# METAPSYCHOLOGICAL FORMULATION

# A NEW SCIENTIFIC METHOD OF PSYCHOANALYTIC

# CLINICAL RESEARCH AND PRACTICE

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## ABSTRACT

*Many claim that Metapsychology is of no use in the clinical situation and should be abandoned. The author's researches show that this attitude is the result of an incomplete scientific evolution of the theory. If enabled to mature, it provides a sound foundation for the creation of a true science of clinical research and practice.*

*On entering the field of psychoanalysis, the author assumed that metapsychology would be its "basic science" and that its "applied" ("technical" or "clinical") theories would be created from it. In keeping with this belief, he steeped himself in its study and developed respect for some parts of the theory before discovering that his assumption was wrong. His curiosity persisted in spite of collegial disinterest, however, and he was drawn into a long series of surprising and unusual encounters that produced: a scientific method of clinical research; several original researches; an unusually effective self-analytic method; an intellectual bridge between psychoanalysis and its neighbouring sciences; and a technical theory impervious to inappropriate subjective influence.*

*This paper introduces a formulation method that is rooted in scientifically developed metapsychological concepts and principles and makes primary use of the clinician's conscious, cognitive mental processes. It should have special appeal to those who sense the nearness of a fine marriage between psychoanalysis and cognitive-emotional science followed by a scientific revolution.*

*An illustration of the approach is provided.*


## INTRODUCTION

If the research principles of the hard sciences are applied to psychoanalysis, and its theories are examined in "basic" and "applied" ("technical" or "clinical") terms, the body of theory known as "Metapsychology" would be considered its original basic theory. As all psychoanalysts of the post-modern era would know, however, the "meta" theory has fallen into gross disfavour as a basic set of ideas to explain the phenomena of the psychoanalytic domain. It has also become popular tradition to say that it is of no use as an applied theory and should be put to rest as such. Many would even say that as *any* kind of theory, basic *or* applied, it is near death and should not be resuscitated. Only a very few have called for its revival, and their appeals are not being heard. However, the author's experiences in the course of a lengthy, scientific examination of its concepts and principles reveal this dismissive trend to be the unwitting outcome of undetected scientific errors.

Metapsychological theory was never given the chance that the traditional sciences would have granted it. While it had an auspicious beginning as a collection of reasoned "hypotheses" tied to

observational data, many of its ideas were elevated to the status of "accepted conclusion" without being subjected to all the steps of the scientific method. Its *concepts* (e.g. transference) were never concretely defined for standardized clinical use, and its *principles* (e.g. symptoms are compromise formations) were not exposed to research designs that permitted intra-clinical testing by prediction. The loose and expansive clinical observational field on which the theory took root was never narrowed to allow for in-session objective perception. And although the first analysts accepted Metapsychology as their evolving *basic* theory, they fashioned their *applied* theories by a parallel means that left them increasingly separated from it. In the case of formulation theory, for example, they sanctioned the creation of a method that traditional scientists would have rejected outright, and in doing so left a legacy of problematic theory-making habit that has lasted. There are seven different formulative methods that have been developed for clinical use to date, and all are subject to symptomatic user defense and drive needs that can neither be identified, controlled nor permanently removed from everyday operative effect. They are approaches that invite emotional attachment to untested theories, a phenomenon that would cripple the research endeavours of any science. When several theories are competing to explain the observed data of a scientific domain, it can be assumed that none have been scientifically proved. And if one is adopted as a "favourite"[1], what is "believed" soon presses to become what is "perceived". Then scientific possibilities come to an end.

This situation has undermined practitioner efforts to offer treatments that are predictably successful and complete, and disturbed the confidence of consultees who are attracted by *some* of the ideas and methods of psychoanalysis[2]. It has also created major problems for clinicians who seek to conduct scientific researches in combination with their daily clinical work. With no methods that make exclusive use of their conscious, cognitive mental functions, practitioners and clinician-researchers are forced to formulate with processes they cannot know (i.e. that are "unconscious"), and the formulative act becomes a hit-and-miss affair. Without them, as well, they are unable to define the "knowns" and "unknowns" of the analytic domain and to separate researches that are completed from those that are needed. Thus myriads of unexplained clinical phenomena escape notation, delineation and investigation on a daily basis.

This paper is intended to provide a first, brief outline of an unplanned, twenty-six-year series of encounters in an unusual area of clinical study that led to a demonstrable solution to these problems. It is also intended to serve as an introduction to a book ("Metapsychological Formulation") that is nearing completion. The author came to psychoanalysis with an education in the clinical and experimental research methods, and basic and clinical theories, of general, internal and psychiatric medicine. On beginning his analytic training, he assumed that the inspired research frameworks medicine had offered him would be applicable in his new field, and he was well along the way to transposing them to it before discovering that he was headed in an unpopular direction. By then, however, his interests had a firm

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[1] Pearl King, in "The Freud-Klein Controversies" (1991, p.2) provides a striking description of this trend.

[2] See panel report (L. Kirshner, 1998) for references to the public's declining respect for psychoanalysis.

hold on his curiosity, and he was led from the mainstreams of psychoanalytic theoretical endeavour to unexpected research pathways that proved startling, exciting, astonishing and rewarding at every major turn.

The paper describes how: (a) the currently accepted *concepts* of the psychoanalytic "schools" (many of them originally metapsychological) were studied for identifiability by concrete signs in clinical material; (b) accepted *principles* were tested by prediction using new clinical research methods; (c) some concepts and principles were retained and reliable bodies of basic and applied theories were created; (d) original researches in the areas of *the psychoanalytic observational field, symptom identification, surfaces and layers, the aggressive drive*, *the genesis of symptoms, transference layering* and *curative factors* were carried out; (e) new concepts and principles were conceived and added to already-developed theories; (f) and a new conscious, cognitive-emotional method of formulation was developed.

The approach to be outlined is standardizable, teachable, and anchored in logical premises that can be stated in explicit detail. It enables analytic clinicians to spot all successively-appearing symptomatic elements in clinical sessions and develop split-second, accurate formulations of each as they proceed. It thus allows them to keep a finger on the clinical-process pulse and monitor its activity closely.

## The Pertinent Literature

The papers and books of a few psychoanalytic writers and at least one academic critic contain implicit and explicit appeals for fundamental changes in the methods by which psychoanalytic theories are created. As the "M.F." concept offers significant responses to their authors' requests, some aspects of the writings will be summarized to reflect the timeliness of its introduction into analytic discourse.

***Adolph Grünbaum (1993)*:** pointed out (p.xi) that if Freud's central ideas were to be tested clinically, research designs not yet imagined would have to be developed.

***Philip Holzman (Grünbaum, 1993)*:** (p.xviii) observed that most journal papers do not describe scientific explorations; (p.xxi) emphasized the need for close examination of the basic premises of analysis; and recommended the development of test methods capable of establishing validity on the basis of sound evidence.

***Robert Holt, (1989)*:** asked (p.323) that metapsychology be brought from the brink of death and made into a vital science able to explain clinical phenomena; (p.324-327) summarized the problems with the theory that plague most scientific critics; spoke of them as the result of disciplinary default; observed that the analytic profession had never defined and standardized its meta concepts; noted that it used them inconsistently; described (p.338-339) the development of the applied ("clinical") theory as philosophically problematic in the extreme; and recommended (p.322-323) that analysts stop

formulating by the use of unconscious derivatives [as artists create] and change to methods anchored in the observable clinical data.

***Philip Holzman and Gerald Aronson (1992)*:** noted (p.74) that most psychoanalytic hypotheses had never been tested for validity; observed (p.79) an intra-institutional hopelessness about testing them in the clinical situation; noted that this attitude had led to the hermeneutic conception of analysis: saw (p.83-84) the possibility of fine analysis of observed data; considered the possibility of investigative methods capable of prediction; described the current metapsychology as pliably submissive to clinician desire and therefore scientifically useless; asked that it be revitalized, not abandoned; and spoke of the intellectual isolation of psychoanalysis from the other sciences as a nemesis to its theory development.

***Otto Kernberg (1993):*** said (p.48, 49) it was generally thought that analytic research had not been impressive; observed that practising analysts knew ittle about what was being done[3]; and listed (*1996*, p.1031) thirty features of analytic institutes destructive to trainee creativity.

***Arnold Cooper, (1995):*** described (p.389) most psychoanalysts as: preferring to work like artisans; highly aversive to standardization; antagonistic to operating from an exclusively cognitive base; and attracted to freely-hovering attention and vague open-ended thought.

## Common Misconceptions that Collect about this Method

Because presentations of the M.F. method to psychoanalysts for the first time were met with a number of unchecked assumptions and gross misconceptions, some effort to dispel misunderstandings at the start of this report will be made.

***(1) The Method and Empathy:*** This paper is only intended to outline the method's concept, development and approach to creating clinical formulations, not to describe all aspects of its application. It should be understood that those who use it are driven by a wide-ranging empathic capability obtained by dismantling serious and severe symptoms at root level. It is not the "rigid" and "obsessional" product of a defensive mind, but the scientific yield of one freed of symptoms by long, hard, original work on the self after a typically "incomplete" training analysis.

***(2) The Method, Clinical Priorities and Clinical Research*:** When the M.F. clinical situation is simultaneously used for investigative purposes, the requirements of the treatment have absolute priority. Research findings emerge from parallel observations of the natural treatment process.

***(3) The Method and the Pleasures of a Working Relationship:*** All of the pleasures of a functionally-appropriate, real object relationship are regular aspects of M.F. analyses. Analysands and their exploratory assistants have fun, get excited, and experience satisfactions over "jobs well done".

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[3] See the Joseph Schacter and Lester Luborsky article, "Who's Afraid of Psychoanalytic Research?" (1998, p.965-969) for confirming evidence on this point.

***(4) The Method Compared to the Other Formulative Approaches:*** This method is quite unlike the other prominent methods of psychoanalytic formulation. In particular, it is not at all like the "free-floating attention" approach to which it has unfathomably been compared. As will become clear, the M.F. clinician's "attention" is neither "free" nor "floating". It is singularly directed to the hard data of the analysand's free-associative efforts and the concrete signs of all symptomatic phenomena revealed by them. When symptoms are observed, their meta structure-processes are dissected by conscious, cognitive means, and when none are active the presented material is monitored continuously so that assistance can be provided when needed.

***(5) The Literature and the Subject of this Particular Method:*** There is no *specific* literature on this subject. As indicated, a great deal has been written on the inadequacy of the analytic profession's science (see also Edelson (1988, p.xiv), and some have advocated an improvement of metapsychological theory as an attempt at solution. However, no one who has addressed its formidable theory-making problems (of "conclusions without proofs" and "categorical dismissals of possibility in the face of obstacles") has recommended a *primary, conscious, cognitive-emotional, metapsychological method of formulation* as a way out of the long-standing speculation wilderness that has been imprisoning a potential psychoanalytic science.

## Conception, Philosophy and Evolution of the Method

When the author came to psychoanalysis from psychiatric medicine, he

brought a long-established interest in the field and a particular curiosity about its theories that was already well-developed and at work. It was to examine clinical material in process for the presence of metapsychological *concepts*, and define such entities as "ego", "resistance", "defense", etc., in terms of the concrete signs of their shifting presences in patient sessions. Having pursued this interest for some time during a prior psychotherapy teaching career, he soon developed an automatic ability to recognize the concepts that "held water", and, when several had been collected, the *principles* said to link and explain their clinical behaviours became the subject of his attention. However, while the identification of *concepts* posed no problem of methodological design (being as it was a process based on observation and definition), the study of accepted *principles*[4] needed a method of testing not yet devised[5]. He

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[4] For instance, if there is truth in the postulate that claims a "self's" "aggressive drive" has been turned from an "object" to the "self", the concepts grouped and made interrelated in the dynamic system described should prove to be linked by a logical "principle" that can be used to predict the occurrence of such a system in advance.

[5] The tasks of defining concepts and developing testable hypothetical principles to explain their interactive operations have been neglected by the analytic profession. In an edited collection of Benjamin Rubinstein's papers on the philosophy of science, Robert Holt (1997) pointed out that the author worked on the problem from 1965 to 1983 but his efforts were never followed up. Holt later (1989) analyzed the problem in detail himself, and expressed hope that some young analysts would continue the work, but his effort still awaits his response.

therefore adapted some of the strategies of general medical research and developed the following technique.

## The "Minimalist Intervention" ("M.I.") Method

To straddle the difficult fence between the demands of treatment and those of combined clinical research, only the most basic and uncontroversial technical principles were employed in the course of the treatment task. (One example was the provision of a well-thought-out, realistic and explicitly-stated free-association process instruction.[6]) No non-standardizable *concepts* or untested *principles* were used, and conventional theories that drew conclusions several inferential removes from the observed clinical data (that were "data distant") were especially avoided.

Data-distant theories are untested theories developed by theoreticians who moved from phenomenon to conclusion without knowing and demonstrating the validity of the many inferences they made in the process. Analytic theories need to be developed in steps that test single inferences using predictive methods if they are to become clinically reliable[7]. However, hardly any received analytic applied theories have been exposed to validation procedures[8], and when they are used to posit deep-layered structure-processes from small pieces of surface material, intervening layers of great technical significance get lost and process disruptions are produced.

**Examples**

**1:** A common application of one aspect of Freud's "Oedipus Complex" hypothesis serves to explain the nature of the scientific problem posed by such theories. If the clinician observes signs of a rivalry within a triadic relationship system, he/she commonly infers and assumes the general and specific natures of the analysand's *drives* without their having appeared in his/her releasing associations. A passage in an article by Theodore Shapiro (1977, p.577) illustrates this problem. In it, the author speaks of that "Complex" as a main means of progress in work with character pathology, and of how it can convincingly show analysands how they repeat the past. However, the clinical example (p.565-568) used to back the claim is not supportive. In it, the purported "Oedipal" material does not emerge

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[6] The psychoanalyst, Patrick Mahony, expressed surprise when he reviewed the literature on the Free Association Procedure (1987) and found (p.16) that it had never been subjected to systematized, sustained development and study in spite of being such a central part of the analytic process. He also described (p.35-37) several different types of free association instruction, all of which, in this author's experience, are incapable of serving as reference points against which the subtly-operative, negative transferences that attach to, and transform, perceptions of consultants and their instructions at the start of consultations can be identified.

[7] Wm. Massicotte, a philosopher of psychoanalytic science has recommended this approach (1995, p.21).

[8] J. Weiss and H. Sampson are two of the few workers to have developed and applied methods for doing so. For a brief summary of one facet of their work, see Weiss, J., in Shapiro and Emde, 1995, p.7-29

spontaneously in the subject's associations without suggestive influence. The idea is introduced by the analyst in an interpretation, and the manifest content of a dream is offered as confirming evidence. By contrast, the M.I. approach directs the practitioner to develop single inferences from the clinical data and test each formulative hypothesis without suggestion. When the method is used to determine the nature of the *drive* in effect at a specified moment, the free-associative stream is observed for concrete signs of drive material, and if none are present, the "layers" within identified "surface" "defense systems"[9] are studied. Then

minimal interventions are directed at successive layers of the systems until the drive makes a direct appearance. This procedure allows for the testing of formulations, whether they are based on established theories or on new creations. It also removes the possibilities of theoretical bias and confirmation of hypotheses by suggestion.

**2:** Of course it is not uncommon for analysts to say it is impossible to design unbiased methods for testing the validity of theories. Donald Kaplan (1994, p.192-193), for example, spoke of his disillusionment with such ideas and opined that those who adhered to them did so out of naivety and need. But his sweeping generalization was argued without any factual proofs.[10] The "naive" and "needing" people were not identified, and no concrete support for the existence of their wrong-headedness was provided. But even if the author's assertions had been bolstered with data, there is little currency in closing the door on scientific possibility. Reasons are scant for taking the position that what has not yet been possible can never become so.

As the present author's experience with the M.I. approach grew, he found it easier to reconcile his research use of the clinical situation with his primary treatment obligations. All treatment work proceeded well with "minimal interventions" when they were simple, certain, and not contaminated with theoretical imaginings.

## A Philosophy of Science Puzzle Forms, and Views Are Changed

When he began his intra-clinical studies of the formulation process, the author was in the habit of using the formulative methods he had been taught. When working with the material provided by analysands, he:

- *allowed formulations to emerge from the unconscious (Freud, 1912, p.112, 115);*
- *gave "evenly-suspended [free-floating] attention"* (Freud, 1912, p.111);

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**9** The old maxim, "interpret defense before impulse" is misleading. A *defense* is only one component of a *"defense system"* that includes an *object* in the *superego-ego-ideal structure* applying a *standard* backed by a *judgement* and creating a *motive for defense* – and one or other of the highlighted parts lies at the system's *surface.*

**10** The *categorical statement without evidential support* should be considered an enemy of analytic science.

- *provided "evenly-hovering attention"* (Hollender, 1965, p.71);
- *remained equidistant from id, ego and superego* (uncertain origin);
- *used the counter-transference to assess the transference* (Racker, 1968, p.127-173);
- *studied empathic responses as signs of analysand subjective experience* (Kohut, 1971, p.300-307);
- *used symptoms appearing in the self during sessions as indicators of analysand communications* (Jacobs, 1973)

As someone impressed by the powers of scientific methods, he had vague difficulties in accepting the logics implied in these approaches, but they were so widely used and unquestionably advocated that he tended to accept them. Questions pressed, however, and his pursued curiosities eventually made their philosophical difficulties less puzzling. As the barest use of the simplest, most indisputable techniques began to prove itself capable of assisting analysands with their self explorations, the traditional methods of formulation started to reveal their fallacies. And Freud's advice to formulate using the unconscious was the first to stand out.

Freud's recommendation was examined in light of the generally-accepted fact that, by definition, the broad *unconscious* included an area comprised of internal conflict that was impossible to know without lengthy and extensive self work on the repression defense. Thus the idea that its surface, conscious "derivatives" (i.e. "symptoms" - "compromises of defense and drive") could contain capturable and specifiable information that informed one person's mind about the particular operations in the unconscious of another, became more than doubtful.

## A New Approach to Intersubjectivity Theory is Taken

Of course the idea that the unconscious activity of one mind can *affect* the unconscious of another was not dropped, but it became important to remove the seeming perpetual mysteries in existing "intersubjectivity" theories and explore the phenomena they addressed scientifically. To that end, then, a simple, testable hypothesis was created and notations made of clinical material that illuminated it.

It was postulated that the most logical means by which unconscious minds could be expected to influence each another was by the effect of one person's *concrete behavioural expression* of conscious "derivative" material on the *perceptual apparatus* of another that was *particularly primed to apprehend* it for reasons unknown. It was then posited that this idea could be examined for validity if the clinician:

- developed a heightened ability to observe his/her own perceptual functions;
- observed their behaviour when derivatives of unconscious activity in self were noted;
- observed the physical and verbal expressions of analysands being perceived;
- developed a self-analytic method capable of identifying and dismantling the layered defense systems in the self's derivative material;
- analyzed the systems until depth-unconscious roots were released;

- examined the perceived analysand expressions and the stimulated self unconscious material for matches that suggested specific causal connections or otherwise.

The author undertook this investigative course, and his findings illuminated what went on in at least one clinician's "responding" mind. They revealed that it was acutely observant of analysand derivative material because it was driven by still-unconscious depths that directed it to: *defend from traumata it had never mastered*; and *seek material indicators in the other that offered the possibility of satisfying inappropriate needs*. They also showed that it *projected feared traumata and need-satisfying opportunities into the material that, when analyzed, contained no such things*. In other words, they indicated that long after the completion of a training analysis considered successful at the time, the analyst had a large reservoir of unsolved internal conflicts in his depths. They also revealed that it was finding outlets for displaced expressions of defense-drive derivatives being issued at his working self's surface, and jeopardizing his formulative efforts without his knowledge. It was using his conventional formulative theories, to produce conflict-driven misperceptions of incoming analysand material, rationalizing its misdirected technical responses to it, and achieving its aims without being caught by his simultaneously-active observing self.[11]

## Two New Studies Help To Focus The "Puzzle"

As the author's experience and thinking progressed, he began to wonder why conventional methods of formulation held such positions of popularity and domination. He asked himself if they contained hidden truths that could be scientifically discovered, then developed an examination into one of them - the method suggested by Jacobs.

### 1: Symptoms in the Analyst During Sessions

This study (Anderson, 1979) addressed the question of whether symptoms that appeared in the analyst during clinical sessions could be reliably used to formulate the analysand's unconscious processes. Employing his developing M.F. theory to analyze *symptomatic acts* that he observed in himself during sessions, the author was able to undo enough layers to see that his free-associative efforts were regularly leading him away from analysands as the sources of stimuli that specifically stirred the mental operations responsible for his symptoms. They were taking him to recent, personal social situations in which intense conflicts had been mobilized, conflicts that were continuing to percolate beyond awareness days after the events that had aroused them.

He then proceeded to compare his metapsychological analyses of self with the "meta" analyses of patient structure-processes he had recorded (as a matter of routine) in the moments when his

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[11] Of course all of what has been described here supports the commonly-accepted belief that "no analysis is ever complete". This work, however, begins to narrow the problem down to the details of *what remains and why*. It also challenges the analytic discipline to find a means for changing the situation for good

symptomatic phenomena had appeared, and no "matches" turned up. The corresponding meta configurations offered no reason to suggest that studies of the analyst's symptoms and their unconscious roots could provide *reliable* information about the unconscious processes at work in the minds of his analysands.

In one such investigation, for example, the analysis of a "slip" in the analyst's mind – one that distorted a patient's name as he welcomed the person in to a session - brought back a rankling memory of a personal incident that had occurred while presenting a brief to a social organization a week before. While the event had not continued to capture his attention at an everyday conscious level, it had remained very much alive and simmering in the nether region of his mind. In that obscure place, defense and drive derivatives from a "social trauma" had been waiting to spring to the forefront of his mental experience at the simple sound (i.e. phonetic property) of another's name.

Further exploration of this experience revealed that, in the face of a gratuitous critical attack on his character, the analyst's range of serviceable aggressive responses had been seriously undermined by unknown and initially-unknowable processes. When his self-analysis eventually released them to consciousness, he came upon a traumatized self that was frustrated and fuming at its lack of effective defenses in a situation that had rightly called for them. It emerged in the midst of abundant signs of a multifaceted conflict that: (a) had not been significantly touched by his personal analysis; (b) had attached to a *non-specific* expressive stimulus from his analysand; (c) and was dysfunctionally seeking (and nearly finding) an inappropriate outlet in his work.

**2: Symptomatic Behaviours in Consultees During Assessments**

This study (Anderson, 1982) developed as a natural next step in the author's expanding sequence of curiosities. With his new ability to observe self perceptions taking place beyond common awareness, and using the valid "meta" theories he had collected to date, he examined the symptomatic behaviours of consultees in thirty-eight (38) consultations, and some interesting findings were cast up.

It became apparent that he was *very* sensitive to consultee symptoms expressed in the form of transference-determined behaviours, and that he spotted their signs with an intensity of purpose. It also became clear that such symptoms were: (a) numerous and frequent from the time of the first telephone contact onwards; (b) of a range much greater than that covered by common diagnostic categories; (c) exclusively of the "character" type; (d) imbedded in "operative transferences" that produced "resistances"; (e) always in need of immediate formulation and intervention; (f) and often revealed by concrete signs that were obscure to the point of being subliminal.

This work continued to open his eyes to the subtleties of concrete patient process to which his perceptual apparatus was spontaneously cognizant. It also led to the discovery of a very important

phenomenon underpinned by a principle that he came to call the "Glover Effect"[12]. By the terms of the principle, transferences that are derived from the root processes responsible for character symptoms and are syntonic to the ego of the consultee's observing self: (a) operate at once in consultation; (b) change perceptions of the real consultant behaviours, by imposing transference-determined misperceptions upon them; (c) lay down consultant internal mental representations that are indistinguishable from those of the symptomatic self's original problem objects; (d) incorporate and transform the consultee's perceptions of the essential elements of the consultative process; (e) nullify all possibility of using such elements; (f) and subtly destroy entire consultation-treatments at the start if left undetected for long.

**Recording Methods are Introduced**

The next natural development in the author's expanding complex of interests was the introduction of four methods of recording that made it possible to capture the many intertwining elements of the clinical process as consultative and treatment sessions progressed.

A type of ***Automatic Writing*** in small pen-hand allowed him to record the details of the analysand's free-associative material and objectify his parallel formulative processes as the two session elements interwove in series of stimuli and responses. This practice also helped him to define the frontiers of theoretical development by illuminating material that could not be formulated because no tested theories to explain it existed.

A ***Codification* system** helped him to record his moment-to-moment monitoring of the clinical process as his perceptual and other cognitive apparati carried it out. For example, an *operative* "transference-of-defense" (Sandler with Freud, 1985, p.41), 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:

**[ < This entire codification is recorded *in the left-hand margin of the process note - as indicated below*, - and *paralleling the pertinent free-associative material to the right*> ]**

**R/** Resistance

**T/**Transference

**OT/** Operative Transference

**SEEI/** (particular features of standard-setting activity cited)

**TI(agg.?)/** (particular drive and form of drive cited – the drive form here unknown)

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[12] Named after Edward Glover who unwittingly sowed the seed of the idea in a brief line in his 1955 book.

**TF** (details of object expression - content and form)

**MSD/** (effects of object threat upon self)

**SD/** (particular defenses listed)

**G** (object origin of the transference-of-defense)

**That is:**

**R:** a resistance is present;

**T:** of the transference type;

**OT:** of the "operative transference" type, (i.e. affecting an element of the patient's use of the analyst and the other process elements)

**SEEI:** from an object in the superego-ego ideal structure that is imposing the "standard" ----- and forcing compliance with the object's "judgements" by the threats of "repercussions" ----

**TI(agg/?):** directed against the --?-- form of the aggressive drive;

**TF:** resulting in the transference-determined fantasy of the therapist -----

**MSD:** motivating the self to defend by the effects of -----

**SD:** forcing the implementation of the self defenses ----- ;

**G:** deriving from an earlier and ultimately original object ----- (the object is named).

[If symptomatic activity appeared in the analyst's working self as he developed and recorded his formulation, it was also identified, defined, formulated and similarly codified at the point that it entered the process.]

Detailed ***Notations*** of material pertinent to researches in progress helped the author to highlight and follow the several types of clinical phenomena he was in process of studying at the time. They also allowed him to report the concrete details of his formulative experiments and results when making

presentations, and enabled him to make such material available for third-party study if suitable occasions were to arise.

Although ***Audio and Video Recordings***, proved limited in their usefulness for following and understanding the therapeutic process (i.e. they said nothing of the analyst's internal-formulative and subjective-reactive experiences, and nothing of the self analysis of his symptomatic responses), but when combined with the other forms of recording described they helped create a multidimensional recording approach that was capable of catching much of the analytic process in progress.[13]

## An Unusual and Thorough Self Analysis Evolves

As the author's ability to observe and separate symptomatic processes in "other" and "self" increased, and as he isolated and defined still-active symptoms in his working self, he was stirred to explore that self more thoroughly. His written recordings of *patient* process began to contain more on-the-spot self work, and his M.F. method led[14] him into a systematic analysis. It was a daily process that lasted twelve years, went to the bedrocks of underlying conflicts, produced extensive lasting results, gave rise to new researches, and complemented those involving analysands.

A partial summary of this experience written at its halfway mark in 1985, was published in 1992. The work was completed in the early nineties, and revived only on rare occasions when the emotions associated with familiar and already-analyzed conflicts became activated by unusual combinations of events in sleep.[15] Because it was carried out with the same writing technique used with analysands, the entire process was recorded, and its 5000 pages of on-the-spot notes have been preserved.

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[13] The video recordings soon proved so unwieldy and of limited use when not allowed to intrude upon the basic requirements of the clinical situation that they were dropped as a viable investigative tool.

[14] To say that he was "led" is the most accurate way of describing his journey. None of his "trip" was the result of intention or design. A clinical nose for the unexplained pulled his curiosity and it pulled him.

[15] Fear to the point of raw terror was a common emotion experienced. It appeared in dream contexts, and was of an intensity that could arouse the sleeper. Its effects disappeared on waking, however, and the dreams themselves gave way to analysis in seconds. The experiences were reminiscent of the type of memory stored in the amygdala. It seemed that unusual "day-residue" perceptual fragments could converge to produce stimuli that re-awakened the cortical-amygdalian circuits of an early-childhood self organization, one that the self analysis had replaced. It also seemed clear that the new adult self created by the analysis could quickly absorb and disperse the emotions released, and strengthen itself further as a result of the mastery involved in the experience. And as the affective power of the phenomenon was reduced by repeated effort, it further became clear that the amygdala's memory was not impervious to the new adult self's instrumental capabilities for they eventually effected changes in its night-time operations themselves. (This observation fits that of Schacter – 1996, p.214 – who reported that, as well as taking in and remembering primitive input from early perceptual

## Some Particular Advantages of the M.F. Method

This method:

- Draws on the impressive power of an asymptomatic, theoretically-informed and fully-functioning cognitive apparatus that is being energized by situation-appropriate emotions
- Enables the user (clinician or lay person) to create immediate, accurate, objectively-determined formulations of any kind of symptomatic material in self or other, and to do so under any clinical or **extraclinical** circumstances.

  **[Note: July, 2013** The above reference to the "extraclinical" – outside the clinical situation – is interesting in that my work has led to making MF theory available for formulation and intervention with conflicts in self and others in the everyday world. I submitted an abstract to a Social Psychology Conference on the subject this spring. It will be included later in this book.**]**

- Insulates the clinician doubling as a clinical researcher from endless, impenetrable, subjective mysteries, and allows him/her to work with data that is concrete, completely knowable and could be quantified.
- Allows for the intra-session testing of old or new hypotheses by prediction.
- Provides a means for undoing clinical confusions generated by unsuspected and undetected lacunae in conventional basic and technical theories.
- Permits the self-analytic user to proceed towards as-yet unreachable depths, carry out ground-breaking researches on the way, and permanently dismantle the conflicts responsible for incomplete analyses and the countertransferences that result from them[16].
- Arms the practitioner with confidence in the face of apparent treatment impasses (those dark days of the clinic when analysands are proclaiming the futility of the process and the inadequacies of the clinician's contributions) by enabling him/her to know if a present technical position is correct and should be maintained.
- Offers a theoretical framework for accurately assessing the research claims of others, and for doing so with an economy of effort.
- Allows the practitioner to have conscious, cognitive-emotional, moment-to-moment access to all of the elements of the two-sided clinical process at all times.
- Allows teacher/authors to know and describe the intricacies of their observational and formulative efforts in detail.[17]

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stations, the amygdala has access to more sophisticated information from later-developed processing systems.)

**16** The writings of the few authors who have described their personal self-analytic experiences over the years indicate that no other methods have yet proved capable of this task. They also reveal a resulting tendency towards hopelessness, resignation and acceptance of the status quo. James Barron's 1993 book, *Self Analysis, Critical Inquiries, Personal Visions* provides some telling examples.

- Could be programmed to create a sophisticated software program used for consultative and a variety of other purposes.
- Can contribute to the development of cognition-emotion science by the creation of finely-detailed visual representations of the structures and processes of symptomatic mind function.

## ILLUSTRATION OF THE METHOD IN OPERATION

The following example is from a consultation taken at random from thousands of records on file. While it involves only a few brief moments of the preliminaries to a possible first consultative meeting, the material involved is of a type that could present at any point in any analytic work. The situation to be described calls on the consultant to respond with a constructive interventive contribution to the prospective consultee's communication, and his/her ability to formulate systematically, correctly, and at once, is excitingly challenged.

It should be understood that the material to be provided is intended only as a brief *illustration* of the Metapsychological *"Formulation"* Method. The inclusion of fine definitions, intraclinical predictive testing methods, new research findings, interventions and effects, would take the author far beyond the goals set for this paper. All such topics, along with a follow-up report of the situation to be outlined, will be provided in the earlier-mentioned book on formulation. The M.F. method's Theory of Intervention, a subject in its own right, will then be separately addressed.

In what follows, all technical terms when first introduced will be highlighted by ***bolding and italicizing*** (as so), and when used in a final summary of the formulation to be developed, **bolded** (as so). Several of the terms will be recognizable from general psychoanalytic writings[18], while others that have

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[17] One cannot teach mental operations that take place beyond one's consciousness. The author's analytic training demonstrated this problem in psychoanalytic education. His supervisors taught general approaches to formulation, e.g. "examine your countertransference", and suggested particular interventions, but they did not explain how the interventions were conceived. (A 1974 paper by J. Ramzy is pertinent to this point.)

[18] **In the course of his several presentations of this paper, the author discovered that many analysts think of the Metapsychological theory in terms of Freud's earliest work and not in terms of what it would look like today had it been continuously developed. They therefore reject concepts such as "transference" for inclusion in it. However, if those concepts are broken down to their subcomponents, they can be readily observed to be complexes comprised of many of Freud's original metapsychological postulates. [2013, "Amen!"!]** [For example, the author has described the "transference" phenomenon as "a misperception of a current object (*structural theory* and the perceptual element of *ego* function), deriving from an earlier experience with a previous object (*genetic theory*), one that is often, if not always, mentally represented in the superego-ego ideal structure (*structural theory*), the memory of which may be repressed (topographic theory), the internal effects of

emerged from M.I.-M.F. researches will prove original. Although the new terms will not be defined, the contexts in which they are applied should help to explain them.

**A Telephone Call**

In January, 1981, a mental health professional in a western Ontario town, "Mrs. K."[19], referred "Victor C.", a twenty-nine year old visiting researcher from Europe, for consultation regarding the possibility of his entering analytic therapy. She did not forward anything other than the person's name.

**Mr. C.** phoned and left a brief message, and when the consultant called back this conversation took place:

**"Hello, Victor C------- here."**

***"Hello, Mr. C, Dr. Anderson returning your call."***

**"Thanks for getting back to me, Dr. Anderson. I've run into quite a problem.**

**I'm over here from -------- with my partner, *Den*------ . We've been living together for seven years. We've talked about marriage and kids but we've never taken the step. About five months ago, I met a visiting consultant from the U.S. Her name is *Bel*------ . We had an affair before she went back to ----- ------- (a university on the west coast) and things haven't been good for me since. She phones me often, and I keep in touch. There's a possibility that I might move to be with her, but I can't decide anything at this point. Meanwhile, I've been getting increasingly anxious and depressed and I haven't been keeping my deadlines at work. I'm a research engineer and I'm on a special job. (pause) ..... I don't think I've ever felt so bad in my life." (pause) ....."I guess you would recommend meeting separately with me and then with *Den*------.... (brief pause) not that I want to keep secrets." ..... (pause) ..... "I sound awful, don't I."**

This excerpt lends itself to an illustration of the number of metapsychological *concepts* that can be concretely identified in a small segment of clinical material, and how, when combined with tested linking *principles* (proven "meta" *theories*), they can be used to develop a metapsychological formulation.

## The Identification `of Symptoms

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which (dynamic theory), may lead to the erection of a variety of defenses (*structural theory – the ego*) that are directed against powerful drives (*structural theory – the id.*]

**19** All initials and part names used in this segment of clinical material are pseudonyms.

The M.F. clinician's initial task with this presented material is to identify the signs of any "symptomatic" elements[20] within it and formulate the underlying mental operations responsible for them. Traditional analytic theories put little stock in the importance of systematically spotting and working with symptoms from the start of consultation[21], but the author's close metapsychological monitoring of many consultative engagements has shown that such an effort is essential to successful treatment. As earlier indicated, the processes underpinning character symptoms become manifest in the first moments of a clinical contact, and they create untold complications if not addressed at once. The problems they produce are not grossly apparent at first, but hey can seal the fate of an entire treatment, without anyone knowing what is happening.[22]

In Mr. C.'s case, the consultee's initial consultative communication contains elements that are symptomatic of three separate, but related problem mental operations, and the expression, **"I guess you would recommend meeting separately with me and my live-in lover."** is the first. This is a statement made within seconds to a new *object*, about whom nothing is known that could explain how it was generated. Mrs. K., the referring consultant, had no information about that object that could have been communicated to the consultee to account for it, and it is obvious that the present consultant has not even thought of how he would recommend approaching the consultation, let alone said anything to that effect. The consultee, however, is talking to him as if he *were* someone who *has* formed such an opinion, and this behaviour is a hallmark of problematic mental activity that is either ***syntonic*** to the ***ego*** of the consultee's ***observing self*** (i.e**. *ego-syntonic***) or beyond the scope of its self-observing powers (i.e. *unconscious*)[23] because of being ***repressed***.

## Developing a Formulation

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**20** The author uses this term as physicians do, meaning "the surface signs of an inferable, underlying pathological process, the operations of which are not at first accessible to direct observation". In the case of an analytic consultation, it means the material presenting at the working surface, issued from the conflicts responsible for the problems that have led the consultee to seek assistance. And that means the communicated, concrete, material responses to the consultant and situation that are not the products of objective perceptions. (Ego-syntonic "operative transferences" are "symptomatic", and they are the main type of symptoms under discussion here.)

**21** The passive, "expectant" technique (e.g. Glover, 1955, p.32), an approach that (p.125) downplays the importance of transference symptoms at the start of treatment, serves as an example of this common trend.

**22** The M.F. consultant considers the situation so critical that he/she approaches consultation with the mind-set of the emergency room physician. In the latter case, although the patient may only complain of an upset stomach and fatigue, a faint smell of acetone on the breath (a sign of diabetes) points to something more dangerous than the flu.

**23** Analytic writers often confuse concepts when discussing the signs of transference activity that patients have not observed as such. What close study often reveals to be *conscious* but *ego-syntonic*, is commonly called "*unconscious*", and the unchecked assumption leads to technical errors.

In this part sentence, a ***self*** of the non-observing type - a functioning structure comprised of ***ego***[24] and ***drive***, but not the ***suprastructures*** - has contacted a consultant to describe a painful, unresolvable personal problem and find out if the psychoanalytic method would be a suitable means of repair. It may have other uses to which it wishes to put its newly-met object, but this is the one it has implicitly expressed and the one that is realistic, and when the consultant has clarified this idea in his mind, it becomes a ***reference point*** for his study of the consultee's ***material***. If he observes engagement behaviours that do not fit the referential framework it provides, he will be able to identify, describe and explain what he has observed so that the consultee's ***observing self*** can obtain self-analyzing access to the internal sources of its troubles and join in a collaborative study of their properties.

The ego of the described self has developed a ***fantasy*** of the new object that is not the result of objective perceptions of the real figure's behaviour. It is the outcome of a ***projection*** of the features of an ***internal object***, and the marker of a ***transference*** that has developed prior to the described telephone conversation.

In this material, there is no concrete sign of an observing self that is monitoring the self organization that is in contact with the consultant (i.e. the ***self-in-contact***). The ***transference-determined*** "consultant" fantasy is largely in ego-syntonic relationship to any latently-operative observing self because the self-in-contact is engaging its new object in the belief that its perception of it is reality-based. It is also doing so with little sign of restraint (such as in, *"I've been wondering if you would suggest seeing me separately and then my partner, doctor, but tell me, how would you recommend approaching the situation?"*). The **"I guess"** part of the consultee's statement removes it from the realm of complete ego-syntonicity, but its functional effect on the self-in-contact's behaviour is not insignificant. An unsuspecting observing self is allowing the engaging self to ***act out*** its response to an unwitting misperception of the consultant that has been created from the projected features of an internal object.

Here, the ***transference mechanism*** has forwarded the properties of an object in a ***mental representation*** developed by the ***internalization*** of objective perceptions of an earlier, "real"[25] object, to the self-in-contact's perceptual apparatus. This operation has primed it to perceive what the self has been expecting, and it has formed a mistaken mental representation of the consultant from the details forwarded. It has endowed its new object with a thought and behaviour pattern that is not the result of

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[24] As the "ego" concept is one that is especially poorly and variably defined, if defined at all, and as one's use of it without clarification can be the source of considerable confusion, an exception to the plan to omit definitions of concepts in this illustrative account is in order. Therefore: "The **Ego** is all of the properties and capabilities of the mind (and the body that is its extension and under its control) that are not the *Drives* or the *Internal Objects*. It is: visual, auditory, taste, touch and smell perception; kinesthetic sense; cognitive functions; emotional experience; motile ability, and so on – all of the in-taking, experiencing, processing, mediating and responding functions that operate when the Self is engaging its external or internal world, or creating reconciliations between one and the other."

[25] This point will be elaborated in a chapter of its own in the forthcoming book.

objective perceptions of its real behaviour, and its attribution has resulted in a ***symptomatic*** response. Although the material communicated does not directly reveal the operative presence of the above-described underlying processes, they can be inferred from it.

The symptom type outlined here is one of the ***character symptom*** kind, because tested M.F. theory allows the prediction that the behaviour it produces will prove to be repetitive, and therefore "characteristic" of, the self's manner of relating to many objects[26]. It can be differentiated from symptoms of the ***symptom neurosis*** category (i.e. phobic, dissociative, obsessive-compulsive, conversion, or reactive-depressive) by the observable presence of a direct, object-relationship feature. In symptoms of the symptom-neurotic kind, signs of direct, conscious, self-expressive connections with engaged objects are missing.

## The Metapsychology of Character and the Developing Formulation

The author's researches have revealed that character symptoms are the behavioural expressions of ***character transferences*** from problematic, internal objects, transferences that regularly and unwittingly attach to new objects, including analyst consultants, throughout the self's life span. The priming and biasing of the perceptual apparatus that is fundamental to the phenomenon, is the process that was earlier termed the ***Glover Effect***. By the terms of the "Effect", when what has been experienced becomes expected, and what is expected becomes perceived, the in-taken elements of real object behaviour become grossly and essentially transformed, and, when the self-in-contact's mental representation of its new object is explored, the figure is found to be behaving in the same manner as the old. And if the process is not interrupted, it repeats with the same object and every other subsequent ***significant object*** encountered, and the recalled behaviours of all previously-engaged objects become indistinguishable from those of each other and the original problem-figure. The self-in-contact is led to expect that a new consultant will repeat the behaviours it believed were experienced at the hands of its earlier objects, starting with the person most recently encountered and proceeding back through several relationships to the original. This means that when the concrete signs of a first-appearing, consultation transference fantasy are delineated in detail, exploration of its parts leads to the *most recent* figure in a long ***chain*** of transference-transformed real objects that, followed over time, ends with its ***genesis*** in an infant-childhood caretaker-relationship context.

In Victor C.'s case, this theory permits the prediction that Mrs. K., the referring consultant, will be the initial source of the first ***operative transference*** to the present consultant and the most recent transference object in a lengthy transference chain leading backwards in time. If she did not observe and

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[26] A theory that can be readily confirmed by others if the idea is developed as an hypothesis and thoroughly tested by use of the Minimalist Intervention Method (as the author has done).

address Mr. C.'s transferences from the start of her consultative process[27], he will be found to have developed a mental representation of her endowed with the negative properties of an original caretaker object and those of a succession of subsequent figures perceived in minimally objective and maximally projective terms.

It can also be predicted that Mr. C.'s self-in-contact will approach the current consultation with its ego and drives under the influence of the hypothesized transference from Mrs. K., and in view of the fact that untroubled people (i.e. those who have had optimal, growth-enhancing, self-expressive freedom in relationships with their original caretakers) do not seek psychoanalytic consultation, that ego's mode of relating will not involve direct expressions of the self's aggression or desires (i.e. drives). Much of its original capability to engage in straightforward interactions will have disappeared during development, and it will approach the current consultant as the negotiating part of a self that is vulnerable to what it expects to be the assumed "wants", "not-wants" and dangerous reactions of the other.

In the light of these formulative considerations, then, the present consultant will not be remiss if he postulates that a ***technically-significant*** transference was unwittingly operative in Mr. C.'s earlier consultation, and that a transference of the ***intermediate transference*** type from Mrs. K. will prove to be the source of the first one he encounters (an hypothesis that can be tested by the means that have been earlier discussed).

## The Telephone Call, Continued

**" ... not that I want to keep secrets**" is a brief statement, but when its structure-process is metapsychologically dissected a great deal of Mr. C.'s internal mental activity can be inferred from it. It is an example of the familiar *negation*.

Here, Mr. C.'s self-in-contact continues to operate beyond the scope of his observing self and in ego-syntonic relationship to it. It is under the influence of an operative ***transference-of-defense*** in which the fantasied object of the consultant is critical of those who wish to keep secrets. There is nothing in the material to indicate the nature of the criticism or the threat that it can be presumed to be posing, but whatever it is, the self is seeing fit to ***defend*** from it and doing so by particular means.

First it is ***anticipating*** that the object <u>is</u> critical of selves that keep secrets from their partners, is sensitive to possible signs of such intent, and would try to catch them out if any became manifest. Then it is ***preventing*** that possibility by interrupting and ***constricting*** its description of its problem and its wish

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[27] This would be the situation that could be deemed most likely. Given current levels of theory development, such a technical effort would be most unusual. The author, for one, has never been witness to it.

for assistance, and ***denying*** that any such intention was present in the statement that it made a millisecond before.[28]

As this whole sequence of inferable mental process has taken place in the self without a specific stimulus from the consultant, the expressive behaviour it has produced qualifies as a "negation". That is, the self is defending from a fantasied object by counteracting (negating) the impression that it thinks the object has started to form. It is not simply clarifying a *mis*impression that the consultant has expressively indicated he *is* or *could be* forming. The consultant has not, in any objective way, stirred the process.

It should be noted that this material does not necessarily indicate that "secrets" are inferable from the self's initial statement (i.e. **"I guess you would recommend meeting separately with me and my live-in lover."**). The stimulus for the denial is open to the possibility that the self is dealing with a very suspicious, standard-bearing object, one that finds and judges "secret-keeping" under every rock, so to speak. However, the most likely hypothesis is that, in its initial statement, the self was indirectly expressing a desire, and the transference fantasy in which the consultant was recommending separate meetings was derived from an internal object that only grants wishes when expressed by *suggestion*.

An effort of this sort is usually called a "***manipulation***"[29]. It implies that the transference-determined "consultant" has a symptomatic character structure disposing him to be nudgeable to suggestive input but not by direct request. A behavioural phenomenon of this type goes hand-in-hand with a transference of this order, and, on observing such a behaviour, the author postulates the presence of what he calls a ***manipulation transference***.

At this point in this formulative process, the question of where the idea of "couples therapy" arose should be raised. Was it in Victor C. or Ms. K.? Is the consultee seeking it, or did the first consultant suggest it? Has a whole sequence of defense operations been set in motion by a recommendation from Mrs. K. that was incorporated by an undetected intermediate operative transference? Or has Victor C. set out to indirectly shape his further engagement with the present consultant without making his own aims explicit?

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**28** The behaviour described involves a triad of defenses used by selves that have been incorporated into the service of neurotic caregivers and forced to abandon more natural forms of defense not requiring an anticipatory mind-set. The author has observed them to be prominent in all selves that enter the consultation situation, and he has called them the *anticipate and prevent by self constriction* defense. In spite of its commonality, it has not been reported in the many lists of defenses described in analytic publications (e.g. Vaillant, 1992, p.39-45).

**29** This term usually has a derogatory connotation, but nothing of the sort is implied here. Children manipulate caretakers when their direct need-seeking behaviours have been blocked, and the ingenuity they display when doing so is admirable testimony to the strengths of their life instincts and perceptual-cognitive capacities. They then do the same thing as adults when unwittingly under the influence of transferences from those original figures.

Whatever the answers to these questions may be, the presence of an internal object located in one of the suprastructures, either the ***superego*** or the ***ego ideal***, has been established. It is making itself known by the signs of a character transference, and its presence so early in the consultation illustrates a principle that is generalizable in clinical work, namely that the character transferences in effect at the start of consultation are always derived from objects in the suprastructures.

## The Telephone Call, Continued

**"I sound awful, don't I?"** begins to confirm the formulative hypothesis that a transference of the operative transference-of-defense type from an object in the superego or ego ideal is at work. It is also functioning as a *resistance* in that it is creating a perception of the consultant that is causing the self-in-contact to behave in a manner at odds with its own consultative goals. The resistance is of the ***transference resistance*** type, and it is entirely ego-syntonic to the observing self. The consultee will therefore be unable to observe, contain, explore and dismantle it without the consultant's informative input.

In this segment, the self-in-contact can be heard to be monitoring and anticipating the fantasied object's responses to its disclosures as it proceeds, and, before it goes very far, it is indicating that it "knows" what it is reporting is bad stuff in the extreme (i.e**. "awful"**). Here, the conception of ***multiple selves*** (*not* a reference to MPD) in simultaneous operation is useful.[30] One self organization is listening to the verbal expressions coming from another, as well as to the consultant as it expects him to be. It is aligning itself with a transference-determined consultant who is issuing a ***judgement*** based on a held ***standard***, and it is indicating knowledge and acceptance of the latter's critical reception of the expressing self's utterances. Because of the protective and social features of the listening self's action, the author calls it the ***defense part*** of the ***social self***.

[*Note: The latter term has proved to be more accurately descriptive and less misleading than that of Winnicott's "False Self". In the author's usage of it, it is one part of the *self-in-contact,* the other part being that of the *"real self"*. It (the *social self)*, in turn, is comprised of both a *defense* and an *adaptive* part. When new objects are engaged by the *social self* of a *self-in-contact* that is suffering from an unwitting operative transference, the material issued from its *defense part* is more surface to, and therefore more technically significant than, what is observable from its *adaptive part*. Meanwhile, the *real self* material (what little if any there may be of it at first) is

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[30] The concept is similar to that of the Parallel Distributed Processing (of information) systems idea of modern Cognitive Psychology, with the exception that the multiple, parallel, separate, but interactive, self organizations of the M.F. theory also process emotions and drives and have executive capabilities for acting on the perceptions that stimulate them. (We say, for example, "Why the hell did I do that!", where *one* self organization is frustrated, puzzled and angry at a related, but separate, *second* such organization , one that has processed a perceptual stimulus and executed a drive discharge without subjecting itself to its – the first's – potentially-inhibiting influence). In the domain of cognitive science, the researcher, Wilma Bucci (1997, p.12) has described the human information-processing system as a complex of multiple, parallel processing devices, all of which handle different varieties of content in different formats at the same time and interact with each other.

expressed in the context of the *adaptive part's* behaviours, and it is a further layer down in the total self-in-contact communications. This is to say that: the "defense part" of the "social self" of the "self-in-contact" is to the fore and looking out for the signs of the transference-determined dangers it is assuming; the *adaptive part* is one layer down and seeking indicators that would allow it to give expression to as much of the *real self's* drive as would be safe, and the *real self* is not directly represented in the presented material.]

In this segment, the defense part of Victor C.'s social self is anticipatorily assuming an affective response akin to revulsion from the consultant. There is no material to indicate the details of the self's fantasy of the object's mental processes (i.e. the content and tone of the "consultant's" "judging" thoughts and the form they are expected to take when expressed), but it can be presumed that, as the expressive self was describing its reason for consultation, the defense part of the social self's perceptual apparatus experienced the effect of a visual and/or auditory representation of a critical object that it took to be the consultant. And in the representation it perceived the details of the judging behaviour it assumed.

Although the object from which the transference has formed is clearly in one of the suprastructures, the material provided does not say in which structure it is to be found. Nor is the nature of the ultimate threat implied by the self's object-monitoring behaviour known (i.e. the object-behavioural *repercussion* that can be presumed to follow the critical judgement if the latter goes unheeded). However, the ego ideal is suggested by the type of negative affective response that the self is expecting ("sounds awful"). Objects in the superego tend towards affects of the "anger" type, whereas those in the ego ideal show a prevalence of the "disappointment" kind.

## The Formulation Summarized

The material Mr. C. provided in the first moments of his phone call was formulated as presented[31], and a running metapsychological formulation of its symptomatic elements was created in seconds. In developing it, the consultant followed the principles of observation and hypothesis used by the "hard" sciences and functioned as an expert informed by tested, data-close theoretical concepts and principles. Stripped to its essentials, it emerged as follows.

**Characte**r symptoms are being stimulated by the consultation process that Mr. C. has set in motion. Three **character transference** elements are in effect[32]. They are from an **object** or **objects** in

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[31] Of course the consultant did not think out all the steps of the formulation as described. When a theory has been tested and made reliable, the steps between observation and conclusion during its development become condensed and compressed in the user's non-Freudian unconscious – just as the physician who smells acetone on the patient's breath does not go through the steps of diabetes theory development before suspecting sugar in the urine.)

[32] That is: (a) "separate meetings can only be obtained by manipulation"; (b) "safety from detection and criticism over keeping secrets requires anticipatory denial"; and "attenuation of 'revolted' reaction requires a show of anticipatory acceptance of, and compliance with, the object's standard".

the **suprastructures**. The first two cannot yet be placed in a particular substructure, but the third is likely located in the **ego ideal**. They are **syntonic** to the **ego** of the **observing self** and that of the **social self** that is engaging the consultant, and their ego-syntonicity is of a very high degree. They are **operative transferences** and they are functioning as **resistances**. The **transference fantasies** of the analyst that are involved are possibly, but not necessarily, **unconscious**.

The transferences are causing the **defense part** of the **social self** that is the **self-in-contact** to closely observe and monitor the **object's** responses as well as material from the **adaptive part** (and its **real self** connection) that could escape into expression if not caught at the point of pre-discharge. The monitoring is in the service of apprehending and preventing fantasied **traumas**. The traumas are ones that involve negative **judgements** followed by **repercussions** from the fantasied consultant, based upon **standards** he is incorrectly believed to hold. In response to the third transference element, the monitoring self is assuming that non-compliance with the involved standard will invoke an object affective response of the "shocked revulsion" type and stimulate affects associated with an experience of **loss of esteem**.

The affects have been experienced in an earlier situation with an original object that stirred them. They have been **traumatic** to the self that was engaging that object, and the defense part of the social self developed from the experience.

The potential for expecting a repetition of the original traumatic experience in the present consultation has been given "real possibility" status by a default of systematic transference analysis that characterized the previous consultation.

Nothing is known yet about the specific object or objects and events responsible for the **genesis** of the described **symptomatic** mental activities.

Material bearing on the type of self **drive** that is in underlying effect is minimal, but the M.F. theory of character development would predict **aggressive drive** forms layered over **libidinal**.

The suggested **manipulative** means by which the self is attempting to get its wishes met points to an aggressive drive form of the **assertive** type that is bound from direct expression by operative **defense systems**.

Nothing is yet known of the self's interchanges with the referring object, or of the transferences present during the first consultation, or of how the idea of couples therapy was started and given momentum. But **the intermediate transference** concept suggests that the referring consultant is the most likely immediate source of the "couples" idea.

The **surface** elements of the problematic operative transferences are comprised of **ego-syntonic**, **ego ideal** type **fantasies** of the consultant that may or may not be **unconscious**. In them, the consultant is *directed against oppositional and assertive forms of aggression* in the consultee's social

self. He is *coercing it into inhibiting direct expressions of "want*", *blocking expression of a reasonable right to keep a secret*, and *forcing it to accept inappropriate censuring of its reported behaviour*. The threat that he is applying in conjunction with his censuring activity is one that produces a loss of esteem, and the motive for defense that it is generating is a painful affect that the criticism is expected to release upon being taken in.

At its surface, the self has *no **effective defenses** to stop the fantasied consultant's inappropriate demands, and no effective means for reversing his inhibiting behaviours*. It cannot *act to obtain its reasonable privileges without anticipating dangerous interference that cannot be repelled*. It cannot *demand (assert) its rights to direct expressions of want to "meet separately" and "keep secrets" (i.e. speak confidentially*) if it chooses. Nor can it *oppose the inappropriate object application of a dysfunctional standard-judgement-repercussion system*. It can only: comply outwardly with the other's standards; use **manipulation** to get its needs met; apply the **anticipate-prevent-by-self-constriction** and **denial** defenses to retain its rights to privacy; and absorb and suffer misplaced censurings as it attempts to make its troubles known.

## Conclusion and Follow-up

The above illustration demonstrates the extensive amount of detailed mental structure and process that the M.F. method can reliably extract in seconds from small segments of spontaneous consultee expression. By its application to the material provided, it has allowed the consultant to develop a remarkable first formulation of his consultee's initial operative transferences and obtain suggested information bearing on the latter's symptom-generating experience(s) with at least one early, problem, caregiver object.

As can be seen, the formulation is in a hypothetical form that is testable. Each of its elements can be used as the basis for a prediction and further examined by means of the M.I. Method. And in this case, as the theories applied in its development have already been scientifically validated, the consultant can use it immediately. If he can adapt it to the situation in which he finds himself (i.e. listening to a prospective, but not-yet-decided, consultee for the first time and on the phone), he can begin helping Victor C. to mobilize his observing self's interest in what can be hypothesized to be the same mental processes responsible for his depression and lethargy symptoms.

The consultant was able to do so, and after offering two, simple, purely-analytic (i.e. not deviations from regular technique) interventions, Mr. C., sounding relieved from seeming certain dangers at the hands of his new object, set about enthusiastically arranging to meet for consultation.

An elaborated version of the consultant's formulation along with his interventive input and Mr. C.'s responses will be provided and discussed in detail in the book to come.

**REFERENCES**

(Papers: small case and underlined; Books: capitals and italicised)

**Anderson, H. M**. 1979. Theory of technique: the metapsychology of the analyst's working mind. Its place in psychoanalytic science and potential contribution to theory of technique. Presented to: the Toronto, Montreal and Ottawa Psychoanalytic Societies, 1979-80. Recipient of the Canadian Psychoanalytic Society's Miguel Prados Essay Prize for Members, 1979.

Anderson, H. M. 1982. A research into symptomatic behaviours occurring in assessments for psychoanalysis and the psychoanalytic psychotherapies. Presented to: the Canadian Psychiatric Association, 1982; the Toronto Psychoanalytic Society, 1983.

Anderson, H. M. 1992. The self analysis of an experienced analyst: development and application of an uncommonly effective technique. *Free Associations*, London. Vol. 3, Part 1, Number 25, 111-135.

**Barron, J.** 1993. *Self-Analysis: Critical Inquiries, Personal Visions*. Analytic Press: Hillsdale, NJ.

**Bucci, W.** 1997. *Psychoanalysis and Cognitive Science – A Multiple Code Theory*. The Guilford Press, New York, NY 10012.

**Cooper, A. 1995.** In Shapiro, T. and Emde, R. 1995. *Research in Psychoanalysis: Process Development, Outcome*. Madison, Connecticut: International Universities Press.

**Edelson, M.** 1988. *Psychoanalysis: A Theory in Crisis*. Chicago: University of Chicago Press.

**Freud, S.** 1912. *Recommendations to Physicians Practising Psychoanalysis.* S.E. 12.

**Glover, E.** 1955. *The Technique of Psycho-analysis*. New York: International Universities Press.

**Grünbaum, A.** 1993. *Validation in the Clinical Theory of Psychoanalysis*. New York: International Universities Press.

**Hollender, M. H.** 1965. *The Practice of Psychoanalytic Psychotherapy*. Grune& Stratton.

**Holt, R.** 1989. *Freud Reappraised: a fresh look at psychoanalytic theory*. Guilford Press.

**Holt, R.** 1997. *Psychoanalysis and the Philosophy of Science - Collected Papers of Benjamin B. Rubinstein, M.D*. Madison Connecticut: International Universities Press.

**Holzman, P. and Aronson, G.** 1992. Psychoanalysis and its neighbouring sciences: paradigms and opportunities. Journal of the American Psychoanalytic Association *40: 63-88*.

**Holzman, P.** 1993. Introduction to *Validation in the Clinical Theory of Psychoanalysis* (Grünbaum, 1993). International Universities Press, pp xviii.

**Jacobs, T.** 1973. Posture, gesture and movement in the analyst: cues to interpretation and countertransference. Journal of the American Psychoanalytic Association 21: 77-92**.**

**Kaplan, D.** 1994. Theory as practice. *Psychoanalytic Inquiry* 14: 185-200.

**Kernberg, O. 1993**. The current status of psychoanalysis. Journal of the American Psychoanalytic Association 41: 45-62.

**1996.** Thirty methods to destroy the creativity of psychoanalytic candidates. International Journal of Psycho-Analysis 77: 1031-1040.

**King, P.** 1991. *The Freud-Klein Controversies 1941-45*. New York: Tavistock/Routledge

**Kirshner, L. A.** 1998. Challenges facing to-day's psychoanalytic practice. International Journal of Psycho-Analysis 79: 595-596.

**Kohut, H.** 1971. *The Analysis of the Self*. New York. International Universities Press.

**Mahony, P.** 1987. *Psychoanalysis and Discourse*. Tavistock Publications Ltd., London and New York

**Massicotte, Wm.** 1995. The surprising philosophical complexity of psychoanalysis (belatedly acknowledged). Psychoanalysis and Contemporary Thought 18: p.3-31.

**Racker, H.** 1968. *Transference and Countertransference*. New York: International Universities Press (1976).

**Ramzy, J.** 1974. The mind of the psychoanalyst. International Journal of Psycho-Analysis 55: 543-550.

**Sandler, J., with Freud, A.** 1985. *The Analysis of Defense*. New York: International Universities Pres.

**Schachter, J. and Luborsky, L.** 1998. Who's afraid of psychoanalytic research? Analysts' attitudes towards reading clinical versus empirical research papers. International Journal of Psycho-Analysis 79: 965-969.

**Shapiro, T.** 1977. Oedipal distortions in severe character pathologies. Developmental and theoretical considerations. The Psychoanalytic Quarterly: XLVI: 559-579.

**Shapiro, T. and Emde, R.** 1995. *Research in Psychoanalysis: Process Development, Outcome*. Madison, Connecticut: International Universities Press.

**Vaillant, G.** 1992. The historical origins and future potential of Sigmund Freud's concept of the mechanisms of defence. The International Review of Psycho-Analysis 19: 35-50.

**Weiss, J.** 1995 Empirical studies of the psychoanalytic process. In *Research in Psychoanalysis: Process, Development, Outcome*, ed. Shapiro, T., Emde, R., International Universities Press, pp. 7-29.