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THE SECOND ANALYSIS

Philip S. Wagner, M.D.

A current popular ditty states that love is better "the second time around". What is love, and how much better, the lyricist does not explain. He need only renew the hope that one can love again, and again. The patient coming to the second analyst has the same hope, clouded by some disillusionment with the first affair. The analyst shares this hope, but like a widower's new wife, knows he too will be compared with the illusory past, and more likely than not, will also be found more wanting than wanton.

Indeed, a second analysis, like a second marriage, inevitably recapitulates the first, at least in the early maneuvers. Here the analyst, unlike the new wife, must hastily familiarize himself with the gambits of the earlier analytic relationship before this second marriage drifts toward an equally unhappy dissolution. Multiple analysis, like multiple marriage or promiscuity, follows the same pattern: idealization and hunger, gratification, then depreciation, then contempt and fear, and finally, flight to another similar sequence.

There is a curious disinclination on the part of analysts to relate their experience with patients who leave their colleagues, at least until they are old enough to realize that divorce is sometimes preferable to an unsatisfactory and stagnant marriage, and old enough to know that many of their own patients have availed themselves of a more fresh and renewed opportunity in another therapeutic experience.

Analysts pose as non-judgmental of the trials and errors of their patients. They are disinclined toward such leniency either for themselves

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or their colleagues. Like a second wife, they hope for success and acceptance, but unlike the wife if they too are abandoned, they cannot protest the philanderer was never fit for any marriage.

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The patient seeking a second analysis presents a variety of diagnostic and technical problems, concerning which the psychoanalytic literature offers no specific guidance. No model technique has been suggested for a second analysis. The second analyst needs to evaluate the residual neurotic conflict, the quality and depth of the previous analytic experience, residual transference hang-overs, the added complication of intellectualized "insights" which provide new opportunities for defense, and the economic and emotional cost entailed in further therapeutic effort.

Some of these patients, despite long analysis, present themselves as if "nothing happened". Their memory seems vague, almost amnesic for this prolonged and costly experience. Isolated happenings or phrases may be remembered, or general impressions may be offered, but the entire experience of the first analysis may have an elusive, discomforting, dream-like quality. Others come directly from a confused transference involvement, anxious, still enamoured, or still violently antagonistic to the first analyst. In others, there is an underlying pathological process which has progressed despite prolonged psychoanalysis. Frequently the patient seeks a second analysis but presents only residual or current problems for which only short term "clarification" is sufficient.

Separate from such immediate clinical problems presented by the patient many questions arise concerning the validity of basic assumptions on the nature of the psychoanalytic experience, and the appropriateness of

technical modifications which on a hindsight basis may have resulted in a more effective first psychoanalytic experience. Are there technical problems or characterological findings typical of most patients seeking a second analysis? Does the first experience alter the course of the second? Does it facilitate the second analytic experience, or act as a hindrance? How meaningful was the first analysis as a subjective intrapsychic experience, as therapeutically helpful, as helpful in effecting more realistic and gratifying interpersonal experience? If the first analysis is appraised by the patient as a disappointment, is this measured by the patient in terms of time lost, money wasted, or as a personal injury? Does the need for a second experience in itself suggest a doubtful prognosis? What could the first analyst learn from the second, or the second from the first? What, if anything, can be learned from the patient about the first analyst: his idiosyncrasies, his technique, his theoretical convictions? Does the failure to remember ever mean that "nothing happened" in the first analysis?

I need hardly interject the observation that data concerning all these questions, as offered by patient or analyst, are largely impressionistic. Conclusions derived from such data are hardly ever final or generally applicable. For example, the coterie of patients in a senior psychoanalyst's practice are affected by the fact of his seniority and presumed greater skill, by his selection of patients who can afford his fee or who can adapt to his preferred mode of practice, and <u>his</u> selection by patients who perceive themselves as either sufficiently hopeless, or sufficiently worthy so that the "best" only will suffice. Such patients may be assumed to have more than the

usual share of omnipotent strivings, ambivalent deference, and attitudes of ownership toward their therapist. They present a talent for more charm and elusiveness than most other patients, and more sophistication than most in the techniques of upper-class upmanship.

In an effort to limit areas for observations concerning the questions posed at the outset I have arbitrarily excluded from consideration in this paper (a) candidates in psychoanalysis, (b) patients referred by the first analyst after adequate preparation of both the patient and the second analyst, (c) those patients whose first psychoanalytic experience was less than two years in duration, and (d) whose first analyst was not identifiable as a member of a recognized psychoanalytic institute. The patients to be considered therefore were those who had been treated with a high degree of professional competence by individuals accepted by the professional community as mature and experienced therapists, whose patients nevertheless disengaged themselves from their first experience and after the elapse of a varying amount of time, sought a "second analysis".

In addition the essential dynamics and transference problems of patients will be categorized according to the predominant characterologic or neurotic defense which quickly became apparent in the second analysis and which proved to be relatively intractable and self-defeating in the first psychoanalytic experience, and frequently equally intransigent in the second. Despite the tradition of dealing with defense, a characterologic or symptomatic defense may frequently be ignored or circumvented, and the essential goals of therapy may still be achieved. But the foremost defense indicates the character structure, the transference relationship that will develop, and gives clues to the genetic background.

I. Resistance to Transference Involvement.

In the special circumstances of upper socio-economic psychoanalytic practice the majority of patients seeking a second analysis remain aloof from transference involvement and seek to retain a phantasy that they are only observing and are always in control. There is indirect evidence of deep underlying anxiety which interdicts regressive dependency and may limit awareness of transference phantasy and affect. The compulsive intellectual defense is actively maintained, and there is a tendency for the second analysis to get into the same course as the first: an outwardly compliant patient who is basically unyielding in his resistance to the analytic compact or experience.

Such patients listen and respond intellectually. They are assisted primarily by clarification of the realistic basis for their tensions and frustrations, and the frustrations they impose on others. They cannot feel their hostility but logically deduce that it exists. They return to analysis because of the recurrence of depression, or from misgivings about their ability to omnipotently control their circumstances and their relationships. Their gains in therapy derive from clarification of such needs, from support of their efforts to rearrange their relationships and life in a more harmonious framework, and through their identification while in analysis with the point of view of the therapist.

They usually complain that their former analyst was without feeling, unrealistic in his interpretations, and biased in his theoretical

convictions. They deny any hostility toward the former analyst, or even any degree of disappointment in the previous experience, but they insist that the former analyst must not be told that they sought a second experience with a different analyst, lest the previous analyst "feel hurt" by this evidence of their limited gains in the first experience. Charitably they insist that he was nice and kind, but that he was also basically inaccessible -- a transparent projection of their own characterological defense.

In my experience, the most helpful approach was usually one of direct support, together with realistic confrontation; but their masochistic needs are such that confrontation is felt by these patients to be a narcissistic hurt and results in a feeling of anguish and self-reproach, which more often than not seems of no profit to the patient, and usually flows out sadistically to those around him. Their significant gain in therapy appears to follow a diminution of their sadistic superego through identification with the more tolerant and realistic perspective of the analyst. (Clinically, these patients are usually categorized as aloof, intellectual, obsessive-compulsive individuals.)

II. Transference Idealization.

The first analysis is terminated on the basis of an equilibratory pact between patient and therapist: "let us love and respect each other". The termination of the first analysis had been characterized by reciprocal high regard, but by some doubt, usually not verbalized, on the part of both analyst and patient, that either had been able to achieve or risk complete honesty in the relationship. The potential

for intense anxiety and the impulse to "act out" had been suppressed by maintaining the relationship at a level in which, at least in phantasy, reciprocal idealization seemed justified. There was evidence that underlying intolerable anxieties were related to phantasies of genital mutilation or castration which were sometimes manifestly evident in conscious masochistic phantasies, and in characterological traits and dreams which suggested strong underlying, ambivalent homosexual trends.

In the second analysis such patients sought to again establish an idealized transference, to find support in an effort to maintain and enlarge an idealized ego, and to covertly experience libidinal and narcissistic gratification in the friendly relationship with a patient, kind therapist.

Almost invariably in the second analysis, considerably more direct transference hostility was accessible. They disengaged themselves from the first analyst out of a disinclination to disillusion the kind parent and to avoid showing the parent the depth of their rage. Despite the seemingly good relationship which existed when the first analysis ended, there was rarely any contact with the first analyst, or any inclination to spontaneously refer to him in the second analysis. Almost invariably they insisted that the first analyst never learn of their displaced loyalty. Their situation was comparable to the child who leaves the parental home and in the main, thereafter, remains

dissociated from his parents.

In my opinion, many of these patients are capable of basic characterological change in a second analysis, and the first analytic experience provides an opportunity for ego strengthening so that the patient could deal more realistically and honestly with the second analyst. Here, too, however, the analyst must be guided by the patient's tolerance for anxiety and the trend toward a sometimes obstinate depression when the self-deception is uncovered and the underlying pregenital strivings are revealed.

These patients may give the impression of intense interpersonal involvement but they are basically narcissistic. These individuals have access to their own feelings and enjoy awareness that others are involved with them, but they are themselves relatively uninvolved.

III. Chaotic Transference Reactions.

These patients frequently give a history of more than one prior analytic experience. They introduce almost at once highly emotional, ambivalent transference phantasies. Their obsessional needs and their prior therapeutic experiences allow them ready access to "unconscious material" and "dynamic formulations". They are eager to be analyzed, and to demonstrate their aptness and sophistication as patients. Their immediate hunger is for approval and this is sought by reiterated appeals for help, and by a preference to dwell on their positive feelings for the analyst. They cannot

experience a genuine analytic relationship quite as they cannot tolerate a genuine intimate human relationship. If placed on the couch in a resumption of a classical approach, the effort goes on interminably. "Free association" provides them with an opportunity for flight from, and resistance to, a realistic evaluation of their extravagant reactions to current experiences. They seek in the analytic experience a comforting and ego-sustaining refuge. Nothing may be really "analyzed", that is, nothing may be finally explored, resolved, and set aside. The availability of such a relationship appears to spare some of them from a psychotic denouement or suicide. Nevertheless, for some, a vis-a-vis realistic relationship which discourages the symbolic, and which insists on a continuing survey of the tension and frustration which they suffer and impose on others, disengages them from their infantile, sick self-image. They often profit from an early spacing of sessions so that regression is not encouraged, and from a long sustained relationship which keeps in the foreground their capacity for real, if limited, relationships, and gives encouragement to their increasing capacity for rewarding and impressive creative work. The problem for the second analyst is actually to avoid "more analysis". He sometimes must disabuse these patients of the conviction that "more analysis" is necessary for their survival. (Clinically, such patients are usually categorized as borderline or potentially psychotic character disorders.)

IV. The On-going Analysis.

In marked contrast, there are those patients who manifestly for external reasons must resume their analytic work with a second analyst. These are patients who have learned to use the analytic situation and have learned to work "analytically". The patient tends to act as if the second experience is a continuation of the first analysis. The second analyst, therefore, has to establish promptly the essential facts of the life history, the essential conflicts, and achieve an early understanding of the transference dream which the patient establishes almost as soon as he "returns to the couch". As a rule, minimal work is necessary on the current transference. A re-exploration of insights gained in the past work, as it relates to the current reality situations, and as it derives from childhood situations and conflicts, provides the main content of the psychoanalytic work. With such patients the second analyst carries on to a conclusion the first analysis, and termination is by mutual agreement, often in a relatively brief time, depending on the quality and duration of the previous work. Such patients ordinarily give clear indication of when they feel they have achieved their goals in the second analysis. Their judgment should ordinarily be viewed as realistic and not as a manifestation of "resistance".

V. The Transference Impasse of the Primarily Hysteric Patient.

For most of us psychoanalytic work with the Hysteric continues to be the most instructive of all our psychoanalytic experience. The unconscious issues are dramatically portrayed in symptoms, in dreams, in the transference, and in the vivid and highly emotional

recollections of early childhood strivings and conflicts. The enduring oedipal conflict portends a repetition of such problems during all later critical periods of development or interpersonal experience. Each new intimate relationship can be discouragingly analogous to earlier hopes and disappointments. The Hysteric unconsciously makes each succeeding partner a disappointing parent surrogate. More often than not he models each succeeding choice in the likeness of the original, ambivalently loved and abandoned object. In his second analysis, he seeks to reestablish the seemingly irreconcilable issues which may have resulted in an impasse during the first analysis. From this group of patients I have chosen two which demonstrate the problem of the second analyst in avoiding a similar impasse, and his almost invariable need to modify his technique in order to keep in perspective the intense and confusing transference feelings which encumbered and brought to a halt the first analytic experience.

Case No. 1.

Helen complained that her first analyst, with whom she had spent several years, was soft, ineffectual, indecisive, afraid of her, never evoked any clear, positive, or definite feelings, and always impressed her as more of an old woman than a man. Her analyst, according to the patient, was in many ways like her husband. Helen's husband had exploited and criticized her for 20 years. Evidence of any appreciate was rare. He was dependent on her financially for many years of the marriage, but always acted like an insatiable tyrant who always took, never gave, and never acknowledged. Although a tyrant and feared, she felt that he was not really a man, but a dependent, small boy. The marriage was always tentative, and for 20 years she had been weighing its satisfactions in comparison with some idealized prospect. Curiously, the idealized prospects, in the form of transient, romantic, extramarital attachments, were always with sick, dependent, deprived, and ineffectual lovers.

Her first analyst, therefore, developed as another in a series of disappointing lovers. She felt, however, that her second analyst was definitely different, a wonderful man, etc. From the outset the second analyst

attended to her effort at patterning this new relationship according to previous relationships, such as the first analyst and her marriage. The work hinged on this repetition compulsion and its meaning. The last dream she remembered from her first analysis epitomized the final transference situation. In the dream she was "vigorously chopping down a tall tree with an ax."

It was unnecessary and undesirable to permit the development of the same sequence in the second analytic experience. It was necessary only to hold the patient to an awareness of her need to recreate the same ultimately dissatisfying neurotic relationship. It was unnecessary to explore regressively, in a second transference neurosis, the infantile conflicts and their symptomatic repetition. Data concerning these conflicts were abundantly evident as the first analysis was reexplored. The patient felt that she wanted from the analyst something which she felt able to give to her 10-year-old daughter: "a big, comforting person". Her own mother she remembered as an attacking, frustrating woman. She remembered how, at the age of 4, her mother discovered the patient's masturbatory activities and shamed and humiliated her. The rage at this mother provided grounds for angry disappointment in the father. She could retaliate only by a remembered wish to kill the baby brother or win the acceptance of the father, but mother and brother were always preferred and father always hindered gratification of her narcissistic, destructive strivings.

Like many patients who are natively, or neurotically, intuitive and introspective, this woman after several years of analysis did not need further "uncovering". She needed, instead, an integration of scattered or dissociated insights and painful affect. Initially the second analyst thought she had to work through her hostility to men. The patient corrected him and said, "it will be no good if I have to fight and destroy

you, too."

The patient was treated vis-a-vis. The "healthy ego" was appealed to for an exploration of relevant experiences in the first analysis. The therapist insisted that the patient see clearly the infantile defenses and manipulations which had made the first analysis not a failure, but a stalemate. Reconstructing the first analysis, one had to assume that further work was impossible because of the caricature she had effectively established of her first analyst. Having chopped down her analyst, she could not risk expressions of tender interest in, or expectations from, the injured phallic male. She had altered him into an ineffectual, feminine partner, and continued the romantic infantile search for, and flight from, the strong but feared father, who would accept with kindness the gentle woman. The patient was quite familiar with the concept of the analyst as an extension of the feared mother, but a continued preoccupation with split images and split affects would have continued her fears and anxieties. She required a period of work with an intact, accepting therapist, and not with a "loved object" in the transference sense, since this image re-evoked anxious longing, angry flight, and the sought for refuge with a person perceived as an unaccepting mother. In the second analysis she disengaged herslef from her traumatic childhood, and from the traumatic recapitulation of her childhood and the many endless fragments in the first analysis. As the patient herself described it, she required a person who would separate her from the "mess of the past".

Helen was disappointed in her first analyst because she modeled him

as a weak, ineffectual, and dependent person. A variation of this theme, which is less often seen because of our increased alertness to the destructive intent of an erotized transference as a defense, is presented by a patient who was dismissed by her first analyst while still in the turmoil of "love".

Case No. 2.

Mary came to her second analysis in a cloud of anxiety and desperation concerning the termination of her experience with her first analyst. Her previous therapist, even after several years, remained an idealized, cherished image. No superlatives were sufficient in describing this paragon; he was slim, dark, sensitive, kind -- everything a woman would want in a man. He had injured her deeply, but she still loved him. Yet she could never tell him that she loved him, or why and how he had injured her.

The facts were, according to Mary, that her first analyst was in love with her. During the first phase of her second analysis she recounted her experience with the first, producing alleged evidence of his infatuation: the occasional smile, the courteous and gallant manner, his occasional sighs and sad demeanor, the hearsay rumors that perhaps all was not well in his own marriage, his note to her on the back of a calendar page given to her on Valentine's Day. All these bits of information, rumor, and gesture, she saw as tokens of love to be stored in her heart and never, except through unwitting somatic repercussions, to be revealed in any manner to her analyst. Throughout this first analytic experience, her husband had dwindled from a disturbing nuisance whose affectionate overtures were usually revolting, to a non-entity who had eventually been maneuvered by her into his own analysis and then ignored. The endearments of her husband she described as cold, tentative, stilted, unimaginative, and repulsive. In contrast, the imagined carresses of her analyst were consuming, and although imagined, were more satisfying than the real efforts of her husband.

The first analyst was so involved with her, according to the patient, that he had consulted a colleague who decided that he was unsuited for classicalpsychoanalytic practice. She reported this to her second analyst slyly and with glee. Thus, as she seemingly kept intact her idol, she gradually demolished him. Her second analyst could only wonder whether in the face of all this smoke, there was not, indeed, some fire. Where was her first analyst during all this hot consummation?

Mary conceded that her first analyst undoubtedly saved her from either psychotic disorganization, or some self-destructive impulsive resolution. Perhaps he was kind and accepting because he realized her deep feelings of

inadequacy and unworthiness? But why, she asked, was he never more explicit about his feelings? And why had he allowed the accumulation of so much evidence which could only be interpreted as affection?

The description of her first experience clearly indicated the tactics necessary if the patient's confusion and residual intense ambivalent attachment could be finally acknowledged as indeed transference and not reality. There had to be a watchful lack of interest in any role other than analytic; explicit discussion of any happening in the relationship which might give the patient a chance to distort its meaning; a gradual dilution and dissociation of the patient from her distortions concerning the first analyst's predicament and from her attendant feelings of responsibility and guilt; the gradual and continual confrontation that the almost paranoid preoccupations concerning her first analyst were displaced reaction formations from anxieties concerning an earlier incest object; and, hopefuly, an eventual acknowledgement that her disappointment in her husband derived not only from a compulsion to castrate him, but to establish him as a mother who would be tender, understanding, supportive, undemanding, and asexual.

Her husband, responding to these needs, became, in fact, such a person. He ceased making sexual demands, or having sexual expectations. They became good friends. His own career flourished as he gave up the frustrating effort to be accepted as a husband, or to view his failure to meet his wife's needs as evidence of his failure as a person.

The second analyst never quite achieved his hoped for goals. The patient gradually disengaged herself from her excessive preoccupation with the first analyst. The second analyst was established as a firm, tolerant,

but never altogether trusted father. Her husband sturdily, and perhaps masochistically, resigned himself to his limited and symbolic role in the marriage. Although the patient's basic hunger and anxiety had homosexual determinants, the patient was by this time a middle-aged woman and because of her definite recovery from her transference neurosis, it was considered inadvisable to tamper with a basically fragile ego.

Curiously enough, during an interruption of the second analysis, the patient found a lover, and in some respects made her greatest gains during this experience. He was marginally employed, middle-aged, passive, tender, and sexually adventurous, and made the patient feel womanly and adequate. She handled this "other life", as she called it, with great discretion, and gave up any further real interest in either her first or second analyst. She found external reasons, as well as subjective ones, to discontinue the second analytic experience, when the second analyst suggested that perhaps more work was needed on the meaningfulness of this extramarital relationship.

The first analyst felt he was dealing with a schizoid and unstable individual whom he treated with tact and gentleness, which was interpreted as "love" by the patient. The second analyst's primary concern was the near-psychotic furor with which the patient terminated her experience with the first analyst. The patient's own solution was to stablise her needs and her world by a frigid relationship to the husband, a dependent relationship with her second analyst, and a warm, protective relationship to a lover, a solution which is perhaps more common than we analysts (with our idealized goals and Calvinistic morality) acknowledge.

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In most of these patients, admittedly a select group, the first analytic experience altered inevitably their attitude toward their second. Their expectations were more limited and more realistic. Most observed early in the second experience that "I know now there is no magic in this and that most depends on me". Most were able to be specific about what they sought in further analysis, the problems that were insufficiently understood, the attitudes toward work or relationships which required modification. Some introduced the prospect with the reservation that they intended to devote only a limited amount of time to the second endeavor. The two patients I have described pointed to the couch and said, "I never want to go through that again. I want you to stay <u>real</u>. "

I could not find evidence that those patients who presented themselves in a muddled obsessional state, ambivalent, disappointed and hurt by their first experience, were indeed damaged in this way by their first analyst. I felt certain that they had presented themselves in a like manner to their first analyst, and that this interpersonal approach was characteristic of them in prior dependent relationships.

There is the occasional patient who after many years of hopeful effort is dismissed as unsuitable for further psychoanalytic work. Their resentment is not unjustified. One would have hoped that in these instances our colleagues had not been so tenacious or doctrinaire. The patient suspects his own perseverance and loyalty to the work has been exploited. When the psychoanalytic work bogs down, consultation with a colleague is always helpful. On occasions I have asked a colleague to see such a patient. The patient experienced this as realistic and helpful. Early assessment of

poor prognosis and a decision to terminate or transfer leaves the patient less hurt emotionally and financially, and sometimes spurs him into a second endeavor which is more profitable.

Except for patients who have been "over-treated" it has not been my experience that a first analysis complicated or handicapped the second analyst. The second analyst can arrange his technique and goals according to evidence from the patient's first experience. One is not, as the patient fears (or wishes) in the position of having to "start all over again". If indeed this is the case, then the second analyst may well consider the advisability of not starting at all, or at least of limiting sharply his own and the patient's expectations. Even when the patient has little if anything to say about the first analysis, one can see in the early hours a recapitulation in the transference of the essential developments, or resistances, in the first analysis.

In my experience there is often no need or advantage in developing an "analytic situation", with "intensity" and "frequency", and a renewed transference involvement with patients who have already had years of analysis. The patient's needs are best served if both patient and therapist realistically review the reasons for the patient's return, the meaning of his past experience, its possible relevance to on-going and current problems. Further exploration in an arrangement encouraing "transference" is always possible after vis-a-vis study is finally considered as offering insufficient information.

Do any counter transference attitudes emerge as an occasional interference with the patient's efforts? I would rate first as most frequent,

moralistic attitudes in the analyst which convey disapproval, or actively interdict experiences, for example, "acting out". Sometimes there is no better way to unglue the defensive rigidity of a patient than to allow him to experience a little social difficulty or sexual mischief. There is occasional evidence of rigidity in analysts which is not necessarily characterologic but is pedagogic in origin. I have even heard that a Psychoanalytic Institute forbade its candidates to hear a paper on "Pornography and Psychoanalysis".

There is evidence in some analysis of a degree of activity which suggests that the transference provides a setting for the analyst's histrionics rather than for the transference drama. In the main, however, most patients observe, regarding their former analyst, "he never said anything".

Finally there is suggestive evidence that inevitably the analyst's personal value judgments affect the analytic work. Some analysts have conceptions as to how the analysis should go and the sort of person the patient should be. Usually this is in the direction of creativity, productivity, and marital fidelity.

How meaningful are we to our patients? Almost none of these patients gleaned any information about the analyst's personal life, theoretical convictions, political affiliations, etc. All analysts succeeded in withholding any real data concerning themselves, or if they revealed it, it was not sufficiantly important for the patient to remember.

Only real people and real relationships are meaningful. Analysts are shadows and symbols. I have never been impressed by evidence of termination

grief at the prospect of loss and separation from the analyst. Such grief appears to me as evidence of residual transference longings and anxieties. Our patients want us to stay well as long as they need us. What happens to us thereafter seems of no special moment to them. I dealt with two patients who were referred after their analyst died. There was certainly some evidence of anxiety and feelings of abandonment. But these were not tears shed for the loss of an important object. These were tears of self-concern and self-pity.

The situation is different when an analytic relationship evolves into a real friendship. Our anonymity has indeed demonstrable usefulness. But an essential experience is lost to the patient when such anonymity is always maintained. As the patient Mary, who thought her analyst loved her, frequently said: "he never allowed me to be a person, or allowed himself to be a real person with me. Even years after I was no longer his patient, whenever I met him he took the doctor role. I felt he rejected me as a real person and accepted only the patient. Perhaps he was afraid of real contact with me". I believe that she had a point, in that much of her anxiety during the later months with him was due to her need finally for experience and acceptance by the analyst as a person, rather than as a neurotic, transference-involved patient. The second patient, Mary, discontinued her first analysis after five years without ever having looked at her analyst. Some analysts maintain a degree of detachment and reserve which helps convince the patient he is only a construct of defense and impulse, and that when these are analyzed he is nothing else that interests the therapist. Some patients need conviction

that they are meaningful beyond their participation as patients. We cannot always assume the patient's frustrations originate altogether from unfulfilled transference longings. Some of the most conclusive analytic work I have seen was in cases where doctor and patient became friends and colleagues, and perhaps occasionally used each other, not as therapists, but as concerned and interested friends.

How tenacious is the transference involvement with the former analyst? Hardly at all if there is a new transference object available. Transference is maintained out of hope for transference gratification, and when the patient is finally convinced this is not possible, transference evaporates. Residual and enduring vindictive feelings toward the former analyst may indeed keep transference involvement active, but in two cases where this was evident the patient's bitterness appeared to have considerable realistic justification.

What of those cases where transference appears not to develop, where the entire work was primarily "ego analysis"? Transference always develops, even though it does not become [illegible] accessible as part of the working relationship. Nevertheless, I cannot say that these patients profited less than those who developed transference involvement and transference neurosis. Analysts appear to have a "transference bias". If the patient doesn't "buy it" we assume there is resistance and we aren't getting anywhere.