# TOWARD A DEFINITION OF PSYCHOANALYTIC PSYCHOTHERAPY

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I am grateful to the members of the Planning Committee for having inserted the word "toward" in the title of this symposium, i.e., "Toward a Definition of Psychoanalytic Psychotherapy." According to Webster's dictionary, the word "definition" has several meanings, two of which concern us here. In one sense, the term signifies what a word or phrase means. What psychoanalytic psychotherapy means to me, its nature and characteristics -- that I am prepared to state. But there is another meaning, more complex and challenging, one that will certainly stimulate controversy and generate uncertainty. According to this meaning, "definition" consists of setting limits and marking boundaries. In this respect, it may be safe to say in advance that we will do well to move toward a definition, even if we do not necessarily move together.

While reviewing some of the literature in preparation for this panel, I observed how regularly previous publications refer to the uncertainty and obscurity surrounding the subject of psychoanalysis vs. psychoanalytic psychotherapy. Between 1947 and 1954, there appeared many articles and reports by committees of the American Psychoanalytic Association, as well as summaries of panels dealing with the similarities and differences between these two disciplines. A committee of the American Psychoanalytic Association, set up in 1947, worked for several years but could not arrive at any agreement as to what constitutes psychoanalysis, psychoanalytic therapy and possibly transitional forms. In those days the controversy

was limited almost exclusively to the confines of organized psychoanalysis. It arose in response to certain modifications in the approach to analytic technique proposed by Franz Alexander and other members of the Chicago school. Alexander (    ) believed that the technical goal of psychoanalysis could be modified in a limited way so as to concentrate on relief of symptoms or on partial character change. In keeping with this altered goal were certain technical modifications and alterations. The patient could be seen only once or twice a week instead of four of five times, and instead of lying down he could sit up. The analysis of childhood experiences could be treated as of lesser significance, while the interpretive effort could be directed to particular conflicts. While transference manifestations could be noted, the development of a full transference neurosis might be discouraged. According to Alexander, "The basic feature of psychoanalysis, that is, confronting the ego with repressed conflicts and resolution of them by means of working through, would be present regardless of the degree to which other technical elements are utilized." There are crucial questions as to whether the technical innovations proposed could be made to achieve the ends intended -- for example, is it really possible to curb or limit the development of the transference neurosis, can one permit transference phenomena to be disregarded, to remain uninterpreted with impunity? -- but, leaving such questions aside, the principle of the revisionists was clear. They intended to make psychoanalysis more like psychoanalytic psychotherapy. Today the situation is quite different. Not only are fewer people prepared to undertake complete psychoanalysis as a form of therapy; fewer practitioners want to or deem it necessary to undertake complete psychoanalytic training and to practice this technique along

what may be called classical lines. Nowadays the thrust seems to be how to make psychotherapy more psychoanalytic.

In his introduction to Aichorn's Wayward Youth, Freud ( ) said, "The possibility of analytic influence rests upon quite definite preconditions which can be summed up under the term analytic situation. It requires the development of certain psychical structures and a particular attitude to the analyst. Where these are lacking...something other than analysis must be employed, though something which will be at one with analysis in its purpose." The analytic situation is, of course, the sine qua non of psychoanalytic technique. Its essence consists of establishing a set of conditions that will facilitate the emergence into consciousness of derivatives of unconscious conflicts, derivatives untainted, as far as possible, by exogenous influences. The recumbent position, the regularity of appointments, the schedule and terms of fees and the neutrality of the analyst are all essential components operating toward this technical goal. The essential vehicle of psychoanalytic treatment, according to Gill (1954), is a technique employed by neutral analysts which results in a regressive transference neurosis which is resolved by techniques of interpretation alone. The methodology of psychoanalytic technique derives from a number of basic assumptions and established principles. These are the concepts of psychic determinism and the principle that neurotic conflict and character formation, as well as most of normal psychological functioning, are the resultants of unconscious dynamic conflicts that generate modes of defense and alleviation or resolution of conflict by compromise formations. The genetic approach in psychoanalysis is an empirical finding, a generalization

of observations, repetitively confirmed in individual psychoanalytic experiences.

In psychoanalytic psychotherapy, the principles of psychoanalytic psychology outlined above are employed for purposes of modification of patterns of defense and compromise, leading to alleviation of symptoms and/or character formation, and involving three types of changes in the analytic process: (1) a tendency to curtail the spontaneous productions of the patient. This leads either to a neglect of unconscious motivation or a failure to understand such motivation; (2) the minimization of interpretive work in favor of manipulative interventions, that is, relying less on insight achieved by the patient through verbalization and working through than on improvement based on transference, educational procedures, model projections or corrective emotional experiences; and (3) departures from the structure of the analytic situation to the degree that the conditions of the therapeutic interaction interfere with the emergence of an analyzable transference or its resolution by interpretation. In this connection, Gill (1954) warns against ridiculous adherence to ritualistic details, against an undue emphasis on certain mechanical aspects of the analytic situation. He points out that sometimes more analysis goes on when the therapist is seeing a patient three times a week, sitting up, than in cases where the analyst sees a patient five times a week with the patient lying down. These are only the outward trappings of the analytic situation. The attitude of the analyst toward the patient -- his neutrality -- and the attitude of the analyst toward his own reactions -- his persistent pursuit of the truth in an objective manner -- these are

the important factors.

When events in the therapeutic interaction make it impossible for the patient, in his thoughts, fantasies and behavior, to distinguish between those elements in his relationship to the therapist that reflect the effects of persistent unconscious conflicts from childhood and those elements which are realistic consequences of interaction between him and his therapist, either inside or outside of the analytic situation, then psychoanalysis as a technical procedure is no longer possible. This is one of the principal technical difficulties confronting the psychoanalytic psychotherapist. The modifications of technical procedure and clinical setting introduced for purposes of psychoanalytic psychotherapy render the formation of an analyzable transference neurosis very difficult and its ultimate resolution practically impossible. The main difference, it seems to me, revolves about those procedures which interfere with the neutrality of the analyst. Neutrality does not mean mechanical rigidity of behavior with an effort to suppress any spontaneous response. The analyst will have his responses but his attitude toward them is the distinguishing feature of the truly analytic approach. The response of the analyst is a cue pointing the way toward a merging apprehension of the patient's conflicts.

Keeping problems of transference uppermost in his mind, the analyst follows the rule of abstinence, namely, he does not gratify transference wishes, whether they are manifestations of positive or negative transference. It becomes a matter of tact and sensitivity to the analytic situation, under special circumstances, for the analyst to make certain minimal departures from this rule, either by permitting the patient to abandon the

recumbent position or by confirming a patient's guess about some action of the analyst during the session. This abandonment of a small area of the analyst's anonymity under special circumstances, as Loewenstein (1958) pointed out, may have a positive effect on the analysis of the transference.

In summary, we may regard as psychoanalytic psychotherapy those forms of psychotherapy that are based upon analytic principles, using the concept of psychic determinism, unconscious conflict over persistent, dynamically active, childhood instinctual wishes, the modes of defense and the means of compromise used in dealing with them, and finally an awareness of transference phenomena together with some attempt to interpret such reactions. These are the essential features of psychoanalytic psychotherapy and, as such, constitute a "definition" of psychoanalytic psychotherapy in the first sense of the word.

The limits or boundaries of psychoanalytic psychotherapy represent quite another matter. How the individual elements of the psychoanalytic approach are emphasized, disregarded or circumvented is subject to almost infinite variation in the course of psychoanalytic psychotherapy. As Rangell (1954) noted, while almost all of the ingredients of the basic definition of psychoanalytic therapy appear to be part of dynamic psychotherapy, they all do not exist systematically and together, nor are they pursued with the same consistency and to the same degree over the long-range treatment of the patient.

Cut loose from the secure and relatively comfortable guidelines that govern the technique of psychoanalysis, the psychoanalytic psychotherapist must rely to a much greater extent than the classical

analyst upon the <u>immediate utilization</u> of his intuitively perceived insight. The total setting does not afford him the luxury and the advantage of the rich, dynamically derived validation and confirmation of insights that the analytic situation makes possible. This, however, is not always true, because so much depends on the particular style and flexibility of the therapist as he orients himself to the specifics of each individual case. If time permits, I will give a number of examples to illustrate this point. Through the years I have reached the conclusion that analytically oriented psychotherapy may be a much easier discipline for the individual who has had a rich background of experience in classical psychoanalysis than for the relative neophyte to whom most of the patients requiring psychoanalytic therapy are referred.

There are certain conditions pertaining to the historical development of psychoanalytic technique at the present stage that tend to make one or another technical procedure especially appealing to the psychoanalytic psychotherapist. Here we see the influence of the extrapolation or the elaboration of certain suggestions that were offered for improving the effectiveness of classical psychoanalytic technique. Overly emphasized and transformed to the psychoanalytic psychotherapy setting, these techniques often become the fundamental instruments of certain therapeutic procedures. In several articles, for example, Greenson ( , ) put forward the thesis that one must not only take into account the actual nature of the analyst as a real person but must also think of that factor in evaluating the therapeutic effectiveness and the planning of treatment. In the hands of some practitioners, this has been interpreted as an indication to dispel illusions which the patient has concerning the analyst by having him

sit up, by emphasizing the patient facing the therapist and looking at him for his reactions. On the opposite side of the dynamic equation, one emphasizes the fact that the analyst has feelings about the patient that grow out of the real interaction between the two. This leads to the principle of communicating these interactions which then can be examined together, in the course of which examination the patient's sense of reality is enhanced and his archaic illusions about the therapist are dispelled. He learns that the therapist is not omnipotent, that he has his own problems and has in fact been able to overcome some of them. Sharing such experiences with the patient is supposed to establish a closer bond which builds confidence and strengthens the sense of empathy and identification with the analyst. The analyst thus becomes a model for conflict solution.

Empathy, in fact, has come very much to the fore in considerations of therapeutic technique in recent publications. This factor has been emphasized in the writings of many authors, from Winnicott (     ) to Searles (     ) to Kohut (     ). Here the emphasis falls on the factor of verbal and non-verbal communication, especially fostered by the experience in childhood of facial scanning, which becomes a prototype of the primitive mirroring considered by many as a necessary step in promoting stable, healthy object relations. There is, as we know, a school of object relations theorists who hold that psychopathology represents miscarried or distorted development of object relations. Originally at fault was an unempathic, unsympathetic, non-nurturing mother. The essence of therapy is to correct this faulty development. The role of the analyst, therefore, becomes one

of helping the patient to get well by permitting development to proceed along those lines that it presumably would have followed if not for the derailing effects that followed in the train of poor mothering. Since precise reconstruction is difficult if not impossible in the psychotherapeutic situation, the therapist may often be tempted to circumvent the process of gathering data of early development, if indeed he can at all, and to substitute for it interpretations based upon phenomenological analysis of the patient's history or productions.

In discussing the therapeutic factors in classical analytical treatments, Zetzel ( ) distinguishes between the analysis of the transference and the analysis of the so-called therapeutic alliance, that is, the ability to enter into a working relationship with the therapist. Without such a working relationship, which is independent of the transference, Zetzel feels treatment is impossible. He traces the ability to trust the analyst back to the earliest confidence which the child placed in the nurturing mother, the so-called basic trust (Greenacre, ). According to Nacht (1962), the essential element of any therapeutic situation is the analyst's or therapist's real, personal feelings about his patient. The therapist's attitude must be one of unconditional kindliness, which enables him to do the right thing intuitively in every situation that arises in the patient's treatment. In terms of the recent emphasis on object relations, the analyst has to be the perfectly empathic mother. In this respect, Isakower ( ), for example, expects that with a properly functioning analytic instrument, the analyst intuitively and empathically will always come up with the correct

interpretation of the patient's mental state and productions. In effect, he too expects the analyst to function as the perfectly intuitive, empathic mother, a suggestion made by Dr. Levine of Philadelphia ( ).

Relying heavily on empathy, Searles ( ) establishes a technique which may eventuate in an approach dramatically opposite to that suggested by Nacht. In fact, many of the elements of the approach suggested by Searles seem to echo Melanie Klein's concept of projective identification as developed by some of her South American followers. In an initial interview or very early in the treatment, Searles may communicate to the patient the fact that he, the therapist, is possessed by some kind of mood or fantasy in connection with the patient and he will inquire of the patient what it is about him that makes the therapist feel that way.

All these examples illustrate one trend, namely, that by extrapolating what has been learned in the analytic situation concerning empathy and by using suggestions about changes in analytic technique based on empathy and countertransference feelings, many different and sometimes contradictory principles may be derived regarding psychoanalytic psychotherapy. Kohut ( ), for example, put empathy at the center of his theory of pathogenesis and technique. Some of his suggestions about how to deal with narcissistic transferences represent attempts to compensate in the therapeutic setting for the unempathic and inappropriate behavior on the part of the parents to the young child's burgeoning sense of grandiosity. He suggests that the therapist permit the patient to experience in the treatment what was frustrated during the development, the blissful sense of narcissistic grandiosity. If in treatment the patient projects this grandiosity onto the analyst or sees himself mirrored in the therapist's

grandeur, Kohut suggests that this vicissitude of the transference should not be dealt with, at least for some time, through interpretation. To have such an experience is an essential feature of development and up to a point therapeutic progress rests on the beneficent and existential effect of having this experience. Just how far to let this process go depends upon the intuition of the empathically attuned therapist.

What I have attempted to demonstrate in this section of my presentation is the wide range of possible psychoanalytically oriented psychotherapeutic measures based upon the emphasis, exaggeration, extrapolation, or what you will, of one or another particular or specific feature of the psychoanalytic interaction. Any one of these holds the promise of attaining some short-term technical advance in therapy. From what I have been able to observe in supervising psychotherapy as well as from reading, many of the decisions of the particular approach to use are based on a quick, intuitive grasp of the patient's situation, a condition not at all unlike that in the psychoanalytic setting. When we add to these considerations the fact that the range of psychopathology for which psychoanalytic psychotherapy is sought is so much broader and wider than the indications for psychoanalysis, we realize how staggering is the challenge to the therapist. He must perforce rely on his intuition, at the same time maintaining a firm conviction in the validity of the dynamic of the treatment situation. To what extent it is possible under such circumstances to lay down a precise set of technical procedures to be followed is very hard to say. In the same spirit, it is difficult to know in advance what goal one can set as the endpoint for therapy.

Surprises are inevitable and sometimes they are more agreeable than anticipated. Here we are dealing then with two aspects of the problem, namely, selection of patients and goals of treatment, which fortunately will form part of the discussion by the other panelists. I have purposely left open the question of correlating the method of approach and the goals of treatment with the nature of the patient's psychopathology. As you undoubtedly have noted, I rely heavily on the intuitive process in this regard. I do so advisedly, because, as I tried to indicate earlier in this presentation, while the essence of what constitutes a psychoanalytic approach to psychotherapy is communicable and definable, the boundaries and limits of the approach remain difficult to delineate.