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Original Paper

An Operational Analysis of the Clinical Goals of Psychoanalytic Technique

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An operational description is presented of the clinical goals of analytic technique shared by various analytic orientations. This operational schema of their similarities is then used to organize their differences. In this schema, analytic schools differ from one another in three areas: the kind of unconscious content looked for in uncovering; aspects of the process considered subject to direct intervention; and the most effective stance and interventions with which to pursue their shared analytic goals. Organizing the differences between approaches in the context of shared analytic process goals makes it possible to clarify implicit clinical assumptions and to develop empirical rather than theoretical clinical discussions between analytic orientations. Understanding the intent or purpose of an intervention is useful in comparing approaches, exploring clinical controversies, clarifying implicit clinical assumptions, and understanding approaches more deeply in their own terms.

Most analytic schools describe the analytic process and the therapeutic action of analysis through the lens of their theory of development, pathology, and change. Since these are different, the analytic processes they describe sound different. This can obscure the fact that the goals of analytic technique remain similar to those outlined by Freud in his papers on technique (1911-1915). What I will do in this paper is first present an operational description of the goals of the analytic procedure outlined by Freud. These are the goals of analytic technique that different analytic orientations still share. They represent a version of what could be called common ground in psychoanalysis. I will then look at the differences in

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how the various analytic schools conceptualize and implement these goals, based on their different views of development, pathology, and change. Finally, I will indicate some of the ways this analysis may be useful in exploring clinical controversies and in understanding and comparing different analytic approaches.

What does the analytic procedure look like operationally? We start an analysis by asking the patient to lie down and say whatever comes to mind, while we, as analysts, listen with evenly hovering attention, which is basically an open mind about what is most relevant in the communication and a simultaneous awareness of our own internal thoughts and reactions. What happens then is that the analyst hears certain things, the patient and the analyst experience things, a relationship develops, and patterns of thinking and relating emerge. The analyst chooses to make the patient aware of some of what is occurring, and intervenes in ways to "deepen the process"—that is, to facilitate and enhance the experience of certain aspects.

I believe the following seven functions describe, in generic terms, the goals of psychoanalytic interventions (the analytic change process). Achieving these goals is what it means to deepen the process.

1. *Safety.* To create an atmosphere conducive to self-exploration, where patients experience a sense of safety and develop the trust needed to begin to talk about and experience thoughts, feelings, expectations, motivations, and meanings they have been unable or unwilling to experience.
2. *Motivation.* To use this trust to develop patients' motivation for exploration, their curiosity about how their internal world operates and how they relate to themselves and to others. This is done by demonstrating that thoughts and feelings have a meaning and a relationship to each other that the analysand had not recognized and that these previously unrecognized elements are relevant.
3. *Uncovering.* To use this safety and curiosity to help the analysand uncover, experience, and explore thoughts, feelings, memories, meanings, expectations, and motivations they have been unable to experience or recognize, even though this expanded experiencing creates anxiety and confusion.
4. *Emotional exposure and reflection.* To provide an atmosphere that enables patients to tolerate this new experience and the affects it generates, and to maintain their exposure and motivation in the face of anxiety, depression, guilt, shame, and confusion, thereby enabling them to experience and reflect at the same time.

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5. *Reflection and integration.* To provide integration by establishing new meanings, perspectives, and ways of processing these new experiences that enable them to become owned and integrated into a fuller and more complex sense of self, which may include an understanding of the origin of the old meanings, perspectives, expectations, motives, and defenses. This also involves a greater acceptance by patients of these different aspects of themselves.
6. *New action.* To enable this new awareness and capacity to experience more to lead to new actions, experiences, and relationships in life that alter and consolidate these more complex and realistic views of the self and the world.
7. *Symptom relief and character change.* To enable these new perspectives, experiences, and relationships to lead to the amelioration of the symptomatic behavior and characterological issues that necessitated the analysis.

I want to be clear that though I have outlined these goals sequentially, their actual achievement is rarely, if ever, linear. For example, new actions can lead to further uncovering, not simply result from it. Self-reflection and self-acceptance can lead to new uncovering, and the creation and re-creation of a sense of safety is generally a recurrent analytic task. Also, as I will discuss later, different analysts tend to directly focus more (or fewer) of their interventions on different aspects of the process, but they all aim to have the analytic process achieve all seven of the goals I have outlined.

Let me summarize in a more narrative way these goals, which I believe all analytic schools are trying to achieve, if in different terms and by various means. All analytic schools are interested in creating a safe enough atmosphere for the patient to develop trust in the analyst, and all want to use this trust to bring into affective awareness patterns of interaction with the analyst that have not been recognized, and a wide range of psychological phenomena not previously experienced or recognized—feelings, motives, beliefs, fantasies, thoughts, wishes, fears, and needs that have not fit in with the patient's conscious view of self and other. The patient is encouraged to stay with and elaborate these experiences, become less afraid and more accepting of these aspects of the self, to reflect on them while experiencing them, and by so doing to develop new perspectives on the patterns and experiences and to integrate them into a fuller sense of self and other. This new awareness and capacity to experience more should lead to new actions and experiences in life and outside

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relationships which in turn should consolidate and enhance the changes, including amelioration of the symptomatic and characterological behavior that necessitated the analysis, thereby enabling the patient to function more effectively in life.

This operational schema of the goals of analytic technique represents a similarity among different analytic approaches, but it can also be used to *organize* their differences and promote more constructive dialogue. Different views of development and different theories of mind lead to different clinical assumptions. These assumptions lead to different ways of conceptualizing and implementing the goals outlined in my schema. In my conception, there are three kinds of difference that characterize the different analytic approaches: (1) different organizational patterns of unconscious content and therefore different transferences looked for in uncovering; (2) the *active* targeting of different steps in the process with direct technical interventions; and (3) different ideas about how best to promote the process (that is, different views of the most effective analytic stance and most effective interventions). I will take them up one at a time.

The most obvious difference between approaches is in their way of understanding and organizing unconscious phenomena. Freud originally looked for infantile drive conflicts, expressed as wishes and fantasies in the transference. With the development of his structural model and his second theory of anxiety **(Freud 1926)**, the unconscious content he looked for expanded. He paid equal attention to uncovering unconscious aspects of the superego and the defenses, as well as the anxiety that motivated their use. Uncovering defenses and thereby promoting the access to drive derivatives is still the preferred content of ego psychologists. For analysts with different theoretical orientations, the expected unconscious content is different. Unconscious contents now include not only drive conflicts but innate fantasies, pathogenic beliefs, relationship conflicts, pathogenic internal object relationships, early selfobject needs, distorted views of the self and the world, preoedipal concerns, the unthought known, problematic patterns of attachment, difficulties in affect regulation, other psychological deficits, and the list goes on. These differences in content reflect the variety of important aspects of development that can create psychological problems. They attest our recognition of the various factors that have been recognized as determinants of behavior and therefore of pathology also **(Levey 1984)**. They represent a real and important difference between approaches. They lead to expectations of different transference configurations to be recognized and interpreted.

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These differences have led to heated debates about the relative centrality of various contents. At times this has threatened to fragment the field, since many approaches define themselves by the specific content they expect. For example, self psychologists will look for idealizing, mirroring, and twinship transferences. Kleinian analysts will look for paranoid anxieties of annihilation and depressive anxieties of abandonment, expressed through projective identifications and splitting in the transference. Relational analysts will look for patterns of interaction in the here and now of the analytic relationship.

When the analytic enterprise is defined by specific content, these contents can be viewed as mutually exclusive. However, when these differences are viewed as alternative narrative templates for organizing the elements of what all analytic approaches are interested in uncovering, they can complement each other. As I noted in describing goal 3, all of the phenomena that the different approaches uncover and organize consist of thoughts, affects, motives, memories, expectations, and meanings that have not been experienced and/or effectively integrated. These are the elements that all analysts track, and which they then organize and interpret in terms of their theory.

What is essential in analysis is uncovering what has been avoided in a way that it can be effectively recognized and integrated by the analysand. When the "what" that has been avoided is thought of as affects, motives, etc., then the different schools are interested in uncovering similar unconscious content. When the "what" that has been avoided is thought of in terms of how the analyst expects it to be organized, then the "what" is different for different analysts. For example, an analysand may present with a complaint that he is unable to effectively assert himself at work and in personal relationships. Different analysts will have different preliminary ideas about what may be behind this symptom. Some will expect to find conflicts around aggressive impulses, others will expect to find a fragile sense of self, others may expect primitive annihilation fantasies, and still others may expect to find inhibiting relational expectations from previous relationships. However, all of these analysts will try to explore the patient's associations, fantasies, and affective reactions to the analyst in the transference, in order to obtain the data that will confirm or alter the expectations, and will be the basis on which the analyst makes interpretations.

In the above vignette, for example, when a Kleinian analyst is trying to make an analysand aware of his "paranoid position," the analyst will point out certain affective reactions in and out of the transference, and

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articulate particular expectations, fears, and desires in relationships, which the patient has not clearly recognized. Similarly, the "vulnerable self" that a self psychologist identifies would be recognized by a focus on affective reactions to the analyst and feelings about the self when the analysand is in that relationship. The conflict around aggressive impulses, which might be recognized as an "oedipal transference," is made of similar elements: affects, wishes, fears, expectations, etc. So all of these paradigms focus on activating and bringing into awareness *unconscious elements that have been avoided*, even though the templates and patterns used for organizing them are different.

I realize that analysts who define analysis in terms of content believe that the unconscious is actually structured in accord with their paradigm, and that crucial understanding will inevitably be missed without that paradigm. For them, the fact that all the different organizations are made up of thoughts, affects, motives, and meanings can seem trivial. However, analysis does not have to be defined by any particular unconscious content.

Some analysts, such as **Schwaber (1990)**, do not define their approach by a particular content. These analysts explicitly view the expansion of the analysand's world as the essence of the analytic process, without privileging specific contents. **Gabbard and Westen (2003)** describe the analytic process as opening up access to networks of associations, regardless of the different ways these experiences can then be organized and understood. When one adopts this stance, then the different organizations of content are not necessarily mutually exclusive. **Pine (1998)** suggests a way of using the different paradigms in a complementary fashion. He uses his four psychologies, which are different ways of organizing warded-off experience, to find the narrative templates that have the most affective resonance with the analysand. Pine (2002) recognizes some clinical situations where one narrative template is a better fit than others for recognizing and understanding a pattern of affective reactions or relationships. There are other clinical situations where the unconscious elements can be effectively organized by more than one paradigm. However, Pine views this phenomenon as a function of particular patient characteristics rather than as a theoretical prescription.

In summary, by saying that all analytic approaches are trying to have the analysand uncover, experience, and explore thoughts, feelings, memories, meanings, expectations, and motivations they have avoided or been unable to recognize and experience, I am articulating a common

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goal central to all approaches. All approaches focus interventions on uncovering, and what they actually directly uncover are unconscious elements and their conscious derivatives, not the proposed organization of the elements. At the same time, the different approaches distinguish themselves from one another mostly by the particular way each has of understanding and organizing these unconscious elements. When different analysts have a different organizational narrative in response to clinical material, such as the inhibition of assertiveness in the above example, it is useful to clarify when they are addressing and uncovering the same affective content while organizing it differently, and when there may be important affective experiences and patterns that are not being effectively accessed by a given approach. As I stated earlier, I realize that there are analysts who believe that the unconscious is actually structured in accord with their template, but I am suggesting that whether a particular pattern or narrative is most appropriate in a given analysis at a given time can be viewed as an empirical rather than theoretical issue. The empirical criterion in the vignette presented above would be the effectiveness of the interpretation in providing the analysand an experience/recognition of aspects of himself that enables him to effectively address the inhibition of assertiveness that necessitated the analysis. My main point is that both the similarities and the differences between approaches are important, as it is their *juxtaposition* that can contribute to the richness of analytic exploration. I will expand on this below.

The second difference between approaches is in their tendency to actively focus their interventions on different goals in the process. In Freud's original understanding of therapeutic action, analytic cure was accomplished by mobilizing the infantile wishes in repression, having the energy transfer to the person of the analyst, and preventing the discharge of the liberated libidinal energy. The assumption was that this would lead to new ego development, with the now adult ego binding some of the liberated energy and being able to use it to develop adult, genital discharge paths that would eliminate the anxiety. So, for Freud, the focus of *active* technique was on uncovering: undoing repression through the use of defense and transference interpretations. Since it was the uncovering of the repressed conflicts that led to cure, the rest of the process, as I have outlined it, was seen as either ancillary to, or as evolving spontaneously from, effective uncovering, without requiring a direct technical focus by the analyst.

In terms of safety, Freud's assumption was that the interest of the analyst would automatically promote the positive transference and the

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motivation to change. The acceptance, as demonstrated by neutrality, a respectful and affirmative attitude toward whatever the patient produced, and the consistency of the analytic attitude of finding out, would all combine to establish an atmosphere of safety that would create the alliance and promote the revelation of previously avoided unconscious material. The resultant atmosphere of safety was viewed as the background for effective interpretation of unconscious content, which was the essence of therapeutic action.

The goals I have listed after uncovering were grouped together by Freud as "working through." Although Freud acknowledged the necessity of working through, he viewed it as being effected by repeated uncovering, combined with genetic reconstructions, leading automatically to eventual new integration. The classical assumption, most clearly stated by **Strachey (1934)**, was that uncovering would automatically lead to integration if the traditional analytic stance was maintained. When the affective experience emerged in the transference relationship to the analyst, and in the context of the analyst's being neutral and withholding reality as much as possible, then there would be the maximum possibility of the experience being recognized by the patient as a product of his or her own transference and projection, which would result in new integration. Strachey stressed the modification of the superego by the identification with the neutral, accepting analytic stance as the important factor that eventually permitted integration. **Sterba (1934)**, by contrast, focused on a split in the ego, resulting from the analysand's identifying with the analyzing function, as the crucial step for integration. In both instances, however, the traditional stance was seen to enable these identifications automatically, without direct technical attempts to promote them.

So, although safety and working through were important parts of the process for Freud, it was uncovering the repressed through interpretation that was the essence of therapeutic action and the direct focus of technical interventions. It was the analytic role of interpreter and frustrater that mattered for therapeutic action, not the person of the analyst. Now, however, with our current understanding of development, along with the widening scope of patients suitable for analysis, all of the goals outlined in my schema have become a focus for active interventions for different analysts, leading to very different-looking analytic processes. The creation of a safe environment has become a focus for active interventions for two reasons. The first is the recognition that the traditional stance does not always *automatically* create the desired goals of providing safety,

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motivation to change, and allowing avoided unconscious material to emerge in a way that heightens the development of an analyzable transference. For some analysts, benign neutrality is not viewed as necessarily the most useful and effective stance. *It is the way in which that stance is experienced that determines whether it is effective in promoting safety, uncovering, and integration.* What is empathic and tactful with any given patient must, to some extent, be individually determined. I will give specific examples later of different stances advocated by different analysts.

The second reason for the creation of safety becoming a focus for active interventions is that with our more comprehensive understanding of development, including recognition of the importance of attachment and the difficulties that sometimes attend it, fostering a secure attachment is viewed by some analysts as part of therapeutic action for some patients, not just background. For both of these reasons the need to create safety and a secure attachment has become an active focus of analytic technique for some analysts with some analysands. So the similarity is that creating a safe environment for exploration has always been, and remains, an analytic goal. The differences are based on different views of what stance will promote this goal (the traditional stance was advocated precisely because it was thought to do so), and on the realization that for some analysands being able to create a safe relationship is a central part of therapeutic action and is therefore a major focus of technical interventions.

In regard to working though, I have separated it into three separate goals (goals 4, 5, and 6), because I believe a significant difference in analytic approaches is based on a different degree of direct focus on each of these aspects of the process. Goal 4 refers more to the process of working through, goal 5 refers more to the internal outcome, and goal 6 to the behavioral outcome. As with safety, these are clinical goals for all analysts, even when they are expected to automatically follow from effective uncovering. However, there are real differences in how directly these steps are promoted. For example, analysts who believe that the analysand comes to analysis with a strong innate push for health will tend to focus more of their interventions on helping the analysand stay with the new experiences generated by the analysis (goal 4). They will actively intervene to keep making the analytic space safe. They assume that if they do that, the unconscious content will continue to emerge and be worked with by the analysand. Many of these analysts view the analysand's experience of the analyst's active interest in the patient's development (as conveyed

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in various ways, including "supportive comments") as an integral part of therapeutic action. Analysts, on the other hand, who believe in a strong repetition compulsion will intervene more often to actively interfere with defenses in order to promote more uncovering. They tend to think of their efforts to keep the patient in touch with the emerging uncomfortable content simply as analytic tact, and not part of therapeutic action. However, these analysts are still aware of the need to keep the uncomfortable affects alive, and the very fact that there are alternative strategies in this regard means that deciding whether and how to promote emotional exposure and integration has become part of active technique.

In regard to goal 5, the effective integration of the uncovered material has always been an analytic outcome goal, and the technical approach to uncovering has always been based on an idea of how to maximize the potential for effective integration. Now, however, there are disagreements about what stance by the analyst in working with the transference is most conducive to achieving this self-awareness, and whether this goal should be a direct target for interventions. **Gill (1979)**, for example, has suggested that actually focusing on what he called "the resistance to resolution of the transference" was often necessary to promote integration. In addition, analysts like **Fonagy et al. (1993)**, who view the development of the capacity to mentalize and reflect as an important analytic goal the analyst may need to actively promote, will directly focus interventions on this step. **Caligor et al. (2009)**, in work with borderline patients, describe interventions that directly promote integration very early in the analysis. For them this is a central aspect both of creating an alliance and of therapeutic action with these patients.

Traditionally, new actions (goal 6) were seen as an outcome goal that was the province of patients regarding how they decided to use their insights to change their lives. As such, action was an outcome of change and not a direct focus for technical interventions. Many analysts now view new actions as an integral aspect of therapeutic action and as necessary to actually enable change. Changing patterns, they believe, requires new behavior. **Wachtel and McKinney (1992)** have made the point that old patterns tend to be strengthened by current reality, and that altering a pattern requires new behavior and new feedback, not just insight. **Westen (1999)** has written that insight does not necessarily weaken implicit connections between representations and affective responses. To change the affective response, the patient needs new experiences in order to associate the representation with a different affective state. So insight may make new actions possible,

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and it can enable them to be experienced differently, but new behavior is also required for patterns to actually change.

Analysts who see actions, both in the room and outside, as necessary and integral to the process have advocated a range of different stances toward new actions and even at times toward action that is recognized as part of an old, characterological pattern. In addition to interpreting and discouraging action (a stance that comes from the view that action interferes with the necessary reflection and remembering that must occur), some analysts will actively engage with the enactments of patients. At other times responses that are welcoming, supportive, and even encouraging of actions have been advocated. **Freud (1919)** himself, though he generally believed that actions should be the decision of the analysand, and was concerned about interfering with autonomy, wrote that sometimes the phobic patient, in order to change, must be encouraged to enter the phobic situation. Analysts who view analysis as a process of resuming development often view new actions as an *engine* for change, not just its result. My point here is that by thinking about and choosing a stance, the analyst's response to action, whatever it may be, becomes part of technique. So new actions are one of the analytic goals to be considered by all analysts, both in their own right and as a means to further develop the other parts of the analytic process. The differences are in how much they become a focus of active technique and how central they are to a given analyst's conception of therapeutic action.

The third difference between approaches is in the variety of stances and interventions employed by different analysts to effectively promote the process. As I have indicated, focusing active interventions on different steps in the process implicitly calls into question the universal effectiveness of the traditional stance of an interested, nonjudgmental, neutral, non-gratifying, benign interpreter in providing safety and promoting integration.

The original theoretical basis for Freud's suggested stance came from his theory of how the mind develops. His idea, described most fully in “Project for a Scientific Psychology” **(1895)** and reiterated in chapter 7 of *The Interpretation of Dreams* **(1900)**, was that the mind develops in order to discharge instinctual tension. It is only the buildup of instinctual desire, and the inability to effectively discharge it, that results in behavior. To discover how to effectively discharge built-up instinctual tension, some of the instinctual energy becomes permanently bound by the mental apparatus. This was Freud's view of how the ego is established. In this

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model, reality testing and ego development occur only as a result of bitter experience and the frustrations of life. Any part of the analytic interaction that leads to some of the repressed libido staying repressed (that is, the childhood memories not being remembered) would therefore limit the effectiveness of the analysis. Also, any interactions in the analytic situation that result in gratification would limit the motivation to develop new and reliable channels for discharge, and would diminish the energy available for further ego development.

Today, however, despite the fact that the energy discharge model is no longer viewed as the sole basis of development, and analysis is seen as operating through the creation of new meanings in an influential relationship, rather than by promoting shifts of psychic energy, many analysts continue to prefer the traditional stance. Some even include this stance in their definition of analysis. For them the expectation that gratification will undermine therapeutic action remains, as does the idea that any breach of neutrality or anonymity will interfere with resolution of the transference. As **Strachey (1934)** put it, it is the stance of a neutral, benign interpreter that will lead to the analyst's being introjected differently from anyone else in the analysand's life.

However, different views of development have led other analysts to reexamine the question of the most effective analytic stance. With an understanding of the many complex ways important relationships are related to individual development have come other ideas of how most effectively to promote the safety, uncovering, and new integration that characterize the analytic process. **Mitchell (1996)**, for example, talks of responding to the transference in a way other than the old objects did, and being uninvolved or neutral may not necessarily be different. Other analysts suggest that a focus on the intersubjective context of the patient's reaction will highlight the patient's own subjectivity. **Hoffman (1994)** talks of being willing to throw away the book in a constant struggle to figure out what would really be in the patient's best interest, as the position of the analyst that is most likely to promote the ownership and integration of new recognitions and understandings. What all these suggestions have in common, with the traditional stance and with one another, and what makes them all versions of analysis, is that they are all aimed at achieving the analytic goals outlined above. Their effectiveness is an empirical question in any given analysis.

It should be noted that some analysts, notably **Schwaber (1990)** and **Gray (1973)**, include a particular stance as part of the definition of their

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analytic approach. As is the case with different organizations of unconscious content, when analysis is defined by a particular stance, constructive dialogue between analysts becomes limited. **Levy and Inderbitzen (1990)** have convincingly argued that it is not necessary to define analysis by a particular stance. They characterize the various possible stances as different analytic surfaces, and make the point that many different surfaces can potentially lead to an effective analytic process (i.e., can effectively promote the seven goals). **Kantrowitz (1992)** explicitly demonstrates the value of flexibility in her stance. In the case she reports, she consciously altered her usual stance in order to promote new actions when she realized that a stalemate was being created by the analysand's avoiding trial actions. Thus, a variety of stances, as well as a variety of unconscious contents to attend to, can increase the range of clinical situations an analyst can effectively handle.

The focus on actively promoting goals other than uncovering with direct interventions has also led to an expansion of the kinds of interventions analysts have suggested. Interpretation was Freud's preferred analytic intervention, and it is designed to interfere with defenses and uncover and name what has been avoided. If the focus of a given intervention is on creating a safe environment, or helping with integration, or promoting new action, there is no inherent reason to expect that an intervention in the form of an interpretation will be the most effective. With patients who need active help in developing the capacity to integrate, for example, interventions such as reflection, reframing, modeling, and self-disclosure (such as communicating the analyst's experience of the patient) have been recognized as central, rather than ancillary, to technique.[1]

In summary, the goal of creating a safe environment in which to uncover thoughts and feelings that have been avoided, enabling the analysand to integrate these phenomena and have that change his or her subjective reality and ability to function effectively, is the common goal of all analytic schools. The schema I have presented is a way to define, at an operational level, what we mean by an effective analysis. The schema also provides a

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[1] **Gedo and Goldberg (1973)** made a similar point in *Models of the Mind.* They viewed the immediate self-organizational state in which the patient was functioning as the prime indicator for the kind of intervention that would be most helpful in deepening the process, with interpretations of latent meaning being the appropriate intervention when patients were functioning in mode 4 of their model. **Gedo (1979)** has continued to write about the necessity for developing interventions that can provide belated psychological learning and help patients modify and overcome their apraxias.

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way to clarify, organize, and understand the ways in which analytic approaches meaningfully differ from one another in terms of how most effectively to promote the goals they have in common. In that context, the different ways of understanding development, pathology, and change can provide opportunities for the analyst to discover what is most helpful for a given patient.

Because these goals are general and are relevant to other types of psychotherapy, there is a danger that the specificity of analysis will be obscured. Analysts share outcome goals and some process goals with other approaches. Research has shown that patients in all forms of psychotherapy are looking for symptom relief, better relationships, enhanced self-esteem, and a more coherent identity. These outcome goals are shared not only by all analytic approaches, but by other schools of psychotherapy. It is also true that all forms of psychotherapy are trying to achieve these goals by changing how information is processed, including affective information, cognitive information, and communication with self and others. Many of the principles of change that are encoded in the seven clinical goals are shared by other approaches. All therapies need to build an alliance, enhance motivation, provide insight (shifts in meaning), provide new experiences that change expectations, and promote new actions. What, then, differentiates psychoanalysis? It is in attempting to create a very broad experiencing of previously unrecognized phenomena and promoting their wide-ranging integration, *within the treatment relationship itself*, that psychoanalysis distinguishes itself from other psychotherapeutic approaches. Psychoanalysis approaches these factors from an intrapsychic point of view and balances them to get as much uncovering and new integration as possible, while also promoting the analysand's affective contact with new feelings and motivations until they are integrated in an experientially genuine way. Indeed, it is somewhat ironic that an important part of what distinguishes psychoanalysis as an approach is its capacity for including all the various aspects of development as potential factors in the analytic process, not having to select between them on a priori grounds. **Friedman (1976)** has written that the avowed goal of psychoanalysis, which distinguishes it as a therapy, is creating a major restructuring of the personality, which he refers to as forcing full freedom. This is the overall process goal unique to analysis, and analytic interventions can be compared in terms of their effectiveness in promoting this goal and their potential for derailing it.

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Discussion

One use of the schema I have presented is to reframe some of the ongoing clinical controversies in psychoanalysis. These controversies stem from differing views of development, pathology, and change. Several fundamental differences in our understanding of development have affected our understanding of the therapeutic action of the analytic process. These ideas have come from child observation, developmental research, and clinical experience. One difference is the recognition that there is an innate push for development, that it is not just bitter experience that creates it. Frustration is not the only educator; children learn from positive and gratifying interactions as well. As a result, some analysts are more focused on mobilizing the analysand's innate push for health, while others are more concerned with combatting the power of the repetition compulsion that resists change. Also, the need for relationships is now recognized as primary in its own right; other people are not just targets for and frustraters of drive discharge. The importance of the attachment to the primary caregiver, the organizing effects of interactions, and the personality of the caregiver are now seen as crucial determinants of the development of mind. The organization and integration of experience is understood to take place in a social context. As a result, analysts differ in how much they operate from a one-person or a two-person view of the analytic process. They also differ in their tendency to focus on internally driven recurrent patterns, as against focusing on dyadic interactions that activate both old and new patterns. In addition, these differences lead to different views of the sources and nature of psychopathology. Conflict is not the only basis for development, and it is not seen as the only aspect of development that can lead to psychological problems. Insecure patterns of attachment, problems with separation and individuation, the failure to develop needed psychological skills, difficulty regulating affect, problems with creating a cohesive self-organization, pathogenic beliefs, and negative identifications with caregivers are just some of the additional ways of understanding developmental problems.

It is easy to see how these different views have led to intense controversies about technique, since the analytic process of these different analysts look very different, and they result in interventions that are, on the surface, very different. In fact, there are many suggested interventions that are seemingly polar opposites. For example, Freud believed that the way to make the relationship safe was to be neutral, interested, and nonjudgmental. **Winnicott (1954)**, by contrast, felt that for some patients to feel safe enough to “regress to dependency,” the analyst had to be available at all times. **Brenner (1969)** believed that an interpretive stance is the most

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effective way to explore the unconscious. Hoffman, **Newman (1992)**, Mitchell, and others believe that many patients have to change aspects of themselves before they can put interpretations to use, and that different kinds of interventions by the analyst are often necessary to enable fruitful exploration of the unconscious. **Gray (1973)** believed that the best way to maximize access to unconscious content was to take the stance of an observer of the patient's associations. **Schwaber (1990)** and some self psychologists believe that the way to maximize access to unconscious content is to empathize with and communicate understanding of the patient's experience; to share it rather than observe it. Schwaber believes that every intervention from the analyst should arise from a question, while **Racker (1968)** believed that analysts now have the knowledge to make many inferences that can usefully be conveyed to the patient. **Strachey (1934)** felt that the best way to promote resolution of the transference is to withhold reality from the patient, whereas **Gill (1979)** thought that the best way to promote it is to actively locate and acknowledge its reality base or trigger.

These differences, arising from different theories and different clinical assumptions, have limited useful dialogue between positions. Partly in response to this, there has been increasing interest in relating the different approaches to one another. This interest can take three different forms. First is the suggestion that various aspects of the different approaches be used in different situations. In the psychoanalytic literature this approach is exemplified by **Pine (1998)**. As mentioned earlier, he has distinguished four basic analytic approaches (his four psychologies) and suggests employing each at appropriate times. The second way of relating the different approaches is to develop an integrated theory that embraces them all. To date, little has been written that is truly an attempt at such theoretical integration. The major exception is the work of **Gedo and Goldberg (1973)**, who used a developmental paradigm to integrate different models into a hierarchical system, and then described the clinical conditions for using one model or another. Their paradigm suggests different interventions, depending on the developmental level of the analysand at any given time, but their model is not conducive to dialogue between the approaches. The third way of relating approaches is to recognize the similarities among them.

To be clinically useful, however, these similarities must be able to be juxtaposed with the differences in the approaches. Perhaps the most comprehensive effort in this regard is the ongoing comparative clinical methods workshops that originated with Tuckett's group **(Tuckett et al. 2008)**.

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They have developed a methodology for comparing and contrasting different clinical stances and interventions, and using the differences to clarify the analyst's underlying clinical assumptions. The categories they use to classify interventions are generally based on the form of the intervention. I believe that the schema I present here, which can be used to characterize interventions on the basis of their goal in promoting different aspects of the analytic process, is complementary to the one they propose.

Both schemas, individually or in concert, can be used to discover clinical assumptions implicit in technical interventions. Recognizing those assumptions provides a basis for viewing different approaches as complementary rather than competitive. Clinical case discussions tend to highlight the differences between approaches. Since clinicians organize material with different narrative templates, analysts from one school will see patterns that those from another school don't address, and will often suggest an alternative organization of the unconscious elements, and often a different stance as well. Since every analytic school can always find material that, based on its clinical assumptions, isn't adequately addressed by another, it is hard to constructively move past the debate over what material to address and in what way. However, when the *purpose* of addressing the different material is explored (the clinical assumptions of what each school expects to happen as a result of its interventions), the potential complementarity of the approaches can come into focus, since those purposes are often similar. Two questions can usefully be asked of any intervention: *what* did the analyst hope or expect to accomplish by the intervention, and *why* was that deemed important? These questions can begin to make explicit the implicit clinical assumptions that characterize an analyst's approach.

The idea of the analyst hoping to accomplish something with an intervention may seem incompatible with the call for evenly hovering attention and lack of therapeutic ambition. However, evenly hovering attention is an information-gathering stance, and when an analyst decides to make an intervention he or she has something in mind, even if it isn't fully conscious. These thoughts are more clearly conscious for a discussant or supervisor responding to a case presentation. Discussants and supervisors usually offer what they might have said and why. When the discussion addresses the analyst's intent, even if it is consciously recognized only after the fact, then there is an empirical basis for evaluating the immediate effectiveness of the intervention on its own terms, and also a basis for clarifying areas of disagreement in a useful way.

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An example might be a patient who comes into a session feeling “flat,” associates to the previous session, in which the analyst had raised her voice, and realizes that that made him believe she thought him stupid. Depending on where in the analysis this has occurred, the analyst might have very different reactions. Early on, she might wonder with the patient about his interpretation of the previous session. Later in the analysis, when this kind of reaction had often been explored, the analyst might look to encourage the patient to work with the reaction. However, different analysts would have different clinical goals at this point, and they may also have different strategies for pursuing the same goal.

One possible goal would be to help the analysand see that he is creating that belief—that it is not an accurate view of what the analyst was thinking and experiencing. An intervention designed to do that might be a genetic interpretation such as, “It sounds as if you experienced me as you used to experience your father when he would yell at you and call you stupid.” In this case, the genetic interpretation would be aimed at goal 5 (integration), and, by pointing out the source of the patient's expectation, the analyst would also be implying that she did not see the patient that way. The hope would be that the patient would hear it that way and then take the step himself of questioning his readiness to read the analyst as disparaging him.

A different analyst might see this as an occasion to promote goal 3 (uncovering), helping the patient recognize and experience more fully the affect, anger or sadness perhaps, that might be truncated in the experience of “flatness.” An analyst who sees it this way might focus on flatness as a defense and might say, “I wonder if you are aware of some discomfort in expressing what you felt toward me yesterday.” Another might try to uncover the underlying affect more directly, saying, “I think you are furious with me.” Both of these analysts would be trying to uncover and heighten the experience of the affect. They might believe that bringing up the father, as the analyst proffering the genetic interpretation did, would be counterproductive, as it would take the affect out of the room. Although that may well be true, the *intent* of the first analyst at this point was not to heighten the affective experience. Arguments can be made for choosing one focus or the other (or for the belief that knowing which is more useful at any point is part of the art of analysis), but the discussion would be more productive if, in addition to the interventions themselves, the clinical assumptions behind them were considered.

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The analyst who made the genetic interpretation in this example might be operating with the following assumptions. She might see the patient as being quite competent but lacking in confidence at this point. The genetic experiences that had led to this may already have been uncovered in the analysis. The analyst may see the patient as now trying things he hadn't tried before and relating in new ways. The analyst may also feel that although these new experiences are objectively successful, the patient's tendency to experience the other as negative is preventing him from subjectively feeling consistently successful enough to have his experience solidify a more confident sense of self. The immediate intent of the genetic interpretation, then, is to help the patient recognize his tendency to negatively distort the analyst's view of him. The hope is that this will lead the patient to be more clearly aware of his negative bias, and that as he questions this bias and recognizes it, he will experience his successes more consistently and his sense of self will shift. The analyst's working hypothesis might be that new, successful experiences are important for consolidating change at this point, and that the patient's negative bias is what is limiting his capacity to recognize new experiences as consistently different.

The two analysts who want the patient to experience more fully and more clearly the affects being avoided by the experience of “flatness” would have a different view of the therapeutic need at this point. They might, for example, see the patient as unable to tolerate a feeling of anger, and as needing to avoid and pull out of any experience or relationship that activates it. In their view it may be this inability to tolerate anger and deal with it effectively that is interfering with the patient's ability to experience consistent success in developing more fulfilling relationships. The immediate expectation would be that as the patient is able to feel his anger more fully and express it directly to the analyst, he will become more comfortable with that aspect of himself. The hope is that he will then be able to successfully negotiate deeper relationships that will inevitably activate anger on occasion. Their working hypothesis might be that it is the inability to tolerate anger, and the need to avoid situations that activate it, that is limiting the patient's capacity for new experience at this time. Having to tolerate the affect, then, is implicitly viewed as a necessary (though not necessarily sufficient) step in effecting a deeper engagement in relationships, an outcome goal that all three analysts share.

The two different ways of trying to uncover the anger also reflect different clinical assumptions. The analyst who works with the flatness as an

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avoidance may believe that the ability of the analysand to recognize his defenses is the best way to ensure ongoing access to uncomfortable emotions. The analyst who more directly names an underlying affect may believe that demonstrating his awareness of the patient's affect is the best way to make it safe enough for him to experience fully. The analyst may feel that experiencing the anger fully, tolerating it, and realizing that it is safe to feel will promote ongoing access.

If an intervention is successful in terms of the immediate process (that is, has the immediate effect the analyst hopes for), then it becomes an empirical question, to be answered as the analysis continues to unfold, whether the intervention effectively addressed what was needed to help the patient move forward in the analysis and in life. In this example, it can be seen that both a perspective on one's tendency to distort others' reactions and a fuller connection to one's own affectivity can be important for therapeutic change. Interventions addressing either one can ultimately be compared based on their effectiveness in achieving the therapeutic end, which is the same even when the immediate process goal is different.

The focus on common goals also suggests useful questions these analysts could ask each other that could shed further light on the analytic enterprise. Would they expect an intervention other than the one they propose to achieve the same eventual effect? Why or why not? What concerns might they have about the other approaches, and how might they think to determine whether those concerns actually become problematic? What differences would they expect to occur as a result of the difference in approach, and how do they understand those differences as being important for outcome? Questions such as these create the potential for mutual enrichment among the different approaches.

This example also demonstrates a second way in which the schema I have presented can shed new light on clinical controversies. In addition to clarifying clinical assumptions, it can clarify the intent of interventions—the clinical goal or goals they were meant to address. All analytic interventions can be viewed as addressing one or more of the seven clinical goals in my schema. In fact, these goals can be thought of as a set of reasons analysts have for making interventions. By clarifying the analyst's intent in making a particular intervention, other interventions, from different analytic orientations, can be recognized as having similar clinical goals. An awareness of the intent of an intervention is particularly important, since the same intervention can have different purposes at different times. For example, an interpretation can be used to promote any of the steps in the

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analytic process. It can be used to convey empathy and enhance a feeling of being safe and understood; it can be designed to interfere with the functioning of a defense; it can be an attempt to bring an aspect of the unconscious into awareness; it can be used to summarize and help integrate disparate awareness; or it can be an indirect suggestion for a kind of action or experience (see **Raphling 1995**). Keeping this in mind can help create constructive dialogue around technical controversies.

For example, a Kleinian analyst may use a deep interpretation early in the analysis to increase the sense of safety in the relationship (to demonstrate that he or she can tolerate the deeper affect), while at a later time the interpretation could be an attempt to activate unconscious content. To meaningfully compare the deep interpretation with an intervention from a different orientation, it is important to recognize the goal of the deep interpretation at that point in the analysis. Being able to compare different stances and interventions in terms of the intent of the analyst can shift the discussion from a theoretical level to a clinical one concerning the effectiveness of the stance or intervention in achieving clinical goals.

It follows from this discussion that some controversies about technique are fueled by the fact that the same intervention can be used for different purposes and, conversely, that different interventions can be used for the same purpose. When this is kept in mind, many of these theoretical controversies around technique can be translated into empirical discussions about what effectively promotes a given goal in the analytic process. For example, the debate about how neutral to be can be translated into the question of what analytic stances and interventions most effectively promote safety for, authentic recognition of, and subsequent integration of a broad range of new affective experiences for a given patient. This is something potentially observable in analytic processes. The debate becomes less a discussion about whether neutrality is correct or incorrect, and more about discussing the expected effects of the stance and its actual effects. The debate about whether an enactment promotes or interferes with the analytic process can similarly be brought into sharper focus when the purpose of a particular enactment is clarified. When **Mitchell (1996)** discusses entering into enactments early in the analysis, taking the role the patient gives you in the relationship, he is explicitly describing this as a way to promote engagement and safety. When **Hoffman (1994)** describes his enactment with a patient who demanded that he call her internist to get her medication, he is using it as the most effective way to uncover the wishes and fears behind the demand. Once the function of the enactment is clarified,

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then being able to look at whether and how it has fulfilled its function, and being able to think further about why it did or didn't work, can lead to empirical comparisons of enactments with more traditional ways of performing the same analytic task.

In addition to being useful in comparing analytic approaches, the focus on the intent of a given intervention can also be used to explore an approach on its own terms. This can even become a part of supervision. Insofar as there is a difference between a candidate and a supervisor, is it a difference in what one would want to achieve in the clinical moment, or a difference in how one would expect to effectively accomplish it, or both? Being more explicitly aware of the implicit assumptions about therapeutic action also puts us in a better position to respond at those times in an analysis when our assumptions are not borne out. To be able to pinpoint which step in the change process is not happening, and therefore which assumption is not holding up in a given analysis, can suggest alternative approaches.

There are other ways in which being able to contrast common goals with differences in approach can help us clarify the analytic enterprise. Child analysis, for example, has the same goals as adult analysis, which makes it analysis, but the ways of most effectively attaining those goals look very different. Child analytic technique may be more easily understood when it is presented in a framework such as this. Another advantage of defining analysis operationally at the clinical process level is that it enables our clinical data to be organized by theories other than analytic theories when that is helpful. The related disciplines of cognitive science, neuroscience, linguistics, child observation, and attachment research all have information relevant to understanding development, learning, and change. Being able to state our goals in language that is usable by the different analytic approaches enables our understanding of change and therapeutic action to be more usefully available to these other disciplines as well. Due to limitations of space I have provided only an outline of the ways in which my schema might prove useful. In the future I plan to provide detailed clinical material to illustrate its usefulness in framing discussions and clarifying assumptions.

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