

Psychoanalysis and Psychoanalytic Psychotherapy: Is There a Meaningful Distinction in the Process?

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The pluralism in models of development, pathogenesis, and technique and the expansion of the applicability of treatment that characterizes the current psychoanalytic scene further erode the traditional criteria for psychoanalysis and the long-standing but increasingly fragile distinction between psychoanalysis and psychoanalytic psychotherapy. The purpose of this article is to delineate general features of the psychoanalytic process that are more encompassing of contemporary theoretical models and to use these features as criteria to explore if a meaningful distinction can be made between psychoanalysis and psychoanalytic psychotherapy. Following a brief historical review of the literature, I reassess on the basis of theory, research, and practice the so-called extrinsic and intrinsic criteria for psychoanalysis, and I conclude, from today's perspective, that a meaningful distinction with psychoanalytic psychotherapy cannot be made. I then arrive at what, in my view, are the fundamental features of the psychoanalytic process that can include all psychoanalytic approaches.

The pluralism in models of development, pathogenesis, and technique and the expansion of the applicability of treatment that characterizes the current psychoanalytic scene further erode the traditional criteria for psychoanalysis and the long-standing but increasingly fragile distinction between psychoanalysis and psychoanalytic psychotherapy. The criteria for assessing a psychoanalytic process continue to change, and it has become clear that the pluralism of models can only be housed under a most general definition of psychoanalysis. As more theory-based specificity is introduced into the definition of psychoanalysis, the definition becomes more exclusive and parochial, and, therein, potentially more politicized and less useful in reflecting accurately how psychoanalysis is practiced. With an

unachieved consensus on the most general criteria for psychoanalysis, it becomes even more difficult to approach the question as to a meaningful distinction between psychoanalysis and psychoanalytic psychotherapy.

With these limitations notwithstanding, the purpose of this article is to delineate general features of the psychoanalytic process that are more encompassing of contemporary theoretical models and to use these features as criteria to explore if a meaningful distinction can be made between psychoanalysis and psychoanalytic psychotherapy. I first present a brief historical review of the literature with regard to the criteria used for differentiating psychoanalysis and psychoanalytic psychotherapy. On the basis of theory, research, and practice, I reassess, from today's perspective, the so-called extrinsic and intrinsic criteria for psychoanalysis to determine if a meaningful distinction with psychoanalytic psychotherapy can be made. I then arrive at what, in my view, are the fundamental features of the psychoanalytic process that can include all psychoanalytic approaches.

HISTORICAL REVIEW OF THE DISTINCTION BETWEEN PSYCHOANALYSIS AND PSYCHOANALYTIC PSYCHOTHERAPY

The distinction between psychoanalysis and psychodynamic psychotherapy, later referred to also as psychoanalytic psychotherapy, principally occurred in the United States beginning in the mid-1940s (see Wallerstein, 1989). Robert Knight (1945/1972, 1952) led the way in developing a "dynamic psychology" based on the scientific contributions of psychoanalysis. He differentiated between two groups of psychotherapy—those aimed primarily at the *support* of the patient with suppression of erupting material and those aimed at *expression*. This became a general criterion for the distinction between psychodynamic psychotherapy and psychoanalysis. Supportive psychotherapy was the treatment of choice for those patients with the more severe psychopathology, and expressive psychotherapy or psychoanalysis was utilized for the neurotic patients who had the ego strengths to undergo structural or characterological change.

As pointed out by Wallerstein (1989) in his excellent review of these developments, Gill (1954), Rangell (1954), and Stone (1951, 1954) were the principle protagonists in the 1950s in defining psychoanalysis and distinguishing it from psychoanalytic psychotherapy. It was Gill's (1954) statement that was the most often quoted: "Psychoanalysis is that technique which, employed by a neutral analyst, results in the development of a regressive transference neurosis and the ultimate resolution of this neurosis by techniques of interpretation alone" (p. 775). The treatment of choice for Gill (1951) revolved around the "gross major decision [as to] whether the defenses of the ego are to be strengthened or broken through as a preliminary toward a reintegration of the ego" (p. 63), a decision based on whether

it was necessary and safe. Supportive psychotherapy became the treatment of choice for those patients too ill for analysis (Stone, 1954) and whose egos were unable to withstand the stresses of analysis (Gill, 1951). Rangell (1954) differentiated the two approaches technically on the basis of interpretation versus interaction. Bibring (1954) delineated five distinct technical principles: suggestion, abreaction, manipulation (i.e., a redirection of the emotional systems of the patient possibly through exposing the patient to novel experiences or "learning by experience"), insight through clarification (i.e., enhancing self-awareness in the absence of resistance), and insight through interpretation. Psychotherapies, including psychoanalysis, could be classified on the basis of their relative use of these principles, individually and in combination.

Twenty-five years later, in 1979, Gill, Rangell and Stone were invited to a symposium to update their views on the topic "Psychoanalysis and Psychotherapy: Similarities and Differences: A 25-Year Perspective." Although Stone's (1982) views remained relatively unchanged, he added a new dimension involving the nature of interpretation that occurs in each treatment. In psychoanalysis, interpretation, according to Stone, is focused on the transference neurosis; in psychoanalytic psychotherapy, interpretation is focused on the patient's current conflict and the relationship of such conflict to actual objects.

Of the three, Gill (1984a) had changed the most in his views. His work on transference led to his view that the interpretation of transference is *the* criterion for psychoanalysis. What is uniquely psychoanalytic, for Gill, is the interpretation of transference in the here-and-now. Gill (1984a) reviewed the "intrinsic criteria" for psychoanalysis, the same as set forth in his 1954 article: "the centrality of the analysis of transference, a neutral analyst, the induction of a regressive transference neurosis and the resolution of that neurosis by techniques of interpretation alone, or at least mainly by interpretation" (p. 161). He then assessed the "extrinsic criteria," which are "frequent sessions, the couch, a relatively well integrated patient, that is one who is considered analyzable, and a fully trained psychoanalyst" (p. 161). He concluded that none of the extrinsic criteria can validly delimit a psychoanalytic process, for "no universal meaning of any aspect of the analytic setting may be taken for granted" (p. 174). For example, "while the couch is ordinarily considered to be conducive to regression, it may enable an isolation from the relationship which has a contrary effect" (p. 174). Addressing the meanings frequency of sessions might have, Gill (1984a) stated:

It would seem obvious that one can accomplish more with greater frequency simply because there is more time to work. But if greater frequency is frightening to a particular patient, frequent sessions may impede the work despite interpretation. One cannot simply assume that more is better. ... Some take to it like a duck to water and can work despite infrequent sessions, while others never seem to find it congenial." (p. 174)

Gill's (1984a) overall emphasis is to "sharply narrow the indications for psychoanalytic psychotherapy and primarily practice psychoanalysis" (p. 163) with its centrality on the analysis of transference. Reacting to Gill's singular emphasis on the analysis of transference, Rangell (1981) called for a more balanced perspective, emphasizing that analysis of transference, although central, was not sufficient. He stated

The analyst hovers, equidistant not only from the three psychic structures but between intrapsychic and interpersonal, the internal and external world, past and present, transference and original objects. ... If a patient relates only to the analyst, or to external objects and not the transference figure, or if he speaks of the past and not the present, or only about sex, or only the deep unconscious without the daily and trivial, the needle has become stuck and needs a tap. (p. 678)

On the basis of his experience, Rangell asserted that

there is no analysis without its share of each of the technical maneuvers noted by Bibring (1954) [i.e. suggestion, abreaction, manipulation and clarification, along with interpretation]. ... There is no analysis without some of these mechanisms, which are not inadvertent but built-in and by design. (pp. 670-671)

His distinction between psychoanalysis and psychoanalytic psychotherapy became a quantitative rather than a qualitative difference—that is, it is based on the proportionality of these technical interventions with psychoanalysis involving more interpretive interventions.

RESEARCH FINDINGS

The most comprehensive and influential empirical study that has focused on the question of differences among treatment approaches with regard to interventions and therapeutic change is the Menninger Research Project, a longitudinal investigation of psychotherapeutic treatment along the entire expressive/supportive spectrum. Specifically, the study differentiated three treatment modalities: psychoanalysis, expressive psychoanalytic psychotherapy (what they called the "intermediate" form), and supportive psychoanalytic psychotherapy. Robert Wallerstein (1986) wrote up this project in *Forty-Two Patient Lives* (a massive volume of 800 pages), with a summary article in 1988.

In sharp contrast to prevailing psychoanalytic theory, the research team found that structural change cannot be linked to interpretation alone, for it occurred both in psychoanalysis and the more supportive therapies as well. On the basis of these findings, Wallerstein (1989) strongly questioned the usefulness of attempting "to link the kind of change so tightly to the intervention mode" (p. 587). According to

their research findings, "therapeutically induced change is at least proportional to the degree of achieved conflict resolution—though it is clear that there can be significantly more change than there is true intrapsychic conflict resolution, change brought about by all the varying supportive [measures]" (p. 587). Indeed, effective conflict resolution "turned out *not* to be necessary to therapeutic change." Many changes were brought about by the supportive therapies which in many instances were "quite indistinguishable" from the change brought about through insight. Supportive interventions tended to produce change—far more than was anticipated—and tended to be incorporated, with similar effectiveness, in the psychoanalyses and the more expressive psychotherapies. This study directly challenges the following traditional beliefs about psychoanalysis: (a) Structural change is brought about only through interpretation, working through, and insight; (b) structural change is brought about solely through conflict resolution; (c) supportive measures do not bring about structural change; (d) change brought about by supportive measures does not involve structural change and is, therefore, not as lasting; and, finally, (e) supportive measures do not occur within psychoanalysis.

These research findings support Rangell's claims that *all* of the technical measures are used in both psychoanalytic psychotherapy and psychoanalysis. Moreover, *all* of these technical measures are a source of therapeutic action in both psychoanalytic psychotherapy and psychoanalysis. These empirical findings, in conjunction with close readings of detailed clinical work (not easily found in our psychoanalytic literature, yet readily available in supervisory consultations), make it clear that our theory of technique in psychoanalysis has been far too narrow and has not included many of the facilitative interventions that occur in psychoanalysis as practiced. Indeed, I recall that, when in analytic training, I had difficulty grasping the distinction between supportive therapy and psychoanalysis, for it seemed to me that to be deeply understood—a psychoanalytic aim—was the most supportive measure of all.

THE CURRENT PSYCHOANALYTIC SCENE

Today psychoanalysis continues to undergo fundamental change in theory and technique. A paradigmatic transition from positivistic to relativistic science and, now for many, to hermeneutics has dethroned the analyst from a position of objectivity and a purveyor of interpretive "truth." Instead, the analyst is a co-participant in a complex interactional field, called a relational (Greenberg & Mitchell, 1983; Mitchell, 1988, 1992) or intersubjective field (Atwood & Stolorow, 1984; Stolorow & Atwood, 1992; Stolorow, Brandchaft, & Atwood, 1987). Although a fundamental psychoanalytic aim to understand the inner world of the patient remains unchanged, we now recognize that an analyst both interactionally affects the patient's experience and subjectively shapes his or her perceptions and understandings of the patient.

Early in the development of psychoanalysis, interpretation was juxtaposed with suggestion and used as a major criterion as to what was distinctly psychoanalytic (Freud, 1919; Glover, 1931, 1954; Jones, 1910/1918). All psychotherapies other than psychoanalysis were seen as entirely based on suggestion. Ironically, from today's relativistic perspective, *interpretations are essentially suggestions* (Fosshage, 1991; Gill, 1994; Stolorow, 1990)—that is, interpretations, in contrast to an “objective truth,” emanate from the analyst's subjectively organized perceptions and are offered to the patient as “suggested” understandings.

From a positivistic perspective interpretation was also juxtaposed with interaction, the latter tended to be viewed as a problematic countertransferentially induced enactment. Only when it became clear from a relativistic position that interpretations are not objective statements could it be realized that they, too, are actions or responses of the analyst, or fundamentally a part of the interaction (Fosshage, 1991; Gill, 1994; Namnum, 1976; Stolorow, 1990). The emergent model that best captures the analytic situation is an interactive systems model in which all of the analyst's intended and unintended, verbal and nonverbal responses are actions that enter into the interactional system (a host of authors have contributed to an interactive systems model; see Fosshage, 1995b). Within this model, interpretation and interaction are no longer dichotomized, for interpretation is a form of interaction.

Similarly, insight and relationship, traditionally divided within our theory of technique (Friedman, 1978), can now be viewed as “two aspects of a whole—that is, in analysis insight emerges within, is made possible, is shaped by ... gains its potency from the relationship” (Fosshage, 1995b, pp. 461–462), and, in turn, shapes the relationship.

EXTRINSIC AND INTRINSIC CRITERIA REASSESSED

In light of this very different psychoanalytic scene, I address the extrinsic and intrinsic criteria that have been used for differentiating psychoanalysis and psychoanalytic psychotherapy, focusing particularly on transference and technique.

The extrinsic criteria can be dealt with more easily. To reiterate, they are “frequent sessions, the couch, a relatively well integrated patient, that is, one who is considered analyzable, and a fully trained psychoanalyst” (Gill, 1954, p. 161). Psychoanalysts differ as to what frequency of sessions is needed for psychoanalytic treatment. Although the International Psycho-Analytic Association stipulates a requirement of four sessions per week to call an analytic treatment psychoanalysis, many psychoanalytic institutes require three sessions per week, and some even require two. Gill (1984a, 1994) went to the heart of the matter when he addressed the *meaning* the frequency of sessions has for the patient. Certainly more sessions provide more time for the work; yet, patients are quite individual as to how

effectively they work and as to what frequency is therapeutically facilitative. Some patients take to analysis, in Gill's apt description, "like ducks to water" on a once-a-week basis. Indeed, I was initially surprised to observe both in my own practice and in supervisory sessions an in-depth analytic process occurring with remarkable change on even a once-a-week basis. For other patients, analysis four times per week proves optimal. The frequency of sessions clearly can not be used as a meaningful, hard-and-fast criterion for assessing an ongoing psychoanalytic process.

In a similar vein, the couch, as Gill suggested, cannot be used as a criterion for psychoanalysis, for it depends again on its *meaning* to the patient. Whereas the couch for some patients facilitates tuning into their affective experience and fantasies, for others the couch deprives them of the requisite visual cues to more fully experience the analyst, needed in order to feel safe and to proceed with the analysis.

A relatively well-integrated patient is also no longer a criterion for psychoanalysis, for the applicability of psychoanalytic treatment has been extended to include the widest spectrum of psychopathology. Treatment is unique to each patient and does not appear to be limited by diagnosis. In addition to expanded theory and technical innovations, the adjunctive use of the much improved psychotropic medications has contributed to the more severely disturbed patients becoming amenable to psychoanalysis. The particular patient and analyst match is likely to be the most facilitative or limiting factor. In emphasizing the importance of the intersubjective system, Stolorow (1990) stated, "While there are doubtless some patients who could be analyzed only by the most gifted of analysts, I believe that, in principle, anyone with an intact nervous system is analyzable by *someone*" (p. 129).

The last extrinsic criterion, a "fully trained psychoanalyst," is also not problem-free. The distinction between psychoanalysis and psychoanalytic psychotherapy is made on the basis of whether the therapist has undergone formal training and has been certified as a psychoanalyst. In this way we attempt to formally structure and regulate our profession, a meaningful requirement for any profession. More and more therapists, however, are supervised to do psychoanalytic work. Depending on their skill level, we all know from our supervisory experience that some therapists without formal psychoanalytic training are quite capable of working analytically at a level commensurate with certified analysts. To be a certified psychoanalyst importantly regulates the profession, yet this cannot be meaningfully used to designate psychoanalytic work.

Let us turn to the intrinsic criteria by which psychoanalysis is defined. They are, in Gill's (1984a) words, "the centrality of the analysis of transference, a neutral analyst, the induction of a regressive transference neurosis and the resolution of that neurosis by techniques of interpretation alone, or at least mainly by interpretation" (p. 161).

Although the analysis of transference is commonly seen as a central task in psychoanalysis, opinion widely diverges as to the nature of transference and, correspondingly, to the task of how to effectuate its analysis—for example, promoting or not promoting the transference, exclusiveness of transferential focus, management of extratransferential material, and disclosure of our subjective experience. It is often claimed (Miller, 1991) that whereas the transference or transference neurosis is promoted in analysis, it is avoided in psychoanalytic psychotherapy; whereas the transference is central in psychoanalysis, conflicts with others are focused on in psychoanalytic psychotherapy; and whereas transference is resolved via interpretation in psychoanalysis, it is manipulated into a so-called transference cure in psychotherapy. Whereas suggestion is viewed as a primary mode of intervention for psychotherapy, interpretation is seen as the predominant mode for psychoanalysis and is used to overcome the “contaminant” of suggestion. (This latter distinction is negated with our understanding from today’s perspective that interpretation is a form of suggestion.)

Psychoanalysis is often said to promote a regressive transference neurosis, whereas psychotherapy either avoids the transference or is not sufficiently intense to create it. Despite considerable disagreement as to how transference differs from transference neurosis, those who make the distinction commonly hold that the difference is quantitative. Transference neurosis is usually seen as entailing a patient’s more comprehensive, intense, and persistent involvement with the analyst. However, if the difference is only quantitative, as Arnold Cooper (1987) argued, we should not use a terminological distinction that connotes qualitative differences. An intrinsically different type of transference should not be posited and used to differentiate psychoanalysis from psychoanalytic psychotherapy. Moreover, clinical experience clearly reveals that the intensity of transferential experience varies more according to patient, analyst, and treatment moment rather than to the frequency of sessions or a presumed distinction between psychoanalysis and psychoanalytic psychotherapy.

The recent reconceptualization of transference (including, among others, Fosshage, 1994; Gill, 1982; Hoffman, 1983, 1992; Lichtenberg, 1990; Lichtenberg, Lachmann, & Fosshage, 1992, 1996; Stolorow & Lachmann, 1984/85; Wachtel, 1980)—what Hoffman (19XX) called the social-constructivist model and what I call the organization model of transference—identifies transference as perceptual-cognitive-affective organizing activity. Organizing patterns or schemas are established on the basis of thematic lived-experience and serve as patterned ways of organizing one’s world. Transference, within the organization model, refers to the primary organizing patterns with which the patient constructs and assimilates the analytic experience. Transference, thus, is ever present in both psychoanalysis and psychoanalytic psychotherapy. In contrast to the traditional belief of promoting a regression in psychoanalysis, from the vantage point of the organizing model, we cannot promote or set in motion a linear regression to an earlier period in one’s life

(Stolorow & Lachmann, 1984/85), for primary organizing patterns are always potentially operative within a given context. In combination with motivational priorities and the current context, these patterns may become active in organizing the analytic relationship. Some of the analyst's actions will trigger specific schemas, whereas other actions will serve as the basis for the establishment of new patterns. Within a psychoanalytic process (no different for psychoanalytic psychotherapy or psychoanalysis), the principal goal is to affect the transference—that is, to help the patient to gain freedom from repetitive problematic ways of organizing his or her world and to form new more vitalizing attitudes or organizing patterns.

The principal procedure deemed for addressing the transference in psychoanalysis is interpretation—namely, the illumination, understanding, and explanation of the transference. Whereas interpretation occurs in psychoanalytic psychotherapy, it is often claimed that the transference in psychotherapy is frequently addressed through suggestion, support, and manipulation. In contrast, the Menninger Project demonstrated that all modes of intervention occurred in both processes and were similarly effective.

Moreover, the distinctions in technique among interpretation, suggestion, support, and manipulation, as we have seen, are not feasible. Interpretation, to reiterate, is suggestion, although it may be more subtly suggestive than what we usually think of as suggestion. What distinguishes interpretation from other forms of suggestion is that it includes an understanding and explicit explanation. An interpretation can also be supportive or not. For example, whereas interpretation is typically not aimed to support a defense, interpretation can be supportive of the patient's efforts to consolidate and maintain a positive sense of self. In addition, Bibring's (1954) view of manipulation, which for him did not carry a pejorative connotation, refers to experience that shifts the "emotional systems of the patient" and ranges from exposure of the patient to novel experiences, to "experiential manipulation" (cf. Alexander's "corrective emotional experience"), to "learning by experience" (pp. 747–759). Manipulation referred to an interactive, in contrast to an interpretive, form of intervention. From today's perspective, a *facilitative* interpretation is part of an interaction that exposes the patient to a novel experience, to a corrective emotional experience, and to learning by experience, or when using Bibring's definition, it is also a manipulation. Indeed, for interpretation to be effective, Kohut (1984) felt that it had to provide for the patient a *new experience* of being understood (see also Stolorow, 1993). As we have removed interpretation from its elevated status of objectivity, its suggestive, manipulative (i.e., a nonpejorative aim to shift "emotional systems"),¹ and potentially supportive aspects emerge, all of which

¹ Although *manipulate*, according to Webster's dictionary, can mean "to manage or utilize skillfully," its more pejorative meaning, "to control or play upon by artful, unfair, or insidious means especially to one's own advantage," is more common in today's psychoanalytic parlance (typically used to refer to patients' actions) and, therefore, is not used to refer to a viable technical intervention. Although we

provide a view of interpretation as far more multifaceted than previously thought. Because all interventions occur in what we have traditionally called psychoanalysis and psychoanalytic psychotherapy and interpretation has potentially suggestive, supportive, and new relational features, would it not be better to think in terms of a singular psychoanalytic process with analysts' actions varying according to patients' needs and analysts' predilections?

Some common examples of different forms of action follow. An analyst makes a suggestion pertaining to a patient's difficulty in sleep regulation or in dealing with a relationship (Frank, 1993; Lichtenberg et al., 1992). Yet, for such a suggestion to be therapeutic, it must convey an understanding of the patient's plight and either an implicit or explicit explanation. On another occasion, an analyst might more directly and spontaneously engage with the patient or, in a more reflective manner, interact with the patient by talking about the process that is occurring between them. A patient, for example, may ask a question. We may respond directly, which is one way of directly engaging with the patient, or we may respond by inquiring about the meaning of the question, which is interactively focusing on the process and encouraging reflection about it. Which approach will be facilitative differs, not according to assumed different treatment modalities, but according to the momentary interaction.

Technical neutrality, another intrinsic criterion for psychoanalysis, is riddled with problems from today's relativistic vantage point (Aron, 1991; Greenberg, 1986; Hoffman, 1991; Stolorow, 1990). The notion emanated from a positivistic perspective in which it was thought that an analyst could be objective and, therefore, neutral. Recognizing that the analyst always subjectively perceives the patient as well as variably impacts the patient makes clear that neutrality is an impossibility. Kohut noted (see Miller, 1985), for example, that analysts are invested, not neutral, in helping the patient—a position that is better to be open about with the patient. Convictions about how to help patients analytically differ considerably, and none can claim to be objective or neutral. In an attempt to redefine neutrality, Gill (1994) suggested that it is the analyst's awareness of the "influence of patient and analyst on each other and his attempt to make that influence as explicit as possible that constitute his 'neutrality'" (p. 50). Aron suggested that "in Piagetian terms the analyst's neutrality facilitates the equilibrium between assimilation and accommodation which enables optimal growth and adaptation" (p. 105). Although we are attempting to redefine this concept of neutrality to capture something of the analyst's stance, there is no reason to assume that this stance differs substantially for the psychoanalytic psychotherapist. Neutrality can no longer be used as a differentiating criterion.

would not use the term *manipulation* in the same way today, its referent, however, to novel and new relational (corrective emotional) experiences is increasingly seen by analysts as primary in therapeutic action.

THERAPEUTIC ACTION: TWO PATHWAYS

A group of self psychologists and intersubjectivists conceptualize transference as having two, variously described, fundamental dimensions (Fosshage, 1994; Lichtenberg et al., 1992, 1996; Stolorow et al., 1987), what I call the repetitive relational patterns and the selfobject experience seeking dimension. Stern (1994) recently referred concisely to these dimensions as the needed relationships and the repeated relationships. These dimensions are intricately related and, when taken in conjunction with interpretive and more directly supportive interventions, inform us of two different routes to psychological change. Schematically, facilitative interpretations of repetitive relational patterns create new perspectives and gradual freedom from rigid patterns of perceiving the world. The interpretive process, in addition, contributes to a needed relational experience of feeling heard and understood (a selfobject experience) that serves as the basis for the formation of new organizing patterns (structural change). Facilitative supportive interventions, in contrast, more directly provide needed relational experience that, in turn, serves as a basis for the gradual formation of new organizing patterns (structural change). New relational experiences, in addition, increase a person's awareness (insight) of old relational patterns and attitudes. Thus, psychological reorganization occurs along two different pathways: (a) interpretation leads to awareness of a problematic relational pattern (insight), to gradual freedom from the pattern, to new relational experience, and to psychological reorganization; and (b) an analyst's support (e.g., affirming comments) creates a new relational experience and, in turn, leads to awareness (insight) of an old pattern in juxtaposition with the new experience and to the gradual formation of a new organizing pattern. These different pathways to therapeutic change offers an explanation for the Menninger Project's findings that interpretive and supportive techniques lead to similar, indistinguishable, and long-standing structural change.

I am reminded of an incident that happened over 20 years ago with a patient who was entering psychoanalysis. During our first session the patient, a recent graduate in a mental health field, informed me that she was going on her first job interview that day. During our second session, 2 days later, the patient paused after the first 10 to 15 min and, out of my curiosity and what Goldberg (1990) labeled "ordinary human intercourse," I inquired as to how her job interview had been. What I considered to be a question emanating out of concern and interest could have been criticized for intruding with a nonanalytic remark, using suggestion, manipulating the transference, imposing my agenda, and so on. To my surprise, my patient broke down into tears. In our exploration, we discovered that my question about her job interview had been a question that her father would never have asked. My question conveyed to her a sense of acknowledgement and interest on my part that served as a profound beginning of a needed relational experience. This is an example of an interaction that created a new relational experience and, aided with analytic

inquiry, an increased perspective about an old relational pattern, all of which incrementally led to psychological reorganization.

Both interpretive and supportive techniques are utilized in what we have designated as psychoanalysis and psychoanalytic psychotherapy. Can their proportionality, as Rangell (19XX) suggested, be used to distinguish two treatment processes?

The distinction between interpretation and supportive measures was originally based on Freud's structural theory wherein the function of supportive measures was primarily to bolster the defenses. From the perspective of a self psychological model, interpretations and supportive measures are unified in attempting to help a person to develop and maintain a positive cohesive sense of self. Accordingly, the distinction is less pertinent. When a patient feels truly understood by an interpretation, the interpretation will be experienced as supportive. Conversely, a reassurance not anchored in a deeper understanding and attunement to the patient will not be experienced as supportive. This is why I had difficulty in understanding, when I was in analytic training, the difference between supportive and interpretative measures.

In my view, the proportionality of interpretive and more directly supportive interventions does not distinguish two treatment modalities (in keeping with the findings of the Menninger Project) and needs to be understood as variability within psychoanalytic work. The proportionality of interventions is related to other features within the interactive system, such as the variability in patients' styles and needs and in analysts' styles.

In conclusion, theory, research, and practice, in my view, indicate that the distinction between psychoanalysis and psychoanalytic psychotherapy cannot be feasibly maintained. Instead, we are viewing the variability within psychoanalytic process. The one reason for maintaining the distinction is to regulate our profession, requiring certification from an institute or perhaps from a general accrediting body for those who are not institute trained, for the practice of psychoanalysis. Based on these assessments, we can well understand the difficulty in reaching a consensus about the standards for our training institutes and psychoanalytic associations. Once a clinician is a certified psychoanalyst, however, I agree with Gill's (1988) sentiments that "the question of converting psychotherapy into psychoanalysis should rarely arise in the practice of a psychoanalyst because almost always he should be practicing psychoanalysis" (p. 262).

THE PSYCHOANALYTIC PROCESS

Although our theory of technique needs to include a far wider range of interventions to capture psychoanalysis as practiced, the question remains, What is distinctive about psychoanalysis and the psychoanalytic process?

The analysis of the transference traditionally has been central to psychoanalysis. In Gill's view, the analysis of transference is the criterion for assessing a psychoanalytic process. In my view, it is *a* central criterion. How we define transference is crucial in assessing it as a criterion.

Gill (1984a) defined transference as the patient's experience of the analytic relationship and proposed that the analyst *always* focus on the transference. When discussants of his book in the third issue of the 1984 *Psychoanalytic Inquiry* questioned the extremity of his position, he retreated minimally and said that the transference should "usually" be focused on (Gill, 1984b). Regardless of what the patient is saying, Gill recommended that we hear the content as transference, or, in other words, as applicable to the analytic relationship (see the case studies in Gill & Hoffman, 1982).

All of the patient's communications are clearly transference, when using Gill's definition, in that they involve the analytic relationship. Yet, what is crucial, in my view, is to differentiate between the *content* and the *process* of the communication (Fosshage, 1994). When a patient is describing, for example, a painful, shamed-filled experience of physical abuse, the patient at that moment is most likely not experiencing the analyst as abusive—that is, applying the content to the analytic relationship—but is probably experiencing the analyst as a safe, trustworthy person to whom he or she can communicate this painful material—that is, applying the process of communicating to the analytic relationship. To differentiate between content and process enables us to hear the importance of patients' other relational experiences and not to assume that the themes under discussion are necessarily occurring within the analytic relationship. Indeed, inaccurately assuming that a problematic organizing pattern emergent in a relationship outside the analysis is also occurring in the analytic relationship tends to rivet the patient to that particular pattern of experiencing the world. Because Gill's definition of transference does not include a patient's relationships with others, which also need to be analyzed, the analysis of transference cannot serve as *the* single criterion for psychoanalysis. In other words, transference, as defined by Gill, does not adequately depict our psychoanalytic domain of inquiry.

In my view, transference refers to the primary organizing patterns or schemas with which the analysand constructs and assimilates his or her experience of the analytic relationship (Fosshage, 1994). These organizing patterns operate within all relationships and, thus, can be usefully explored and understood wherever they emerge—that is, within the analytic and other relationships. The psychoanalytic aim is to illuminate these patterns and their genetic origins to enhance a patient's perspective and to foster gradual freedom from their dominance. *Transference* refers to the activation of primary organizing patterns within the analytic relationship. Analysis of transference, therefore, becomes *a* central, not *the*, criterion for psychoanalytic work. The analysis of organizing patterns, as they emerge within the patient's experience, is a more inclusive criterion for psychoanalysis. This

understanding of transference and organizing patterns counters Stone's (1982) differentiating thesis that interpretation in psychoanalysis focuses on the transference neurosis and in psychoanalytic psychotherapy on the conflicts with actual objects. From my perspective, we do both in psychoanalysis, for the organizing patterns and attendant conflicts emerge in both the analytic and other relationships.

Stolorow (1990) recently proposed three intrinsic criteria that define the essentials of the psychoanalytic process: (a) its central aim, (b) its investigatory stance, and (c) its distinctive domain of inquiry. The central aim of psychoanalysis is, in Stolorow et al.'s (1987) words, "the unfolding, illumination, and transformation of the patient's subjective world" (p. XX). This formulation is sufficiently broad to include all of the patient's experience as well as psychoanalysts of all persuasions.

Stolorow (1990) suggested, with his collaborators, that

the investigatory stance most likely to create a therapeutic situation in which this aim can be maximally achieved is best characterized as an attitude of *sustained empathic inquiry*—one that consistently seeks understanding from within the perspective of the patient's own subjective frame of reference. (p. 126)

Although sustained empathic inquiry, in my judgment, needs to be the primary investigatory stance, I propose that an additional investigatory stance can provide invaluable data about the patient.

I identified two primary listening/experiencing perspectives (Fosshage, 1995a): the empathic mode of perception (i.e., listening from within the perspective of the patient's frame of reference; self psychology's emphasis) and the other-centered listening vantage point (i.e., listening as-the-other in a relationship with the patient; frequently an emphasis in object relations and interpersonal approaches). Clinically all analysts *variably* use both listening vantage points. Whereas sustained empathic inquiry gives us direct access to an analysand's experience and is most effective in fostering a therapeutic situation, the use of both investigatory stances gives us access to a fuller range of an analysand's experience. For example, when self needs are in the foreground, the empathic mode in its singular focus on a patient's self experience is facilitative of self-cohesion. When a patient shifts to self-with-other concerns, listening and experiencing as the other in a relationship with the patient (the other-centered perspective) can provide needed information about a patient's relational experience (Fosshage, in press).

Stolorow (1990) assumed, like Gill, that "the distinctive domain of psychoanalytic inquiry, and the one in which its therapeutic action can be found, lies in the investigation of the patient's experience of the analytic relationship—the analysis of transference" (p. 126). To define transference as the patient's experience of the analytic relationship, which both Stolorow and Gill have done, limits our domain of psychoanalytic inquiry. Indeed, to focus so exclusively on the patient's experience of the analytic relationship will limit the full "unfolding, illumination, and

transformation of the patient's subjective world." I propose, as an alternative, that the distinctive domain of psychoanalytic inquiry is the patient's experiential world (which includes all of a patient's relational experience).

In summary, our theory, research, and practice all lead us away from a meaningful distinction between psychoanalysis and psychoanalytic psychotherapy. Instead, we need to focus on what is distinctly psychoanalytic. The pluralism of models of development and pathogenesis account for very different readings of the patient, yet a central aim is to understand the patient. I have proposed that the psychoanalytic investigatory stance involves inquiry based on a variable admixture of the empathic and other-centered listening vantage points. I have also proposed that the distinctive domain of psychoanalytic inquiry is not just the patient's experience of the analytic relationship, but the patient's total experiential world.

I close with my final remarks made at the 1990 Self Psychology Conference as a discussant of Jule Miller's (1991) paper, "Can Psychotherapy Substitute for Psychoanalysis?":

We are in the process of expanding and reconceptualizing analytic technique and recognizing that its application generally does not need to be restricted by [what has become known as the] extrinsic criteria. What's critical is not the differentiation between psychoanalytic psychotherapy and psychoanalysis, but the consistent application of expanded psychoanalytic technique within the work that we do as psychoanalysts, work designated as psychoanalysis. In this sense, psychoanalytic psychotherapy cannot be substituted for [or, I will add, converted into] psychoanalysis, it is psychoanalysis. (Fosshage, 1991, pp. 70-71)

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