CONTEMPORARY PSYCHOANALYSIS

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Reanalysis1

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Not to enlighten one who can be enlightened is to waste a man; to endeavor to enlighten one who cannot be enlightened is to waste words. The intelligent man wastes neither his man nor his words.
CONFUCIUS

THERE IS HARDLY any vocation in which there is so much coincidence between the person and his work as in our profession. The psychoanalytic tenets must become part of one's personality rather than an external set of theoretical conjectures. What the analyst *is or wants to be* has more to do with the way he works than the theoretical frame he uses. And since the work is accomplished in discrete segments of direct, immediate experience and response, this is very difficult if not impossible to reproduce in an abstract form, suitable for generalization.

Psychoanalysis is an aristocratic method. It is meant for few by few. It is a method of self-investigation, self-correction, self-redirection, and reorganization, which require disciplined thought and serious commitment. The democratization and widespread application of this method, irrespective of the qualifications of the recipients as well as the practitioners, have brought many disappointments to both sides. The institutionalization of the method has taken away some of the freshness it had in its earlier stages and rigidified it and put it into harness—an added burden toindividual initiative.

Yet psychoanalysis remains the method of choice in acquisition of self-knowledge and alleviation of unnecessary mental suffering for suitable patients. For many of us have felt the immense benefits in our development and increased knowledge in the ways of man. I am one of those who has never lost sight of what psychoanalysis has done for me in making my life easier, as well as providing me with a method of investigation and understanding of human behavior. But the indiscriminate use of this method has, at times, done injustice to psychoanalysis. All this becomes evident, even exaggerated, as one considers the problem of the "repeaters" who persistently seek further treatment in spite of disappointments. Of course, this paper does not consider a perhaps larger number of patients who derived as much as they wanted in their first analysis, and therefore never returned to the analyst. Thus, they do not come to our attention.

Exercise in Definition

First, what is reanalysis? The word is currently used to describe any attempt to work with a new analyst, irrespective of what type of treatment the patient received before or is currently engaged in. With all of the reservations about definitions in our field, I shall attempt to give my own. I would suggest that the term "reanalysis" be used literally; it must be preceded by a dynamic analytic experience, not by ritual alone. The patient must be capable of dealing with conscious and unconscious forces, with transference and resistance and the analytic method of introspection. In short, he evidences a measure of integration of the analytic method and technique. Those who come to reanalysis are expected to have given the first analysis a running trial in the ordinary way of life. Furthermore, after the first analysis, they should be able to make emotional reinvestments in real people, integrate the benefits of the first analysis with a positive effect on their personal lives, and show some evidence that the original inadequacies that were prominent during the first analysis have disappeared. Sufficient time should have elapsed between analysis and reanalysis so as to allow for stabilization of the original accomplishments and for testing them in everyday life.

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[1]From a paper delivered before the Association for Psychoanalytic Medicine, New York City, November 14, 1967. The subject was suggested by the Program Committee Chairman, Dr. Ruth Easser, to whom I extend my appreciation. Thinking about it for a year was a very rewarding experience.

[3]Cf., for example, Kramer. 8

Can one call each and every attempt analysis? Obviously not. It might be necessary then to distinguish between this term and other terms used widely, such as "continuation, " "interruption, " "intermittent analysis" (Mahler), "second analysis" (Wagner), and to decide whether, in spite of overlapping, there is enough difference to warrant the use of "reanalysis."

In a 1959 paper, Maria Kramer 8 speaks of the autoanalytic function; according to her, it develops during analysis:

> *I have made the assumption that the capacity to integrate unconscious conflicts in the form of insight can become an independent ego function, which for purposes of this communication, I shall call auto-analytic. I assume this function to be initiated by psychoanalytic therapy …*

I think that the capacity for introspection is a prerequisite for a successful analysis, and some measure of it needs to be present at the start. Her point, however, is well taken for this is sometimes *the* major problem in analytic work: how to get the patient to use insight, to ask pertinent questions; how to kindle this capacity and interest in scrutinizing his behavior; how to induce the patient to examine his *intention*, notice the *form* his communication takes, follow the content, observe the effect, register the feedback, and correct or modify when necessary. This faculty is clearly absent or markedly thwarted in the obsessive, paranoid, and melancholic groups. And these are the patients who are most likely to seek additional treatment. I mention Maria Kramer's observations because I think the presence or absence of what she calls the "autoanalytic function" may be helpful in distinguishing whether or not the subsequent attempts are to be called "reanalysis."

How should we distinguish between "continuation of analysis" and "reanalysis"? It is not always easy, and there may be overlapping. For example, analysis may have been interrupted by force of circumstances, death of an analyst, or moving to a different city or country. These are realistic reasons why a patient may seek to continue analysis; this should not be called reanalysis, I think, even though a certain type of reanalysis may or will take place. The continuation of analysis may proceed immediately or after a number of years. Of course, short interruptions occurring regularly due to vacations, illnesses and the like are not taken into account. It may still fall within the category of continuation of analysis even when the interruption is due to a "divorce, " to use Wagner's analogy of second analysis to second marriage, or a third to athird marriage. 14

Another question: Does a second or third attempt at analysis rate the name "continuation of analysis"? There are some cases in which analysis did not really occur in the first place. I have come to the conclusion that only too often the first or subsequent attempts can not be called analysis, though the patient may have worked with an outstanding person in the field. This is not to say that the previous work was useless. In a number of cases, the patients praised their former analysts for concrete help, such as in graduating from a university, finishing a doctoral dissertation, or overcoming a depression. However, the patients were unable to explain exactly what helped them or what happened during the treatment. In some cases, they were encouraged by their former analysts to seek more therapy but with a different therapist. In these cases, the former analysts termed the treatment they had given "psychotherapy." Since it was difficult to spot any real acquaintanceship with the analytic method for this group, it might be more appropriate to look on their previous experience as a preparation for analytic work and to call their second attempt their first analysis.

There is very little literature directly related to this topic. In a broader sense, however, the entire accumulated analytic experience over the years has a bearing on the problem of reanalysis. Valuable comments may be found dispersed in a great many works of many contributors, among them Freud, Greenacre, Greenson, Karush, Kris, and Winnicott. Wagner's very readable paper, "The Second Analysis" 14 has a direct bearing on this discussion. The others are Maria Kramer's, 8 which I have already mentioned, and Pfefer's "The Meaning of the Analyst after Analysis." 10 Freud's paper, "Analysis Terminable and Interminable" remains a treasure for stimulating ideas.

I found it expedient to take Wagner's view, since he conveniently points out that the patient

> *seeking a second analysis presents a variety of diagnostic and technical problems, concerning which the psychoanalytic literature offers no specific guidance. No model technique for a second analysis has been suggested.*

It seems that we have not learned to translate the analytic experience into a communicable form because the mechanisms of change are unknown. We actually deal with consequences, not causes. It is the complexity of the task that frightens us away more than anything else. Wagner, too, fails to supply a model for reanalysis, and I'm not really sure that one is needed. Perhaps what we need more is to revise our model for analysis.

Among the various interesting items contained in Wagner's paper, I want to pursue one at length. He states that there is "a curious disinclination on the part of analysts to relate their experience with patients who leave their colleagues." We show the same "curious disinclination" to report our experiences with our own patients, let alone that of others, even though we are all in the same boat—all of us have had our successes and failures. I think that some of this reluctance can be explained by the relatively low self-esteem we hold for ourselves in our profession. This is particularly true of the noxious tendency to interpret compulsively and always with a negative slant on things. Criticism often is looked upon in our groups as aggression and hostility, not a difference of opinion or pursuit of truth.

In summarizing his views, based on twenty-two cases, Wagner indicates that most of his patients had more than one prior, experienced analyst, and a considerable number arranged for further analytic work in later years. He states that

> *for most of these patients there was no justification for considering the first analysis a 'failure.' In most cases, all that could be elicited through further transference involvement, through exploration of unconscious fantasies, and the essential genetic facts, had been uncovered in the first experience. … I have suggested that in most of these patients the experience of transference was unacceptable, and that if any technical error existed it derived from the first therapist's insistence that the patient work 'analytically' and accept the reality of the transference.*

Clinical Observations on Reanalysis

I have selected thirty-seven patients whom I *reanalyzed*, to use the term rather loosely. Were I to apply it more rigorously, only fifteen would meet the requirements I set for reanalysis in discussing the definition earlier in this paper. Unlike Wagner, who excluded from consideration candidates in psychoanalysis, I included them. Like him, I consider here only patients who have been treated by highly competent therapists for a minimum of two years. Among these patients were six drop-outs from psychoanalytic institutes. There were seven candidates on probation, twelve graduate members of psychoanalytic institutes, five with advanced standing and repute, and twelve patients not affiliated with our profession.

Nineteen of these patients came for a second analysis, eleven for a third analysis, five for a fourth analysis, and two for a fifth. This group included two of my own patients whom I reanalyzed several years after termination; it may well be that this should be considered delayed termination. Four of my patients in this group made arrangements for further treatment.

As Wagner would put it, in a marriage the last person to find out about infidelity is the spouse. Patients consider changing analysts to be a mark of infidelity; perhaps analysts do likewise. In my consultation practice, I have often had to act as a referee to "divorce" a patient from his therapist.

I was once called in for consultation about a patient who was hospitalized because of a suicidal attempt. She had been in analysis nine years. I interviewed the patient in the presence of the analyst at his request. It gave me an opportunity to observe their relationship. It deteriorated into mutual accusations and justifications, more by implication than in overt content. There were fear and hate between them. The therapist maintained that this patient would not survive without him. The patient maintained the same.

After the interview I asked the therapist how he felt about having the responsibility for someone's life in his hands. I tried to discuss the transference-countertransference implications but I met with a deaf ear. It took quite a deal of doing and a number of meetings for him to be ready to let her go and wean himself from her. It took much more doing for him to wean himself from the situation than it took the patient to wean herself from him. This is just a brief summary of a complicated and instructive situation.

Diagnostically, the patients under consideration fall within the usual categories suitable for analysis. Severe borderline and schizophrenic patients are not included. We might arbitrarily, with some benefit, consider in our discussion three categories even though they do not nearly cover the whole range of possibilities: interrupted analysis, addicted to analysis, and reanalysis.

First, we find patients who *interrupted analysis* for a variety of reasons and who considered continuation necessary or worthwhile. These patients clearly demonstrate gains obtained from previous analysis. Work with them becomes a rewarding and gratifying continuation and consolidation of their efforts with a previous analyst. In these cases, it is relatively easy to see what has been accomplished. At any rate, it is not any harder than evaluation of one's own work.

The second category could be called *addicted to analysis*. This is the group of patients who, I suspect, form the majority of those who repeat analysis and, perhaps, even form the bulk of the patient load in large-city practices. It would be interesting to make a study in this direction to find out to what degree my supposition is true. Wagner's experience clearly corroborates this view. These individuals are addicted to a form of interpersonal existence, which consists in establishing a type of interchangeable symbiosis with any analyst whom they can, as it were, switch on and off as if plugging an electric gadget into an outlet. The moment they sit down, oblivious to the fact that they have just met a stranger, they start talking about whatever enters their minds or wherever they left off with the previous analyst. Such a person uses a form of free association based on an assumption that every analyst reads the patient's mind without effort and knows ahead of time all about the patient and all the patient may say. He may show not only impatience but indignation at being interrupted or stopped. An analyst is not supposed to talk. "Talking" then becomes the great reward that analysis offers, makes it worthwhile to go on and is actually what the person becomes addicted to—a sort of compulsive logorrhea without being able to get anything else out of it.

In some cases, this behavior does not convey any malice, but a self-perpetuated starvation for human contact. It is a desire to have someone for one's own for as many hours as one can afford. It could very well be that behind this compulsion to talk is anxiety at the imminent separation—of being left alone. One patient said, "As I start the session, I am already at a loss as to what it will be like when the hour is over." This behavior may be due to feelings of despair, helplessness, and lack of belief in change. In other cases, it is prompted by a need for revenge, for doing unto another something that has been done to him. This is a different way of dealing with despair.

As an illustration, let us take a father who did not permit his child to talk unless asked and who, in addition, did all the talking himself. Such a child, in adult life may imitate and caricature his father; he may even outdo him in being loquacious. Not having a listener and feeling unacceptable to others or rejected by them, he may turn to analysis as a means of overcoming his interpersonal difficulties, but instead he requires a captive listener and will repeat his pattern endlessly. He will be a good patient in that he will associate freely. To an analyst, this may appear to be the "real stuff." The patient will go on almost gleefully from one thing to another. An analyst may listen for a long time unaware that there is no integration taking place, no insight forthcoming, and no change occurring. It is, as one may clearly notice, a transference manifestation. It can be said that the patient turned father, and treats the analyst as he was treated. And so the analyst turns into the patient, and the patient behaves like his own father, thus dramatizing an old conflict and maintaining the status quo. I have seen a number of patients who come from one period of treatment to the next unchanged. The switch from one analyst to another occurs because the patient or the analyst finally decides that enough years have passed without result; it is time to go to someone else. The patient then turns to another analyst and spends a number of years with him, terminating with equally unsatisfactory results.

Some may object to any intervention from the analyst from the start. More exactly, the patient can not tolerate being *treated*. All he wants is the joy which he finds in the compulsion to talk with a captive audience. Satisfying the need to talk gives him enough gratification, which is particularly increased because of its being coupled with a sense of power. The following incident took place and illustrates this point.

An intelligent college student, aged twenty-four, was referred to me for further treatment. I asked him during the first and only interview, "What did psychotherapy do for you so far?" He was surprised at this question. He had never thought of it before. "Well, " said I, "think about it right now." He grimaced, shook his head and shrugged his shoulders. "I can not think of anything, " he retorted. "Why do you want more of it?" I persisted. "You see, " he explained, "I am like Ibsen's scorpion, and you are the orange peel, and I eat at you, and you sit there, and you can't do anything, you can't say anything." He continued, "Of course you are well paid for it." In his case, an uncle paid for the treatment. I never thought of myself as an orange peel, but then I never thought of a patient as a scorpion either.2

From this and other experiences, I have learned that very often all one can do with patients in this category is just to listen and answer an occasional question so as to reduce their guilt, anxiety, and loneliness. But every question addressed to them is perceived, not as an inquiry, but as questioning them—thus, as an accusation and disapproval. So anything that is said has to be formulated in such a way that no accusation can be implied. To repeat, this group of patients is likely to become addicted to treatment. They consume the analyst's time because they can afford treatment, and they can go to the best. "Nothing but the best, " one patient told me. One should not assume that they do not need treatment; these are very lonely, bitter, isolated, desperate individuals. In essence, they cannot tolerate treatment unless it is done by therapists who are skilled in dealing with paranoid defense mechanisms, and the therapist finds a way to teach the patient to learn from experience.

The difficulty in treating the patients of this group lies in the monomanic restricted equipment they have at their disposal in relating to people. They are easily provoked and even more adept in provoking others. Their skill is in making others, specifically the analyst, feel wrong and guilty. They are adroit in making any therapist feel in the wrong, in taking the opposite view of whatever the therapist may say, and of taking personally any disagreement. Even though analytically oriented psychotherapy is indicated and applied, the repeated and continued treatment of such individuals cannot be called analysis or reanalysis. It is worth noting that some of these patients avoid a lifelong hospitalization or suicide thanks to their perpetual association with psychiatrists. As one patient told me, "It is a question of survival."

The third category we should consider here is reserved for what I term *reanalysis*. These are cases in which analysis terminated in a mutually satisfactory manner for the participants. The occasion for reanalysis may be created either by new stresses that reactivate old symptoms, or new symptoms that develop for traumatic reasons or other unforeseen stresses in life. Also included here are analysts who, at the time of termination of their analysis or training, were aware of areas which deserved further investigation, and postponed it for the future. All patients of this group show a sufficient familiarity with analytic method and ritual. They have a conviction, maybe even a faith, in the efficacy of analytic insight. This group should hopefully contain us professional analysts because for us certainly analysis is interminable.

Unlike other branches of medicine, there is the basic requirement that each psychoanalytic candidate undergo psychoanalysis, not only because he is preparing for the practice of analysis but also because he is subject to some of the same abnormalities he will be treating in his future patients. It might be said, not without justification, that he will be treating or re-treating himself in others. But rather than being a source of distinction and pride that each member of our profession has to undergo the same kind of treatment as his future patients, it is too often turned into a source of shame, embarrassment, even disgrace.

True as it may be, this part of training forms a very small, albeit important, segment of the work to be accomplished during analysis and particularly reanalysis. The predominant emphasis on this aspect is an important error for it minimizes the major goal—namely, that it should be an educational experience in matters of human nature, living, and self-knowledge. The premise that analysis is primarily the treatment of morbid qualities puts a stigma on the process of analytic training which prevents practicing analysts from entering reanalysis or from admitting it when they do.

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[2]I subsequently tried in vain for a considerable time to find out what connection Ibsen had with a scorpion until I ran into the book by his daughter-in-law, Bergliot Ibsen— *The Three Ibsens* —which quotes him (6, p 28) as follows: "While I was writing *Brand*, I had on my table a scorpion in an empty beer tumbler. Now and again, the creature seemed to be ailing; then I used to drop a piece of soft fruit into the tumbler, which it fell on with rage, releasing its poison into it; then it was well again at once. Isn't that rather like us poets? The laws of nature seem to apply to spiritual life, too."

The trainees, graduates of various schools of thought and institutes, whom I happened to analyze, treat, or see in consultation claimed that they felt considerable constraint during the years of training analysis and could hardly follow the principal rule of being true to themselves. They had to serve, so they claimed, "the reality principle"; that is, they felt pressured to conform and adjust to requirements that are a far cry from love of truth. I have had a great deal of experience with a number of such analysts so that I feel entitled to draw some tentative conclusions, which indicate a need for critical re-evaluation of some of our attitudes toward training. After graduation from an institute, such trainees come for reanalysis with defined and well formulated goals for further work. It should be stressed that the work with this group is relatively easy and gratifying, and whatever they achieve in this second attempt has already been prepared by the first one.

This second sequence is characterized by a type of freedom that seemed inconceivable to any of them during their years of candidacy in an institute. They invariably commented on the pressure experienced from the training institutes to pretend a posture of sanity or of neurosis, or of both. Whether in such instances this second analysis should be classified as reanalysis or as continuation remains an open question. It could be considered as completion of an apprenticeship that started with one therapist and terminated with another. It certainly was a worthwhile experience for the majority of those whom I treated. It is understandable that coming on one's own volition to do some work for oneself after years of preparation for it by the training institute, but without the pressure for "grades, " will make a difference.

No matter how much allowance one might make for the need to regress in order to be analyzed, the general lack of courage on the part of candidates, their individual neurotic reaction to analytic training and apprenticeship and all the rest of it, an inescapable thought intrudes itself—analytic training as currently conducted is by and large a traumatic experience that takes years to overcome.

I have lingered longer with this third group because it forms the bulk of my case load, and also because it interests me more in connection with reanalysis. With a few exceptions, those who come on their own for reanalysis, years after their training is completed, do well. I find it necessary to qualify what I mean by "doing well" because one might wonder what standards were applied and whether any ideal goals were accomplished. It seems clear from any recent writings on termination of analysis and from Freud's "Analysis Terminable and Interminable" that expectations of ideal endings have been given up and, similarly, that one should not expect ideal endings from reanalysis either. Through the years of my work, I can count on the fingers of one hand the times when I felt that the patient terminated at a point where he had derived more than he or I could ever have expected. Moreover, this happened only to remarkably endowed people. Most of the time, the termination of reanalysis took place, in a way similar to termination in general, after the usual preliminary preparation for it—the reanalysis of the transference—and after considerable duration of the mourning process that goes with it. And just as in the first analysis, areas were outlined for further investigation should the patient be interested in doing it at some future time or on his own.

Concordant with my view is that of Rudolph Ekstein, 2 who states the following on the subject of termination of analysis:

> *In order to stress that this ideal ending—for example the complete resolution of the transference neurosis, the disappearance of all symptoms, the structural changes, the perfectly integrated personality, etc.—is an overidealized goal, hardly ever reached, the technical literature has dealt more and more with interruptions, with the likelihood of later reanalysis, and has become more concerned with indications for termination, the necessity for re-evaluation of therapeutic results, and has given up the notion of the ideal ending.*

This applies to reanalysis also. Even though reanalysis might not achieve these ideals either, it usually does afford the individual a higher degree of integration, further resolution of the transference neurosis, and additional relief of symptoms.

Self Reanalysis

The question of whether reanalysis differs in any substantial way from analysis was foremost in my mind. In answering this question, I was faced with a serious obstacle right from the start. In fairness to our tradition of knowing the experience firsthand, I should have had the experience of reanalysis before embarking on this venture. Why not go for reanalysis right now myself? First of all, a problem: To whom should I turn? My preference would have been to go to the one who analyzed me first. This could easily be interpreted as a sign of an unresolved, residual transference. Nevertheless, this would be my choice if it weren't for the hundreds of miles separating us. I felt no pressure for seeking more analysis, other than this commitment, and I felt no desure to inconvenience myself to any considerable degree. And I did not fear that this might expose me to the common criticism of "not being well enough analyzed.' (8, p. 18) I go on the assumption that this is the general rule—nobody is analyzed well enough in another person's eyes.

Therefore, with reanalysis seemingly out of the question, I tried to pursue my new assignment in two ways available to me: on the basis of my experience as a therapist and by self-observation. It would seem that taking more detailed notice of anything pertinent to this subject during the current work, and thinking about activate the process of self-observation, and intensify my long-standing habit of listening carefully to the inner monologue while listening to my patients. I made my interest explicit. I told most of my patients, who were in the process of being reanalyzed and were in the same profession, that I was preparing a paper about reanalysis. I found myself directing more frequent questions, aimed at finding out the points of comparison between me and other analysts—questions pertaining to the reasons for seeking more therapy, as well as the benefits derived from every single attempt. However, nothing else happened, other than perhaps more focused intellectual activity such as takes place whenever preparing a talk, along with an accumulation of notes which I found difficult to use.

During the meetings of the American Psychoanalytic Association in December, 1967, I met socially with my analyst after an interval of at least fifteen years. We had lunch and talked about various topics such as trips abroad, theater, and other social items. Perhaps because of the preliminary preparation for the process due to the program in view or because of the years that had elapsed in-between, this meeting suddenly brought on an analytic mood. During this lunch, I felt as though I had moved back twenty years. This feeling of living in the past persisted for several weeks.

In addition, a process akin to analysis took hold of me and persisted for over three months. This process consisted of absorbed attention, directed inwards, occupying every free moment of my time. It took the form of a *report-to-my-analyst*, in which I recapitulated and recounted my life. It could be said that this was an interpersonal process, mirroring analysis except perhaps for a subdued intensity of transference-neurosis and minimal need for projections. I would liken it to what occurrs in revaccination, for example, smallpox revaccination: the same stages as in vaccination, but all in attenuated form, and shorter duration. Similarly, my reanalysis was accompanied by pain, despair, uncertainty, separation anxiety, transference feelings and grief, all in comparatively diluted form. At a certain point, I even asked myself in distress, "What have I gotten myself into?" and "Will it ever end?" But by then, there seemed to be no other choice about this process than to proceed. It had a quality of compulsion. It was a very rewarding experience for me, for it brought to light a number of childhood memories hitherto inaccessible. I had always had a reverence for the analytic method as an effective tool toward self-knowledge. This feeling became reinforced. I became once more awed by the strength of early life experiences and their indelible mark on our lives.

I am including here for illustration the initial episode which led me into this process, which I named *self reanalysis*. The evening before the lunch engagement with my analyst, a song haunted me. I had heard it in childhood; the song had to do with death and solitude. I dreamt that night of my mother, something that had not happened for a long time. It was following this lunch that I started a sort of review of my life. The next morning, I awoke at 6 A. M., a rare occurrence for me. Irritated, feeling like a four-year-old girl, and in a mood for a tantrum, I felt like hitting someone, and my fists felt tiny. It was something I don't ever remember doing or wanting to do. My father would not have stood for it.

I then saw myself as a four-year-old child in a light beige dress standing in front of my grandmother; I was speechless and frightened, incapable of uttering a word, while she stood there, big and awesome, scolding me. I tried hard to think, to recall what I had done. What was my sin? I felt helpless and hopeless. There was no one around to rescue me, no one to turn to.

Immediately on recapturing this image, I felt a tremendous relief. A number of situations when I had felt speechless in front of older women with gray hair went through my mind, and a curious inner ease, like taking a deeper, freer breath filled my chest. This kind of thing had happened to me a couple of times during my analysis. It is as good as any illustration of what is meant by the lifting of a repression. Concomitantly, I think, a correction of a traumatic perception is accomplished through awareness of its chronological impact and differentiation of the consequences.

I am aware that to many this account will sound unbelievable. When one has had an experience, he never forgets it, and if he did not have it, he will never believe it. Apparently, my grandmother sensitized me to a fear of rejection by older women, notably those with grey hair. I could recall retrospectively a number of situations in which I found myself speechless with gray-haired women. I was not aware of having a difficulty in this area. It did not interfere with my life sufficiently for me to notice it. What puzzled me, and still does, is why such a persistent, strong repression? And how many similar repressions may still operate within me?

The analytic implications are many. I leave it to the experts to interpret, as a good patient should. Why did it become accessible at this moment? My grandfather died when I was two and a half, my grandmother when I was four and a half. My most clear-cut countertransference problems and examples have been drawn from my relationship, and that of my parents, to my grandmother. Why was it necessary for so much time to elapse to recapture this memory, and why should it be so important in its consequences? Two lines of thought emerge immediately: *One*, that the transference indeed was not analyzed enough; *two*, that it could not be analyzed at that time even though or because they were the only losses of my early life. It is possible to assume that I had first to mourn later losses before I could go so far back. It is hard to decide whether this could have been accomplished earlier during my training analysis. I suspect it could have.

In reanalyzing patients, I usually find a neglect of the analysis of early losses of any kind, whether the death of grandparents, parents, siblings, friends, pets, and even loss of toys. Mourning and confrontation with death are not too popular themes in many analyses. We are biographers who have to manage to interest the patient in his own life and help him relive it dramatically and meaningfully. The tendency to avoid feelings and thoughts on death is natural to man. It brings out the deepest helplessness in his destiny. It was Spinoza who said that a wise man thinks about life, not about death. I don't believe it is possible to think freely about life if one excludes death and denies it. Only too often both the analyst and the patient are in complicity about this omission.

Some Technical Problems

Perhaps a few remarks should be made about what might be considered modifications of technique; these items all relate to preparation for free association, analysis of the transference, and handling of regression. Multiple analyses are likely to follow similar or identical patterns unless the new analyst becomes promptly aware of that fact and engages the patient in a drastically different manner than the previous analyst did, so as to take him out of the sterile and stereotyped rut. Occasionally, the patient may learn from his previous experience and embark on his own on a different start. This, however, is a rare occurrence. The most difficult obstacle is the "narcissistic injury, " the sensitivity to hurt, and humiliation present at the start and blown up more and more through the years. An added humiliation is that it is customary to blame the patient for the lack of progress in the previous analysis. Nobody knew better than Dostoevsky about the lot of the 'injured and the insulted." There is a lot to learn from literature other than the psychoanalytic about this aspect of the human soul in order to be more effective in desensitizing the hurt. Long preparation may be necessary to raise the patient's self-esteem through steps leading to increase in psychointegration before analysis of the transference proper can proceed.

Wagner suggested 14 that "in most of these patients the experience of transference was unacceptable, and that if any technical error existed it derived from the first therapist's insistence that the patient work '*analytically*' and accept the reality of the transference." My experience does not exactly coincide with Wagner's, possibly because of a different view on transference.

Invariably I found in the previous analysis an omission of an important early relationship, usually with a sibling. I also found frequent avoidance of analyzing some aspects of negative transference in conjunction with intense dependency needs and pregenital drives. I had reanalyzed three patients who came from one and the same analyst, and was able to deal with their negative transference only indirectly, using the previous analyst as the target for their aggressive impulses. In this instance, it is possible to assume that these three patients could not deal with intensely ambivalent feelings directed at the same person—or perhaps it was an easier way out.

Similarly, in a number of cases it was evident that regression got out of hand, or was thwarted and discouraged during the previous analysis, thus preventing the transference from developing. I am omitting in this discussion countertransference problems for I cannot cover this subject in a sentence or two. Some of the countertransference issues are evident.

Free association is often conceived as *free talk*, a type of superficial monotonous narrative rather than absorbed thinking that would allow the formation of new, unknown connections. For this, a *safety factor* is needed. Analysts do not always manage such an atmosphere. There is a need to show some resourcefulness. As one of these patients said, "a daring" is needed in reaching a patient and eliciting a response. I don't see any discrepancy in this kind of activity on the part of the analyst with the psychoanalytic tenets. It does not differ from the analysis of a dream. Perhaps that is why dream analysis is so useful; it gives a legitimate opportunity for the analyst to use his imagination.

The difference between free association and what I call "free talk" can best be expressed in Shakespeare's words:

> *Pray can I not,*
> *Though inclination be as sharp as will:*
> *My stronger guilt defeats my strong intent;*
> *And, like a man to double business bound,*
> *I stand in pause where I shall first begin,*
> *And both neglect…*
> *My words fly up, my thoughts remain below:*
> *Words without thoughts never to heaven go.*
> *(Hamlet, Act III, Scene 3)*

There are three qualities which are indispensable in order for the patient to benefit from free association: thoughtfulness, courage, and curiosity about his mind and the history of his own life. Surprisingly, many patients do not have this curiosity. We know that children are curious, and I think that their curiosity antecedes any of the curiosity about the bedroom of their parents. I don't consider it necessary to accept wholeheartedly psychoanalytic views on the origin of curiosity, but it is definitely to the advantage of the patient to desexualize the curiosity in order for him to be able to recapture it and use it.

A total lack of curiosity in the working of one's mind or that of other people is perhaps *more* morbid than an exaggerated curiosity in this direction. It pertains to the narcissistic disorders. Lack of narcissistic interest is incompatible with acquisition and use of insight.

Reviving the curiosity about one's childhood has a marked positive influence on the quality of free association. The obsessive-compulsive group is masterly adroit at endless narratives with lack of introspection. What sustains them in a vicious circle are anger and righteous indignation, a strategy in avoiding anxiety and depression. Working through the depression seems to me the unavoidable task in order to correct the narcissistic disorder which led to what I call *disengaged pseudo-independence* in the obsessional. A therapist has similar difficulties with the *hysteric's pseudo-engaged dependency*. I think that the technical problems are the same in analysis as in reanalysis. I do not believe that any modifications are needed in the way one uses the couch and the number of sessions per week, regardless of the degree of regression.

The therapist's burden is making himself useful to the patient, and it is the patient's responsibility to make the best use of what the therapist has to offer. This is not always the case. In reanalysis, however, the patient is more ready to deal with what he does *for himself* than what the analyst does *for him*, and he takes more responsibility for making the best use of the analyst's skill and the process of analysis. If the patient does not do well, it is a consolation for the therapist that someone failed before him. Unfortunately, the burden of the failure is usually put on the patient. There are lights and shadows in working with patients who come for a second, third, or whatever sequence.

SUMMARY

Apart from having to undo some of the unfavorable types of interaction between the patient and the previous analyst, so as not to repeat them, there is no evidence that reanalysis poses different technical problems from analysis. If anything, where the term *reanalysis* applies strictly, the work is easier because the patient's cooperation is more assured. The greatest number of people who make a second, third, or fourth attempt fall either into the category of the so-called non-analyzable patients or those who need a great deal of psychotherapy before analysis can be envisaged.

All of those who seek treatment need it; the tendency, nay aspiration, of being able to treat whoever presents himself in the broad range of mental suffering is eminently justifiable, pragmatic, and in keeping with the medical tradition and the philosophy of a healer. The problem is how to make the method more useful for the patients, how to perfect our methods of dealing with them so as to avoid the years of unproductive work and wastefulness that I have had an opportunity to witness in my work and that of others.

It would not be out of place to discuss now the problem of regular periodic reanalysis of members of our profession. We all know Freud's recommendation that such a procedure should be applied every five years, and we know why. The question is this: What is there in the atmosphere of the psychoanalytic societies that makes this recommendation not realizable or scorned?3

If anything, reanalysis could be an essential part of postgraduate education. It would be looked upon as an "advanced course" in the same procedure—more thorough, more extensive, more elegant, more artful, and more rewarding in its results both for spontaniety in performing this "impossible" profession and in the art of living. Reanalysis thus conceived should add stature, rather than lower self-esteem. If one attitude of the psychoanalytic institutes and societies could be singled out as responsible for this reluctance to be reanalyzed, it is the high price put on conformity rather than on development of individual and individualized responsiveness. A routinized procedure may be identical in concept, yet individualized in realization.

As I reviewed the case material, I noticed that the therapies employed by colleagues differed as widely as the individuals who applied them varied. The use of the same procedures and concepts by different analysts shows a wide variation in emphasis. The values attached to different aspects of human behavior also have had a marked influence on the emphasis and on the direction of treatment.

"Nature, " Dr. Walter Cannon said, "practices the 'economy of abundance'; we often practice the 'economy of waste'." Perhaps this is unavoidable. A step by step, painstaking search to find new forms for putting forth the same insight so as to make the person *see* is not as easy as it sounds. This work requires as much patience on the part of the therapist as courage to endure on the part of the patient. It takes a very long time to make a friend of one's mind instead of an enemy, to paraphrase William James.

The analyst or psychotherapist of today often assumes the role of practical philosopher to whom people come in search of happiness. This conquest of happiness is supposed to be achieved without pain. One can not place on a platter that which has to be done by effort and suffering. The therapists are often not immune from the same tendency to avoid pain.

To conclude in a more optimistic vein, I shall quote Mencken as he spoke of philosophers. I think this statement is very applicable to our work: "There is no record in human history of a happy philosopher: They exist only in romantic legend. Many of them have committed suicide; many others have turned their children out of doors and beaten their wives. And no wonder. If you want to find out how a philosopher feels when he is engaged in the practice of his profession, go to the nearest zoo and watch a chimpanzee at the wearying and hopeless job of chasing fleas. Both suffer damnably, and neither can win."

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