

## Learning from the Patient - The Cooperative Endeavor of Analytic Psychotherapy

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### Abstract

Communication involves intimate human interaction that creates shared realities and forges connections. Nowhere is this more apparent and more necessary than in the therapeutic relationship, where the communication is, essentially, the curative agent. By following the patient's lead, the many nuances of the various levels of communication are harnessed to promote insight and understanding. In this way, that analytic space becomes grounds for new restorative experiences and healing.

**Keywords:** Learning, Patient, Cooperative, Endeavor, Analytic, Psychotherapy

### Introduction

*"Psychotherapy is the systematic use of a human relationship for therapeutic purposes"*

*Hans Strupp, Vanderbilt University Psychologist*

Psychoanalysis and its related therapeutic process can be conceptualized as both a science and an art. As a science, it seeks to forge an understanding of the human mind. As an art, it may be considered the endeavor by which an individual, in close relationship with an analyst, may become acquainted with his/her unconscious feelings and release imprisoned emotions, giving up illusions that were once useful, but have become exaggerated, redundant or outmoded and thus cause pain and dysfunction. Methods of psychoanalytic therapy, "provide for a situation in which a systematic exploration is undertaken of the patient's automatic, unconscious, defensive solutions to conflict, based on the fact that since childhood he or she has perceived certain wishes, fantasies, emotions and impulses as too dangerous to manage at a conscious level" (Moore & Fine, 1990, p.16). The major aim of such exploration is to help the patient achieve increasingly mature, conscious or preconscious solutions to his or her conflicts.

Often referred to as the "talking cure", psychotherapy relies heavily on the interaction and relationship between therapist and patient, which develops through extensive communications. However, communication in a therapeutic environment, occurs on many levels and is not limited to the direct and explicit verbalizations that ensue in a session. On the contrary, the very nature of analysis determines that the majority of communication which addresses the underlying issues relevant to therapy is not of a direct and obvious nature. It is the derivative communication, "the indirect communication of thoughts or feelings unconsciously associated to or derived from whatever has primarily provoked them" (Casement, 1992, p. 14), and the subsequent response of the therapist to this communication, that often serves to direct therapy in a forward motion toward the exploration of the patient's unconscious conflicts. It can be argued that in the context of therapy everything that occurs is a communication of some type. Greater attention to the content and process of interactive communication in the therapy session, while suspending premature theory-based interpretations, can facilitate the development of the trusting relationship and the progress toward more effective insight and subsequent change.

### Elements of the Psychoanalytic Process - How One Learns from the Patient

#### Symptom Formation

Sigmund Freud hypothesized that symptoms of psychopathology arise when conflicting emotions produce unmanageable psychic distress. Mirroring scientific notions regarding the conservation of energy, he theorized that psychic conflict creates an energy imbalance in the psychiatric apparatus that manifests itself in the subjective experience of anxiety, which, in turn, induces the psyche to relieve the distress by transferring awareness of the conflict into the unconscious. This process of

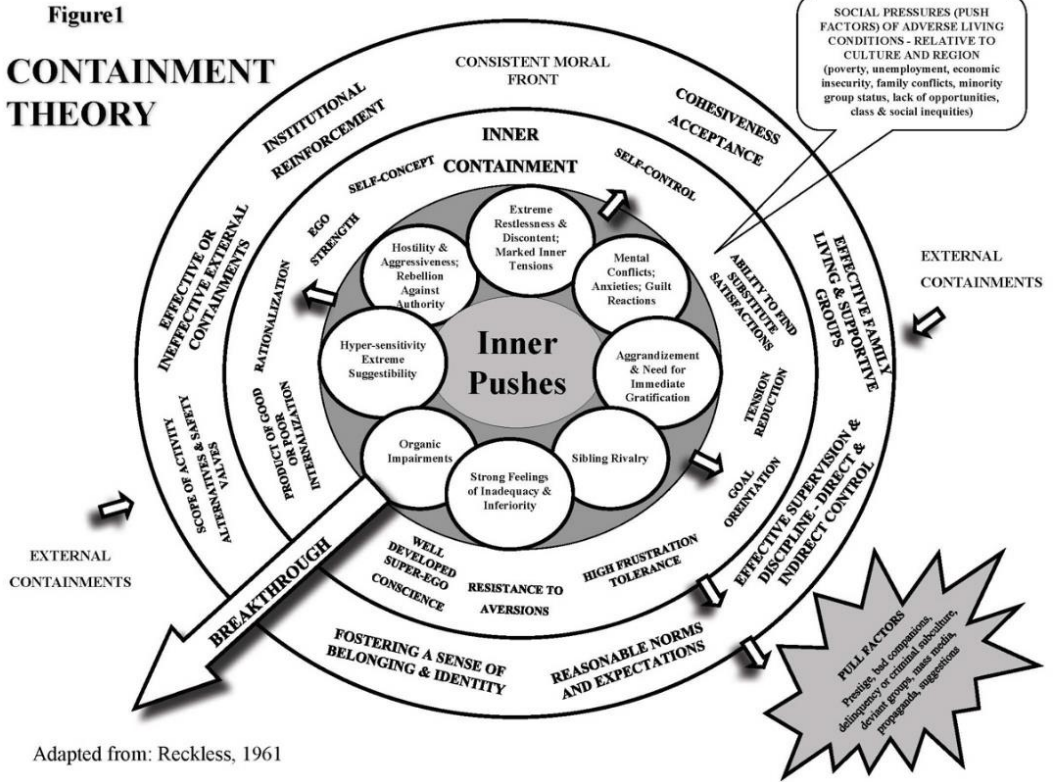
psychic repression, however, is typically incomplete and elements of awareness leak into consciousness, again causing anxiety. In response, the psychic apparatus further attempts to relieve the anxiety by transforming it into a neurotic symptom. In essence, Freud posited psychic defenses against intrapsychic conflict and anxiety and considered symptom formation largely as a consequence of the failure of the psychic defense mechanisms (Goldman, 2011).

(See Table 1)

<i>Table 1: Psychic Defense Mechanisms</i> <i>Goldman, H. H. (2011). Review of general psychiatry, 10e. New York, NY: McGraw-Hill.</i>	
<i>Denial</i>	<i>The unconscious literally deletes from awareness an unpleasant or anxiety-provoking reality.</i>
<i>Sublimation</i>	<i>The redirection of an unacceptable impulse into an acceptable form of behavior.</i>
<i>Reaction Formation</i>	<i>The redirection of an unacceptable impulse into its opposite.</i>
<i>Displacement</i>	<i>An impulse toward a given person or situation is redirected toward a "safer" less distressing object.</i>
<i>Projection</i>	<i>An unacceptable or anxiety-provoking impulse or affect is transplanted to another individual or situation.</i>
<i>Rationalization</i>	<i>An acceptable explanation for a feeling or behavior is used to camouflage the unacceptable underlying motive or impulse.</i>
<i>Intellectualization</i>	<i>The avoidance of "feeling" by taking refuge in "thinking".</i>
<i>Repression</i>	<i>Disturbing psychological material is secondarily removed from consciousness or primarily prevented from becoming conscious.</i>
<i>Isolation of Affect</i>	<i>The removal of disturbing affect from an idea or event, with the dispassionate details or description remaining.</i>
<i>Suppression</i>	<i>Intentional repression of unpleasant conscious material.</i>
<i>Humor</i>	<i>A conscious and unconscious defense that allows material that stirs unpleasant affects to be better tolerated in consciousness.</i>

Correspondingly, Walter C. Reckless proposed the Containment Theory which posited dysfunctional behavior (or alternatively functional behavior) as the product of interplay between various forms of stressors, known as pushes or pulls, and internal and external controls, known as containments. While originally formulated as a sociological premise, Containment Theory is extrapolated to a representation of intrapsychic functioning and conflict, encompassing the unconscious structure of both adaptive and maladaptive responses. It assumes that for every individual there exists, in varying levels of strength and functionality, containing external structures as well as protective internal structures. The relative integrity and stability of these entities determines one's predisposition toward either health or dysfunction (Reckless et al., 1956; Reckless, 1961, 1967). Therapy then, would seek to make conscious and fortify these psychic structures.

(See Figure 1)



### Transference and Countertransference

The psychoanalytic orientation to psychotherapy specifically emphasizes the processes of transference and countertransference in the progression of the therapeutic relationship. Transference refers to “the largely unconscious displacement of patterns of feelings, thoughts and behavior, originally experienced in relation to significant figures during childhood, onto the therapist or other significant figure” (Moore & Fine, 1990, p. 196). As therapy progresses transference concentrates more pointedly on the analyst and increases in intensity as it serves to replicate the childhood neurosis. Patients strive to elicit in an analyst a duplication of their basic life struggles, and analysts must interpret that transference while regressively experiencing and containing their own countertransference. In this way the analyst’s personal anonymity and neutrality creates a frame within which the transference issues can be worked through and resolved.

According to Freud, (1910; 1963) the concept of transference constitutes a one-person, intrapsychic construct reflecting the patient’s psyche. From this perspective, pathology is viewed as a manifestation of the manner and processes in which the individual’s instinctual drives are developed and defended against. Subsequently, healing occurs when these drives are made conscious in a therapeutic environment through the development of a transference neurosis whereby a patient experiences regression and the drives are displaced from their original objects onto the analyst. In this context, the analyst represents a neutral “blank screen” and therefore does not contribute to the nature of the transference, but rather merely receives the patient’s projections. The analyst “is presented as a vessel for transference, a potential space within which the patient can live infantile life anew” and furthermore, “. . . is assumed to approach becoming a perfect observing instrument, transcending his or her idiosyncrasy through submission to the powerful analytic process” (Bollas, 2017, p.200). This strategy is designed to maximize conscious scrutiny of a patient’s previously unconscious mental life. Furthermore, this orientation contends that for an analyst to explicitly state his or her own view of reality constitutes a personal disclosure on the part of the analyst that tends to foreclose a patient’s exploration of his or her own view.

Conversely, Moreno (1937) espouses an interpersonal alternative to the intrapsychic perspective, stating that, "Transference does not take place toward a generalized person or a vague Gestalt, but toward a role which the therapist represents to the patient. The therapist, in turn, can be caught in experiencing the patient in complimentary roles" (p.8). Thus, Moreno implies that transference is the product of the engagement of two persons in commendatory roles, which, in terms of the therapeutic context, occurs as the reciprocal influence of therapist and patient represented by the processes of transference and countertransference. From this interactional viewpoint, the therapist is not viewed as a blank screen but rather as an active participant and the therapeutic transference is the product of both the patient's inner world and the therapist's behavior. Moreover, Yalom (2005) asserts that increasing therapist transparency would actually decrease transference because the process evolves not through projection but rather through engagement and complementarity.

From either orientation transference can be characterized as "a form of memory in which repetition in action replaces recollection of events" (Corsini & Wedding, 2013, p. 39). It represents the patient's unconscious communication regarding the inner conflicts and motivations for defenses which constitute the integral issues of therapy. Through analysis and interpretation of the transference neurosis, insights can be gained, repressed memories recalled, issues re-worked in the safe therapeutic environment, and ultimately, substitute sublimated interests developed for effective functioning in the world at large.

Correspondingly, the analyst develops countertransference reactions to the patient that may encompass a form of negative feelings and/or disproportionately positive, idealizing or even eroticized reactions. Countertransference refers to "the displacement onto the patient of attitudes and feelings derived from earlier situations in the analyst's own life in response to the patient's behavior toward the analyst or a more specific reaction to the patient's transference" (Blum & Goodman, 1999, p.121). Countertransference may exist in relation to a particular individual, to a type of patient, to an aspect of psychopathology, to significant objects and figures in the patient's life, to tangential and adventitious aspects of the patient's current life situation or to his/her history or personality attributes. Additionally, countertransferences are generally a blend of the therapists' own displacements from the past and their reactions to the issues of the patient's transferences. Through this process of interpersonal collaboration therapists often adopt roles in reaction to subtle transference interactional pressures from their patients. Such induced roles indicate to therapists how the patient experiences the therapeutic relationship and provide a glimpse into the kinds of relatedness in the patient's earlier life.

While unanalyzed countertransference reactions are considered negative and even an impediment to effective therapy, conscientious scrutiny of this phenomena can facilitate discernment of the meaning of the patient's feelings, thoughts and behaviors as well as the dynamics of their interpersonal interactions. In many cases, when used appropriately, the process of countertransference makes transference a more efficient and effective agent for change. If, even more than being a blank screen, an analyst can be a detached, safe acknowledgment of the typical way a patient is experienced by others, then this representation can assist in the process of moving the patient beyond the underlying conflict fueling those repetitive reaction patterns. According to Freud, who first noted the existence of this interplay in the therapeutic context, "Countertransference is a major source of the trials and tribulations of the analytic encounter, with the potential for both destructive regression and constructive progress in understanding" (Freud, 1910, p. 151).

This powerful energy flow of transference and countertransference between analyst and patient constitutes the driving force of psychoanalytic work. Commenting on this complex interaction, Bollas (2017) writes, "...for differing reasons and in various ways, analysts re-create their infantile life in the transference in such a determined and unconsciously accomplished way that the analyst is compelled to re-live elements of this infantile history through his countertransference, his internal responses to the analysand" (p.200).

Effective management of the processes of transference and countertransference is essential in understanding the unconscious communication of the patient and ultimately in facilitating progressive insight and change. It is the therapist's role to step back from the subjective experience of these processes as they occur in the therapeutic session and to consider the various cognitive and affective aspects in the context of the patient's life history and problems. In this way, these issues, which characteristically represent recurring patterns of maladaptive and dysfunctional behavior, can be viewed in a new light and used to encourage new, more adaptive and functional responses. Casement (1992, p. ix) refers to this aspect of the therapist's role as the development of internal supervision whereby "analysts monitor the interaction between themselves and their patients, and their impact upon the analytic process."

### **Interpretation and Containment**

Within the context of the evolving therapeutic relationship and the dynamic interplay of transference and countertransference previously described, the analyst offers both progressively insightful explanations and emotional support as the patient explores unconscious material. Interpretation refers to the central activity of the analyst during treatment whereby, "the analyst expresses an understanding of the patient's mental life, based on the patient's description of memories, fantasies, wishes, fears and other elements of psychic conflict that were formerly unconscious or known to the patient only in incomplete, inaccurate or otherwise distorted form, as well as on the way a patient distorts the relationship with the analyst to meet unconscious needs and to relive old experiences" (Moore & Fine, 1990, p.103). This process of interpretation requires the contribution of both therapist and patient and involves modification as new material emerges. Interpretation allows patients to understand their past and present inner life in a new, less distorted and more complete way, and thus lays the groundwork for the possibility of changes in feelings, attitudes and behavior. In a sense, interpretation represents the overt communication by the analyst based on the cumulative conscious and unconscious communications of the patient and is intended to offer patients explanation and extended knowledge about themselves and the previously unacknowledged aspects of their suppressed unconscious conflicts.

Containment occurs when an individual "projects a part of his or her psyche, especially the uncontrolled emotions, to be held or incorporated by another in a supportive relationship, who absorbs them and translates them into specific meanings, and acts upon them thoughtfully, the whole transaction resulting in a transformation of the projective identifications into meaningful and unthreatening thought" (Moore & Fine, 1990, p.32). Using the vehicle of the transference-countertransference experience patients purposefully communicate their need for the therapist to experience, understand and successfully manage those feelings which the patient has heretofore experienced as unmanageable. Typically, patients bring with them a history of past experiences whereby previous attempts at finding containment in the context of other relationships has failed. In this way, the patients' desperate need to further suppress the emotions has been reinforced and strengthened. Therefore, unconsciously and/or consciously they expect and seek to induce the same reaction from the therapist. Through the process of analytic holding, the therapist's ability to endure these emotions and interpret them in such a way that the patient feels truly understood allows patients to develop their own capacity to manage difficult feelings without resorting to the standard defenses of suppression, repression and avoidance (Casement, 1992, 2013).

In order to move the analysis forward toward useful insight, the therapist must, within the context of the ongoing therapeutic processes of transference and countertransference, provide an adequate balance of interpretation and containment. Interpretation without containment establishes a protective and defensive distance from the emotions a patient is communicating, reinforcing the notion that they are dangerously unmanageable and must remain repressed. Containment alone keeps a patient stuck in a dependency state with the therapist in relation to the quagmire of emotions which the patient experiences as unmanageable and bewildering. Through a balance of interpretation and containment the therapist communicates both a willingness and an ability to comprehend, connect with and tolerate those feelings which the patient experiences as overwhelming.

### **Analytic Space and Analytic Process**

The analytic space, unlike the mental and emotional space in any other interpersonal interaction, exists for the purpose of allowing a unique type of relating, involving transference and subsequent working through the patient's resistance which will bring about significant and lasting change. While there is an exchange of ideas, the space exists for, and is focused on, the needs of the patient and is protected from internal and external influences which distract from the primary purpose. In order to be therapeutic, the analytic space must be free from the intrusive pressures of influence, expectation and judgment which exist in the space of most relationships. The therapeutic space allows the patients to spontaneously be, think, feel and express whatever is reflective of their experience of an autonomous self in that moment. It is from these natural projective expressions that the patient will consciously and unconsciously communicate their issues and lead the therapist toward accurate interpretation of their unresolved conflicts. Within the analytic space the analyst provides a reflective viewpoint and monitors his/her countertransference interactions in order to maintain a level of security that allows the patients to risk examination of heretofore repressed internal conflict and feeling states. It is the maintenance of the analytic space and a willingness to respond to the direction indicated by the unconscious communication of the patient which allows for progress in the analytic process.

As part of the analytic process some individuals may benefit greatly from a period of dependency on or idealization of the therapist (Kohut, 2009; Winnicott, 2014). Ultimately, however, for the patient to grow, this mode of relatedness must be worked through. As Kellerman (1985) states, "Learning to see who the therapist really is is one of the unavoidable steps in acquiring a greater capacity for reality testing and for achieving autonomy. The distortion of reality inherent in idealization leaves the patient a child, unable to grow up. And sooner or later patients will realize that they were cheated by a leader who did not challenge their flattering idealizations" (pp. 91-92).

### **Not-Knowing - the Uncomfortable Realm of the Unknown**

Casement asserts that in "any unfamiliar situation elements that can be regarded as familiar are responded to as signs" (1992, p. 9). In this way, therapists as well as patients can sacrifice a true understanding of the uniqueness of a situation for the sake of the comfortable security of moving beyond the not-knowing and into the knowing. For therapists, theory-based expectations of typical behavior or a typical course of therapy can hamper progress by too quickly veering the analyst off course and not leaving room for discovery. Casement further asserts, "If too much weight is given to what is already known, then the unknown remains elusive and our attempts at understanding introduce their own distortions to what is being studied" (p. 190).

### **Conclusion**

Communication has been referred to as "the process of constructing shared realities through human interaction" (Shockley-Zalabak, 2014, p.23). It can be argued that nowhere is it more imperative to establish a genuine understanding of a shared reality than within the context of a therapeutic relationship where the ideal, as first expressed by Freud, is "to replace the unconscious repression of impulses, wishes and attitudes with rational judgment, to give the patient the opportunity to make conscious decisions about his conflicts, to redirect the psychic energy into higher and more valuable social and cultural activities; in essence, to become the kind of individual he would have become had not the neurosis interrupted his development toward maturity" (Freud, 1963, p.68). From the first expressions of symptomatic behavior patients communicate their unconscious search for help and wholeness. Following their lead, the analyst must "be instrumental in generating a new experience of a different order and disconfirming the patient's pathogenic beliefs" (Ehrenberg, 1984, p.23)

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