about his inability to know that about himself, and leave him to some extent dependent on the analyst for all such knowledge. If we add 'The nature of this thought or phantasy explains your difficulty in knowing it for yourself,' we still leave the patient with increased understanding related to a particular thought and phantasy only, and imply, 'One must know the thought and phantasy first before one can understand the difficulty about knowing it.' The dynamics of the patient's disability to find his own way have been comparatively untouched if the resistance was more than the thinnest of crusts, and will therefore still be at work to some extent and in some form whatever the change brought about by the interpretation of absent content [p. 479].

Abend's perspective (1990) serves as a useful contrast. Writing about

beginning with patients who know something about analysis, he makes the following statement:

> Helping the patient at the very start of analysis to become aware that he has ideas in his mind that he hardly knew were present, that these exert an influence on his behavior in sessions, and that uncovering these beliefs can help explain why he behaves as he does, is a useful introduction to what lies ahead. There is no one special technique recommended for bringing out the preexisting ideas about analysis. Merely by keeping in mind that patients probably possess theories and ideas about analysis, analysts will be more likely to take that possibility into account in formulating interventions during the opening phase of analysis, especially when the patients' idiosyncratic reactions to the analytic situation make their appearance [p. 60].

While I agree entirely with the substance of Abend's comments, their focus nonetheless is quite clearly on the analyst and on what that party to the analysis must keep in mind in order to facilitate the process. Again it is the analyst's understanding that is at center stage. It isn't that I find this perspective inaccurate; it is simply that it skews the psychoanalytic process in a manner that can threaten the analysand's inclusion. The importance of how one communicates material to the analysand should not be forgotten. Technique in this area will have as decisive an impact on the purpose, goals, and outcome of the analysis as whether we correctly identify unconscious fantasies. We have tended in our literature to focus on the latter, sometimes at the expense of the former.

Compare this model skewed toward the analyst to Gray's paradigm, in which the goals of the analysis are defined in terms of the analysand's conscious "and increasingly voluntary co-partnership with the analyst" (1982, p. 624), and in which the analyst's "aim is a consistent approach to all the patient's words, with priority given to what is going on with and within those productions as they make their appearance, not with attempts to theorize about what was in mind at some other time and place" (1992, p. 324). This returns us to a model based on free association (Kris, 1982, 1983, 1990, 1992), one that closely monitors the patient's associations in order to demonstrate, in a way tied as closely as possible to the observable data, one aspect or another of the patient's conflicts. A method with other purposes as well, it attempts to take into account the role of the ego

and its important monitoring and integrating functions. Although analysis touches people in many different ways, it is through the conscious ego, after all, that self-analysis is accomplished. By attempting to include the conscious ego in our interpretive strategies, we go a long way toward aiding the process of self-analysis in our patients (Busch, 1993).

While many forms of treatment offer understanding, what is unique about psychoanalysis is that it sets into motion a process that allows for the development of a self-analytic capacity. This, identified as the hallmark of successful analyses by Schlessinger and Robbins (1983), depends on the development of self-observational qualities. By using and drawing attention to the process of analysis from the very beginning, we highlight its importance for self-understanding. Weinshel (1984), in describing the significance of the psychoanalytic process, notes as a product of the "reasonably successful analysis . . . the operation of a more effective and 'objective' capacity for self-observation" (p. 82). Gray (1986) sees self-observation as not so much the byproduct of psychoanalysis as its focus: "Systematic attention to self observation, when clinically appropriate, can become a more explicit aim of analysis of the neurosis" (p. 260).

How we as analysts conceptualize the opening phase has much to do with how we think analysis works. My own view, outlined above, is based on my conviction that we have insufficiently mined the analytic technique of listening closely to the patient's associations, in a way that is easily usable by the analysand. Greater attention needs to be paid to the work of analysis as a demonstration of the work of analysis.

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