

**The Tendency to Neglect Therapeutic Aims in Psychoanalysis**

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**ABSTRACT**

In our theory and practice as psychoanalysts, we have a tendency to idealize and elevate process goals over therapeutic outcome. This tendency is problematic because it deprives us of a vital check and balance in our technique and can lead to an implicit pessimism about our ability to systemically evaluate and modify our theory of therapeutic action. This trend in analytic thinking is traced, and vignettes are presented to illustrate it. Speculations about the reasons for the tilt toward process goals and away from therapeutic goals are offered.

Psychoanalysis is under attack today by a wide range of critics who dispute its efficacy and condemn its length and cost. Our own attempts empirically to study exactly what we do—and how well—have been plagued by serious flaws in our methodology (**Bachrach, et al., 1991**). Many of our research programs, for instance, have not reliably demonstrated a strong correlation between the development of an analytic process and therapeutic change or clearly superior comparative long-term cures.

In addition, the qualitative methodology for validating our clinical propositions has come under intense scrutiny and criticism. Psychoanalysts' preferred method for substantiating clinical formulations has always been the case report. As critics such as Grünbaum (**1984**), Spence (**1987**), and Edelson (**1988**) have pointed out, this format and our general style of argumentation are riddled with epistemological and logical problems, e.g., arguing by appeal to authority or by tautology, the use of a priori reasoning, etc. As psychoanalysts, we are having increasing difficulty

defending our results and the logic of how we achieve them.

I believe that our critics are regularly aided by the presence of a "fifth column" within psychoanalytic theory and culture. This "enemy within" is a particular attitude toward therapeutic outcome and symptom relief that tends to make it harder than it might otherwise be to validate our propositions and defend our therapeutic efficacy. Specifically, I believe that as a result of a wide range of factors, psychoanalysts can become distracted from their focus on therapeutic change and symptom relief (outcome goals) in favor of a too-narrow focus on the goals of insight and other variables *within* the psychoanalytic situation (so-called "process goals"). Our reluctance to use therapeutic improvements—or a lack thereof—as important signposts guiding our technique has complex and justifiable determinants, but if this hesitation about focusing on outcome becomes extreme, we leave ourselves open to the charge that our claims to truth are solipsistic, immune to refutation, and self-justifying.

In its extreme form, this tendency can create disturbing tensions and confusions. Analysts want to cure their patients but tend to regard this therapeutic ambition as a potential obstacle in their work. If viewed with too much suspicion, however, therapeutic ambition can be suppressed so much, and therapeutic gains or stalemates granted so little bearing on technique, that the analyst can lose an important source of feedback with which to measure the validity of his or her interventions. The fact that patients can get better in nonanalytic therapies and can get worse over long periods in good analytic treatments can lead to a potentially exaggerated tendency to regard a patient's symptomatic improvement as independent of the analytic process.

The issue here is clearly one of degree, for analysts have long known that there is not a simple linear relationship between the analytic process and therapeutic outcome. As Bibring (**quoted in Wallerstein, 1965**) acknowledged, "A procedure and its results have, in a certain sense, to be treated independently: for different

procedures often have the same or nearly the same results; or a procedure may not lead to any success ...'" (p. 763).

The tendency to treat therapeutic progress as only an inevitable *by-product* of good analytic technique and to view outcome goals as secondary to "process goals" leads to several potential problems. First, the analyst is deprived of a variety of evidence that can confirm or disconfirm his/her working hypotheses and technical approaches. Second, ignoring such patient-specific information may tend to weight the analyst's clinical theory in the direction of received authority. And third, opportunities for the exploration of alternative clinical strategies that might enhance the efficacy of psychoanalysis are needlessly limited.

However, even if one agrees that there are potential problems associated with an undue "tilt" among some analysts away from therapeutic aims, one is immediately confronted with the enormous complexity and confusion that surround defining, assessing, and interpreting outcome in any form. What does it mean to say that a patient is "getting better"? How does one measure it? Who decides? Using whose values? There is clearly no consensus among analysts about what constitutes a good analytic process, much less a good therapeutic outcome, and the methodological problems in assessing change and its relationship to technique are daunting. All analysts struggle with these issues. Some (e.g., Weiss and Sampson, 1986) have attempted to correlate outcome variables with specific therapeutic strategies, while others have written about the importance of using therapeutic stalemates as particular spurs to changing technique (e.g., Renik, 1990, 1992).

In spite of the fact that most analysts are concerned with these issues, and against the background of the methodological difficulties in thinking about outcome, there continues to be a tendency to turn away from a rigorous attempt to keep therapeutic outcome in our analytic cross-hairs and, instead, to focus more and more on those small units of intra-analytic behavior that can be studied. I am suggesting that a persistent effort to use outcome

as an important source of validation for our propositions and technique is needed, even if the methodology for doing so is problematic. In the discussion that follows, I hope to show that the potential costs of failing to do so are too high. The data to be presented will consist of several public discussions of clinical material presented in scientific meetings. Since the bias I am discussing is a tendency and not a theoretical or technical position, it cannot be "proven" to exist. Instead, I will attempt to paint various portraits of this bias in my vignettes, which I hope will be recognizable to the reader. I will then trace some of the currents and tensions in our literature about therapeutic versus analytic aims in order to suggest that this antitherapeutic bias in practice can claim sponsorship in theory, even if one could argue that this represents a *misreading* of the theory. And finally, I hope to suggest several factors in addition to the methodological ones mentioned above that might have contributed to this attitude toward cure.

### **THE ANTITHERAPEUTIC TILT IN PRACTICE**

At a recent meeting of a local analytic society, a male analyst presented his work with a depressed and underemployed female patient. The patient had an intense, erotic transference to the analyst, which frequently led her to masturbate in the analyst's bathroom after the sessions. The analyst described his—and the patient's—understandings of the complex meanings of these transference fantasies and enactments. His interpretations were sophisticated and sensitively conveyed, and our discussion group contributed our understandings of the case as well. At the end of the discussion the presenter mentioned, almost incidentally, that the patient's depression and marriage problems were unchanged and that he had recently referred her to both a psychopharmacologist and a vocational counselor for help with these symptoms.

The point I am making is not simply to note that the analyst's formulations and interpretations had not helped the patient with her symptoms, but to underline the fact that this was not mentioned by the presenter, except as an afterthought, nor was it information sought by the seminar participants. The formulations of the treating analyst and of our group might well have been correct. But it was clearly crucial to try to explain the fact that they did not help the patient, and yet this was not addressed—not by the treating analyst or by the conference participants. There was no sense in the group that anything was missing.

On the one hand, this might legitimately be viewed as simply a bad case conference in which intellectualized insight was isolated from affect, or insight had not been internalized by the patient because of unanalyzed resistances. However, my experience of the discussion was that the presenter and the group were distracted from a focus on the therapeutic impasse by the vividness of the sexual fantasies and behavior within the transference, a phenomenon that I believe is more common than we would like to admit. Elegant and complex case formulations are often presented and discussed, focusing on the nuances of the transference/countertransference matrix, without consistent regard to whether the patient's symptoms are being addressed. It sometimes appears as if we can share the work-appropriate satisfactions of *understanding* the dynamics of a case more comfortably than the satisfactions of helping the patient get better in his or her outside life. Further, the possibility that we might be able to discern causative connections between our interventions and outcome variables, offering us a method of validating our propositions, is not adequately exploited. Despite the difficulty in evaluating the scope and meaning of therapeutic outcome, analysts should nevertheless consistently attempt to use it as a means of validating technique.

At a recent scientific meeting of experienced analysts, an analyst presented a paper in which he argued that when a patient's perceptions and theories about us conform to our own sense of

ourselves and our technique, we are more likely to overlook the important transference and/or resistance functions of those perceptions and theories. He argued that this oversight on the part of the analyst can convey an unspoken sense of permission and gratification that can interfere with analytic work. To illustrate this problem, he presented his work with a woman from a troubled family who used her analysis to make substantial therapeutic gains. The patient was eventually able to tell the analyst that she was gratified that his attention did not have to be earned. The analyst did not interpretively pursue or challenge this comment. Five years later, the patient returned with some new symptoms. Upon re-analysis, the analyst discovered that his patient had harbored an idealization of him during the first analysis and over the intervening years, an idealization that had been hinted at in her earlier expression of gratitude, but had not been analyzed because it conformed to the analyst's self-representation as nonjudgmental.

While the analyst acknowledged in his paper that this idealization was, in fact, a probable key to the patient's earlier therapeutic success and had been used as a source of comfort in the intervening years, he presented his failure to analyze it as a mistake, a blind spot that had limited the earlier effort and was a probable ingredient in the patient's later difficulties. He briefly explained how the idealization became absorbed into the patient's later symptoms, but he did not present the clinical data that led to this assertion. Although he was careful to caution the audience that "mistakes" are inevitable—and even useful—in clinical work, the audience could easily have been left with the impression that this particular "mistake" was problematic mainly *because it was not analyzed*. If it was left unanalyzed, it was—almost by definition—a problem. The various *process* goals involving maximum exploration of transference fantasies were incompletely attained and this was necessarily problematic. On the other hand, the patient had actually appeared to make good *therapeutic* use of the idealization. Since no clinical data were presented to suggest that either (1) greater therapeutic gains

could have been made had the analyst not made his "mistake," or (2) that the patient's later symptoms were causally related to this error, then it could easily appear as if the analyst were implicitly favoring an ideal of total understanding over that of therapeutic ambition. If the goal is mainly to understand, then a failure to do so is always suggestive of a problem.

The final vignette I will present involves a paper given to a local society meeting by a visiting analyst. The analyst was arguing strongly against certain recent interpretations of the working alliance. She felt that specific interventions outside the analytic frame which were intended to promote a working alliance detracted from a true analytic process. She gave, as an example, a candidate in her local institute who presented a case to her progression committee, a case in which the candidate reported that she had visited her analytic patient in the hospital after the latter had undergone cardiac surgery. The candidate justified the action with the clinical rationale that this had been necessary to maintain a working alliance.

The senior analyst presented this in her lecture as clear evidence of an action taken by an analyst that, to the speaker's mind, rendered the work nonanalytic. It might well have been the case that the training analyst had a great deal of evidence that the subsequent course of the analysis in question was grossly skewed and that the patient did not benefit from the work. Instead, she offered this example as *prima facie* support for her definition of analysis. She did not feel the necessity of presenting any evidence. The audience might have construed that it did not matter, at that moment, whether the patient got better, gained insight, etc. What seemed to matter was that the case did not conform to the *formal* requirements of an analysis.

This example highlights a phenomenon that can sometimes be seen in our field—a treatment is designated a "true" analysis by reference to certain formal parameters, derived from theory and a certain implied authority, and not necessarily related to what is occurring in the patient. In this case, for instance, a hospital visit might have been essential for the maintenance of

an analytic process—from the patient's point of view—and might have helped her move forward therapeutically. Again, this could reasonably be understood as simply a bad paper in which a claim is made without supporting evidence. However, other claims *were* supported with evidence in this case, and it appeared rather that the presenter felt the behavior in question was so "far out" that it warranted the judgment of nonanalytic on its face. Too often, one hears a case subtly criticized by virtue of pronouncing it "not an analysis." Although these judgments are sometimes based on the critics' prior experience with such cases, at other times it turns out that the analyst's technique falls short of an ideal derived mainly from theory, rather than from what is actually occurring in the patient's mind and life. In either case, there can emerge a reluctance to maintain an empirical and open-minded attitude toward the clinical consequences of deviations in technique.

These vignettes—highly selective accounts, subjectively filtered through my own sensibilities—are offered not as proof, but as suggestive or illustrative of an attitude that can often hover around discussions of clinical material and technique in our scientific meetings and training environments. This attitude suggests that therapeutic outcome is either mysterious and unpredictable (in which case we are on safer ground paying attention to micro-processes within the analysis), or else it is an inevitable and natural result of an analytic focus on the resistances to self-understanding (in which case we are most efficient if we singularly focus on insight within the analysis). In either case, there is a tendency, in the analyst's mind, to de-emphasize the functional importance of concrete therapeutic change in the patient's life in favor of the operational priority of deepening the patient's experience of the analytic relationship. Since most analysts would reasonably maintain that their primary professional purpose is to help the patient get rid of his or her symptoms, it seems more accurate to describe this phenomenon as a tendency in our attitude toward technique rather than a formal theory of technique. And yet, I believe that most analysts will

still recognize the kinds of intellectual and attitudinal "reflexes" toward cure that are illustrated in these vignettes. Thus, these reflexes, and what I believe to be the problematic attitudes and sensibilities that subsume them, continue to be operative in psychoanalytic culture.

This conceptual relegation of therapeutic ambitions to a secondary status at its worst leads to a caricature—interminable analyses that are preoccupied with the minutiae of the transference or countertransference relationship without regard to the patient's real life. This image of the endless analytic quest for knowledge unrelated to living has been pilloried—at times unfairly—by the popular media. Consider the portrait of the analyst, "Aaron Green," for instance, that emerges from Janet Malcolm's (1981) book, *Psychoanalysis: The Impossible Profession*. Green, clearly still quite symptomatic, confides to Malcolm that after fifteen years of analysis, he discovered that his most secret and formative wish, determinative of his personality, was to be a beautiful woman. This insight, given Green's continued psychological angst, is recounted by Malcolm in such a way as to make many readers cringe. The germ of truth, thought, in such a caricature of analysis was also invoked and criticized by Rose (1974), who said, "To understand everything to the point of doing nothing, rather than to understand enough to do something realistic, is a miscarriage of analysis" (p. 515).

Even in its more subtle manifestations, this idealization of process over outcome can sometimes hamper our ability to study how our technique helps people. We tend to be too suspicious of and estranged from empirical efforts to track and explain the change process. Of course, as I mentioned above, the outcome and process research that is available to us is often methodologically primitive and not reliably able to identify good cause and effect relationships between process and outcome. The effort to study the micro-relationships between our interventions and therapeutic changes is thus often stymied. We are left with a *theory* that encourages us to look exclusively at the current interaction within the analysis and leave the patient's

difficulties in his or her life to resolve themselves as a natural consequence of our work. The danger of this is that our approach can become too theory-driven and not responsive enough to the patient's actual need for help. As Freud (1893) once said, quoting Charcot, "Theory is good; but it doesn't prevent things from existing" (p. 13, n. 2).

## THE THEORETICAL BACKGROUND

While many analysts will recognize the presence of the tilt in our field away from the therapeutic, it is difficult to find justification for it in our literature. Generally, theories of psychoanalytic technique assume a link between process and outcome goals and thus cannot be seen as sponsoring an antitherapeutic bias. However, it is possible to trace a theoretical current within psychoanalysis from the beginning that could be interpreted as reinforcing such a bias. Sometimes this point has been made explicitly; other times, it is only implied. Sometimes, it appears as a warning against therapeutic zeal; other times, *knowing* is counterposed to *helping* as contradictory and analytic goals. And sometimes, the presence of this bias is evidenced only by the arguments raised against it.

I will attempt to document, with extensive quotations, the presence of this antitherapeutic bias in psychoanalysis and suggest that the appearance of this bias in practice is not simply an aberration of technique but could be seen as a logical, although distorted extension of one line of thought in our theory. Each individual quotation cannot be seen as sponsoring this tendency, but I believe that, taken as a whole, there is enough antitherapeutic sentiment in our literature to at least make its expression in practice seem theoretically comprehensible, if not explicitly dictated.

As with most controversies within psychoanalytic theory, Freud can be used as an authority for opposite sides of this conflict. He clearly believed that psychoanalysis was the most

ambitious of the psychotherapies and had the greatest chance of producing permanent and far-reaching characterological change in its patients. He stated that the aim of analysis was to bring about "permanent results and viable changes in its subjects" (1913ap. 329), changes that "under favourable conditions ... are second to no others in the field of internal medicine" (1917p. 256). Although he always understood that these changes were a *by-product* of analysis, he also was clear that the success of the treatment could be forfeited if the analyst "from the start takes up any standpoint other than one of sympathetic understanding" (1913bp. 140). On the other hand, Freud himself eschewed a strong motive to "cure" his patients, because of factors of both temperament and principle. In his polemic against the medicalization of analysis, for instance, Freud (1926) asserted that he, himself, had "no knowledge of having had any craving in my early childhood to help suffering humanity" (p. 253). Theoretically, he was adamant that any hint of therapeutic zeal or overt expression of physicianly sympathy or helpfulness could hinder the analytic task. His famous remark that "it is not greatly to the advantage of patients if their doctor's therapeutic interest has too marked an emotional emphasis" (1926p. 254) was entirely consistent with his discovery that the key to alleviating symptoms was to help the patient understand the unconscious conflicts that produced them and not to aim or aspire to eliminate the symptoms directly. Thus, in discussing the Little Hans case, Freud stated, "Therapeutic success ... is not our primary aim; we endeavour rather to enable the patient to obtain a conscious grasp of his unconscious wishes" (1909p. 120). In addition, it is well known that, with advancing age and experience, Freud began to counsel modesty about the extent to which profound therapeutic objectives could be achieved at all.

In the *New Introductory Lectures* (1933), he argued that the therapeutic ambition of some of my adherents has made the greatest efforts to overcome these obstacles so that every sort of neurotic disorder might be curable by psycho-analysis. They have endeavoured to compress the work of analysis into a

shorter duration, to intensify transference so that it may be able to overcome any resistance, to unite other forms of influence with it so as to compel a cure. These efforts are certainly praiseworthy, but, in my opinion, they are vain. They bring with them, too, a danger of being oneself forced away from analysis and drawn into a boundless course of experimentation (p. 153).

Culminating in his essay, "Analysis Terminable and Interminable" (1937), Freud's therapeutic conservatism and caution set the stage for later theorists to define the ideal analytic attitude as incompatible with therapeutic ambition.

Freud's model was simple and powerful. Symptoms and neurotic suffering were caused by unconscious conflict. The goal of psychoanalysis was to cure the patient's symptoms. The means to this goal was insight and understanding—making the unconscious conscious. Therefore, the most important focus of the analyst was to increase the patient's self-understanding; symptom relief would be a necessary by-product. Deliberate attempts, such as those proposed by Ferenczi, to increase the therapeutic efficacy of the technique were misplaced, according to Freud, because they substituted authoritarian manipulations for the slower, but more permanent, increases in self-awareness that were the goal of proper psychoanalytic technique. The analyst's overall goal was still to cure the sick, but the operational goal was to increase the patient's conscious awareness and insight with the faith that the overall goal would naturally follow. An analyst's wish to cure or to be therapeutic was thus both asserted and cautioned against. Wallerstein (1965) described this as a paradox between

goallessness (or desirelessness) as a technical tool marking the proper therapeutic posture of analytic work and the fact that psychoanalysis differentiates itself from all other psychotherapies, analytically oriented or not, by positing the most ambitious and far-reaching goals in terms of the possibilities of fundamental personality reorganization. In regard to the first side ... Freud and classical analysts following him have been

most explicit; the analyst analyzes; the patient gets where he wants, and can (p. 749).

In the decades following Freud's death, many analysts have addressed the issue of the merits of therapeutic intent and outcome in psychoanalytic technique. On one side of the question, various authors have inveighed against the dangers of therapeutic zeal, reformist passions, and impulses to cure and heal. Sharpe (1950) stated:

The desire to cure, educate and reform, useful and valuable enough when employed in certain environments with specific people, is not the motivating power that produces the most efficient psychoanalyst. Cure and re-education, or stated more analytically, psychological readjustment, happens as a result of the analytical process. It does not occur because of the analyst's desire to cure and reform, but because of his understanding and ability to deal with his patient's psychological mechanisms (p. 116).

Greenacre (1948) singled out undue therapeutic zeal for criticism when she cautioned the analyst who "has too great a stake in the patient's recovery, not actually for the patient's sake but for the analyst's own comfort, either for prestige gain or even for the feeling of power in curing" (p. 622). Eissler (1963), in discussing a case vignette, argued that "a principle such as 'Nothing succeeds like success' has no place in a psychoanalytic approach. If anything, the patient's success prevented her from ever taking a further step on that road of: know thyself" (p. 461).

Modern writers have added their voices to this tradition of skepticism and caution about the place of therapeutic ambitions in the analytic attitude. Grinberg (1980) argued against the tendency to "'saturate' the development of the analytical relationship with the aprioristic idea of 'leading' our patients to achieve the 'therapeutic goals' which we had already fixed for them from the very beginning" (p. 25). Skolnikoff (1990), in defining the difference in stance between the psychotherapist and the

psychoanalyst, described the difference as one in which the therapist aims to *help* and the analyst to *understand*. Oremland (1991) asserted that "the psychoanalytic orientation attempts to understand" and "not offer the promise of relief, healing, or cure (medical concepts) or salvation (a religious concept)" (p. 11). Schafer (1983) seemed to be arguing against therapeutic zeal when he reminded us that "analysts do not view their role as one of offering or promising remedies, cures, complete mental health, philosophies of life, rescue, emergency room intervention, emotional Band Aids or self-sacrificing or self-aggrandizing heroics... It is more than likely that each of these alternatives to a primarily interpretive approach manifests countertransference" (p. 11). Brenner (1976) takes the position that "'to analyze' can only mean to help a patient to know himself better. Any other form of psychotherapy is not analysis... It may be even more successful than analysis in some cases, but it is not psychoanalysis" (p. 49). Joseph (1979) summarized the general position around which these authors clustered as follows:

Another approach to the therapeutic effectiveness of psychoanalysis is to state that therapy is not the goal of psychoanalysis. Rather, it is a procedure designed to explore mental life in depth and to extend the range of understanding of mental processes. Anyone undertaking psychoanalysis should understand that goal and, to the extent that it is achieved, has gained from the experience regardless of any therapeutic benefit (p. 73).

Effectiveness, symptom relief, therapeutic aims—these are byproducts of analysis, but, for some, do not define its essential goal, or, for most, the operational intent of its practitioners.

This position can be seen in various forms in other theoretical traditions. Bion's aphoristic paper, "Notes on Memory and Desires" (1967), attempts to elaborate on Freud's discussion of the analyst's attitude of evenly hovering attention by advising the analyst to approach each session without "memory, desire or

understanding." The most powerful desire that Bion believes interferes with the analyst's ability to "hear" the unconscious of his or her patient is the desire to "cure" the patient. The Lacanians have explored and made centrally important the danger of the analyst's enacting the role of "the one who knows," an alienated transference authority with whose projected desires the patient can defensively identify, much as he or she did with the original object. For Lacan, the desire to "do good" functions as an alibi covering a misuse of authority with which the patient, out of a need for love, defensively complies. As Lacan (1977) said:

So we have now reached the cunning principle of the power that is even open to a blind direction. It is the power to do good—no power has any other end—and that is why the power has no end. But it is a question here of something else, it is a question of truth, of the only truth, of the truth about the effects of truth (p. 275).

Further evidence of the prevalence of this kind of critical attitude toward therapeutic cure can be adduced from the passionate counterarguments that this attitude provoked. In the 1960's Leo Stone and Ralph Greenson, among others, made important contributions to broadening the psychoanalytic theory of technique, and sought to incorporate certain noninterpretive activities of the analyst and relational dimensions of the clinical encounter into the realm of acceptable analytic technique. One aspect of this liberalization of technique included a strong defense of the centrality of the analyst's desire to heal the analysand, relieve his or her suffering, and achieve therapeutic aims. Stone (1961), for instance, described what he believed was the unfortunate legacy of traditional technique—the fact that "'only to analyze' or an equivalent phrase became a sort of catchword or slogan for the definition and circumscription of the analyst's function, and often, by implication, of his personal attitude" (p. 28). Stone (1984) argued, instead, that the analyst's basic attitude should primarily be a physicianly commitment to

the relief of the patient's suffering. He summarized his view of the problem in the following way:

Now as to the therapeutic purposes of psychoanalysis: I cannot give serious recognition to any conception of psychoanalytic practice in which these purposes are not the primary and central consideration of the analyst, however highly developed his other interests, including scientific interest, may be... Our knowledge and our methods were born in therapy. I know of no adequate rational motivation for turning to analysis—and persisting in it through its deeper vicissitudes—other than the hope for relief of personal suffering (p. 425).

In his now-classic book on technique, Ralph Greenson (1967) argued against what he, like Stone, saw as a legacy of rigidity when it came to the role of therapeutic ambition in psychoanalytic technique. He complained that "from time to time in the psychoanalytic literature one gets the impression that the wish to relieve a patient's misery is fundamentally antagonistic to analyzing and understanding his problems ... at other times it seems that analysts are more concerned with preserving the purity of psychoanalysis than with improving their therapeutic results" (p. 404). Greenson, himself, took a clear stand on behalf of therapeutic ambition:

Freud's attitude notwithstanding, I contend that the therapeutic intent in the analyst is a vital element in his makeup if he is to practice psychoanalysis as a method of treatment... In my personal experience, I have never known an effective psychoanalytic therapist who did not feel strongly a desire to relieve the suffering of his patients. I have met M.D. psychoanalysts who were essentially misplaced researchers or data-collectors, and their therapeutic results were below expectations (p. 404).

Stone and Greenson were clearly grappling with the difficult issues involved in understanding the role of therapeutic aims in psychoanalytic technique. Although they were not specifically arguing that therapeutic improvements, or the lack thereof, should be used as a barometer of the correctness of analytic

technique or propositions, they were certainly in the forefront of those analysts who sought to place the wish and intent to heal at the center of our professional ambition.

Many other analysts have also contributed to this project. My attempt to trace the theoretical roots of and debates over the role of therapeutic aims in psychoanalysis deliberately neglects those authors, past and present, who argue that therapeutic and analytic aims completely coincide in a well-conducted clinical analysis. Freud (1926), after all, reminded his readers that "in psycho-analysis there has existed from the very first an inseparable bond between cure and research" (p. 256). Most modern analysts would probably subscribe to a theory of technique that assumes such a synthesis. As Weinshel and Renik (1992) put it, there is likely a manifest analytic consensus that "no distinction can or need be made between investigation of the analysand's self-observational difficulties and investigation of his psychopathology," and that "insight into the manner in which the analysand interferes with his self-examination is also insight into the causes of his pain" (p. 97). Sophisticated analysts are clearly concerned with the complex relationships that exist between process and outcome and certainly should have no need to defend the extent to which they care about their patients' welfare, work toward the alleviation of their symptoms, and are thoroughly convinced, on the basis of experience, that the best route to that end lies in attending primarily to the process goals of expanding the patient's self-awareness and capacity for self-inquiry (see also Boesky, 1990).

Notwithstanding this manifest consensus, there continues to be a tendency within analysis to split off and subtly devalue the therapeutic aims of analytic work. The hints of skepticism and distrust toward therapeutic ambition that run through some of our literature, with the concomitant elevation of intra-analytic process goals over outcome goals, continue to be influential in our field. The fact that this imbalance occurs as frequently as it does in spite of a theoretical position that promotes the simultaneity of understanding and cure is itself an important phenomenon

worth explaining. In other words, while almost all analysts would share Weinshel and Renik's assertion that analysis should always primarily serve therapeutic aims, we still see evidence of confusion over or neglect of these aims in practice. Almost by definition, then, this is a tendency that is easier to see in others than in oneself. It is also tempting to attribute this bias *only* to inexperience or to a misunderstanding of proper analytic technique. However, even if this were true, I believe that this misunderstanding is prevalent enough in our professional culture, and consistent enough with certain theoretical traditions, to deserve to be identified and debated.

### **FACTORS CONTRIBUTING TO AN ANTITHERAPEUTIC BIAS**

It seems likely that there are many sources of this tendency to de-emphasize the role of therapeutics. I have already mentioned the significant methodological problems that all of us face in our attempts to use outcome criteria as a source of validation of our technique. Freud, by temperament and by theoretical conviction, embraced a spirit of scientific rationalism that sought to strip away illusions, whether they appeared as self-deceptions in a patient or as the mysticism behind religious faith. From the standpoint of theory, one of the ways that Freud courageously broke with prevailing medical/therapeutic approaches to the treatment of mental illness was to substitute *understanding* for strategies at symptom elimination that relied on direct suggestion and/or physical and somatic manipulations. Gay (1988) sees in Freud's various self-appraisals a consistent image of the "researcher more interested in science than healing" (p. 278). As my earlier discussion of Freud indicated, this negative attitude toward therapeutic aims always conflicted with the desire to cure illness. According to Gay, even while a medical student, Freud confessed to Eduard Silberstein that his greatest wish in life vacillated between "a laboratory and free time ... with all the

instruments the researcher needs" and "a large hospital and plenty of money, to curtail some of the evils which befall our bodies" (p. 26). Notwithstanding this ambivalence and a formal theory of psychopathology that explicitly sought to combine analytic and therapeutic aims, it could be argued that the current within Freud's thought and temperament which regarded helping as secondary to knowing and which posited the image of the analyst-as-surgeon contributed to a certain bias that still exists today. So-called classical technique, implying a special fidelity to Freud, is often equated—with approval or disdain—with this identity of the psychoanalyst/scientist as opposed to the psychoanalyst/healer.

The debate over the relative weight to be given to process versus outcome goals inevitably became embroiled in psychoanalytic politics and conflicts over what constituted "true" psychoanalysis. In the 1950's, for instance, Franz Alexander claimed that he had improved his therapeutic results by strategically altering certain elements of the analytic frame, thereby providing a "corrective emotional experience." In the ensuing years, these ideas were hotly debated within American psychoanalysis, debates that have since been rekindled in various forms in response to other challenges to so-called "classical" technique **(for the relevant history, see Wallerstein, 1990)**. At no point during the debates over Alexander's controversial technique, did his critics seriously engage him in print about his claims that this technique produced superior results. The arguments were purely theoretical and focused exclusively on the question of what differentiated "true" psychoanalysis from mere psychotherapy. Alexander's claims to results were simply irrelevant compared to his claims that his means were psychoanalytic. The main interest of Alexander's critics was in establishing the error of his ways, and not his goals. In this spirit, Gill **(as quoted in Wallerstein, 1990)** wrote:

I think that there is little doubt that Alexander is correct in stating that by overt behavior toward the patient one can more

quickly get him to change some aspects of his behavior. But what is the meaning of such a change? It is an adaptation to this particular interpersonal relationship—as it exists between patient and analyst. *But this is not the goal of analysis.* The goal of analysis is an intrapsychic modification in the patient ... (p. 296, italics added).

Gill's argument here, echoed by many other analysts at the time, was that only one very particular analytic technique could produce intrapsychic modifications that were durable and, therefore, if a divergent technique appeared to demonstrate therapeutic results, these results had to be suspect. As far as I have been able to determine, clinical material was never seriously presented as evidence for these claims. Although undoubtedly derived from clinical experience, these arguments tended to read as if they were theory-driven and based on notions of analytic purity. A prescribed and proper technique leads to good and durable results. Considerations of results should never, therefore, significantly alter the definition of good technique.

Within certain sectors of American psychoanalysis in the post-World War II era, debates over "correct" technique were often passionate enough to result in ideological splits. Most analysts are familiar with this history and the extent to which irrational and heated conflicts over loyalty and authority rendered the debates more religious than scientific in nature. This history also suggests how psychoanalytic and institutional politics may have contributed to skewing our interest away from outcome and cure. Analysts might, at times, be tempted to elevate the process of analysis over therapeutic outcome because it is in the analytic *process* that we can define our professional and ideological boundaries, and establish what makes our approach unique and distinguishes us from other therapists, as well as from other analysts. It is in our need to distinguish our analytic approach from others within our own profession—often from within our own institutes—that the danger of losing sight of our primary goal of helping the patient arises. When loyalties to Freud, to

other authorities in our institute and field, to our own teachers and training analysts, lead to an exaggerated need to define who practices "true" psychoanalysis and who does not, then there is a heightened tendency to focus on small differences in one's formal theory of technique and neglect the real results and outcome of that technique. In this discussion, it should be clear that I am attempting to describe an institutional or group phenomenon that has at times marked our field and not a primary intention of individual analysts.

An additional factor underlying this attitude toward cure is the doubt that some analysts have about the extent to which cure is even possible. There is an understandable, although not necessary, tendency to increase one's emphasis on intra-analytic processes and decrease one's focus on extra-analytic change in proportion to one's disillusionment about the therapeutic effectiveness of analysis. Freud certainly took various positions over the course of his career about the limitations of his method, including the dark assessment at the end of his life in "Analysis Terminable and Interminable" (1937). Various historical periods have witnessed expressions of extreme optimism as well as more cautionary voices. Weinshel (1990) has traced the gradual movement within the psychoanalytic theory of technique away from "the myth of perfectibility" to the more modest and "relative" goal of helping the patient develop more adaptive compromise formations. Weinshel argued that "a conspicuous therapeutic overoptimism must reflect not so much an idealization of Sigmund Freud, as an overidealization of psychoanalysis as a therapeutic instrument" (p. 277).

It can sometimes be seen, however, that while modesty is essential to the effective functioning, as well as temperament, of the analyst, it is also possible for modesty about outcome to function to inhibit our openness to change and improvements in our technique. In other words, if therapeutic outcome remains our primary goal, and we find ourselves frustrated or disappointed in the results that our technique yields, this conflict *could* productively confront us with the opportunity and need to

re-evaluate and improve our technique, and not simply challenge us to work through and accept the reality of our limitations. I believe that too often this frustration with results can lead us back to a study of the process, to an idealization of that process, and we miss a potential opportunity to improve our clinical theory and practice.

This is an extremely complex issue and my treatment of it begs the important questions of what constitutes change, what are the differences between focusing on short-term and long-term change, and the serious problems that Weinshel rightly points out of idealizing the therapeutic power of analysis and our own narcissistic investment in that power. However, it is also possible to argue that what is reasonable caution for one analyst is, for another, a resignation about analysis which can inadvertently justify a rigidity of technique.

Psychoanalysts aim to help their patients with their suffering. They bring to this task a theory of the mind and a theory of how the analytic process will help their patients overcome their symptoms. Various pressures—ideological, psychological, and social—have often weighed heavily on these therapeutic intentions and subtly shifted them, in practice, toward an imbalanced and often exclusive emphasis on the study of the complex dynamics within the analytic encounter and the formal requirements of this encounter. It is certainly crucial to understand and theorize about intra-analytic processes. However, I have tried to illustrate the ways that, as psychoanalysts, we can sometimes lose sight of and neglect our primary goal of helping patients solve the problems that bring them to treatment.

## **SUMMARY**

There is a tendency in our theory and practice as psychoanalysts, to idealize and elevate process goals over therapeutic outcome in psychoanalysis. At times, we tend to retreat from our manifest goal of helping to alleviate our patients' suffering under

the banner of studying and interpreting aspects of the analytic process. This tendency creates problems because it deprives the analyst of a vital check and balance on his or her technique, namely, the fact that a patient's therapeutic improvement, or lack thereof, should be one indicator of the validity of our formulations and technique. In addition, it tends to lead to a relatively pessimistic attitude about our ability to improve our technique, since improvements are often regarded with caution or skepticism.

I have attempted to trace the origins of this attitude in psychoanalytic theory by a review of certain writings of Freud's and other notable historical figures who have cautioned against therapeutic zeal or ambition. Modern writers have also written in this spirit, although more often it is assumed that, as analysts, we simultaneously seek to expand our patients' insight *and* cure their symptoms. It is interesting that, despite this theoretical axiom, there continues to be a tilt within our field away from a focus on therapeutic aims. I have presented three illustrative vignettes to try to illustrate how this "tilt" is manifested in practice and how it can unnecessarily confuse or inhibit our efforts to help our patients. Finally, I have suggested that complex theoretical, institutional, and social factors have contributed to the antitherapeutic bias within some of our circles.

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