

The Second Century of Psychoanalysis

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The topic here is the second 100 years of psychoanalysis. This topic is certainly not modest. It requires us to attempt to predict the future from our knowledge of the past and present.

Obviously we cannot expect to see 100 years ahead. We cannot even expect to see 10 years ahead. Moreover, our ideas about where we are going inevitably are highly subjective. They reflect our particular vantage point, which is shaped by our particular assessment of what is useful and progressive in the present and recent past.

My attempts at prognostication are unabashedly subjective and will no doubt reflect my wishes as well as my expectations. I make my predictions from my own vantage point, which has been shaped by a particular psychoanalytic theory and the research based upon this theory (Weiss, 1993a, 1993b; Weiss, Sampson, & The Mount Zion Psychotherapy Research Group, 1986). So before attempting to look into the future, I briefly present this theory and one relevant research investigation. This theory is distinctive in its ideas about unconscious mental life, psychopathology, and therapy.

UNCONSCIOUS MENTAL LIFE

The theory, developed by my collaborators and me, assumes that a person unconsciously performs many of the same kinds of functions that he performs consciously. He thinks, assesses reality, and develops beliefs about it. He makes decisions, carries out plans, and regulates his unconscious mental life in accordance with his decisions and plans.

A person unconsciously controls his repressions. He keeps a particular mental content repressed as long as he unconsciously assumes that his experiencing it would endanger him, and he brings it forth when he unconsciously decides that he can safely experience it.

The assumption that a person unconsciously makes use of his higher mental functions finds support in current research done by academic cognitive psychologists. For example, Lewicki, Hill, and Czyzewska (1992; Lewicki, 1986) demonstrated that a person can make inferences from complex data nonconsciously that he cannot make consciously.

PSYCHOPATHOLOGY

The unconscious mental life theory proposed by my collaborators and me holds that psychopathology is rooted in cognition. A person's problems stem from maladaptive (pathogenic) beliefs about himself and his interpersonal world. These beliefs are acquired, often nonconsciously, in infancy and early childhood by inference from traumatic experiences with parents and siblings. They are concerned both with reality and morality. They are maladaptive in that they warn the person guided by them that if he attempts to reach certain adaptive, desirable goals, such as a successful career or a satisfying relationship, he will put himself in danger. He may expect to hurt someone he loves or be hurt by him, or he may expect to develop severe guilt, shame, fear, remorse, or self-torment. For example, a person may suffer from the belief that he does not deserve happiness; that if he is assertive, he will hurt others or be rejected by them; or that if he attempts to experience his sexuality, he will be punished.

THE PSYCHOANALYTIC PROCESS

The concept of the analytic process presented here follows from this theory. It is the process by which the patient works with the analyst at the task of disproving his pathogenic beliefs. A person suffers from these beliefs and so is highly motivated to disprove them. He works to disprove them by testing them with the analyst. He carries out trial actions and observes the analyst to determine whether the analyst behaves as the beliefs predict or whether, as the patient hopes, the analyst does not. (For example, a patient who believes he should be rejected may test this belief by threatening to stop treatment, hoping that the analyst will urge him to continue.) Also, he makes use of the analyst's interpretations to become aware that he is guided by certain beliefs that are false and maladaptive.

After the patient experiences the analyst as passing a test or offering an interpretation that he can use in his efforts to disprove his pathogenic beliefs, he

may take a small step toward disproving them. He may feel safer and less anxious. Also, because he maintains his repressions in obedience to his pathogenic beliefs and the dangers they foretell, he may become slightly more insightful, less inhibited, and less defensive.

The patient in analysis unconsciously develops a simple plan that tells him which problems to tackle at any one time and which ones to defer. In developing the plan, the patient is concerned with avoiding danger. For example, a certain patient, during the beginning of her treatment, felt endangered by her belief that she must comply with the analyst lest she hurt him. Therefore she decided to work at disproving this belief. She tested it by repeatedly disagreeing with the analyst and was reassured when he did not seem to be hurt by her doing so.

A RESEARCH STUDY

I participated in a study led by George Silberschatz (Silberschatz, Sampson, & Weiss, 1986) that was designed to determine why a patient, Mrs. C., persistently made unconscious transference demands on the analyst. We hypothesized from our understanding of Mrs. C.'s psychopathology that Mrs. C. made these demands to test the analyst and that this testing was an effort to disprove her pathogenic belief that she could push him around. It was assumed that Mrs. C. acquired the belief in her omnipotence from childhood experiences with fragile parents whom she easily dominated.

We tested this hypothesis against a hypothesis developed by another group of investigators who subscribed to the theory presented by Freud in *Papers on Technique* (1911–1915). (Freud's 1911–1915 theory assumes that mental life is determined by the dynamic interaction of impulses and defenses. This interaction takes place automatically in accordance with the pleasure principle, uncoordinated by unconscious purpose or plan. Freud's 1911–1915 papers cannot accommodate unconscious control, feeling, or planning.) The other investigators, after studying the transcripts of Mrs. C.'s analysis, hypothesized that Mrs. C. made transference demands on the analyst to gratify certain unconscious impulses. We could test the two hypotheses against each other because they made different predictions about how Mrs. C. would feel when the analyst did not yield to her demands. We assumed that Mrs. C. would feel anxious while testing the analyst, fearful that he would fail the test by yielding to her demands and that she would feel relieved when she observed that he did not yield. In contrast, the investigators who subscribed to Freud's (1911–1915) theory hypothesized that Mrs. C. would feel frustrated when the analyst did not yield to her demands and so would become more tense.

Silberschatz's first step was to locate in the transcripts of the first 100 sessions of Mrs. C.'s analysis a list of all interventions in which Mrs. C. made a powerful unconscious demand on the analyst (Silberschatz et al., 1986; Weiss et al., chap.

18). He then honed this list so that it would include only those demands that fit the criteria of both hypotheses—that is, demands that could be construed either as attempts to gratify an important unconscious impulse or as attempts to test an important pathogenic beliefs. He did this by having the investigators who subscribed to our hypothesis identify the instances in which Mrs. C. was attempting to test an important pathogenic belief and by having the investigators who subscribed to the hypothesis based on the Freud's (1911–1915) theory identify the instances in which Mrs. C. was attempting to gratify an important unconscious impulse. He then selected for further study those interactions that satisfied both groups of judges.

Silberschatz et al. (1986) studied the patient–therapist interactions in the overlap group by having several other sets of judges rate the therapist's responses to the patient's unconscious demands. He asked judges who subscribed to Freud's (1911–1915) theory to rate each analyst's response for how well the response frustrated the patient's unconscious impulses. He asked judges accustomed to thinking in terms of our hypothesis to describe how well each response passed Mrs. C.'s tests. This procedure enabled Silberschatz to correlate the findings of the two sets of judges and thus to demonstrate that the analytic responses thought of by one set of judges as frustrating Mrs. C.'s impulses were thought of by the other set of judges as passing her tests.

Silberschatz et al.'s (1986) next task was to assess how Mrs. C. responded to the analyst's nonyielding responses by determining how her behavior changed from just before such a response to just after it. He did this by asking a new set of judges to rate segments (from the transcripts) of Mrs. C.'s speech from just before and from just after each of the analyst's responses. The speech segments were rated by scales designed to assess Mrs. C.'s levels of boldness, anxiety, relaxation, and loving feelings. The judges were blind as to whether a segment came before or after an analytic response and as to which analytic session it came from.

Silberschatz et al. (1986) then calculated the shifts in the patient's behavior from before analytic responses to after them by comparing the preanalytic response segments and the postanalytic response segments. He found that when the analyst did not yield to Mrs. C.'s unconscious demands, Mrs. C. became less anxious, bolder, more relaxed, and more loving. (We assume that Mrs. C. became more loving because she appreciated the analyst's responses.) These findings are statistically significant and they demonstrate that Mrs. C. was not frustrated but relieved when the analyst did not yield to her demands.

This study illustrates the importance of formal quantitative research for deciding the validity of competing hypotheses. In this study each team of investigators assumed on the basis of their theory and their clinical experiences that their hypothesis was predictive. Clinical discussion between the teams could not resolve the differences. Such resolution was possible only by careful formal quantitative research designed to test the one hypothesis against the other.

THE PAST AND THE FUTURE OF PSYCHOANALYSIS

From my perspective, certain parts of Freud's early theory (1911–1915) developed at the beginning of this century are just as important today as when Freud first proposed them. Other parts, however, have not passed the test of time. They have not been useful clinically and have not found support in formal empirical research such as the Silberschatz study described here.

Among Freud's enduring contributions are his discovery of the existence of unconscious mental functioning, repression, infantile sexuality, and the importance of early life experience (including trauma) for later development. Also of enduring importance is Freud's discovery that dreams have meaning. Finally, of great importance is Freud's discovery that patients, by free-associating, will reveal *significant unconscious material that, with the help of the analyst's interpretations, can be made conscious and that the whole process could lead to the patient's resolving his problem* (Freud, 1900, 1911–1915).

UNCONSCIOUS MENTAL FUNCTIONING

Not enduring, and indeed greatly modified by Freud himself, is the conception of unconscious mental functioning that Freud proposed in his early writings. The unconscious mind as Freud conceptualized it in *The Interpretation of Dreams* (1900) could not accommodate thought, belief, inference, or the capacity to assess reality. Indeed, Freud thought of the unconscious mind as functioning by entirely different principles than the conscious mind. He thought of it as consisting of psychic forces, namely impulses and defenses, that interact dynamically in accordance with the pleasure principle. Nor in Freud's early theory (1900, 1911–1915) is the unconscious mind capable of anything resembling logical thought. In it both ideas and mental images are connected by the principles of the primary process—that is, by the displacement and condensation of mental energies.

In his late writings as part of his ego psychology, Freud gradually evolved a new conception of the unconscious mind. According to these new conceptions, a person unconsciously performs many of the same kinds of functions that he performs consciously. He can unconsciously think, test reality, and make and carry out decisions and plans (1940, p. 199). He exerts some control over his repressions (1940, p. 199). He has a powerful wish to solve his problems (1920, pp. 32, 35; 1926, p. 167), and he may work with the therapist to accomplish this (1937, p. 35). Also, he may suffer unconsciously from profound feelings of guilt (1940, pp. 179–180).

Unfortunately, Freud's new ideas have not been as influential as they deserve to be. They were developed in passages concerned with theory scattered throughout Freud's late works and were not applied clinically. The theory of technique

presented in *Papers on Technique* (Freud, 1911–1915) remained the basis of analytic work. The new ideas were assimilated to the early theory of technique without changing it organically.

The theory that I propose here has systematically applied Freud's late ideas of unconscious mental functioning to clinical work. Indeed, it has made these ideas the basis of a theory of technique (Weiss, 1993b).

PREDICTIONS

From the vantage point of my own views, I assume the idea that the patient can do unconsciously many of the same kinds of things that he does consciously will become widely accepted and that its implications for technique will be further developed.

Freud's early theory of unconscious mental functioning is even now much less influential than it once was. It is not much invoked today, for example, either in cognitive psychoanalytic theory or in self psychology. However, these theories make little use of the concept of repression. This is a loss which I hope will be corrected. As research has demonstrated (Weiss, Sampson, & The Mount Zion Psychotherapy Research Group, 1986; Weiss, 1990; Weiss, 1993a, 1993b), a person does repress mental contents that he assumes would endanger him, and he brings them forth when he unconsciously decides that he can safely experience them. I predict that in the future the concept of repression will continue to be a significant part of psychoanalytic theory.

THE PURITY OF PSYCHOANALYSIS

The concept of analytic purity includes the idea that the analyst should be neutral (i.e., impartial) when confronting the patient's unconscious conflicts. This idea is based on Freud's early theory of the mind (1900; 1911–1915). In this theory, all impulses and defenses are on the same level of the psychic hierarchy. (That this is so is implied by the idea that impulses and defenses are additive and that they interact dynamically.) The analyst's task (in the early theory) when confronted by a patient's unconscious conflict is to make both sides of the conflict conscious, thereby giving the patient the opportunity to resolve the conflict. The analyst must remain neutral so as not to influence the patient in his efforts to resolve the conflict.

In Freud's late theory (1920, 1926, 1937, 1940) and the theory proposed here, all motives are not on the same psychic level; nor is impartiality prescribed. Rather, the analyst should support the patient's efforts at mastery. Consider, for example, the analyst's task, when, as he conceptualizes it, the patient is testing him by threatening to quit treatment as part of his effort to assure himself that the analyst

will not reject him. The analyst's task here is to pass the patient's test by indicating to the patient that he should continue treatment. The patient in this instance would experience neutrality as rejecting. Instead of helping the patient to feel safe, it would contribute to his feeling endangered.

In the early days of analysis, at the beginning of this century, analysis was seen as an activity quite different from ordinary human activity. Analysts assumed that because they had discovered a new dimension in human psychology, the *Unconscious*, and because they were acting on the patient's Unconscious solely by interpretation, they were doing something quite unlike anything that had been done before. With their new kind of therapy, analysts assumed that they had eliminated from their repertoire the familiar, common ways in which one person helps another.

The theory proposed here brings analysis closer to common sense and to ordinary human relationships. It assumes that, depending on the patient's pathogenic beliefs and methods of testing them, the analyst may help the patient in some instances by offering encouragement; in other instances by warning against danger; and in others still by giving advice, sharing information, offering protection, and so forth.

I predict that the analyst will bring back into treatment, and indeed consider essential, various well-known ways in which one person helps another. Also, I predict that the analyst of the future will be less constrained. He may, depending on the patient's pathogenic beliefs and ways of testing them, vary the frequency of the sessions, agree to call the patient at home, share his experiences with the patient, forgo the use of the couch, put less emphasis on free association, and so forth.

Another way of putting this is that the analyst will increasingly realize that he and patient are developing a significant relationship and that the experiences which the patient acquires in this relationship are essential to the patient's receiving help.

RELATION OF ANALYSIS TO OTHER FIELDS OF STUDY

At its inception, analysis had little contact with other disciplines. Analysts assumed that their work with the unconscious was so new and different that what they could learn from other disciplines was quite limited. Today analysts are beginning to realize that analysis is not so different from other human experiences and that analysts can learn from other disciplines. As I mentioned earlier, analysts can learn from the research of academic cognitive psychologists such as Lewicki et al. (1992; Lewicki, 1986), from the research of developmental psychologists such as Stern (1985) and Emde (1989), from evolutionary psychologists, from neurologists, from specialists in linguistics, from self-help programs such as *Alcoholics Anonymous*, and so forth. They also can learn from research carried out on the analytic process, such as the Silberschatz et al. (1986) study that I discussed earlier.

I assume that in the future analysis will have more and more contact with other disciplines and that research in other fields and in analysis itself will continue to enrich analysis. Perhaps psychoanalysis will evolve much as internal medicine evolved at the beginning of this century. Toward the end of the 19th century, lacking a solid research knowledge of disease, physicians turned for authority to prominent members of their field, such as Sir William Osler. Today, the ultimate authority for physicians no longer resides in the teachings of the prominent, but in the findings of research investigations. I predict that analysts similarly will turn more to research findings than to the pronouncements of influential authorities.

SUMMARY

In sum, I predict that psychoanalysis will shed its concern for purity. Analysis will accommodate the various common-sense ways that one person helps another. Analysts will become less constrained. Analysis will have more contact with other fields and that it will benefit greatly from research in related fields and in analysis itself.

REFERENCES

- Emde, R. N. (1989) The infant's relationship experience: Developmental and affective aspects. In A. J. Sameroff & R. N. Emde (Eds.), *Relationship disturbances in early childhood: A developmental approach* (pp. 33–51). New York: Basic Books.
- Freud, S. (1900). The interpretation of dreams. *S.E.*, 4, 1–338; 5, 339–627.
- Freud, S. (1911–1915). Papers on technique. *S.E.*, 12, 83–171.
- Freud, S. (1920). Beyond the pleasure principle. *S.E.*, 18, 3–64.
- Freud, S. (1926). Inhibitions, symptoms and anxiety. *S.E.*, 20, 77–175.
- Freud, S. (1937). Analysis terminable and interminable. *S.E.*, 23, 272–278.
- Freud, S. (1940). An outline of psycho-analysis. *S.E.*, 23, 141–207.
- Lewicki, P. (1986). *Nonconscious social information processing*. San Diego, CA: Academic.
- Lewicki, P., Hill, T., & Czyzewska, M. (1992). Nonconscious acquisition of information. *American Psychologist*, 47, 796–801.
- Silberschatz, G., Sampson, H., & Weiss, J. (1986). Testing pathogenic beliefs versus seeking transference gratifications. In J. Weiss, H. Sampson, & The Mount Zion Psychotherapy Research Group (Eds.), *The psychoanalytic process: Theory, clinical observations & empirical research* (pp. 267–276). New York: Guilford.
- Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.
- Weiss, J. (1990). Unconscious mental functioning. *Scientific American*, 262(3), 103–109.
- Weiss, J. (1993a). Empirical studies of the therapeutic process. *Journal of the American Psychoanalytic Association*, 41(Suppl.), 7–29.
- Weiss, J. (1993b). *How psychotherapy works: Process and technique*. New York: Guilford.
- Weiss, J., Sampson, H., & The Mount Zion Psychotherapy Research Group. (1986). *The psychoanalytic process: Theory, clinical observations & empirical research* (pp. 267–276). New York: Guilford.