The gulf between psychoanalysis and psychotherapy is so broad in the thinking of psychoanalysts that any searching re-examination of the relationship between the two techniques is easily suspected of seeking to undermine the uniqueness of psychoanalysis. I have found this to be true even for the re-examination I propose despite the fact that its ultimate conclusion is that the gulf between the two, as I will suggest they be defined and practised, is even greater than it is usually considered to be. The reason for this may be that I am risking serious confusion by dealing with two separate major topics in this paper. The first is reconsideration with suggested changes of the intrinsic criteria by which analysis is ordinarily defined. The second is the argument that the changes in my conceptualization of the intrinsic criteria significantly extend the range of the extrinsic criteria within which these intrinsic criteria can be fulfilled. So I may be considered to be first abandoning psychoanalysis because of the changes in the conceptualization of the intrinsic criteria I propose and then to be abandoning the distinction between psychoanalysis and psychotherapy because for many that distinction is based on the necessary though not sufficient difference in the extrinsic criteria of the two techniques.

I cannot confine myself to a discussion of my changed view of the relationship between psychoanalysis and psychotherapy and my view that psychoanalytic technique can be employed in this extended range of extrinsic criteria because these two propositions depend upon the changes I suggest in the conceptualization of the intrinsic criteria. I hope to minimize such possible confusion by dealing first with the changes proposed in the intrinsic criteria and then the repercussions of these changes on the extrinsic criteria.

By the intrinsic criteria by which analysis is ordinarily defined I mean the centrality of the analysis of transference, a neutral analyst, the induction of a regressive transference neurosis and the resolution of that neurosis by techniques of interpretation alone, or at least mainly by interpretation. By extrinsic criteria I mean frequent sessions, the couch, a relatively well integrated patient, that is, one who is considered analysable, and a fully trained psychoanalyst.

I emphasize at the outset that I am distinguishing between analytic technique and an analysis. That is, I am suggesting that analytic technique can be employed even if a complete analysis is not carried out. The contrary idea is that the issue is one of all or none, that is, unless the technique is designed to bring about a complete analysis, it is not analysis.

Although I will propose that psychoanalysis (i.e. psychoanalytic technique) as I will define it is applicable across the whole range of psychopathology, my convictions are the strongest for its application to patients ordinarily considered analysable for whom issues of time and money preclude the usual setting of an analysis. I stress that point at the beginning because I do not want my discussion to be overshadowed by the question of the applicability of the psychoanalysis I will
describe to graver psychopathology, though I do believe that experimentation with it in such psychopathology is warranted.

See the appendix for a history of this paper.

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1 These intrinsic criteria could be divided into techniques-neutrality, analysis of transference and interpretation—as distinguished from what they are designed to accomplish—a regressive transference neurosis and the resolution of that neurosis mainly by interpretation—but I believe the differentiation is unnecessary for the clarity of my argument and hence to attempt to maintain it explicitly would only be distracting. Stone (1954) uses the terms functional and formal for what I am calling intrinsic and extrinsic respectively.

A REVIEW AND THE PRESENT SITUATION

Today, as in 1954, I am writing about psychoanalysis and psychotherapy from the vantage point of psychoanalysis. Some years after Freud developed psychoanalysis, psychotherapies began to be progressively infused with psychoanalytic practices to the point where it became progressively urgent to keep the differences between the two clear and yet at the same time recognize that they overlap.

Those analysts who contrasted psychoanalysis and psychotherapy most sharply were likely to use the formula that the transference is analysed in psychoanalysis but manipulated in psychotherapy. Those who were impressed by the overlap said that this formula opposes the two methods too sharply. They said that psychotherapies vary in the extent to which the transference is interpreted, sometimes being interpreted a great deal, and in the extent to which the transference is manipulated, sometimes being manipulated not at all. To this latter argument, which brings psychoanalysis and psychotherapy closer together, those who insist on the distinction reply that the intrinsic criteria, as usually stated, apply only to analysis.

The thrust of my 1954 paper was to insist on the difference and at the same time to recognize that the two are on a continuum. My conclusion that there are 'relatively autonomous' conflicts which can be resolved in psychotherapy and that therefore the distinction between the two should not be exaggerated led me to say at the end of my paper in 1954 that I feared I would be misunderstood to be saying on the one hand that psychotherapy cannot do what psychoanalysis can and on the other hand that it does in fact do so. I urged that we should import more of the non-directive spirit of psychoanalysis into our psychotherapies, and that while the difference between the two with regard to how they deal with transference could be diminished, it would not be eliminated. I also agreed that only psychoanalysis is characterized by the intrinsic criteria which I accepted as usually stated. I did leave open the door that analytic work might be possible in less than optimal extrinsic criteria.

The question of the relationship between psychoanalysis and psychotherapy is even more important in practice today than it was in 1954 because of the practical difficulties in maintaining the
ordinarily accepted extrinsic criteria of analysis. Many analysts are perforce seeing patients less frequently because they cannot afford to come more often as well as because of the competition of the briefer therapies which have become popular. For any particular analyst the urgency of the topic is related to the conditions of his practice. Training analysts, for example, whose practice is more likely to include patients coming 4 or 5 times a week, feel less urgency than other practitioners. The question becomes: How widely can the range of extrinsic criteria be expanded before the analyst must decide for psychotherapy rather than psychoanalysis?

There is even more questioning now among analysts than there was in 1954 as to how rigidly the extrinsic criteria must be maintained for the feasibility of the employment of analytic technique, although less question has been raised about the intrinsic criteria.

What is considered the necessary frequency is gradually dropping. Freud started with six times a week but found that he could work at five times a week when the 30 hours he had expected to divide among 5 patients had to suffice for 6 (Kardiner, 1977). Four is commonly accepted these days. Freud said that 'for slight cases or the continuation of a treatment which is already well advanced, three days a week will be enough. Any restrictions of time beyond this bring no advantage either to the doctor or the patient; and at the beginning of an analysis they are quite out of the question (1913, p. 127). Nevertheless many experienced analysts begin a case in analysis with one or two hours a week, either because the patient can afford no more or the analyst has only that much time available, with the hope of later increasing the frequency.

The issue of frequency has been discussed relatively little except in relation to the proposal by Alexander (1956) and some of his associates to influence the transference by decreasing or increasing the frequency of sessions. Whatever value such a technique may have, I agree with the consensus that it violates the central tenet of analysis—the analysis of the transference rather than its manipulation—and should therefore be classed as psychotherapy rather than psychoanalysis. As a foretaste of what is to come,

however, I ask two questions. First: is it possible that it is compatible with analytic technique to alter frequency if at the same time the meaning of the alteration is thoroughly analysed in the transference? Alexander (1954, p. 699) spoke of analysing the transference which in his view necessitated the alteration of frequency but he did not say anything about analysing the repercussions on the transference of the manipulation itself. Second: is it possible that the very insistence that a certain frequency is necessary to conduct an analysis without the interpretation of the meaning of that insistence is a manipulation of the transference which bears some similarity to the technique for which Alexander has been so roundly criticized?

The issue of chair or couch is often glancingly referred to. Various points like these are commonly made: a patient should not be forced on to the couch. 'Couch-diving', that is, a patient's excessive eagerness to use the couch, may bespeak serious resistance rather than otherwise. An analysis is not ruined if the patient gets up sometimes (the Rat Man paced the office in early hours) but it is important to analyse discomfort in either lying down or sitting up. The former is more likely to be investigated than the latter. It is recognized that the couch may be preferred for the analyst's comfort rather than the patient's. Critics of analysis are fond of pointing out that Freud said he could not bear being gazed at for eight hours a day (1913). In general it is agreed that while the couch has advantages and an inability ever to lie down bespeaks an unresolved problem, its use may be defensive, and it is not absolutely essential.
The issue of the patient's pathology has received extensive discussion in our literature. A minority of analysts believe that a strict analysis can and indeed should be conducted with even the sickest of patients whereas most analysts believe that, at the very least, important alterations of strict technique are mandatory.

The issue of training of the therapist would seem to be beyond discussion. How can someone untrained in analysis conduct an analysis? But how much training is necessary? Are there certain basic elements of technique which it might be better for the therapist to employ as well as he can rather than to attempt to avoid altogether? I will return to this question when I have laid a better basis to discuss it. I will argue that with the definition of analytic technique at which I will finally arrive, it should be taught to all psychotherapists and that how well it will be employed will depend on their training and natural talent for the work.

The changes I will propose are more radical than a simple extension of the recommendation I made in 1954 that we carry more of the non-directive spirit of psychoanalysis into our psychotherapies. To confine the changes to that would be to imply an acceptance of the prevailing conceptualization of the intrinsic criteria of psychoanalytic technique. The attempt to fulfill the prevailing intrinsic criteria while expanding the range of the extrinsic criteria would actually exaggerate the defects of the prevailing conceptualization of the intrinsic criteria. In fact such practice is what we sometimes see in beginners who are aping what they consider the correct withdrawn posture of the psychoanalyst. The recommendation to broaden the range of the extrinsic criteria within which the intrinsic criteria can be fulfilled is therefore bound up with the changes I will recommend in the intrinsic criteria.

I suggest that with the changes in the conceptualization of the intrinsic criteria I will propose, on the one hand psychoanalysis and psychotherapy become more sharply opposed, and on the other hand the range of applicability of psychoanalytic rather than psychotherapeutic technique broadens. I mean that analytic technique as I will define it should be employed as much as possible even if the patient comes less frequently than is usual in psychoanalysis, uses the chair rather than the couch, is not necessarily committed to a treatment of relatively long duration, is sicker than the usually considered analysable patient and even if the therapist is relatively inexperienced. In other words, I will recommend that we sharply narrow the indications for psychoanalytic psychotherapy and primarily practise psychoanalysis as I shall define it instead.

The length and nature of these introductory remarks are a result of what I consider to be the misunderstandings which have met earlier presentations of my views and which I am attempting to head off or at least to gain a longer suspension of judgment on the reader's part.

I believe the prevailing theory and practice of

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psychoanalysis and psychotherapy and the relation between them have not changed significantly since 1954. The reconsideration I am proposing is an outgrowth of my changed views on transference and its analysis which I shall soon summarize. This reconsideration has led me to propose changes in the conception of each one of the intrinsic criteria as I had accepted them in 1954. I am not attempting to review in this paper the contributions of my many predecessors who have similarly reconsidered one or more of these intrinsic criteria.

There is a broader perspective than that of transference, however, within which these changes can be conceptualized. It is that the interpersonal interaction between patient and analyst requires reconceptualization. While the usual psychoanalytic perspective on the interpersonal aspect of the
The analytic situation is how the patient's view of it is distorted by his intrapsychic organization, I suggest instead that the integrate arising from the patient's intrapsychic organization and his experience of the interpersonal interaction should initially be treated as a rational formulation in a relativistic, perspectival framework of interpersonal reality.

The issue relates to an old one in psychoanalysis—often discussed as the difference between a two person and a one person view of the analytic situation. What I believe I am contributing is a spelling out of the repercussions of taking the two person view seriously in the context of the classical view of analytic technique. One way of stating the changed view in its application to the analytic situation is that the setting and the analyst's behaviour exert an influence, ranging from a minor one to a major one, on the manifestations of the potential intrapsychically organized patterns of interpersonal interaction and in that sense co-determine the transference. Another way of stating the issue in terms of analytic technique is that without this view of transference the setting and the analyst's behaviour can become vehicles of inadvertent suggestion which if not attended to exert their effects without being recognized or altered.

TRANSFERENCE AND ITS ANALYSIS

The first intrinsic criterion of psychoanalysis which I will take up is the centrality of the analysis of the transference. That psychoanalysis aims at as complete an analysis of transference as possible while psychotherapy does not, remains correct, but this formula acquires new meaning through the changes in my concept of transference and its analysis. I have presented them in an article (1979) and in an expansion of that article into a monograph (1982). Here I can only summarize my conclusions:

1. The notion of an 'uncontaminated' transference is a myth because the expression of the transference is always influenced by the here-and-now interaction between the analyst and the patient. But even more, the nature of interpersonal interaction is such that the transference will always have some degree of plausibility in terms of something related to the analyst. This something includes things the analyst has not done as well as what he has done. The usual view is that the patient distorts the situation by constructing it in terms of his intrapsychic patterns. I say instead that the therapist's behaviour lends plausibility to the patient's experience. The relative roles of these two contributions differs from instance to instance. The important thing is not to approach any single instance with a predetermined conviction as to their relative importance.

2. The examination of the transference should begin with a careful clarification of exactly what the patient's experience is, including whatever influences in the current situation are involved. The therapist must not ever assume that he necessarily clearly understands the patient especially if the patient is vague, indefinite, and elusive.

3. It is commonly not recognized that transference is ubiquitous because the resistance to becoming aware of it on the part of both patient and analyst leads to its appearance in disguised form in associations not manifestly about the current relationship. The clarification of what the patient is experiencing requires seeking out these allusions to the present relationship and making them explicit. I suggest that this activity be designated interpretation of resistance to the awareness of transference in contrast to interpretation of resistance to the resolution of transference.

4. The analysis of transference, after the
Work in the resolution of the transference analogously should seek the plausibility in the patient's experience of past relationships (Hoffman, 1983).

clarification of what the patient's experience of the relationship is, should begin with a search for what makes the patient's experience at least somewhat plausible to him. This amounts to a major change from the usual emphasis on how the patient's experience is a distortion of the situation to an emphasis on how the patient's experience can be understood as a plausible understanding of the situation. The compulsion to re-experience and re-enact the past is a major motivation for the selective attention with which the patient experiences the present as he constructs his plausible understanding of it.

A major role in the resolution of transference is played by the patient's coming to see that this plausible meaning of the situation is indeed no more than only plausible and not unequivocal, that is, that his experience of the situation is based to a greater or lesser degree on determinants within himself.

The awareness that there are such determinants will probably sooner or later lead to data from the past which help explain how they came to be. Such explanation falls into the familiar category of the resolution of the transference by the examination and re-evaluation of the past.

The patient not only experiences the analytic situation in a way which conforms to his preconceptions, whether conscious or not. He also behaves in a way designed to get the therapist to justify these preconceptions which in turn lends further plausibility to them. The extent to which the therapist is unaware of how he is being experienced may well be a measure of his unwittingly responding to pressure from the patient and coming to behave in a way which increasingly justifies and makes plausible the patient's preconceptions. Sandler (1976) has described this phenomenon as the analyst's role responsiveness. Otherwise expressed, the patient stimulates countertransference.

I add a point about countertransference, to which I directed little attention as such in my monograph. It is that the most important aid to the therapist in discerning his countertransference is the patient's interpretation of it, to a large extent in disguised references in his associations. Langs (1978) and Hoffman (1983) have described how the patient can be seen as an interpreter of the analyst's experience. This similarity between Langs' views and the view which Hoffman and I share must not be permitted to obscure a crucial difference. Langs sees the patient as correctly perceiving the analyst's unconscious intent whereas we see the patient as only constructing a more or less plausible view of the analyst's motivations.

A frequent criticism of my view of transference and its analysis is that it is said to be in opposition to what many others believe to be the essence of the psychoanalytic method, namely the recovery of the patient's history. I believe it is not a matter of opposition but of technical priority. When I spoke of the important role played in the resolution of the transference by the recognition that the patient's experience of the relationship is plausibly but not unequivocally determined by the actuality of the analytic situation, I did not mean to derogate the role of the patient's awareness and integration of his history in resolving the transference. I do believe, however, that priority of attention to the recovery of the history can lead to important inadvertent effects on the transference. Such priority is often a defensive flight by either patient or analyst or both from the discomfort aroused by explicating, examining, and interpreting the transference phenomena in the here-and-now. To the extent to which this is true the recovery of the past may exert its effect by way of inadvertent suggestion.
The issue which I am discussing has a long history in analytic technique in another regrettably and unnecessarily polarized controversy over the relative importance of experiencing and remembering. I expect to be considered to be underemphasizing the past as Ferenczi & Rank were in their monograph of 1925—over 50 years ago—entitled The Development of Psychoanalysis. While I am not discounting the value of remembering, I believe that an analysis in which priority of attention goes to the transference expressed in the here-and-now, including the analyst's contribution, will be much freer of lasting effects of inadvertent suggestion than one in which priority of attention goes to genetic interpretation which may bypass transference. The analysis of the transference may be defined as attempts to understand the patient's current experience, in relation to the analyst, including its plausible sources in the here-and-now, so that its sources in the past experience, wishes, and conflicts can be illuminated and more conscious, and flexible integration of past and present is brought about.

ILLUSTRATIONS OF INADVERTENT INFLUENCE ON THE TRANSFERENCE

Much of the analyst's behaviour which from the patient's point of view leads him to a plausible interpretation of the analyst's motivations is from the analyst's point of view inadvertent. For initial illustrations I turn to two of Freud's cases. First, the Dora case (1905). Freud defended himself against the possible criticism that he should not have talked about intimate sexual matters with a young woman by arguing that to do so was not necessarily prurient or harmful. True enough. But would it not have been plausible for Dora to interpret his obvious interest in her sexual life—and the possible apparent concomitant relative lack of interest in what was consciously her primary concern, the hypocrisy in her family—as a more subtle variant of Herr K's sexual interest in her? Second, the Rat Man (1909). Would it not have been plausible for the Rat Man to have interpreted Freud's interest in getting the detail of the rat torture to be a form of torture? Freud has been criticized (Kanzer, 1980) for influencing the transference by trying to guess what the torture was. We may infer from Freud's explicit disavowal that he wanted to torture him that he was trying to dispel any such feeling on the Rat Man's part.

I am not saying that Freud should not have inquired into Dora's and the Rat Man's mental content. I disagree with those who believe that all such material can emerge spontaneously in free association, and that they should wait for it to so emerge so that the patient has no rational basis for imputing sexual or aggressive intent to the analyst. I am suggesting on the contrary that such plausible imputation is unavoidable precisely because of the multiple interpretations to which human behaviour lends itself and because the patient is primed by his past selectively to interpret the present. Rather than to pursue such impossible avoidance on the basis of a mistaken premise as to the nature of the analytic situation, the analyst should bend his energies to detecting the implicit indications that the patient is making such imputations and bring them into the open by interpretations of their plausibility in the light of the here-and-now with the ultimate aim of elucidating the patient's own contribution. The latter stems from the patient's past, the there-then.

Here is an illustration from a recent paper by Rangell (1979). He writes that for a period of time a patient's response to every interpretation or achievement of a piece of insight was 'So what?' or 'So what happens now?' or 'So what am I supposed to do?' and such. He does not describe any investigation of the meaning of the 'So what?' but says he soon came to feel this was a genuine seeking of information partly from the patient's impatience to have his behaviour improve more rapidly and partly to block the progression to more painful insights. So he made the following
intervention: 'You ask so what and not so why'. He considers that the patient needed this suggestion to stimulate progress in the analysis. He explicitly disavows that the patient was being reprimanded or ordered to think along these lines.

I believe this disavowal betrays Rangell's peripheral awareness that the feeling of being reprimanded or ordered to think along these lines might well have been plausibly experienced by the patient as an inadvertent effect of his interpretation on the expression of the transference. In fact he introduces the vignette to the reader by saying he wants to make the point that an active role on the part of the patient must be enlisted continually. This was therefore probably the implicit message both as intended by the analyst and experienced by the patient. I believe he should not have assumed that he knew what the 'so what?' meant. He should have attempted to understand its meaning in the transference. Furthermore, once having made his remark he should have been alert to its possible repercussion on the expression of the transference.

Rangell says the interpretation was successful

and cites some subsequent insights about the patient's relation to his mother. He does not provide enough data to say how these insights may have combined disguised references to the patient's past and to the analyst's intervention.

I believe the example illustrates a typical failure to recognize that primary attention should be directed to the examination of the transference in the here-and-now, in this instance first to the 'so what?' and then to the response to the intervention, rather than to the there-and-then as implied in the therapist's asking 'why?' I suggest that the repeated 'so what?' is a sign of a persistent and central issue in the transference being expressed in the here-and-now with roots in the past, and that unless it is elucidated the continuing analytic work may well be essentially intellectualizing and under the influence of suggestion.

The examples I gave all illustrated how the patient experienced interventions. What is also often not focused upon by analysts is the role they have played in the common transference responses to features of the analytic setting themselves. The fact that these features may be experienced very differently by different patients or by the same patient at different times, or even simultaneously, probably increases the likelihood that the analyst will regard the patient's experience as essentially or even entirely self-determined. But the analyst's attitude is also a determinant of how the patient experiences these features of the analytic situation. The couch may be a welcome indication that the patient need not concern himself with the therapist's reactions or it may mean that the patient is deprived of the cues he must have to the analyst's reactions without which he is too frightened to speak. The manner in which the analyst brings it about that the patient lies down will to a varying extent co-determine whether the patient experiences the couch as a relief from fear of meeting the therapist as an equal or as a degrading submission. The way the frequency of sessions is settled will co-determine to a greater or lesser extent whether frequent sessions mean a promise of indulgent unending care or a loss of respite from a relentless invasion of privacy. Similarly, open-ended duration may be a reassurance that there is adequate time but it could also be experienced as an indeterminate sentence without possibility of probation. Jacobson (1954) writes: 'many depressives tolerate four or even three sessions weekly much better than six or seven … Daily sessions may be experienced once [ sic ] as seductive promises too great to be fulfilled, or then again as intolerable oral sadistic obligations which promote the masochistic submission' (p. 603). The way the therapist exercises restraint will codetermine whether it is interpreted by the patient as aloof austerity,
sagacious thoughtfulness, or an anxious effort to avoid breaking some rule of proper analytic conduct (Stone, 1954, p. 575).

While these possible experiences may be divided into a stimulus—lying down for example—and the patient's experience, this distinction is not the same as the division of the patient's experience—possible only conceptually at best—into plausible responses to the present and transferences from the past. For the patient's experience is the transference, an indivisible unity.

The analytic interaction and setting thus inadvertently influence the patient's experience of the relationship. Freud (1919) explicitly based his recommendation of abstinence on the substitute gratifications which the patient may get from the transference relationship itself. One may disagree with Alexander's recommendation to interfere with the dependent gratification sometimes afforded by the analytic setting by diminishing the frequency of sessions but one must applaud his recognition of this phenomenon and his recommendation that it be interpreted. Weigert (1954) discusses well the magical meanings of the rituals of the setting although she does not put enough emphasis on their detailed analysis in the transference. I suggest that a technical conclusion which may be drawn from these illustrations is that in analysing the transference the analyst should first focus on his contribution to the patient's experience of the relationship in the patient's response both to interventions and to the features of the analytic setting.

**NEUTRALITY**

In the light of this suggested changed view of transference I turn to the second of the intrinsic criteria of psychoanalysis as I defined them in 1954 and as they are generally accepted. It is the neutral analyst.

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The implication that, whether advertent or inadvertent, the therapist's influence on the transference is avoidable is carried in the concept of neutrality. In my 1954 definition I said that psychoanalysis was conducted by a neutral analyst. I realized then that the recommendation for neutrality is an effort to avoid effects on the transference but that it cannot accomplish that aim because the patient inevitably interprets the analyst's behaviour in ways other than those the analyst had intended. This realization is in fact an aspect of one of the most fundamental propositions in psychoanalysis. It is that the meaning to a person of an external situation can never be determined from the outside alone. The analyst tries to avoid behaving in a way that will be construed correctly and clearly as obviously reflecting some erotic or hostile intent, but even so he can never take for granted that a particular behaviour on his part has a particular meaning to the patient, both because he cannot have unequivocal knowledge of his intentions and because of the transference. To know the meaning he must explore the patient's experience. While investigating the meaning the patient ascribes to his behaviour the analyst does not reveal his intended meaning because such revelation prejudices the exploration of the patient's experience. If the analyst is persuaded that he can indeed behave in a completely neutral way he will think that a patient who experiences him as different from what he consciously intended is distorting his intentions. The analyst will be motivated to search for such inadvertent effects of his behaviour only if he is convinced not only of how commonly such effects occur but also that they will be expressed in disguised ways.

I believe it is a partial awareness of this point which has led to the degree to which analysis is characterized by a reluctance to engage in interaction with the patient. It is as though we try to prevent the patient from mistaking our intent by having no intent. The belief that the analytic process has a kind of automaticity which takes over once it is set in motion fosters this reluctance to interact.
But such reluctance implies a failure to be fully aware that because analysis takes place in an interpersonal context there is no such thing as non-interaction. Silence is of course a behaviour too. Nor can one maintain that silence is preferable for the purpose of analysis because it is neutral in reality. It may be intended to be neutral but silence too can be plausibly experienced as anything ranging from cruel inhumanity to tender concern. It is not possible to say that any of these attitudes is necessarily a distortion.

Because I was partially aware of this fact in 1954, I suggested that the analyst could at least adopt a stable relatively neutral attitude so that there would be a baseline against which to measure the patient's attitudes. What I now recognize and did not in 1954 is that these experiences which the analyst inadvertently produces are not distortions of the analyst's behaviour because he cannot assume that these experiences have no rational basis. With this realization the analysis of the transference takes on a new complexion. While inadvertent effects on the transference can be overlooked even with the best of intentions, they are more likely to be recognized if the analyst has become persuaded of the role played by the here-and-now interaction in how the transference becomes manifested.

**THE REGRESSIVE TRANSFERENCE NEUROSIS**

The third intrinsic criterion I take up is the regressive transference neurosis. Even if it be granted that the transference can be analysed in an expanded range of extrinsic criteria, there remains the alleged difference between psychoanalysis and psychotherapy that only in the former does a hallmark of the analytic process develop—a regressive transference neurosis. I will deal first with the concept of transference neurosis and then with regression.

How transferences differ from a transference neurosis is by no means agreed upon in our literature. Many definitions seem to make the distinction a quantitative rather than a qualitative one, the transference neurosis being a more comprehensive, organized, and persistent set of attitudes directed toward the analyst, than transferences. There are other definitions of a transference neurosis which are more qualitative. For some authors the term seems to mean the development of a significant object relationship with the analyst, albeit a kind influenced by the past, in contrast to a defence transference.

I suggest that to some extent at least the distinction between transferences and a transference neurosis is artificially induced by the manner in which analysis is ordinarily practised. I mean that if the analyst refrains from the early analysis of transference he creates an unnecessary distinction between a beginning phase in which the transference remains implicit and a later phase in which it can no longer be ignored. In prevailing practice this later phase is considered to be the appearance of the true transference, but in my opinion that presumed observation of the appearance of the transference is heavily influenced by the fact that it has been ignored until then, at least in so far as its interpretation is concerned. The manner in which its appearance is thus co-determined is generally not examined. There is another related 'inherent' feature of the course of an analysis which may actually depend on how it is conducted. The current practice of delaying the analysis of the transference because of the failure to realize that it is a resistance from the beginning may play a role in the common phenomenon of a rapid amelioration of symptoms. Only later when the transference as resistance can no longer be ignored is it interpreted, with a recrudescence of symptoms.
The arguments I have presented so far in this paper imply two conclusions about the transference neurosis. First, the role of the therapist's inadvertently suggestive behaviour in inducing the transference neurosis has been underestimated while the failure to interpret its disguised manifestation has been misunderstood to mean that it has been prevented from existing. Second, the technique of interpreting fairly obvious, albeit disguised, transference expressions, in the here-and-now, from the beginning, will more quickly lead to a more observable detailed and readily demonstrable and therefore analysable transference than prevailing practice would allow.

For Glover (1955) the definition of a transference neurosis is that regression has taken place in the transference to the time at which symptom formation first began, i.e. an infantile neurosis. It is this conception that a genuine analytic situation involves a regressive transference neurosis to which I now turn.

The inconsistency in our technical literature between the concept of regressive transference neurosis as a spontaneous largely internally determined phenomenon which reinstates the conflictful experience of an earlier period and the description of how the analytic set-up is designed to bring about the observable expression of a regressive transference neurosis is worth pondering. The paper which most sharply disputes the idea that the regressive transference neurosis is spontaneous is that by Macalpine written over thirty years ago (1950). She defines transference as 'a person's gradual adaptation by regression to the infantile analytic setting'. She compares the regression in analysis to that in hypnosis, distinguishing it from the latter in that it is induced slowly rather than suddenly, in response to the infantile analytic setting rather than to a direct suggestion, and is followed by continued pressure to further regression rather than by continued suggestion (p. 533). One wonders how convinced she is of the distinction when one finds her writing that 'assessing the process as a whole … the analysand is misled and hoodwinked as analysis proceeds' (p. 527). Macalpine suggests that further study is required to see to what extent the frequent negative feelings toward the analyst are a 'response to the emotional and environmental pressure exerted on him' (p. 516). After calling the coexistence of positive and negative feelings in the analysand a 'pseudo-ambivalence' because the patient is reacting to two different objects simultaneously rather than having two attitudes to the same object she writes: 'The common appearance of this pseudoambivalence can then no longer be adduced as evidence of the existence or part of a preanalytic neurosis' (p. 527).

It is worth noting that as staunch a believer in the generally accepted definition of transference and the desirability of regression in the analytic process as Anna Freud (1954) hinted at similar misgivings. After saying that she believes that in so far as the patient has a healthy part of his personality his real relationship to the analyst is never wholly submerged she wonders 'whether our—at time complete—neglect of this side of the matter is not responsible for some of the hostile reactions which we get from our patients and which we are apt to ascribe to "true transference" only. But these are technically subversive thoughts and ought to be "handled with care"' (pp. 618–9).

In 1954 I emphasized not only Macalpine's demonstration that regression is wittingly induced in the usual analytic situation but I also wrote approvingly of how the analytic situation exerts a steady pressure toward regression. What I failed to see is how this unacknowledged manipulation of the transference constitutes a major unanalysed suggestive influence. Macalpine too did not draw this conclusion. Despite her own arguments to the contrary she said that 'The analytic transference relationship ought … not to be referred to as a relationship between analysand and analyst but … as the analysand's relation to his analyst' (p. 525) and that 'suggestion can inherently play no part in the classical procedure of psychoanalytic
technique' (p. 526). As part of the general argument I have advanced that all aspects of the setting of an analysis should be examined from the point of view of both advertent and inadvertent manipulation I now add that the analysis of the transference demands the examination of how the transference is influenced by this pressure toward regression.

In 1961 Stone criticized prevailing practice in relation to regression when he wrote that the 'overwrought and indiscriminate application of the principle of abstinence … may induce spurious and prolonged iatrogenic regression of untoward impact on the progress of the analysis' (p. 15). I believe he did not go far enough. I believe prevailing analytic theory and probably prevailing analytic practice do constitute the 'overwrought and indiscriminate application of the principle of abstinence'.

The argument that regression is a necessary part of the analytic method is based on the idea that an earlier infantile neurosis has to be revived and resolved. I believe that the very idea that an earlier state can be reinstated as such is an illusion. Furthermore in the sense in which the infantile neurosis is still alive in the present it will be manifested in the present and does not require special measures to bring it to life. By the very fact that a regression beyond what the patient begins the treatment with has been induced, that regression cannot be a simple reinstatement of the past.

What one should seek in analysis is not a level of regression beyond that which characterizes the patient's pathology but a drawing into awareness of the regressive manifestations which up to that point have been expressed in disguise. As Arlow (1975) has said: 'the oft repeated statement that psychoanalytic technique induces regression in the patient … is a principle which has been quoted and circulated without challenge for a long time. It seems to me what the psychoanalytic situation does is to create an atmosphere, a set of conditions, which permit regressive aspects of the patient's mental functioning, long present, to reemerge in forms that are clearer and easier to observe' (p. 73). I would differ only in that I would say that what Arlow describes is what analysis should aim for but that the usual analytic setting and practice may well often induce an additional unnecessary, if not harmful, iatrogenic regression.

The progressive emergence in awareness of aspects of the patient's functioning is surely a feature of successful therapy. The more time available for work the more likely that such awareness will develop, other things being equal. I am arguing that, unless a regression beyond that which characterizes the patient's pathology has been induced, the appearance of regressive manifestations in awareness is accounted for by the increased awareness of previously disavowed mental content, not by regression.

As with all the other features of the analytic setting each patient in conformity with his particular transferences, will ascribe his particular meanings to those features which the analyst employs to induce a regressive transference neurosis. In 1954 I called such an induced regression a regression in the service of the ego. I would still call it that but now I suggest that when the regression goes beyond what the patient brings to the therapy the useful results obtained are in spite of this increment of regression, not because of it. The relatively healthy patient has the capacity to adapt to the manoeuvres designed to produce a regressive transference neurosis and still to work usefully. But effective analysis does not require a manipulated increase in the patient's regression. If the setting is responded to by increased regression this too can and should be interpreted. I consider that a well conducted analysis is marked by a transference, not necessarily by a regressive transference. The necessity for induced regression is the intrinsic criterion which most urgently calls for further investigation. It has been suggested that my argument is reducible to a terminological clarification but I believe it is substantive as well.
It is necessary to discuss free association because many analysts are convinced that if the external criteria are fulfilled the patient's free association will from time to time show spontaneous regressive features which are not simply making manifest the regression already characteristic of the patient and because free association is sometimes listed as one of the intrinsic criteria. In contrast to the view that regressive phenomena in free association are correctly assessed as spontaneous manifestations I suggest that this view of free association is untenable in the same sense as the idea of an uncontaminated transference. Both transference and free association are mistakenly considered to be uninfluenced by the therapeutic situation and simultaneously, and paradoxically, to be strongly influenced by it! Freud (1900–1901) said that free associations are not literally free but are determined by concealed purposive ideas, two major sets of which concern the illness and the therapist (pp. 531–2). He might well have made more explicit that the patient's associations are influenced not only by the analytic setting but by the therapist's interventions as well. Every time the analyst intervenes he may be experienced as suggesting a direction for the patient to pursue.

I understand the rule of free association to mean that the therapist establishes the general condition that the patient is invited and even urged to express his thoughts freely even if he feels reluctant to do so and that after intermittently intervening the therapist is alert to the consequences of his interventions upon the patient's flow of ideas. Freud referred to analysis as a conversation, not as a soliloquy (1926, p. 187). Whether or not the patient is being permitted to free associate is not a matter of the quantity of the therapist speech but of whether or not he persists in keeping the conversation in a direction that he is determining, or fails to take account of his influence in possibly determining the direction. The therapist can determine the content of the hour by one utterance quite as much as he can by chattering. It is also an error to conceive of free association as necessarily 'deep' or as a string of apparently disconnected ideas (Lipton, 1982).

NEW EXPERIENCES IN THE THERAPEUTIC PROCESS

I come to the last intrinsic criterion of the analytic process as stated in the definition I offered in 1954, that the transference neurosis is resolved by interpretation alone. I understood the implication to be that the role of the interpersonal relationship is temporary and ultimately dissolved. I believe this belittling of the relationship as mutative in an analysis was itself an effort to sharpen the distinction between psychoanalysis and psychotherapy, according to the usual formula that psychotherapy results in transference effects while psychoanalysis resolves the transference. In 1954 I attempted to modify the sweeping character of this formula by arguing that psychotherapy which analyses the transference in some connexions and not in others can produce useful and lasting results which are more than simply transference cures. I still believe that may be true despite the emphasis I now place on the inadvertent effects on the transference which are permitted to stand unresolved in psychotherapy.

My changed view is based on the increasing acknowledgement of another kind of interpersonal relation beside a transference enactment, not deliberately engaged in as a therapeutic measure, which nevertheless plays an important, though variable, role in every analysis and indeed in every psychotherapy. It is the new experience which the patient encounters in the relationship itself, an experience he may never have had before. A particularly important part of this new experience is that which accompanies the interpretation of the transference. In fact in transference interpretation cognitive insight into the patient's interpersonal schemata and new affective experience are aspects of a complex whole. The new interpersonal experience which is part of this complex whole is vital to the revelation and restructuring of the patient's neurosis, as Strachey (1934), Loewald (1960), and more recently Dewald (1979) have emphasized.
The factors leading to change in a therapy then are persisting transference effects, new experience and insight. They all play a role in both psychotherapy and psychoanalysis. But psychoanalytic technique aims towards as complete an exposure of the transference as possible while the new experience is not deliberately engaged in as such but is an inherent accompaniment of the treatment as a whole and particularly of the technique of analysing the transference. In prevailing practice inadvertent transference effects are inadequately recognized and dealt with while in prevailing theory the role of new experience in bringing about change is understated.

My reconceptualizations of these intrinsic criteria of analysis, namely transference and its analysis, the neutral analyst, the regressive transference neurosis, free association, and the role of experience in addition to interpretation lead me to the conclusion that the centrality of the analysis of transference, as I have defined transference, the refusal to manipulate it, and the searching out and making explicit whatever one can discern of inadvertent manipulation of the transference is alone the distinguishing characteristic of analytic technique. I do not necessarily imply that it is the whole of analytic technique. For analysis includes more than the analysis of transference. But it is the distinguishing feature of psychoanalysis. It is what distinguishes it from psychotherapy. It remains for me to try to show that it can be maintained even in an expanded range of external criteria.

**CONTROLLING THE TRANSFERENCE**

I have so far distinguished between psychotherapy and psychoanalysis in terms of the centrality of the analysis of transference. In effect my considerations have been an expansion of the distinction that in the former the transference may be manipulated while in the latter it must not be. My main point has been that even if advertent manipulation is avoided, there is unavoidable and inadvertent influence on the transference in any therapeutic set-up. Unless this inadvertent influence is sought out and interpreted, a therapy which purports to be an analysis becomes by that much a psychotherapy.

I turn to another way in which the difference between psychotherapy and psychoanalysis is often stated in terms of the transference. It is that in psychoanalysis the transference should be fostered in its development while in psychotherapy it should be inhibited from developing. I first note that a discussion of fostering and inhibiting the development of transference would have to take into account the inevitable effects on the transference I have already pointed out. But now my concern is to question the generally accepted idea that the transference can be controlled to a greater or lesser degree and more specifically that its development can be inhibited in psychotherapy.

This control is said to be exerted by keeping the sessions less frequent, by not using the couch, by engaging in an active realistic exchange, by directed rather than free association and by interpreting transference only sparingly. Dewald (1969) who has written widely on the subject refers to this supposed exercise of control as 'titrating' the transference. Stone (1979) also writes that although the transference can be 'used', that is, manipulated in psychotherapy, his aim in his practice of psychotherapy is to 'regulate it to a reasonable degree as to its speed and/or intensity of emergence with the severity and depth of illness as a limiting parameter'.

Stone concedes not only that the transference cannot be regulated in very severe illness but also that even in the 'controlled and benign psychotherapeutic situation' the transference will appear and have to be interpreted. The limitations which Stone sets on his position betray its weakness. In effect he is
admitting the inevitable appearance of the transference and hence the limitation on its susceptibility to regulation. While my own argument as to the role played in the manifestation of the transference by the here-and-now also bespeaks a degree of regulatability of the manifestations of the transference, I suggest that the way the regulatability of the transference is ordinarily conceived underestimates both the ubiquity of transference and inadvertent effects on how it becomes manifest.

It is doubtless true that the failure to interpret the transference limits the range of interpersonal attitudes the patient will become aware of but it does not limit those that will become actualized in the relationship with the therapist. The alleged gain for the therapy is illusory. I believe the therapist sacrifices thereby what he might have achieved. Pathological transference phenomena do not disappear. They only remain unperceived by the patient and perhaps by the analyst as well. They may also remain unperceived in the patient's life outside the treatment situation and even if they are seen there they are less likely to be successfully examined and resolved. Since the explication of the transference plays its role as part of the here-and-now which determines the manifestation of transference, these unexplained transferences are different from what they would have been had the transference been dealt with, but they are surely no less pathological for not having been made explicit. Why observing and interpreting actualization of the transference in the therapy situation is necessary was admirably stated by Freud (1912): 'One cannot slay an enemy in effigy'. The conception of the transference I am proposing is that it cannot be prevented from existing any more than the neurosis can be prevented from existing because it is ubiquitous and continual. It can be inhibited from becoming explicitly identifiable and identified by patient and analyst, but if there is a relationship, there is transference—both conscious and unobjectionable transference and preconscious or unconscious suppressed or repressed transference.

In psychoanalysis on the other hand, the general view is that the transference should be fostered, even to the point of bringing about a regressive transference neurosis. Indeed one does those very things which are avoided in psychotherapy allegedly to inhibit the development of the transference. Sessions are frequent, the couch is used, exchange is kept to a minimum to lessen the realistic aspects of the situation, and transference is interpreted actively—but only after it has allegedly 'spontaneously' developed! According to the line of argument I am advancing, instead of speaking of fostering the transference one could speak of making its manifestations as explicit as possible in the analytic situation including the inadvertent influences on its manifestations which come from the setting and the analyst's interventions.

APPLICABILITY OF ANALYTIC TECHNIQUE IN VARIED SETTINGS

My changed conceptions of the intrinsic criteria of analysis, some beginning efforts to apply them, and experience in teaching them to therapists of varied experience has led me to believe that the attempt to use analytic technique in this broader range of circumstances is justified.

The shift from a view of transference as a distortion and concomitantly to initial emphasis on the analyst's contribution to the transference, alters both the atmosphere of an analysis and the sequence by which the deeper more regressive aspects of the patient's pathology become explicit. The change in atmosphere is one from the patient being wrong and misguided to one in which his point of view is given initial consideration. In other words his rational capacity is respected rather than belittled. It is in such an atmosphere, after his point of view has been acknowledged, that he is more likely to be willing to look for his own contribution to his experience. The position is of course contrary to the
one which argues that to acknowledge the rationality of the patient's point of view is to confirm his belief that his experience is fully accounted for by the current behaviour of the analyst.

As to the sequence in which the deeper aspects of the transference become explicit, initial attention to the here-and-now as an interaction makes it easier to obey the classic analytic injunction to proceed from the surface to the depth (Fenichel, 1941). The presenting material will not even be as deep as preconscious but rather conscious but withheld ideas. I note that the current discussion in our literature of the role of construction in the analytic interaction in contrast to the uncovering of fixed schemata raises important and difficult questions about the validity of the concept of the exposure of progressively deeper verbally organized psychic material. A concept of continuing construction in the analytic interaction which at the same time re-evaluates the conceptualization of the relationship between conscious, preconscious, and unconscious may fit the data better.

The less time available the less opportunity will there be for the development of the patient's history if priority is given to the transference in the here-and-now. But only if one begins with a prior conviction that the history must be reconstructed as much as possible will one see this as unfortunate. I believe that less is accomplished if one gives priority to interpretations of transference outside the therapeutic situation and of genetic material at the expense of facets of the transference within the therapeutic situation. At

the same time, an expanding and therapeutically useful awareness of pathogenic history is not only not incompatible with the conception of transference and its analysis which I am describing but on the contrary it is more likely to be enhanced by such analysis.

The relevance of this view of the analysis of transference to the possibility of carrying it out in an expanded range of extrinsic criteria is different for two major classes of the extrinsic criterion of the patient's pathology—schematically stated, the relatively more healthy allegedly analysable and the relatively sicker unanalysable. The distinction I advanced between transference and regressive transference now becomes crucial. With the healthier patients frequency is often considered necessary to 'keep open the wound into the unconscious' as I put it in 1954. With a concept of proceeding from the beginning from more obvious surface manifestations, the image of painful probing against strong resistance is no longer appropriate. To question the necessity for an induced regression is also to question the necessity for going beyond what the patient can acknowledge with relative comfort. Nor is this a programme for remaining superficial. It is rather a recommendation to take progressive steps more in tune with the patient's resistance. The couch is likewise considered essential in terms of the need to induce regression. It too then becomes dispensable if one accepts the reasoning I have just outlined.

Whereas in the case of the patient usually considered analysable the objection to the use of psychoanalysis in less than the optimal analytic setting is that a regressive transference will not develop, in the case of the sicker patient it is said that a dangerous regression may develop spontaneously. The catastrophic regressions that sometimes takes place in analysis make analysts careful not to employ the method if the patient is considered incapable of withstanding the rigours of an enforced regression. My suggestion that regression beyond that which already characterizes the patient's pathology is not only unnecessary but undesirable, as well as my description of an initial focus on the therapist's contribution and on the presenting layer of transference in a changed conception of transference and its analysis, mitigate the potential dangers of analysis of the transference in sicker patients. With this different way of working, the couch and frequent sessions likewise become less dangerous as promoters of regression.
Frequency and the couch must be looked at not only in terms of their potential for inducing regression but for their almost contrary potential for providing support. It is argued that frequent sessions are necessary to gain access to the transference in healthier patients but it is also argued that frequent sessions are necessary to provide the support which sicker patients require to tolerate the analysis of transference. While it may be true that for some patients frequent sessions imply support, it may be true for others, as I said above, that frequent sessions imply the dangers of no respite. So too while the couch is ordinarily considered to be conducive to regression it may enable an isolation from the relationship which has a contrary effect. No universal meaning of any aspect of the analytic setting may be taken for granted. It follows that no universal prescription can be given for this or that type of case. One may generalize that analytic work goes better with healthier patients lying down and sicker patients sitting up and with frequent sessions for both kinds of patients but a particular patient may not conform to the rule. The meaning of the setting must be analysed in each instance. Nor is degree of pathology the only variable which determines a patient's response to the analysis of transference. Apart from pathology some take to it like a duck to water and can work despite infrequent sessions, while others never seem to find it congenial.

It would seem obvious that one can accomplish more with greater frequency simply because there is more time to work. But if greater frequency is frightening to a particular patient, frequent sessions may impede the work despite interpretation. One cannot simply assume that more is better. The optimal frequency may differ from patient to patient. We must not confuse optimal frequency with obligatory ritualized frequency.

The analyst's experience in the setting is likewise an important consideration as well as one which varies from analyst to analyst. It is not only the analyst's character structure which determines how he can work best but his training and habits too. Some analysts say they have difficulty in keeping abreast of the transference in a patient who comes less frequently. Some analysts feel themselves isolated from a patient on the couch whereas others are more comfortable with the usual set-up.

I turn to the matter of neutrality. As Lipton (1977) has so well described, neutrality is not a matter of any particular behaviour on an analyst's part but of the attitude with which he conducts the analysis.

The argument that psychoanalytic technique cannot be used in the face-to-face position because of the reality cues afforded the patient is a variant of the mistaken idea that it is the external stimulus rather than the patient's interpretation of that stimulus which matters. Discussions of the issue seem to gravitate to quantitative terms as though there are fewer stimuli if the patient cannot see the analyst. It may be that the patient facing the analyst is exposed to a wider range of stimuli but the patient's response is to the quality not the quantity of stimuli. The difference between the lying down and the vis à vis position is not that the transference is necessarily less contaminated in the former than in the latter. It is rather that the contribution of the analyst is different in the two situations with concomitant different contributions by the patient. The argument that the demonstrability of the patient's contribution is enhanced in the usual non-vis-à-vis situation likewise presupposes that the quantity of stimuli is less in the usual position.

In practice the difficulty in maintaining analytic technique in the vis-à-vis position seems to be at least as much a matter of the analyst's psychology as the patient's. The technique requires a stance on the therapist's as well as the patient's part which is significantly different from the give and take of most human relationships. The therapist may find it easier to refrain from ordinary human
interaction if the patient is on the couch because the physical arrangement is different from ordinary human interaction. If he is also uncomfortably struggling with minimizing cues as to his own subjective experience he may find it especially difficult to maintain analytic technique in the vis-à-vis situation. I believe the situation is eased for the therapist by experience in conducting himself this way as well as by really becoming convinced not only that the notion that the transference can develop without contamination is an illusion but also that however revealing he thinks his cues may be they may nevertheless be ambiguous to the patient, especially if the analyst generally does not affirm or deny the patient's conjectures. I shall not attempt to discuss the complex issues of self disclosure.

The difficulty of maintaining neutrality is of course greater in sicker patients whose demands for interpersonal interaction rather than talk are often greater and whose relatively slow change in the therapeutic situation frustrates the therapist's hopes. The very obviousness of the therapist's participation in an interpersonal interaction in such cases has made it easier to overlook the subtler but equally important role played by the interpersonal interaction in the less sick patients.

My position on the intrinsic criterion of resolution by techniques of interpretation alone will be obvious from my earlier discussion. While the more opportunity and the more successful the work the less the role which unanalysed interpersonal effects will play in the outcome, it remains true that unresolved transference and new experience play a role in all psychological therapy.

I do not have much to say about the experience of the therapist. I believe there is an automatic safeguard in that the therapist is likely to see only that which he is capable of dealing with. At the same time I believe it is an error to teach a beginner to stay away from the transference that he sees. I find the technique easier to teach and learn for beginners than the usual psychotherapy since the usual psychotherapy offers no useable guidelines for when transference should be dealt with and when it should be avoided. Therapists use the technique to whatever degree their skill and comfort in exposing the transferential significance of the patient's experience of the relationship permits.

There is another feature which is considered to be an essential of the psychoanalytic setting if psychoanalytic technique is to be used. I refer to the fact that the psychoanalytic process is considered to be possible only if it is open-ended in time. A predetermined limited duration of a therapy introduces many additional issues. I do not know the lower limit in duration for the use of the technique I advocate, but I have used it successfully in once-a-week therapy preset to last no longer than nine months.

The assumption that a regression is necessary for analysis is related to another, often only implicit, assumption about the psychoanalytic process which I would like to question. It is that analysis is a kind of all or none proposition, yielding its positive results only if carried through to the end. It is this belief which may sustain patient and analyst through long periods of apparent stagnation and stalemate, but this belief is often a vain illusion. Freud compared interrupting an analysis to the interruption of a surgical operation. I suggest, on the contrary, that in the changed way of conducting it which I am proposing analysis may be a process with progressively cumulative benefits, interruptable at various points without necessary loss of what has been gained.

It might be argued that with certain kinds of pathology and with limitations of time, useful effects could be obtained by psychotherapeutic methods which would be lost if the psychoanalytic method
were used. As with all the issues I have discussed this one too requires much more experience and systematic research.

The technique I advocate would make the practice of someone who sees patients in a combined psychoanalytic and psychotherapeutic practice more integrated and consistent. As of now in such practice the gross and witting manipulation he may permit in his psychotherapy makes it more difficult for him to adopt the frame of mind of searching for even unwitting suggestion in his analytic work, while, influenced by prevailing psychoanalytic technique, his psychotherapy suffers through excess restraint on interaction and interpretation, especially of the transference.

I am in a position now to make a suggestion about a change in the prevailing practice of setting a predetermined limited goal for patients who cannot be seen in the usual analytic setting. Not only do I question the desirability of a predetermined limited goal, but I also question the desirability of a predetermined ambitious goal, which latter can also be characterized as one of the extrinsic criteria allegedly necessary for an analysis. In either case the setting of a goal by the therapist whether explicitly or by implication in recommending either psychoanalysis or psychotherapy as the preferred treatment is a major initiative on his part which, to return to a central theme of this paper, can be experienced by a patient in many different ways. It may well remain a silent unexplored but influential suggestive and directive context of the entire therapy. There is much to be said for flexibility and delay in fixing a goal, and with continuing examination of implicit references to a goal. Lipton (1980) has argued that one of the unfortunate consequences of the division between psychoanalysis and psychotherapy is the effort to set a goal at the beginning by way of a relatively prolonged diagnostic period. He points out that Freud practised only analysis, whatever the circumstances.

My opinions about type of case and type of therapist to which, and by whom, I consider the analytic technique applicable obviously have major implications for the economics and sociology of the practice of psychological therapies. These considerations will assuredly make it more difficult for the proposals that I have advanced to be considered on their own merits.

Should the use of the technique I describe in less than the optimal setting for an analysis still be called psychoanalysis? There is a difficult terminological problem here. Other things being equal, obviously an analysis conducted at lesser frequency and for a shorter time cannot accomplish what otherwise could be. There ought to be different names for an analysis carried through as fully as it could be and one which is partial and incomplete. The name psychoanalytic psychotherapy should be reserved for a technique which does not deal with the transference in the way I have suggested is the essential criterion of analytic technique. If a therapy which uses analytic technique with less than optimal extrinsic criteria and without the intention of going as far as one could be called neither psychoanalysis nor psychoanalytic psychotherapy, what should it be called? Psychoanalytic therapy might be a solution even though that name was used by Alexander for what I would call psychoanalytic psychotherapy. Perhaps it will be time enough to worry about the name if my overall argument gains some acceptance. For a further discussion of terminology see Gill (1983).

**APPENDIX: THE HISTORY OF THIS PAPER**

A history of this paper will help the reader to set it into perspective. The original version was written for a symposium on the comparison of psychoanalysis and psychotherapy organized by the Atlanta Psychoanalytic Society and Institute and held in October 1979. The symposium was conceived of as a 25th anniversary retrospective by the three participants in the symposium, Leo Stone, Leo Rangell, and myself who had written articles on the same subject which appeared in the Journal of the American Psychoanalytic
Association in 1954. Although it was originally hoped that the three presentations and discussions would be published as a unit, that never came to pass. Rangell's paper was delivered from notes. It was written later and published in the Psychoanalytic Quarterly, 1981, 50: 655–694. Stone's paper was not published as such but its essential contents have been published in two papers. The first is 'Some thoughts on the “here-and-now” in psychoanalytic technique and process' published in the same issue of the Psychoanalytic Quarterly in which Rangell's paper appeared (pp. 709–733). The second paper appeared in 'Psychotherapy: Impact on Psychoanalytic Training' (1982) edited by E. Joseph and R. Wallerstein, New York: International Universities Press. My own paper is now being published for the first time in a revised version.

Both Rangell's and Stone's papers in the Psychoanalytic Quarterly make critical references to the original version of my paper as read in Atlanta. The present version has therefore had the benefit of these criticisms, so I do not know whether they would consider that their criticisms still apply.

The difference between the present paper and the one originally read rests upon what I believe is a significant improvement in my presentation of my understanding of transference since the time of the original paper. I consider transference to have two sources of determinants which are separable only conceptually and misleadingly even then: the interpersonal patterns of expectation and behaviour which the patient brings to the treatment on the one hand and the actual treatment situation, including its setting and the analyst's interventions, on the other hand. As for the actual situation, one must distinguish between its description by an external observer and how it is experienced by the patient. The transference is the expression of the simultaneously active pre-existing patterns and the experience of the situation and is thus an indivisible unity. Nevertheless one can assign different weights to the two sources. In the constructively proceeding analytic situation the weight falls on the first source and one can refer to the relationship between the two sources as the way in which the analytic situation influences the specific manifestations of the transference. If one wishes to emphasize the two sources equally one can formulate the transference as co-determined by the two sources. This latter formulation, however, may imply a greater degree of involvement on the part of the analyst than most analysts would accept as descriptive of a constructive analytic situation. It would be desirable to have a general model which would not make a prior commitment to the relative role of the two sources. In that case one could formulate the transference as the resultant of the two sources.

The original version of this paper was written in the perspective of the formulation of the two sources as co-determinants. The present version is largely written in the perspective of the transference as the specific manifestation of the first source as influenced by the second. The reason for this shift is a recognition on my part that the first version was written in the context of the assumption that the analytic situation usually includes a contribution from the second source which is greater than is usually acknowledged. I still consider that to be true but because the essential point of the paper does not rest on that conviction and in deference to the usual assumption that transference should be defined in terms of the ideal of a constructive analytic situation, I have written this version in accordance with that latter assumption. I will elsewhere attempt to explicate further the three possible formulations, namely the two contrasting biases and the formulation which attempts to state a model which avoids either bias.

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SUMMARY

The increasing recognition that all aspects of the analytic situation are contributed to by both parties, in however varying proportions, must be taken into account in conceptualizing crucial psychoanalytic concepts like transference, free association, regression and the role of the experience of the relationship. This recognition highlights the role of unwitting suggestion in all psychological therapy. It suggests that rather than by criteria of the setting, psychoanalytic technique may be characterized not only by the avoidance of witting suggestion but also by the analysis of both witting and unwitting suggestion and thus distinguished from psychoanalytic psychotherapy. Psychoanalysis and psychoanalytic therapy then become more dichotomous than continuous and the range of applicability of analytic technique, even if in the pursuit of only a partial and incomplete analysis, can be broadened in terms of frequency of sessions, recumbency, pathology, and experience of the therapist. In consideration of the possibility that analytic technique in such broadened circumstances may fail to include an induced regression, the role of unwitting suggestion in such induced regression is pointed out and the question is raised whether such regression beyond what the patient brings to the therapy is a desirable and necessary part of an analysis.

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