The Causes of and Patient Reactions to Change in Psychoanalysis

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In recent years, there has been an increased understanding of change in psychoanalysis. Under the auspices of the Committee of Clinical Observation of the IPA, a three-level (3-L) method of observation was created to study the transformation process in analysis. This method went from observing patient material from a phenomenological perspective, to hypothesis formation around explaining change in analysands, and finally to theoretical explanations around transformation phenomena. Analysts present case material to colleagues over a three-year period and then evaluate the sessions using numerous methodological tools in their evaluations. Besides the great insights gained by participants and presenters, the 3-L method has demonstrated that agreement could be achieved around the

nature of change regardless of theoretical orientation (de Litvan, 2014 & Fitzpatrick Hanly et al, 2021).

With the great gain achieved here, what has not been sufficiently addressed are the factors that lead to patient transformation in any given analysis. Reading the psychoanalytic literature and speaking with colleagues, one gets the impression that the nitty gritty of the details of how patients change is often ignored, as if it were a given. Over the past number of years, I have written and presented a number of papers on this topic ranging from analysts' attitudes towards change, to patient participation in their own analytic improvement (Rosenbloom, 2009, 2014, 2018 & 2019). In a recent paper, Blass (2023) attempts to examine Freud's own difficulties in understanding what he himself has coined as the process of working through (1914). Blass examines Freud's realization that insight is not enough and that something other than interpretations themselves must be occurring for progress to be made.

My intention here is to examine how the progress around how change in psychoanalysis has evolved in recent years. As well, I will present the evolution of my own analytic style since my training. I hope to illustrate several key variables concerning patient transformation as they emerge, as well as how analysts and analysands alike deal with positive developments arising in any given therapy. In one sense, my aim is to clarify processes that emerge which have not been addressed that frequently in the literature.

I will start by presenting a somewhat abbreviated overview of my analytic training in the late 1970s, that probably was replicated in many graduating classes of analysts at that time. As in traditional psychoanalytic curricula from a Freudian perspective, I was trained to understand neurotic structures, defenses and repetition compulsions, with the aim of making unconscious conflicts conscious during the analytic process. This was to be done by using transference and extra

transference interpretations. The importance of countertransference issues had not quite permeated analytic training as it did in later years. The major focus of our work was to make “correct interpretations” around traditional psychoanalytic conflicts be they oedipal or pre-oedipal with the notion that the working through process would lead to patient improvement.

Particularly for candidates and beginning analysts, as in the past and the present, the enormity of psychoanalytic data from sessions often leads many practitioners to doubt what they are doing. An example of a similar phenomenon in recent years is presented by the 3-L authors around Uruguayan candidates who were suffering from these doubts. Clearly the question of what constituted change and how it came about was far from the reasoning of these new analysts. A point that I will revisit in this paper is that until one has successfully analyzed a few patients, it is difficult to understand how the analytic process works.

In an earlier paper (Rosenbloom, 1992), I examined some of these issues as they occurred at the beginning of psychoanalytic careers. In addressing these difficulties, I coined the term “psychoanalytic work super-ego”, by which I meant all those variables that inhibited or facilitated psychoanalytic work. My contention here was that beginning analysts often developed a rigid, stereotyped manner of doing psychoanalysis. In this model, these analysts had a notion of psychoanalytic therapy as a pristine condition in which things such as “incorrect interpretations”, “talking too much in sessions”, and “making any self-disclosures” would be egregious errors. This led to an unnatural way of functioning for young analysts. Some became “transference chasers”, developing the notion that only transference interpretations would lead to change. I make these points because here was a zeitgeist where notions around patient transformation were distorted or exaggerated.

The loosening of my work superego began to occur when I started teaching a course on object relations theories to psychiatric residents, a course which I taught for 25 years. In this era of the emergence of object relations as an important component of psychoanalytic work, I started to learn some important lessons. Firstly, I saw that analysts from different persuasions were using different types of interpretations, many of which sounded credible and interesting. I began to wonder how patients were changing given these different approaches. Among the theoretical and clinical ideas presented were those of Winnicott (1994), who believed that interpretations were not all that useful when dealing with patients with severe pathology. Gradually, I began to question, although I had been trained to the contrary, whether it was **only** the content of interpretations that helped patients change. As time went on and I gained experience, it seemed to me that the quality of the relationship between the patient and the analyst was playing a greater role in patient progress than I had thought originally. The emerging literature on countertransference,

with particular emphasis on patient-analyst fit, led me to see analytic change as more dependent on the flexibility of the analyst, including the willingness of the therapist to engage with patients in an authentic manner.

A recent reprint of an article by Marmor (2022) led me to recognize techniques that I had been using for years, where patients were successfully analyzed. For example, I came to see that a “to and fro” style of work in sessions suited my analytic style. I somewhat guiltily began to see that asking questions of patients was often helpful in determining the existence of resistances. I noticed that some patients began in their own way to identify with my analytic style in situations that were useful to them. I also realized that timely suggestions might be necessary for patients who used defenses which caused them to occlude reality, something which I recognized as my friend, Joseph Fernando, identified as “attentional defenses” (2009). In these situations, the analyst might operate as an “auxiliary ego”, which I will refer to later in this paper. There are also

situations where questions asked by patients themselves might be crucial to their functioning in their own analysis. An example that comes to mind is from an article written by the analyst, Donna Orange (1998) whose patient started asking her personal questions about how she spent her weekend and queries about how she was doing in general. Orange was initially flustered by these questions, but she answered in a friendly and perfunctory manner. After the patient stopped doing this, material emerged that this analysand had an “internalized dead mother” and needed to be certain that her analyst was alive between sessions. It goes without saying that at this point my emerging way of functioning in sessions was taking me away from the notion of psychoanalysis as a pristine condition.

Patient Participation in the Management of Change

During my analytic career, I have encountered patients who were grateful for the work we did together, but did not match the insight-oriented model of my training. I and others in the psychoanalytic community, often wonder how

transformations occur in patients' minds where it is hard to understand how they changed. In many analyses, patients begin to participate in their own therapies by inadvertent experimentation that often leads to insights.

My experience has led me to believe that this occurs under a couple of circumstances. The outcome of what I am going to describe is a loosening in the superego of patients which leads them to try to determine how closely their internalized world corresponds to their real world. This is best exemplified by the work of Weiss and Sampson in their Mount Zion research group (1986). These analytic researchers have put forward a model based upon what patients <u>want</u>. They argue that analysands struggle against pathological introjects which they are both consciously and unconsciously trying to dispel. These patients begin to suspect that their analysts' superegos are less severe than their own and they attempt to test out these hypotheses with their analysts. Weiss and Sampson argue that when these experiments occur, the patients are inducing pro-plan

interpretations, that is, proving that the environment they perceive as dangerous is far less severe than their superegos.

An example which comes to mind is that of a 26-year-old elementary school teacher who was starting her third year of analysis. This young woman was extremely rule-bound and claimed that she wanted to loosen up a bit and enjoy life more. Miss X treated the analysis with the same degree of rigidity as the other parts of her life. She came early to every session and spoke in a meek voice, which suggested that she needed to be obedient to authority figures. In the period of which I write, she started her session in her usual meek style, but for the first time asked to change a session because she wanted to attend a local conference. I opened my appointment book and offered her two different times, one of which she accepted. This was followed by a sigh of relief which we didn't address until the following session. At the next appointment, Miss X explained by saying, "In my family, you never asked anything from anyone. You were

out there on your own". This led to a more detailed account of her experience with paranoid and distant parents. Weiss and Sampson would argue that my offering the appointment change is an example of their pro-plan formulation. Douglas Levin, my first supervisor, called these phenomena, "testing the transference".

Another example of patient participation in one's own analytic work is what I call, the "gun-to-the-head" phenomenon. Individuals in this category have the misplaced notion that if they are not studying or working ridiculous numbers of hours, their lives will fall apart. Often what transpires is that in the regular course of analysis, their superegos reduce in strength, leading them to feel less compelled to behave in this manner. They then become afraid that this sudden loosening of strictures will result in a catastrophe. I have found that when I notice these changes and interpret the loosening of their superegos, this becomes an important component in allowing the patients to accept what is occurring. In another example of this

phenomenon, a patient who was an A student, became convinced that his more relaxed attitude would result in his failure, only to find that his grades at school were almost identical with this less strict attitude.

Another non-standard area of analytic interpretive work occurs in those situations where analysands use Fernando's attentional defenses to the extreme. Fernando argues that denial of reality is a defense which can be easily interpreted but keeps occurring over and over again. In the cases I describe, denial of reality is ego syntonic and becomes extremely difficult to produce change. The analyst must in this instance repeatedly demonstrate that patients' expectations are grandiose, resulting in frustration and failure, and ultimately, this leads them to discover a cycle of grandiosity and low self-esteem.

My final major clinical example is designed to illustrate that psychoanalysis is a developmental process which requires that analysts pay exquisite attention to transformations in

patients, to assist them in the moving-along of the analytic process.

One of my patients, Sam, has recently become a successful member of the entertainment community. He comes from a background where his negative, paranoid father believed that there was no such thing as success. This led Sam to feel afraid that he was poor, although he was doing quite well financially. He had recently told me that his agent suggested that he buy a higher end car, because Sam's appearance at major events driving a dusty old Ford was not a good look. My patient, who has made good progress, has alternated between feeling the weight of his father's dicta and being blown away by his emergent success. Recently he brought the following dream. In the dream, he is a younger guy who is competing with Wayne Gretzky. His associations were, "It's funny. I just realized that Alexander Ovechkin is getting close to beating Gretzky's all-time career goal mark". I said, "I just looked up those statistics myself. I think you are starting to feel like less of a loser. If

Ovechkin can catch up with Gretzky, maybe you can get pretty good at what you are doing”. Situations like these are examples where a patient achieves a milestone, and it is necessary for the analyst to note and acknowledge this accomplishment.

Amending the Working Through Process

I believe that working through, which is the ultimate goal in a psychoanalysis, is a complex learning process that involves a number of important variables. Interpretative work around key conflicts is essential for the process to be put in motion. The well-known phenomenon in analysis that interpretations must be repeated over and over again, is a product of the strength of resistances and the lifting and the closing over of repressions. As I demonstrate in this paper, the patient’s ego becomes a participant in the change process, wherein analysands experiment around the validity of their pathological introjects. It is often these experiments which lead to material offering patients greater insight into their problems. Besides factors

mentioned earlier on in the paper related to patient-analyst fit, flexibility of technique, and a willingness to engage with the patient in an authentic manner, a successful analysis requires that the analyst be able to adapt to the type of material that is presented by the patient.

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