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AN OPTIMISTIC FUTURE FOR PSYCHOANALYTIC EDUCATION:
HOW OUR STUDENTS DEMONSTRATE THAT THEY “GET IT”
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What does a psychoanalyst do when she realizes she is in the throes of a resistance? Analyze! Analyze! Analyze! My paper on how do we know when students “get it” is about how to treat the narcissistic, preoedipal patient and is from my longer paper in the *Journal Modern Psychoanalysis*, 2004.¹² That paper offers seven relevant points on how we train all students. But I also discovered a parallel process in the writing of this paper.

In keeping with this realization I came to see that the process of distilling a 25-page paper into a 15-minute talk is a bit like helping students in the training process to become psychoanalysts by truly listening to the patient, and learning to talk and offer interventions when appropriate while having many induced thoughts and feelings, as we silently study transference and resistance.

Now similar to the students’ need in the courses I taught was my need for a good supervisor. I was lucky and found one in Carmela Perez, who gently and persistently guided me toward limiting my paper and hence my words, just as I worked toward the same goal with my students and their patients in the courses I taught at the Academy of Clinical and Applied Psychoanalysis (ACAP) and The Center for Modern Psychoanalytic Studies (CMPS).

¹ An earlier version of this paper was published in *Modern Psychoanalysis*, Vol 29 (2004), as Understanding the fieldwork experience: How do we know when students “Get It” about narcissism?

² Pumilia, M., and Zaretsky, S. (Spring, 2004). *Externship Manual for the Paper and Presentation*. The Academy of Clinical and Applied Psychoanalysis. Unpublished.

Carmela instinctively was considering the contact function (Spotnitz, 2004), which involved following my lead in whether I needed some input from her. And because she did not intrude and made infrequent but interested comments, I became aware that I was having a resistance, a to finishing my paper and the necessity of “cutting my production.” Now whether this was an object-oriented resistance to the conference or more a narcissistic one, I have not fully deciphered. Was I more alone in the room, feeling at one with my paper and not wanting intrusion, was I a twin of my paper, or was I in a more oedipal state, dealing with some anal or genital issues around the directives of the conference? How did my destructive impulsivity and my libidinal impulses shape these personal blocks?

Was this dynamic why I was struggling so with writing a 7-page paper? Thus I began to understand my defenses in this process as well as the symbolic and unconscious meaning of “cutting my paper.” Was I immersed in a repetition from my past from the first couple of years of life or the later two to six years?

Since I was able to respond to my “supervisor” I also became interested in my fellow panelists. In the course of the conference, I hope to interact successfully with my “classmates” today as we listen and learn from each other, in spite of the arousal of all our impulses, and I look forward to hearing from you if I say anything that has a negative effect.

So now you have actually heard the seven criteria, benchmarks of how to determine if the student has acquired some of the skills useful to the treatment of all patients. Let me review them.

1. The student's observation of the contact function, based on the idea that the patient knows the amount of input, words, or stimulation he can tolerate and teaches the therapist this by how he withdraws or approaches the therapist with questions and/ or enactments. The goal is for the student to learn to follow the patient's contacts, i.e. questioning of the therapist, in opposition to reacting as a result of his or her own discomfort by talking too much and perhaps over stimulating the patient.

2. The student's interventions will be based upon the student therapist's responses to the patient and awareness of whether the patient is seen as in an objectless state, with a slight awareness of the other, seeking a mirror, or operating on an object-related level. Another important aspect of the student analyst's interventions is whether he is busy thinking about the patient life outside the room issues "or remaining in the moment and thinking of the transference. Using variations in technique to resolving resistances to personality maturation is emphasized by the modern psychoanalyst externship experience (CMPS Bulletin, 2005).

3. The student's defenses and reactions to those defenses. Can the student at a more advanced level illustrate an ability to tolerate and describe emotional reactions to the patient and feel, for example, non-existent, inadequate, incompetent, hopeless, rageful and passionate yet stay with the patient's feelings, however empty, indifferent, seductive, rageful, horrible, and primitive?

4. How the student becomes aware of the patient's symbolic and unconscious and non-verbal communications. In this criteria the student begins to make inferences about the patient's manifest and verbal communications, as well as in symbolic, non-verbal unconscious communications, representing character defenses, unconscious conflicts.

5. The student's reactions to the patient and an understanding of those reactions guide the student becoming aware of countertransference and whether the patient's budding transference is a narcissistic or object one. The induced countertransference and respect for the induction of emotional reactions between analyst and analysand is accepted as a clinical tool (Spotnitz, 1976). Is the student able to describe the primitive feelings and impulses aroused by the patient or simply become immersed in them? Thus the student examines the transference repetitions to include not only Oedipal experiences but also those from the first years of life.

6. The student's reaction to supervision. Is the student able to accept and make use of supervision to convey a full picture of the case? The ultimate goal is to have the student demonstrate curiosity about the patient sharing that with the supervisor.

7. Last is the student's interaction with classmates. Is there interaction with classmates in a flexible, nondefensive manner? Has the student resolved consistently self-attacking or self-aggrandizing styles and moved toward constructive communications to help colleagues?

So in preparing for today I experienced what I think we help our students experience: frustration and learning in a model for a growing ability to limit ourselves and our own talking for the good of the patient. And maybe this goal is similar in a parallel process in our work together today toward building a community of psychoanalysts from all different ideologies and schools. In the silence the student hears the patient and studies transference, resistances, and countertransference reactions that are so essential to the psychoanalytic practice.

For most students whether from mental health professions or those from other fields, this proves to be a watershed experience in their training, deepening their understanding of how to be with all patients syntonically.

The importance of this aspect of the training at my two institutes ACAP and CMPS is essential to understand. Only after a number of courses and participation in one's own psychoanalysis can a certificate student opt to begin the exciting and often-dreaded fieldwork. During this introductory clinical phase of training, students experience the reality of being with regressed individuals in a protected mental health environment in either a mental hospital or a day treatment program.

I have a couple of vignettes to illustrate these overlapping criteria.

As an example of how the student's interventions became more shaped by an understanding of the transference let me describe the work of Mrs. D.

A patient in a fieldwork placement began talking about the fact that the counseling facility was planning to throw him out. Operating more from her social work background, Mrs. D, the therapist, knew this was not true. She tried to reassure the patient. But she began to hear his fear as a projection and even a wish, and developed an intervention that took into account that the transference was all that mattered. Instead of helping him with his reality, she then wondered with the patient whether he could keep his appointments with her, even if he did not remain in the program. This was a joining technique accepting the patient perception. She was able to do this while feeling totally irrelevant and unimportant to this patient. Related to this intervention was her awareness of the withdrawn state of the patient and how she was induced to respond in kind. While she was "in the transference," she was truly understanding what it means to be "alone in

the room” with a patient. She noted how earlier in her training she could not describe the state with a patient except to characterize it as “just some very uncomfortable alone feelings.” Now she has words for the situation and feels alone in the room as if she does not exist. But she is also able to feel that state, but continue to think about the transference.

Another example might be the student’s growing awareness of the patient’s symbolic and unconscious verbal and non-verbal communications that became the induced countertransference.

A student noted that after sessions in a placement she felt dirty and had to go wash herself and even wanted to brush her teeth. After months of this pattern, she suddenly became aware that this reaction followed the session with Mr. F. who dressed immaculately and talked obsessively, discussing it in supervision, she became aware of what might be the patient’s message about himself as an induction in the therapist. She developed a hypothesis that there was something “dirty” and “disgusting” about him that the patient had been expressing through the therapist’s reaction.

It would seem in looking back at the seven criteria we are observing the therapist developing an ability to step back from reactions to the patient and talk about the experience in an emotionally relevant fashion. It may, in fact, be this ability to be in the moment—to pause and talk about the experience—that is the essential indication that our students are more fully understanding the patient in a psychoanalytic framework. So when Spitz (1976) described the goal of treatment as helping the patient to resolve resistances to “saying everything,” he is also describing the process of psychoanalytic education, where the teacher and supervisors help students resolve their resistances to

saying everything about the patient with goal of helping the patient do the same with the therapist.

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