

'After the Analysis...'*

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Most patients come for analysis as for any other form of treatment with the concrete aim of getting rid of some definite symptom. Although, as Nunberg has shown, their rational ideas are bound up with unconscious fantasies ('getting rid of a symptom', 'cure', etc., possess sexual symbolic meanings whether it is a question of mental or physical treatment), they have on the whole a reasonable idea of what they can expect from analysis. But there is another type of patient for whom psychoanalysis has become the new religion whether or not he comes for analysis because of some distressing symptom, he will never be satisfied with a mere alleviation of symptoms or any other simple tangible result. He expects that after being 'fully analyzed' he will never have any more difficulties or disappointments in life, and never under any circumstances experience guilt or anxiety; that he will develop remarkable intellectual or aesthetic powers, perhaps even prove to be a genius, be blissfully happy, perfectly balanced, superhumanly unbiased and absolutely free from the slightest neurotic symptom, caprice of mood or bad habit. I have actually heard the view expressed that a 'fully analyzed person' will be free from aggression and pregenital interests, have no polygamous tendencies and never make a slip of the tongue or any other kind of mistake. Analysis is sometimes regarded as a panacea for all evil and the best or only solution for every individual or social problem. In a community where every member had been analyzed there would be no crime, war, unemployment, hatred, misery, sexual entanglement or divorce.

Of course if you press so ardent an apostle of psychoanalysis, he will soon have to admit that he has never yet come across that marvel of perfection, 'that fully analyzed person', in real life. But he will give convincing reasons why analysis could have been fully effective in this or that particular case, or at any rate, argue that if psychoanalysis cannot yet achieve such successes it will certainly be able to do so in the future.

These fantasies of what a person will be like after he has been analyzed (which the patient refuses to regard as fantasies but believes to be reasonable views based on objective foundations) are replicas of the child's ideas of what it is like to be grown up. Adults ('fully analyzed persons') have none of the shortcomings and miseries of children; they do no wrong, have no bad habits, make no mistakes, are absolutely perfect; they are free from anxiety, from difficulties of any sort, and of course they are extremely clever. If the patient is prepared to admit that psychoanalysis cannot yet achieve these results but maintains that it will do so in the future, then again analysis is regarded from the viewpoint of a child that has to grow up in order to develop its marvellous potentialities. The patient clings so much to these fantasies of future omnipotence because they offer compensation for the helplessness of childhood or the misery of neurosis. He can bear anxiety only if he can believe that a time will come when he will be absolutely proof against it. The more he is ashamed of his neurotic difficulties (having dirtied himself) the greater his urge to become perfect (clean) after being analyzed (washed). The Utopia of perfect and never-to-be-disturbed happiness 'after being thoroughly analysed' is the Utopia of a deeply unhappy person. The more he feels inferior to others because he is neurotic (a child), the more he hopes to be superior to them as a 'fully analyzed person' (an adult). The child tends to shift to the future his ideas of grandeur which he cannot

maintain in the face of his actual helplessness. He gets over his feelings of inferiority and anxiety by imagining that as an adult he will be able to do all the things he would like to do but cannot.

We all know that cure is conceived in terms of libidinal gratification. What the patient wants from the analyst is love, sexual gratification, the fulfilment of all his unconscious wishes. One patient had a rooted objection to the idea of getting a 'little better'; he wanted either a complete cure or nothing, and his refusal to allow himself to become a little better for fear I might force him to be satisfied with the improvement - was a definite handicap in treatment. 'A little better' was like food or love shared with his sister which he refused to accept; being 'quite well' meant that he satisfied his wish to have all the food and happiness in the world. The guilt over this greed for happiness may lead to the superego demand that the patient shall remain ill, just as oral greed causes an inhibition in eating. Thus the neurotic urge to get well and the negative therapeutic reaction (the neurotic urge to remain ill) are two sides of the same problem. The negative therapeutic reaction is frequently the outcome of specific transference reactions, especially when 'getting well' or 'remaining ill' have acquired a special emotional significance. Another way of putting it would be to say that the unconscious guilt which prevents the patient from getting well is largely due to the nature of the unconscious infantile fantasies which underlie the rational wish to get well. Thus a patient felt very guilty because he had, as he thought, denied a man (who had nearly been his successful rival but had then broken down completely) the possibility of getting well by deliberately not advising analysis for him; therefore the patient had to punish himself by not getting anything out of his own analysis.

Often the patient's hopes and expectations from the treatment are repeated day after day, month after month, almost year after year, and have an unmistakably querulous note. The patient is really demanding compensation for all his past and present sufferings, for all the trouble and expense caused him by the analysis (with all the symbolic implications of these things). The intensity and persistence with which these demands are repeated leave one in no doubt as to the strength of the underlying reproaches against the analyst. Such demands like all querulous demands are largely a defense against guilt. The patient feels guilty for not getting better. He feels that the analyst demands a standard of health which he can as little live up to as to the moral standards set by his parents. This is one reason for not giving the patient exaggerated ideas about the results of analysis.

The patient sometimes displaces his narcissistic valuation of himself onto the analysis; he will insist that analysis is far superior to every other kind of treatment, and refuse to allow anything else to exist outside it, just as he once felt superior to every other child and was unwilling that his brothers and sisters should exist. The inferiority feelings of the neurotic are largely a defense against and overcompensation for terrifying ideas of grandeur which carry with them the danger of losing hold on reality, but they are also a continuation of them in a distorted form. Thus when a patient has substituted the idea that he is the stupidest person on earth for the original narcissistic one that he is the cleverest, the narcissistic element is still present: he is the most stupid person, and his remarkable stupidity distinguished him from others. And if after complaining day after day in the analysis how stupid, abnormal and neurotic he is instead of boasting how clever, unusual, and superior he is, he expresses the hope that the analysis may rid him of his inhibitions and turn him into a genius, then we see that the original narcissistic idea has broken through, only it is displaced into the future.

You will probably have observed that I am using the term 'narcissism', a word that has practically disappeared in recent years from the vocabulary of English analysts. While continental analysts have tended – and perhaps still tend – to treat every manifestation of narcissism as if it were a primary one, and neglected the dynamic forces that caused the regression to it (extreme ambivalence, paranoid anxieties, excessive superego demands)¹, English analysts now seem to go to the other extreme and to regard it almost exclusively as a secondary phenomenon, and even then only in terms of the relation to introjected objects. But introjection is only one of the ways in which a withdrawal from the external objects to the self in secondary narcissism takes place.² Still more important clinically, however, is the pathogenic action of primary narcissism; for example the fact that inferiority feelings are so often an overcompensation for narcissistic ideas of grandeur (ideas of grandeur may cover up inferiority feelings) or that the pleasurable narcissistic interest in one's own body may through guilt be replaced by hypochondriacal worry of it. This aspect of the matter has been rather neglected recently.³

The patient's assumption that perfect bliss characterizes the condition of a fully analyzed person really expresses his longing for past happiness; an idealized memory of his babyhood is projected into the future. As a baby he was happy, had no need to work or to make decisions and was in fact all important, judging at least from the love and admiration his parents gave him. Analysis is for some patients an escape from life, a return to childhood. This type of patient lives almost literally only through and for the analysis. He would feel guilty if he were to deal with a difficulty or get over an emotional crisis without first having it analyzed. He prefers analysis to ordinary everyday methods just as, from guilt over his wish for independence, he had to prefer his parents to ordinary people or other children. He would like analysis to protect him against reality as his parents kept him from life; he wants to remain a baby and puts off any effort or unpleasant decision until the situation has been 'fully analyzed', with the expectation that in the life after analysis work will never be an effort, there will be no need for renunciation and no decision will ever cost pain. To justify these absurd demands he proceeds to exaggerate his real difficulties in order to prove that they are neurotic and therefore curable. Everybody has to make a certain effort when learning something new or reacts with pain and frustration, but for such patients as these it is a narcissistic insult to be like others; it is so much more flattering to suffer from inhibitions and bizarre pathological reactions. Such people are extremely sensitive to pain and unable to bear it, largely because of their fear of their masochism, partly because they have suffered so much already that every additional discomfort acts as a last straw. By exaggerating the pain or disappointment they deny it. This *denial through exaggeration* seems to me an important *defense mechanism*. Patients may go on complaining for months on end how unhappy they feel and reproaching me for not admitting it, but they are most upset when I agree. The more they repeat their complaint the less they really believe it, and my agreeing makes it real to them.

In his over-evaluation of analysis the patient often repeats his attitude to religion: he makes the same desperate efforts to believe in it and the same excessive demands from it. The analyst can convince him only if he makes symptoms disappear the way that Christ performed miracles of healing. In return for this he is prepared to believe only a thorough analysis can save him from the agonies of mental suffering and bring eternal happiness, just as the true believer will be saved from hell and enjoy eternal bliss in the life after death. But one must believe implicitly – 'be free from resistances'. Such religious ideas about analysis are often accompanied by a religious self-righteousness, and intolerance at its worst for the slightest deviation

from what the patient conceives to be the accepted analytic doctrine or any possible doubt or criticism of it. He betrays an over estimation of the 'correct' analytic terms and rituals similar to that of the liturgy of the church. He holds that interpretations, like prayers, must be given in the right order and form, and he demands that every child be analyzed at an early age, as others insist he shall be baptized. He sets out to convert others, sometimes the most unsuitable persons under the most absurd circumstances, much as the evangelists went out to preach the Bible.

One needs not go far to discover that this exaggerated belief covers a profound unbelief. The patient lays so much stress on the miraculous effects of analysis in order to be justified in discarding it altogether if it does not work miracles. By preaching analysis to all and sundry and making the most exaggerated statements about it, he succeeds in rendering it ridiculous while appearing to extol it. By creating a super-analyst of the future or attributing miraculous wisdom and abilities to some living analyst with whom he identifies himself, he can look down disdainfully on his own analyst. He is the good boy who will be rewarded for his faith, while the skeptical analyst will be condemned for his analytic heterodoxy by other analysts and perhaps even be excluded from the Analytical Society, the seat of all the righteous, in other words from Heaven.

The super-ego attitude towards analysis seems to be more important even than its libidinal significance. Analysis is regarded as an atonement, as a cleansing process, as a religious exercise; getting on in the analysis means doing one's duty, obeying one's parents, learning one's lessons, saying one's prayers, defaecating. To get better, improve, is to be good. These ideas are sometimes increased through the attitude of the analyst when, for example, the analyst displays an overestimation of analytic ceremonial or is inclined to regard it as the only true therapy.

The 'fully analyzed person' is the ideally good child, free from all aggression, pre-genital interests, or even the most minute symptom or difficulty. The patient is as intolerant of his symptoms as his parents were of his naughtiness, anxiety, bad habits and crying. The impatient wish to get rid of the neurosis may be a repetition of his parent's impatience with his childhood helplessness or illnesses, or it may be also an overcompensation for the wish to retain them and to enjoy the 'gain from illness'. The fear of symptoms is itself an over-determined symptom. If the symptoms are considered to be a result of masturbation they must be concealed or suppressed almost as much as the forbidden sexual activity itself. Sometimes they are interpreted as indicating mental disease and the fear that this may be detected can assume paranoid proportions. The fear of madness is a specific form of hypochondriacal worry, the brain – the content of the head – being equated to the contents of the body. It is also largely a fear of having mad uncontrollable (sexual) impulses. This may lead to the suppression of every spontaneous reaction; excessive control over the excretory system is displaced to mental processes. Excessive fear of being ridiculed or humiliated (originally for wetting, not having a penis, etc.) creates a need to be free from all weaknesses and peculiarities. The wish for a perfect body and mind (to have penis, or breasts, be grown up, clean, unhurt, godlike) is a reassurance against hypochondriacal anxieties and a fulfilment of the narcissistic wishes of a small child.

A woman patient was specially anxious to be free from all neurotic symptoms or organic illnesses; she tried hard not to give way to any weakness and even refused to rest when she was tired. Being weak or tired or ill meant that she was babyish or feminine, despised by her brothers. The admission that she was weak or ill would

aggravate her sense of helplessness against attacks and her fear of becoming seriously ill and dying. The position she had the greatest difficulty in adopting was that of the baby or being ill, because it brought back all the helplessness and anxiety of her childhood. With a really unsympathetic mother the only consolation she had had during her long childhood illnesses was the attention her father had given her. This combined with her mother's neglect came too near to the guilty oedipus situation to make it possible for her to enjoy a repetition of the situation in later life. Being ill and neurotic also represented an identification with her very unhappy father, which was frightening partly because of its oedipal significance, partly because of its masochistic aspects.

Frequently a patient has the fantasy that by getting well himself his parents or some other person with whom he identifies himself may recover from a neurotic or from an organic illness. The wish to keep his father weak and impotent may form the basis of his wish to remain ill, or by way of over-compensation he may develop a specially marked superego drive to get well. An intense wish to be cured of all his symptoms may have its origin in a desire to make his father perfectly whole, to restore his body and mind alike with respect to real weaknesses and fantasised injuries; but it may also express by way of an identification, an intolerance to his parent's imperfections and difficulties. The more the neurosis and the wish to be cured are 'borrowed', the more the patient's neurosis serves to cover up and excuse the neurosis of some present or past object of ambivalent love, or to indict it. The more complicated are these reactions, the more unrealistic ideas of cure and the more unlikely he is to show the 'negative therapeutic reaction'.

Masochistic fantasies of grandeur, such as an identification with Christ, often influence the unconscious wish to get or remain ill. Fantasies of saving the world are an overcompensation for fantasies of world destruction and a cure for paranoid anxieties. If the neurosis is equated with Christ, sacrifice and crucifixion, then the world is being saved through the patient's continued illness, renouncing all happiness for the sake of others and inhibiting his aggression and normal activity. If getting well is thought of as resurrection, then it is of the highest importance since the salvation of mankind depends on it.

Fantasies of being godlike, or an identification with the analyst regarded as superhuman (or inhuman) being, can often be detected in the wish to be absolutely unbiased and objective, free from all symptoms and prejudices. Some partially cured patients are free from symptoms but have an artificial and unnatural attitude. The struggle to suppress their symptoms takes up most of their mental energies. It is sometimes pathetic to watch the efforts they make to appear 'normal', that is free from symptoms, and how relieved they feel when they are allowed again to experience anxiety and suffering openly. Because they regard the disappearance of symptoms as the test of therapeutic success, having symptoms has come to signify criticism and disloyalty to the analyst. The feeling of giving the analyst away to others by maintaining symptoms usually repeats the patient's early childhood idea that he and his playmates would be betrayed in their sexual games by the consequence (symptoms) which these are supposed to entail.

Usually it is a sign of progress if the patient's ideas of cure become more realistic and he is able to tolerate his symptoms. This is an indication that he has in some degree given up his ideas of grandeur and can like himself as he is; that he is more tolerant of weakness and instinctual manifestations, and that his hypochondriacal worries and anxiety are reduced. In my experience, analysis of the patient's fantastic

expectations and idealization of analysis is of the greatest therapeutic importance because these ideas often constitute the core of his transference neurosis, are closely bound up with the negative therapeutic reaction and present a subtle but most effective resistance towards accepting reality. Criticism of analysis is – apart from more obvious factors – often a defense against the overestimation and idealisation of it.

When he was discussing this paper Dr. Glover called attention to another factor in assessing the perfection fantasies of patients: the countertransference. Patients are quick to recognize and imitate the attitude of their analyst. Every patient has his favourite defense mechanism and in the countertransference each analyst uses a defence system of his own. It is the custom when considering countertransference to stress exclusively the mechanism of repression. There is no reason why mechanisms of projection and introjection should not play as great if not a greater part. The pathological type of projection countertransference tends to make the analyst distrustful of the patient, in particular signs of improvement. The introjection type of countertransference may also lead to an unnecessary prolongation of analysis. If the analyst has a form of starvation anxiety, a fear of being deserted, or the dread that the patient may become a permanent 'bad object', he will retain (swallow) the patient and find it difficult to discharge (disgorge) him.

It seems that many analysts are more ready to analyze the patient's skepticism concerning therapy, which is regarded as a manifestation of his negative transference, while his over-estimation of analysis, so long as it is not too glaringly absurd,⁴ is more easily condoned because it is flattering to the analyst and coincides with his own idealization of analysis.

The fantastic ideas entertained by patients as to the possibilities of analytic therapy are encouraged by the fact that analysts themselves are not always very clear in their minds on the subject. They are more inclined to discuss the criteria of the cure in an ideal sense, or to consider the workings of analysis under ideal conditions, than to describe the actual imperfect results achieved under the very imperfect conditions of real life. Thus recently there was a symposium on 'The theory of Therapeutic Results'⁵ and on the 'Criteria of Therapeutic Success'⁶ but never one, so far as I am aware, on the 'Nature and Frequency of Therapeutic Success'. It seems almost as if there was sometimes a feeling that it is beneath the analyst's dignity to be too interested in questions of success, that it is bad form to claim good results, or again that to be skeptical is a confession of failure. Statistics such as those published by the analytic clinics are of little value because they do not explain what is meant by 'cured' nor do they give details of the cases. Most case histories that are published deal with patients who are still under treatment or have just completed it. It would be of great value to observe the development and the reactions of patients over a number of years after they have been discharged and to find out if those described as 'cured' showed any neurotic reactions and the nature and intensity of these, how they reacted to specific difficulties and frustrations experienced, how they dealt with situations of emotional stress, what proportion could be regarded as permanently 'cured' or 'improved', defining the terms in detail, and which were the decisive factors for a favourable prognosis.

Some analysts may be reluctant to draw conclusions from past experiences, in the belief that therapeutic possibilities are being greatly extended with the increase of our knowledge. There have been many waves of therapeutic enthusiasm during the last thirty years; time and time again it was thought that a new technical device (e.g

active therapy) or theoretical discovery would revolutionize therapy. These waves of enthusiasm were usually short lived, however, and disappointment and pessimism followed in their wake. It seems that advances in therapy depend more on a steady progress than on revolutionary discoveries.

There can be little doubt that therapeutic results improve with increasing knowledge but equally little doubt that they do not improve in the same proportion. This fact, which has puzzled many analysts, would go to show that an 'all-round analysis' and the analysis of the preconscious is more important than the singling out of certain newly discovered fantasies or mechanisms; that the knowledge and interpretation of the unconscious is only one element in the therapeutic process. The human relationship to the analyst which remains unaffected by any increase in our knowledge is certainly no less an important factor.⁷

I believe that with certain patients an optimum result is achieved after a certain time which cannot be bettered to any considerable extent however long one persists with the treatment, at least with the same analyst. It seems to me that it is essential in therapy to know the right time to stop. One must weigh the advantages of continuing treatment against the disadvantages and also take into account the psychological effects of unduly great sacrifices and drawbacks. If the patient feels, perhaps with some justification, that the analyst expects him to regard analysis as the most important thing in his life for which he should be prepared to sacrifice every penny or deny himself such simple pleasures as going to the pictures or buying new clothes, then it will be difficult to analyze his inhibition of pleasure and to correct the effects of his parent's attitude in expecting him to sacrifice everything for them and trying to make him 'unselfish' and modest.

One must also consider the unfavourable effects of direct or indirect pressure put upon the patient to go on as for example, making him feel guilty for wanting to become independent of the analyst, or increasing his hypochondriacal worries about his state of mind. I have heard of analysts who actually frighten the patient into continuing the analysis by warning him of the grave consequences of breaking off the treatment: that he may get worse, go mad, commit suicide, sometimes using direct or indirect outside pressure in addition. I think that the ill effects of such a procedure can hardly be exaggerated. In earlier times analysts used to stress the fact that the patient clings to analysis as a defence against life and as a continuation of his infantile fixations. Although their method of counteracting this tendency by setting time limits was rather crude and often unsatisfactory, the view underlying it was sound. The danger of our recent attitude of trying to make the patient go on as long as possible is that we behave very much like the possessive parents who make the child afraid of life because they do not want him to grow up and break away. There are those who claim that the fact that the analyst repeats an unfavourable parental attitude is of little importance so long as the fantasies stimulated by it are 'thoroughly analyzed'. I do not share this opinion. The main danger of long analyses (six, eight, even ten years of analysis do not seem unusual any more) is that it estranges the patient from reality.⁸ As both analyst and patient have staked so much on the treatment they will be more unwilling to admit failure and therefore be more biased in judging the results of analysis.

There seems to be a special narcissistic appreciation of the 'long' or 'deep' analysis, partly an overcompensation of resentment and criticism. Dr. Glover told me about a patient who, after a talk in which he experienced such inferiority feeling because his own analysis had to be a great deal shorter than that of his friends, had a dream in

which he equated the 'short analysis' with a short penis. In other cases a 'long analysis' satisfies superego demands.

An over-estimation of long analysis, just like any other preconceived idea about the course or the results of analysis, is likely to stimulate the patient's unconscious fantasies and transference reactions, and thus in fact influence the course and length of the treatment. It is known for example that a number of patients pass through a phase of depression. Some analysts think that while such a phase is unavoidable in certain cases, that in others it is due to imperfect technique. Other analysts think that no analysis is satisfactory or 'deep-going' enough if the patient has omitted to pass through a phase of depression and will not hesitate to express an opinion to that effect.

The idea that he must necessarily pass through a phase of depression may stimulate the patient's anxiety, punishment fantasies and masochistic impulses; it may also play into his religious views concerning the repentance and atonement which must precede salvation (cure); or it may be felt as a command to produce depression (unconsciously, faeces) with which he complies or obstinately refuses to comply. By means of these and other complicated transference reactions – apart from the obvious factor of direct suggestion – a phase of depression is brought about or a spontaneous tendency towards depression is increased. It is therefore not very surprising if analysts who expect to observe depressive phases find them in all their patients. In the same way the analyst's expectations relative to the length of the treatment and his standards of cure are bound to affect his patients. If for instance an analyst, and through him his patient, feel that only results achieved after long analysis are of any value, it may happen that initial improvements appear once more after perhaps five years of analysis the patient having duly passed through the phases of depression and anxiety which are considered necessary, they are hailed as signs of a successful treatment.

There is a tendency to regard what amounts to the same practical result as more valuable if it has been achieved after a long period of analysis, on the assumption of course that the patient has been more 'thoroughly analyzed'. The idea of 'being thoroughly analyzed' has often a moralistic flavor of the 'inner cleanliness' type; it sounds at times almost as if the patient were being urged to get rid of his 'complexes' or his 'anal erotism' or in more recent times his 'paranoid anxieties' and 'manic defenses', much as the newspaper advertisements urge one to get rid of the 'poison in one's system'. The conception of a 'thorough analysis' implies a demand that radical alterations should take place in the unconscious apart from those effected in the patient's conscious attitude and behavior. But we must first inquire how far we are entitled to look for radical changes in the unconscious.

Only a fraction of the primitive impulses and fantasies made conscious during analysis remains conscious and is assimilated by the ego; the greater part is forgotten or becomes emotionally unimportant, is dealt with partly or wholly by repression. Thus it seems that the process of becoming conscious is of greater therapeutic value than retaining the unconscious material in consciousness. As to the anxiety and other painful emotions diminished through analysis, it is difficult to say how much real reduction of latent anxiety has been achieved or how much must be attributed to better defenses. In the same way it has yet to be ascertained how far pre-genital fixations are really given up or to what extent they seemingly disappear owing to a more successful repression of pre-genital interests. As one sometimes hears pronouncements that a patient cannot yet be considered normal because he

still has this or that 'defense', it is perhaps not entirely superfluous to point out once more that however prolonged as analysis has been, it will still leave all the patient's defense mechanisms in operation though they will function in a more even and harmonious way. It follows that the effect of analysis may be to reinforce certain defence mechanisms: repression, manic mechanisms or projection.

So long as the theoretical conceptions underlying 'unconscious criteria' are not clear they are apt to be misleading. Stipulations such as that 'the patient should have reached unconsciously the genital level' are vague and unreliable when our theoretical conception of phases, regression, fixation and progression are still in the melting pot. Others as for example that 'the patient should have obtained to full object relationships and have given up part objects', are difficult to reconcile with the common clinical observation that he gets well by becoming more independent of people and taking more pleasure in concrete things ('part-objects').

The alterations in the deep unconscious (the id) effected by analysis are comparable in my view with those one might make in the sea by taking a few spoonfuls of water from it. So long as proof is lacking that analysis does effect radical alterations in the unconscious as distinct from the preconscious, we must be guided primarily by the practical results of our therapeutic efforts, by alterations in the patient's attitude and behavior. It is in fact with those ends in view that the patient comes for treatment. The objection that a patient cannot be well because he still has manic defenses, unconscious paranoid anxieties or an anal fixation would be justified only if it could be proved that there are people without them.

We must try to retain a sense of perspective with regard to the practical results we can expect. It is very natural that analysts should feel gratified if their patients excel in one way or another, just as parents are pleased if their children accomplish all they would like to have done themselves. This narcissistic gratification however is not the most important motive in excessive ambition for one's patients. More important seems to be the superego drive based on an identification of the patient (or child) with the analyst's own id. The analyst feels he must improve his patient (or child, or pupil) as he should have improved himself. These considerations raise one point of practical importance: such superego pitfalls are especially great in training analyses where we have fewer symptomatic criteria and a greater feeling of responsibility. The more we are dissatisfied with ourselves, the higher the standards we are likely to demand of the student in training and the more intolerant we will be if he falls short of them.

One should not expect too much in the way of intellectual or social development from the patient in any direction. There is no reason to suppose that because a patient writes second-rate poetry she will through the analysis become a first rate writer. The result is more likely to be that she will either resign herself to her limitations but continue to enjoy turning out second-rate work, or else give it up altogether. If a patient instead of writing inferior poetry begins to enjoy cooking or knitting, this change is quite favorable from the point of view of personal happiness and should not be regretted from a cultural point of view.

But even as regards the human development of the patient we should not be too exacting. Some analysts seem to assume as a matter of course that analyzed parents are also the best parents. This is definitely not the case. All we can legitimately expect is that a person who has been successfully analyzed will have a better relation to his child than before he was analyzed. But this improved attitude is

not necessarily better and is in fact often less good than that of a genuinely good parent.

It seems to me that analysts sometimes have too intolerant an attitude towards 'acting out' during the analysis and towards symptoms – especially those which are obviously manifestations of primitive impulse life. One would like to think that all analysts have developed a genuinely tolerant attitude as a result of having been analyzed themselves. This idealistic view is not in keeping with the facts and we should probably find as many variations in this respect among analysts as among members of any other profession. The fact that the analyst does his best to avoid giving any indication of disapproval to his patients, and indeed often allows himself no spontaneous reactions whatsoever so far as they are concerned, is not necessarily a sign of genuine tolerance; it may equally well be evidence of a severe 'analytic superego' due to guilt over human reactions and the sadistic elements in the disapproval. We are likely to learn more of the analyst's true attitude from his views on subjects on which there is as yet no standardized body of opinion (e.g. upbringing) and from his behavior in real life, than from the air of imperturbable calm which he assumes during the analytic session. Most patients are able to penetrate behind the analytic mask to the real attitude which it conceals, a fact which goes far to explain many therapeutic successes and failures. There are many indirect ways in which the analyst's moral bias finds expression and it is important that he should at least be aware of it. His decision as to what is 'normal' or 'neurotic' is often influenced by similar considerations regarding what is 'good' or 'bad', and his attitude towards symptoms may repeat a dislike of 'bad habits'. Although it is far from my intention to minimize the importance of the guilt and anxiety drives in such manifestations as nail-biting, excessive smoking, polygamy, perversions, stealing, these reactions are to be regarded primarily as expressions of instinct, and renunciation of them after however lengthy an analysis may be just as much due to increased inhibition as to reduced anxiety. Some patients give up their 'pre-genital interests' or masturbation to please the analyst, just as they once gave up their 'dirty games' to please their parents; they feel that if the analyst suggests that they are 'narcissistic', he is really reproaching them for being 'selfish', that 'infantile fixations' are sometimes only another term for 'childish behavior', and that the ideal patient who has reached 'full object relations' is the analytic edition of the good boy who loves his parents. Again to say that a patient employs manic defense may be just another way of calling him a nuisance; to allege that he is paranoid may simply imply that he is rebellious and distrustful. The patient is often right in regarding these descriptions as reproaches. It does not matter that the words have an imposing scientific ring; far more important is the attitude underlying their use.⁹

I do not think that it should be the aim of an analysis to remove every manifestation which might be regarded as a 'symptom', but only those which are really interfere with the patient's life. If the analyst is free from moral bias, the result of analysis may sometimes be that the so-called pathological manifestation of instinct does not disappear but that it gives the patient less trouble or loses some of the punishment tendencies expressed in it. Thus a patient may remain homosexual or polygamous, continue to bite his nails, or to masturbate, though usually not to excess, without feeling guilty over it. In evaluating symptoms I should be disposed to attach greater importance to those representing inhibitions of instinct (e.g. inability to enjoy food) than to manifestations of primitive impulse life. This policy might usefully be adopted if only to counteract the analyst's unavoidable moral bias against too open expressions of instinct, especially when he fears the disapproval of parent substitutes: other analysts, the patient's relatives, the police, probation officers, etc.

Quite apart from this, it may be said that on the whole anxiety giving rise to inhibition is more likely to interfere with the patient's health and happiness than to an equal amount of anxiety which has the effect of increasing his primitive instinctual drives.

Again, we should not entertain exaggerated ideas in regard to the reduction of anxiety to be effected. A patient came to see me about a year after she had completed her analysis. She told me that she felt well and that her symptoms had disappeared but added that she would like to have a few months further analysis. I asked her why she wanted to recommence analysis if she felt well, to which she replied that feeling well was such a strain. She had been pregnant during the first analysis which had lasted about twelve months, and again during the second one. During her first pregnancy she was remarkably fit and free even from the minutest symptom, and this had to be regarded as something of an achievement because before being treated she had had unusually great anxiety and hypochondriac worries over pregnancy and childbirth and a rather ambivalent attitude towards having children. In her second pregnancy she was also perfectly well and free from symptoms but not so exceptionally fit as on the earlier occasion. She herself regarded this as the healthier occasion. Because she was now fundamentally less afraid and made less stringent demands on herself, she could allow herself manifestations of physical weakness or anxiety. In the same way I believe that for most people it is more normal to have slight peculiarities, anxieties, minor neurotic symptoms or bad habits than to be absolutely free from them, provided they are in a position to tolerate them without difficulty.

Dr. Glover has pointed out in discussing this paper that the projection into the future of perfection or imperfection fantasies depended very much on what happened during the analysis to the factors of primary and secondary gain. Many patients compensate the loss of secondary gain by living up to conceptions of health which are so rigid and arbitrary as to be neurotic. Through this 'neurotic conception of health' they become as great a nuisance to their friends as they were previously through their illness.

It is certainly gratifying to the analyst if the patient as a result of the analysis not only gets rid of his symptoms but advances in his whole development. One should not be too ambitious for him and above all not judge him by one's own standards. He should live his own life and conform to his own ideals and not to those of the analyst. A possessive attitude in the analyst is even worse than a possessive attitude in the parent. I consider it satisfactory that a number of patients whom I analyzed successfully differed as fundamentally from me after the analysis as before it in their political, religious, social, and artistic convictions.

The foremost task of the analyst as of every doctor, is to mitigate human suffering. There is consequently no justification for looking with contempt on treatment that 'only' relieves symptoms. Every form of therapy, analytic or non-analytic, that relieves suffering is valuable.

The great possibilities of analytic therapy are likely to stimulate the ideas of grandeur inherent in us all; we must admire the sense of proportion that enabled Freud to realize the limitations of analysis almost as much as we admire his creative genius in discovering it.¹⁰ Analysis can and does achieve a great deal both in the way of removing symptoms, the difficulties for which the patient originally came for treatment, and also in bringing about favourable changes in his character and attitude, usually accompanied by alterations in his physical habitus and facial

expression. But we should not imagine that we can by means of analysis develop a special category of analyzed persons, a class of supermen.

I should like to conclude with a story in point. A patient of mine told somebody at a party that she had been analyzed. This individual looked at her with great amazement and said she could hardly believe it, because my patient was so free and easy and natural, quite like an ordinary person in fact, and unlike any 'analyzed person' she had met before. I consider that for a patient to become 'just like anyone else' is the best result one can expect from analysis.

* Read before the British Psychoanalytic Society, March 17, 1937. Reprinted from: *The Psychoanalytic Quarterly*, 1938. JCFAR is grateful to *The Psychoanalytic Quarterly* for permission to reprint this article.

ENDNOTES:

¹ Shmideberg, Melitta: 'Einige unbewusste Mechanismen im Pathologischen Sexualleben und ihre Beziehung zur normalen Sexualbetätigung'. *Int. Ztschr. F.Psa.* XVIII, 1932, pp.73-77; 'Psychotic Mechanisms in Cultural Development', *Int. J. Psa.*, XI, 1930, pp. 407-411; 'Persecutory Ideas and Delusions', *Int. J. Psa.* XII, 1931, pp. 345, 366.

² Freud, S. *The Ego and the Id*, trans. Riviere, London, 1927, p. 65.

³ There is the same tendency among analysts in England to regard masochism as a secondary phenomenon almost exclusively in relation to the 'introjected objects' and to neglect the pathogenic importance of primary masochism. If, for example, patient waiting has acquired too masochistic a significance, fear of one's masochism may lead to extreme impatience.

⁴ According to Dr. Friedlander Misch, if one begins to analyze the apparently quite rational expectations the patient connects with analysis, it frequently happens that these expectations become more and more fantastic.

⁵ The XIVth International Psychoanalytic Congress in Marienbad, 1936.

⁶ The British Psychoanalytic Society, 1936.

⁷ This view does not conflict with Glover's opinion that many of the earlier successes were largely due to inexact interpretation, nor with the view expressed by Helene Deutsch who emphasized that theoretical knowledge and expectations often handicap the analyst in his practical work.

⁸ There is even some danger that the analyst may lose contact with real life if he has the same patients (usually comparatively few) over a number of years.

⁹ I cannot say, of course, how frequently analysts speak thus of their patients, but I have heard observations of this kind made by quite a number of persons who had undergone analysis and it is certainly not rare that analysts speak about their patients in this way to other analysts.

¹⁰ Freud shows again the same moderation in his most recent paper, 'endliche und die unendliche Analyse', *Int. Ztschr. f. Psa.*, XXIII, 1937 (trans. *Int. J. Psa.* XVIII.)