SITUATION, AMBIENCE, AND PROCESS

The psychoanalytic endeavor takes place in a psychoanalytic setting. The psychoanalytic situation, the psychoanalytic ambience, and the psychoanalytic process designate three different aspects of the clinical psychoanalytic setting. All three are so closely intermeshed that change in one is usually accompanied by changes in the other two as well. But a differentiation of the psychoanalytic situation from the psychoanalytic ambience and from the psychoanalytic process will clarify our thinking about each one of these aspects of clinical psychoanalysis and how they affect one another.

By psychoanalytic situation I mean the participants, that is, analyst and analysand, the arrangements of time, place, fees, and other obligations and, in general, anything observable and reportable by an outside party. At times it may also be interesting and germane to ask how the psychoanalytic situation appears to nonparticipants, for example, to spouses, friends, relatives, third-party providers, and the general public. The situation, then, is viewed from an objective-interpersonal perspective.

By psychoanalytic ambience I mean to designate how the psychoanalytic situation is experienced by the participants. The ambience is viewed from a subjective-intrapsychic perspective. Therefore, the ambience is likely to be experienced differently by the analysand than by the analyst.

Finally, the psychoanalytic process designates the presumably lawful psychological changes initiated and maintained by the participants in the psychoanalytic endeavor by virtue of their participation. Conceptually, one may distinguish two different intrapsychic psychoanalytic processes: one in the analysand and one in the analyst. In practice, we are mostly concerned with the process that has been initiated in the analysand and that eventually—we hope—will lead to an analysis of his or her self by that self. We are interested in the
process that has been activated in the analyst only to the extent that it might hinder or facilitate the analytic process in the analysand by affecting the analyst's conduct in the analytic setting, that is, the countertransference reactions.

The aim of the clinical psychoanalytic endeavor is to initiate and maintain a psychoanalytic process. Strange as it may seem, however, the psychoanalytic endeavor does not aim to end the process that it seeks to initiate; in fact, a successful conclusion of the mutual endeavor of analyst and analysand is indicated by the continuance of the process, albeit within each individual, without further facilitation from the other. Let it be noted at this point that this self-analytic process would ideally continue for both analyst and analysand ad infinitum, even after any formal relationship between them has ceased.

Analyst and analysand can anticipate that they will be working with each other for a number of years. The workplace, therefore, should be quiet, comfortable, and neither luxurious nor austere. Analytic neutrality does not require the clean sterility of the laboratory; analysts inevitably reveal aspects of their style, taste, and other personal predilections. Patients know that their analysts are human beings with idiosyncratic interests. Trying to pretend otherwise is bound to fail sooner or later. But, worse, attempting to be someone other than oneself contradicts the whole spirit of the analytic endeavor, which, I believe, is to acknowledge and strengthen the self and its self expression.

The analyst should furnish his or her consulting room in harmony with his or her aesthetic preferences and intellectual interests. Ambiguous invisibility is not a necessary precondition for the emergence of intense transferences, nor does the presence of the analyst as a real person inhibit the transference relation. Indeed, the analyst is a real person who likes and dislikes and who unavoidably manifests his or her personality in his or her office and personal decor, thus evoking certain transference reactions that can be recognized and interpreted. There is no need for the analyst to pretend being anonymous and ambiguous like a Rorschach ink blot. The analyst cannot hide, yet should not intrude beyond visibly and audibly stating his or her presence. By implication the analyst thus announces his or her availability as a potential carrier for the selfobject function without forcing himself or herself upon the analysand. A reasonable regard for protecting his or her own privacy will underline the analyst's determination to similarly protect the privacy of his or her
patients. Soundproof walls and doors are as important as some relatively private space in which the patient may comfortably and unobtrusively wait for his or her appointed time.

It is the hallmark of psychoanalytic treatment that the analysand reclines on a couch with the analyst sitting behind the patient out of his or her sight. By contrast, psychotherapy, including psychoanalytically oriented psychotherapy, usually means patient and therapist are sitting face-to-face. In recent years this distinction has become quite blurred. Some analysts claim to be doing good analytic work with patients in face-to-face encounters, and some therapists quite frequently allow their patients the use of a couch during therapy sessions. Most self-psychologically oriented psychoanalysts reserve the use of the couch for the intensive clinical work of psychoanalysis when a regression—albeit limited—is to be facilitated. When doing psychotherapy, or when regression is not to be facilitated, then a face-to-face posture is the rule.

Strictly speaking, it is the analyst and the analysand alone who, as participants in the psychoanalytic situation, create a psychoanalytic ambience that allows the initiation and maintenance of the psychoanalytic process. But it is well to keep in mind that the analyst's and analysand's endeavor do not take place in a vacuum. Many extra-analytic forces and events have a marked influence on what happens in the analysis and vice versa. There are a number of interested parties, such as spouses, children, parents, relatives, friends, third-party providers, including health insurers and public agencies. Even under the best of circumstances, the analytic endeavor is a lengthy, expensive, and in some ways unpredictable undertaking. Its goal of optimally strengthening the analysand's self may not always redound to the benefit of the other interested parties. Not infrequently, a successful analysis may strengthen an analysand to the point of his or her becoming able to dissolve an unsatisfactory marriage, not necessarily always to the benefit of spouse and children. A hierarchy of values is implicit.

**VALUES**

Values are inherent in the psychoanalytic clinical endeavor, and values are brought to it by both analyst and analysand. A thorough discussion of these would exceed my present purpose, but a state-
ment of my position is in order. I have chosen to practice psychoanalysis because this method of psychological treatment appears to be the most suitable method for certain patients that come to me as a physician specializing in psychiatry. In general, I find myself in harmony with the traditional ethics of medical practice. I recognize that patients consult psychoanalysts because they are experiencing psychological pain and have the hope that psychoanalysis will ameliorate their suffering. In accepting such patients as analysands, I express my belief that there exists a reasonable expectation of their finding some alleviation of their discomfort through psychoanalysis, and I agree to make this presumed goal of the patient the overriding aim of the joint analytic endeavor. I realize that some patients' unhappiness is reflected in their behavior, and that often these patients seek to alter their behavior with the help of psychoanalytic therapy. However, psychological methods of treatment are limited by their very nature to strengthening the patient's self through the experiences and understanding gained as part of the psychoanalytic treatment process. The psychoanalyst, therefore, cannot presume to alter another person's behavior except by helping him or her to be stronger and understand himself or herself better. Nevertheless, the patient's goals remain the final justification for the treatment effort. Other goals, such as the facilitation of the patient's comprehension of his or her mental life and behavior—although of great importance to the psychoanalyst—are merely instrumental and subordinated to the overall well-being of the patient. A common belief among many psychoanalysts holds that an analyst's therapeutic ambition is detrimental to the success of the psychoanalytic venture. I regard this belief as false; it contradicts the very function of a psychological physician in our culture. Such apparent contradictions derive from differences in the definition of the goal of a clinical psychoanalysis. Traditionally, this goal has been defined mainly in terms of the patient's knowledge of himself rather than in terms of his experience of himself. The idea has been that the quest for psychological truth should be the foremost guide, and that the therapeutic results, when possible, will follow almost automatically.

For a number of reasons, a definition of the task of clinical psychoanalysis that refers only to the truth of the patient's knowledge of himself, and not also to his affective state and experience of himself, is unacceptable to me. There is very little evidence that a facilitation of the patient's knowledge of his mental life and behavior
will in itself increase his sense of well-being. On the contrary, I have observed—and I think most psychoanalysts can corroborate this observation—some postanalytic patients who were well “analyzed” but not cured: They had achieved wide and deep knowledge about the dynamics of their conscious and unconscious mental functioning but had not benefited to any significant extent from a lasting amelioration of their psychological pain nor from any meaningful improvement in their unhappy relations with others. It is too easy to dismiss these unfortunate cases by saying they were not really analyzed, when indeed they did gain a markedly better comprehension of their mental life. Perhaps, with many of these patients, nothing more ambitious can be achieved, and certainly, no psychoanalyst should promise more. But such analyses fall short of the goals with which the patient came into treatment, and we should not hesitate to call them failures.

On the other hand, we can also observe patients who seem to garner very little reportable self-knowledge in their analyses and who after termination can hardly remember what happened. Many of these patients clearly feel better, function better, are more creative and happier in their relationships. These may be patients who have achieved—to speak conceptually—an uninterrupted tension arc from the pole of ambitions to the pole of ideals and are thus enabled, perhaps for the first time, to enact their nuclear program in a self-satisfying productive and creative fashion. Are we to say that they had a good therapeutic result but were not really analyzed? I prefer a definition of the goals of clinical psychoanalysis that does not slight the patient’s goal of an improved sense of well-being and an improved overall functioning. By making the patient’s experience of himself, his functioning, and his relations with others the touchstone by which the analytic achievement will be measured, I make no implied promise that we will necessarily reach that goal. Indeed, most of the time we must be satisfied with small increments of improvement, but these will be improvements that can be appreciated by the patient, and not just by the analyst. Such improvements may be small on some scale, but have the most significant and beneficial impact on the patient’s life.

From the beginning, therefore, the emphasis is on the subjective experience of the analysand rather than on so-called objective assessments by criteria emanating from outside the analysand’s self-experience. There are pitfalls in such a commitment to the analy-
sand's self-centered view of himself. The dangers of solipsistic illusions entered into by the patient and supported by the analyst are obvious. In this book, most of the substance of the numerous technical questions about conducting a psychoanalysis make strengthening the analysand's self its primary goal without at the same time falling into the trap of mutually shared illusions.

However, at this point I wish to touch on the rarely discussed relationship of society to this rather precious twosome, the analyst and the analysand, in their very private analytic cocoon. It is a measure of the strength and maturity of a society when it can tolerate and even support in its midst an encapsulated precinct of commitment to just one individual. I have previously noted (Wolf, 1980a) that

I can approach the ethics of medical practice only from the point of view of my own commitment to the primacy of the individual who comes to the physician for help. I am fortunate that the society in which I live and work allows me and my patients this privileged corner where my patient's innermost and private goals, whether conscious or unconscious, can, by and large, be freely explored. And I am totally convinced that the well-being of that society depends, in large measure, on its willingness to encourage enclaves, such as my consulting room, where it is not necessarily the values of the group but those of the individual that prevail. (pp. 43-44)

All these considerations, however, still miss the point for many patients, who are not particularly interested in the analyst's values and ethics nor in his or her professional commitments. Such patients are unhappy because they feel unloved and unlovable—in fact, they usually were unloved as children and did become unlovable as a result—and they demand, more or less covertly, that the therapist prove that he or she really cares. The psychoanalyst who insists that the best and only service he or she can perform for the patient is to analyze is likely to be misunderstood and to lose those patients who experience such an explicit analytic posture as not caring. Many times such treatments will drag on for months or even years before the participants face up to the sad fact that they are operating at cross-purposes.

But will the treatment fare any better if the therapist decides to demonstrate to the patient in word and deed that he or she really is...
concerned? Unfortunately, the chances for successful treatment are little better with the expressly caring therapist. Love is not enough, because there is never enough love. The present cannot undo the past. What hope is there for such stalemate treatments? Should the analyst implicitly hold out the hope that the patient’s goal of feeling better about himself and his world is attainable through finding a substitute, even if more or less illusory, for the missing parental love? Or should the patient be told about the impossibility of his quest and be encouraged to reduce his expectations to a realistically more achievable level?

Apparently the answers to these questions depend on the analyst’s value system, on whether he or she believes the most important value is to care for what happens to another human being, or whether the analyst deems the truth, as best as he or she can determine it, as the highest value. I believe much of the animosity between various analytic groups—for example, the accusation that one is soft and perhaps doing good psychotherapy but poor analysis, or, on the other hand that one is cold and unempathically indifferent to human suffering—is derived more from conflicting value systems than from different theories. Viewed from the point of view of a scientific depth psychology, that is, psychoanalysis, the conflict is a spurious one. I hope to be able to demonstrate that the choice is not between empathy or truth, but rather that the psychoanalyst can and should be committed to both. The analyst can appreciate why the patient who was or felt deprived of the needed parental care during childhood is now demanding the analyst’s utmost concern. In trying to understand the patient’s past and present, the analyst accepts the patient as he or she is without making any demands for change. Indeed, the analyst is not concerned with either loving the patient now or whether the patient’s past experience actually happened that way or not. The analyst simply tries to accept, understand, and explain as best he or she can, and always not nearly as well as the patient expects. If the patient, in spite of painful disappointments, can also come to accept the analyst with his or her shortcomings, then a psychoanalytic process will establish itself and will likely be blessed also with the patient’s experience of an improved sense of well-being.