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How to Teach Psychoanalysis...Revised.

This paper evolved out of my preparing to organize and teach the self psychology course for the TICP 1st year class in the spring of 2009. I realized that often when I heard candidates describe their clinical work, or more tellingly, apply self psychological concepts to their work, it ended up sounding like discussions of processes following every other psychoanalytic model except that different terminology was used. Something about the basic nature of the clinical process and the conceptualizing of the process was essentially the same. In practice it seemed that self psychology models were being used in the service of finding alternative explanations for what the patient was saying and then transmitting them to the patient, as if this was understood to be the basic way that psychoanalysis was meant to operate. The clear short-range goal was always to tell the patient what is going on. In other words I felt that I had often not laid a glove on the students when I was teaching. It is as if the concepts of self psychology had morphed into exactly those experience-distant formulations which self psychologists had taken such righteous pleasure in rebuking. This phenomenon represents to me my own failure to have conveyed the essential nature of the messages of self psychology, messages which are supremely clinical, messages which should primarily denote the nature of the interaction between analyst and patient, messages which at their core are about how the therapist engages and relates to the patient. My own question was how to understand what was amiss in the teaching and how might I correct it. I felt that the method I was using to present self psychology was all wrong and in itself perpetuated the outcome that I feel is so problematic. I was teaching self psychology in a very safe and traditional way. I would first position the shifts represented by self psychological concepts in their historical context and explicate these concepts. I would often start with some of Kohut's earlier seminal papers on narcissism and empathy, moving on to papers and chapters on

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basic self psychological ideas such as the “self” and “selfobject” etc. I would always be sure to include “The Two Analyses of Mr. Z.” but even in this, what seemed to me a quintessentially clinical paper, the emphasis always subtly seemed to be on which interpretations were more correct, (self psychological versus ego psychological) than on how to be with the patient.

I decided that perhaps I needed to think backwards. Instead of thinking about developmental theories and models of psychological functioning, and trying to derive technique from these concepts (this has historically been the way psychoanalysis has operated and has resulted in clinical practices in which only a small percentage of our interventions can be clearly connected to the model which is supposedly guiding the therapist), I would try to think first about what the goal of psychoanalysis is and also what limits or possibilities are created and delimited by the nature of the psychoanalytic act itself...what are we able to do and what are we trying to achieve? In turning to these questions I could only think about what seemed at first like two different types of answers. One type was case-related...i.e. the answers would depend on which patient I was thinking about...what kind of changes could be hoped for with that person...but which changes could not necessarily be generalized to others. The other type of answer seemed at first more generalizable and comprehensive e.g. goals like flexibility, cohesion etc. But when I looked at these answers more closely they also began to seem more specific than I had at first thought. For example, at first I thought that the notion of personal “liberation” was generic and would be a good way to depict what every psychoanalytic treatment could be said to aim for. But I began to wonder what “liberation” actually means. What of the patient whose aim is not to be “liberated” but to find someone or some group to whom to be attached? Who are we to say that this is not a legitimate or “healthy” striving and outcome? What if the therapist’s goal that the patient be liberated is really a need of the therapist imposed on the patient? Moreover, when I thought about those patients whom I have treated and who described the benefits of the treatment, almost without fail they talked about changes they could not have anticipated (and in fact expressed surprise at the kinds of things inside them that had changed) and were not aware of wanting, but which felt substantial and transforming to them. Moreover they were not changes which I had consciously in mind nor could have anticipated either when I began with them. In retrospect, of course, they seemed natural and necessary but this was nothing but hindsight.

If, as in fact I believe, self psychology provides a set of guiding principles that are particularly coherent and have significant clinical utility, then the model of self psychology should embody those practices and attitudes which could be seen to be organically behind the changes that actually take place in therapy. What I mean is that what is truly possible in therapy and what actually happens, broadly speaking, should be exemplified, not implied, but explicated, in the essential core ideas and statements of that model. Moreover what our particular practice of psychotherapeutic conversation makes possible should be explicitly linked to guiding principles about how we as therapists are to behave in order to try to get “there”. It is the fact that conversation is the methodology of psychotherapy which forms the foundation of self psychological thinking. That is, the essential (not all of the principles are essential of course) principles of self psychology have to do with the nature of the relationship between the two parties in the conversation. How does the patient need to “use” the therapist? What are the obstacles in the way of the patient essentially being able to have access to his capacity to use the therapist? One can see that there is an implication at work here as well. This implication is that in each human being there is always a tendency to self-repair, self-restore, when possible to seek satisfaction..to self-correct...that is an urge and a trend toward looking after oneself...whether this has immediately to do with security or self expression and fulfillment. A primary notion of resistance (as other than a positive effort on the part of the patient to be self-protective) would be anathema in this view of analysis. So the orienting clinical questions for the psychoanalyst should be: “What is the patient trying to do?” and “How is the patient viewing, using and relating to the therapist in trying to do this?” The therapist must ultimately have faith that there are answers to these questions and even if neither party knows what they are, they are still propelling the work forward.

I am implying something about the nature of our “particular practice”. Obviously it is that we institute a special kind of conversation between two people, a patient and a therapist. This psychotherapeutic conversation like any other different conversation has its own unique context and rules. The context and rules stem from the fact that one person is coming to another for help and in fact paying the other for that help. The therapist, who has decided to essentially use conversation as his instrument is, because of the above context and rules, required to play a particular role in this conversation. In this conversation, he is obliged like the visitor at a shiva does with the mourner, to follow the lead of the patient. He is to engage in the way that he is

needed. As the visitor to a shiva is not directing the mourner to follow some preconceived developmental line of grief, so the therapist is obliged not to direct the discussion nor to promote his own emotional needs but to “be there” for the other. What does the visitor at the shiva hope to do? To help. To help with what? With whatever the mourner needs help with and in whatever way the mourner needs help. The therapist is there to help with whatever is needed, *even if neither party knows what that is!* The therapist like the visitor at the shiva does not have a specific goal in mind beyond this role...he cannot. Moreover, in spite of a natural tendency to codify human responses to loss or trauma, we recognize that to do so, to codify, is an artificial practice, and the antithesis of helping someone with his own individual, subjective, unique form of suffering and of helping him to find solutions or ways of coping that work for him. Given then the limiting qualities of our methodology, what is possible? In a conversation many forms of influence are possible. Conversation can be used to cajole, persuade, intimidate, seduce. Of course when a therapist does any of these things at least persistently, he is determining a priori what he wishes the patient to do and how to be. This therapist should be doing some form of therapy other than psychoanalysis because those of us who choose to do psychoanalysis or psychoanalytic psychotherapy have already concluded that this is either not effective or not interesting or not how we and the patient have agreed we wish to engage his particular form of suffering. If we do not use conversation primarily in order to lead to specific behaviors or feelings in the patient and yet we are offering conversation as our means of helping, then we must accept that we cannot predetermine the direction of the conversation, let alone the outcome. We must operate on the belief that benefit can accrue to an individual from having the kind of conversation that is outlined above. What kind of benefits have we found to take place? When things have been working in what the patient experiences as a positive way, then the benefits that have been noted have been feeling supported, feelings of connection, self awareness and self acceptance etc. Of course all of these findings could easily lead therapists to consciously and self-consciously attempt to bring about such results by aiming at them specifically. Many therapists, however, would argue that in fact those benefits come about precisely when (and because) the therapist does not aim at them but in fact has no idea how to get there. Nor do we know which of them will be particularly meaningful or real for any individual. To position the discussion of what is truly possible in therapy, which I believe has to be the starting point for the

teaching of psychoanalysis, I would like to first look at the kinds of matters which lead patients to come to therapy.

In life, one ongoing and unavoidable task for any person is that of dealing with whatever situation he finds himself in. This may seem too trite a notion to bother saying. But a person is in a constant state of adaptation as well as of creation. He must adapt to immediate crises, to chronic difficulties, (e.g. living with a partner who is very difficult, with whom he is unhappy and yet cannot bring himself to leave or “kick out”, or a chronic feeling of dissatisfaction and inability to construct a life of accomplishment and meaning), to changes of all kinds including successes and new responsibilities. Most of the time his familiar methods of adapting and coping feel adequate or inevitable. Patients come to therapy usually because they have arrived at a point where they do not *feel able* to deal with these situations i.e. control or master or overcome them or because they have hope that something fundamental even if unknown can change...or be changed by a therapist. Our job as therapists to try to help our patients to find their own solutions or sense of balance even if that sense of balance, for example, ends up being an experience of realistic acceptance and resignation, (which would in itself be an accomplishment), from which they have been blocked because of an intense sense of shame or fear.

The point above is that something *new*, some new skill, or self awareness or attitude or sense of connection is needed for the patient to feel a sense of freedom or value etc. and that the therapeutic process is “developmental” in that sense. That is, some new skill or attitude has to be developed. Moreover the value or benefit of this development is ultimately determined exclusively by the subjective experience of the patient. In addition, I will repeat that this new skill or attitude cannot be known a priori, let alone planned, brought in or produced from outside. All of this may seem to be simplistic and obvious, hardly needing restating. What I am trying to say is not that this is a new idea but that this idea has to move to the center of the psychoanalytic field and not be some vague thing that takes place while the real work is going on.

Development may have different “goals” in different contexts. For example, for a medical student, development may at any one point be about the learning and integration of skills relating to functioning in the operating room. For a new father, development may be about learning to subjugate one’s own needs to those of his child. For a psychiatric resident learning psychotherapy, it may be about tolerating ambiguity, and living without “scientific” certainty.

For a depressed person development may be about learning that one has value and that one's ideas are the reliable core of one's personhood. What is required for development depends on what the task is. For a patient in psychotherapy, although there are many part skills that may be required to be developed (e.g. the skill of learning to adapt to the requirements of regular appointments) generally speaking the developmental task for the patient is that of whatever is generated by the particular central discomfort and/or trouble which he experiences - how to deal with the disappointment of narcissistic needs for example? In any immediate situation, however, there may be other tasks which confront the person...for example whereas the preoccupation with feeling valued and the need to be special may be the underlying problem organizing much of the patient's experience, on any given day this underlying problem may lead him to engage in behavior which is destructive to his own desires² and it may behoove the therapist to comment to them that although their outrage is understandable, it might be a good idea for them to learn to be more strategic and self-protective in their dealings with others. On the other hand it may be best for the therapist to resist giving this kind of advice or admonition if it is likely to be felt as a crushing rejection of the legitimacy of the patient's outrage.

Development is an ineffable process which is simultaneously profoundly influenced by the environment and is at the same time completely unpredictable and invisible no matter how much we think we know about environmental influences. Moreover, development as a notion of the nature of the *psychotherapy process itself*, stands in *specific contrast* to organizing notions of psychoanalysis as a process which restores previously thwarted or distorted development (although it is easily confused with this) or achieving particular goals let alone the way it is diametrically opposed to the notion of problem solving, (although helping a patient solve problems may be valuable and essential at any point in the therapy). There are two reasons that development is a most suitable idea to denote what happens in psychotherapy. First of all very often we actually cannot provide answers to the problems that the patient faces...e.g. the problem of trying to decide what kind of career to undertake and how to go about doing it. We begin with the assumption that we do not and cannot know a priori what the full scope or even

² When I first wrote this I used the word "interests". The fact that I did is symptomatic of a tendency in me and other therapists to begin to think from an "objective" point of view rather than staying with the subjective experience of the patient. It is crucial, of course, that one reach the patient in a way that does not inadvertently infringe on the thinking and autonomy of the patient.

the most influential elements of the patient's experience and difficulties are so that we could not determine a course of action until this is so. There is not one size that fits all. Having said this, it should also be said that there is a ubiquitous clinical problem. Each society has a broad consensus about what constitutes normal development. For example in our own society, we prize highly qualities of autonomy, emotional yet modulated expressiveness, personal security and self care...that is all of these qualities are elements of what constitute normal and healthy development. It is not we therapists alone who hold these views, our patients do as well. No patient is likely to easily accept a recognition or affirmation of how he is feeling (let alone an implied direction for him to move towards) that involves an abnegation of those qualities which society and he himself view as mature and healthy. That is a patient will often have a great objection to identifying qualities or feelings within himself which do not fit with societal expectations. This alone is a common problem for therapists but when it is on the table, so to speak, it is not a serious one. Far more serious is when patient and therapist collude unknowingly with normative ideas which they share and which are in opposition to important impulses and feelings of the patient. That is there is no one attitude or activity or behavior or belief which we can aim at that will suit another person. The attitude that he comes to has to be one that works from within. (So for example an obese patient who complains about his misery about being obese may achieve an important benefit in the analysis without his obesity being changed at all. It is more than possible for an obese person to achieve a successful, satisfying and rewarding life. If the analyst becomes preoccupied with...and therefore anxious about...obesity per se and eliminating this "symptom" then the possibility of developmental change becomes much more elusive.

The question then becomes, what is required of the therapist in order to achieve a productive process of development? What about technique? What is the therapist to do? If the therapist's primary function is to be a facilitator of development via conversation, what are the guidelines for the therapist to help achieve this aim?

In order for development to take place, a marriage of two factors is required. More modestly one could say that two factors can and may profoundly affect the shape or nature of development, for one could argue that development is not something that could not happen but is

rather always happening. The issue is whether the development that will inevitably take place in any individual will be felicitous or not...will it enhance the sense of satisfaction or accomplishment or security or acceptance, i.e. move towards a personal solution? The two factors include first innate predispositions, strengths, tendencies to self-righting, loci of pleasure and satisfaction etc. and second the environment in which the individual is embedded, what it fosters and encourages, what it supports and what it inhibits and prevents. In psychotherapy the therapist is the main environment. At least it is that part of the environment which is introduced in order to be helpful and the part that we can influence.

The crucial question for the therapist is *how* to be facilitative? It is a central tenet of this paper that facilitation is an emergent property of “presence” or to use another word “availability”. How is the therapist best *present* with the patient, how is he to be *available*? If we argue, as I would, that the singular task of the therapist is to be available then some very important questions are raised. Does this mean that the therapist has no goals for the therapy? How is availability expressed? What form does it take? What are the guiding principles that inform the therapist as to how to be available? Students may easily feel that positioning therapy in this way leaves them with no footing, no ground on which to stand. To come back to the issue of goals: it is not that the therapist has no goals for the patient...although these goals will almost certainly be obscure and approximate at first and may in fact stem from countertransference when they become too specific too soon. The therapist wants to help, to alleviate suffering, to expand the sense of self of the patient. But these are akin to the goals a tennis player has of wanting to win a match. This goal does not help much when the ball is coming over the net. It hardly tells him what to do. While the therapist, like the tennis player, has a long term goal, he must operate with short term goals. The short term, immediate and functional goal of the therapist is that of understanding and of being available. What we lack in psychoanalysis is a comprehensive clinical theory of availability. Underlying this and perhaps causing this is that we do not think of or teach psychoanalysis as a primarily a clinical conversation. We do not say that where we must *start* is with the premise that our main job is to think about how to play our roles in this conversation, how to be available in this particular and unique conversation. This is not to say that there has not always been a very significant amount of attention paid to the issue of availability (however the issue has been labeled or defined).

Writers from all models of psychoanalysis have addressed elements of availability. In recent times particular focus has been placed on the so-called “co-creation of transference” and on self-disclosure among myriad other details of interaction. Moreover there has been considerable discussion of the centrality of the relationship between therapist and patient in understanding the process of change. But I think that there is a vital link that must be established between the nature of the change in the patient...i.e. development...and the specific role of the analyst...i.e. availability which should be the centre of conceptualizing and teaching psychoanalysis. There are well established and long written-about principles of availability. Therapists of all stripes speak of an essential need for the therapist to provide an atmosphere of friendliness, emotional availability, honesty, and respect. Lichtenberg et al (“The Clinical Exchange) have described their view of 10 principles of technique which enunciate some of them. Unfortunately in many if not most or even all traditional psychoanalytic approaches to such matters of technique the principles of “availability” are contaminated by other ideas of what the therapist is supposed to bring about in an active way and so the principles of availability are honored in the breach, that is they are actually used in the service of “accomplishing” something more specific. To a very large extent the issues in the literature that relate to “availability” have been addressed as things to consider and to do in order to do the *real work* of the therapy. But availability does not set the stage for therapy it *is* the therapy. The notion of development comes in as an orienting guide to how to be available. What are those qualities that we believe assist one with his personal development?

Of course there is a large, vital, and growing literature which puts relationality at the center of the psychoanalytic enterprise. I am not able to engage the “Relational” perspective (as opposed to a relational perspective) as I have not been a very close reader of this literature. The group of Relational psychoanalysts who are a group of similar-minded thinkers (Mitchell, Aron, Davies, Hoffman, Bromberg etc. etc.) share a strong clinical sensibility. I suspect that much of what I have to say is harmonious with their position. But as is evident in the recent on-line colloquium sponsored by the IARPP, there is some general agreement amongst many of the contributors that issues of technique have been difficult to address and there is some need for attention to them. In fact there has been one reference to the need to establish principles of technique which rest on a foundation of therapeutic intent. I could not agree more. It is up to the profession to establish principles of therapeutic intent and to derive principles of technique from

them. In fact the teaching of psychoanalysis must, to my mind, begin with the establishment of principles of therapeutic intent. Although it appears to me that the essence of the Relational literature does focus on what one could call the nature of “availability”, it is often taken by students of it to mean that one is supposed to be helping the patient to achieve a certain specific type of relationality, that of “intersubjectivity” (as defined in the Relational literature). Thus from this point of view, availability tends to be used with the particular aim of developing a certain type connectedness between patient and therapist. This type of connectedness is considered to be optimal.

There is a significant danger to the idea that I am suggesting, that is the idea of basing the teaching of clinical work on applied “availability”. There is always an inevitable tension in clinical work between focusing on the needs of the patient and being directed by one’s own needs as a therapist and a person. When therapists feel anxious or uncertain or curious or impinged on or not treated with respect or merely when their own views of what is right or what is normal human nature become aroused they are often prone to interventions which look conventionally correct and are buttressed by theoretical rationales, but are actually ones whose motives stem from personal needs of the therapist. In fact it is more difficult than that because it is often not possible to tell from the content of the intervention what the motive is. Psychiatry residents are taught that what they are thinking, their intention, matters more than what they actually say (Schwaber 19). In fact the exact same words could be said by three different therapists and have three different purposes and meanings. The danger of emphasizing the therapist’s availability is that it may appear to and actually may be used to encourage the very opposite of its intention...it may encourage therapists to focus on their own behaviors rather than focusing on understanding the patient. Availability is not an end in itself. It is meant to allow the patient’s self-expression and to facilitate the patient’s development. If “availability” comes with a hidden agenda of satisfying the therapist’s need for contact and affirmation, or an agenda of being “kind” or effective, then things will be turned on their head yet again, and the needs of the therapist will be penetrating the interventions and guiding them.

I will now present a preliminary effort at outlining an approach to defining “clinical intent” from which should derive principles of technique. Both of these are necessary for providing some coherent basis for our practice of psychotherapy/psychoanalysis.

- 1) No matter what presuppositions, assumptions or the values of the therapist, the clinical outcome of the process of psychoanalysis has as one of its determining factors, and ultimately a limiting factor as well as a source of potential, the fact that the analytic encounter is essentially a conversation. Thus it is conversation that determines the opportunities and possibilities as well as the limits of clinical work.
- 2) Conversations may take many forms including self-indulgence, hectoring, advice, efforts to coerce, simple listening etc. But the psychoanalytic conversation has as its essential principle the idea that the therapist does not know what the patient needs or at least certainly does not know the path to this goal nor the path that the unique constellation of this patient’s constitution and experiences will permit and move towards.
- 3) Thus the term “development” is what can be said to define what transpires in a psychoanalytic process. Development can be defined as the principle that things are not the same at the end of something as at the beginning. Moreover, development is in its very nature also something that cannot be predicted or controlled by either party to the process, but is rather the unpredictable outcome of the relating of the two people.
- 4) There is an innate impulse in each and every person to self-restore, self-protect, advance etc., in short to always do his “best” no matter how strange and incomprehensible that may appear to the “other”. Resistance can never be understood as anything more than an opposition to a perceived threat and is never the “bottom-line” motivation of an individual’s behavior.

I wish to emphasize that I do not present the issue of “development” because I think that the therapist should have this in mind but rather as a orienting framework which should help to guide the distillation of clinical principles and practices and also as an internal guide when anxiety-based questions arise in the mind of the therapist...questions such as: “what am I doing?” “where is this leading?” etc. Even the idea of “availability” is an abstraction which is meant to help direct the process of listening.

Ultimately the principles of technique that are derived from therapeutic intent can only be derived from the case-based application of the principle of facilitation of development. How does this look in practice? I would, however, suggest a set of beginning general principles of technique.

- 1) There can be no expectations made of the patient, other than being in the therapy and paying for it (when this is the arrangement). Being “in” the therapy may not necessarily even include showing up regularly, as long as it can be understood that the irregular attendance is a meaningful aspect of a meaningful engagement with the therapist. But essentially the patient has no responsibility other than to “show up”. In a way the therapist is the one who has to “show up”...as the guest at a shiva. At a shiva we expect nothing of the mourner.
- 2) The therapist must direct his efforts to understanding which will in turn guide the nature of his involvement and availability. This understanding always has the subjective experience of the patient as its focus.
- 3) Availability can take manifold forms and discussion of any of these details in isolation (e.g. discussion of frequency, or use of the couch, or self-disclosure) can easily become circular and interfere with a sense of the coherence of the therapeutic project.
- 4) There are general principles of “availability” which facilitate development and there are specific ones. The general ones relate to everyone (e.g. listening to subjective experience, non-intrusiveness etc.) and the specific ones are derived from the experience of working with an individual.

OTHER POINTS FOR INCLUSION OR FUTURE CONSIDERATION:

- 1) If a mourner finds consolation in a faith that we don't accept, we don't want to shake the faith of this mourner...e.g. if he says that God spared him some catastrophe (when others were killed and the listener may wonder where was God for those people?). In some other context we may choose to address this issue....

- 2) What about situations where something that the patient wants from the therapist conflicts with something else that the patient wants (needs?). The “wanting” here may be latent or potential (i.e. not yet developed as an understood desire) in that the person is not yet aware of this in a conscious way....e.g. the crying child who demands to stay up whereas there is a need for rest and in fact the fatigue may be at the root of crying. There is a familiar clinical issue here when a patient demands something that the therapist knows is not going to satisfy other broader desires they have (e.g. for self regulation)
- 3) Question: Do things change as the therapy goes on? As the therapist, over time, begins to recognize patterns ...can he become less at sea? This may be something useful in the teaching of psychotherapy to help beginners feel less anxious.