

PSYCHOTHERAPEUTIC THEORIES DEVELOPED BY MEANS OF THE SCIENTIFIC METHOD

And an Unknown Clinical Phenomenon that Destroys Treatments at the Start

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PART 1

INTRODUCTION

Psychoanalysis has long been at a standstill in terms of developing a capability for scientifically testing its central hypotheses and advancing beyond them. The discipline's communal will is lacking when it comes to making a large-scale assessment of its theories and entering a revolutionary period that would usher it into the world of the true sciences. As a result of this situation, the profession is having considerable difficulty convincing a still-interested but cynical public and a potentially-embracing scientific community, of the validity of its premises.

Waiting in the wings, and primed to begin a drama to behold, is a considerable cast of validatable, psychoanalytic hypotheses ready to remonstrate against being lumped with an equally large array of pretenders. They want their logic acknowledged and their predictive powers displayed. They would like to end the fruitless insubstantial debates that the profession carries on with its occasionally-credible scientific critics. They also want respect for what they already are, and can be much more of, i.e. sound components of a powerful instrument for understanding and enabling root changes in the world ills that are the consequences of unfortunate psychological developments.

This paper describes and discusses the prominent factors that are keeping the analytic discipline from entering a new scientific era. It then proposes a restructuring of the traditional Societal approaches to research, education and clinical training, a reorganization designed to make the psychoanalytic enterprise more permeable to multidisciplinary intellectual influence, the principles of logic, and the Scientific Method. Finally, the paper describes a new clinical theory of formulation in which concepts are concretely defined, principles are logically conceived, existing hypotheses are tested for predictive capability, and the analyst's efforts are made impervious to unwitting subjective intrusions.

THE OPPOSITION TO SCIENCE AND ITS CONSEQUENCES

Close observations of psychoanalytic habit note an antagonism to the Scientific Method and an attraction to the so-called psychoanalytic "art". In a manner peculiar

for a profession with scientific ambitions, it has opposed available possibilities for developing its endeavours along common scientific lines and by scientific approaches. While it has a body of "Basic Theory", Metapsychology, it shows little interest in defining its concepts and validating its principles. And unlike the other sciences, it does not make its Basic Theory the foundation of its "Applied" Theory. When it turns to developing clinical applications of its hypotheses, it proposes to discard its metapsychology and create a separate, so-called "Clinical Theory".

This situation has posed serious problems for practitioners and clinical researchers, and stalled the profession's growth. Without a scientific approach to the development of its hypotheses, it has been impossible to create a nucleus of tested, standardized theory that can be taught, learned, practised, recorded, and examined for process and outcome based upon skill levels alone. It has also been impossible for researchers to delineate the limits of existing theory and define the unknowns of symptomatic phenomena in and out of the clinical situation. And there are many phenomena in the psychoanalytic "domain" that cannot be explained by current theories.

WHY THE LACK OF A TRUE PSYCHOANALYTIC SCIENCE?

A: OBSTACLES OF THE "PUSH-AWAY" VARIETY

1. Clinical Mind-Sets and Educations

Many, or most, who train in the helping humanities and then in psychoanalysis, are preparing for primary lives of service and treatment, and they bring mental sets and educational experiences that are different from those whose callings are to the traditional sciences. When they address clinical phenomena, it is not part of their interested "second nature" to think scientifically, and when faced with unexplained phenomena, they are driven away from scientific researches because they have not developed the conceptual tools required to conduct them.

Holzman and Aronson (1992) spoke to this point. They said that (p.74) because training was largely limited to people who would only practise, few analysts possessed the interest, knowledge, ability and time to contribute to the development of science.

2. Action and Scientific Research

Analyst clinicians also take care of suffering people who press them for action, and, responding to interpersonal and social forces, they are led towards instrumental behaviours and away from the long, painstaking work with unknowable outcomes involved in clinical scientific investigations.

3. Inadequate Theory and Limited Personal Analyses

The profession's gross lack of proven technical theories does not allow candidates in training analyses to reach and eradicate the deepest roots of personal conflicts, and the problems remaining drive unwitting would-be clinical researchers away from scientific methods. I will elaborate.

4. Opportunity Knocks but No Doors Open

Graduated analysts and psychotherapists *could* (practically and theoretically) identify previously undetected or still-active symptoms in themselves and make new forays into deeper layers of their own developments. Individual analysts *could* exploit the situation to confirm and disconfirm existing theories, then use the surviving conceptions to travel to theoretical frontiers and explore beyond them. And moving about in those virgin territories, they *could* spawn new general hypotheses directed to understanding a host of clinical-symptom mysteries (e.g. the terror that prevents interest in the dreaded "fragmentation" state). However, few, if any, are led by curiosity to pioneer the development and application of depth self-analytic methods and practices. Instead, most clinician/researchers champion the idea that "no analysis is ever complete". They leave countertransferences (which, by definition, are the products of unsolved conflict between original caretakers and self) at the "recognize and control" level of understanding and technique. More than a few analysts even carry on romances of sorts with their own transference responses to patient material.

5. Institutional Sanctions and Sleeping Selves that Wake

At the institutional level, the profession supports retreats from the "investigative self-analysis" concept by accepting the irrational idea that a multiplicity of different, unscientific theories can all explain a same phenomenon. It thereby encourages clinicians to operate for years with what could later prove to be mistaken principles. It also encourages them to establish and live within theoretically-narrow subgroups that continually reinforce their circumscribed ranges of thought.

Pearl King, in the King and Steiner review of the British "Controversial Discussions" (1991), indirectly referred to the "favourite theory" and "opposition to change" phenomena when she wondered (p.2) why professionals became abundantly unhappy and "nasty" when new findings required them to change their theoretical beliefs.

6. Science Accepted and Depths Disturbed

Science undoes logical fallacy and leads the scientist into the fallacy's origins. But in the psychoanalyst's case, the problem is not comparable to those solved by general-science theories like that of the faulty electrical circuit. The cause is not a mistaken idea about which pole should receive the red wire, and the solution is not a simple change in the hookup. The problem is the analyst's incomplete analysis, the cause is his(her) unwitting, defensive fear and avoidance of earliest psychological conflicts, and the solution is a complex, protracted study that moves towards

unforeseen changes that send volts of violently-charged anxiety through the technician's psyche and do not quickly stop.

8. Deficiencies of Logic and Uncheckable Retreats

A further obstacle to science is the general lack of experience that analytic theoreticians have had with the principles of formal logic. Fallacies abound in their writings where they largely remain unrecognized and unchallenged by the authors, journal editors, conference program-committee members, and readers of their papers. And unsupportable categorical statements that offend reason and the facts of experience are often the result.

Didier Anzieu, in his book, "Freud's Self Analysis" (1986), arrived at a number of generalizations regarding self analysis that this author's experience (Anderson 1987) completely contradicted. For example, he said that (p.569) for a self analysis to take place, it had to be communicated to someone else.

B: THE PULL-TO OBSTACLES

1. An Attraction - the "Analyst as Artist"

Prominent in this category of barriers to scientific development, is the attraction that the "artistic" conception of clinical practice holds for most analysts. Arnold Cooper (Shapiro and Emde, 1995) acknowledged this fact in the book, "Research in Psychoanalysis: Process, Development, Outcome". He said (p.389) that the majority of analysts probably liked to regard themselves more as artists than practitioners of a standardized type of treatment, and that most would be averse to replacing their favoured "freely-hovering attention" formulation method with one rooted in cognitive processes.

2. The Reasons for the "Pull" of Art

This oft-proclaimed "art of psychoanalysis" has much in common with the "art" of the "artistic creative process", and both processes have major properties in common with the "neurotic symptom". Like the symptom, the artist's creations are derivatives of unconscious mental structure-processes. They are therefore, by definition, "compromise formations" of defence and drive. But in the case of the *artistic* creation, the formation that emerges is a desirable release of expression and communication through defences from the creator's depths, as this author discovered (Anderson 2011, Chapter 20).

Reaching up to the self at the artist's surface, deeper self parts solicit the pursuit of an artistic career. An expressive unconscious self that wants out (but not by way of the long and frightening route that undoes defences) issues derivatives that seduce the surface self to its thinking. Then the professional artist accepts his/her existing symptoms and rejects psychoanalysis, and it is reasonable to presume that the "artist analyst" is similarly inclined.

3 Freud's Invitation to Join, an Exclusive Club

Freud's "psychoanalytic movement" mentality, with his "them and us" "shibboleth" talk (1905 (p.226), offered prospective analysts "exclusive membership" in psychoanalytic Societies. Then those to whom such status appealed had their activities sealed from the world at large, and an aura of mystical superiority developed in and around them. Then the external world became excluded as a source of critical influence. It was unable to force the discipline's excessive self-estimations down to earth and help it separate many of its wonderfully-provable theories from a host of failures,

A PROPOSED SOLUTION

As an answer to these problems, it is recommended that the isolation of the psychoanalytic profession, and its relative impermeability to reasoned scientific critique and assistance from the external world, be undone. It is proposed that psychoanalytic clinical research, education and training be shifted from analytic Societies and Institutes to the universities, where vital aspects of the discipline can benefit from exposure to the criticisms of an interdisciplinary body of thinkers skilled in logic, versed in the scientific method, and familiar with the methodologies of experimental design. It is also recommended that analytic hypotheses, past and future, be regularly subjected to rigorous intellectual assessment and scholarly research. In this advocated schema, psychoanalysis would become an academic, teaching and training department on its own, or a sub-department of an existing discipline, and, thus formed, would offer a variety of trainings in addition to that of clinical treatment. Among them would be:

- clinical research conducted by the clinician him/herself in parallel with his treatments
- extraclinical experimental psychoanalytic research;
- adaptations of tested basic and technical theories to the treatment of problems of infant-child development, the dysfunctional family, psychologically-derived societal ills, and international afflictions of the same nature.

PART II

A NEW SCIENTIFIC METHOD OF RESEARCH AND PRACTICE: THE METAPSYCHOLOGICAL FORMULATION METHOD

INTRODUCTION

In support of the above-proposed movement to create a true science of psychoanalysis, an overview description and illustration of a progressive, forty-year study is offered. It describes how:

- the viable Metapsychological theories of Freud and other analysts of the early years were identified and isolated from the rest
- concepts were defined in concrete terms
- principles were tested for predictive capability in the clinical situation hundreds of times
- a new, scientific, teachable, rapidly-operative, predictably-accurate, conscious, cognitive method of formulation applied exclusively to the analysand's concrete, objectively-observed material was developed for use with all varieties of presenting symptoms.

The development of the method is outlined and an illustration of a critical clinical situation at the very beginning of consultations is provided. It will describe a phenomenon that the author's research first encountered during a study of early transferences (Anderson, 1982), then move to the technical importance of identifying and addressing transferences from the start of consultation. It will also establish the "start" as the time of the first phone call to arrange the first meeting.

Note: In all that follows, the author's purpose is illustrative only. The details of the material to be presented are more complicated than a first reading would allow one to absorb, and concentration on the specifics of the following example for treatment purposes is not recommended.

EVOLUTION OF THE METHOD

The Conventional Formulative Techniques and Some Doubts

At the start of this research, the investigator was using the formulative techniques that he had been taught, many of which still exist. He:

- allowed his formulations to emerge from his unconscious (Freud, 1912, p.112, 115);
- gave "evenly-suspended attention" (Freud, 1912, p.111) (commonly referred to as "*free-floating attention*");
- provided "evenly-hovering attention" (Hollender, 1965, p.71);
- remained equidistant from id, ego and superego, (uncertain origin)
- used his counter-transference to assess the transference (Racker, 1968, p.127-173);
- studied his empathic responses as indicators of the subjective experiences of his analysands (Kohut, 1971, p.300-307);
- used symptoms appearing in himself during sessions as signs of communicative processes in patients (Jacobs, 1973).

These approaches posed problems in logic. For example, Freud's advice to formulate using the "unconscious" became a contradiction in terms. It claimed that what could not (by definition) be known could be used to know. Interest in these

problems then led the researcher into a series of investigations that produced unexpected results.

METAPSYCHOLOGY CONCEPTS DEFINED, A NEW INVESTIGATIVE METHOD CREATED, NEW RESEARCHES CARRIED OUT

A: Testing Metapsychological Concepts for Definability and Standardizability

The researches began with the examination of clinical material in process for the metapsychological concepts that could be identified and defined in concrete terms (for example, "ego", "resistance", "defence" – unlike, for example, “introject”) and those that survived were retained.

B: The Minimalist Intervention (M.I.) Research Method and Testing by Prediction

This method was developed for predictively testing meta principles (e.g. the "compromise formation" of symptoms, slips of the tongue as involuntary emergences of repressed material). By its terms, the clinician made the least possible use of the most basic technical principles (e.g. giving rationally and realistically developed instructions like the method's “Free Association Principle”), and did not use poorly defined theoretical concepts or scientifically untested principles. **M 17.7.16**

He particularly avoided use of "data-distant" theories, untested theories that make large, inferential leaps from the hard data of phenomenological observations. Freud's Oedipus Theory is an example. Applying it, upon observing signs of rivalry in a triadic relationship system, the practitioner infers the nature of his subject's drives without their being required to appear in the patient's releasing associations. His subsequent interpretation, combined with a lack of monitoring of the operative transference of the moment, leaves the situation open to patient confirmation via suggestion. By contrast, the M.I. method did not assume the nature of drives until they were released by work with defense systems (that suppressed/repressed them) and appeared directly in the patient's associative material.

Using this method, hypotheses were tested by prediction. A formulation employing the hypothesis was created, explicitly recorded, and not provided. Criteria for its validation or otherwise were determined and the test result was decided on the basis of the subsequent, spontaneously-emerging, patient material.

C: Testing the Jacobs Formulation Hypothesis (Above)

In this test (Anderson, 1979), the formulative method suggested by Jacobs was examined. The analyst observed his own *symptomatic acts* in sessions and analysed them. The self-analytic material led away from patients and onto personal conflict issues.

Example

The self analysis of a near mispronunciation of a patient's name led the analyst to a recent social situation in which he had presented an important and well-documented brief to a volunteer organization. At the end of his presentation the work had been unreasonably and aggressively attacked, and his self analysis revealed that, in his efforts at self defense, he had been handicapped by unconscious restrictions in the range of his healthy aggressive-drive capabilities. It further revealed that he had unwittingly continued to be rankled by his experience, and that aggression inhibited from expression at the time had been seeking outlet since. It had then found it in the sheer phonetic similarity that his patient's name shared with his particular aggressive drive form (namely, "hate").

A retrospective meta-structure comparison of the analyst's self-analytic material and the (recorded) material of his analysand at the moment of his internally-observed parapraxis was then carried out. It showed no evidence of specific connection to suggest that observation of the derivatives of the analyst's own unconscious activity could be put to use in the formulation of his analysand's free-associative efforts

D: A Research into Symptomatic Behaviours in Assessment

Thirty-seven (37) assessments for psychotherapy/psychoanalysis were examined as they took place over a period of three years (Anderson, 1982). In all instances, operative ego-syntonic transferences deriving from character symptoms had attached to, and negatively transformed, perceptions of the actual consultant and the consultative process at the start. The mistaken perceptions were then taken back in to form mental representations of the consultant in which he became a replica of the once real, then internalized (in-memory), still-active, original problem objects. This situation then nullified the expressed assessment intentions and efforts of consultant and consultee until it was concretely identified and effectively addressed.

Out of this research, a new name for this "projection-reinternalization" phenomenon was created. It was called the "Glover Effect" (after Edward Glover - see Anderson 1982), and it became something much to be prevented.

E: A Study of the Theories of Intersubjective Influence

An on-going, less formal attempt was then made to take the mystery out of Intersubjectivity Theory.

The analyst-investigator posited that:

one mind's unconscious, influenced another by way of the concrete, behavioral-expressive effects of its "derivatives" upon a perceptual apparatus of the other that was particularly primed to apprehend them.

Patient material that had stirred the analyst was then held up against the elements that had been stirred in him, and it was discovered that, out of the analyst's awareness, his mind was acutely observant because it was unconsciously directed to:

- defend from traumata that it had never learned to master;
- seek indicators that offered possibility for satisfying inappropriate needs.

It was also noted that his mind:

- frequently projected its feared traumata and wishful need-satisfying opportunities into patient material that did not objectively contain such things.

F: Recording Techniques Introduced

Recording techniques were gradually introduced and included:

written process notes (in small, effortless, automatic pen-hand, and covering near-verbatim patient material and analyst formulative processes, symptoms, subjective experiences and self-analytic material)

notations of important research material

a codification system.

An Example of Codification

[An operative "transference-of-defense" (as indicated by such a statement as,]

" ... I KNOW YOU THINK I'M STUPID, SO I WON'T BURDEN YOU WITH .. ",

[was codified, in its context, in the following terms without accompanying definitions]

R/ (*resistance*) <In the left-hand margin of the process note, and
 OT/ (*operative transference*) paralleling the pertinent material to the right>
 TD/ (*transference of defense*)
 SEEI/ (*details of object's standard-setting activity*)
 TI/ (*aggressive drive category and form*)
 TF/ (*details of object behaviour - content and form*)
 MSD/ (*motive of self defense/defenses*)
 SD/ (*self defense/defenses*)
 G (*object origin of the transference-of-defense*)

G: A Self Analysis is Started and Becomes Unusually Systematic, Thorough and Complete

The M.I. and M.F. methods, when applied to the analyst's self, identified recurring symptoms that had not been touched by his prior training analysis. Then using them in self analysis (Anderson 1987), he was led into a surprising and

astounding ten-year analysis that systematically went to bedrocks, produced extremely impressive and lasting results, and eventually undid predilections to countertransference responses. (The recorded, unmodified, on-the-spot process notes have been preserved in sixteen three-ring binders and could be made available for third-party examination.)

THE METAPSYCHOLOGICAL FORMULATION THEORY EMERGES FROM THE RESEARCHES

A Reliable Body of Theory is Secured and its Application is Practised

Over time, the above investigations came together in a mix of complementary, interactive influences, and the M.F. Method took increasing shape. Then, after building a body of definable concepts and validated principles, the analyst practised its application in patient sessions. There, he formulated thousands of symptoms and tested thousands of predictions, and in the process acquired the ability to formulate complex material correctly and at once.

The Self Analysis Contributes to its Development

It became a secondary arena for the testing of hypotheses, and the depth to which it went brought new benefits to the clinician-researcher's efforts at theory-making. It released him from early-infant conflicts, removed previously-undetected anxieties that had limited his ability to accompany his patients into new and untravelled areas, expanded the range of his serviceable empathy, and widened his observational range for the detection of new symptomatic phenomena.

The Theory of Formulation Becomes the Basis of a Metapsychological Theory of Intervention

Next came an extension of the formulative method to the creation of a theory of intervention. It evolved naturally and without planning. Interventive hypotheses, logically derived from reliable formulations, were devised, offered, and assessed for correctness in the light of the patient's subsequent, non-intruded material.. Then a clinical theory of technique became reliably operational.

The Aims and Limitations of this Initial Presentation of the M.F. Method

The chief aim of this paper is to provide a description and illustration of the Metapsychological Formulation Method. It is not part of the author's intention to demonstrate the processes of prediction used in the theory's development, or the M.F. Theory of Intervention. In an "Outcome" part of the section to follow, brief mention of the formulation's results will be provided, but only for the purpose of offering the reader a vision of the M.F. concept in its overall clinical context. By approaching the description of his researches in this manner, he hopes to inspire others to investigate the idea of introducing scientific methods into psychoanalytic research. He also hopes that some will replicate his research designs and test his conclusions.

ILLUSTRATION OF THE METHOD IN OPERATION

INTRODUCTION

A Telephone Call

In January, 1985, Dr. B-----, a psychologist colleague in a nearby town, referred a thirty-year-old teacher (Mr. A) for consultation with a view to his entering a form of analytic therapy. He phoned, identified himself, and said:

"Yes, Dr. Anderson, Dr. B----- spoke to you about my calling you. I'll give you an idea of the situation.

I have been living with C-----, my lover, for four years. We have made some plans to marry, but I recently had a relationship with R----- who was visiting the family of a friend of mine. She went back to the U.S. last month. She calls me often and there's been some talk of my going there, but I have never felt so bad in my life, and my work is suffering.

I guess you would recommend meeting separately with me and then with C-----, (pause) not that I want to keep secrets. ... (pause) ... I sound awful, don't I."

THE IDENTIFICATION OF SYMPTOMATIC BEHAVIOURS

"I GUESS YOU WOULD RECOMMEND MEETING SEPARATELY WITH ME AND THEN WITH C",

DEVELOPING A METAPSYCHOLOGICAL FORMULATION

This is a statement made within seconds to a new object (the consultant). No opinion as to what the consultant would recommend has been formed in the analyst's mind, let alone expressed or suggested. The behaviour is thus Symptomatic¹. It becomes a Reference Point of reality against which the consultee's engaging Self (comprised of Ego and Drive) can be assessed.

The Ego of that self has developed a Fantasy of the new Object by way of a Transference.

¹ That is, a surface indicator of an underlying process that is initially inaccessible.

There is no Observing Self monitoring the Self-in-Contact with the consultant. The Transference-Determined ("Analyst") Fantasy is Ego-syntonic to the Ego of the Observing Self and the Self Acts Out its response to what is actually an Internal Object.

The properties of an internal object, in a Mental Representation determined from the Internalization of perceptions of an earlier, "real" object, have been Projected to become parts of the newly-forming Mental Representation of the consultant.

The Symptoms that have resulted are of the Character type.

THE METAPSYCHOLOGY OF CHARACTER

Character Symptoms are expressed in Character Transferences. Transferences from original objects unwittingly attach to a succession of new objects, including previous consultants/therapists, throughout the lifespan. Their elements mingle with real perceptions, and the resulting fantasy is taken back in by the mechanism earlier termed the "Glover Effect". Analysis of the first transference elements in consultation leads to the most recent object in a Transference Chain of objects that progresses backwards to the original figure.

In this case, the object will have been Dr. B ----- . If he did not identify and address Mr A.'s first transferences, he (Dr. B) will be found to be the most immediate source of the first transference. He will be endowed with the negative properties of the patient's original caretaker objects. And because the transference has formed from the transference-transformed Dr. B, it will be of a type that the M.F. method calls an Intermediate Transference.

THE TELEPHONE CALL, CONTINUED

" ... NOT THAT I WANT TO KEEP SECRETS."

This statement is an example of a Negation with the following meta structure:

The self has a Transference-of-Defense Fantasy of the consultant in which the latter is critical of it should it wish to keep secrets. It Defends by Anticipation and Denial. When the above two parts of the patient's first symptomatic statement are examined together, the simplest of two hypotheses says that the self is defendedly expressing a desire by Suggestion. The behaviour is a "Manipulation" and an expression of a Manipulation Transference, by the terms of which, the consultant is believed to have a character structure that disposes him to be nudgable to action by suggestion, but not by direct expression.

In this segment, the presence of an internal object in one of the Suprastructures, the Superego or the Ego Ideal, has also been established.

THE TELEPHONE CALL, CONTINUED

"I SOUND AWFUL, DON'T I?"

This expression begins to confirm the presence of an Operative Transference-of-Defense from an Object in one of the Suprastructures. It is incorporating the consultative process and is a Transference Resistance.

In this segment, Multiple Selves (not a reference to Multiple personality Disorder) are in operation.

A Social Self (or Protective or Defense Self) that is engaging the consultant, is monitoring the expressions from another self part. It is protecting itself from a Judgement and an Affective response akin to revulsion by an Anticipate-and-Prevent-by-Self-Constriction defense.

This type of response points to the object's being in the Ego Ideal.

A SUMMARY FORMULATION

Problematic Character elements, as expectable in those who consult therapists, have been immediately stimulated by the consultation process that has been set in motion.

A Character Transference is in operation.

It is from an Object in one of the Suprastructures. The Ego Ideal is the indicated structure.

It is Ego-Syntonic to the Ego of the Social Self that is in contact with the consultant.

It is an Operative Transference and functioning as a Resistance.

The Transference Fantasy of the analyst may or may not be unconscious.

It is causing the Self-in-Contact to monitor the analyst's responses and the expressions from its own inner parts in order to prevent a fantasied trauma.

The trauma involves an Object with a Standard that is issuing a Negative Judgement.

It is one that results in a Loss of Esteem.

The self's susceptibility to the trauma was formed in an original situation with an original object, and out of it a Defense Self has developed.

Nothing is known yet about the specific object and specific situation that were involved in the Genesis of these Symptomatic mental activities and behaviours.

Drive material is not directly present. Character developmental theory points to the Aggressive Drive.

The Manipulative means by which the Self approaches having its wishes met, points to the Assertive form of the aggressive drive behind Defenses.

An Intermediate Transference from the referring consultant is predictable as the first source of the first operative transference.

The Surface of that Transference is an Ego Syntonic (and possibly unconscious) Ego Ideal type Fantasy of the analyst in which he opposes assertive forms of aggression. That is, he forces inhibition of direct expressions of "wants" and nullifies the esteem.

The engaging Self has no Effective Defenses that would stop the fantasied analyst's unreasonable demands and *reverse* his inhibiting behaviours. It cannot act to obtain its rights to "direct expression of wants" and "confidentiality".

It can only Comply outwardly with the Object's Standards, while using Manipulation to get its needs met

THE OUTCOME

This formulation was developed in seconds on the phone. Two interventions² that were adapted to the particular (not-yet-clinical) conditions were created immediately and provided at once.

They were very well received and the patient's responses - "*I feel better. I felt that Dr. B. was critical of me.*" - revealed that:

- An undetected and unaddressed Transference to Dr. B----- had been carried into the present consult;
- It had operated Ego-syntonically in the present consultation to produce the Character Symptoms identified;
- It was derived from a Transference-transformed Mental Representation of Dr. B. in the Ego Ideal part of the Superego-Ego ideal structure;
- There may or may not have been elements of real Dr. B. behaviour that contributed to the Intermediate Transference to him
- That Transference was dissolved by the present consultant's input.

A consultation and therapy then followed, and the formulation that had been developed continued to hold up to its predictive capability in increasing detail.

The interventions will be described in a later account of Applied Theory (i.e. Theory of Intervention). The stratification (Surface and Layers) elements in the above material will also be discussed then.

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² The author does not like the term "intervention". The "provision of information" would be better, but convention must stand for now.

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