■ 11 *continued*
not seem to fit many workaholics who find themselves patients in psychoanalysis. One could say that many of today's analysands have sublimated too extensively, and there is little energy left for intimacy and closeness in their personal lives. It might be better to leave this idea completely and conceive of people having conflicts in various areas of their lives; these conflicts may or may not affect other areas of their lives depending on the nature and intensity of the conflict.

rule most rigidly with those patients whose habitual manœuvre it is to shirk analysis by sheering off into the intellectual, and who speculate much and often with great wisdom over their condition, thereby sparing themselves from taking steps to overcome it. For this reason I dislike resorting to analytical writings as an aid to patients; I require them to learn by personal experience, and I assure them that in this way they will acquire wider and more valuable knowledge than the whole literature of psycho-analysis could afford them. I recognize, however, that under the conditions of institution treatment it may be very advantageous to employ reading as a preparation for patients in analysis and as a means of creating an atmosphere favourable to influence. ■ 12

The most urgent warning I have to express is against any attempt to engage the confidence or support of parents or relatives by giving them psycho-analytical books to read—either of an introductory or of an advanced kind. This well-meant step usually has the effect of evoking prematurely the natural and inevitable opposition of the relatives to the treatment, which in consequence is never even begun.

I will here express the hope that advances in the experience of psycho-analysts will soon lead to agreement upon the most expedient technique for the treatment of neurotic persons. As for treatment of the 'relatives', I must confess myself utterly at a loss, and I have altogether little faith in any individual treatment of them.

■ 12
At times, analysts have forbidden their patients to read analytic works. One can only say that such rules for analytic patients are counterproductive. In any case, Freud's admonition against the use of influence is a good one. Patients will lead their lives, and the analyst can only help them to lead a less conflicted life; hopefully, this will help the patient find more fulfilling alternatives for himself.

Further Recommendations in the Technique of Psycho-Analysis[1]

ON BEGINNING THE TREATMENT. THE QUESTION OF THE FIRST COMMUNICATIONS. THE DYNAMICS OF THE CURE.

(1913)

He who hopes to learn the fine art of the game of chess from books will soon discover that only the opening and closing moves of the game admit of exhaustive systematic description, and that the endless variety of the moves which develop from the opening defies description; the gap left in the instructions can only be filled in by the zealous study of games fought out by master-hands. The rules which can be laid down for the practical application of psycho-analysis in treatment are subject to similar limitations. ■ 13

I intend now to try to collect together for the use of practising analysts some of the rules for the opening of the treatment. Among them there are some which may seem to be mere details, as indeed they are. Their justification is that they are simply rules of the game, acquiring their importance by their connection with the whole plan of

■ 13
In chess, of course, there are voluminous writings on beginning the game, but in contemporary psychoanalysis, interestingly enough, the beginning of treatment has received relatively little attention.

[1]First published in *Zeitschrift*, Bd. I., 1913; reprinted in *Sammlung*, Vierte Folge. [Translated by Joan Riviere.]

the game. I do well, however, to bring them forward as 'recommendations' without claiming any unconditional acceptance for them. ■ 14 The exceptional diversity in the mental constellations concerned, the plasticity of all mental processes, and the great number of the determining factors involved prevent the formulation of a stereotyped technique, and also bring it about that a course of action, ordinarily legitimate, may be at times ineffective, while one which is usually erroneous may occasionally lead to the desired end. These circumstances do not prevent us from establishing a procedure for the physician which will be found most generally efficient.

■ 14
It is understandable that Freud should be ambivalent about whether to consider his writing recommendations or rules. On one hand, he wanted to stem the spread of what he considered to be "wild analysis," while, on the other hand, he did not want to stifle all new attempts at technical innovation.

Some years ago I set forth the considerations of chief importance in the selection of patients, which I shall therefore not repeat here,[2] since that time other psycho-analysts have confirmed their validity. I will add, though, that since then, when I know little of a case, I have formed the practice of first undertaking it only provisionally for one or two weeks. ■ 15 If one breaks off within this period the patient is spared the distress of an unsuccessful attempt at cure; it was only 'taking a sounding' in order to learn more about the case and to decide whether it was a suitable one for psycho-analysis. No other kind of preliminary examination is possible; the most lengthy discussions and questionings in ordinary consultation are no substitute. This experiment, however, is in itself the beginning of an analysis, and must conform to its rules; there may perhaps be this difference in that on the whole one lets the patient talk, and explains nothing more than is absolutely necessary to keep him talking.

■ 15
The trial analysis has largely been replaced by the preparatory analysis. The issue of diagnosis and analyzability is, however, still a topic that is quite current. Stone was one of the first of contemporary analysts to advocate and suggest how the scope of analysis could be widened. His criteria for analyzability differed from Freud's stated positions. In his writings on borderline patients, Kernberg has spoken most directly to ways in which one can conduct a diagnostic interview to determine the patient's analyzability.

For the purposes of diagnosis, also, it is an advantage to begin with a period of a few weeks designed as an experiment. Often enough, when one sees a case of neurosis with hysterical or obsessional symptoms, mild in character and of short duration (just the type of case, that is, which one would regard as suitable for the treatment), a doubt which must not be overlooked arises whether the case may not be one of incipient dementia præcox, so called (schizophrenia, according to Bleuler; paraphrenia, as I prefer to call it), and may not sooner or later develop well-marked signs of this disease. I do not agree that it is always possible to effect the distinction so easily. I know that there are psychiatrists who hesitate less often in their differential diagnosis, but I have been convinced that they are just as often mistaken. For the psycho-analyst, however, the mistake is more serious than for so-called clinical psychiatrists. The latter has little of value to offer either to the one type of case or to the other; he merely runs the risk of a theoretical mistake, and his diagnosis has but an academic interest. In an unsuitable case, however, the psycho-analyst has committed a practical error; he has occasioned useless expense and discredited his method of treatment; he cannot fulfill his promise of cure if the patient is suffering from paraphrenia instead of from hysteria or obsessional neurosis, and therefore he has particularly strong motives for avoiding mistakes in diagnosis. In an experimental course of a few weeks suspicious signs will often be observed which will decide him not to pursue the attempt further. Unfortunately I cannot assert that an attempt of this kind will invariably ensure certainty; it is but one more useful precaution.[3]

[2]'On Psychotherapy', Collected Papers, vol. i.

[3]There is much to be said on the subject of this uncertainty in diagnosis, on the prospects of analysis in the milder forms of paraphrenia, and on the explanation of the similarity between the two diseases, which I cannot bring forward in this connection. I should be willing to contrast hysteria and the obsessional neurosis, under the name of 'transference neuroses', with the paraphrenic group, under the name of 'introversion neuroses', in accordance with Jung's formula, if the term 'introversion' (of the libido) were not alienated by such usage from its only legitimate meaning.

Lengthy preliminary discussions before the beginning of the treatment, previous treatment by another method, and also previous acquaintance between physician and patient, have certain disadvantageous consequences for which one must be prepared. They result in the patient entering upon the analysis with a transference already effected, which must then be slowly uncovered by the physician; whereas otherwise he is in a position to observe the growth and development of it from the outset. By this means the patient gains a start upon us which we do not willingly grant him in the treatment. ■ 16

One must distrust all those who wish to put off beginning the treatment. Experience shows that at the appointed time they fail to return, even though their motive for the delay (that is, their rationalization of the intention) appears to the novice to be above suspicion. ■ 17

Special difficulties arise when friendship or acquaintance already exists between the physician and the patient, or their families. The psychoanalyst who is asked to undertake treatment of the wife or child of a friend must be prepared for it to cost him the friendship, no matter what the outcome of the treatment; nevertheless he must make the sacrifice unless he can propose a trustworthy substitute. ■ 18

Both the general public and medical men—still fain to confound psycho-analytic with suggestive treatment—are inclined to attribute great importance to the expectations which the patient brings to the new treatment. They often believe that one patient will not give much trouble because he has a great belief in psycho-analysis and is fully convinced of its truth and curative power; and that another patient will doubtless prove more difficult because he is of a sceptical nature and will not believe until he has experienced good results in his own person. Actually, however, this attitude on the part of the patient has very little

■ 16
In many analytic centers, it is difficult to have a practice if one doesn't see patients who have been in other forms of treatment or in other analyses. It is surprising how accurate Freud is when he reports that past transference reactions will endure in the present treatment. It is difficult to imagine that in 1911–1912 he saw many patients who had previously been to another analyst. Clearly some patients who came to see him had been in other treatment methods, and Freud could experience himself as a recipient of these continuing transference reactions. Here is another indication of how firmly the concept of transference is established in Freud's attempts at explaining clinical phenomena (see Part II).

■ 17
Mistrusting patients who want to delay the beginning of treatment is probably good advice statistically. I had always been impressed by this advice. Then a patient referred to me suddenly had the opportunity to

■ 17 *continued*
direct a play and had to delay the beginning of his treatment. A year later, I was surprised when this patient called and subsequently began treatment. The patient had felt he didn't want to begin when he couldn't give his treatment sufficient attention. This person proved to be someone who was quite dedicated to his treatment and for whom analysis has been beneficial. This is an example of how, even though Freud's observations are generally correct, one must remember the difference between clinical inference and statistical generalizations.

■ 18
This is an interesting comment given Freud's performing various analyses of people who became his friends and supporters. We also know that Freud analyzed his own daughter, Anna Freud. We must assume that he rationalized this undertaking by maintaining that he could not find a trustworthy substitute. It is my interpretation that Freud felt he could somehow be an exception to the workings of the unconscious. Despite Freud's actions, he has presented good advice, and his later experiences with Ferenczi attest to the difficulties of mixing friendship with an analytic relationship. Ferenczi presents his side of the analysis in his *Clinical Diary* (1988).

importance; his preliminary belief or disbelief is almost negligible compared with the inner resistances which hold the neurosis fast. A blissful trustfulness on the patient's part makes the relationship at first a very pleasant one; one thanks him for it, but warns him that this favourable prepossession will be shattered by the first difficulty arising in the analysis. To the sceptic one says that the analysis requires no faith; that he may be as critical and suspicious as he pleases; that one does not regard this attitude as the effect of his judgement at all, for he is not in a position to form a reliable judgement on the matter; his distrust is but a symptom like his other symptoms and will not interfere if he conscientiously carries out what the rule of the treatment requires of him. ■ 19

Whoever is familiar with the nature of neurosis will not be astonished to hear that even a man who is very well able to carry out analysis upon others can behave like any other mortal and be capable of producing violent resistances as soon as

■ 19
Freud is warning analysts not to be overly impressed with a patient's conscious attitude toward analysis. He maintains that a person's initial confidence in analysis is of little im-

■ 19 *continued*
portance in the course of his or her analysis. What are more crucial are the patient's internal resistances, which once encountered will shatter (or at least disrupt) the patient's initial confidence in analysis. The thinking involved in this formulation assumes that the analyst, to some extent, will confront the patient when a resistance is met. Freud's meaning of resistance in this context is anything that the patient utilizes to inhibit the flow of associative process. Counterbalancing the patient's reactions will be the confidence they will require if they carry out *what the rule of the treatment requires of* them, that is, continuing to free associate. This type of thinking leaves as unanalyzable the resistant patient who is unwilling or unable to conscientiously carry out what is "required" of him. Many patients cannot trust the analyst until the analysis has been going on for a long period of time. Some analysts have advocated changes in the analytic situation to enable these patients (whom Freud might have considered unanalyzable) to have successful analytic treatments. One can consider some of Greenson's, Stone's, Bach's, or Kohut's suggestions as ways of allowing certain patients to establish trust in the analyst and in the analytic process. Bach details the experiences of nonclassical patients in a manner that is useful for any practitioner who wants to gain a sense of the inner world of this type of patient.

he himself becomes the object of analytic investigation. When this happens it serves to remind us again of the dimensions which the mind has in regard to its depth, and it does not surprise us to find that a neurosis is rooted in mental strata that were never penetrated by an intellectual study of analysis.

Points of importance for the beginning of the treatment are the arrangements about time and money. In regard to time, I adhere rigidly to the principle of leasing a definite hour. A certain hour of my available working day is appointed to each patient; it is his, and he is liable for it, even if he does not make use of it. This arrangement, which is regarded as a matter of course for teachers of music or language among our upper classes, perhaps seems too rigorous for a medical man, or even unworthy of the profession. All the many accidents which may prevent the patient from attending every day at the same hour will be referred to, and some allowance will be expected for the numerous intercurrent ailments which may arise in the course of a lengthy analytic treatment. My only answer is: No other way is practicable. ■ 20 Under a less stringent régime the 'occasional' non-attendances accumulate so greatly that the physician's material existence is threatened; whereas strict adherence to the arrangement has the effect that accidental hindrances do not arise at all and intercurrent illnesses but seldom. One is hardly ever put in the position of enjoying a leisure hour which one is paid for and would be ashamed of; the work continues without interruptions, and one is spared the disheartening and bewildering experience that an unexpected pause in the work always occurs just when it promises to be especially important and productive. Nothing brings home to one with such overwhelming conviction the significance of the psychogenic factor in the daily life of mankind, the frequency of fictitious 'indispositions', and the non-existence of chance as the practice of psycho-analysis for some years strictly on the principle of hire by the hour. In cases of indubitable organic illness, the occurrence of which cannot be excluded in spite of interest in the psychical work, I break off the treatment, regard myself as entitled to dispose otherwise of the hour which becomes free, and take the patient back again when he has recovered and I again have a free hour.

I work with my patients every day, except Sundays and public holidays, that is, usually six days a week. For slight cases, or the continuation of a treatment already well advanced, three days a week will suffice. Otherwise, restriction of the time expended brings no advantage to physician or patient; it is not to be thought of at the beginning. Even short interruptions have a disconcerting effect on the work; we used to speak jokingly of the 'Monday-crust' ■ 21 when we began work again after the rest on Sunday; with more frequent intervals the risk arises that one will not be able to

■ 20
In today's psychotherapeutic world, there are many other practices concerning missed hours. Very few therapists today see patients six times a week as Freud did. In fact, most psychotherapy is probably conducted on a once- or twice-a-week basis. This, of course, constitutes a much smaller percentage of one's income than is the case if one sees a patient four to six times a week. Thus it is easier for a therapist not to charge for missed sessions. Many analysts think that other policies concerning missed sessions put the analyst in a position of judging the patient's reasons for missing sessions, and this is the main reason for the policy that Freud is advocating.

■ 21
The Monday crust is a famous passage, and given today's ten-

keep pace with the patient's real life, that the analysis will lose contact with the present and be forced into by-paths. Occasionally one meets with patients to whom one must give more than the average time of one hour a day, because the best part of an hour is gone before they begin to open out and to communicate anything at all. ■ 22

An unwelcome question which the patient asks the physician at the outset is: How long will the treatment last? What length of time will you require to relieve me of my trouble? ■ 23 If one has proposed an experimental course of a few weeks one can avoid a direct reply to this question by undertaking to give a more trustworthy answer later on. The answer is like that of Aesop in the fable of the Wanderer; on being asked the length of the journey he answered 'Go', and gave the explanation that he must know the pilgrim's pace before he could tell the time his journey would take him. This explanation helps one over the difficulty at the start, but the comparison is not a good one, for the neurotic can easily alter his pace and at times make but very slow progress. The question of the probable duration of the treatment is hardly to be answered at all, in fact.

As a result of the lack of insight on the part of patients combined with the lack of straightforwardness on the part of physicians, analysis is expected to realize the most boundless claims in the shortest time. As an example I will give some details from a letter which I received a few days ago from a lady in Russia. Her age is fifty-three; her illness began twenty-three years ago; for the last ten years she has been incapable of continued work; 'various cures in homes' have not succeeded in making an 'active life' possible for her. She hopes to be completely cured by psycho-analysis, of which she has read, but her illness has already cost her family so much that she cannot undertake a visit of more than six weeks or two months to Vienna. In addition to this there is another difficulty: she wishes to 'explain herself' from the beginning in writing, since any discussion of her complexes would excite an attack or render her 'temporarily dumb'. No one would expect a man to lift a heavy table with two fingers as if it were a little stool, or to build a large house in the time it would take to put up a wooden hut, but as soon as it becomes a question of the neuroses (which mankind seems not yet to have fitted into the general scheme of his ideas) even intelligent people forget the necessity for proportion between work, time and success—a comprehensible result, too, of the deep ignorance which prevails concerning the ætiology of neuroses. Thanks to this ignorance a neurosis is generally regarded as a sort of 'maiden from afar'; the world knows not whence it comes, and therefore expects it to vanish away some day.

Medical men support this happy belief; even the experienced among them often fail to estimate properly the severity of nervous disorders. A friend and colleague of mine, to whose credit I account it that after several decades of scientific work on other principles he has betaken himself to the recognition of psycho-analysis, once wrote to me: What we need is a short, convenient form of treatment for out-patients suffering from obsessional neurosis. I could not supply him with it, and felt ashamed; so I tried to excuse myself with the remark that probably physicians would also be very glad of a treatment for consumption or cancer which combined these advantages.

To speak more plainly, psycho-analysis is always a matter of long periods of time, of six months or a year, or more—a longer time than the patient expects. It is therefore a duty to explain this fact to the patient before he finally resolves upon the treatment. I hold it to be altogether more honourable, and also more expedient, to draw his attention, without alarming him unduly but from the very beginning, to the difficulties and sacri-

■ 21 *continued*
dency toward less frequent sessions, one wonders how thick the crust often is in some treatments in which the sessions are once or twice a week.

■ 22
Here Freud is showing a type of flexibility that is rare in today's analytic world. Generally patients are now seen for extended sessions only if there is some type of emergency. Freud, of course, assumed that the length of an analysis would be much shorter, and that it was important to have a patient "open out." Today one would assume that this altering of the normal schedule would introduce some elements into an analysis that would need to be analyzed and perhaps be undesirable. In today's analytic world, treatments almost always go on for a longer time than in Freud's era, and so analysts may wait a longer time for a patient to begin to communicate. Since the fundamental rule is so central to Freud, it is, of course, crucial to get the analysand to begin to free associate.

■ 23
The question of length of treatment is still frequently asked despite the well-publicized length of psychoanalytic treatment(s). There are people who advocate telling the patient the average length of treatment, but this procedure has its drawbacks. The question would undoubtedly arise as to the length of one's stride as Freud has put it. The length of stride or one's

■ 23 *continued*
propensity for analytic work is naturally not the only factor that will determine the length of an analysis. Frequently, accidental factors such as the death of a parent or spouse, or any of the exigencies of life, will have a decisive impact on the course of a treatment. Analysis is, in addition, such a personal unfolding of one's life experiences that it is hard, if not impossible, to talk with any degree of accuracy about the length of stride or propensity for analytic work.

fices involved by analytic treatment; thereby depriving him of the right to assert later on that he had been inveigled into a treatment the implications and extent of which he did not realize. The patient who lets himself be dissuaded by these considerations would later on have shown himself unsuitable; it is a good thing to institute a selection in this way before the beginning of the treatment. With the progress of understanding among patients the number of those who stand this first test increases.

I do not bind patients to continue the treatment for a certain length of time; I permit each one to break off whenever he likes, though I do not conceal from him that no success will result from a treatment broken off after only a small amount of work, and that it may easily, like an unfinished operation, leave him in an unsatisfactory condition. In the early years of my practice of psycho-analysis I had the greatest difficulty in prevailing upon patients to continue; this difficulty has long since altered; I must now anxiously exert myself to induce them to give it up.

The shortening of the analytic treatment remains a reasonable wish, the realization of which, as we shall hear, is being sought after in various ways. Unfortunately, it is opposed by a very important element in the situation—namely, the slowness with which profound changes in the mind bring themselves about, fundamentally the same thing as the 'inappreciation of time' characteristic of our unconscious processes. ■ 24 When the patients are confronted with the great expenditure of time required for the analysis they often bethink themselves of suggesting a makeshift way out of the difficulty. They divide up their complaints and describe some as unendurable and others as secondary, saying, 'If only you will relieve me of this (for instance, a headache or a particular fear) I will manage by myself to endure life with the other troubles'. They exaggerate the selective capacity of the analysis in this. The analyst is

■ 24
Freud's views on shortening the treatment show that he recognized various obstacles to speeding the natural processes of analysis. In the case of the Wolf Man, we will see he felt that he had to attempt to shorten the process, so a time limit was set. Freud discusses this in "Analysis Terminable and Interminable."

certainly able to do a great deal, but he cannot determine beforehand exactly what results he will effect. He sets in operation a certain process, the 'loosening' of the existing repressions: he can watch over it, further it, remove difficulties in the way of it, and certainly do much also to vitiate it; but on the whole, once begun, the process goes its own way and does not admit of prescribed direction, either in the course it pursues or in the order in which the various stages to be gone through are taken. The power of the analyst over the symptoms of disease is comparable in a way to sexual potency; the strongest man can beget a whole child, it is true, but he cannot effect the production of a head alone, or an arm, or a leg in the female organ, he cannot even prescribe the sex of the child. He, too, only sets in operation a highly complicated process, determined by foregone events, and ending with the severance of the child from the mother. Again, a neurosis has the character of an organism; its component manifestations are not independent of one another, they each condition and mutually support the others; a man can only suffer from one neurosis, never from several accidentally combined in his person. Suppose one had freed the patient, according to his wish, from the one unendurable symptom, he might then have discovered that a symptom which was previously negligible had increased until it in turn had become intolerable. In general, the analyst who wishes the results to be as independent as possible of the influence of suggestion from himself (that is, of transference) will do best to refrain from using even the fraction of selective influence upon the results of the cure which is perhaps open to him. The patients who are most welcome to the psycho-analyst will be those who desire complete health so far as they are capable of it, and who will place as much time at his disposal for the cure as the process requires. Naturally, such favourable conditions are to be met with only in the minority of cases.

The next point to be decided on beginning the treatment is the money question, the physician's fee. The analyst does not dispute that money is to be regarded first and foremost as the means by which life is supported and power is obtained, but he maintains that, besides this, powerful sexual factors are involved in the value set upon it; he may expect, therefore, that money questions will be treated by cultured people in the same manner as sexual matters, with the same inconsistency, prudishness and hypocrisy. He is therefore determined beforehand not to concur in this attitude, and in his dealings with patients to treat of money matters with the same matter-of-course frankness that he wishes to induce in them towards matters relating to sexual life. By voluntarily introducing the subject of fees and stating the price for which he gives his time, he shows the patient that he himself has cast aside false shame in these matters. Ordinary prudence then demands that the sums to be paid should not be allowed to accumulate until they are very large, but that payment should be made at fairly short regular intervals (every month or so). (It is well known that the value of the treatment is not enhanced in the patient's eyes if a very low fee is asked.) This is of course not the usual practice of neurologists or other physicians in our European cities. But the psycho-analyst may put himself in the position of surgeons, who are both honest and expensive because they deal in measures which can be of aid. In my opinion it is more dignified and ethically less open to objection to acknowledge one's actual claims and needs rather than, as the practice is now among medical men, to act the part of the disinterested philanthropist, while that enviable situation is denied to one and one grumbles in secret, or animadverts loudly, over the lack of consideration or the miserliness shown by patients. In estimating his fee the analyst must allow

for the fact that, in spite of strenuous work, he can never earn as much as other medical specialists.

For the same reasons he may refrain from giving treatment gratuitously, making no exceptions to this in favour of his colleagues or their relatives. This last requisition seems to conflict with the claims of professional fellow-feeling; one must consider, however, that gratuitous treatment means much more to a psycho-analyst than to other medical men—namely, the dedication of a considerable portion (an eighth or a seventh part, perhaps) of the time available for his livelihood over a period of several months. Another treatment conducted gratuitously at the same time would rob him of a quarter or a third of his earning capacity, which would be comparable to the effects of some serious accident. ■ 25

Then the question arises whether the advantage to the patient would not outweigh the physician's sacrifice. I may rely on my own judgement in this matter, since I have given an hour daily, and sometimes two, for ten years to gratuitous treatment, because I wished, for the purpose of studying the neuroses, to work with the fewest possible hindrances. The advantages which I sought in this way were not forthcoming. Gratuitous treatment enormously increases many neurotic resistances, such as the temptations of the transference-relationship for young women, or the opposition to the obligatory gratitude in young men arising from the father-complex, which is one of the most troublesome obstacles to the treatment. The absence of the corrective influence in payment of the professional fee is felt as a serious handicap; the whole relationship recedes into an unreal world; and the patient is deprived of a useful incentive to exert himself to bring the cure to an end. ■ 26

One may stand quite aloof from the ascetic view of money as a curse and yet regret that analytic therapy is almost unattainable for the

■ 25
Freud must have been concerned with the prospect of analysis being a profession whose practitioners make a decent living. He was maintaining that analysts have a right to charge for their time, for their services are valuable. The question of allowing for professional courtesy is important, since many (or most) members of the analytic community are or have been patients at one time or another. It is hard to imagine what would have happened to analytic practices if Freud had insisted that one always show professional courtesy.

■ 26
The whole question of fee must have been difficult and highly conflictual for Freud. As he

■ 26 *continued*
states, he had been much more flexible than he advises others to be. This flexibility did not disappear with the writing of this article, and as we know, at times he assisted a patient who no longer had any monetary resources (for example, the Wolf Man).

poor, both for external and for internal reasons. Little can be done to remedy this. Perhaps there is some truth in the widespread belief that those who are forced by necessity to a life of heavy labour succumb less easily to neurosis. But at all events experience shows without a doubt that, in this class, a neurosis once acquired is only with very great difficulty eradicated. It renders the sufferer too good service in the struggle for existence; the accompanying secondary 'epinosic gain' has here too much importance. The pity which the world has refused to his material distress the sufferer now claims by right of his neurosis and absolves himself from the obligation of combating his poverty by work. Any one who tries to deal by psychotherapeutic means with a neurosis in a poor person usually makes the discovery that what is really required of him in such a case is a very different, material kind of therapy—the sort of healing which, according to tradition, Emperor Joseph II. used to dispense. Naturally, one does occasionally meet with people of worth who are helpless from no fault of their own, in whom unpaid treatment leads to excellent results without exciting any of the difficulties mentioned.

For the middle classes the necessary expense of psycho-analysis is only apparently excessive. Quite apart from the fact that restored health and capacity for life on the one hand, and a moderate outlay in money on the other, cannot be measured in the same category; if one contrasts a computation of the never-ceasing costs of nursing homes and medical treatment with the increase of capacity to live well and earn well after a successful analytic treatment, one may say that the patient has made a good bargain. Nothing in life is so expensive as illness—and foolishness.

Before I conclude these remarks on beginning the analytic treatment a word must be said about a certain ceremonial observance regarding the position in which the treatment is carried out. I adhere

firmly to the plan of requiring the patient to recline upon a sofa, while one sits behind him out of his sight. ■ 27 This arrangement has an historic meaning; it is the last vestige of the hypnotic method out of which psycho-analysis was evolved; but for many reasons it deserves to be retained. The first is a personal motive, one that others may share with me, however. I cannot bear to be gazed at for eight hours a day (or more). Since, while I listen, I resign myself to the control of my unconscious thoughts I do not wish my expression to give the patient indications which he may interpret or which may influence him in his communications. The patient usually regards being required to take up this position as a hardship and objects to it, especially when scoptophilia plays an important part in the neurosis. I persist in the measure, however, for the intention and result of it are that all imperceptible influence on the patient's associations by the transference may be avoided, so that the transference may be isolated and clearly outlined when it appears as a resistance. I know that many analysts work in a different way, though I do not know whether the main motive of their departure is the ambition to work in a different way or an advantage which they gain thereby.

The conditions of the treatment being now regulated in this manner, the question arises at what point and with what material it shall begin.

What subject-matter the treatment begins with is on the whole immaterial, whether with the patient's life-story, with a history of the illness or with recollections of childhood; but in any case the patient must be left to talk, and the choice of subject left to him. One says to him, therefore, 'Before I can say anything to you, I must know a great deal about you; please tell me what you know about yourself'.

The only exception to this concerns the fundamental rule of the psycho-analytic technique which the patient must observe. This must be

■ 27
The whole question of the couch is one in which the deviations to which Freud alludes have continued to this day. Interestingly, some analysts who have rejected a good deal of what Freud has said, use the couch while some avowed "Freudians" eschew the use of the couch. The reasons that Freud states here seem more idiosyncratic than the ones he put forth in other places. To call the couch a remnant of the hypnotic method is true historically but allows for certain misunderstandings of the theoretical rationale for the use of the couch. The same might be said of Freud's "personal motive." If the only reason that one gave for the use of the couch was that it was difficult for the analyst to endure patient's gazes, then I suspect the use of the couch might have died an early death. Freud also allows that the use of the couch facilitates regressive tendencies and is useful as well to clearly spell out and isolate tranference tendencies, particularly as they manifest themselves in the resistance. It is all too frequently stated that Freud's use of the couch was dictated by his aversion to looking at patients. While this may have been a contributing factor to his instituting the couch, its importance in the analytic situation goes beyond this accidental circumstance.

imparted to him at the very beginning: 'One thing more, before you begin. Your talk with me must differ in one respect from an ordinary conversation. Whereas usually you rightly try to keep the threads of your story together and to exclude all intruding associations and side-issues, so as not to wander too far from the point, here you must proceed differently. You will notice that as you relate things various ideas will occur to you which you feel inclined to put aside with certain criticisms and objections. You will be tempted to say to yourself: "This or that has no connection here, or it is quite unimportant, or it is nonsensical, so it cannot be necessary to mention it". Never give in to these objections, but mention it even if you feel a disinclination against it, or indeed just because of this. Later on you will perceive and learn to understand the reason for this injunction, which is really the only one that you have to follow. So say whatever goes through your mind. Act as if you were sitting at the window of a railway train and describing to some one behind you the changing views you see outside. Finally, never forget that you have promised absolute honesty, and never leave anything unsaid because for any reason it is unpleasant to say it.'[4] ■ 28

[4]Much might be said about our experience with the fundamental rule of psycho-analysis. One meets occasionally with people who behave as if they had instituted this rule for themselves; others offend against it from the beginning. It is indispensable, and also advantageous, to mention it at the first stage of the treatment; later, under the influence of resistances, obedience to it weakens and there comes a time in every analysis when the patient disregards it. One must remember how irresistible was the temptation in one's self-analysis to yield to those cavilling pretexts for rejecting certain thoughts. The feeble effect of the patient's agreement to the bargain made with him about the 'fundamental rule' is regularly demonstrated when something of an intimate nature about a third person rises to his mind for the first time; the patient knows that he must say everything, but he makes a new obstacle out of the discretion required on behalf of others. 'Must I really say everything? I thought that only applied to what concerns myself.' It is naturally impossible to carry out an analysis if the patient's relations with other people and his thoughts about them are excluded. *Pour faire une omelette il faut casser des œufs.* An honourable man readily forgets such of the private affairs of strangers as do not seem important for him to know. Names, too, cannot be excepted from communication; otherwise the patient's narratives become rather shadowy, like the scenes of Goethe's *Natural Daughter*, and do not remain in the physician's memory; moreover, the names withheld cover the approach to all kinds of important connections. One may perhaps leave names until the patient has become more familiar with the physician and the process of analysis. It is a most remarkable thing that the whole undertaking becomes lost labour if a single concession is made to secrecy. If at any one spot in a town the right of sanctuary existed, one can well imagine that it would not be long before all the riff-raff of the town would gather there. I once treated a high official who was bound by oath not to communicate certain State secrets, and the analysis came to grief as a consequence of this restriction. The psycho-analytic treatment must override everything which comes in its way, because the neurosis and the resistances are equally relentless.

■ 28
Here is the rule of free association stated in two distinctly different forms. When one says to a patient that they are free to choose at what point to begin, this is a communication that starts to give the treatment to the patient. However, Freud states that the patient must observe the fundamental rule. When Freud intones that the patient "must proceed differently" than they ordinarily do, he is invoking the authority of the analyst and putting his instructions in a form that can be potentially highly critical or

■ 28 *continued*
judgmental. When he says,"You must never give in to these criticisms," he is again intoning that the patient should fight against what he knows will eventually take place; transference–resistance will at some point negate even the most motivated patient's attempt to follow the "fundamental rule" of psychoanalysis. But one might ask why adherence to the fundamental rule is so crucial to the success of an analysis, particularly if we know that at some point an analysand will fail or break the rule? One could say to the patient that it is important that you say whatever goes through your mind, although at times you may find it difficult to do so. Included in this preamble might be an illustration of how side thoughts occasionally intrude, and that these thoughts may be as important as the main theme that a patient has begun to talk about. This type of instruction would still encourage the patient to verbalize thoughts, but at the same time would acknowledge to the patient that at times he might not be able to follow the instruction. For Freud, however, the failure to free associate is to be combatted so that one can reach pathogenic memories. This is the case even if the analyst must pressure the patient to associate.

At this point in time, Freud was somewhat concerned about the secrecy of his method of treatment. It is unlikely that he wanted to tell the patient too much about what might follow in the course of treatment. Interestingly, once having said this, we can see that Freud often seemed to give little lectures to his patients about the nature of mental functioning, as well as the process of psychoanalytic technique. The resolution of these paradoxical trends awaits yet another analysis of Freud, which, of course, will never be accomplished satisfactorily. One can only state that, while he set down these principles and frequently expressed concern about the secrecy of the psychoanalytic method, once he was engaged in a treatment he did not feel bound to follow these principles.

Patients who date their illness from a particular time usually concentrate upon the events leading up to it; others who themselves recognize the connection of their neurosis with their childhood often begin with an account of their whole life-story. A consecutive narrative should never be expected and nothing should be done to encourage it. Every detail of the story will later have to be related afresh, and only with this repetition will additional matter appear enabling the significant connections which are unknown to the patient to be traced.

There are patients who from the first hour carefully prepare their communications, ostensibly so as to make better use of the time given to treatment. This appears to be eagerness on their part, but it is resistance. One must disallow this preparation; it is employed to guard against the appearance of unwelcome thoughts;[5] the patient may believe ever so honestly in his praise-worthy intention, but resistance will play its part in this kind of considered preparation and will see to it that in this way the most valuable part of the communication escapes. One will soon find that the patient invents yet other methods by which the required material may be withheld from analysis. He will perhaps talk over the treatment every day with some intimate friend, and in this discussion bring out all the thoughts which should occur to him in the presence of the physician. The treatment then suffers from a leak which lets through just what is most valuable. It will then soon be time to recommend the patient to treat the analysis as a matter between himself and his physician, and to exclude everyone else from sharing in it, no matter how closely bound to him or how inquisitive they may be. In later stages of the treatment the patient is not usually tempted in this way.

[5]Exceptions may be made only of such data as the family relationships, visits, operations, and so on.

Certain patients wish their treatment kept secret, often because they have kept their neurosis secret, and I put no obstacle in the way of this. That in consequence the world hears nothing of some of the most brilliantly successful cures is of course a consideration not to be taken into account. Obviously the patient's decision in favour of secrecy at once reveals one feature of his inner history.

In advising at the beginning of treatment that as few persons as possible shall be informed of it, one protects patients to some extent from the many hostile influences seeking to detach them from the analysis. Such influences may be very mischievous at the outset of the cure; later they are usually immaterial, or even useful in bringing into prominence resistances which are attempting concealment.

If during the course of the analysis the patient requires temporarily some other medical or special treatment, it is far wiser to call in some colleague outside analytic work than to administer this treatment oneself. Analysis combined with other treatment, for neurotic maladies with a strong organic connection, is nearly always impracticable; the patients withdraw their interest from the analysis when there is more than one way leading them to health. Preferably one postpones the organic treatment until after the conclusion of the mental; if the former were tried first, in most cases it would do no good. ■ 29

To return to the beginning of the treatment. Patients are occasionally met with who begin the treatment with an absolute disclaimer of the existence of any thoughts in their minds which they could utter, although the whole field of their life-history and their neurosis lies before them untrodden. One must accede this first time as little as at any other to their request that one should propose something for them to speak of. One must bear in mind what it is that confronts one in these cases.

■ 29
Here Freud is presaging some of the views that he will later express in his ideas on lay analysis. It is his view that the analyst should not engage in medical or organic treatment; he uses this later as one argument to demonstrate that there is no necessary benefit in being a medical doctor in the practice of psychoanalysis.

A formidable resistance has come out into the open in order to defend the neurosis; one takes up its challenge then and there, and grips it by the throat. Emphatic and repeated assurance that the absence of all ideas at the beginning is an impossibility, and that there is some resistance against the analysis, soon brings the expected confessions from the patient or else leads to the first discovery of some part of his complexes. It is ominous if he has to confess that while listening to the rule of the analysis he formed a determination in spite of it not to communicate this or that; not quite so bad if he only has to declare the distrust he has of the treatment or the appalling things he has heard about it. If he denies these and similar possibilities when they are suggested to him, further pressure will constrain him to acknowledge that he has neglected certain thoughts which are occupying his mind. He was thinking of the treatment itself but not in a definite way, or else the appearance of the room he is in occupied him, or he found himself thinking of the objects round him in the consulting-room, or of the fact that he is lying on a sofa; for all of which thoughts he has substituted 'nothing'. These indications are surely intelligible; everything connected with the situation of the moment represents a transference to the physician which proves suitable for use as resistance. It is necessary then to begin by uncovering this transference; thence the way leads rapidly to penetration of the pathogenic material in the case. Women who are prepared by events in their past lives for a sexual overture, or men with unusually strong, repressed homosexuality, are the most prone to exhibit this denial of all ideas at the outset of the analysis.

The first symptoms or chance actions of the patient, like the first resistance, have a special interest and will betray one of the governing complexes of the neurosis. A clever young philosopher, with leanings towards æsthetic exquisite-

ness, hastens to twitch the crease in his trousers into place before lying down for the first sitting; he reveals himself as an erstwhile coprophiliac of the highest refinement, as was to be expected of the developed æsthete. A young girl on the same occasion hurriedly pulls the hem of her skirt over her exposed ankle; she has betrayed the kernel of what analysis will discover later, her bodily beauty and her tendencies to exhibitionism.

Very many patients object especially to the arrangement of reclining in a position where the physician sits out of sight behind them; they beg to be allowed to undergo analysis in some other position, mostly because they do not wish to be deprived of a view of the physician. Permission is invariably refused; one cannot prevent them, however, from contriving to say a few words before the beginning of the 'sitting itself', and after one has signified its termination and they have risen from the sofa. In this way they make in their own minds a division of the treatment into an official part, in which they behave in a very inhibited manner, and an informal 'friendly' part, in which they really speak freely and say a good deal that they do not themselves regard as belonging to the treatment. The physician does not fall in for long with this division of the time, he makes a note of what is said before or after the sitting, and in bringing it up at the next opportunity he tears down the partition which the patient has tried to erect. It again is a structure formed from the material of a transference-resistance.

So long as the patient continues to utter without obstruction the thoughts and ideas rising to his mind, the theme of the transference should be left untouched. One must wait until the transference, which is the most delicate matter of all to deal with, comes to be employed as resistance.

The next question with which we are confronted is a main one. It runs: When shall we begin our disclosures to the patient? When is it

time to unfold to him the hidden meaning of his thoughts and associations, to initiate him into the postulates of analysis and its technical devices?

The answer to this can only be: Not until a dependable transference, a well-developed *rapport*, is established in the patient. The first aim of the treatment consists in attaching him to the treatment and to the person of the physician. To ensure this one need do nothing but allow him time. If one devotes serious interest to him, clears away carefully the first resistances that arise and avoids certain mistakes, such an attachment develops in the patient of itself, and the physician becomes linked up with one of the imagos of those persons from whom he was used to receive kindness. It is certainly possible to forfeit this primary success if one takes up from the start any standpoint other than that of understanding, such as a moralizing attitude, perhaps, or if one behaves as the representative or advocate of some third person, maybe the husband or wife, and so on.

This answer of course involves a condemnation of that mode or procedure which consists in communicating to the patient the interpretation of the symptoms as soon as one perceives it oneself, or of that attitude which would account it a special triumph to hurl these 'solutions' in his face at the first interview. It is not difficult for a skilled analyst to read the patient's hidden wishes plainly between the lines of his complaints and the story of his illness; but what a measure of self-complacency and thoughtlessness must exist in one who can upon the shortest acquaintance inform a stranger, who is entirely ignorant of analytical doctrines, that he is bound by an incestuous love for his mother, that he harbours wishes for the death of the wife he appears to love, that he conceals within himself the intention to deceive his chief, and so forth! I have heard that analysts exist who plume themselves upon these kinds of lightning-diagnoses and 'express'-treatments, but

I warn everyone against following such examples. Such conduct brings both the man and the treatment into discredit and arouses the most violent opposition, whether the interpretations be correct or not; yes, and the truer they are actually the more violent is the resistance they arouse. Usually the therapeutic effect at the moment is nothing; the resulting horror of analysis, however, is ineradicable. Even in later stages of the analysis one must be careful not to communicate the meaning of a symptom or the interpretation of a wish until the patient is already close upon it, so that he has only a short step to take in order to grasp the explanation himself. In former years I often found that premature communication of interpretations brought the treatment to an untimely end, both on account of the resistances suddenly aroused thereby and also because of the relief resulting from the insight so obtained. ■ 30

The following objection will be raised here: Is it then our task to lengthen the treatment, and not rather to bring it to an end as rapidly as possible? Are not the patient's sufferings due to his lack of knowledge and understanding, and is it not a duty to enlighten him as soon as possible, that is, as soon as the physician himself knows the explanations? The answer to this question requires a short digression concerning the significance of knowledge and the mechanism of the cure in psychoanalysis.

In the early days of analytic technique it is true that we regarded the matter intellectually and set a high value on the patient's knowledge of that which had been forgotten, so that we hardly made a distinction between our knowledge and his in these matters. We accounted it specially fortunate if it were possible to obtain information of the forgotten traumas of childhood from external sources, from parents or nurses, for instance, or from the seducer himself, as occurred occasionally; and we hastened to convey the information and

■ 30
When are we to make our communications? When Freud says that we should wait until there has been an effective transference or a proper rapport, he is telling us something that is extremely important and that has been a subject of discussion up through the present time. Various analysts have used the concept of therapeutic alliance to capture and elaborate on what Freud called a proper rapport. It is interesting that Freud sees the analytic process as literally unfolding naturally if one gives the patient time and follows his other suggestions. He expressly warns even the skilled analyst to avoid the tendency "to fling (the analyst's) 'solutions'" in the face of the patient in the first interview. Freud then extends this idea and points out that it is thoughtless to presume that

proofs of its correctness to the patient, in the certain expectation of bringing the neurosis and the treatment to a rapid end by this means. It was a bitter disappointment when the expected success was not forthcoming. How could it happen that the patient, who now had the knowledge of his traumatic experience, still behaved in spite of it as if he knew no more than before? Not even would the recollection of the repressed trauma come to mind after it had been told and described to him.

In one particular case the mother of an hysterical girl had confided to me the homosexual experience which had greatly influenced the fixation of the attacks. The mother herself had come suddenly upon the scene and had been a witness of it; the girl, however, had totally forgotten it, although it had occurred not long before puberty. Thereupon I made a most instructive observation. Every time that I repeated the mother's story to the girl she reacted to it with an hysterical attack, after which the story was again forgotten. There was no doubt that the patient was expressing a violent resistance against the knowledge which was being forced upon her; at last she simulated imbecility and total loss of memory in order to defend herself against what I told her. After this, there was no alternative but to abandon the previous attribution of importance to knowledge in itself, and to lay the stress upon the resistances which had originally induced the condition of ignorance and were still now prepared to defend it. Conscious knowledge, even if it were not again expelled, was powerless against these resistances. ■ 31

This disconcerting ability in patients to combine conscious knowledge with ignorance remains unexplained by what is called normal psychology. By reason of the recognition of the unconscious, psycho-analysis finds no difficulty in it; the phenomenon described is, however, one of the best confirmations of the conception by which mental processes are approached as being differ-

■ 30 *continued*
anyone could or would be willing to hear intimate observations about his conflicts from someone who doesn't even know him well. The question of when to interpret, of course, is a subject still under much discussion. At this point in time, Freud had clearly moved from what he called an intellectualist position to one that firmly considered the patient's readiness to hear the analyst's observations. Unfortunately, he frequently did not follow his own advice.

■ 31
Freud's views on the importance of intellectual knowledge have obviously undergone a dramatic shift from his views as presented in *Studies on Hysteria* and his implicit views in the Dora case. Shortly after he wrote the technique papers, he was quite concerned with conceptualizing

■ 31 *continued*
(or reconceptualizing) questions that concern the status of repression or defense. This had previously been a concern to him in Chapter 7 of *The Interpretation of Dreams* ("Little Hans, Two Principles of Mental Functioning"), as well as his paper on wild analysis. The question of intellectual knowledge (and of what he will call *double representation*) will be taken up explicitly in his papers on the unconscious and repression. Thus, in the next page, he gives what he might have called a *metapsychological analysis* of the processes that he had just been discussing. One might state parenthetically that all the points that he summarizes in energetic language had been made previously by him without the aid of this language. It is also of interest to note that, in the course of this summary, he gives a working definition of the concept of what will later be called *transference cure* and mentions the concept of secondary gain, which he had begun to formulate in the Dora case.

Freud states that the patient may be able to get better simply under the influence of the transference, but, once that influence is gone or diminished, the cure will leave as well. Implicitly then, he is suggesting that there are other criteria than symptom removal that one must employ to evaluate the efficacy of a treatment.

entiated topographically. The patients are aware, in thought, of the repressed experience, but the connection between the thought and the point where the repressed recollection is in some way imprisoned is lacking. No change is possible until the conscious thought-process has penetrated to this point and has overcome the resistances of the repression there. It is just as if a decree were promulgated by the Ministry of Justice to the effect that juvenile misdemeanours should be dealt with by certain lenient methods. As long as this concession has not come to the knowledge of the individual magistrates, or in the event of their not choosing to make use of it but preferring to deal justice according to their own lights, nothing will be changed in the treatment accorded to youthful delinquents. For the sake of complete accuracy, though, it may be added that communicating to the patient's consciousness information about what is repressed does not entirely fail of any

effect at all. It does not produce the hoped-for result of abolishing the symptoms, but it has other consequences. It first arouses resistances, but when these are overcome it sets a mental process in action, in the course of which the desired influence upon the unconscious memory is eventually effected.

At this point we should review the play of forces brought into action by the treatment. The primary motive-power used in therapy is the patient's suffering and the wish to be cured which arises from it. The volume of this motive-force is diminished in various ways, discoverable only in the course of the analysis, above all by what we call the 'epinosic gain'; the motive-power itself must be maintained until the end of the treatment; every improvement effects a diminution of it. Alone, however, the force of this motive is insufficient to overcome the illness; two things are lacking in it, the knowledge of the paths by which the desired end may be reached, and the amount of energy needed to oppose the resistances. The analytic treatment helps to supply both these deficiencies. The accumulation of energy necessary to overcome the resistances is supplied by analytic utilization of the energies which are always ready to be 'transferred'; and by timely communications to the patient at the right moment analysis points out the direction in which these energies should be employed. The transference alone frequently suffices to bring about a disappearance of the symptoms of the disease, but this is merely temporary and lasts only as long as the transference itself is maintained. The treatment is then nothing more than suggestion, not a psycho-analysis. It deserves the latter name only when the intensity of the transference has been utilized to overcome the resistances; only then does illness become impossible, even though the transference is again dissolved as its function in the treatment requires.

In the course of the treatment another helpful

agency is roused—the patient's intellectual interest and understanding. But this alone is hardly worth consideration by the side of the other forces engaged in the struggle, for it is always in danger of succumbing to the clouding of reasoning power under the influence of resistances. Hence it follows that the new sources of strength for which the sufferer is indebted to the analyst resolve themselves into transference, and instruction (by explanation). The patient only makes use of the instruction, however, in so far as he is induced to do so by the transference; and therefore until a powerful transference is established the first explanation should be withheld; and likewise, we may add, with each subsequent one, we must wait until each disturbance of the transference by the transference-resistances arising in succession has been removed.