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Introduction

Psychoanalysis has changed the way we think about our minds and what it means to be human. Its reach includes a groundbreaking form of psychological treatment, as well as models of psychological functioning, development, and psychopathology. Many divergent psychoanalytic theories and treatment modalities have been developed over more than a century through the writings of a host of different theorists and practitioners. Nonetheless, it is possible to speak in general terms about basic principles that cut across all psychoanalytic perspectives. These include (a) an assumption that all human beings are influenced by wishes, fantasies, or knowledge that is outside of awareness (*the unconscious*); (b) an interest in facilitating the awareness of unconscious motivations, thereby increasing choice; (c) an emphasis on exploring the ways in

As noted in the Acknowledgments, Jeremy Safran passed away in 2018 during early discussions for the revision of *Psychoanalysis and Psychoanalytic Therapies, Second Edition*, which was subsequently completed by Jennifer Hunter. As in the first edition, "I" statements are used throughout this book to represent Dr. Safran's perspective, voice, and work.

http://dx.doi.org/10.1037/0000190-001
Psychoanalysis and Psychoanalytic Therapies, Second Edition, by J. D. Safran and J. Hunter

which people avoid painful or threatening feelings, fantasies, and thoughts; (d) an assumption that people are ambivalent about change and an emphasis on the importance of exploring this ambivalence; (e) an emphasis on using the therapeutic relationship as an arena for exploring psychological processes and actions (both conscious and unconscious); (f) an emphasis on using the therapeutic relationship as an important vehicle of change; and (g) an emphasis on helping clients to understand the way in which their construction of their past and present plays a role in perpetuating habitual patterns.

In the early days of psychoanalysis, clients typically saw Freud and his colleagues four to six times per week, and treatment lasted from 6 weeks to 2 months. As the goals of psychoanalysis evolved from symptom reduction to more fundamental changes in personality functioning, the length of the average analysis gradually increased over time to the point at which it became common for an analysis to last 6 years or longer.

Many contemporary psychoanalysts still believe that long-term, intensive treatment has important advantages as a treatment modality. As the empirical evidence shows, although circumscribed symptoms can improve in short-term, less intensive therapy, more fundamental changes in personality functioning and underlying psychological structures take time (e.g., Howard, Kopta, Krause, & Orlinsky, 1986). Moreover, given that the client–therapist relationship is seen as a central mechanism of change, the theory holds that longer term, intensive treatment is necessary to allow this relationship to develop and play a transformative role. In contemporary psychoanalytic practice, it is common to see clients once or twice a week for a shorter term, but the basic analytic values and goals remain.

Psychoanalysis was the first modern Western system of psychotherapy, and most other forms of therapy evolved out of psychoanalysis, were strongly influence by it, or developed partially in reaction to it. The term *psychoanalysis* was originated by Sigmund Freud (1856–1939), a Viennese neurologist who with a number of key colleagues (e.g., Wilhelm Stekel, Paul Federn, Max Etington, Alfred Adler, Hans Sachs, Otto Rank,

Karl Abraham, Carl Jung, Sandor Ferenczi, Ernest Jones) developed a discipline that combined a form of psychological treatment with a model of psychological functioning, human development, and theory of change. The emergence of this discipline was influenced by a variety of developments taking place at the time in psychiatry, neurology, psychology, philosophy, and social and natural sciences. In addition, early psychoanalysis was influenced by Freud's attempts to defend against criticism from outside the field as well as dissenting perspectives and ideas raised by his own students and colleagues. Significant conflict lead to estrangement from many of his most important early colleagues as they developed their own divergent ideas; this group includes Jung, Rank, and Adler (Gay, 1988; Makari, 2008). Freud's theoretical perspective and ideas about psychoanalytic technique evolved over the course of his lifetime, and although his thinking is often presented as a unified and coherent system of thought, reading his articles and books is more like reading ongoing work in progress rather than a systematic and unified theory.

Although Freud undeniably was the single most influential figure in the initial development of psychoanalysis, many other creative thinkers played a role in its development from the very beginning. Some of their ideas led Freud to sharpen his thinking in response, some of their ideas were assimilated and modified by Freud in various ways, and some of their ideas were not assimilated by Freud but had a subsequent impact on their own students' thinking and on future generations of psychoanalysts (Makari, 2008). Although psychoanalysis began with Freud's writing and lectures and the early writing of a small group of colleagues around him in Vienna, by the time of Freud's death in 1939, it was becoming an international movement with important centers in Vienna, Zurich, Berlin, Budapest, Italy, France, England, the United States, and Latin America. Each of these centers contributed its unique influence to the development of psychoanalysis, and a host of different schools and theories of psychoanalysis have evolved in different countries since 1939 (Makari, 2008). Adherents to different traditions within psychoanalysis interpret Freud differently and can disagree about major premises and technical recommendations.

PSYCHOANALYSIS TODAY

Although it is understandable for critics to equate psychoanalysis with Freud, it is important to recognize that the value of psychoanalytic treatment and the validity of psychoanalytic theory are not tied to the validity of Freud's thinking. Freud was one person writing from a particular historical and cultural place. Some of his ideas were more valid in their original historical and cultural context than they are in contemporary times, and some were flawed from the beginning. As readers will see, there are some dramatic differences between early psychoanalysis and the form it has today. Relative to Freud's time, contemporary American psychoanalysis has a greater emphasis on the mutuality of the therapeutic relationship; an emphasis on the fundamentally human nature of the therapeutic relationship; more of an emphasis on flexibility, creativity, and spontaneity in the therapeutic process; and a more optimistic perspective on life and human nature. Contrary to common belief, there is actually substantial and growing empirical support for the effectiveness of psychoanalytically oriented treatments (Leichsenring, Luyten, et al., 2015; Levy, Ablon, & Kaechele, 2012; Shedler, 2010) and the validity of various psychoanalytic constructs (Westen, 1998; Westen & Gabbard, 1999). And there has been a growing emphasis on adapting psychoanalytic theory and practice in a culturally and politically responsive fashion (Altman, 2010; Aron & Starr, 2012; Gutwill & Hollander, 2006; Perez Foster, Moskowitz, & Javier, 1996).

In the United States, psychoanalysis has evolved under the influence of certain characteristic American attitudes, including a tendency toward optimism and the philosophy of American egalitarianism. Another important factor is that many of today's leading analysts came of age during the cultural revolution in the 1970s—a time when traditional social norms and sources of authority were being challenged. In addition, prominent feminist psychoanalytic thinkers have challenged many of the patriarchal assumptions implicit in traditional psychoanalytic theory, raised important questions about the dynamics of power in the therapeutic relationship, and reformulated psychoanalytic thinking about

gender (e.g., Benjamin, 1988, 1995, 2018; Dimen, 2003; Harris, 2008). Another influence has been a postmodern sensibility that challenges the assumption that one can ever come to know reality objectively, maintains a skeptical attitude toward universalizing truth claims, and emphasizes the importance of theoretical pluralism. A final influence has been an influx of clinical psychologists, social workers, people of color, women, and people with diverse gender identities and sexual orientations into postgraduate psychoanalytic training institutes in the past few decades. This has led to significant and intellectually interesting changes in a discipline that was traditionally dominated by White male psychiatrists.

Unfortunately, many in the broader mental health field and the general public are unaware of these changes within psychoanalysis and are responding to a partial or caricatured understanding of the tradition on the basis of aspects of psychoanalytic theory, practice, and attitude that are no longer prominent. Although there are many valid critiques of psychoanalysis in both its past and current forms, I believe that the current marginalization of psychoanalysis is partially attributable to certain contemporary cultural biases, especially in the United States, that are not unequivocally healthy ones. These biases include an emphasis on optimism, speed, pragmatism, instrumentality, and an intolerance of ambiguity. Although all of these emphases certainly have their value, they can underestimate the complexity of human nature and the difficulty of the change process. American culture tends to gloss over the more tragic dimensions of life, to espouse the belief that we can all be happy if we try hard enough, and to be biased toward a "quick-fix mentality." Psychoanalysis originated in continental Europe—in a culture that had experienced centuries of poverty; oppression of the masses by the ruling classes; ongoing religious conflict and oppression; and generations of warfare culminating in two world wars that were unprecedented in scale, degree of devastation, and tragedy.

Although American psychoanalysis tends to be more optimistic and pragmatic than its European counterpart, it still retains many of the traditional psychoanalytic values, such as the appreciation of human complexity, a recognition that contentment is not necessarily the same as

a two-dimensional version of "happiness," and a recognition that change is not always easy or quick. Additionally, there has been movement in contemporary psychoanalysis toward recovering some of the culturally subversive, socially progressive, and politically engaged spirit that was once more characteristic of the discipline. My hope is that this book will both correct misconceptions about traditional psychoanalysis and introduce some of the more important recent developments in psychoanalytic theory and practice. This will be done through discussion of current theoretical developments and the use of clinical examples that demonstrate current clinical practice. In the latter, the client names and identities have been disguised throughout the book.

THE TENSION BETWEEN CONFORMIST AND SUBVERSIVE THREADS IN PSYCHOANALYSIS

For many years, psychoanalysis was the dominant theory for mental health practitioners in the United States and many other countries. From the late 1960s until the present time, however, psychoanalysis in the United States has become increasingly marginalized within both the health care system and clinical training programs. There are reasons for the declining fortunes of psychoanalysis. One important factor is that during its heyday, psychoanalysis earned a reputation as a conservative cultural force with a tendency toward orthodoxy, insularity, arrogance, and elitism. It also earned a reputation as a somewhat esoteric discipline with a limited interest in grappling with the concrete problems that many people deal with in their everyday lives and a limited appreciation of the social and political factors that affect their lives. Instead, psychoanalysis came to be seen by many as a self-indulgent pastime for the financially comfortable.

The fact that psychoanalysis came to earn this reputation is ironic. Although Freud initially began developing psychoanalysis as a treatment for clients presenting with symptoms that other physicians were unable to treat, his ambitions and the ambitions of subsequent psychoanalysts ultimately extended beyond the realm of therapy into social theory and

cultural critique. Freud and many early analysts had medical backgrounds. Nevertheless, Freud came to feel strongly that psychoanalysis should not become a medical subspecialty and, in fact, prized the cultural and intellectual breadth that could be brought to the field by analysts with diverse education backgrounds and intellectual interests. Many early analysts, including Freud, were members of an emerging, educated Jewish middle class whose upward social mobility was made possible by the open, politically progressive policies of the Austro-Hungarian Empire at the turn of the century and who contributed to the development of this culture.

The early analysts thus tended to be members of a liberal, progressive intelligentsia—a traditionally oppressed and marginalized group. They aspired toward social acceptance but at the same time tended to regard prevailing cultural assumptions from a critical perspective. This critical and in some respects subversive stance went hand in hand with a vision of progressive social transformation. Psychoanalysis began in part as a radical critique of the illness-producing effects of social suppression and consequent psychological repression of sexuality. Freud was deeply interested in broad social and cultural concerns. He was critical of various trappings of the physician's privilege, and until the end of his life he supported free psychoanalytic clinics, stood up for the flexible fee, and defended the practice of psychoanalysis by professionals without medical training. Many of the early analysts were progressive social activists committed to political critique and social justice. Sandor Ferenczi, one of Freud's closest colleagues, critiqued social hypocrisy and conventionalism, founded a free clinic in Budapest, and passionately defended the rights of women and homosexuals. In Berlin in the 1920s, Karl Abraham, Ernst Simmel, and Max Etington set up a public psychoanalytic clinic that became a bastion of social and political progressivism (Danto, 2005). A number of these analysts were influenced by left wing socialist thinking. This is not surprising given that they came of age in the politically charged culture of Vienna and Berlin, where the Marxist critique of capitalism was widely discussed in intellectual circles. They viewed themselves as brokers of social change and saw psychoanalysis as a challenge to conventional

political codes and as more of a social mission than a medical discipline. Prominent analysts such as Wilhelm Reich (1941), Erich Fromm (1941), and Otto Fenichel (1945), among others, were well known for their socialist or Marxist commitments and their fusion of psychoanalysis and social concerns.

This subversive trend stands in contrast to the "professionalization" of psychoanalysis in the United States, by which it became increasingly conservative and conformist. During the early decades of the 20th century, when psychoanalysis was beginning to take root in the United States, the medical community was struggling to upgrade and standardize physician training. In 1938, a fateful decision was made early by the American Psychoanalytic Association to restrict formal psychoanalytic training to physicians. A concern about protecting the professionalism of psychoanalysis played a role in developing a purist, elitist, and rigid form of psychoanalysis with a veneer of scientific respectability, a discouragement of innovation, and a tendency toward social conservatism. As psychoanalysis became established as a subspecialty of medicine, the social prestige of the psychoanalytic profession grew as well. Chairs in most major psychiatry departments were psychoanalysts, and most psychiatry residency training programs provided at least some training in psychoanalytically oriented treatment.

The United States became the center of the psychoanalytic world, and massive amounts of time, effort, and money went into psychoanalytic training and the development of the profession. Psychoanalysis became a lucrative, high-prestige, and socially conservative profession, attracting candidates who often had an interest in becoming respected members of the establishment rather than in challenging it (Jacoby, 1983; McWilliams, 2004). Unlike the original psychoanalysts in Europe coming from backgrounds and educational systems that were intellectually rich and scholarly in nature, many of the candidates entering psychoanalytic training in the United States came from educational systems that were technical in nature. There was a tendency for psychoanalysis to be applied as a narrow, technical approach with rather inflexible ideas about correct and incorrect technique, analogous to the way one tends to think of medical procedures.

Over 50 years ago, Robert Knight, then president of the American Psychoanalytic Association, remarked on the more "conventional" character of the psychoanalytic candidates of his era, relative to the more original and individualistic character of the candidates of the 1920s and 1930s. According to Knight (1953), the psychoanalytic candidates of the 1950s were "not so introspective, are inclined to read only the literature that is assigned and wish to get through with the training requirements as soon as possible" (p. 218).

In addition, medical education, with its traditional respect for hierarchy and authority, tended to infuse the training of psychoanalysts with a sensibility that led to an unquestioning acceptance of the words of one's teachers rather than to the development of a critical and reflective spirit. And this same sensibility tended to color the therapist–client relationship in a way that institutionalized and exacerbated the inherent power imbalance in the therapeutic relationship instead of encouraging a more democratic egalitarian relationship (Jacoby, 1983; Moskowitz, 1996).

Meanwhile, various forces at play were about to lead to dramatic changes in American psychoanalysis. With the rise of biological psychiatry and the explosion in the development of new psychotropic medications, psychoanalysis became less favored within American psychiatry. The publication of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; third ed.; American Psychiatric Association, 1980), which attempted to purge the *DSM* of psychoanalytic thinking, further contributed to the growing marginalization of American psychoanalysis (e.g., Horowitz, 2003). Training curricula within psychiatry residencies shifted away from introducing residents to the basics of psychoanalytic theory and practice, and the number of psychiatry residents applying for training in psychoanalytic institutes decreased dramatically over time.

Around this time, the Division of Psychoanalysis (Division 39) formed within the American Psychological Association. In 1986, Division 39 filed a class action suit against the American Psychoanalytic Association, arguing that the refusal to admit psychologists as candidates within psychoanalytic training institutes was a violation of the antitrust regulations because, by establishing a monopoly of the field of psychoanalysis by

physicians, it was preventing fair competition for clients by psychologists and depriving them of their livelihood. Ironically, by the time the lawsuit was settled, market forces were already opening the doors of psychoanalytic training institutes to psychologists, because as the number of candidates seeking psychoanalytic training continued to dwindle, traditional institutes became eager to recruit psychologists (McWilliams, 2004; Moskowitz, 1996).

In the past 30 years, many of the more significant and innovative contributors to the development of American psychoanalytic theory have been psychologists. Psychologists have become the torchbearers for psychoanalysis in this country. This new breed of psychoanalytic theorist and researcher has played a vital role in transforming psychoanalysis into a less insular and more intellectually vital discipline, grounded in an appreciation of contemporary developments in a broad range of social sciences, including psychology, sociology, political science, and philosophy. The revitalizing influence of psychology on psychoanalysis is attributable to certain factors. First, there is more of an emphasis in clinical psychology training programs on the development of critical-thinking skills, in contrast to residency training in psychiatry, which places a greater emphasis on memorization of facts and technical mastery. Moreover, training in psychology does place more emphasis on the study of basic psychological, developmental, cultural, and social processes that are relevant to understanding both psychopathology and the process of change. In addition, psychologists receive more training in empirical research methodology than do psychiatrists. Although this does not necessarily lead psychologists to maintain empirical research programs after going into psychoanalytic training, it does help to hone their critical thinking skills and to deepen their appreciation of the limits of various theoretical constructs.

Another important variable influences the changing character of American psychoanalysis. Given that pursuing formal psychoanalytic training in today's culture is less likely to be a pathway to professional prestige or financial success, the typical candidate is more likely to be

drawn to the field for intrinsic reasons. Especially given the increasingly marginal status of psychoanalysis within the general culture and within mainstream clinical psychology, those attracted to the field are less likely to buy into prevailing cultural and professional values and assumptions and are more likely to have a critical perspective. Thus, ironically, the marginalization of psychoanalysis provides a potential catalyst for innovative thinking. In this respect, important aspects of the emerging sensibility in contemporary American psychoanalysis may be closer in nature to the sensibility of the early psychoanalysts than that of American psychoanalysis during the mid-20th century.

PSYCHOANALYSIS VERSUS PSYCHODYNAMIC THERAPY

Traditionally, psychoanalysts have made a clear distinction between *psychoanalysis* and what is referred to as *psychoanalytic* or *psychodynamic therapy*. The term *psychoanalysis* has been reserved for a form of treatment with certain defining characteristics or parameters. The term *psychodynamic therapy* has been used to refer to forms of treatment that are based on psychoanalytic theory but that lack some of the defining characteristics of psychoanalysis. Over the years there has been some controversy over which parameters of psychoanalysis are defining criteria and which are not. A common stance has been that psychoanalysis is long term, intensive (e.g., a minimum of three sessions per week), and open ended (i.e., no fixed termination date or number of sessions). In addition, traditional psychoanalysis came to be characterized by a specific therapist stance that involves refraining from giving the client advice or being overly directive, maintaining anonymity by reducing the amount of information one provides about one's personal life or one's feeling and reactions in the session, attempting to maintain the stance of the neutral party by speaking sparsely, and having the client recline on a couch while the therapist sits upright, out of view of the client. This traditional conceptualization of some of the key characteristics of psychoanalysis came to be known as *classical psychoanalysis.*

HOW DID THE DISTINCTION BETWEEN PSYCHOANALYSIS AND PSYCHODYNAMIC THERAPY EMERGE?

In the 20th century, psychoanalysts in the United States often asserted that only those within the milder range of pathology were suitable for analysis. They would speak of a client in terms of their "analyzability," referring to their ability to tolerate and benefit from intensive analytic work. Over time, analysts have experimented with treating a broader range of clients than had initially been the case. As a result, it became necessary to modify various treatment parameters to adapt the approach to clients with different characteristics and needs. Some clients find it too threatening, anxiety provoking, or destabilizing to explore their unconscious motivation and benefit more from structure, advice, and help with problem solving. Some require active reassurance and find the therapist's reluctance to provide direction or exert direct influence too frustrating or anxiety provoking. Some feel uncomfortable lying on a couch and experience it as a form of submission to the therapist. Some do not have the time or the financial resources to attend frequent sessions per week or long-term treatment. To adapt to the needs of these clients, therapists experimented with modifying all of these parameters. These modified versions of psychoanalysis came to be termed *psychodynamic therapies.* This has resulted in inevitable tensions within the professional communities over what can be considered "pure psychoanalysis."

Although it is premature to say that debates of this kind have ceased, I think it is fair to say that many psychoanalysts no longer make such rigid distinctions. Practitioners today often use the term *psychoanalysis* to refer to a depth-oriented treatment performed by a trained analyst, irrespective of frequency or the fine points of technique. My own perspective is that although the distinction between psychoanalysis and psychodynamic or psychoanalytic treatment has more to do with the politics of the discipline and professional elitism than any theoretically justifiable criteria, it is a mistake to assume that all of the parameters associated with a traditional psychoanalysis are outdated. There is often an important trade-off with these decisions of technique. For example,

the traditional analytic stance of attempting to maintain anonymity can alienate clients, especially in contemporary American culture, which tends to be less formal and hierarchical. At the same time, less explicit discussion of the analyst's thoughts and feelings can leave more room for the client's associations, including assumptions about the analyst that may be informed by transference. Many clients really do need and value advice and active feedback, but too much advice can interfere with clients' ability to develop their own resources and perpetuate a stance of helplessness. Some clients benefit from short-term treatment, but many really do need longer treatment.

Many analysts have found that using the couch facilitates therapeutic processes, such as helping clients to direct their attention inwards toward more important experiences that are subtle in nature and less accessible. It may be easier to free associate without looking to the analyst for a reaction. However, I feel that there are treatments or times in a treatment when an ongoing process of face-to-face encounter between the therapist and client plays a central role in the change process. For example, if the client comes to treatment with problems in intimacy, the ability to explore the quality of emotional contact between the therapist and client on a moment-by-moment basis can be important. It can also be critical for the therapist to be able to see the client's face to develop a nuanced sense of what he or she is feeling and to be able to attune empathically. Or it may be important for the client to have face-to-face contact with the therapist to be able to gauge his ongoing emotional reactions. Psychoanalysts are increasingly viewing the process of ongoing mutual affective regulation between client and therapist as an important change process. This process is facilitated when there is visual contact between the two and they are able to engage in an ongoing process of mutual responsiveness to each other's affective experience.