

***The Importance Of  
Psychoanalytic Psychotherapy Training:  
A Tale of Two Programs***

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*If psychoanalysis survives into the next century, it will be because people at long last have come to value the imperishable truth that there is something to be said for being heard by an objectively neutral but empathically interested person who can withstand the rigors and bear the joys of an inner journey with a stranger. (James S. Grotstein, 1985)*

## **PREFACE**

It was the best of times. It was the worst of times. In the late 1970's Freudian psychoanalysis was in the beginning of a downhill spiral. The economy was such that people had trouble affording this expensive and time-consuming form of treatment, and its results were being contested by writers who challenged Freud in different ways. Heinz Kohut (1971) wrote "The Analysis of the Self," advocating a new type of therapy called self psychology that focused on the patient's idealization of the analyst and the need to be mirrored, ideas that precluded the types of interpretation that Freud had advocated. Otto Kernberg (1975) spoke of the Narcissistic Personality Disorder, a diagnosis that he felt required confrontation of aggression by interpreting projective identification, and by including a social worker to set limits with sicker patients. A decade of discussions in the psychoanalytic literature attests to the contributions made by both theoreticians. The culture had become increasingly narcissistic (Lasch, 1979) and theoreticians were addressing a seemingly new patient population with new theories.

This state of affairs effected Freudian trained psychoanalysts who saw their practices begin to dwindle along with their bank accounts. As their morale suffered, their lowered confidence level seemed to seep through to their patients as fewer potential analysands were willing to undertake four and five times a week treatment. This, combined with the new category of narcissists and so called borderline patients, led to renewed interest in Leo Stone's 1954 paper, "The Widening Scope of Indications for Psychoanalysis," which encouraged analysts to broaden their skills to deal with the more difficult patient. Rothstein, in his book "Psychoanalytic Technique and the Creation of Analytic Patients" (1995) states that the analyst's countertransference directed the diagnosis and that analysts had themselves to blame for fewer analytic patients in their practices. Rothstein also sees a patient's refusal to agree to a course of analysis as a resistance meant to frustrate the analyst. I challenged

this view by proposing that a “wading in” approach is more acceptable to an average person who perhaps has never even heard of psychoanalysis (1998). I agree with Bernstein (1983) in seeing a period of psychoanalytic psychotherapy as a possible prelude to psychoanalysis.

In 1974 Gertrude and Reuben Blanck tackled the problem of what form of treatment to offer the “less structured” patient with a book “Ego Psychology: Theory and Practice,” and by forming the Institute for the Study of Psychotherapy (ISP) dedicated to teaching psychotherapy based on their ideas. They reasoned that before a patient could deal with lifting repression (Freud’s idea), there had to be a strong enough ego in place. They called their method Ego Psychology (not to be confused with Freudian ego psychology) and based it on strengthening the ego; and they used the theories of Spitz, Mahler, and Jacobson as a basis for their thought. After many years of success they retired, and five of their students (some analytically trained and some not) went on to form the New York School of Psychoanalytic Psychotherapy (NYSPP). In designing the three-year curriculum, the founders combined what they had learned from the Blancks with a more Freudian approach.

Other institutes began psycho-dynamic psychotherapy programs, and by 2005 many psychoanalytic institutes include a program in psychotherapy. Taught in most cases by medical analysts, many of whom never had training in psychoanalytic psychotherapy proper, courses in diagnosis and psychopathology are a chief factor in determining techniques such as support, direction, manipulation and management, along with courses on development and psychopathology. JAPA has published debates on the differences in the two forms of treatment, first in 1954, and again in 1979. Results seemed to give a message that psychotherapy was less than psychoanalysis. The term “less than neurotic” was coined and measurement often clouded a patient’s chance to grow (Flarsheim, 1972). When a panel (JAPA, 1979) addressed the issue of the therapeutic action of psychotherapy, Robert Wallerstein posed a question: *is psychotherapy only a derivative form of psychoanalysis, or does it have distinctive emergent properties of its own*. He acknowledged that psychotherapy might well be a major part of a psychoanalyst’s practice. I pose a different question: *is psychoanalysis a specialty of psychoanalytic psychotherapy that should be taught once psychotherapy training is complete (or at least after several years of course work and supervision)?*

Many analysts when treating a patient who is not either ready or able to participate in psychoanalysis use non-analytic techniques such as support and advice, while ignoring transference manifestations completely (Hall, 1998). This paper questions where or whether a prospective psychoanalytic candidate, or even a psychoanalyst, receives training in *psychoanalytic*

*psychotherapy*. It also recommends that programs in psychoanalytic psychotherapy increase in number. Too many people have been judged as not amenable to the kind of therapy that includes transference interpretation, the encouragement to say what comes to mind, the connection of the past with the present, and the awareness of the unconscious and how to tune in on it and use it. Such treatment need not be called psychoanalysis proper, and need not be conducted on a couch or with a frequency of three or more times a week. Each person has a right to be seen as an individual with capacities clinicians often overlook. It also makes the point that capacities increase with trust, and discusses the establishment of trust between patient and therapist.

Psychoanalytic psychotherapy has long been a stepchild in our field, and as a result, too few patients are receiving the kind of help that could serve them in a deeper more long-lasting way. Many clinicians do not have the analytic training needed to effectively employ the skills of neutral objectivity and empathic interest. However, these skills, and others based in the Freudian legacy of understanding how the past resonates in the present, can be taught through programs in psychoanalytic psychotherapy. (Psycho-dynamic psychotherapy also gives credence to the idea that complex issues of one's past effect one's present, however, the technique is an intellectual one for the most part and is not to be confused with *psychoanalytic* psychotherapy.) Furthermore, the vast majority of people who need a therapist's help are not candidates for analysis, whether by virtue of readiness or socioeconomic status. Creating alternative training programs not only puts those much-needed tools in more hands, it also makes it possible for more people – particularly those who may not have means, access, or interest in analytic training or analysis – to give and receive deeper treatment. Many existing programs view psychoanalytic psychotherapy as supportive, directive, and at best, psycho-dynamic. This paper discusses an approach to training that includes the concepts and techniques of transference, countertransference, projective identification, resistance and free association, and stresses the idea that psychotherapy does lead to intensive analysis for some patients. But, since most clinics do not permit clinicians to see patients more than once or twice a week, and do not provide couches, a teaching program is limited to what I will call intensive psychoanalytic psychotherapy. Such treatment, however, respects the potential of the patient as opposed to the labeling, patronizing, and condescending attitudes of many trained in psychiatry alone. The mentally ill are rarely treated with the respect that the physically ill receive, and this attitude exacerbates their illnesses in my opinion. The first thing a psychoanalytic psychotherapy program must teach is to respect the patient and to use benevolent curiosity instead of judgment.

## A CASE IN POINT

In a class at the New York School of Psychoanalytic Psychotherapy, a candidate who had been working in a treatment center like Daytop Village where the behavioral model is used, presented a case showing that although a behavioral approach is useful and often necessary in work with substance abusers, high relapse rates underscore the need for a psychoanalytic component that targets the roots of conflict. Due to the time-limited nature of most community-based drug clinics, the behavioral approach can have a temporary impact on patients struggling to work through the trauma suffered in their formative years.

Drug use (heroin, cocaine, marijuana, alcohol etc.), if seen as self-medication, alerts the therapist to severe pain. Telling a patient to stop as a condition of treatment rarely works. Understanding with a patient what the drug means for her, how it alleviates pain, pinpointing the pain if possible, are approaches that over time lead to a working alliance and avoid a power struggle. When the therapist has respect for the patient's attempts to negotiate life, and when she can replace her critical tendencies with benign curiosity, an inroad is made. If the drug is seen as a necessary crutch by the patient, the therapeutic journey can begin that way.

Informed by the theoretical and clinical insight gained from institute training, the therapist began listening to her patient's stories with a different and more attuned ear. Using a psychoanalytic lens, she could view the constant flight and drug-induced highs as an attempt to defend against the loneliness, pain, and rage her patient was unable to express in words.

*Ms. S, a Native African/ American in her mid-30's, entered drug treatment for alcohol and cocaine addiction as a condition of regaining custody of her three youngest children who, for the past two years, had been in kinship foster care with her mother after being removed from Ms. S on child neglect charges. Ms. S began drinking alcohol and smoking marijuana in adolescence and developed a cocaine habit in her mid-20s; by age 30 she was inhaling cocaine on an almost daily basis. She had called her mother for help after suffering a "breakdown" and was hospitalized for a short time. She had been in two different treatment programs before coming to the clinic, but had been discharged from both because of what had been described as her "acting out" behavior. .*

*Ms. S had a history of suicide attempts and gestures, obesity, bulimia, and self-mutilation, and she had undergone several psychiatric hospitalizations and medication regimens. She also had a history of "running away" from things when they proved too much for her: family, men, jobs, and, therapy. The clinic was no exception. She bolted from therapy twice, the first time about six months into treatment following the therapist's absence for a week's vacation, and the second time following a brief but inevitable disruption inflicted by the World Trade Center disaster.*

In this case, the therapist was able to resolve the first treatment break, which was accompanied by an alcohol and cocaine relapse, by a gentle but firm insistence that Ms. S come in to

talk about what had happened. The therapist reported that after examining her own feelings, it became apparent that she had assumed her assigned role in Ms. S's sadomasochistic enactment and that Ms. S. was hoping to be coaxed back following a display of disruptive behavior that she knew would worry and disturb the therapist.

Ms. S had early on become very attached to the therapist, who seemed to represent her father in the transference, and became frightened before the therapist's vacation, and then enraged by the anticipation of devastating loss (father, the only person she felt accepted and loved by, died suddenly from an overdose when patient was 14). She was reliving the drama by reacting to a separation with the therapist, acting out a memory that she was not able to verbalize.

The therapist recognized her own countertransferential feelings of worry, anger, and helplessness that ensued when Ms. S. abruptly left treatment. This enabled her to interpret Ms. S's flight and use of drugs as "an attempt to avoid the rage she was experiencing and to defend against further loss." The therapist also noted:

*At the time, Ms. S largely resisted this attempt to engage her in an exploration of the anger she was projecting, but acquiesced to return to treatment. "I don't see it," she said with a sheepish, satisfied grin, "but if you think it will help, I'll give you another chance."*

It is not unusual for a patient with a history of abuse to deny her feelings of rage. The internalized object representation, now part of the self, is impossible to give up (Hall, 2004). The best the therapist can do is to modify or overlay the attachment by providing a new object with whom to identify. Sometimes the rage is expressed in self-injury and in frustrating the therapist.

These concepts of transference/countertransference, resistance and the repetition compulsion are part the foundation of the coursework in a psychoanalytic psychotherapy program. The therapist, having completed courses in technique along with courses in object relations and acting out was empowered to apply these concepts to her own cases.

Ms. S's addiction masked the loss and subsequent depression she experienced in her formative years. Drug and alcohol abuse is essentially a passive response by the ego to conflict and loss, providing an illusion, albeit short-lived, of power and control. In her adult years, a cocaine/alcohol high served as a defense against closeness, separation, and rage (Hall, 1998). Through identification with a neglectful narcissistic mother and a frequently absent alcoholic father who surrendered to their own emotions, drug use also represented an attempt to recapture the lost objects and thereby ward off her depression.

This is an example of how masochistic behavior and the symptom of drug abuse are indicators of buried rage; the non-verbalized, acted-out anger that often ends the treatment.

*The second break was complicated by Ms. S having witnessed the 9-11 terrorist attack from a bus on her way to work in the downtown financial center. Witnessing the horror had re-traumatized her, and she had isolated herself in her apartment, located in the same downtown area, for approximately two weeks before calling to say she had decided to hospitalize herself for symptoms of posttraumatic stress. The therapist, who had not been able to reach her during the two weeks because of the shutdown of phone service in the area, supported her decision and said she would be waiting for her when she got out. Unlike the past, when she had welcomed the "rest" of a psychiatric hospital stay, Ms. S checked herself out after a few days, feeling, she said, that she didn't "belong there anymore." She returned to treatment the next day.*

The world shattering event of 9/11 seemed to have shifted her perspective, and Ms. S became more reflective about the quality and meaning of her life and more responsive to the therapist's attempts to direct her anger to the therapist as transference and new object, one that could contain and not be destroyed by her rage (Hall, 1998). Thus began a new chapter in the treatment process.

*For the first time Ms. S. was able to acknowledge her anger at the therapist for not being there in her time of crisis, for not protecting her in her time of desperate need. Reflecting some measure of self-object differentiation, she also acknowledged that her fantasy of rescue was, given the nature and magnitude of the event, a wish that could not realistically have been realized. In subsequent sessions she began to voice the longing she felt for her mother's "unconditional love" and the deep disappointment she experienced, over and over, as a result of her mother's inability to empathize with her needs.*

Other smaller breaks also occurred during the treatment.

*A less disruptive break occurred after the therapist's absence during an extended holiday weekend, when Ms. S did not appear or call the entire next week. When she did come in the following week, she initially denied any anger towards the therapist but later, with some encouragement, was able to talk about feeling abandoned and alone, even though, she felt obligated to point out, the therapist was "entitled to a day off once in a while." She was able to verbalize feelings of wanting to hurt the therapist by "picking up" [using cocaine] and disappearing for a while "to get even." She reluctantly described a fantasy she had been nursing, in which she confronted the therapist with bitter accusations of blame for her relapse and was greeted with the therapist's extreme contrition for having caused her so much pain. Her discomfort at revealing her feelings seemed to ease with the therapist's acknowledgment of how very difficult it must have been for her to put her true feelings into words and how much progress it revealed. She was then able to go on to talk about how an incident with her mother over the weekend had triggered her anger and how alone and "little" she had felt. This time she had not resorted to drug use to mask her rage, believing, she said, that she would only have ended up hurting herself.*

Here the therapist was able to see these illustrations of Ms. S's acting out in the treatment as a reaction to her sense of loss and abandonment by two narcissistic parents, and the lack of individuation that had taken place as a result. The therapist noted that: "Like so many others

addicted to drugs and alcohol, Ms. S. entered treatment lacking a stable self-image and a sufficiently self-observing ego, and treatment was an effort to engage her in a self-reflective process that would enable her to put words to her thoughts and emotions and, over time, strengthen her ego capacity to self-regulate. While working with abused, addicted individuals is almost always an uphill battle, it can be gratifying when even small advances in the treatment occur.”

The therapist’s theoretical understanding of child development, with its issues of separation/individuation; her knowledge of the compulsion to repeat (abandoning her own children as she was abandoned); her ability to work with transference, countertransference and projective identification; along with her clinical understanding of consistency, neutrality, interpretation, and empathy helped her treat Ms. S in psychoanalytically oriented psychotherapy.

### **A MODALITY ON ITS OWN: PSYCHOANALYTIC PSYCHOTHERAPY**

Psychoanalytic psychotherapy is a specific form of treatment that provides a corrective emotional experience with the therapist as new object who explains, tolerates, strengthens ego functioning, uses transference interpretations when appropriate, connects free associations, and permits more benign object relating to occur, enabling/empowering the clinic patient (as well as the private patient) to resume the developmental process that has become derailed. Programs that teach the therapist that each individual who crosses their threshold is unique, worthy of respect, and doing the best he/she can, are teaching the kind of psychotherapy that, if given an opportunity, can give a second chance to the disadvantaged, the traumatized, and the abused who so often turn to addictive and other self-destructive behaviors.

I saw this first hand in the early 1970s while working at Greenwich House, a mental health clinic serving the needs of drug users, many of whom were on welfare. At that time, fresh out of social work school, I was in a psychoanalytic psychotherapy program that gave me important tools with which to work. One group of seven African American ex- heroin users in their 40s and 50s and 60s, who still used occasionally and were mandated to come to the clinic by welfare, really took to the respect and benign curiosity with which I greeted them. First of all, being called Mr. and Ms. was a new experience for them. Being listened to without judgment was also a new experience and within a few months of weekly meetings, some requested private therapy. As the members in this group began caring about each other, they became a more cohesive group. When a member was arrested for petit larceny, the group wrote to him while he served his jail term. One thing I learned, that really surprised me, was that stealing was a valued skill; one addict told us that when he gave up using

heroin, what he really had more trouble giving up was petty theft. He had no other skill and this was one that he knew he was good at. It gave him self-esteem.

Psychoanalytic Psychotherapy must be given its place in the sun. In New York I have been privileged to join with colleagues to found two psychoanalytic psychotherapy programs: The New York School for Psychoanalytic Psychotherapy (NYSPP) training program in 1979, and the New York Freudian Society (NYFS) psychotherapy program in 2002.

The philosophy of the NYFS and NYSPP is based on the premise that almost everyone who crosses the therapist's threshold is looking for a second chance; a chance to live richer, less restricted lives (Hall, 1998). Even those patients who are required by the courts or other outside agencies to see a therapist (often at a clinic) had an often hidden wish to improve their lives. Both institutes created programs that teach clinicians that second chances depend on the therapist's ability to show the patient that present life is colored by the past, and that understanding how the echoes of the past resonate and shape one's life gives a person new choices and opportunities to resume development and resolve conflicts that are crippling. The idea of being listened to in a non-judgmental way in a safe, consistent, empathic setting is a new experience for most patients, and the psychotherapy students would learn that such an approach could contribute meaningfully to growth and development. Insight and empathic listening gives the patient a beginning sense of mastery not unlike the mastery achieved in learning a new skill. The training committees of these psychotherapy programs believed that beginning therapists would learn the skills necessary to deepening the treatment (technique) alongside the normal and pathological development of the human being (theory) – from birth through old age. Understanding developmental stages of life, and what can go wrong, enables the therapist to empathize rather than judge. In fact, in my mind, understanding the frustrations and calamities of the growing child is the most important ingredient in learning to empathize. Both programs stress the developmental approach and teach Freud during the first year. (See appendices for brief course descriptions for both programs.) I was recently impressed by a colleague who teaches at a high school for the disadvantaged where the children read Freud eagerly. These troubled children seemed to sense the power of the unconscious and the idea of repression before defenses had become rigid.

During the beginning stages of working with a patient the therapist has time to assess the patient's potential for psychological mindedness, which is often over-shadowed by initial anxiety. In this same period, the patient has time to determine whether she feels enough rapport with the

therapist to begin the gradual process of relating and revealing difficult, long-standing secrets. The way in which the therapist provides a safe environment while engaging the patient in psychoanalytic work, all the while maintaining her conviction that this work is effective in the face of the patient's despair and negativity, is the centerpiece of psychoanalytic psychotherapy programs. Consistency is the A of the ABCs. Most patients have never experienced consistency and this goes far in engendering trust. A therapist who is there, waiting at the appointed time, rain or shine, is crucially important. A psychotherapist who respects the patient's pushes towards and pulls away from exploring her inner life is on the way to enabling the patient to trust in the psychoanalytic process.

Psychoanalytic psychotherapy programs must aim to teach that it is up to us as therapists to see to it that our patients are presented with the "imperishable truth" of which Dr. Grotstein speaks. The NYSPP program, having been founded by both analysts and non-analysts, was not originally intended to be a stepping-stone to analytic training. The NYFS Psychotherapy Program, conversely, was created by analysts for the clinicians who, while not committed or ready to begin a program in psychoanalysis, were interested in a less rigorous training experience, an experience that would help the beginning clinician do psychoanalytically oriented treatment. As many people come to a therapist's office, whether in a clinic setting or in private practice, prepared to undertake weekly therapy (sometimes referred to as counseling), so too do clinicians often need to wade in to practicing on a deeper level. Such wading depends on knowledge of the theory of human development and an education in basic psychoanalytic technique.

Patients often have little idea that their presenting problems are just the first few bars of their song (Hall, 1998). Weekly counseling is rarely enough to achieve lasting change, but it is a reasonable way to begin. This is true with beginning therapists who often 'counsel,' which includes such techniques as advice giving, sharing their personal experiences, giving information, taking sides, making judgments, and being supportive or punitive. Psychotherapy programs must be formed to give these beginning clinicians the tools for understanding development and the tools of technique, with an understanding of appropriate neutrality and abstinence and the concepts of transference, countertransference, and resistance. In short, the aim is to teach psychoanalytically oriented psychotherapy and also to interest those who wish to do deeper treatment to enter psychoanalytic training. These programs would be for the mental health professional interested in learning the basics of psychoanalytic technique, and for the clinician who knows that 'fast cures' are rare and

understands that while a behavior modification approach can help specific problems it does not touch the deeper problems of living.

## **ISSUES AT NYFS**

The NYFS, a component society of the IPA, in business for 45 years, began with an established psychoanalytic program. When that program failed to attract analytic candidates for three consecutive years, a committee was formed to create a new, shorter program based on psychoanalytic thinking. The students for this program, wishing to learn how to improve their psychotherapy skills, would gain important understanding of the human beings coming to their clinics or offices, and those who wished to go on for in-depth training in psychoanalysis would be a bonus.

In creating their psychotherapy program, the NYFS committee sought to address three issues: competition from other societies, the validity of psychotherapy, and morale in the society.

By the late 1990s, many psychotherapy based training programs had come into existence. The NYFS committee felt the need to compete with three-year programs and set about crafting a two-year program with the hope that the students would want further training later.

The debate in the psychoanalytic literature between the values and differences in the two modes of treatment, *psychotherapy* and *psychoanalysis*, began with Freud. When thinking about the large-scale application of psychoanalytic treatment, he spoke of the pure gold of psychoanalysis vs. the copper of direct suggestion (Freud, 1918). The debate continues to rage, and perhaps it always will. In 1998 NYFS addressed the question.

Some members of the NYFS opposed the idea of a psychotherapy training program because they feared that it would compromise the image of NYFS as a psychoanalytic training institute. This hurdle was finally overcome as the committee presented its plan to the Board of Directors; a plan that affirmed psychoanalytic psychotherapy as a specialty that requires specific training and that ensured such a program would not compete with the psychoanalytic program already in place.

Using the framework of the life cycle, this unique training program would focus on recognizing the unconscious, how it affects and is affected by development, and how it influences life choices. The curriculum would provide exposure to a wide range of psychoanalytic thought, and emphasize the integration of theory and technique. Clinical material would highlight theory throughout the coursework (NYFS 2002). It was hoped that studying development along with technique would help the clinician in his or her present clinical work. For instance, understanding how trauma and abuse

along the spectrum of development affects a human being increases the clinician's ability to empathize with a patient suffering from bulimia, self-cutting, drug addiction, etc.

Another motivating factor in beginning this psychotherapy program had to do with addressing low morale at NYFS. This morale problem was closely linked to the lack of analytic candidates, which affected all members. Encouraging non-faculty members to gain teaching experience was an important goal. The same held true for supervisors not yet training analysts. The committee's recommendations regarding instructors were based on a dual mandate: for those NYFS members who had never before taught at NYFS, to provide the experience needed to apply for future positions in the analytic track; and to select teachers who had enough experience in other settings (clinics and private practice) to work with beginning clinicians. Every effort was made to offer teaching and supervising positions to this group. A senior faculty person was asked to visit or give one class during each 12-week course. Everyone taught and supervised without financial remuneration.

The committee enlisted Sheldon Bach, Fred Pine, Anni Bergman, Martin Bergmann, Ruth Lax, and Marsha Levy-Warren, all senior members of the NYFS Institute and well known in the field. They graciously donated their time, as did all teachers and supervisors. The donation of time is an indication of the enthusiasm and generativity of a large group of dedicated people.

## **ISSUES AT NYSPP**

Because NYSPP grew out of an institute in which analysis was not the focal point, the NYSPP curriculum was able to evolve without the having to fight the battle of supremacy: psychotherapy versus analysis. Morale was already high, as the founders were eager to carry on the work of their first mentors, the Blancks. And as for competition at its inception, there was none to speak of, as the Blancks were truly among the pioneers of this thinking. That is not to say that NYSPP never had any problems to surmount – all groups suffer growing pains as ideas evolve. But being a forerunner definitely had its advantages.

One important hurdle was the need to prove that the teaching skills were of high caliber. The Blancks had an excellent reputation and filling their shoes was a real challenge. Also, as years passed, and their name was no longer as well known, NYSPP lost the cache of its original mentors. The institute also suffered in the 1980's as the other institutes sprang up offering programs in the Sullivanian method, Eriksonian hypnosis, a gender identity focus and other alternative programs. Fads came and went but NYSPP managed to survive and is now in its 27<sup>th</sup> year. The curriculum is basically the same, however it is updated each year as new literature abounds. The institute formed a

society early on and this gave a sense of cohesiveness, a place for presentation of scientific papers, and a referral service. After a few years, some graduates wanted more training and an analytic track was formed, but never truly flourished, as it could not really compete with NYFS and other IPA institutes whose reputations were impressive. Interestingly, 12 graduates of NYSPP went on for analytic training at NYFS and several are now members of the NYFS psychotherapy faculty.

## **NYFS PSYCHOTHERAPY PROGRAM**

NYFS accepted its first class of psychotherapy students in the Fall of 2002, and from its inception there were a number of challenges. A look at the recent experiences of NYFS might be informative to others in the field who must also be grappling with these issues. The first class comprised five social workers, one research psychologist, and a journalist pursuing a career-change. The committee expected that candidates would come from diverse theoretical backgrounds, but no one anticipated the effect of accepting students who had no prior clinical experience. Those not working directly with patients had no cases to which they could apply the theory and techniques discussed in the classroom. This led to some frustration, not only on the part of those students, but also on the part of fellow students who felt that they were carrying the burden in class discussion, and on the teachers who found it difficult to gauge the effectiveness of their teaching.

Addressing this problem included providing those students with private referrals and/or assisting them with placements in agencies. This worked for some but not all. The people not in the mental health field could not be accepted by mental health agencies due to insurance requirements. Plans to better address this issue in the future include increasing outreach to mental health facilities, homes for the elderly, foundling homes, and hospices where those in need benefit from being listened to. Learning to listen is a prime requisite for a psychotherapist. The NYFS consultation service has also agreed to refer low fee patients in need of psychotherapy.

Another related issue to emerge is that of faculty and supervisor expectations. While clinical work was a requisite for analytic candidates, not all of the psychotherapy students had patients. Furthermore, those who were seeing patients in a clinic setting were frequently unable to follow a case through, as many clinic patients, whether by virtue of a lack of money, family obligations, or psychopathology, do not continue treatment with any regularity, if at all. Accordingly, those who had taught and/or supervised in the analytic program found it necessary to adjust their approach for the psychotherapy program. A seminar for supervisors of psychotherapy cases is important in such

programs because the skills needed are not formally taught in most institutes I know of. NYFS offers supervisory training for training analysts, but not for psychotherapy cases.

During the second year, another challenge emerged. The students, having realized all along that upon graduation they would not be eligible for professional NYFS membership, began to wonder if there was some way that they might be allowed to participate in NYFS activities that were restricted to members and current analytic students. In order to continue their affiliation with the Society they asked if a special membership category might be created.

The problem with giving the psychotherapy students a form of membership reflects the same bias that made the program difficult to start in the first place. Many analysts at NYFS continue to feel that the high standards of the analytic program would somehow suffer if psychotherapy students were granted even associate psychotherapy membership. This problem is compounded by the fact that in order to be open to incoming students, rigorous supervision and therapy requirements were not enforced. This dilemma of how to attract students with little or no clinical opportunities while at the same time exercising high standards is being debated. A compromise seems to be in the works: those students who do complete supervision and a number of their personal treatment hours may be granted an affiliate or associate psychotherapy membership. As of this writing, the program is in its fourth year and students are coming primarily from clinics and therefore have cases. There is a list of applicants for 2006 so we are experiencing success as we grow.

When creating this program the committee's intent was two fold: to train psychotherapists, and to interest students in entering analytic training at NYFS. While none of the psychotherapy program's graduates have applied for acceptance to the analytic training institute yet, several have continued with supervision, and some have expressed a desire for further training sometime in the future. Two are pursuing areas of specialization: one, interested in child psychotherapy, enrolled in another training institute in New York City, and the other, with a special interest in autism, is working privately with autistic children and their families.

In the fall of the second year there were not enough applicants for a new class, so the committee redoubled its recruitment efforts and succeeding enrolling a class for January of 2004. At present, the psychotherapy program is back on track, and a waiting list is now employed when there are too many applicants. At present, classes meet in the instructor's private office. Eight to ten students are accepted due to this space limitation. As the program grows, a classroom in a school will

be rented. However, because the focus is on class discussion, case presentations and not on lecturing, large classes will never be feasible.

Maintaining an ongoing and open dialogue with students has been critical to the success of the program. In addition to the issues already discussed, two changes in the curriculum were a direct result of student input. The original curriculum did not include a course in psychopathology, and students were quite vocal in expressing their interest and need. To accommodate the addition of an additional course, the committee decided to combine the courses covering the adult phases of development, mid-life and aging, into a single semester. Another suggestion under consideration is the addition of an optional third year to provide courses addressing the diagnosis and treatment of borderline and narcissistic pathology. This is an idea that holds particular interest, as one of the committee's intentions from the outset was to better equip clinicians working the more disturbed patient, and those patients in the lower socio-economic strata. Student interest in this possibility was evident at the graduation of the first year class when they expressed their sorrow at ending the program.

It seems clear to me that due to the success of the first year class and their wish to continue formal training, the program should evolve into a three-year program for those interested. Giving students a choice in advanced study maintains the idea of a two-year program and at the same time makes a three-year program viable.

The last challenge I will raise here is the issue of whether or not to require psychotherapy students to be in therapy themselves. While I feel strongly about this requirement, the program is run by a committee and a majority rules. Reasoning is based on the hope that an entrance level student will see the value of personal psychotherapy on her own, while making it a requirement might be alienating. The compromise is to "strongly recommend" personal treatment, but not to make it an absolute requirement. However, only those students in their own personal therapy can receive referrals from the NYFS Consultation Service or clinical affiliates. So far every student has been in psychotherapy.

An important goal is to continue to make useful distinctions in the training, both theoretically as well as clinically, between psychotherapy and psychoanalysis. Although the two can be seen on a continuum for some patients, the aim is to better tailor the curriculum to address psychoanalytic psychotherapy as a discrete entity, and adapt supervisory techniques as well as theoretical understanding. Rather than feeling like stepchildren of the analytic program, the psychotherapy

students should feel that they have a distinct and valid identity, while at the same time understanding that a more intensive process, psychoanalysis, is an important option, and one that they can see as inviting.

## **IN CONCLUSION**

Thus far, a great deal has been accomplished (morale in the society, teaching and supervision opportunities for members, community outreach, and a pioneering spirit), but most importantly, it is a successful beginning in furthering the goal of serving a broader and more diverse population of both clinicians and patients. Psychoanalysis proper, as effective and important as it is, needs to address the patients who for whatever reason are not able to partake of it.

The effort to see psychoanalytic psychotherapy as a treatment separate from yet influenced by psychoanalysis proper has been a long struggle. An innate belief exists among many analysts that psychoanalysis is almost always the treatment of choice (Rothstein, 1995) and is a superior form of treatment. As an analyst I believed this to be true for many years until my students in the psychotherapy programs taught me otherwise. Many of these students have not gone on to study psychoanalysis, although most of them continue in peer supervision and/or study groups. It has become my firm belief that their patients, by and large in once, sometimes twice a week therapy at clinics and agencies, have been given second chances as illustrated by Ms. S. Across the diagnostic spectrum and across all socioeconomic strata, more patients are being listened to in non-judgmental ways by empathic, benevolently curious therapists, who rather than giving advice and direction, engage the patient in thinking through rather than acting on their dilemmas. This is a gift and an enticement towards building a stronger ego, allowing for a richer, less dependent life....a life where compulsions are replaced by choices, and where the stranglehold of the past eases.

The NYSPP psychotherapy program continues to be successful, and while the NYFS program may still be in its infancy, early indicators are positive. The experiences in both societies support the case for freestanding psychotherapy programs, programs steeped in the application of psychoanalytic theory and technique without the additional requirements of training in classical psychoanalysis for candidates.

More analytic work goes on in therapy sessions than is generally discussed. Mr. X, in the ex-heroin group mentioned earlier, was able to feel his hatred and rage when he said to a fellow group member who had insulted him: "You're just like my father – a bully and a loser." This insight opened the door to his past. On another occasion he skipped group one week after the therapist's vacation

and was able to see how this was a retaliation for the therapist's absence, experienced as the abandonment he felt as a child. Heroin had been his way of dulling his pain. Words helped him face it. The insight was moving for the entire group. Like many others, Mr. X would never have been a candidate for formal analysis. But Mr. X's experience was like an epiphany to him. When more clinicians are armed with the analytic tools needed for deep and long-lasting treatments, many more Mr. Xs and Ms Ss will benefit.

## **APPENDIX I**

### The New York Freudian Society Psychoanalytic Psychotherapy Program

The curriculum includes coursework in normal and pathological development, technique and case discussion. Two courses will meet for one and a half hours (one evening a week) for 12-week semesters. Electives will be determined on the basis of interest. Weekly supervision is included in the tuition and can be applied toward the "R" in social work and to licensing hours for psychologists. It is recommended that the candidate be in treatment. NYFS has a roster of therapists who offer a sliding fee scale.

Those candidates who successfully complete the two years of coursework and 100 hours of individual supervision will receive a certificate in psychoanalytic psychotherapy from the NYFS.

The course descriptions are as follows:

Course #1 – Models of the Mind: This course offers an exploration of the dynamic unconscious, unconscious fantasy and symbolism. The tendency to repeat the familiar (enactment and acting out), the four perspectives of psychoanalytic thinking (drive, ego, object and self). An overview of the relational and intersubjective points of view will be presented and highlighted by clinical material.

Course #2 – Psychoanalytic Theories of Development I: This course offers an overview of the psychological development of childhood (infancy, toddler hood and latency). The focus is on the normal and pathological development of drives, ego, object relations and narcissism.

Course #3 – Psychoanalytic Theories of Development II: This course continues the exploration of development from adolescence to young adulthood. Included here are issues of Separation/individuation, consolidation of autonomy, gender formation, object choice, and

achievement of intimacy. This knowledge will be applied to issues around relationships, education and career choice.

Course #4 – Technique I – Clinical Practice and Providing the Frame: This course includes listening, engaging the patient, neutrality and abstinence as it relates to different psychopathologies. Therapeutic alliance, nature of therapeutic action, transference and countertransference, the opening phase of treatment along with boundaries and boundary violations are discussed. Clear and concrete knowledge necessary for setting up a professional practice, beginning with the practical issues involved; the initial interview, a thorough beginning diagnostic assessment, and the beginning of the psychotherapeutic process.

Course #5 – Psychoanalytic Theories of Development III: This course continues an exploration of the life cycle of development from young adulthood through mid-life. Included here is the psychology of pregnancy, infertility, developmental stage of parenting, intrapsychic tasks of mid-life. Classical and contemporary readings and clinical material will be used to illustrate concepts.

Course #6 – Technique 3 - Clinical Case Seminar: The differences between psychoanalysis and psychotherapy will be explored. Transference and countertransference will be emphasized. Interventions according to levels of pathology will be the focus of discussion.

Course #7 – Psychoanalytic Theories of Development IV: The focus of this course is on menopause, aging, illness, bereavement and mourning. Clinical assessment, approaches to treatment interventions will be discussed.

Course #8 – Technique IV –Middle Stage of Treatment and Termination: Deepening of the psychodynamic themes and the technical implications will be discussed. Criteria for ending treatment will be delineated along with the ending process. Issues of unplanned endings, planned termination and how to handle each will be discussed.

## **APPENDIX II**

### THE New York School for Psychoanalytic Psychotherapy Program

NYSPP offers a three-year program. As set forth in NYSPP promotional materials the Psychotherapy Training program is “based on contemporary theory which integrates the perspective of psychosexual development and ego psychology with the contributions of self and object relations theory. The integration of these theories in a developmental frame of reference provides the best

scientific understanding of the human mind available, and serves as a reliable guide to the effective evaluation and treatment of a wide range of patient problems.”

The course descriptions are as follows:

100 The Theory of Psychoanalytic Psychotherapy I: This seminar explores Freud's seminal concepts of the origins and manifestations of neurosis, the psychosexual phases of development, the function of defenses, narcissism, and dream theory.

101 The Beginning Phase of Treatment: This seminar focuses on the origins and implications of psychoanalytic ego psychology for the development of a therapeutic focus during the early phase of treatment. Techniques for handling initial resistances are illustrated by case material from both students and instructor.

102 The Theory of Psychoanalytic Psychotherapy II: This seminar examines Freud's development of the structural theory as the basis for later ego psychology, and his reformulation of the theory of anxiety with its profound impact on psychoanalysis. It also continues the investigation of the theory of dreams started in the previous semester.

103 Introduction To Ego Psychology: This seminar shows how developmental ego psychology of both normal and abnormal states is clarified by the contributions of Anna Freud, Hartmann, Kris, Lowenstein, Jacobson, Mahler, Brenner, Spitz and others.

200 The Clinical Theory of Psychoanalytic Psychotherapy: This course focuses on how conflict, compromise formation and object relations impact on psychic structure and how interventions and interpretations in psychotherapy lead to healthy changes in patients.

201 Clinical Case Seminar: Students and instructor present clinical case material relevant to the theoretical issues under consideration in Seminar 200.

202 Diagnosis From A Developmental Point of View: Anna Freud's diagnostic profile and its elaboration by G. & R. Blanck as a guide to treatment planning, provides a framework for this course. There is a detailed consideration of such basic diagnostic constellations as hysteria, obsessional neurosis and depression.

203 Clinical Case Seminar in Diagnosis and Treatment Planning: Students present case material relevant to Seminar 202.

301 The Theory of Technique of Psychoanalytic Psychotherapy: The theories of transference, countertransference, enactment, and resistance as applied to the technique of psychoanalytic psychotherapy are taught. The contributions of G. & R. Blanck regarding technique is considered in depth.

302 Clinical Case Seminar: Students present case material relevant to treating the more structured patient.

303 Techniques in The Less Structured Patient: This seminar focuses on the theory and technique of treating the more severe pathologies including the narcissistic disorders. The contributions of G. & R. Blanck, Kernberg, Kohut, A. Reich, Shengold, E. Jacobson, J. & K. Novick to technique are discussed.

304 Clinical Case Seminar: Students present case material relevant to treating the more disturbed patient.

400 Case Presentation Seminar: The seminar is offered to those third year students who wish to formally prepare for presentation of cases. This course is optional and is given in the spring semester of the third year, time and place to be announced. No fee.

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