Chapter 9
Psychoanalysis and psychoanalytic psychotherapies

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"You are under the influence of unconscious forces."

1. Introduction

Psychoanalytic schools of therapy explain mental processes, the occurrence of diseases, therapeutic strategies, tactics and techniques, and the process of healing by means of the psychoanalytic theory first formulated by Sigmund Freud in the late 19th century. In Hungary, Sándor Ferenczi, Mihály Bálint, Alice Bálint, Lipót Szondi, Imre Hermann, Géza Róheim, Sándor Radó and others played a major role in the formation and development of the psychoanalytic movement. Both psychoanalytic theory and therapeutic practice have changed greatly over the century since then. Psychoanalysis is widely followed in Hungary, as are the other analytically oriented schools of brief dynamic therapy, Jungian analysis, individual psychology and analytic group therapy. The main psychoanalytic schools, started by followers of Freud, are self-psychology, object relations theories, the intersubjective school, relationship psychoanalysis, neuropsychoanalysis and brief dynamic schools. In this chapter, we present the basic principles of psychoanalytic psychotherapy.

2. Theoretical principles

During the century and more since Freud developed his psychoanalytic theory, many of his theses have been challenged and refined through research into development psychology, neuroscience, outcome and process studies of psychoanalytic therapy, clinical experiences gained in analytic situations, and new theoretical models.

2.1 Unconscious processes

One of the most important novelties of psychoanalytic theory was that the human mind is under the influence of unconscious processes. In attempting to understand conscious processes, we must always take into account the individual's unconscious drives. An important role in exploring unconscious motivations is the analyst's attentiveness to the action of unconscious phenomena and his or her ability to create circumstances of dialogue through which the patient becomes aware of his or her unconscious motivations. The allows the analyst to maintain the internal position of "not knowing" and be open to thinking about various alternatives even in emotionally difficult situations.

Experiences which come into consciousness are the results of processing in the background. A conscious experience is always associated with an emotional experience or mood, and this is an important basis for understanding the unconscious organizing processes behind the operation of the patient's mind.

In the course of therapy, the client becomes consciously aware, and gains an emotional understanding, of processes which he or she learned in the course of personality development. These processes control thinking, emotions, and interactions with others. The analyst-patient relationship provides the means for the client to learn new relationship patterns. Much of this learning process is itself unconscious.

A special case of unconscious mental activity is the dynamic unconscious, the location of conflicts among the motivational subsystems of the mind. This, by its nature, cannot be made conscious.

A girl who is in love with her the doctor brother-in-law would like to embrace him, but this feeling and intention is unacceptable and she has no conscious awareness of it. At family gatherings, she has panic attacks and faints into his arms. Because of her intense chest pains, he is obliged to examine the girl's heart. The panic attack and fainting constitute a "compromise formation" through which the unacceptable desire for attention and physical intimacy, forced into the unconscious, is satisfied in the form of a compromise through her brother-in-law examining her. Psychoanalysis identified the unpleasant feelings experienced during the brother-in-law's medical examination and the shame and tension that arose from them. The patient became conscious of the conflict underlying her symptoms. On one hand was a desire for her brother-in-law and competition with her sister and, on the other, love for her sister and the moral command "not to covet another woman's husband".

2.2 The mind as a set of subsystems in mutual conflict

The incorporation of neuroscientific findings into modern psychoanalytic theory has produced a more differentiated model of the subsystems organizing the operation of the mind. Lichtenberg has distinguished five motivational subsystems, all of which influence the psychoanalytic relationship. Motivational subsystems are inborn programmes that promote satisfaction of basic needs, and then are formed by interaction with the environment. Each is associated with an affect. The motivational subsystems implement the following needs: 1. maintenance of physiological balance; 2. attachment and affiliation; 3. exploration and assertion; 4. aversive response by antagonism, withdrawal or both; 5. sensual enjoyment and sexual excitement (Lichtenberg, 2001). The foreground of self-experience at any moment is determined by the motivations of one or more subsystems and the related emotional states. When one motivation is dominant, the other motivations can also be active in the background of consciousness. As dominance changes over from one motivational system to the other, self-perception changes significantly. A condition of mental health is that the individual be capable of directing, organizing, differentially perceiving and integrating the activity of the various subsystems. A neurobiologically separate motivational subsystem holds control over the subsystems. In the course of personality development, individuals learn from reactions of the environment whether the satisfaction of their needs is legitimate, and under what conditions it is possible.

As an illustration of conflict among motivations, consider an incident where a young child accidentally pokes his finger into his mother's eye. She immediately gets angry. Her attachment motivation, however, causing her to protect her child from danger, restricts the expression of her anger, and she gently explains to her child that he should take more care, because this hurts his mummy. The restrained anger, however, takes effect in a headache. Then, as she recognizes her anger and reinterprets the situation, explaining to herself that her child did not deliberately poke her in the eye, her anger evaporates and her headache subsides.

2.3 Affect regulation skills and expressions of emotion

The central activities in psychoanalytic therapy are to explore and discuss patients' emotions. The therapist helps patients put their undifferentiated tensions into words, discover their contradictory emotions, face up to the feelings that threaten them, and make conscious emotions which are at first hidden to them. Psychoanalytic theories integrating modern advances in neuroscience see attention as being under control of motivational and affective systems which have various levels of activation and are in constant mutual conflict.

A young man always gets miserable and moody in the presence of his mother. He has just graduated from university, and considers himself restricted from moving to the city to work and live in a rented

flat with his girlfriend, because he has to look after his mother in his home village (conflict between two motivations). At Christmas, his mother says that the best present she could get would be if her son got a job in Budapest and was able at last to move in with his girlfriend. Her son feels a great sense of release that his mother does not expect him to live with her and look after her. Subsequently, he does not feel so tired and miserable in his mother's presence.

2.4 Structural aspects

The original psychoanalytic theory viewed the mind as consisting of three structures: the ego, the id and the superego (Freud, 1991).

- The id is the sum of inherited, biologically determined drives plus those acquired by repression during the development of the personality. Its purpose is to satisfy instinctive drives.
- The superego is responsible for upholding social norms. It is in conflict with the id and the ego. It consists of rules generated by internalizing parental and social demands.
- The ego has the task of reconciling the often-contradictory demands of the id and the superego with the possibilities offered by external reality, by means of defence mechanisms.

Later psychoanalytic theories put greater emphasis on the concept of the self, which is responsible for organizing motivational and affective subsystems.

A female therapist unsuccessful in couple relationships has an intelligent, good-looking, well-mannered patient who is always telling her how pretty she is. She feels pressure from her id to simply enjoy all of these compliments, but her superego stops her, because her internalized ethical rules of therapy do not permit her to use therapy for her own pleasure. The task of the ego is to regard the compliments being made in reality as material which she can use to help the patient understand why he feels the constant need to make compliments. This puts the self-love into a more acceptable, professionally satisfactory, sublimated form, by being glad that she is functioning well as a therapist.

3. Personality development

Psychoanalytic theorists have devised different ways of approaching the stages of development of the personality.

Theories focusing on *instincts* link the stages of development to the dominance of erogenous zones (oral, anal, genital), and ascribe particular meaning to the oedipal stage.

The *object relations theory* of Klein, Fairbairn, Winnicott and Jacobson is more concerned with the consequences of the reactions of caring persons to the child's basic needs. Responses to the child's needs are stored in the course of development in the form of relational representations and determine the quality of later relationships (Hamilton, 1996).

According to the *attachment theory* of Bowlby (2009), the actual relationship between child and caregiver gives rise to internal working models of the extent to which the attachment person is accessible to the child. There have been many empirical studies of the role of attachment disorders in the formation of mental disorders. These attachment working models also determine relationships in adulthood.

According to Kohut (2001), many mental disorders (narcissism, sexual disorders, addictions, relationship disorders) arise from parents' inability to empathize properly with the needs of their children, who are left with a deficit. The task of the psychotherapist is to provide empathy to restore this deficit.

Contemporary psychodynamic development theory integrates research into infants, experimental developmental psychology and development pathology research, resulting in the rejection of some of the early psychoanalytic ideas. For example, the idea that a baby is born in a narcissistic state without relationships, similar to psychosis, and gradually develops by sensing real objects and relations, is no longer accepted (Fonagy and Target, 2005).

In the psychoanalytic case conceptualization, it is important to review the patient's personality development and identify the links between the complaints and the problems arising during the development of the patient's personality. Briefly, an individual in the course of personality development gains relationship experience concerning the ability to satisfy needs. When an instinct or need is triggered, the relationship patterns go into action and the individual assumes that others will react to his or her needs in a similar way as the person who was dominant in early life.

4. Psychopathological theories

According to modern psychodynamic theories of psychopathology, disease arises out of both biological determination and social effects experienced at different stages of personality development.

In the view of *self psychology theory*, many symptoms constitute a compromise formation to resolve the conflict between the instincts and the subsystems of the mind. The action of the defence mechanisms is responsible for creating these compromise formations (Freud, 2008). The significance of defence mechanisms changes during development. For example, splitting is part of normal operation in the early stage, but if too active at a later stage can be pathological except in emotionally burdensome situations, when it can again become temporarily adaptive.

The goal of therapy is for the patient to acquire more and more adaptive, mature defence mechanisms. Table 9/1 shows the most widely known defence mechanisms.

Table 9/1
Defence mechanisms

	Definition
Primitive defences	
Splitting	Not capable of simultaneously experiencing contradictory traits in oneself and/or another person. Seeing oneself or others as purely evil or purely good. For example, the patient at different times either hates or loves the doctor, and is unable to perceive the doctor's good and bad traits at the same time.
Projective identification	The patient's behaviour involuntarily forces others into a form of behaviour not characteristic of them but corresponding to a figure in the patient's inner mind. For example, a patient's behaviour evokes anger in a doctor of a serene nature, and the doctor himself is surprised at his own reaction.
Projection	The attribution to others of urges one finds unacceptable. For example, a patient is in love with the doctor, but has the experience that the doctor is in love with the patient.
Denial	The avoidance of external events by means of not perceiving them at a conscious level. For example, a patient does not hear bad news said by the doctor.
Dissociation	A change in the experience of continuity in identity, memory, consciousness or perception. The effect is to detach painful experiences from the conscious identity and thereby to escape suffering. For example, an individual does not remember being abused, or feels that she stepped out of her body and saw herself being raped from outside.
Idealization	Regarding somebody as perfect, with the purpose of keeping contempt, envy or anger at bay. For example, a patient always praises the doctor to keep away the

	feeling of resentment because the doctor is not always available
Acting out	Expressing oneself in actions instead of expressing feelings for another person in words. It impulsively implements an unconscious desire or fantasy at the level of action instead of talking about it. For example, a patient dissatisfied with the doctor jumps up and runs out instead of saying what is wrong.
Somatization	Experiencing mental pain and negative feelings by attending to the physiological phenomena that go with it instead of becoming conscious of the mental phenomena. For example, A patient required to wait in the waiting room for a long time feels an intolerable headache, and that is what she tells the doctor, rather than that she is angry.
Regression	To avoid conflicts at the present level of development, the individual returns to the mode of working of an earlier stage. For example, a sick doctor talks consulting another doctor acts in a childish way, like an ignorant patient, in order to avoid rivalry.
Schizoid fantasy	Avoidance of tensions inherent in real social situations by retreating into one's own fantasy world. For example, fantasising about a miracle cure instead of going for medical tests.
Higher level (neurotic) defences	
Introjection	Internalizing attributes of a significant other person in order to cope with losing that person. For example, often thinking about how one's former lover would react to certain acts.
Identification	Internalizing attributes of another person in order to become like the other. For example, a patient acts or dresses like the doctor.
Displacement	Shifting feelings for a person or a subject to another person or subject similar to the original. For example, redirecting anger from the doctor to the assistant.
Intellectualization	Speaking about abstract thoughts to avoid feelings. For example, a doctor speaking to the relative of a dying patient gives pieces of general wisdom instead of talking about the pain the relative feels by the impending loss.
Isolation	Separating thoughts from the emotional state they involve so as to avoid the swirl of feelings. For example, news of a malignant tumour does not evoke any feeling in the patient.
Rationalization	Seeking justification for unacceptable feelings, thoughts or behaviours. For example, a patient who finds a lump on her breast does not go to the doctor with it because it is "just the result of bumping into something".
Sexualization	Attaching sexual significance to another person or behaviour to turn negative experience of that person into arousal or to prevent anxiety. For example, a patient often abused in childhood by her mother finds it sexually arousing for her partner to abuse her.
Reaction formation	Reversing an unacceptable desire or urge. For example, a patient who finds his doctor sexually arousing reacts with disgust when the doctor touches him during an examination.
Repression	Repelling unacceptable thoughts or urges from the consciousness or preventing them from reaching the consciousness. For example, a patient is in love with her doctor, and cannot accept the fact. She pushes this feeling from her consciousness and at the same time forgets about the control examination they arranged.
Undoing	Acting as if the sexual, aggressive or shameful consequences of a previous action had not happened. For example, a compulsive patient thinks about death when shaking hands with the doctor at the end of the visit, and wants to shake hands again without thinking about death, so as to "neutralize" the previous thought.

Mature defences	
Humour	Reducing tension in difficult situations by bringing up a comic aspect. This creates distance from the situation and enables one to examine it more objectively. For example, upon hearing bad news from the doctor, the patient makes a funny comment to defuse the tension.
Suppression	Similar repression, but done consciously. For example, a doctor, when working, consciously avoids thinking about the death of a relative.
Asceticism	Trying to avoid experiences that give pleasure and thus to escape the internal conflict the pleasure arouses. For example, a grieving person avoids pleasurable activity, being unable to reconcile grief and pleasure.
Altruism	Devoting oneself to relegating one's own needs below those of others. For example, a doctor regularly works overtime to give patients proper care, at the expense of her free time, rest and own career.
Delay	Renouncing immediate satisfaction in the interests of future plans and achievements. For example, a patient who has felt severe lower abdominal pain since the start of the examination period only goes to the doctor after the last exam.
Sublimation	Transforming socially deprecated or personally unacceptable goals into acceptable goals. For example, a child who was constantly punished for being nosey and staring grows up to be a doctor and an excellent diagnostician.

Object relations theory sees mental problems as arising when caregivers reject, neglect and abuse children, who then internalize the way their caregivers reacted to their needs. They do this in the form of an object relation having three components: self-affect-other. For example, the caregiver object-relation representation consists of one's own positive experience of oneself (as the person receiving care), the other person (father, mother or partner) and a positive affective experience (pleasure) connecting the two. Serious frustration of development can lead to a negative relationship representation: a negative experience of oneself (I am bad, to be rejected), a negative image of others (maltreating tyrant) and the affective relationship between the two (anger). It is possible to form two completely different object relations concerning the same person. Regarding one's mother, for example, one can have both a persecutor-anger-persecuted and a care-receiving-pleasure-caregiving representation. Individuals with borderline personality organization frequently apply splitting, which manifests itself as the patient having extreme relational schemas concerning another person and being incapable of integrating them into a balanced representation. This results in extreme relationships and fluctuating emotional states (Kernberg, 2011).

A patient with borderline personality disorder sometimes sees herself as interesting, the doctor as a dedicated doctor, and the relation between them as providing security and help. At the slightest inattention by the doctor, she becomes a despicable bitch, the doctor a bastard, and the therapy is a torture for her. This phenomenon of seeing oneself and the other person in black-and-white terms is called splitting, one of the "immature" defence mechanisms.

As the patient proceeds, the patient becomes increasingly capable of learning more mature defence mechanisms and integrating her own and the doctor's good and bad qualities. She still gets annoyed by the doctor's inattention, but is capable at the same time of thinking of all the effort he has made for her, and that a doctor is also human. In such situations, the image of herself no longer flips to her old negative view of herself, and she can conceive that the doctor's inattentiveness is not an expression of his view of her as an "undeserving bitch he would like to get rid of".

According to the *self-pathology* explanation, narcissistic disorders stem from defective self-development. Self-development defects occur when the individual has not developed the mental structures that provide the capability to regulate emotions and relationships (Stavros, 2003).

A narcissistic person does not treat another person as an independent subject but as a "self-object" whose function is to maintain the balance of his or her personality. Narcissistic people need others to admire them, be proud of them or help them achieve something, but these others are only important as long as they fulfil this function.

In brief dynamic therapies, the therapist identifies one central relationship conflict as the focus of treatment (Luborsky and Crits-Christoph, 1998). Relationship conflicts arise from the individual's conception of how other people react to their expression of needs. This conception takes shape the course of personality development, and subsequently becomes the model of how they experience relationships. Three questions arise when approaching the subject of the central relationship conflict:

1. Need: what does the patient want from the other person?
2. The imagined or real reaction of the other: what do you think about how others will react to this? How do they actually react to it?
3. Response to the other's reaction: how does the patient react to the imagined or real reactions of others?

For example, Magda would like to realize her ideas in her business. She starts working out plans and thinks that Károly is bound not to like them, recalling that recently Károly was drawing up different plans. These thoughts make her uncertain, she gives up work on the plans, can no longer pay attention to them, and she loses interest in the whole enterprise.

In sum: in the background of mental conditions treatable by psychoanalytic therapies are psychological conflicts, insufficiently mature defence mechanisms, unintegrated and harmful object relation representations, self-development deficits and central relationship conflicts.

5. Methods of psychoanalytic psychotherapy

A basic characteristic of the modern psychodynamic approaches deriving from psychoanalysis is that they view the analyst's attitude as one of the main determinants of events occurring in psychotherapy. The analyst must above all be open to events in the social space. The determinants of these events are the patient's conscious intentions, unconscious motives and emotions, and the analyst's conscious or unconscious reactions to these. The analyst accepts that neither she nor the patient are capable of seeing the events from the objective perspective of a third person, because what comes up during the therapeutic session is a joint creation of the analyst and the patient.

According to the psychoanalytic development model, early relationships influence how the patient (analyst) perceives the analyst (patient) during therapy and occasionally falsely ascribes to the analyst (patient) thoughts and intentions characteristic of important persons in his or her life. This phenomenon is called *transference* (*countertransference*). In their training, analysts are prepared to be capable of perceiving the relationship patterns that appear in transference. They must also become able to manage countertransference. This means monitoring their own reactions to patients before these reactions become manifest, or contemplating whether actual manifestations carried inappropriate elements.

A psychoanalytically trained therapist enters the therapeutic relationship knowing that patients are not capable of putting certain needs into words. Patients experience an unbearable tension when these needs come to the surface. The problem is rooted in the development of the personality, and derives from the failure of important figures in early life to provide appropriate reactions to manifestations of these needs. This tension generates certain relational behaviours

which take effect on the analyst. This situation confronts the analyst with the emotionally burdensome task of withstanding the tensions aroused by the situation without simply trying to get rid of them. Another difficult task is to withstand the state of not knowing, i.e. the fact that neither the therapist nor the patient know the origin of the tension when it first arises. The therapist must be capable of thinking and fantasizing about the tension and attempt to put its potential causes or give the patient the opportunity of thinking calmly about it. This is known as the psychoanalyst's containment or holding function, which the situation of transference and countertransference makes particularly difficult, because inappropriate containment of the patient's and/or the therapist's undigested tensions and the tensions they arouse in the other cause further disturbance to the patient's development.

In psychoanalytic therapy, the containment function is always to the fore when implementing strategies, tactics and techniques, but with due heed to transference and countertransference processes. This all requires psychoanalytic training.

5.1 Strategies

Strategies of psychodynamic therapies are directed at exploring the unconscious mechanisms in the background of patients' symptoms, making repressed feelings, desires and urges conscious, giving patients insight, and through the corrective emotional experience gained during therapy, enabling patients to develop new, more adaptive relationship patterns and object relation representations.

Strategic goals:

- **Make the unconscious conscious:** understand internal processes which formerly unconsciously controlled the operation of the personality.
- **Resolve conflicts:** explore and resolve unconscious conflicts and promote the development of more adaptive compromise structures.
- **Achieve self-awareness:** find, recognize and convey the real self behind the false self and thus develop the feeling of authentic self-identity. Seek the answer to the questions, "who am I, and what do I want?"
- **Recognize the conception of human relationships and develop new relationship patterns:** analyse the relationship patterns activated in the therapeutic relationship and seek alternative modes of relating.

5.2 Tactics

The main tactical principles are neutrality, anonymity, abstinence and self-restraint.

- **Neutrality** firstly means being non-judgemental, except in the case of threatening behaviours such as child abuse and crime. Secondly, it is connected with free-floating attention, by which the analyst accepts without selection the experiences originating in the patient and in the therapist.
- **Anonymity** means that the therapist does not burden the patient with the details of the therapist's private life.
- **Abstinence** means that the therapist firstly resists using the patient to satisfy the therapist's own needs and secondly does not satisfy patients' needs beyond the bounds of the relationship (sexual relationship, friendship outside therapy, etc.).

A characteristic tactic of psychodynamic therapy is strict adherence to the framework of the therapeutic contract. In psychoanalysis, the patient lies on a couch and the therapist sits behind it. The therapist takes a non-directive approach to therapy, i.e. does not direct the course of the session, but mainly reacts to what the patient says. In the other dynamic therapies, the patient and therapist sit opposite each other at an obtuse angle. A characteristic tactic of brief dynamic therapies

is to select the focus of therapy (e.g. the theme of central relationship conflict) and maintain this focus during the session.

5.3 Techniques

The techniques held to be most important in psychodynamic therapies are management of the *therapeutic relationship* and *interpretation*.

The therapeutic relationship is mainly determined by the analyst's ability to contain the tensions and emotions brought by the patient and to handle the transference and countertransference reactions.

Interpretation is the process of exploring the relation between compromise formations and unconscious conflicts and the similarities observed among the relational patterns which occur within therapy, the patient's relationships outside therapy, and the patient's relationships to persons important in his or her past. It also involves pointing out the rigidly repetitive nature of these and opening a way to discover possible relationship alternatives (Flaskay, 2010).

Interpretation techniques:

- Pointing out the links between the patient's present situation and past experiences.
- Demonstrating that the patient's behaviours and feelings towards the therapist are similar to those towards others.
- Drawing frequent attention to the patient's childhood experiences, so as to explore the origin of the patient's mode of relating. This involves exploring how the patient's relationship style developed and how it affects his or her current problems.
- Drawing attention to the potential causes, functions and purposes of the patient's symptoms or problems and the possible disease benefits, such as avoiding responsibility or avoiding conflict.
- Exploring and discussing the patient's feelings about the therapy, assuming that the therapeutic relationship activates the patient's principal relationship patterns. The feelings experienced in the therapist relationship can foster an understanding of the patient's main relational modes.
- Helping the patient to see that his or her real intentions and feelings are different from the perceived intentions and feelings he or she perceives, and to understand the patient that he or she sometimes projects false feelings and intentions on others.

Psychodynamic therapies also use non-interpretative techniques:

- **Comment:** the therapist draws attention to the recurring themes observable in patients' relationships.
- **Confrontation:** the therapist points out contradictions observed in patients' behaviour. By exploring these contradictory urges and helping to make them conscious, the therapist enables patients to accept the opposing internal forces. These contradictions can show up in
  - what patients say and how they say it,
  - sudden changes in mood or subject,
  - long periods of silence,
  - bursting out laughing, dropping gaze, becoming embarrassed,
  - avoiding mention of certain subjects or persons.
- **Clarification:** the therapist summarizes what she understands and puts questions about what she does not understand.
- **Encouragement to further expression:** the therapist encourages the patient to talk about feelings or desires they have hitherto avoided or never dared to express or found difficult to admit feeling.

- **Empathic reinforcement:** the therapist takes up the patient's point of view to express sympathy for his or her feelings and to recognize their legitimacy.
- The **free association method** helps to bring things from the unconscious to the conscious. It involves encouraging patients to say anything that comes into their mind, indiscriminately.
- The therapist asks about patients' **dreams, fantasies and desires** and encourages them to talk about them to gain a better understanding of their unconscious urges and conflicts.

More rarely used methods in psychodynamic therapies are psychoeducational intervention, praise and advice.

Psychodynamic therapies are performed in individual, family, couples, and group modalities.

6. Evidence

There is an increasing body of evidence supporting the effectiveness of psychodynamic therapies (Shedler, 2010; Gerber et al, 2011). Brief dynamic therapy has been found effective for adult depression, child and adolescent depression, pathological grief, anxiety disorders, panic disorder with or without agoraphobia (Milrod et al, 2007), generalized anxiety disorder (Crits-Christoph et al, 2005), somatoform disorder, borderline personality disorder (Bateman and Fonagy, 2001; Giesen-Bloo et al, 2006; Clarkin et al, 2007), avoidant personality disorder (Emmelkamp et al, 2006), and anxiety personality disorders (Svartberg et al, 2004). Long psychodynamic therapies have proved effective in the treatment of complex mental disorders, i.e. patients suffering from more than one psychiatric condition (Sandell et al, 2000; Leichsenring and Rabung, 2011). Follow-up studies have shown that the healing and development process continues after analytic therapies come to an end.

Summary

Central to psychoanalytic therapies are analysis of the complex regulation processes of the therapeutic relationship, a focus on emotions, acceptance of the determination of the mind's conscious processes by unconscious processes and several motivational and structural subsystems, and the central significance of development.

Psychoanalytic therapists choose and design therapeutic strategies, tactics and techniques after understanding and containing the relational processes. The psychoanalytic training model has produced the most sophisticated methods for handling the transference-countertransference processes that determine the therapeutic relationship.

Questions

1. Discuss the concept of psychic conflict.
2. What are the main psychoanalytic models of psychopathology?
3. What defence mechanisms are there, and how are they classified?
4. What do "transference" and "countertransference" mean?
5. What are the main strategies, tactics and techniques of psychoanalytic therapies?