“Further Notes on Choosing an Analyst”

Commentary on Clara Thompson, “Notes on the Psychoanalytic Significance of the Choice of Analyst”

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We are all in Robert Ursano’s debt for choosing to reprint this excellent article. Many readers will be seeing it for the first time, since Clara Thompson’s writings are no longer well known. That is a shame. Her modest tendency to mediate between conflicting analytic factions did not bring her into the limelight (Waugaman, 2014). She achieves an enviable balance in her opinions, whereas analysts who advocate more extreme positions may draw greater attention to their work. Just as when a given neuron fires, its collateral fibers suppress the activity of adjacent neurons, so do analysts—and writers in all fields—often promote their ideas by minimizing the importance of ostensibly competing authors. Further, Thompson was associated with the once marginalized interpersonal school of psychoanalysis, leading mainstream analysts not to cite her work, and perhaps not to have read it. For example, Judy Kantrowitz (1986, 1995, 2002) has written a series of valuable articles about patient-analyst match, covering some of the same ground of Thompson’s article, but without citing it. Natalie Shainess (1983), in her article about the gender of the analyst, quotes Thompson second-hand, but again without citing her article.

This early article is a gem, filled with still relevant clinical insights. For example, its final sentence admonishes us to get to know which types of patients we can and cannot treat successfully, so whenever possible we can refer the latter to more suitable colleagues instead of undertaking their treatment ourselves. Thompson examines not just
the process of patients choosing their analyst, but what can be learned about salient unconscious determinants and meanings of these choices over the subsequent course of their treatment.

Thompson begins by advocating a position that was controversial when she wrote this article, but which is now widely accepted—that the psychoanalyst is not some sort of flawless interpreting machine, but is a human being whose subjectivity inevitably influences their clinical work. This perspective remains timely, since without it we will have greater blind spots for the analyst’s contributions to unfavorable clinical outcomes. She is astute about the reticence of analysts to disclose their own feelings in their writings, especially in 1938, when this article was published. Her article sheds light on the neglected topic of the analyst’s contributions to an optimal patient-analyst match. As Thomas Szasz (1963) later pointed out, our indispensable theory of the patient’s distorted transference toward the analyst is sometimes misused by analysts to avoid accepting the patient’s realistic perceptions of the analyst—especially when they are unfavorable.

Thompson makes a crucial if humbling point when she notes that “a certain number of patients feel secure with us …because we do not disturb their neurotic patterns too much” (p. 132). All patients have conflicting wishes to change in order to feel better and make better use of their potential; and contrasting wishes to maintain their current psychological homeostasis, which has evolved over their lives as their best way of using their emotional resources to cope with life challenges. Peter Wolff (1988) generously shared his personal experience of looking for an analyst with a background similar to his. An analyst friend with whom he discussed this process “confronted me with his suspicion that I was searching for a psychoanalyst who shared my cultural pretensions and would
therefore conspire with me to protect my neurotic defenses before the analysis had even gotten under way. The example …raises the important issue that analysts as well as patients bring to the psychoanalytic discourse unanalyzed cultural preconceptions that can become a screen behind which the patient's infantile wishes and neurotic conflicts will find refuge when they are shared by patient and analyst” (p. 386).

Not all analysts have much personal experience in choosing their own analyst. After World War II, there were so many physicians whose war-time service inspired them to seek analytic training that there were not enough training analysts available. So would-be candidates often had to accept any training analyst they could find. Some institutes assign training analysts to candidates, again depriving those candidates of personal experience with choosing their own analyst.

Robert A. Cohen, when he returned to work at Chestnut Lodge after helping create the NIMH, served as Director of Psychotherapy. He chose the therapist he believed was best matched to each newly admitted patient. If that therapist already had a full caseload in their salaried work, they were paid extra by Chestnut Lodge for taking on the new patient (in its quirky way, the Lodge placed patient welfare above profits). Patients were routinely asked to meet with this potential therapist, and decide if they wanted to work with that person. Cohen also decided when to re-assign patients to a new therapist, when either the patient or therapist requested a change. When asked how he made that thorny decision, he smiled and modestly replied, “I hope I live long enough to answer that question!” Lodge therapists were notorious for taking oppositional stances when one of us presented our work at the weekly medical staff conference. Many of us agreed that we followed a predictable pattern—if a therapist seemed too complacent in believing the
treatment was going well, we would prove them wrong. By contrast, if a burned-out therapist seemed convinced that the work was hopeless, we would come to their defense, finding innumerable, highly encouraging indications of progress.

Thompson compares choosing one’s analyst to falling in love, since both are based on both realistic and distorted reactions to the other person (p. 126). On the other hand, she vividly observes that many analyses fail because a masochistic patient “with unconscious genius finds the analyst whose specific liabilities are especially bad for them and hurl themselves to their destruction” (p. 133). Kantrowitz (1995) describes a more hopeful “facilitating match” in some analyses, “When analysts were able to become aware of blind spots, either through the supervisory process or through the patient's persistent focus on this area, many analysts became motivated to pursue and elaborate these previously closed-off areas. Under these circumstances, both the patients and the analysts changed psychologically as a result of the analytic work. The analysts moved back and forth between elucidating and exploring the patient's material and analysing their own countertransference and transference responses as a process of joint discovery unfolded” (p. 302). Optimistically, Kantrowitz adds, “I believe the facilitating effect that analysing a patient's difficulties may have on the analyst's personal development has been underestimated in our literature and teaching. I would maintain that every analytic patient is potentially an opportunity for the analyst to learn more about himself or herself and to develop. For this to happen, however, it requires the analyst to be vigilant to countertransference reactions, to employ self-analysis, and to seek consultation when one's own efforts do not lead to a deepening understanding” (p. 309).
Thompson’s article is enriched by her interactions with fellow analysts. Many of her case examples involve patients who had a second analysis. When we are trying to evaluate our colleagues’ strengths and weaknesses, we would do well to recall Freud’s warning that no one is readier to believe a patient’s criticisms of a physician than is another physician. In the training of therapists and analysts, it is often tempting for the supervisor to enact competitive feelings with the student’s analyst by trying to “one up” that colleague. One supervisor, for example, told a psychoanalytic candidate, “I understand why you make that mistake. It’s the same mistake your analyst makes.” Subtler enactments of such maladaptive competitiveness are, of course, more common.

Some of Thompson’s clinical examples are vivid reminders of the hazard of unethical conduct by the analyst. Presciently, she warns that some “bad [i.e., unethical] analytic situation[s]” occur when the analyst is anxious about being physically ill; or is facing the illness or death of a loved one; or is under financial strain. These very risk factors have been highlighted in the more recent literature on boundary violations. One analysis began with the future analyst meeting a woman at a social event and suggesting he analyze her. Not surprisingly, that analysis ended badly. Of another “bad analytic situation,” Thompson concludes provocatively that “Breaking off treatment produced a more definitely therapeutic result than the whole analysis” (136). Harold Searles observed (personal communication, 1985) that the analyst cannot function well if he feels trapped with a given patient; he added that if the analyst feels trapped with a suicidal patient, it may inadvertently increase the risk of suicide, if the patient feels it is the only way out of the treatment situation.
I will now share additional vignettes on the vagaries of the choice of one’s analyst, in order to supplement Thompson’s examples. I am grateful to the anonymous colleagues who contributed several of these vignettes, from their clinical work and supervision.

Patients who have had previous treatment present additional considerations. Their relative satisfaction or frustration with their previous analyst will influence what they are looking for in their next analyst. The circumstances in which their previous treatment ended is another pivotal factor. They often expect their next analyst to be more similar than different from their previous one, extending even to the next analyst’s way of handling missed sessions, vacations, etc. A man whose previous analyst relocated to another city told his new analyst a joke about a driver who accidentally ran over a woman’s cat. Wanting to make amends, the man went to the home of the cat’s owner and profusely apologized. He told her he would like to replace her cat. “I don’t know,” she said, “how are you at catching mice?” The patient seemed to be consciously struggling with his wish to compensate for the loss of his first analyst with the hope that his new analyst would duplicate valued traits of his previous analyst. Another man had previous psychotherapy in an area with no analysts. That therapist advised him to seek analysis if he ever moved to an area where they were available. Ten years later, he did so, and those previous years of anticipating being in analysis seemed to contribute to his completing a highly productive analysis in only three years.

A woman’s therapist, in planning for his retirement, asked her to have a consultation with a potential future therapist. He told his colleague the patient was diagnosed with dissociative identity disorder by a previous therapist. In the middle of the
subsequent 90-minute consultation with the potential new therapist, she showed non-verbal signs of a switch from one self state to another. The consultant reacted to the switch by simply saying ‘Hi’; the surprised patient replied, ‘How did you know it was me??’ At the end of the consultation, she said she would never return to see the consultant. However, she later told her therapist that the consultation was the first time in her life that she felt someone was speaking to all parts of her mind. She did in fact enter therapy with the consultant after her therapist retired.

Thompson writes of patients who get the name of a potential analyst from a third person. As she observes, the patient’s feelings toward this third party may include confidence and trust; submission; competition; etc. And these feelings interact with feelings about the potential analyst. For example, a mental health trainee asked each of her psychotherapy supervisors to recommend a personal therapist or analyst for her. She then waited until she decided which supervisor she felt most comfortable with, and followed their recommendation.

As Thompson notes, this referral source may be someone with whom the patient has a close relationship. A woman proved to have a dissociative disorder. She had become sexually involved with her two previous therapists. She was only willing to seek treatment from her husband’s therapist. He agreed to treat her, although it was his usual policy not to see both members of a couple in individual treatment. She seemed to use her husband as a sort of chaperone, to make sure her new therapist would not abuse her. One man chose an analyst who was recommended by his estranged wife (she obtained the name from her analyst). The man was living with his mistress at the time. Several months
into his analysis, he left his mistress and returned to his wife. Accepting a referral from his wife enacted his conscious wish to reconcile with his wife.

A married woman was given the names of several analysts by her former couples therapist. She was insightful about her difficulties in choosing an analyst. She thought a female analyst might be better, since she planned to have children. Then she realized she could get advice about becoming a mother from her friends, and an analyst might not give advice anyway. Her husband subsequently said he would prefer for her to see a woman analyst, presumably out of jealousy of her seeing a male analyst. She ultimately concluded that she was not well suited for “shopping around” for an analyst. She chose the analyst she felt most comfortable with. She explained, “The problem for me with this decision is that I question whether feeling comfortable is necessary or desireable with regard to analysis—since it is my discomfort I want to understand better, and have less of.” She seemed to be distinguishing between the respective roles of support and insight as mutative factors in analysis.

A woman who had been analyzed many years earlier in a different city got the name of a potential new analyst when the deaths of her parents and only sibling left her with a severe, unremitting depression. Before their first meeting, she sent him an article her previous analyst wrote about her. She assumed the potential new analyst would not be willing to work with her after reading it, and she believed such a rejection would be less painful if they had never met. Her primary goal was to find an analyst, like her first one, who was “there” --“I know from the beginning if someone is there.” She had recently worked with a psychotherapist who, she felt, was “not there,” from the beginning. Her mother was “not there” in the patient’s childhood, delegating nearly all childcare to a
nanny. She did feel the new analyst was “there,” and was pleased when he agreed to work with her.

Some initial transferences appear to be unworkably idealized. One man whose past treatment was ineffective contacted an analyst to say he had heard he was so talented that he planned to relocate from a distant area to the analyst’s city, in order to see him in treatment. The analyst declined, explaining that he simply was not good enough to justify relocating. Initially idealized transferences predictably sour, and this unusual degree of idealization seemed to predict an especially severe disillusionment.

Sander Abend (1979) explores patients’ unconscious fantasies of how they expect analysis will help them. Such fantasies are likely to influence the patient’s choice of treater. For example, one severely depressed woman valued personal authenticity, and was suspicious of façades. When she needed long-term psychiatric hospitalization, she was influenced in her choice of hospital by the respective brochures she received. She told her therapist at Chestnut Lodge that its simple, mimeographed pages of information impressed her more than the more professionally produced glossy brochures of other hospitals. That is, she implied that unassuming authenticity in a hospital augured well for its ability to connect with and to help her.

Ralph Greenson (1967), citing Grete Bibring and Phyllis Greenacre, brought up the important observation that, “For patients who lost a parent in early childhood, the sex of the analyst can be a decisive factor. Such patients need to work with an analyst of the same sex as the missing parent. Patients will otherwise make excessive use of auxiliary figures, outside of the analysis, as supplementary transference figures.” Greenson warned
that such “split transferences” can make for “intractable and unanalyzable transference reactions” (p. 355).

It is interesting that, immediately after he makes these points about potentially severe limitations imposed by the sex of the analyst, Greenson next discusses special obstacles in training analyses. These problems have been recognized, but may not have been adequately explored, much less resolved. Greenson briefly acknowledges, for example, that the psychoanalytic “institute itself takes on an additional transference meaning” (p. 356). He might have linked this with his subsequent observation that, in training analyses, “the negative transference reactions tend to remain absent or are expressed only meekly or submissively” (p. 356) through displacement to other targets. Frequently, these negative transferences which are not adequately explored in the training analysis are instead displaced onto other people in the institute; onto the institute itself; or onto national psychoanalytic organizations and their power structures. This may be one source of the seemingly intractable internecine recriminations that have plagued professional groups such as the American Psychoanalytic Association for many years.

REFERENCES


