The Analyst's Role in Healing:
Psychoanalysis-*Plus*[1]

Second Lecture

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A Brief History of the Origin of Psychoanalytic Praxis

Freud created his etiological theory of neurosis in 1892, writing to Fliess in December that his theory was going to be published (Masson, p. 36). When Freud started his private practice six years earlier, he used the standard neurological treatments of rest and massage as well as hypnosis, but in 1889 he modified his hypnotic treatment by adopting Breuer's cathartic method, consisting of interrogating a hypnotized patient about thoughts and experiences related to their symptoms.

By 1892 Freud had largely dispensed with hypnosis, treating Frau Elizabeth v R mainly without it, relying on what became the new technique of free association. He pressed on her forehead to bring out new pictures and ideas. Prior to that change in technique, however, Freud had formulated his etiological theory of neurosis. Analysts commonly believe that it was derived inductively from Freud's patients's productions, but they fail to recognize that the pre-1892 productions were of hypnotized patients treated *prior* to his use of free association. Stated conversely, to the degree his etiological theory was based on patient material, it was not based on patients who free associated but rather *it was entirely derived from those earlier hypnotized patients with whom he was using the cathartic method.* Freud initially structured analytic technique and theory on the basis of his etiological theory.

We focus on this historical fact both because it is acknowledged that hypnotized patients are extremely suggestible, and, because

evidence suggests that Freud was unaware of making covert suggestions to his patients. Consider Freud's (1896) claim that "In some eighteen cases of hysteria I have been able to discover this connection [to a childhood sexual trauma] in every single symptom, and, where the circumstances allowed, confirm it by therapeutic success" (p. 199). This finding in eighteen consecutive cases is unlikely to occur by chance; we instead assume that it was due to Freud's covert suggestions. Supportive evidence is found in Freud's later painful decision to abandon his seduction hypothesis. There is no indication that Freud ever considered that the reason for his mistaken belief about childhood sexual traumas might have been his own covert suggestions to patients of putative traumatic childhood sexual experiences. To the degree that Freud's etiological theory was developed from the productions of highly suggestible hypnotized patients, plus his failure to recognize his own covert suggestions to patients, raises question about his theory and the structure of treatment derived from it.

These early doubts of some of Freud´s contemporaries support our question of why elucidating the cause of the disorder became entrenched in praxis and was expected to relieve neurotic symptoms. Strenger (1986) notes that even if classical treatment was superior, that "This would still not mean that the original repression of this specific content was causally responsible for the onset of the neurosis. All we could claim is that the maintenance of the repression was causally responsible for the *maintenance* of the symptom. We can thus not infer from processes occurring during therapy any

causal connection between childhood events and the present neurosis" (p. 257).

Why Freud Proscribed Time Honored Healing Techniques

Freud, who was well-read, knew of ancient healing techniques. Why did he prohibit their use in analytic treatment? Freud had wanted to pursue a scientific career but, unable to get an academic appointment in Vienna entered private practice to marry and earn a living. Nevertheless, his continuing drive to engage in science led him to shape his theory of practice into a scientific enterprise. As he told his American patient Abram Kardiner (1977), he was interested in theory, not therapy. He structured his treatment to produce documentary evidence of his etiological theory of neurosis. Freud hoped that developing treatment as a scientific endeavor would lead to the outstanding scientific discovery of the cause of neurosis, equivalent to discovering the *caput Nili* (the source of the Nile) (Freud, 1896, p.203).

To achieve this, he developed psychoanalysis within the context of a (nineteenth century) scientific enterprise: Psychoanalysis, Freud (1932, 1933) wrote, "[i]s a part of science and can adhere to the scientific *Weltanschauung*) (p. 181); "The stress on arbitrary personal views in scientific matters is bad; it is clearly an attempt to dispute the right of psychoanalysis to be valued as a science … Anyone who sets a high value on scientific thought will rather seek every possible means and method of circumscribing the factor of fanciful personal predilections as far as possible …" (1914-1916, p.59); "But scientific work is the only road which can lead us to a

knowledge of reality outside ourselves" (1927, p.31). "[*o]ur* science has as its object that [psychical] apparatus itself" (1940, p.159). Suggestion was the greatest threat to the scientific status of psychoanalysis because of its association with hypnosis, then in bad repute. We hypothesize that Freud proposed neutrality, abstinence and anonymity to try to assure the analyst's objectivity, and insulate psychoanalysis's scientific status from the contamination of suggestion: "The analyst who wishes the treatment to owe its success as little as possible to its elements of suggestion (i.e. to the transference) will do well to refrain from making use of even the trace of selective influence upon the results of the therapy ..." (1913, p.131);

"I cannot advise my colleagues too urgently to model themselves during psychoanalytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible" (1912, p. 115); "The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him" (p1912, p.118); If the transference is able to remove the symptoms of the disease by itself, "In this case the treatment is a treatment by suggestion, and not a psychoanalysis at all" (1913, p. 143).

To assure the scientific status of psychoanalysis Freud urged that all patients be treated under standard conditions, appropriate for research, but, as we have learned, inappropriate for psycho-therapeutic treatment. Freud's lifelong concern about analytic objectivity, about the scientific status of psychoanalysis, focussed particularly on the role of suggestion in undermining that status (Fogel, 1993).

The analyst's neutrality and abstinence served an additional unstated function for Freud and his colleagues; it codified a self-imposed inhibition against troublesome erotic feelings toward women patients (Stone, 1961; Anzieu, 1986; Glenn, 1986; Moi, 1990). Ferenczi, focused on therapy, not science, disagreed with Freud's emphasis on neutrality, abstinence and anonymity (Thompson, 1943). Since he was convinced that the cause of neurosis was the parents's failure to provide the child with needed love, he believed treatment had to take the form of a human relationship in which the analyst provided the missing childhood love. Ferenczi, therefore, expanded analytic technique to include those time honored healing techniques that Freud had recognized and then rejected. We know that Freud never gave up the theoretical ideal of the analyst's objectivity (Fogel, 1993), but he was actually warm and friendly with his patients, on occasion providing food and loaning money (Lipton, 1977, 1983), though not considering such acts as part of technique. This early Freud-Ferenczi debate has continued throughout the history of analytic treatment. So many analysts have contributed to the evolution of treatment that a list will necessarily be incomplete:

Harry Sullivan, Clara Thompson, Erich Fromm, Freda Fromm-Reichman, Winfred Fairbairn, Donald Winnicott, Karen Horney, Franz Alexander, Otto Will, George Groddeck, Harry Guntrip, Hans Loewald, John Bowlby, Leo Stone, Heinz Kohut, Merton Gill, Irwin Hoffman, Robert Stolorow, Anton Kris, Arnold Modell, Benjamin Wolstein, Edgar Levinson, Lewis Bromberg, Stephen Mitchell, Jay Greenberg, Stuart Pizer, Jessica Benjamin, Owen Renik, Lewis Aron, Theodore Jacobs, Irving Hirsch and Mark Blechsner.

The History of Healing

Frank (1973) reviews psychotherapy, primarily in America, and concludes that much of the effectiveness of different forms of psychotherapy may be due to features that all have in common rather than those that distinguish one from another. Although he believes that failures of adaptation arise from early life experiences, psychotherapy aims to help the patient correct current problematic attitudes. He makes contention that the cause of a symptom should not be confused with its current meanings, which often can be changed regardless of their cause. Strupp et al. (1969) characterizes the patient's image of a "good therapist" as a "keenly attentive, interested, benign and concerned listener – a friend who is warm and natural, is not averse to giving advice, who speaks one's language, makes sense and rarely arouses intense anger" (p. 117). Frank, building on Strupp's earlier paper, notes that directive therapies seem at least as effective as evocative (analytic) ones for many types of patients, and for some produce improvement more rapidly. Success in therapy depends in large part on the analyst's ability to combat the patient's demoralization and heighten his hopes of relief. Success also depends on the patient's conviction that the therapist cares about him/her and is competent to help him/her – that the analyst has confidence in his/her theory.

The history of the healer-sufferer relationship, extending over thousands of years and across societies and cultures, was examined by Jackson (1999), who extracts commonalties similar to Frank's: influence is brought to bear by suggestion and persuasion plus consoling and bringing of comfort as well as a search for insight and self-understanding – of 'knowing' what all the suffering has been about.

Classical Views of Neutrality

Whether the analyst will experience his feeling or action as a deviation from prescribed technique will vary with the analyst's own interpretation of "neutrality." Stone (1981), for example, characterizes the true analytic attitude as compatible with human friendliness and warmth, but the analyst "[g]ives no affective response to the patient's material or evident state of mind, nor opinions, nor direction, not to speak of active interest, advice or other allied communications" (p. 99). Kris (1990) believes that analysts need to depart from neutrality by expressing an affirmative attitude toward the patient in order to help the patient overcome punitive unconscious self-criticism. Akhtar (2004) describes Thomä's analytic work as "unabashedly therapeutic, flexible yet firm, supportive yet interpretive and deliberate yet spontaneous" all within a classical theoretical frame.

Rothstein (2005), a classical analyst, acknowledges how intersubjectivity limits the objectivity of neutrality: "[t]he best anyone can do is be more or less able to subjectively reflect on his or her experience, while simultaneously being more or less influenced by the subjectivity of the collaborating analysand" (p. 419). Aron (2005), points out that: "under the guise of neutrality, analysts encouraged their patients to renounce their [infantile] impulses, once they had become conscious" (p. 492). … So much for neutrality!" (p. 443). Benjamin (2005) takes another tack; intersubjectivity should encompass the capacity to identify, to get inside the other's mind and let the other inside us – in Winnicott's sense, to use the object. Ideals

of objectivity, she feels, are not only unrealizable but may well create deep impediments to empathy. She conceives of neutrality as a nonjudgmental acceptance, a loving attitude that allows us to incorporate within our understanding even our mistakes and failures.

The Classical Psychoanalytic View of Explicit Support in Treatment

Freud (1909) himself used explicit support treating the Rat Man (Dr. Lorenz). Mahoney (1986) characterized Freud's role in that treatment as that of a "befriending educator." At one point Dr. Lorenz expressed doubts to Freud that treatment would be able to help him modify the obsessions which had plagued him since childhood. Freud's response to this expression of anxious hopelessness was that "[h]is youth was very much in his favor as well as the intactness of his personality. In this connection I said a word or two upon the good opinion I had formed of him, and this gave him visible pleasure" (p. 178). Clearly, Freud as practitioner had no qualms about the utility of explicit verbal support.

Contemporary classical analysts have diverse views about support. "Psychoanalytic therapy operates on an interpretive-supportive continuum, and the use of more interpretive or more supportive interventions depends on the patient's needs" (Leichsenring 2005) p.844). Blatt (2005, personal communication) writes about support: "With any patient I prefer that the patient struggle to manage their difficulties themselves. But I would offer support only if I thought the patient could not manage the difficulties alone."

Free Association: The Basic Rule of Psychoanalytic Treatment

Although Freud's etiological theory of neurosis antedated his use of free association, free association soon became the fundamental rule of analytic treatment (A. Kris, 1982); and remains so in contemporary psychoanalysis (Gabbard and Westen, 2003). Not all agree about its centrality. Since the data of free association are used to interpret causal connections between the patient's thoughts, feelings and symptoms from which a personal narrative is constructed, Grünbaum argues that these causal interpretations must be evaluated by "modes of inquiry that were refined from time-honored canons of causal inference pioneered by Francis Bacon and John Stuart Mill" (1984, p. 47).

A more clinical criticism comes from many analysts recognizing, when reviewing patient material, that the analyst has substantially shaped the patient's associations (Marmor, 1962; Gill and Hoffman, 1982). Glover (1955) early on asserted that: "When therefore any two analysts or groups of analysts hold diametrically opposed views on mental mechanisms and content, it is clear that one of them must be practicing suggestion" (pp. 381,382) – (or possibly both). The power of such influence has been confirmed empirically (Greenspoon, 1955; Murray, 1956; Murray and Jacobson, 1971; Truax, 1966). Haley (1959) argues that the very subtlety and unobtrusiveness of the therapist's influence, coupled with his/her explicit disclaimer that he/she is exerting an influence, may increase his/her influencing power. It appears, concludes Frank (1973), that a therapist cannot avoid biasing his patient's performance in accordance with his/her

own expectations. Thomä and Kächele (1987) assert similarly that "The analyst who approaches his object, the analytic process, with a specific conception of a model, *influences, by means of his expectations, the occurrence of events* which agree with his model. … He may thus actually determine the direction the process takes, although he believes that he has only observed it" (p. 333).

Masling and Cohen (1987) replicate this conclusion: all psychotherapies generate clinical evidence that support their theoretical positions and so can be understood "[a]s instances of therapists systematically rewarding and extinguishing various client behaviors" (p. 65).

It follows that, due to the analyst's powerful influences upon free association, interpretations based on them will also reflect the analyst's influences. Glover (1952) had declared that there is "[n]o effective control of conclusions based on interpretation, [and this fact] is the Achilles heel of psychoanalytic research" (p. 405).

"[w]e cannot exclude or have not excluded the transference effect of 'suggestion through interpretation" (p. 405). Spence (1992) observes that "The clinician … tends to listen to the clinical material with a favorite set of theoretical predispositions" (p. 562), and concludes that "Interpretations in a clinical setting have an unfortunate tendency to reflect the therapist's expectations rather than the underlying facts of the matter" (p. 559).

The sources of the analyst's implicit influences and suggestions are manifold, in part derived from the analyst's subjectivity which encompasses the analyst's realistic reactions to the patient, the analyst's transference responses to the patient, the analyst's

theoretical orientation, the analyst's current, personal concerns about his/her own life, and the analyst's personal values; the influences of the latter have been widely discussed. Strenger (2005) asserts that "[i]t is unrealistic to believe that a therapist's personal predilection, her sense of what constitutes the central dimension of meaning in life, does not crucially influence each and every one of her interventions" (p. 92).

Renik (1993, 1998, 2004) asserts that many elements of the analyst's subjectivity are unconscious at the moment of interaction, and therefore can only be understood retrospectively. Further, this retrospective understanding becomes accessible only through the analyst's limited and restricted self-analysis or through consultation. In any event, whatever the implicit suggestion expressed by the analyst, once out, it has already influenced the patient, though retrospective acknowledgement and understanding may modify that influence. An analyst striving consciously to minimize the influence of his own unconscious subjectivity in the service of neutrality, will inevitably have only limited success.

Contraindications or Indications For These Additional Techniques

Studies of analytic treatment outcome examining different diagnostic groups are few, although various analysts, starting with Rank, considered personality styles which require techniques other than classical. Blatt (2004) and Blatt and Shahar (2004), originally using a depressed patient population, developed a psychodynamic,

dichotomous characterization of patients' personality styles: "introjective," patients are concerned about their sense of self, including self-worth, while "anaclitic," patients are concerned about maintaining harmonious relations with others. These researchers re-analyzed the original Menninger data set and found that introjective patients did better with classical analytic treatment whereas anaclitic patients improved more with supportive-expressive treatment.
This finding led us to question whether the use of the additional techniques of explicit support, suggestion, consolation and persuasion should be minimized with those introjective patients who appear to do better with classical treatment. Blatt (2005, personal communication) responded that he does not believe that "[t]hese findings lend themselves to conclusions about varying treatment technique. Rather, I think these findings strongly suggest that we should be aware that we offer our patients two primary factors – a therapeutic relationship and interpretation and insight…"

Utilizing Additional Explicit Techniques

We propose utilizing these additional explicit, as distinct from implicit, techniques of support, consolation, suggestion, persuasion and advice, which we term, psychoanalysis-*plus*. It is difficult to determine how analysts actually behave in their office, but it is our impression that many analysts utilize implicit caring, support and consolation, while few are comfortable doing so explicitly, verbally, or exposing these interventions in public reports. Caring may be communicated

implicitly by the analyst's expression or tone of voice, of which the analyst may or may not be conscious. An unfortunate consequence of deviating from prescribed neutrality, either consciously or unconsciously, may be discomfort and guilt, which may therefore deprive the analyst of comfortably examining its occurrence and meaning with the patient.

Implicit, nonverbal expression by gesture, tone or facial expression may imply, both to patient and to analyst, that these communications are somehow illicit. When the analyst doesn't openly "own" the expression, then the patient may not feel entitled to explore and express his/her reactions. This analyst-patient interaction, therefore, may not be analyzed. Explicitness, on the other hand, facilitates the patient identifying and responding to the interventions. If the patient explores his/her reaction, is there then risk that the intervention's effect, itself, may be vitiated? For example, if the analyst was explicitly supportive or encouraging, would identifying and analyzing the patient's reaction undermine the intervention's effect? If so, that, in turn, could be explored.

The patient's acceptance of the analyst's explicit interventions constitutes, in Winnicott's terms, making use of the object. By strengthening the patient's conviction that the analyst genuinely is trying to be helpful, it may also enhance the patient's capacity to explore resistance, and to examine feelings and experiences that feel shameful or humiliating. Further, these affirmative, helpful interventions may also facilitate the patient's identification with these authentic attributes of the analyst (Skolnick, 2006), which hopefully become actively integrated into the patient's internal schemas.

Two examples of such explicit interventions follow.

Possible Risks Associated with Using These Explicit Techniques

Some analysts expresse concern about possible misuse of support, suggestion, consolation and persuasion Several clinical risks should be considered. The analyst's healing gestures may augment idealization to the detriment of the patient's assessment of himself/herself, and also make it more difficult for the patient to express anger towards the analyst. When the analyst's suggestion for real life action is ill conceived, as we've learned some of Freud's proved to be, the application may prove disastrous. Additionally, while a patient may accept a well meaning suggestion or advice out of compliance, unconscious forces may assure a negative outcome. The focus on the patient-analyst interaction may itself overlook the importance of other relationships, while attention to the analyst's conscious interventions may minimize exploration of the patient's dynamic unconscious. One may also also warn that the analyst's helpfulness may shackle patient and analyst to an environmental position which entails blaming the other and avoiding understanding how the patient may have influenced or used the other.

In addition to these clinical issues, there is also the theoretical question, will the treatment still be psychoanalysis? We believe that as long as the analyst continues to interpret the patient's unconscious feelings, conflicts and fantasies and explore transference-countertransference interactions, that we should defer "[t]he question of whether these principles or techniques are analytic and focus

instead on whether they are *therapeutic*" (Gabbard & Westen 2003, p. 826). Westen (2002) refers to "a way of working clinically that is kinder, gentler, and [he adds] *I suspect more effective*" (p. 916, italics added); but, he is concerned that this moves us toward theoretical nihilism, by which he means undermining the rules of traditional technique.

Rather than proposing another model of treatment to incorporate these explicit techniques, we urge a reassessment of the "standard model" which aimed at neutrality, privileged free association and provided interpretations. Given the widespread recognition that the analyst's subjectivity limits neutrality and influences associations and interpretations, a reconceptualization of the standard model is needed.

Naso (2005) argues that postmodern psychoanalysis is no more successful in dealing with the epistemological problems of influence and inadvertent suggestion than traditional or modern psychoanalysis – and we agree. He adds that the implications of the postmodern position would be that "[i]nterpretations enjoy no hegemony over nonpsychoanalytic ones and that their therapeutic results may be indistinguishable from the effects of suggestion and influence that they ambivalently embrace" (p. 382).

Failing to solve the epistemological problems of contemporary psychoanalysis, however, does not mean that postmodern techniques may not enhance the therapeutic effectiveness of treatment. This translates, then, into an empirical, not a theoretical question.

Freud had been concerned that the treatment would destroy the "science" (1926). On the contrary, "It is not the therapy that is destroying the science," writes Holzman (1985), "for it is the therapy that has given us the science" (p. 765). Enhancing treatment effectiveness may revitalize the science by generating empirically-based improvements in psychoanalytic praxis which will increase the respect for and interest in it by other scientific disciplines, and, perhaps, by the public at large.

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