

PART I

RESEARCH ON THE PSYCHOANALYTIC PROCESS I:
A COMPARISON OF TWO THEORIES ABOUT ANALYTIC NEUTRALITY *

Joseph Weiss, M.D.
Harold Sampson, Ph.D.
Joseph Caston, M.D.
George Silberschatz, Ph.D.

PART II

RESEARCH ON THE PSYCHOANALYTIC PROCESS II:
A COMPARISON OF TWO THEORIES OF HOW PREVIOUSLY
WARDER-OFF CONTENTS EMERGE IN PSYCHOANALYSIS *

Harold Sampson, Ph.D.
Joseph Weiss, M.D.
Suzanne Gassner, Ph.D.

THE PSYCHOTHERAPY RESEARCH GROUP

DEPARTMENT OF PSYCHIATRY

MOUNT ZION HOSPITAL AND MEDICAL CENTER

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PART I

RESEARCH ON THE PSYCHOANALYTIC PROCESS I: A COMPARISON OF TWO THEORIES ABOUT ANALYTIC NEUTRALITY

Introduction

Harold Sampson, Ph.D.

I should like to begin by thanking Mardi Horowitz, Director of the Psychotherapy Evaluation and Study Center, for making this forum available to us once again. We are pleased to be a part of this important new Center, and to participate in its scientific work.

I should also like to express our special thanks and gratitude to two persons who have contributed a great deal to our work:

The first is Dr. Emanuel Windholz, who played a major part in the formation of the research group, and who encouraged us to examine the therapeutic process in psychoanalysis in an open-minded, questioning, and rigorous way. His help has been generous and invaluable.

The second is Dr. Robert S. Wallerstein, who encouraged us to follow the example he himself had set of undertaking formal research on the psychoanalytic process. Dr. Wallerstein has also provided us with the administrative support which has made it possible to carry out our work, and he has served throughout the past ten years as a consultant to us on both theoretical and methodological aspects of our research.

Our presentation tonight, and again a month from now (on November 8) form a unified whole. Tonight we will seek to give you a coherent picture of the objectives of our work, of our approach to psychotherapy research, of our hypotheses, and, finally, an important instance of our empirical methods and findings. Our presentation next month will feature another empirical study which tackles in a somewhat different way the very same issues which we shall be taking up tonight.

Our research is concerned with the fundamental laws which govern the behavior of the patient in psychotherapy and in psychoanalysis. In doing our research we have followed a course which has been used successfully in many other scientific fields,¹ but which seldom has been used in scientific investigations of psychotherapy.²

¹Kuhn, Thomas S. The Role of Measurement in Modern Physical Science. Isis, 1961, 52: 161-193.

----- The Structure of Scientific Revolutions. University of Chicago Press, 1962.

²Sampson, H., and Wallerstein, R. S. New research directions: Comment from a psychoanalytic perspective. In H. H. Strupp and E. Bergin, Eds., Changing Frontiers in the Science of Psychotherapy. Aldine-Atherton: New York and Chicago, 1972, pp. 444-446.

As you will see, the fundamental hypotheses which our group is testing differ from other commonly held hypotheses about therapy. These original hypotheses were developed over a period of many years by Joseph Weiss. The hypotheses were developed from an intensive study of process notes and transcripts of psychoanalyses and psychotherapies, from broad experience with numerous other cases of various kinds, and from general knowledge of the field. In developing these hypotheses, Joe sought to articulate fundamental relationships which would apply to all patients in psychoanalysis and in related kinds of psychotherapies. These hypotheses, because of the way they were developed, have certain characteristics:

First, they are broad and general. Second, they are immediately relevant to therapeutic practice, for they were devised to explain the behavior of the patient, and how the behavior of the analyst influences it. Third, although general, the hypotheses are closely linked to observation, and are therefore testable.

In testing our hypotheses, we carry out studies in one case at a time, and then we replicate our findings in new cases.

In practice, we test our hypotheses against other hypotheses which also purport to account for all of the pertinent data of therapy. To do so, we figure out in advance where our hypotheses and those which we are testing against them predict different outcomes. We then devise research designs to determine which theory's predictions--if either--are supported by the data.

When we presented at the Opening Conference of this new Center last fall, we gave a broad overview of 11 interrelated studies which our group was carrying out to test our hypotheses. In addition, Joe Caston presented one of these studies in more detail. Dr. Caston's study compared predictions based on our hypotheses with predictions based on traditional psychoanalytic hypotheses about the immediate effects on the patient of an analyst's interpretations. Tonight, George Silberschatz will present in detail a second study which compares the two groups of hypotheses; and next month, Suzanne Gassner will present a third research approach to the testing of these hypotheses.

Dr. Silberschatz's study--which is our main empirical presentation tonight--was carried out at New York University as his doctoral dissertation. He planned the study in consultation both with our research group and in consultation with other investigators and clinicians who held different hypotheses than ours.

It is immodest of me to comment on his study--since George is now a member of our research group--but I consider his study to be a unique and major contribution to the field. George has taken two alternative theories of a central therapeutic process, and he has devised a research design to test the differing predictions the two theories make about

that process. Because of this, his study has accomplished something which is rare in psychotherapy research; namely, it has produced findings which cast light on fundamental theoretical issues, and which at the same time have important implications for the clinician.

Before George begins, Joe Weiss is going to describe our hypotheses, and Joe Caston is going to report a study which is closely related to Silberschatz's work. Our combined presentations may leave only a little time for questions and discussion tonight, but we hope you will consider this evening and our November 8 presentation as a unit, and will join us then to hear Dr. Gassner's work, and to participate in informal discussion of any and all aspects of the work.

Thank you. Joe Weiss will now describe our hypotheses.

The Theoretical Basis for the Research

Joseph Weiss, M.D.

Before presenting the hypotheses which we are testing, let me say to you, Hal, that in developing them I have been helped tremendously by my almost daily talks with you about them over the last ten years.

Now, for the hypotheses themselves: They are very basic propositions about the functioning of the patient's mind. They are meant to describe the laws underlying the patient's behavior and thus to explain his behavior as a patient. They are about such fundamental things as the patient's chief motivations, the origins of his problems, and his mental organization.

According to these hypotheses, the patient's chief motivation, both conscious and unconscious, is to solve his problems. Moreover, he wishes to solve them in a fundamental way by making conscious and mastering the unconscious conflicts which underlie them. Thus, the patient wishes to attain a solution to his problems similar to the solution to them which the analyst seeks for him. The patient's chief activity, both conscious and unconscious, is his working to solve his problems, and his relationship to the analyst is based on his wish to enlist the analyst as an ally in his struggle to solve them.

The patient is able to work unconsciously to solve his problems because he exerts at least a crude control over his unconscious mental life. He is able unconsciously to think about what he would like to do, to decide upon plans for doing it, and then to carry them out. He thinks, plans, and decides unconsciously much as a person consciously does these things.

Thus the patient plans and carries out methods of working to bring forth and master the impulses, affects, ideas, and plans which he has warded off and with which he is in conflict. His basic strategy in his working to bring such a warded off mental content to consciousness is to create a relationship with the analyst which would make it safe for him to experience this content. He does this work unconsciously by testing the analyst. His purpose in testing the analyst is to determine in advance how the analyst will react to his experiencing the content. In particular, he tests the analyst to assure himself that the analyst will not react to his experiencing the content in such a way as to endanger him. When the patient, by testing the analyst, has gained enough confidence in the analyst to decide that he may safely bring the content forth, he lifts his defenses and brings it forth.

Suppose, for example, that a patient is afraid to bring forth an idea about which he is intensely ashamed, for fear that the analyst will condemn him for it. He may then test the analyst by bringing forth an

idea about which he is much less ashamed. He will then bring out the more shameful idea only if the analyst does not condemn him for the less shameful one.

The patient's testing of the analyst stems genetically from his childhood relationships to his parents. For the patient, in testing the analyst, is unconsciously attempting to assure himself that he will not be traumatized by the analyst as, in his childhood, he had been traumatized by his parents. In testing the analyst, the patient may tempt the analyst to do the very things which his parents had done and which he had experienced as traumatic, hoping that the analyst will not react as his parents had.

It is from traumas which the patient experienced in his childhood in his relationships with his parents that his problems first arose.

The child is vulnerable to being traumatized by his parents because he needs their help in his struggle to attain certain developmental goals which are of crucial importance to him. Traumatic experiences are, in essence, experiences from which the child infers that he will not receive from his parents the help he would need in order to reach these developmental goals.

The child, as a result of being traumatized, sets aside his working to attain these developmental goals. He also represses a number of things. These include the traumatic experiences themselves, the loss of confidence in his parents which results from the traumatic experiences, and his decision to set aside his working to attain certain important goals.

The patient, in his analysis, takes up again his struggle to attain the goals which, in his childhood, he had set aside and, in his working to attain them, unconsciously tests the analyst in order to assure himself that the analyst will not traumatize him as his parents had.

Thus, he does not permit himself to experience the confidence in the analyst which he would need in order to pursue these goals, until, in testing the analyst, he assures himself that he would not be traumatized by the analyst as he had been traumatized by his parents. Nor does he permit himself to remember the traumatic experiences themselves, nor his loss of confidence in his parents which resulted from these experiences, until he has developed confidence in the analyst such as he had not had in his parents.

Our hypotheses are, in certain of their concepts, somewhat similar to those of contemporary psychoanalytic ego psychology. For ego psychology implies that the patient has an unconscious wish to master his unconscious mental life and an unconscious control over it. However, our hypotheses are considerably more explicit and systematic than those of ego psychology. Our hypotheses contrast sharply with those of the traditional psychoanalytic

theory of therapy and technique put forth by Freud in the Papers on Technique³ before he developed ego psychology and which are still the basis of most psychoanalytic thinking.

To make our hypotheses clear, I shall contrast them with those of the traditional theory of the Papers on Technique.

The traditional theory assumes that the patient does not have control over his unconscious mental life and that he does not have an unconscious wish to master it. It assumes that the patient's behavior is based on the uncontrolled play of powerful unconscious forces or drives which are always seeking satisfaction and which interact dynamically with one another.

In Freud's words, "all processes of therapy and indeed all mental processes, except for the reception of external stimuli, may be derived from the interplay of forces which assist or inhibit one another, combine with one another, enter into compromises with one another, etc."⁴ Another way of saying this is that the traditional theory assumes that all mental processes are determined by psychic forces, each of which has a strength and a direction. These forces are, according to Rapaport and Gill,⁵ additive like vectors. From their interaction all behavior can be derived.

According to the traditional theory, the patient's problems arise in his childhood as a consequence of his libidinal fixations to certain infantile gratifications, such as those he once had obtained, or had longed to obtain, in his relationships to his parents or to other important persons. In analysis the patient unconsciously attempts to obtain such gratifications from the analyst. His wish to obtain these infantile gratifications is his most powerful unconscious motivation. It is the basis of his relationship to the analyst. Moreover, the patient's wish to obtain infantile gratifications is the main force in back of his resistances to treatment.

³Freud, S. 1911-1915. Papers on Technique. In SE 12. London: Hogarth, 1958.
 The Handling of Dream-Interpretation in Psycho-Analysis (1911) pp. 89-97.
 The Dynamics of Transference (1912) pp. 97-109.
 Recommendations to Physicians Practising Psycho-Analysis (1912) pp. 109-121.
 On Beginning the Treatment (Further Recommendations on the Technique of Psycho-Analysis I) (1913) pp. 121-145.
 Remembering, Repeating and Working-Through (Further Recommendations on the Technique of Psycho-Analysis II) (1914) pp. 145-157.
 Observations on Transference-Love (Further Recommendations on the Technique of Psycho-Analysis III) (1915) pp. 157-172.

⁴Freud, S. SE, 20: 265.

⁵Rapaport and Gill. The Points of View and Assumptions of Metapsychology. Int. J. Psycho-Anal., 1959, 40: 155.

In order to contrast our hypotheses with those of the traditional theory, I shall compare how each set of hypotheses answers certain fundamental questions:

How do the patient's problems first arise?

According to the traditional theory, the patient's problems arise in his childhood in the fixations and regressions of his impulses to certain infantile aims and objects. Such fixations and regressions arise because these impulses are gratified either too much or too little or because they are unusually strong.

According to our hypotheses, the patient's problems arise in traumas which the patient experiences in his relationships to his parents and which impede him in his working to reach certain developmental goals.

Thus, the traditional theory assumes that if the patient remains infantile, it is because he is gratified to be that way. Our hypotheses assume that if he remains infantile, it is because he is afraid that were he to move to a more advanced position, he would again become traumatized.

What does the patient unconsciously wish to do in his analysis?

According to the traditional theory, the patient unconsciously wishes to gratify certain infantile impulses.

According to our hypotheses, the patient unconsciously wishes to solve his problems by making conscious and mastering the mental contents which he has warded off and with which he is in conflict.

What kind of memories are both deeply repressed at the beginning of the analysis and especially useful for the patient to remember in the course of his treatment?

According to the traditional theory, they are memories of infantile libidinal gratifications.

According to our hypotheses, they are memories of childhood traumatic experiences.

Why does the patient unconsciously tempt the analyst to gratify certain infantile libidinal impulses?

According to the traditional theory, it is because he wants to gratify these impulses.

According to our hypotheses, it is to assure himself that the analyst will not gratify them and thus will not traumatize him.

I shall now discuss how we went about testing our hypotheses against those of the traditional theory.

Our first step required us not to observe but to think. We had to figure out precisely what each set of hypotheses predicts about the behavior of the patient in order to find where the two sets of hypotheses predict discernibly different behavior patterns.

Our second step required us to study patients in order to determine which set of predictions, if either, would be confirmed by observation.

We found that the traditional theory does not predict any behavior patterns which our hypotheses do not also predict. That is, the traditional theory does not account for any behavior patterns which our hypotheses do not also account for.

However, we did find that our hypotheses predict and thus explain a number of behavior patterns which the traditional theory does not predict and cannot explain.

In other words, our hypotheses predict certain behavior patterns which according to the traditional theory cannot occur. I shall describe one such behavior pattern. It is a pattern which we had hoped would be demonstrable by formal research methods. Now George Silberschatz has shown that it is indeed demonstrable by such methods.

Here is the pattern: The patient unconsciously tempts the analyst to gratify an unconscious impulse. The analyst does not gratify it. The patient then is unconsciously pleased with the analyst. He becomes more optimistic than before and more confident that the analyst will help him. He tackles problems which before he had been afraid to tackle. He then becomes conscious of the impulse which he had pulled for the analyst to gratify. He does not isolate the impulse, he is not particularly anxious about it, he keeps it in consciousness, and he proceeds to master it. He may, moreover, unaided by interpretation and calmly, remember occasions in his childhood when he gratified a similar impulse.

The traditional theory can explain both the patient's becoming conscious of previously warded off impulses and his retrieving the previously warded off memories. However, it cannot explain his doing these things calmly, without anxiety or conflict, and without using isolation.

According to the traditional theory, the patient who is tempting the analyst to gratify an unconscious impulse does so because he unconsciously wants the analyst to gratify it. Therefore, the analyst, by not yielding to the patient's pulls, frustrates the impulse. The frustration of the impulse, then, may intensify it to the point that it breaks through the patient's defenses to consciousness. Moreover, if the impulse continues to be frustrated, the libido contained in it may flow back to memories of experiences when the impulse was gratified.

The patient, however, according to the traditional theory, should become more and more tense as the analyst refrains from yielding to his pulls, not relaxed as in the observation I have cited. For, as the impulse is frustrated, it should become increasingly intense and the patient who is unconsciously warding it off should become increasingly tense and beleaguered. Then, after the impulse breaks through the patient's defenses, the patient should develop a conflict with it similar to the one which, in his childhood, had led to his repressing it. He should become anxious about it and should attempt to re-repress it.

The traditional theory can explain the patient's not feeling anxious about the warded off impulse by assuming that the patient is fending off his anxiety about it by the defense of isolation. However, if it explains the patient's calmness in this way, it cannot explain his mastering the impulse. For, according to the traditional theory, a patient cannot master an impulse which he is isolating.

Our hypotheses, however, can explain this observation quite well. According to our hypotheses, a patient who is unconsciously tempting the analyst to gratify an impulse is testing the analyst in order to assure himself that the analyst is reliable and thus that he will not traumatize him by gratifying the impulse as a parent in his childhood may have traumatized him.

Therefore, the patient is unconsciously pleased, not frustrated, when the analyst does not gratify the impulse. Each time the analyst refrains from gratifying it, the patient becomes less anxious, more optimistic, and more confident in the analyst.

The patient, because he is able unconsciously to control his defenses, keeps the impulse warded off until he has overcome much of his anxiety about it. Then he lifts his defenses and brings it forth. Since he has overcome his anxiety about the impulse before bringing it forth, he does not develop a conflict with it after becoming conscious of it. He keeps it in consciousness without feeling anxious about it, and he masters it. Moreover, he develops enough confidence in the analyst and security with him safely to remember those painful occasions in his childhood when his parents hurt him by gratifying a similar impulse.

Let me present an example of the pattern I have cited. It is taken from an analytic case:

A patient who, in his early childhood, was over-stimulated sexually by his mother is unconsciously seductive toward the analyst. He pulls unconsciously for the analyst to admire him and to show a special interest in his sexual fantasies. Moreover, he attempts to induce the analyst to alter his usual procedures: to grant him extra time and to persuade him to look at photographs of his family.

The analyst does not yield to any of the patient's pulls; and as he does not yield to them, the patient becomes less anxious, more relaxed, and more confident. Then, on one occasion, after the analyst refuses to look at the photographs of the patient's family, the patient, after a brief pause, becomes conscious of sexual fantasies about the analyst. He is not particularly anxious about these fantasies, and he talks about them on and off for the next few weeks. Then, at the end of this period, the patient, unaided by the analyst's interpretations, traces his sexual interest in the analyst back to his childhood sexual interest in his mother. Moreover, he remembers for the first time certain sexual games which he had played with his mother on her bed and when she was giving him a bath. He brings these memories forth without great anxiety, but with a sense of disappointment in his mother and anger at her for having been seductive with him.

The traditional theory can explain one part of this pattern, but, as I shall show, it cannot explain another part of it.

The traditional theory assumes that the patient, having been overly stimulated sexually by his mother, developed a libidinal fixation to her. The patient, then, in his analysis, unconsciously transfers his unconscious sexual interest in his mother onto the analyst. Thus, the traditional theory assumes that the patient, by his various pulls on the analyst, is attempting unconsciously to gratify his sexual interest in him.

The patient, for example, by attempting to show the analyst photographs of his family, is offering the analyst a chance to be intimate with him, and thus is trying to satisfy his sexual interest in the analyst in a disguised, symbolic way. The analyst's refusal to look at the photographs causes the patient's libido to flow back to the sexual impulse, intensifying it to the point that the patient becomes conscious of it. However, since the patient cannot gratify his sexual impulses with the analyst, his libido flows back to memories of childhood gratifications with his mother, so that these memories become intense enough to enter consciousness.

What the traditional theory cannot explain, however, is the patient's becoming less anxious, more relaxed, and more confident as the analyst refrains from yielding to his pulls. Nor can it explain the patient's remaining relaxed, confident, and unanxious after he becomes aware of his sexual interest in the analyst and after he remembers his sexual interest in his mother.

For, if, as the traditional theory assumes, the patient is unconsciously frustrated by the analyst's not yielding to his pulls, the patient should become more and more tense as the analyst does not yield to them. Moreover, after the patient becomes conscious of the warded off sexual impulses and the memories, he should, according to the traditional theory, become very upset about them. He should develop a conflict with them similar to the conflict which had led to their being repressed, and he should attempt to re-repress them.

The hypotheses which we have developed, however, can explain quite simply the observation which I have cited.

These hypotheses assume that the patient was traumatized by his mother's seductiveness. He became sexually interested in his mother largely for her sake, fearing that he would hurt her if he were not interested in her. He unconsciously considered his sexual interest in his mother a hindrance to his achieving an important goal, namely that of becoming independent of her. In other words, he unconsciously thought of his sexual interest in his mother as something which he wished to overcome. In his analysis, then, the patient works to master both his sexual interest in his mother and his transferred sexual interest in the analyst, by making these conscious and putting them under conscious control.

The patient is at first afraid to bring his sexual interest in the analyst to consciousness. He fears that the analyst will react to him as his mother had. This would be quite dangerous for the patient. For, were the analyst to react sexually to him, the patient would believe that the analyst, like his mother, needed the patient to be interested in him. The patient might then, out of guilt, permit himself to be seduced by the analyst. His tenuous control over his sexuality might be threatened, and he might be traumatized by the analyst as he had been by his mother.

The patient then works to bring his sexual interest in the analyst to consciousness by testing the analyst. He tests the analyst to assure himself that the analyst will not react to him as his mother had. The patient, then, in being unconsciously seductive with the analyst, is testing him and is not seeking sexual gratification from him. He is hoping unconsciously that the analyst will not be seduced by him. Indeed, each time the analyst refrains from yielding to the patient's pulls, the patient becomes more confident in the analyst and less anxious that the analyst will traumatize him by seducing him.

After the analyst refuses to look at the photographs, the patient is reassured enough about the analyst to decide that he can safely become conscious of his sexual interest in him. For, the patient assumes that if he cannot persuade the analyst to look at the photographs, he certainly cannot seduce him.

Thus, the patient gives the analyst an opportunity to traumatize him as his mother had traumatized him, and the analyst does not take this opportunity. The patient, then, is deeply reassured about the analyst's reliability. He develops a confidence in him such as he had not had in his mother, thereby making up with him for some of his earlier disappointments in his mother, whom he regarded as infantile and needy. He is then able safely to remember his disappointments in his mother for using him to satisfy her own needs.

Now Joe Caston will speak and then George Silberschatz will.

The Reliability of the Diagnosis of the Patient's Plan

Joseph Caston, M.D.

To delineate an unconscious plan in a patient in psychotherapy or psychoanalysis is to make a clinical formulation of a particular kind: it will characterize unmastered areas of the patient's personality which have a high priority for realization, designate the defensive arrangements which lie in the way, and indicate the operations which lead to overcoming the latter. Despite its different emphasis, it has many areas of overlap with the traditional psychodynamic formulation of the patient's central conflicts, the major impulse and defense configurations, the expectable transference constellations, and the relations between these and the symptoms.

But is it possible to effectively teach clinicians how to diagnose an unconscious plan in a psychotherapy case, and can we get them to agree on the diagnosis? This is a crucial matter for all research which takes a particular unconscious plan as a given with respect to certain measures, as in, for instance, the study of the immediate effects of interventions (Caston, October 1976) and the study presented today by George Silberschatz.

Unfortunately, getting judges to agree on complex, inferentially derived formulations from clinical material has a woeful record. For instance, in Philip Seitz's paper on the consensus problem in psychoanalytic research, he could not get five analyst judges to agree on complex psychodynamic formulations for a single case. When he attempted to obtain agreement on more focal issues such as major impulses and defensive motives from small segments of clinical material, he did very little better. Actually, Seitz's judges were more in agreement than he knew or was able to show, because of the untapped overlap in their clinical judgments. The likely source of the difficulty was the high degree of overdetermination in clinically rich material, which expands the number of interpretations possible.

In carrying out the present study for the reliability of plan diagnosis, I solved the problem in the following way: First, the complex concept of "plan" was dissected into several subsets, each of which was much simpler clinical rubric, for which separate statistical reliabilities might be determined; second, by providing a given array of clinical statements or tasks under each rubric, judges' agreement could be statistically demonstrated from a profile of scaled judgments. Each judge would develop his own hierarchy within the given items. Judges could then differ on valuations of specific clinical propositions, yet show general similarity on clusters of items from a large number of judgments.

The rubrics include:

- (1) goals (concrete)
 - (a) immediate
 - (b) eventual
- (2) obstructions (to the goals)
- (3) means (abstract)
 - (a) content (immediate goal)
 - (b) modes
- (4) tests
 - (a) test power
 - (b) plan facilitation by interventions
- (5) test outcomes

This initial study was carried out using the detailed process notes of the first five sessions of a case which the judges had never seen. Four judges from our research group, excluding Weiss, Sampson, and Caston, reviewed the Manual on How to Diagnose the Plan (see below) and the process notes. They then made scaled judgments on schedules of items for each rubric, especially prepared for that case. These judges had had six months to two years experience with the concept of unconscious plans in clinical and research contexts, using other cases.

The manual on plan diagnosis which concludes this section will explicate each of the rubrics listed above. The manual is meant as a guide, for clinician-judges who have already had supervision and experience in the clinical application of the theory, so that they may organize their notions of unconscious plans into these rubrics for research purposes. As a result, the general reader will likely find the manual rather condensed and relatively sparse in the number of clinical examples. While the manual serves as a useful introduction, there is no substitute for case supervision or conferences for learning the technique.

The critical elements which it is necessary to know for the conduct of a therapy include: immediate goals, obstructions, content aspect of means, test power, facilitation of the plan by interventions, and test outcomes. Identifying the mode aspect of means is a difficult judgment, and probably not essential for making correct therapeutic interventions. The schedules of items for each rubric for the judges' task were prepared on the basis of reasonable and potential clinical hypotheses for the case used. The results are given below, summarizing split-half reliabilities for the average of four judges ratings (Spearman-Brown prediction) and the number of items for each rubric. All are highly significant reliabilities.

In N of 1 research which depends on a case specific attribute--such as the plan--it is essential that one must demonstrate reliability in each case.

	<u>No. of items</u>	<u>Scale points</u>	<u>Reliability coeff.</u>
Immediate goals	33	9	.867
Eventual goals	33	9	.717
Obstructions	22	9	.91
Test power	11	9	.848
Intervention facilitation of plan	19	9	.915

Means-content aspect: out of five multiple choices, all four judges agreed on the same choice.

Test outcome: previously determined blind on a different case (Boldness-Insight scale) yielding a reliability of .83.

Manual on How to Diagnose the Plan

Joseph Caston, M.D.

A patient's unconscious plan for mastery of specific issues can often be inferred from the detailed process notes of a number of sessions, particularly from the beginning of treatment. Actually, this diagnosis will be based on the recognition of several contributing elements, each of which must be separately inferred from the material. Together, these elements will be conceived of as making up the total "plan" concept. These include recognition of: (1) the patient's goal or goals; (2) obstructions, in the psychodynamic sense, which have prevented the realization of these goals; (3) the means or route by which obstructions are to be circumvented or overcome; (4) the test situations by which the patient allows for further clarification regarding continued advance toward mastery; and (5) the outcome of these tests.

(1) The goal or goals is represented by some significant behavior, attitude, affect, memory, mood state, objective within an interpersonal relation, or a group of such, which the patient wishes to enjoy, employ, achieve, renounce at will, or render innocuous, but at present is unable to do so.

These fall within the realistic repertoire of achievable human activities and states, and usually represents a developmentally higher achievement than the current state of events. These can be characterized either in a general abstract way, e.g. "the capacity to bear and express sadness", or in a concrete, highly specified way, e.g. "to mourn father's death".

The recognition of goals depends on the application of both a clinical common sense and a dynamic formulational approach. Commonly, goals may be represented by conventional desires (e.g. the wish to not be afraid of girls), developmental goals (e.g. the wish to not be so dependent), or situationally specific goals, such as the need to master a past trauma, or the wish to overcome crippling inhibitions or symptoms.

Goals may be sometimes represented in the chief complaints, or elsewhere stated in a direct way. However, these statements may be veiled or defensively distorted, and the context must be carefully examined to clarify this. For instance, the patient may state the wish "to get married". The context may reveal that the patient would indeed like to, but has felt inhibited on an oedipal conflict basis. On the other hand, evidence for a sense of obligation or guilt surrounding this wish would suggest that what the patient wants more, and is much less able to achieve as a goal, is the freedom to choose not to get married.

Another guide to evaluating explicitly stated goals relates to their plausibility or implausibility. For instance, if the patient says, "I want to spend more time with my sister, but my marriage gets in the way", it does not sound particularly plausible from a common sense point of view, although further examination of the context would be needed to confirm this.

Finally, it is necessary to distinguish between immediate and eventual goals. The immediate goal, or goals, will predominate in the material as a focus of work toward mastery, if not in a cognitive way, then always by "testing" activity (see below). Patients will differ most in the immediate goals which manifest themselves at any point in the therapy. Other goals may be apparent in the material which are less predominant, and do not discernibly form a frequent focus of "testing" activity. These are eventual goals, which may later come to be mastered, and form a larger potential list. Missing from this list will be areas already mastered by the patient; even so, patients may be more similar with regard to this larger set of unattained eventual goals than they are with respect to the immediate goals.

There will be more evidence for, and more clinical agreement on, immediate goals; appropriately, these goals will form the basis for the therapeutic approach. In addition, it will often be the case that an immediate goal must be mastered before a given eventual goal may be approached.

(2) Obstructions represent the present or anticipated state of events which makes the person regard a goal as dangerous at the outset. Frequently we will be able to see what defense is used, usually continuously and inflexibly, to side-step the dangerous consequences of pursuing the goal. Familiar obstructions, which vary in a case-specific way, include guilt over omnipotence, vulnerability to injured self-esteem, confirmation of inadequacy, fear of retaliatory castration, fear of repetition of a previous trauma, shame, fear of loss of control (e.g. as with sadness, or as with rage). . .etc.

Frequently, analytic treatment will in time reveal that the danger has been based on and characterized by a particular unconscious fantasy structure. The basic character of the dangers involved can be recognized from early material, sufficient for the purposes of plan diagnosis, even though the unconscious fantasy which lies behind them has not yet been clarified.

For instance, an architect of considerable talent was troubled by a lack of precision and incisiveness in expressing himself and by meekness in interpersonal relations; moreover, he dreaded receiving phone calls, as though always expecting the worst. In time the analysis revealed that he was unconsciously awaiting the news of his impending execution. His "crime" had been that he had "relentlessly" pursued his education and career goals despite the death of his father when he was eleven. The fear and guilt involved in this

fantasy had brought him to blunt the sword of his assertiveness in an attempt to fool and delay the executioner. It was not hard to pick out the role of fear and guilt as a prominent danger (against the goal of assertiveness) in the early material. That fear and guilt were involved was recognizable early, while later material delineated just how the fear and guilt were governed according to the specific unconscious fantasy.

(3) Means represent routes and steps which permit increments of behavior change toward the goal. Essentially, every means is an immediate goal, which is on the track to a specific later one. For instance, a person may have to master boastfulness preparatory to the later confrontation with the painful unconscious fantasy of puniness. All immediate goals designate the content aspect of the means. The formal aspect is indicated by how the task of mastery is effected. The basic process in this task is the de-jeopardization of what has erroneously been regarded as dangerous.

Various temporary or permanent modes of how this mastery is effected include:

- (a) the graduated approach, i.e. inching up by degrees to the previously dangerous behavior or idea.
- (b) the leap, i.e. a plunging into the behavior, which differs from a counterphobic defense in that it is not in service of denying the danger.
- (c) identification with, or imitation of, stronger others.
- (d) passive into active, getting the other person to survive the danger (e.g. subjecting the therapist to rejection).
- (e) magic feather defense, temporary "use" of borrowed strength or protection to brave or confront the danger, on temporary basis.
- (f) direct conscious re-appraisal of danger.
- (g) employment of other available defenses to diminish or nullify the danger (e.g. intellectualization, joking, naming, grandiose fantasies, etc.).
- (h) mastery of as yet unmastered defenses to render the danger innocuous.

In effect, successful carriage of the means brings about re-appraisal of the danger as diminished, leading to behavior change with respect to immediate goals and, later, other goals.

In the case of the architect described above, for example, multiple modes led to the mastery of assertiveness. In this particular case, the first order of business had been to experience and master his previously unmastered grief over his father's death. The depth of the grief convinced him of the sincerity of his love for his father, as opposed to the obligatory and artificial respect which had always been demanded of him. Armed with this knowledge, he faced and accepted the competitive and aggressive attitudes toward the father for which he felt so guilty. The increasing expression of competitive and challenging ideas and behaviors within the transference were also tested by graduated approaches and occasional sudden leaps into articulate assertive postures. In addition, a kind of gentle humorousness about the analytic goings-on punctuated his crustier moments, sometimes to mitigate them after the fact, or to prepare the way for the next assault. The successful mastery of this assertiveness then made possible the later examination of deeper homosexual material.

(4) Tests are the actual presentations by the patient which have the unconscious or conscious purpose of confirming or disconfirming the present appraisal of the case-specific immediate goal as dangerous. In a test, either side of a dilemma may present itself, i.e. there will either appear to be a retreat from, or advance towards, the immediate goal. If the immediate goal is to master boastfulness, for instance, the patient may present himself as unnecessarily modest (i.e. a retreat), or, on the other hand, display a virtuosity at some idea or behavior (an advance). Either is a test to gather information as to how safe it is, currently, to boast. The test may be carried out on the patient himself (e.g. a patient may follow a line of thought to see if he can scare himself with it, or pursue a regressive path to see if he can reverse it), on the world (e.g. it might constitute a primary process "punishment" if some miserable course of events ensues), or on the therapist.

The therapist either facilitates or hinders mastery with respect to the immediate goal, in a test situation, by the witting or unwitting support or attack by his intervention, or lack of intervention, as perceived by the patient. Acquaintance with the obstructions, dangers, and means, should enable one to predict what therapist behaviors will facilitate or hinder.

From the foregoing considerations, what would constitute a powerful test, and what a weak test by the patient? A powerful test is one with a high likelihood of generating clarifying responses from the therapist regarding the relative danger or safety of the immediate goal (means). An important corollary is that a test which is inherently difficult for the therapist to pass is more powerful than a test which is easy to pass. In other words, if a therapist has passed a difficult test, the patient will have a greater degree of certainty that the (previously dangerous) goal is now safe.

It follows that when the patient expresses a content or behavior which is relevant to immediate goals, how the therapist responds to it will be much more pertinent to the patient's appraisal of the plan, than when the therapist responds to irrelevant material.

For example, consider the patient whose plan is to achieve mastery over boasting as a means to later confrontation of an unconscious sense of puniness. In this patient, instances in which his current productions focus on matters of display or cover-up, or instances in which he manifests modesty or pride in his delivery, can constitute relatively powerful tests, as compared to instances when the patient focuses on irrelevant material. Weak tests in this patient would be exemplified by the patient's questions to the analyst regarding scheduling changes, or by the patient's discussions of his hatred of businessmen. These last two instances are relatively less relevant to boasting; accordingly, almost any response by the analyst on these topics neither increases nor decreases the degree of appraised safety of boasting. That is, for irrelevant topics, it doesn't matter if the patient perceives the analyst's response as open, withholding, pro, con, interpretative, information-seeking, or procedural, or even if there is no response at all. We might, of course, picture other patients with very different plans for whom a question about scheduling changes would be relevant, and hence would represent a powerful test: for instance, a patient who must establish assertiveness as a first order goal, or another who must first establish that the therapist is trustworthy and caring.

To repeat: a test with relevant content is more powerful than one with irrelevant content.

We can refine our clinical distinctions in this area through further consideration of our corollary: Among a group of tests which are all clearly relevant to the plan in terms of their content, those tests which are the most difficult to pass are also the most powerful.

A test may be made easy to pass whenever the patient consciously or unconsciously "coaches" the therapist. For example, suppose that the patient whose plan is to master boastfulness says, "I know you'll think this is ridiculous, but I was the first in my family to learn Esperanto". He has now put the therapist on the alert. It is as though he had said, "Take special care with this utterance--don't do anything that will look like you find it laughable, or kid stuff, and don't ignore it by going on to something else". A frequent instance of "coaching" in many patients is the demand that is preceded by "you probably won't answer this, but..." Here, the patient is usually communicating, "I won't fall apart if you don't respond to this, so don't! Otherwise, you'll make me think that you believe that I'm needy..." etc.

When coaching is absent, the test is usually more difficult to pass. For instance, if the patient above had only boasted that he had been the first to learn Esperanto, an unalerted therapist might unwittingly

overlook this content and respond to some other adjacent material, or respond in a mildly light vein because of the seemingly humorous or trivial quality of the boast. Again, in those patients whom it facilitates the plan not to gratify, tests in the form of overt demands, without coaching, are more difficult to pass; this is usually because the therapist must overcome a pull to gratify an apparently needy patient. The patient makes such a test even harder to pass by adding a threat to the demand.

The most difficult tests are those where only a very narrow range of responses from the therapist will do for a "pass". These are often "damned if you do, and damned if you don't" situations, where only the most clinically deft response passes successfully between the Scylla and Charybdis which the patient has unconsciously set up for the therapist.

For example, a neurotic patient with a remarkable sensitivity to narcissistic injury had often been ignored as a child by her four sisters and parents, except when she was a terrible crybaby. Both conditions made her feel poignantly worthless and small. Her apparent success as mother, and now student, had not brought her sufficient happiness. In this patient's plan, the first order of business had been to establish a modicum of self-worth within the context of the therapy. Under her testing, the circumstances of the therapy would first have to show that she was not despicable but could feel prized and valuable in spite of her bratty provocations; second, that the brattiness itself would not produce responses in the therapist which would confirm that she should be treated as a child or as worthless. A prolonged and turbulent period of testing ensued. The easier part of the therapist's task was fulfilled via his patient, steady, readily accessible manner and presence in the face of her provocative-ness. Since the therapist did not give up in disgust, the rudiments of a sense of unconditional respect by the therapist began to be built.

The most difficult tests, however, would occur when the patient would, in a bratty mood, demand verbal responses from the therapist. To gratify these as demanded, in the typical instance, would confirm her childishness, i.e. that she was a manipulative brat who could only be kept quiet by giving in to her demands. On the other hand, to not respond at all to the demand, either with silence, change of subject, or by certain interpretations, was experienced as confirmation of her worthlessness, just as when the whole family would ignore her. Thus the patient felt belittled and devalued by both kinds of therapist responses. It was clear that some response was indicated in respect of her self-esteem, but not one which either gratified or ignored the direct requests. Therapist responses which were facilitative were those which

acknowledged the nature of her demand, her mood states in making the demand, and in not having it gratified--but only when the patient perceived this response as representing a compassionate and not a pitying attitude. In time a fragile but enlarged initial base of self-esteem was established. Thus encouraged, the patient advanced with safety to a testing posture which became more central for her, i.e. turning passive into active through deprecation and vilification of the therapist.

To sum up, the power of a test relates to its capacity to generate a clarifying response from the therapist regarding the appraised safety of an immediate goal. As the content of the test becomes more discernibly relevant to the goal, and as the test becomes more difficult to pass, the likelihood of generating clarifying responses increases.

(5) Test outcomes. If the tests are passed, the patient will show specific advance toward the goal behaviors by further derivative or direct manifestations of the goal behaviors, but in an increasingly flexible, bold, relaxed manner; or general advance by a relevant expansion of material, or emergence of previously warded-off contents or behaviors, or appearance of generally bold, exploratory, or self-confronting behaviors. A retreat may, accordingly, be characterized in opposite ways.

While most successfully passed tests demonstrate the expansion rule in an immediate way, the expansion effect may be considerably delayed, as when the immediate goal behaviors to be mastered are of a "negative" variety, like stubbornness, superficiality, or silent retention. These may accordingly temporarily delay recognition of the conventional signs of advance. These instances may make differentiation of what is figure, and what is ground, difficult.

* * *

A general clue in determining plan diagnosis is to look for evidence of "advancing" behavior, then work backwards to hypothesize goal, danger, and means. Such behaviors will manifest themselves in the sessions themselves, or they will be reported from the history as temporary paradoxical remissions in the patient's inhibitions, fixations, or symptoms. In such cases, we ask, what accounted for the patient's advance? What circumstances permitted it? What does it say about what the goal is and what prevents its realization? In the sessions, if some warded-off content or behavior emerges, we look back to see what might have brought it about--both in what the patient may have done differently in a test situation, or how the therapist behaved such that the patient perceived the situation as "less dangerous".

The Method and the Findings

George Silberschatz, Ph.D.

The study that I am going to present provides a sharp test between two explanations of an important clinical phenomenon often observed in psychoanalytic treatment. The phenomenon has already been discussed at some length by Joe Weiss, and I'll refer to it as the patient's transference demands--by which I simply mean those instances in which the patient, either overtly or covertly, makes a demand of the analyst or tempts him to gratify a wish. According to the traditional theory, when a patient makes a transference demand and the analyst does not satisfy it (i.e., by remaining neutral), the patient is unconsciously frustrated. The patient's unconscious transference wish is thereby intensified and may force its way into consciousness. This model, which is prevalent in almost all psychoanalytic theories of neutrality, is based on the "rule of abstinence" spelled out in Freud's Papers on Technique; namely, the analyst must abstain from gratifying the patient's wishes so that they may serve as driving forces in the analytic work. In its simplest terms, the rationale for this model is based on the idea that "abstinence makes the wish grow stronger".

As Joe Weiss has pointed out, the role of analytic neutrality is seen quite differently from our perspective. According to our hypotheses, when a patient tempts the analyst to gratify a wish, he does so primarily to test the analyst. That is, he unconsciously attempts to assure himself that he will not be traumatized by the analyst as he had been traumatized by his parents in his childhood. Thus, the patient does not want the analyst to satisfy the transference demand and each time the analyst refrains from doing so, he passes the patient's test. In short, the patient is unconsciously pleased, not frustrated, when the analyst does not satisfy the patient's wish.

These two explanatory models of analytic neutrality lead to hypotheses that are in direct opposition to one another: Our model predicts that the patient is generally reassured by the analyst's neutrality (passing the test), and that the patient's satisfaction is often demonstrated by his becoming more relaxed and productive in the session. By contrast, the traditional model predicts that the patient would be likely to feel unhappy and distressed (frustrated) by the analyst's neutrality.

The question being asked in this study is the following: What are the effects of the analyst's neutrality on the patient's feelings and behavior? When a patient makes a transference demand of the analyst--that is, when he tempts the analyst to satisfy a wish--and the analyst does not do so, how does the patient end up feeling? Is he frustrated and distressed as the traditional theory assumes, or is he generally satisfied and relaxed as our hypotheses suggest?

METHOD

In order to empirically study these two models, the verbatim transcripts of the first 100 hours of a tape recorded psychoanalysis were examined. The patient was seen for psychoanalysis five days a week by an experienced, traditionally trained psychoanalyst. The analysis, which lasted approximately six years, was successfully terminated many years prior to the planning of this study. The patient was a married professional woman in her late 20's. Her major presenting problem was her inability to enjoy and unwillingness to have sexual relations with her husband. In addition to her sexual problem, the patient also complained of feeling chronically tense, self-critical, overly serious, and unable to relax and be light-hearted. As a result, she had trouble interacting comfortably with other people. The patient was carefully screened in order to determine her suitability for psychoanalysis, and she was deemed to be a suitable analytic case. The psychiatrist who referred her for analysis diagnosed her as suffering from obsessive-compulsive problems.

Identifying the Patient's Transference Demands

Nine raters read through the verbatim transcripts in order to identify instances in which the patient pulled for the analyst to gratify a wish. Among the instances included were the patient's attempts to elicit reassurance, approval, affection, encouragement, permission (to be critical, angry, "misbehave"), punishment (for her misbehavior), or more active participation by the analyst. Each rater read a different portion of the 100 hours and selected all instances which in his estimation reflected the patient's attempt to elicit a response from the analyst. Each hour was read by at least two raters independently, thus minimizing the systematic biases of any one judge and also generating the maximum number of such instances. In all, 87 transference demands were identified. Fifteen interchanges not selected by any of the judges as a transference demand were also included for control purposes. Typescripts containing the transference demand as well as the analyst's intervention (which include silences) were then prepared.

Rating the Degree of Neutrality

Two independent groups of judges (psychoanalysts and advanced candidates in psychoanalytic training) were asked to read a brief description of the patient, including her presenting problems and relevant historical data. The judges were then given the typescripts containing the transference demand and the analyst's intervention, and they were asked to rate how well each of the sequences represented the patient's attempt to elicit a response from the analyst (how good an example each one is). Five classically trained analysts rated the degree to which the analyst's response was a neutral one; that is, the extent to which the analyst does not satisfy the patient's wish. Similarly, four analysts familiar with our hypotheses rated the extent to which the analyst passed or failed the patient's test. This procedure made it

possible to generate a set of instances that both groups identified as clinical examples pertaining to their theory. In this way, I was able to identify instances that met the criteria of analysts using two different theories. The reliabilities for these ratings are presented in Table 1. (Since the mean rating was used in analyzing the data, r_{kk} is the appropriate estimate of the reliability.)

Selecting "Key Tests"

Dr. Caston's work has shown that certain tests posed by patients will be more important or critical than others. A test immediately related to the patient's plan is likely to carry greater weight than does a test more distantly related to the plan. The patient's Key Tests were identified on the basis of a previous study carried out by our research group. Time does not permit my going into the details of that study, so let me simply state that a team of analysts were able to specify the patient's plan for the first 100 hours, their predictions were then confirmed in a quantitative research study. Here is their picture of the case and their construction of the patient's plan:

Mrs. C. was very inhibited. We inferred that her immediate difficulties were caused by unconscious guilt based on omnipotent fantasies that if she asserted herself with other people, she would hurt them seriously. Because of this guilt, she was in danger of submitting in a close relationship, and of allowing herself to be criticized, put down, humiliated, and dominated. In order to avoid these dangers, she had to avoid feelings of closeness, including feelings of sexual closeness and responsiveness.

We also inferred that Mrs. C. had developed an unconscious plan to reduce her fears about hurting others, to reduce her guilt and her omnipotence. We inferred that she would attempt to test the analyst to see whether he was hurt when she disagreed with him, criticized him, and found fault with him. More generally, we inferred that she would work in various ways to develop the capacity to fight with others in addition to the analyst; and that when she developed this capacity, she would then feel safe enough to risk feelings of closeness, including feelings of sexual pleasure with her husband. She would feel safe enough to experience sexual pleasure with him, if she could feel able to fight back if he should attempt to exploit her guilt in order to make her submit.

The overall picture of the case is this: She has great problems with feelings of omnipotence. She sees her parents as weak and is afraid of hurting them. As a result, she has become very submissive to them in order to protect them. In her analysis she works to overcome her submissiveness to them in two ways: by turning passive into active and by transferring. She acts hurt by the analyst as her parents were hurt by her in order to assure herself that the analyst will not feel omnipotent the way she did. In addition, she acts independent with the analyst as she did with her parents, hoping that the analyst won't be hurt by her independence as her parents were.

Three raters identified all segments in which the patient was testing the analyst to determine if he became upset, hurt, defensive, etc., when she found fault with him, disagreed with him, criticized him--in general, when she fought with him. A subsample of 46 segments was selected by all three raters as examples of Key Tests. The reliability of these ratings was $r_{kk} = .82$.

Patient Measures

The general methodology employed in this study is as follows: A series of critical incidents (the patient's transference demands) were isolated and the patient's behavior prior to the incident is compared with her behavior following the incident. The effects of the analyst's interventions were assessed in terms of several patient measures, each scored by different groups of judges. The segments--approximately six minutes of patient speech--were presented in random order, without any context, and with the judges unaware whether the segment was a "pre-transference-demand" segment or a "post-transference-demand" segment. In addition, all judges were unaware of the aims of the research.

Derived from a Rogerian client-centered framework, the Experiencing Scale is one of the most widely used psychotherapy process rating instruments. It is a seven-point scale designed to evaluate the quality of a patient's involvement in psychotherapy. The scale assesses the extent to which a patient focuses on his feelings while simultaneously reflecting about these feelings for problem solving purposes. Four raters participated in the standardized training procedure and then scored all of the pre- and post-transference-demand segments. The interjudge reliability was .88.

The Boldness Scale, developed by Dr. Joseph Caston, is a five-point rating scale that assesses the degree to which the patient is able to confront or elaborate "non-trivial material"; that is, the extent to which he boldly tackles issues or retreats from them. Following a brief training period, two judges rated all of the segments with an interjudge reliability of .64.

The Relaxation Scale was designed by Dr. Lisby Mayer and her collaborators to measure the patient's degree of freedom and relaxation in the psychoanalytic session. At the high end of the scale, the patient is able to associate freely, easily, and flexibly; to be playful with ideas and to explore the connections between her thoughts in an uninhibited, spontaneous manner. At the low end of the scale the patient is defensive, constricted, or narrow in her associations; she is halting, timid, or bothered by her train of thoughts; in general, she seems tense, rigid, tight, or grim. Three judges applied the scale to all of the segments with an interjudge reliability of .72.

The patient's emotions were categorized according to an affect classification system developed by Dr. Hartvig Dahl of New York. I will not go into the details of this complicated scoring system except to say

that it yields scores on eight different affects; I shall present results with only four of the affect categories (Love, Satisfaction, Anxiety, and Fear). Two undergraduates who underwent extensive training with Dr. Dahl scored all of the segments with reliabilities ranging from .63 to .94 (see Table 2).

FINDINGS

The correlations between the ratings of neutrality and changes in the patient measures presented in Table 3 were all in the direction predicted by our hypotheses, though only one was statistically significant in the sample of 102 segments. The significant correlation between love and ratings of the analyst's neutrality indicates that the patient was likely to express positive feelings rather than negative feelings following neutral interventions (even when such interventions were not in response to a transference demand--i.e., the patient seems to respond positively to neutral interventions quite generally). Since the love category includes emotion words such as gratitude, cooperation and trust, the correlation implies that the patient tended to become more trusting and cooperative when the analyst was neutral. This pattern is consistent with our hypotheses and contrary to the expectations of the traditional theory.

For the subsample of Key Tests, I found that when the analyst passed the test, the patient became significantly bolder, more relaxed, more productive and explorative, more positive in her attitudes toward others, and less anxious and less fearful (see Table 4). These findings are precisely what we would expect on the basis of our hypotheses. It is of particular interest to note that the results were similar for both groups of analysts. Consider, for example, the significant correlation between anxiety and the neutrality ratings made by the traditional group of analysts. This correlation shows that when the analyst is thought to be frustrating the patient's transference demands, the patient--rather than becoming frustrated and distressed--actually became less anxious! The other correlations show that she also became more productive, positive, relaxed, and so on. These results, therefore, are strikingly contrary to the predictions of the traditional theory. The findings strongly support our hypotheses that a patient is often reassured by the analyst's neutrality (passing the test), and that his satisfaction is often demonstrated by his becoming less anxious, more productive and expansive, and generally more relaxed.

The question that I have been addressing tonight is, I believe, a fundamental one: When the analyst responds neutrally to the patient's transference demands, how does the patient end up feeling--is she frustrated and distressed or is she generally satisfied and pleased. This question and various answers to it have been discussed and argued (often heatedly) almost exclusively in the theoretical arena without ever entering the domain of empirical scientific research. (There are, of course, many reasons for this state of affairs, as Wallerstein and

Sampson have shown.) There is, however, a great potential danger in allowing this debate to continue exclusively in the arena of theory. Freud discussed this problem 60 years ago, and I believe his advice is well worth heeding. He pointed out that theoretical controversy alone will ultimately prove to be unfruitful:

No sooner has one begun to depart from the material upon which one ought to be relying, than one runs the risk of becoming intoxicated with one's own assertions and, in the end, of representing opinions which any observation would have contradicted. For this reason it seems to me to be incomparably more useful to combat dissentient interpretations by testing them upon particular cases or problems.

This study marks an initial attempt to put competing clinical theories to a rigorous empirical test. I have shown that our model is better able to predict and explain the data than the traditional model. Our research group plans to continue to improve this empirical work by further studying the case I have presented and by replicating these results on other cases.

TABLE 1

Reliabilities for the Patient
and Analyst Scales

<u>Rating Scale</u>	<u>Number of Judges</u>	<u>r_{11}</u>	<u>r_{kk}</u>
How good an example segment is of patient attempting to elicit a transference gratification	5	.54	.86
Degree of analyst's neutrality	5	.35	.74
How good an example segment is of patient testing the analyst	4	.42	.75
Degree to which analyst passed or failed the patient's test	4	.47	.78

TABLE 2

Reliabilities for Affect Classification

<u>Affect Category</u>	<u>Number of Judges</u>	<u>r₁₁</u>	<u>r_{kk}</u>
Love	2	.69	.82
Surprise	2	.70	.83
Satisfaction	2	.82	.90
Energetic	2	.57	.72
Anger	2	.80	.89
Fear	2	.46	.63
Depression	2	.68	.81
Anxiety	2	.88	.94

TABLE 3

Correlations between the Neutrality Ratings and
Changes in the Patient Measures for the
Entire Sample of Segments (N=102)

	<u>Passing-Failing the Test</u>	<u>Frustration-Gratification</u>
Experiencing	.18	.10
Boldness	.17	.18
Relaxation	.12	.15
Love	.23*	.18
Surprise	.04	.11
Satisfaction	.06	.07
Energetic	-.02	.16
Anger	.05	-.01
Fear	-.13	-.03
Depression	.06	.06
Anxiety	-.06	-.03

* $p < .05$, two-tailed test

TABLE 4

Correlations between the Neutrality Ratings and
Changes in the Patient Measures for the
Subsample of Key Tests (N=46)

	<u>Passing-Failing the Test</u>	<u>Frustration-Gratification</u>
Experiencing	.33*	.21
Boldness	.32*	.34*
Relaxation	.35*	.19
Love	.37*	.23
Surprise	.12	.16
Satisfaction	.15	.18
Energetic	-.11	.17
Anger	.02	-.01
Fear	-.34*	-.08
Depression	-.01	.07
Anxiety	-.29*	-.30*

*

p < .05, two-tailed test

PART II

RESEARCH ON THE PSYCHOANALYTIC PROCESS II:
A COMPARISON OF TWO THEORIES OF HOW PREVIOUSLY
WARDED-OFF CONTENTS EMERGE IN PSYCHOANALYSISIntroduction

Harold Sampson, Ph.D.

Tonight is the third time our research group has presented at Center conferences. I would like to review briefly what we have covered previously in order to acquaint you--or to reacquaint you--with what we're up to: our broad purposes, our approach to research, the nature of our hypotheses, and the scope of our current empirical work.

Our research is concerned with the fundamental laws underlying the behavior of the patient in psychotherapy. In carrying out our research, we are following a course which has been pursued successfully in other areas of science, but which has been attempted only rarely in psychotherapy research. This course is to develop powerful hypotheses which purport to account for all of the pertinent phenomena in a given field, and then to test these hypotheses against observation.

In practice, we test our hypotheses against other hypotheses which also purport to account for all of the pertinent phenomena in our field. We do so by identifying in advance where the alternative hypotheses would predict different outcomes, and then we examine data to determine which hypotheses provide the best account of what is observed. We test these hypotheses in one case at a time, for this is the only way it can be done. General, basic propositions about psychotherapy must be fit to the specific contents of each case.

Our hypotheses, which were developed by Joseph Weiss over a period of many years, concern such fundamental things as the origins of the patient's problems, the patient's mental organization, and his chief motivation in therapy. These fundamental hypotheses are used to explain the patient's behavior in therapy, and to explain how the behavior of the therapist facilitates or impedes the patient's progress. Suzanne Gassner will review our hypotheses, and the contrasting hypotheses of the traditional psychoanalytic theory of therapy, in her report.

In our first Center presentation, which took place just over a year ago, I presented a broad overview of our ongoing empirical work by summarizing the 11 interrelated studies we are carrying out in a single case. We carry out multiple, interrelated studies because a single

finding or even pair of findings can sometimes be explained by a rather large number of hypotheses, including ad hoc hypotheses. A series of interrelated findings enable us to determine which hypotheses best account for all of the data.

In the presentation last year we also gave the first of what will be--after tonight--three detailed reports of individual studies. These are each studies which can stand pretty much on their own. They illustrate three quite different approaches to testing our hypotheses against the equally fundamental hypotheses contained in the traditional psychoanalytic theory of therapy--i.e. the theory set forth by Freud in the Papers on Technique and related works.

The first detailed report was given by Joe Caston. His study was concerned with our hypothesis that a therapist's interventions are useful, or conversely are counterproductive, to the extent that the interventions are or are not in accord with the patient's own unconscious plan for therapeutic work. Caston's findings confirmed our expectation, for "pro-plan" interventions by the therapist were associated with an immediate increase in the patient's boldness and insightfulness. These findings could not have been predicted by hypotheses contained in the traditional psychoanalytic theory.

The second detailed report was presented here last month by George Silberschatz. George's study provided a sharp test for explanation, versus that of the traditional theory, for an important therapeutic process. George had a group of analysts who adhered to the traditional theory identify therapeutic sequences in which, as they saw it, the patient was making a transference demand, and the analyst either frustrated that demand in a neutral fashion (as by silence or investigation), or, as happened in some instances, gratified the demand. George had a second group of analysts who were familiar with our hypotheses identify therapeutic sequences in which, as they saw it, the patient was testing the analyst, and the analyst either passed or failed the test. For the most part, the therapeutic sequences identified by both groups of analysts were the same--i.e. what one group identified as a test and passing the test was usually the same instance that the other group identified as a transference demand, and a frustration of that demand.

In those sequences which traditional analysts conceived of as involving a frustration of the patient's transference demands, the patient then became less anxious, more relaxed, and more exploratory. These findings are the exact opposite of what would be expected if in fact a frustration of an unconscious wish was taking place, but the findings are precisely what we would expect if instead the patient's behavior was a test of the analyst, and the analyst's response was not a frustration of the patient but rather a passing of the patient's test. Indeed, in therapeutic sequences which were identified by one group as tests, when the analyst passed the test the patient became less anxious, more relaxed, more positive, and more exploratory. Thus George's findings provide a new set of observations--made rigorously by objective, reliable methods--which are incompatible with the traditional theory and consistent with our hypotheses.

Tonight, Suzanne Gassner will present a third natural experiment based on the same case. Her study is an important contribution both to theory, and to psychotherapeutic practice. It provides a direct test of competing hypotheses. As you will see, her study challenges the idea contained in traditional theory that important material which has been previously warded off can only become conscious during therapy with intense conflict and anxiety. This idea, in my opinion, is implicit in the thinking of most clinicians, whether or not they are psychoanalytic in orientation.

Dr. Gassner's findings are almost a mirror image of this common expectation, for, in fact, as she will show, some mental contents which had been most defended against came out during the course of treatment without interpretation, and yet with less anxiety than other material.

We have deliberately planned to allow a great deal of time at tonight's meeting for discussion. We have found that such discussion is crucial to effective communication of our work, for our work contains somewhat unfamiliar and often even contra-intuitive ideas, research strategies, research methods, and findings. The five of us who have presented on this or on previous occasions--Joe Weiss, Joe Caston, George Silberschatz, Suzanne Gassner, and myself--look forward to discussing with you any aspect of this work--theoretical, clinical, or empirical.

And now, Suzanne Gassner will present her study.

A Comparison of Two Theories of How Previously
Warded-Off Contents Emerge in Psychoanalysis

Suzanne Gassner, Ph.D.

This evening I am reporting research which was done in collaboration with Drs. Harold Sampson and Joseph Weiss. They have played a major role in the conception, planning and conducting of this work. Also, members of the Psychotherapy Research Group of Mount Zion Hospital and Medical Center have contributed ideas which have shaped this study. I would like to take this opportunity to thank Hal Sampson and Joe Weiss for the pleasure and privilege of learning from you and working with you.

The research which I am reporting this evening was designed to test fundamental hypotheses about what the factors are in psychotherapy that lead to patients gaining the capacity to experience impulses, memories, attitudes, feelings and ideas which at an earlier time they could not allow into conscious awareness. This research studied two competing theories of how such previously warded-off mental contents become conscious during treatment.

The two theories studied disagree about whether or not a patient will experience anxiety when a warded-off content emerges into consciousness.

In the traditional theory, as warded off contents push towards consciousness, the patient develops intense conflict with them, causing tension, anxiety, and mobilization of conflict. And if the warded-off contents do push their way into consciousness, the patient will re-experience in consciousness the anxiety and conflict which originally led him to repress the content. I am going to call this hypothesis, which is part of the traditional theory, the thrust hypothesis. By thrust I mean that the content is pushing its way forward, and thrust inevitably implies remobilization of conflict and anxiety.

In contrast, our hypotheses assume that a patient works to bring forth warded-off contents, and he does so ordinarily when he feels safe enough to do so. The patient brings forth warded-off contents on the basis of an unconscious decision. When the patient believes that he will not be endangered by consciously experiencing a warded-off content, he unconsciously decides to lift the defenses against these contents and to allow them to emerge.

So, in contrasting the two hypotheses which I shall look at empirically, I shall call one the thrust hypothesis and the other, the decision making hypothesis. These two hypotheses are embedded in two psychoanalytic theories: the one, the traditional theory; the other, the theory which our research group is studying.

The research which I am about to report was designed to provide clear-cut data that could confirm or challenge each of these hypotheses. Our findings disconfirmed the thrust hypothesis of traditional psychoanalytic theory. For in the case that we studied, warded-off contents were found to emerge without any increase in anxiety. Although our findings are in conflict with the traditional psychoanalytic theory, they are consistent with the decision-making hypothesis which our research group has been studying.

Though this research involved the detailed examination of the first 100 hours of a psychoanalytic case, we assume that the processes studied are in no way unique to our psychoanalysis. Broadly conceived, this research studied how a patient learned to face feelings and ideas which she had previously defended against, and how she learned to gain control over these disturbing mental contents. Such a process is not only characteristic of psychoanalysis, but of most psychotherapies.

The way I shall proceed is as follows: First I shall review with you the central propositions which lead to the decision-making hypothesis. I shall do so by reading a few paragraphs from the presentation which Dr. Weiss made here on October 11. For those of you who did not attend the first seminar of this series, I hope that this statement will orient you to the theoretical ideas which are being tested in the research you will hear about tonight.

Next I shall describe the implications of these propositions for understanding how patients in psychotherapy gain conscious awareness of previously warded-off mental contents. I shall contrast our conceptualization with that found in Freud's Papers on Technique, and I shall describe some of the reasons that this latter conceptualization has remained the dominant contemporary explanation.

It is my hope that this discussion will make vivid to you both the theoretical and the clinical significance of the formal research which I shall later report.

Now, to quote some of the essential hypotheses which Dr. Weiss presented last month:

According to these hypotheses, the patient's chief motivation, both conscious and unconscious, is to solve his problems. Moreover, he wishes to solve them in a fundamental way by making conscious and mastering the unconscious conflicts which underlie them. Thus the patient wishes to attain a solution to his problems similar to the solution to them which the analyst seeks for him. The patient's chief activity, both conscious and unconscious, is his working to solve his problems, and his relationship to the analyst is based on his wish to enlist the analyst as an ally in his struggle to solve them.

The patient is able to work unconsciously to solve his problems because he exerts at least a crude control over his unconscious mental life. He is able unconsciously to think about what he would like to do, to decide upon plans for doing it, and then to carry them out. He thinks, plans, and decides unconsciously much as a person consciously does these things.

Thus the patient plans and carries out methods of working to bring forth and master the impulses, affects, ideas and plans which he has warded off and with which he is in conflict. His basic strategy in his working to bring such a warded-off mental content to consciousness is to create a relationship with the analyst which would make it safe for him to experience this content. He does this work unconsciously by testing the analyst. His purpose in testing the analyst is to determine in advance how the analyst will react to his experiencing the content. In particular he tests the analyst to assure himself that the analyst will not react to his experiencing the content in such a way as to endanger him. When the patient, by testing the analyst, has gained enough confidence in the analyst to decide that he may safely bring the content forth, he lifts his defense and brings it forth...

The patient's testing of the analyst stems genetically from his childhood relationships to his parents. For the patient, in testing the analyst, is unconsciously attempting to assure himself that he will not be traumatized by the analyst as, in his childhood, he had been traumatized by his parents. In testing the analyst, the patient may tempt the analyst to do the very things which his parents had done and which he had experienced as traumatic, hoping that the analyst will not react as his parents had.

Thus (the patient) does not permit himself to experience confidence in the analyst which he would need in order to pursue (his therapeutic) goals until, in testing the analyst, he assures himself that he would be justified to place such confidence in him. Nor does he permit himself to remember the traumatic experiences themselves, nor his loss of confidence in his parents which resulted from these experiences, until he has demonstrated to himself that he will not be traumatized in his analysis as he was traumatized in his childhood (Weiss, October 10, 1977, pp. 1-4).

According to the preceeding propositions, patients become conscious of previously warded-off mental contents when unconsciously they decide that it is safe to do so. They work to make it safe by testing the analyst. There are two ways the patient tests the analyst: One is that the patient unconsciously turns passive into active. In this process,

the patient treats the analyst in the very ways which the patient in his childhood felt himself to be treated, and found traumatic. Unconsciously, the patient hopes that the analyst will not feel traumatized too. If the analyst passes such a test; that is, if the analyst is not traumatized or upset by the patient's behavior, the analyst thereby demonstrates a capacity which the patient hopes to acquire. Also, the analyst's behavior implies to the patient that it is acceptable to the analyst for the patient to achieve this same capacity. When the therapist passes such tests, the patient unconsciously becomes more confident in the therapist, and this, too, makes it safer to experience previously warded-off contents. While such testing is occurring, the patient may consciously continue to experience negative feelings about the very therapist behaviors which unconsciously reassure him.

The other way in which the patient works to be able to make it safe to bring forth warded-off contents is by unconsciously expressing transferences. The patient responds to the therapist by manifesting patterns that characterized his responses to his parents, and which led to his being traumatized. By so doing, he unconsciously tests whether the therapist will respond as his parents did, thereby repeating the trauma. Should the patient discover that the therapist does not respond like his parents, the patient feels safer to lift the defenses against the traumatic experiences (Weiss, unpublished manuscript, 1977).

Let me illustrate these ideas about how the patient works in therapy in order to reach a point where he can bring forth previously warded-off contents. Take, for example, a patient who felt as a child very humiliated by his parents. If such a patient tests the analyst by turning passive into active, he will ridicule the analyst. He will look to see if the analyst feels put down. If the analyst does not become upset, the patient can identify with the analyst's capacity to not feel humiliated. Then the patient may begin to risk the danger of being humiliated. He may himself begin to act a little ridiculous.

The patient thus provides the analyst with the opportunity to humiliate him. If the analyst does not humiliate the patient, the patient can feel safe to lift the defenses against the traumatic experiences, and in this instance allow into consciousness the experience of being humiliated by his parents.

According to this thesis, the patient is going to be anxious while testing the analyst.

In our illustration, the patient may become anxious about humiliating the analyst, for he cannot know if the analyst will fail such a test by acting humiliated. The patient is also likely to feel anxious when he behaves in a ridiculous manner. For he is providing the analyst with the opportunity to humiliate him and to thus repeat the trauma which he experienced when he felt himself humiliated by his parents. If the therapist passes such tests, the patient's sense of safety to experience

the warded-off memories or feelings or ideas about being humiliated by his parents is increased and he may allow these mental contents into consciousness without feeling anxious. For, by the time the patient allows himself to experience these mental contents, his unconscious convictions of danger may have already been disconfirmed. This is essentially what George Silberschatz's study, reported last time, found. The patient became calmer after she tested the analyst.

It follows from this perspective that important warded-off contents can emerge in therapy without necessarily being interpreted first by the therapist. Generally, the prerequisite for the patient's gaining awareness of previously warded-off contents is the therapist's passing patient tests, thereby increasing the patient's confidence that experiencing these contents will not endanger him.

Here the therapist's interpretations may be part of his passing the test. Sometimes the patient may be able to achieve a feeling of safety without the therapist making any interpretation.

These hypotheses do not rule out the expectation that sometimes when previously warded-off contents emerge, the patient will experience conflict and become anxious about them. For example, sometimes a patient's life goal will be jeopardized unless he rapidly masters some warded-off content. Under such circumstances, the patient may unconsciously decide that the benefits of facing the repressed contents, even though he is still anxious about them, outweigh the potential risks. Under such circumstances, the emergence of warded-off contents may be accompanied by considerable anxiety.

Now I am going to contrast the decision making hypothesis about how warded off contents emerge with the thrust hypothesis contained in traditional psychoanalytic theory.

In traditional theory it is assumed that the patient enters therapy consciously wishing to be relieved of his symptoms while unconsciously seeking to obtain infantile gratifications from the therapist. These unconscious impulses are assumed to have become fixated because during the patient's childhood they were either too severely frustrated, or because they were too indulgently gratified.

According to the traditional theory then, the patient exercises no control over his unconscious mental life. Despite the patient's conscious intents, he cannot help but work in opposition to the therapist's efforts. His behavior is motivated by powerful unconscious drives which seek satisfaction, and by defenses erected against these drives.

In traditional theory, the patient cannot lift his defenses. Therefore, he can only become aware of unconscious contents in one of two ways: one is with the help of the analyst's interpretations; the other is because the contents force their way into consciousness. The analyst increases the likelihood that the contents will thrust their way into consciousness by refusing to gratify the patient's transference demands. When these contents thrust their way into consciousness, they inevitably revive the anxiety and conflict which originally led to the repression of these contents.

At this point I want to say a few words about the pertinence of traditional theory to the work of contemporary psychoanalytically oriented practitioners. Few clinicians today work exclusively according to the theory of technique which Freud advocated in his Papers on Technique. Undoubtedly, if you are like many psychoanalytically oriented psychotherapists, your technique is influenced by both traditional and ego-oriented concepts. Nonetheless, concepts from traditional theory continue to play a prominent role in shaping contemporary ideas about the nature of human motivation, psychopathology and therapy technique. For example, the literature on the transference neurosis is based on the thrust hypothesis. Transferences and resistances are mobilized and come forth outside of the patient's control.

Let me further illustrate the centrality of the thrust hypothesis about how ward-off contents emerge in treatment by quoting from several contemporary psychoanalysts. Fenichel has written, if a content forces its way into consciousness because of its intensity, "the anxiety that first brought about the repression is mobilized again (Fenichel, 1943, p. 542)." And Bordin has described one fundamental assumption of psychoanalytic theory to be that "sooner or later the facilitation of regression inherent in the basic conditions (that is, of treatment) leads the patient's thoughts and affects to those impulses which are surrounded by conflict, and this in turn provokes anxiety and activates customary modes of reducing anxiety (defenses) which consist of ways to interrupt the experience of blocking off awareness of ideas or the affects or both (Bordin, 1974, p. 10)."

To cite one more example of the thrust hypothesis, let me quote from Chessick's book, How Psychotherapy Heals: The Process of Intensive Psychotherapy: "We begin by interpreting resistances and defenses. This tends to mobilize unconscious conflicts; in addition the 'therapist attitude' leads to regression and also mobilizes the unconscious conflicts. Such mobilization leads to anxiety and the patient 'feels worse'. Then the content of the conflict is interpreted, allowing the ego to further integrate the unconscious material, and the patient 'feels better'. We then revert to the original procedure (Chessick, 1969, p. 73)."

From these quotations it can be seen that the thrust hypothesis continues to be prominent in contemporary writings about how ward-off contents emerge. It is true that the conflicting idea, that patients have unconscious wishes and capacities to master and control their mental life is hinted at in such ego propositions as that "regression may take place in the service of the ego" or that the "ego may be to the id like a strong rider to his horse". But these ideas are inconsistently applied. This is not surprising, since, with the exception of Weiss' and Sampson's work, ego psychology notions have been at best merely tacked on to traditional psychoanalytic theory. The theoretical contradictions that are thus created have gone largely unaddressed.

There is yet another reason that clinicians are highly influenced by the thrust hypothesis. Practitioners are unlikely to make the observations necessary to disconfirm their assumptions. For naturally theories shape observations and vice versa. If one assumes that unconscious

contents come forth only as a consequence of their thrust unless interpreted, then if a content comes forth calmly, it would necessarily be assumed not to have been repressed earlier. When a patient calmly discusses new contents which might have been expected to have been repressed earlier, the traditional perspective leads to the post hoc assessment that such contents do not represent progressive exploration, but instead must inevitably be serving a defensive function, or were never repressed.

This kind of circularity in which observations are made to fit the theory has been implicit in the theory's usage. Because there are many dramatic instances in which patients do struggle when previously warded-off contents first emerge, such observations undoubtedly leave the clinician convinced of the inevitability of such a process accompanying the emergence of warded-off contents.

My point is vividly illustrated by certain quotations by contemporary psychoanalytic writers about how to understand a patient's talking calmly, without anxiety and without signs of intense conflict. Dewald, for example states: "if a patient expresses a particular feeling or attitude in consciousness, without significant manifestation of anxiety or difficulty in verbalization, the likelihood is that at that moment such an expression is serving more in the process of defense and that it hides or disguises a still more anxiety-provoking underlying content (Dewald, 1964, p. 201)." Similarly, Glover asserts, "after all, it is the function of the ego-system to resist, and indeed one of the indications that we must be on the outlook for resistances is the fact that no signs of resistance appear; e.g. the case of fluent associating (Glover, 1955, p. 33)."

Underlying these assertions is the belief that the presence of anxiety is proof that work on previously warded-off contents is occurring and conversely, that the absence of anxiety constitutes post hoc evidence that a patient is successfully defending against gaining awareness of warded-off contents.

Before going on to describe the formal research, I want to stress that doing this research required devising a method for identifying previously warded-off contents which did not contain the problem of circularity. Before I describe how we did this, let me briefly restate what the circularity problem is.

We had to come up with a way to identify previously warded-off contents where we did not use as evidence that they emerged following interpretation, or that they emerged with anxiety. So we had to devise a strategy whereby people would not have cues such as these about whether the patient was conflicted about the contents which emerged.

Now let us turn to the formal research. In this part of tonight's presentation, I shall begin by briefly restating the problem that has been the focus of investigation; I shall then describe the research design and the findings which we obtained. Finally I shall discuss the significance of these findings.

This research compares predictions from two theories about how warded-off contents, contents which a patient is unable to experience at one time, become conscious at a later time during psychotherapy.

The first theory is the traditional psychoanalytic theory. According to this theory, a person wards off mental contents because it would make him anxious to experience them. Once warding off, a person cannot exercise control over these contents. The patient cannot lift the defenses against them. Rather, the contents can only come into awareness because of their intensity, thereby causing the patient to experience anxiety. I have been referring to these ideas as the thrust hypothesis.

The second theory is that the patient wants to bring forth warded-off mental contents in order to master them, and that he will do this when he judges it to be safe to remember. When the patient, through a testing process, comes to believe unconsciously that it is safe to experience previously warding-off contents, the patient unconsciously decides to lift his defenses and allows the previously warding-off contents to emerge. Thus, in keeping with this view, the patient will at times be able to bring forth previously warding-off contents without becoming anxious, and without the analyst's prior interpretation. I have been referring to this as the decision-making hypothesis.

We have identified a three-part observation about the emergence of warding-off contents which traditional theory is unable to account for. The three-part observation that would not be possible to anticipate by traditional theory would be, that a patient is able, first, to bring forth previously warding-off contents without benefit of interpretation from the therapist; second, that he may do so without experiencing much anxiety; and third, that he may then maintain conscious control over these contents.

According to traditional theory, there would be only one way that a patient would consciously experience uninterpreted contents that had previously been warding off. That would be if they should break into consciousness because they had been intensified. Since traditional theory assumes that the patient has no control over his unconscious mental life, uninterpreted warding-off contents can only emerge in this one way.

Should the contents thrust their way into consciousness, the patient would be expected to come into conflict with them, and to experience anxiety, at least at the time of their emergence. Only under one circumstance could traditional theory explain the contents both emerging without interpretation and without anxiety. That would be if the patient successfully uses the defense of isolation. However, should the patient be employing isolation, he should not be able to maintain conscious control over the contents, that is, to experience their emotional impact and to link them up to other contents.

For these reasons, the three-part observation which I have described would disconfirm concepts central to the traditional theory.

Before describing the research methods used, let me briefly describe the case of Mrs. C., the case which our research group has been studying in great detail. Mrs. C. was diagnosed by her analyst as an obsessive-compulsive woman. When she began therapy she reported the following symptoms: sexual frigidity, a general inability to enjoy herself, and chronic tenseness.

The patient was treated by a highly experienced analyst from another city. The analysis was successfully completed many years prior to our research group's planning of this study. The analyst had no knowledge of any of the ideas which we have made the focus of this study.

Because the patient had agreed that her analysis could be used for research purposes, all of the analytic hours were audio recorded. Also, the analyst took unusually accurate and detailed process notes during each session.

Now I would like to describe the research strategy we used to test the evidence for the two competing theories which I have described. First, we needed to devise a method to identify emerging contents which were previously warded off. In doing so we had to meet the traditional psychoanalytic criteria that define warded-off contents as contents which have been previously unacceptable to the patient and consequently warded-off by defenses. Also, the method used had to avoid the circularity problem to which I referred earlier. We had to design a method to identify warded-off contents on bases other than whether or not they had been interpreted, and whether or not their emergence had caused the patient to experience anxiety.

By the employment of such a method for identifying previously warded-off contents, it becomes possible to test the proposition implied in traditional theory that warded-off contents only become conscious through interpretation or because they force their way into consciousness as a result of their increased intensity.

A novel method which would do this was devised by Professor Leonard Horowitz of Stanford University and Hal Sampson, Ellen Siegelman, Abby Wolfson, and Joe Weiss (1974). Their method was replicated in the present study with certain additional methodological refinements which I developed. The major procedural steps were as follows: (1) Two judges read the process notes of the first 100 hours. (2) All mental contents that emerged in hours 41-100 which were not expressed during hours 1-40 were identified.

Although the patient statements studied were derived from the process notes, they were checked against the verbatim transcripts. Only statements which were highly similar to the transcript versions were used.

Approximately 500 such statements were identified. One hundred statements were selected from the 500, which would be presented to the judges. The method used to select the 100 statements was as follows: All of the 500 statements which emerged for the first time during hours 41-100 were organized into groups of thematic contents. Ideas which comprised such families of thematic contents included those which the patient expressed towards key objects, e.g. family members, important friends, etc. and towards thematic concerns, e.g. acceptance-rejection, dominance-submission, fighting, sex, responsibility, etc. The statements subsequently selected for presentation were randomly selected from the families of thematic contents to be proportionate to the total number of statements found in each family.

The 100 statements selected were presented to 19 Experimental judges and 16 Control judges. Contained among these 100 statements were two statements which were presented two times. This was done in order to determine whether the same judge rated the same statement consistently at two different times.

The Experimental judges read the process notes of the first 10 treatment hours. They then examined the sample of new statements from hours 41-100. These judges were told, and I quote, "these statements come from hours 41-100. They appeared for the first time during these hours. Please read each statement. We want to know whether you think that the content had been warded off earlier. Use your clinical intuition to make this judgment, applying whatever criteria would lead you to call a content warded off. As one possible criterion, you might want to ask whether that content would have been acceptable to the patient during the first 10 hours of treatment. Other criteria may also occur to you. Feel free to apply whatever criteria seem pertinent (Horowitz, et al, 1975)."

Control judges were asked to rate the same 100 statements but they were not provided with the process notes of the first 10 sessions. In this way it was possible to compare the ratings which clinicians make on an a priori basis about what is likely to be warded off with the judgments which clinicians make on a case specific basis.

Aside from the use of uniform instructions, judges received no special training for the completion of this task. All judges were given limited background information about the patient, such as the patient's age and sex. The judges were all psychoanalytically oriented including psychoanalysts, other highly experienced clinicians, and several advanced trainees.

Judges were asked to rate the 100 statements on a five-point scale that indicated the degree of confidence they had that a content was previously warded-off. A rating of "1" indicated a strong belief that the content had not been previously warded off; a rating of "5" indicated a strong belief that the content had been previously warded off. Varying degrees of uncertainty were indicated by ratings of the intermediate values.

In order to identify which of the 100 new statements are judged to be previously warded off, the average of the ratings made by the 19 Experimental judges was obtained for each statement. Those statements on average rated 4 or higher on the 5-point scale were designated as previously warded off, and those statements rated 2 or lower were considered not previously warded off. The average of the ratings made by the 16 Control judges was also calculated, and the results of these two groups were compared.

It was found that the degree of interrater reliability between the Experimental judges was high. We compared the average ratings made by one half of these judges with the average ratings made by the other half. The correlation obtained was .90. We designated as highly warded off those statements which most everyone could agree had been previously warded off. Several additional studies were done which provided further evidence for the accuracy of the ratings made.

Part One of the study, the part I have already described, yielded thus a series of 13 statements which were rated highly warded off (i.e. which received a score of 4 or more). This method for identifying previously warded-off contents was then applied to study the competing theories of how such contents become conscious during treatment.

Two members of our research group, Marla Isaacs and Carol Drucker, had cataloged all the interventions which the analyst had made. We looked at each of the analyst's interventions to see if there was anything he had said prior to the hour that the warded-off content emerged, that in any way related to the ideas expressed in the patient's previously warded-off contents. We found that there was one interpretation made by the analyst that related to one of the previously warded-off ideas which the patient subsequently expressed. Twelve of the 13 statements emerged without any prior interpretation by the analyst.

We then studied these 12 statements to find out whether there was an increase in anxiety when they emerged. Suzanne Brumer of our research group applied three techniques for rating the patient's anxiety at any given moment in the treatment. The three techniques are: the Speech Disturbance Ratio which Mahl constructed, the Gottschalk-Gleser content analysis scale, and clinical ratings.

I shall describe each of these three measures before reporting our findings.

The Speech Disturbance Ratio of Mahl's investigates momentary anxiety in patients by quantifying aspects of how they speak. Disturbances in speech are identified. Examples of disturbances are sentence changes, stutters, tongue slips, intruding incoherent sounds, repetitions, omissions, and sentence incompletions. For any segment of speech a Speech Disturbance Ratio can be computed. This is done by establishing the ratio of speech disturbances to the total number of words spoken. Numerous studies have been conducted using the Mahl measure to assess anxiety and its correlate, in psychiatric patients. It has been found to be an objective approach to the quantification of anxiety, and a reliably discriminating measure.

The Gottschalk-Gleser content analysis scale is designed to assess immediate anxiety by measuring manifest anxiety-related verbal content. Six content categories have been identified, and phrases that focus on any of the following contents are viewed as evidence of the presence of anxiety in the speaker: mutilation, death, shame, guilt, separation and diffuse or non-specific anxiety. Since each of the six sources of anxiety are considered of equal importance, in any overall assessment of the magnitude of a person's anxiety, the subtypes are treated additively.

Any direct expression of the six types of anxiety is considered evidence that an internal state of anxiety has been activated. In addition, defensive and adaptive manifestations of anxiety are inferred when the speaker: (1) imputes anxiety or anxiety motivated behavior to other people, to animals or to inanimate objects; (2) repudiates or denies the affect and (3) reports the affect in an attenuated form.

Although there are a number of difficulties with this particular approach to measuring anxiety, there have been numerous studies which have shown the predictive validity of this scale. It has been shown to be reliable and there is some evidence of its validity.

The third method was to use clinical judges. They listened to segments of the audio recording of the analysis and rated the amount of anxiety which the patient was manifesting, using a five-point rating scale.

Interrater reliability was high for all three anxiety measures. A .91 reliability coefficient was found for the two judges who applied Mahl's Speech Disturbance measure. Four judges applied the Gottschalk-Gleser technique, and their interrater reliability was .80. Finally, a .74 interrater reliability coefficient was found for the six raters who made clinical judgments about the amount of anxiety the patient was expressing.

We applied the three techniques for measuring anxiety both to segments in the analysis where ward-off contents were emerging and to randomly selected segments chosen from the same block of hours.

Now to the findings. For all three methods used, it was found that there was no evidence that the patient was any more anxious when previously ward-off contents were emerging than at other times during the analysis. These findings were remarkable. They disconfirm the thrust hypothesis, a hypothesis which would cause one to expect that as ward-off contents finally break into consciousness, that conflict will be mobilized and anxiety heightened. Our findings are in direct conflict with this thrust hypothesis.

In the analysis of data based on Mahl's Speech Disturbance technique, an even more astonishing finding was obtained. Randomly selected patient statements were accompanied by considerably more anxiety than were previously ward-off statements. The difference was statistically significant at the .025 level.

This finding is indeed amazing. It is the very mirror image of the predictions of the thrust hypothesis. We found that the patient became less anxious at those times when warded-off contents emerged. This finding is consistent with the decision-making hypothesis, that the patient can unconsciously decide to lift a defense against a previously warded-off content, if he decides it is safe to do so and under such circumstances he may calmly express a previously warded-off content.

According to traditional theory, the only way a patient could calmly express a previously warded-off content would be if he were using the defense of isolation. That is, the patient might be calm because he does not allow himself to experience the meaning of his statement. For example, in the case that we studied, one of the previously warded-off contents which emerged in the psychoanalysis was the patient's statement that she recalls wanting to kill her brother. Is it possible that when the patient made statements such as this one, she blocked out of awareness any real understanding of just what it was she was saying and that, therefore, she kept herself from knowing the significance of the previously warded-off content.

In order to find out whether the patient was using isolation, we applied the Experiencing Scale to both previously warded off statements and to randomly selected statements.

The Experiencing Scale assesses the degree to which a patient focuses on his ongoing flow of changing feelings as they occur during psychotherapy, how he reflects about these feelings, and puts such observations to use for problem-solving purposes. This scale has been found "to be sensitive to shifts in patient involvement: this makes it useful for microscopic process studies (Klein, et al., 1970, p. 1)." The Experiencing Scale has been widely acclaimed as one of the most accurate bases for objectively studying how progressively a patient is proceeding in psychotherapy.

There are two kinds of scores which can be computed from the Experiencing Scale. One is the modal score, a score that characterizes the overall experiencing level of the therapy segment that is being studied. The other is the peak score which describes the highest scale level reached in the segment that is studied. In our research, we calculated both the modal and peak scores for segments in which previously warded-off contents emerged, and for random segments.

Four judges applied the Experiencing Scale to these segments. Their interrater reliability was found to be in the .70 range.

Our Findings:

It was found that the patient was not using isolation at those times when warded-off contents emerged. Quite to the contrary. Previously warded-off contents were rated significantly higher on the Experiencing Scale than were randomly selected statements. This means that the patient

was actually more involved with reflecting on the feelings she had associated with the warded-off contents than with the randomly selected contents chosen from her psychoanalysis. When the mode measure was used, the difference was significant at the .05 level; when the peak measure was applied, the difference approached significance and was at the .10 level of confidence. This data suggests that the patient was particularly involved in the analytic process at just the times when she was doing the progressive therapeutic work of allowing previously warded-off contents into consciousness.

The combination of findings which we observed contradicts the thrust hypothesis contained in traditional psychoanalytic theory. Traditional theory implies that when previously warded-off contents emerge, the patient becomes more anxious. Many contemporary psychoanalysts have stated just this. To cite one example, Dewald states: "initially, as a defense is reduced and the conflict comes to consciousness, there will be an increase of anxiety...the working through process involves this repetitive cycle of mobilization of conflict and anxiety (Dewald, 1964, p. 102)." Yet, we found that the very opposite is the case. When previously warded-off contents emerge, the patient is if anything, less anxious and less defensive.

We know of no way that traditional theory can explain this finding. The process of emergence of previously warded-off contents which we observed is incompatible with traditional theory. For it follows from traditional theory that previously warded-off contents can only emerge because of interpretation or because of their thrust. And if contents thrust their way into consciousness, the patient should either become more anxious or use isolation as a defense.

Our results are readily explained by our own hypotheses. For according to our hypotheses, the patient wishes to bring forth previously warded-off contents and to master them. The patient has the capacity to lift his defenses, even without interpretation and to bring such contents forth. Further, the patient works to reduce the danger of bringing forth such contents and often does reduce the danger by unconsciously testing the analyst. It follows from this perspective that in psychoanalysis and in psychotherapy generally, a patient can bring forth previously warded-off contents without their prior interpretation and without becoming anxious.