

# Psychoanalytic Education in 2008: Deepening the Treatment

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Those of you in analytic training have a lot to think about in today's world. The market place continues to change due to both the insurance industry (particularly managed care) and due to society's wish for fast cures. But the wish on your part to understand people and what makes them tick is really a calling. A calling, in my mind, is a pull that tugs strongly at your heartstrings – that keeps you going – no matter what. So, I salute all of you for your dedication. And I applaud all of you for following your hearts.

Psychoanalytic education is more exciting than ever; the study of human development is richer and the knowledge already available from the study of genetics is mind boggling. Neuroscientists are proving that our work does affect the brain, but psychoanalysts know that nature is only part of the situation. The human being is no longer seen as a closed system at the mercy of drives, and that relationships can move mountains. Nurture and the quality of attachment play most important roles throughout developmental stages (infancy, toddlerhood, adolescence, parenthood<sup>2</sup> and analysis) and impact each of our lives.

The psychoanalyst is the one person equipped to understand, tolerate, empathize, interpret, confront – and with the patient's partnership revisit, remold, refine, redevelop, and redress the past's influence on how we perceive the present. Tolerance, respect for differences, the ability to live and love deeply are achievements we all strive for throughout life. Understanding each other allows us to empathize rather than criticize.

Learning about development, transference, countertransference; understanding resistance, enactment, and acting out; experiencing the complexity of object relations; identifying drive derivatives; exploring motivation and what impedes it; dealing with crippling defenses; respecting adaptive defenses; learning how fantasy interacts and often shades reality – all these things and more become part of your repertoire.

The richness of psychoanalytic education is unparalleled – especially today as neuroscience proves that the mind, the brain, is influenced by our connection with the outside. Our earliest experiences – and even prenatal

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<sup>2</sup> Benedek, T. (1959). Parenthood as a Developmental Phase - A Contribution to the Libido Theory. Journal of the American Psychoanalytic Association, 7: 389-417.

experiences affect our brains in individual ways, forming our characters and who we are. The plasticity of the brain, now proven, means that old habits and ways of thinking can be modified, altered and changed.<sup>3</sup> The idea of a two-person psychology is here: the analyst is no longer a blank screen, the interaction is to be paid exquisite attention to, and the transference and countertransference include the dyad's own past and present issues in a new and unique relationship that becomes the motor of our work. The term co-transference is being explored. Melanie Klein, Bion, Kohut, Mitchell, and Lacan (to name a few) are inspiring us. Psychoanalytic thought, theory, and work are alive and growing.

The concept of "unanalyzability" is being challenged and as Rothstein has said, it is often the therapist's countertransference that blocks the patient's chances by influencing the diagnosis<sup>4</sup>. (By the way, diagnosis, according to Anna Freud, is not possible until the end of treatment.<sup>5</sup>) Ego psychology is no longer the only game in town. Self psychology and relational theory are contenders. Models of education are also being debated. The French and Uruguyan models are now accepted by the IPA.

But today I want to talk about the analyst's motivation, confidence, and willingness to take the long, never ending road to exploring the human psyche.

Psychoanalytic work – whether called analysis or therapy (actually analysis is a form of therapy) – is a journey, and there are more potential travelers than we can imagine. Everyone wants a second chance and those who cross your thresholds, whether in a clinic, hospital, or private office deserve that second chance. Even people who are mandated to get therapy want a second chance. Never underestimate the motivation of someone who crosses your threshold.

Now, most patients do not come to you, throw themselves on the couch everyday of the work week, free associate, tell you their dreams, and accept your wise interpretations. The skill today lies in selling what you do. Selling involves showing the patient that your slant on whatever he or she says makes sense and is useful. And herein lays a major challenge. You, who have begun the journey, will begin to realize, as you gain confidence and conviction about your own work, that there are indeed enough patients. We must continue to learn about the widening scope patients – those patients who without analysis will remain lost. Analysis today usually begins as psychotherapy – some people even refer to it as counseling which implies direction. Your job is to explain that direction will come through understanding and that understanding takes time. Attunement during the first meeting, however,

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<sup>3</sup> Doidge, Norman (2007). The Brain That Changes Itself: Stories of Personal Triumph From the Frontiers of Science. New York: Viking Press.

<sup>4</sup> Rothstein, A. (1995). Psychoanalytic Technique and the Creation of Analytic Patients. Madison CT: IUP.

<sup>5</sup> Freud, A., Nagera, H., and Freud, W. E. (1965). Metapsychological Assessment of the Adult Personality-The Adult Profile. Psychoanalytic Study of the Child, 20: 9-41.

enables you to connect and contribute something of value – even if it is a new way of listening.

Analysis is the journey of a lifetime, and it is up to us analysts to convey that message. The art of conveying that message is a unique skill that you get better and better at as you go along the road.

The road is bumpy, sometimes treacherous, dangerous, beautiful, enchanting, and tedious. Both travelers get exhausted, invigorated, helpless, enthused, overwhelmed, and hopeful. The trip goes on for years – changing both travelers in lasting and impressive ways. Even when analytic work seems to fail and patients quit – there are gains that have been made.

So you need to make your own journey first. You need to have the kind of partner whom you can trust with your deepest secrets, fears, hopes, horrors, hates, loves, all passionately and with all the normal and natural resistances that your patients will feel. Your trip will help you understand how much we each cherish the status quo – and how deeply we fear change.

When abuse has been experienced, and who has not experienced some form of abuse, either physical, emotional, unintentional, or unexplainable, tiptoeing into treatment is not unusual. In fact we all tiptoe to some degree into a trusting relationship. Severe and ongoing abuse demands our utmost patience, our strength, our fortitude in heroic proportions. These patients deserve help and their traumatic histories are clung to like life support.<sup>6 7</sup>

### **Making the Shift**

Before discussing how, when and why psychotherapy deepens into the most intensive form of treatment, psychoanalysis, it is important to examine the differences between the two to see if there is in fact a definable, recognizable line of demarcation. Historically, psychotherapy has been viewed as problem or symptom centered while psychoanalysis is concerned with the whole person. The goal of psychotherapy was seen as symptom relief, and the goal of psychoanalysis was a total reorganization of personality through analysis of character problems. Techniques used in psychotherapy were said to include suggestion, abreaction, clarification, and manipulation, while the techniques of psychoanalysis were limited to analysis of the transference and the resistance leading to insight through interpretation. It is recognized more and more that each of these techniques is used in both forms of treatment at different times.

Conservative analysts who maintain that there is a clear difference between psychoanalytic psychotherapy and psychoanalysis and assess a patient's "analyzability" to determine the appropriate form of treatment have

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<sup>6</sup> Shengold, Leonard (1989). *Soul Murder*. New Haven: Yale University Press.

<sup>7</sup> Hall, Jane S. (2004). Attachment to Abuse. In *Roadblocks on the Journey of Psychotherapy* (pp. 125-157). NY: Jason Aronson.

been challenged. Gediman<sup>8</sup>, in an excellent discussion of the transition from psychotherapy to psychoanalysis, states her conviction *“that practically speaking analyzability is often, if not always, an emergent phenomenon, dependent on conducting psychoanalytic psychotherapy within the bounds of the basic treatment model.”*

In 1988 Merton Gill<sup>9</sup> wrote: *“The question of converting psychotherapy into psychoanalysis should rarely arise in the practice of a psychoanalyst because he should be almost always practicing psychoanalysis.”* Rothstein<sup>10</sup> believes that *“a trial of analysis is the optimal treatment for most people who seek analysts’ help regardless of the presenting manifestations of their difficulties.”*

I will define analysis as a form of psychotherapy in which the patient is permitted to examine the origins and roots of conflict and fantasy by experiencing them as they come alive in the present with the analyst and others as transference objects. Although this can and does happen in psychotherapy, the frequency of analysis (four to five times a week) allows for a more intense experience and for deeper exploration and understanding. The permission to undergo a regressive transference neurosis is given by the analyst’s posture of empathic abstinence, neutrality (not taking sides whenever possible), and benevolent curiosity. (I qualify the term abstinence with the word empathic because analysts have a stereotypical reputation as being emotionally unresponsive and silent). The analyst’s position of not gratifying the patient’s transference wishes (abstinence) can be explained to the patient in a respectful, empathic manner thereby enlightening and not injuring the patient. An empathic manner does not preclude the patient’s expression of anger and other regressive phenomena, but it does go far in treating the patient with respect. Interpretation is the analyst’s major intervention in working with the patient but this does not preclude explanation – especially in the beginning of treatment. Also, the analyst’s interpretative stance must eventually be joined and finally replaced by the analysand’s ability to interpret what goes on, or isn’t going on.

Things that interfere with and skew the normal development of the transference have to do with the analyst ceasing to behave in neutral and non-judgmental ways. This neutral stance does not make the analyst a ‘blank screen’ or merely a mirror. Neutrality has more to do with not taking sides and with respecting a patient’s autonomy. Everything about the analyst that the patient notices or imagines makes her an object of interest and of transference. The way she looks, the way the office looks, the sound of her voice, the things

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<sup>8</sup> Gediman, H. (1991). On the transition from psychotherapy to psychoanalysis with the same analyst: In *Psychoanalytic Reflections on Current Issues*, ed. H.B. Siegel, L. Barnbel, I Hirsch, et al, pp 177-196: New York: NYU Press.

<sup>9</sup> Gill, M.M. (1988). Converting Psychotherapy Into Psychoanalysis. *Contemp. Psychoanal.*, 24:262-274.

<sup>10</sup> Rothstein, op.cit.

she chooses to comment on make her a person, however true or distorted the perceptions of her become. The tendency to make a 'new' person like an 'old' person is ubiquitous and it is this ability to transfer old feelings onto new experiences that makes analytic work possible. This tendency occurs in psychotherapy but the frequency of analysis, along with the use of the couch, make it easier to stay with and develop transference phenomena. The frequency also permits most patients to become aware of and to explore fantasy.

In an important paper Brian Bird<sup>11</sup> speaks of transference as "*a universal mental function which may well be the basis of all human relationships.*" Bird goes on to propose that transference be considered a major ego function "*giving birth to new ideas, and new life to old ones.*"

Transference will develop automatically. How the transference is used is the major difference between psychotherapy and psychoanalysis. In psychotherapy, often conducted once or twice-a-week, the patient's transference feelings do not usually reach the crescendo heard in the everyday work of analysis (although they may). Also, some disturbed patients are not initially willing and able to experience the analyst as separate enough to absorb or understand object-related interpretations. In analysis the intensity of feeling is allowed to escalate and to go on for longer periods of time because the frequency of sessions permits the patient to tolerate the discomfort involved. Once or twice-a-week therapy is not usually enough to contain the anxiety caused by intense transference experiences. One reason that some once or twice-a-week treatments end prematurely is that the transference fantasies are stifled and consciously avoided by the patient and left unexplored by the therapist.

If the analyst is convinced that the journey inward is a necessary and viable one, and if she feels the match or fit is potentially a good one, it becomes her responsibility to inform the patient and to act as guide and companion. Clearing the way for travel is the analyst/guide's most important job. The other trips she has taken (her own being the most important) prepare her for rigorous travel. This travel experience teaches her that the ability to stay out of the way requires attention and practice. The analyst's tendency to want a more active, larger role must be fought constantly and regularly. Many actors define a good director as one who brings out the best they have to offer in the particular role they are playing. The analyst plays all roles in her life drama and the analyst, like the good director, lets the best emerge. By 'the best' I mean the multileveled aspects of all self and object representations, of all object relationships, of all emotions, of all instincts, and of all agencies of the mind.

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<sup>11</sup> Bird, Brian (1972). Notes on Transference: Universal Phenomenon and Hardest Part of Analysis. *JAPA*, 20:267-301

Using these analogies I envision psychoanalytic psychotherapy as the first leg of a journey that may or may not become analysis. Before a patient makes her first appointment there are transference fantasies and fantasies of cure. When coming once or twice-a-week these fantasies and thoughts about the therapy and the therapist continue. These beginning thoughts can be understood as preliminary exercises that strengthen the muscles and motivation needed for traveling. The beginning phase of psychotherapy can be likened to early 'skit' rehearsals. Whether or not the work deepens into the full-length drama of psychoanalysis 'proper' depends on both parties. In my experience supervising others, and monitoring my own work, I keep my eye on the analyst's stamina, perseverance, and conviction, both conscious and unconscious, and the patient's evolving ability to be curious, to trust, and to explore. Many patients do well in twice a week psychotherapy and I do not mean in any way to elevate psychoanalysis as a superior form of treatment. In fact, I believe, based on my experience, that psychoanalytic work is always done by the analytically informed psychotherapist.

If the therapist keeps sweeping away the obstacles (analyzing the resistance) the patient will frequently find the trip plausible, possible, and worth taking. Many obstacles and fears have to do with trust. If they are understood as appropriate by the therapist, and not judged as enactment resistances meant to frustrate the analyst<sup>12</sup>, these obstacles and fears diminish. Seeing such disinclinations on the patient's part to plunge into analysis immediately purely as resistance puts a pejorative slant on things and can result in a power struggle. Resistance is a natural response to beginning the journey inward. The patient who begins analysis to please the analyst is far more likely to come to a standstill later in treatment. This is one reason that so many analysts seek a personally motivated analysis when their required training analysis is completed. Seeking second and third analyses does not mean that the former treatments were not good enough or even lacking. As people mature, the journey inward is taken for different reasons and with different capacities. Also, the difference in match often provides new opportunities for understanding. Sites already visited are seen in new and different ways.

The main point here is that psychoanalytic work is not just *like* a journey. It *is* a journey. If the therapist stays out of the way and addresses the obstacles in the way, the work deepens naturally. The recent debate about if, when, and how the analyst uses herself in relating to the patient is interesting and complex. It goes without saying that the analyst uses her own experiences and her own transference feelings to understand and to communicate effectively with the patient. If and when she shares her personal experience with the patient (self-disclosure) is a subtle question that defies rules because just as each patient is unique, so is each analyst. Two people working together over a long period of time develop their own style of communicating which falls

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<sup>12</sup> Rothstein, op.cit.

under the heading of ‘match’ or ‘fit.’ If a patient can use the analyst’s sharing of a personal communication to deepen her understanding both parties will know it. If the patient responds poorly to the analyst’s self revelation, something is learned. The analyst’s intuition and style along with her sense of the patient determine if and when she discloses something personal. Some analysts seem most comfortable sharing their personal experience when they feel it would further the work while other analysts are by nature more private. Different analysts have different styles. One analyst might feel that sharing a personal experience will further the analytic process while another believes the process is furthered without self-disclosure. Many patients become secure only when they can count on the analyst not answering questions. Metaphors are shared as well as analyzed. Humor unique to the dyad is used. Silences take on different meanings during a course of treatment. Intimacy grows over time regardless of self-disclosure on the analyst’s part. Essentially, timing is an important element. As the years go by the therapeutic dyad increases its frame of reference.

For different reasons at different times the treatment of psychoanalysis has been reserved for only those people who are considered ‘neurotic.’ It is now recognized by many clinicians that analysis is the treatment of choice for the most troubled patient. I am speaking of people who have often been considered ‘not appropriate’ for analysis by many of the traditional analysts who have been practicing for many years and who have taught and still teach at the major analytic institutes in the United States. Leo Stone’s important paper<sup>13</sup> has done a great deal to educate analysts to see that psychoanalysis is appropriate and necessary for a wide variety of people. Phyllis Greenacre<sup>14</sup> spoke of the long working through process required when there has been early trauma. Hans Loewald<sup>15</sup> discussed the therapeutic action of analysis with patient’s who exhibit defective egos. Michael Pordor<sup>16</sup> sees analysis as necessary for the most “so called” borderline patient. Also it has become clear that the perception of analyzability is different in England and South America where many patients, according to the literature and meetings I have attended, seem to be ‘less structured’ than the so called ‘classic neurotic’ (if indeed there is such a thing.)

My clinical experience as a training and supervising analyst at two institutes has taught me that the more disturbed patient usually can benefit most from intensive psychoanalytic work. Even patients who have psychotic episodes are treatable in analysis. Many sophisticated, seasoned, erudite analysts, both in the past and today, like Edith Jacobson, Sheldon Bach, and

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<sup>13</sup> Stone, Leo (1954). The Widening Scope of Indications for Psychoanalysis. Journal of the American Psychoanalytic Association, 2: 567-594.

<sup>14</sup> Greenacre, P. (1956). Re-evaluation of the process of working through. International Journal of Psychoanalysis, 37:439-444.

<sup>15</sup> Loewald, H. (1960). On the therapeutic action of psychoanalysis. International Journal of Psychoanalysis, 41:16-33

<sup>16</sup> Pordor, M. (1990) On beginning analysis with borderline patients. In T. Jacobs and A. Rothstein (Eds.), On Beginning an Analysis (pp 163-178). Madison CT. IUP

Peter Giovacchini to name only a few, have been analyzing these patients for years but for some reason the traditional, conservative view that analysis is meant only for the 'neurotic' seems to prevail.

As candidates you are learning about different pathologies, diagnostic categories, and assessment techniques that measure whether the patient is suitable for analysis. We tend to forget that the question of suitability also pertains to us as the analysts. The so-called analyzable patient does not depend on a diagnosis of 'neurotic' as opposed to 'borderline' or even psychotic. Often the most neurotic are the most immovable – and the 'so called borderlines' are flexible and amenable to in depth work. The couch is often helpful to patients. I question the received wisdom that using the couch qualifies whether analysis is being done. Each patient is unique and although analysts usually feel more comfortable when the patient uses the couch, the patient's comfort is equally important. I have also seen patients coming twice a week who do well on the couch as it frees them and usually serves to deepen the work.

Now, I would like to talk about benevolent curiosity – a term I borrow from Ella Sharpe<sup>17</sup>, a psychoanalyst (originally an English professor) from London – many years ago. She wrote:

*The fundamental interest of a would-be technician must be in people's lives and thoughts. The dross of the infantile super-ego in that fundamental interest must by analysis be purged. The urgency to reform, to correct, to make different, motivates the task of a reformer or educator. The urgency to cure motivates the physician. A deep-seated interest in people's lives and thoughts must in a psycho-analyst have been transformed into an insatiable curiosity which, while having its recognizable unconscious roots, is free in consciousness to range over every field of human experience and activity, free to recognize every unconscious impulse, with only one urgency, namely, a desire to know more and still more about the psychical mechanism involved. .... When we come to a habit of thought, a type of experience, to which we reply: 'I cannot understand how a person can think like that or behave like this,' then we cease to be clinicians. Curiosity has ceased to be benevolent." (my underlining)*

Two chapters in Sharpe's collection – "The Analyst"; and "The Analysand" – are basic reading for anyone who practices psychoanalytically oriented psychotherapy and psychoanalysis.

Benevolent curiosity comes easier to some than to others, and easier to practice with certain patients than others. But, if we keep it as the most important stance to strive for, we can interest the patient in deepening the treatment. One reason is that patients, over time, see therapists as non-

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<sup>17</sup> Sharpe, Ella (1950). Collected Papers on Psychoanalysis. London: Hogarth Press.

judgmental and worthy of their trust. Another reason is that through identifying with the analytic attitude patients become less critical and more curious. In fact, if there is one thing that engages patients in looking inside it is the ability to be benevolently curious about themselves. The therapist's spirit of inquiry is what makes analytic work possible.

The therapist's attitude of respect, patience and benevolent curiosity combined with her confidence in the analytic process is what impresses the patient and permits her to stay in treatment. The persistent durability and constancy of the therapist and her functions presents the patient with a new reality, one which holds the potential for reviewing and experiencing the calamities of life in a new way. Differentiation becomes safe. Separations become bearable. Competition becomes acceptable. Feelings of effectiveness become more rewarding than feelings of omnipotence and grandiosity. Experiences of success and failure can exist side by side and do not cancel each other out. Closeness and intimacy become possible.

How do we set the stage for the deeper work that needs to be done? How do we create a safe environment? How do we pass the tests?

1. By having an inner conviction that each person has a unique story to tell, and respecting his or her way of relating it.
2. By listening carefully and following what the patient says attentively so that we can make connections and interpretations when appropriate.
3. By being confident that the long-term process of working through is necessary and possible for the patient to resume development and diminish conflict.
4. By being non-judgmental, non-intrusive and open-minded.
5. By listening for strength as well as for pathology, and not letting premature diagnoses or diagnostic labels cloud the picture.
6. By being respectful of the patient's pace and autonomy.
7. By being firm or flexible when appropriate, and learning how to know when to be which.
8. By listening with respect, and by being comfortable not knowing the answers — or even the questions sometimes.
9. By encouraging and protecting the patient's curiosity and capacity for self-reflection.
10. By not burdening the patient with personal information and opinions unless such self-disclosure has a definite purpose.
11. By remembering that no two cases are alike and that each patient creates her own theory (not fitting the patient into the theory).

12. By setting the conditions of treatment such as fee, payment, vacation policy, and missed session policy in the consultation phase so as to clear the way for work without distraction.
13. By remembering that growth and not cure is the goal.
14. By being consistent, reliable, compassionate, calm, and benevolently curious.
15. By providing an atmosphere of trust, safety and confidentiality.

In summary, I want to compare your educations with mine, and offer a few tips in terms of the atmospheres of learning.

I 'trained' from 1974 to 1982. At my institute, the name Melanie Klein was a no-no. Orthodoxy reigned and ego psychology was the only theory. Times have changed radically – at least I hope so. I encourage each of you to read as much as possible – not just the old masters (I grew up on Fenichel, Glover, Waedler, and of course Freud). Do not be afraid to ask challenging questions of your teachers and supervisors. Remember that candidate fear is the greatest danger in being educated (refer to your 'training' as education because it is a more dignified term (seals get trained). Read Jurgen Reeder's book. Get involved and remember YOU ARE ADULTS. Do not be infantilized. You are the future of this profession and your commonsense must never be undervalued – by you or anyone else.