Section 10 - The Art of Engaging a Patient in Treatment and Its Natural Extension: The Conversion of Psychotherapy to Psychoanalysis

Abstract:
This paper outlines a method for conducting psychoanalytic psychotherapy in a manner that makes it natural to have the patient's progressive engagement in the treatment lead to psychoanalysis. The rationale underlying this method, based on decades of experience with few patients presenting as seeking psychoanalysis, has three main components. The first is the assumption that it is possible to conduct psychotherapy in a fashion that is fully compatible with psychoanalysis, but with the understanding that the unsophisticated patient requires some introduction very early in the work into what is going on and why. The second assumption is that the patient has to be introduced to and ultimately convinced of the scope and importance of their own unconscious inner world before they can truly understand the reason for and commit to an in depth treatment. And finally, the movement from once or twice a week psychoanalytic psychotherapy to the frequency and emotional intensity of psychoanalysis is achieved by a careful exploration of what the patient has done between sessions with the contact he or she has made with their unconscious inner world in the last session.

Introduction:
I was recently the discussant of a lovely paper given by English psychoanalyst Elizabeth Spillius on her experiences of supervising psychotherapy and psychoanalysis in London England. The experience led me to reflect on the details of how and why I do psychotherapy in essentially the same manner that I do psychoanalysis. I realized that this congruence is a consequence of pragmatic design, a result of thirty years of trial and error in a private practice where true analytic patients were rare. With as few as two or three referrals per year in my first five to eight years of practice, usually of patients with little or no money and serious characterological difficulties, I learned that psychoanalytic patients were made, not born. I also learned what it took to hold onto patients and did careful postmortems when they quit. This paper is an outline of my thoughts about that technique. It is essentially a "show and tell" of personal experience rather than an overview of a theory of technique.

Two Guiding Technical Principles:
I came to recognize two overarching principles as I explored which patients stayed in treatment and which felt they could justify quitting. The first was the realization that no patient felt a personal necessity to be in treatment until they came to fully recognize that they had an unconscious inner world that influenced in some fashion everything they thought, felt, and did. In effect, I did not have a "patient", or perhaps more accurately the individual did not accept being a patient, until I succeeded in convincing them that they had an inner world, and that to neglect their inner world was to risk peril to their lives and jeopardize their most precious commodity, internal harmony.

The second principle was that once they recognized that they had an unconscious inner world, typically a task of a few months to a year, then the frequency of sessions simply flowed as a natural offshoot of how well they could bear to stay in touch with that inner world between sessions. Where I could demonstrate that the pain of contact with themselves became more than they could stand before they got help with it in the next session, typically propelling them to some unconscious action to unburden themselves, I could then suggest that the obvious solution was do diminish the wait for the next session. Thus frequency became a matter of an inescapable logic, one that we were both able to see. It had added benefits in that it tended to diminish the paranoid fantasy that I wanted more sessions to satisfy my own needs and it undermined future moments of manic impulse to cut back on sessions.

Essentials of My Technique:
I would like to highlight some of the things I do in the earliest stages of treatment that lend themselves to the task of engaging the patient and simultaneously diminishing the need to "switch hats" technique wise as

we gradually move to an analytic intensity of work. These elements fall readily into the following groupings:

1 – Introducing the patient to an analytic therapy setting, with analytic type boundaries.

2 – Gently introducing the patient to their unconscious inner world, often with some initial explanation that has a mildly educative quality, especially when the issue of the moment is beyond access using common sense. This introduction includes unconscious modes of functioning with an emphasis on projective processes, and emotional states of mind including the importance of envy, jealousy, and separations.

3 – Introducing the concept of levels of maturity in thinking, feeling, and functioning, with a particular eye toward learning to recognize infantile states of mind.

4 – A regular linkage of reactions to the outside world with the possibility of a similar reaction to me, long before the frequency of sessions is sufficient to make transference interpretations a staple of the work.

5 – A continual vigilance to anticipating and interpreting negative transference reactions before the patient is in the compelling grip of a negative juggernaut toward quitting therapy.

Analytic Boundaries and Setting:
I graduated from my psychiatric residency and within two months simultaneously began psychoanalytic training and opened my private practice. I very much wanted to do things as I imagined a proper analyst would, so I was running a fairly tight setting and attempting my version of analytic boundaries right from the beginning, awkwardly of course.

Perhaps most prominently, I never answered direct questions about myself and my private life. Over the years I came to realize that although this was originally omnipotent rigidity on my part as I "got inside" the identity of an analyst, it actually served the purpose of creating a serious work atmosphere that was reassuring to patients. It also avoided collusion with the patient's manic unconscious phantasy that therapist and patient are on the same level of functioning and dependence on each other. I became very proficient at responding to the typical sorts of anxiety driven questions, when first meeting a patient, such as the nature of my training, was I married, did I have children, etc. I would point out that the questions were reasonable and fair, but if I could be allowed to do "my psychiatrist thing and not answer them directly", I thought that the questions were an expression of an understandable concern about my competence, but in reality would at best be only a wishful reassurance. The one question that might work, namely how long was my training analysis and with whom, was a question they wouldn't know to ask. Even if they did, it wouldn't guarantee that I had made good use of it, and ultimately we would have to get to know each other by a trial of working together as true trust is necessarily a function of experience over time.

This fairly strict approach to answering questions, as with all the things I say and do early on in establishing a serious working environment, is always buffered by an attempt on my part to explain the logic or rational determining my approach. I assume with all patients, because it is usually correct, that they don't really understand how or why talk therapy works, and it is unreasonable of me to expect cooperation from them when they don't really know what cooperation would look like. This assumption leads me to be mildly educational with patients in the early weeks as new issues come up.

Introduction to the Unconscious Inner World:
Perhaps the area in which I do the most explaining of what we are doing is in relation to introducing the patient to their unconscious inner world. During our first meeting I will often suggest that the things the patient is presenting have their roots in ways of thinking and feeling that were developed in much earlier life, even infancy, as hard to believe as that may seem. I say that I will go out to the frontiers of what we

know about the patient, speculating about the possible origins or meanings of things, and will try to protect both of us from going in the wrong direction by not getting too attached to my own ideas. For example, a very mild mannered man was working on a Sunday in his office, feeling very sorry for himself, and went berserk, totally destroying everything in his office. He went home, his wife insisted he consult a psychiatrist, and a day later he was in my office. For reasons I cannot explain, his description of that Sunday led me to liken his feelings to what I could imagine might be experienced by a colicky baby. It was only six months later that he confided, as he was already well on his way to what became a five day per week analysis, that he would never have come back for a second session if I had not mentioned the colic. He had been told that he was severely colicky from three weeks through three months of age. As I had no way of knowing that, it impressed him that there might be something of value to what I was suggesting and his curiosity was piqued.

I view that type of experience as essential to aiding a patient in recognizing the possible links between their early experiences and their adult personality functioning. I am always on the lookout for historical data from adolescence or adult life that can be speculatively linked back to infancy. These links might include a history of being adopted, born prematurely, having peri-natal difficulties, being weaned from the breast too early or precipitously, having a sibling born while the patient was still a baby themselves [e.g. at 18 or 20 months or less], having serious early childhood illnesses or separations, etc. Whenever I have anticipated such a background, historical element, and asked a pointed question that gets a response of "how did you know to ask that?", I know I have a patient who is likely to be impressed by the linkage between their early experiences and their later functioning, i.e. they have an unconscious inner world.

In a similar fashion, I will suggest to patients that their dreams can be thought of as being written by the baby core of their personality. Because of this, dreams give us a window into what is of the most concern at that deepest unconscious level at that moment and what is being done to deal with those concerns. This approach of the early encouragement of bringing in dreams, which I was taught was undesirable as it is too directive, never the less, jumpstarts and augments the process of learning about the unconscious, especially in the patients who have a natural facility for remembering their dreams. I first learned to bring it up when many months into treatment I remarked to a man that he never brought in dreams and to my dismay he said he had them every night but he didn't know that they were of any significance! That taught me to change my beginning approach. I have never found this early encouragement regarding the value of dreams to be a problem as it is a fairly easy task to interpret their misuse, should that turnout to be an issue.

A typical example of the overarching value of dreams in recognizing the existence of the unconscious world and its myriad of links to early life occurred in the second session with a man who had committed an act that was very out of character. After I had suggested, in our first meeting, that making an effort to remember dreams might particularly aid us when so many of his thoughts and feelings seemed unavailable to his conscious awareness, he brought in two dreams. The first dream clearly expressed his anxiety that I might not take him into treatment, something that he was unable to see until I pointed it out but with which he then wholeheartedly agreed. The second had him trying to get his mother's attention, barely succeeding, and then:

> "the scene shifts and my family and I are crammed into a very small car, like a Geo-Metro, and a man is driving it through an outdoor museum. The field is overgrown with grass around all these varied objects, in various states of neglect and disrepair, cars, airplanes, and lots of other stuff. People are walking around working on various things to restore them. At that point the car has to be driven across a ditch or canal and I'm afraid the water may be too deep to cross. The car manages to splash through it, it is not as deep as I thought, and the car then goes up the bank on the other side and crashes through a fence coming safely to rest".

I suggested to him that this dream seems also to be about our relationship and how it parallels his childhood and current life. In the dream he is waiting for his mom and has to go to some length to get her attention in the midst of a crowd of siblings. In parallel, he has to go to some considerable length to get my attention. I further suggested, and this idea really stuck with him after the session, that the outdoor museum

represented his unconscious inner world which he had neglected his entire life and now required attention and restoration. He wasn't sure he could safely undertake that restoration, and maybe would even like to passively leave it up to others to do on his behalf. If the water and ditch stood somehow for the perils or obstacles of going into therapy, the dream seemed to end with some feeling of relief at having gotten through it and survived. He listened intently, and if his body language was any indication, it was having some impact on him. I then told him I was willing to take him on as a patient, but we would have to struggle for a bit to arrange a regular meeting time. As seems often true with patients, the fact that he authored a dream about which sense could be made, increased both his belief that a lot was going on in his unconscious and that he was even having fairly intense reactions to me, i.e. an early introduction into the idea of transference, and that those reactions had parallels to his childhood.

Because this patient was someone who had a sibling born when he was only 18 months of age, I was also able to suggest that the act he had committed was linked to his anger at his mother for making the sibling, the significance of the sibling and possibility of anger at his mother both being novel ideas to this man who was fairly naïve about psychological issues. I am again both speculating out to the frontiers of our knowledge and being mildly educational. But as I experience it, I am also laying the foundation for an ability to differentiate levels of maturity in what the patient thinks and feels, a crucial element in my arsenal for convincing patients that their unconscious contains really important things about which they know very little.

Infantile States of Mind:

I had a troubled infancy, I knew that fact long before I understood it, and it seems to have created an instinct for intuiting, as I tend to put it, "baby level difficulties" in patients. While it leaves me open to the criticism of being reductionistic or worse yet, projecting my baby stuff into my patients, I can only say again that I try not to get too attached to my own ideas and I always look for corroborating data from multiple vertices. But the key point is that the earlier back into childhood I can trace the origin of an attitude, defensive style, emotional tendency, etc. the broader its implications and explanatory value. Inextricably bound up with this recognition of what I usually refer to as "baby states of mind", is the clarification of what an "adult" attitude or level of functioning might look like in contrast. I suggest in the beginning that the distinction is often hinted at by the intensity of emotions evoked, baby ones often being excessively intense for the situation or issue at hand, adult ones often having a more balanced quality in terms of intensity, less impulse to action, and are more likely to have constructive coping ideas more easily accessible.

There are two key elements in this differentiation that are quite beyond the scope of this paper but are crucial to my work toward an educational introduction to the patient's unconscious. These are the vicissitudes of projective processes and unconscious envy. I view the operation of both to be among the most crucial to mental functioning at a baby level of the personality. I also view the two to be the farthest away from consciousness, and common sense access, of any important mental activities. However, once patients understand how projective processes and unconscious envy operate in daily life, they both tend to be readily embraced by most. This is especially true of envy. I cannot recall any patient who had a significant difficulty with unconscious envy ever bringing it up until I first broached the topic. But I can remember a number who made it a regular staple of their analytic diet once they truly grasped its significance in their daily reactions to people and events around them.

Projective processes are a more complicated and problematic issue for therapists, in no small part due to the confusion attendant to Melanie Klein's monumental discovery of the importance of projective processes in mental functioning at the core of the personality, but unfortunate use of the phrase projective identification. As a colleague once said to me, when he heard I was going to teach a course on the topic, "Okay, I get the projection part but where does the identification come in?" I have abandoned the phrase although I could not practice without the concepts. I explain to patients that it is useful to imagine that the baby part of the personality treats mental and physical states of experience as if they both can be dealt with in a similar concrete fashion, roughly approximating the functioning of the digestive tract. For example, babies will often cope with physical states, especially when uncomfortable, as if they can relieve themselves of the state by pooping, peeing, spitting up, coughing, sneezing, crying, etc. In a similar fashion, they can treat

states of mind as if they could be concretely put outside themselves, evacuated into the outside world. I then suggest that this process continues, even in adult daily life, at a deeply unconscious level, completely outside of conscious awareness. That it is easy to recognize and follow its consequences once the existence of its concrete operation is accepted. All one then needs is to be on the lookout for the content of the projection, the motive for the projection, and/or the imagined consequence of the projection. In fact it can be treated like an algebraic equation in which one can figure out the third element if one knows the other two elements. Any state of mind, part of self, or internal version of mom or dad, etc. can be the content. The motives often range from:

1 – The evacuation of an unwanted or even hated internal element, felt to be uncontainable, but with no particular motive to do harm to the recipient.

2 – The getting rid of something felt to be bad or undesirable with a primary motive of doing harm to or diminishing the value of the recipient to the projector, as is so often seen both in projections that could be described as "envious reversals" and states of manic denial of the importance of the person to the projector.

3 – Depositing something in someone with the hope that the recipient will then better understand how the projector feels, i.e. for the purpose of communication.

4 – Depositing something felt to be good into someone as a gift or for safe keeping where the projector is unsure of their own goodness or ability to preserve it.

One can readily imagine how each of these motives, when combined with the content of the projection, leads to a relatively predictable consequence in the phantasies of the projector and the experience of the recipient. The patient who was mentioned earlier who brought two dreams to his second session, desperately wanted me to be a good parent that could help him, and I think projected that good analyst parent into me. I could palpably feel his assumption that I had the capacity to understand him, even though he had yet to have the requisite experience over time to trust that wish. Any negative projections into me, such as a bad mom who is unavailable to him, was not immediately central to the work at that moment but would probably be a staple of later work in the transference.

In the example I am about to give, the patient projects a traumatized baby part of herself into me, and I am temporarily traumatized as I receive it. But the patient was probably also strongly motivated unconsciously to communicate about this issue that so desperately needed to be born into the light of day, and the evacuation was easily converted into a very valuable communication. My final example, regarding negative transference, contains elements of several motives. This patient regularly projected very bad versions of internal parents into me, especially an alcoholic mother, and would temporarily view me as ruined and ruining her in retaliation. This was often an envious reversal, sometimes a more straight forward ridding herself of something felt to be uncontainable but no harm intended, and occasionally primarily a communication.

Of great importance to the therapist and patient is the realization that all projections, for any motive, are automatically converted into a communication if the therapist can understand them and convey that insight through an interpretation. Nowhere is this more important, as I see it, than in working with the negative transference. Because the patient's inner world is a product of how they viewed their infancy and childhood, and is now alive inside them directing their daily life, I am in a position to anticipate that everything that was negative in their view of their earlier life has a good chance of being repeated with me. My experience has taught me that I should comment in passing, as I take a history or intuit something negative about the patient's attitudes toward others, that that same attitude is quite likely to come out in our relationship. This seems consistently to make it easier for the adult part of the patient to recognize a projection into me from a baby part of the patient, and to more easily consider the distortions of me and our relationship attendant to those projections, when they inevitably come home to roost at some later date. I often then have a better chance to modify with interpretations, what will otherwise be an impulse in the

patient to potentially problematic or destructive action based on the anxieties and distortions caused by the projection.

I would now like to go back to the issue of the importance of recognizing infantile experiences and very primitive states of mind, buttressed by the tools for understanding that a model of projective processes affords.

A very dramatic example of infantile aspects of the personality coming up in the transference occurred with a morbidly shy woman early in my career. She came in on a Monday and told me that she had decided over the weekend to quit her treatment. She had only been in therapy for three months but I had a strong sense that the work was very helpful to her. I had been looking forward to the session with positive anticipation, and was so devastated by her announcement that I was literally speechless for the rest of the session and couldn't wait to discuss it with my supervisor. In the supervision it was suggested to me that she was recreating something of powerful significance from her early childhood. In the patient's next session I broached this possibility and to my amazement she told me, for the first time, that her mother had breast fed her for three months and then abruptly stopped because a well meaning pediatrician had suggested that the baby was not gaining enough weight. The patient who did not quit after all, once she realized she had enacted something primitive with me as a communication about her own infancy. Over the next year she had dream after dream about mothers and babies who had gaping wounds on their chest or face and were in the hospital in various stages of illness and distress. We came to the powerful and inescapable conclusion that she had felt very comfortably joined up to her mother's breast and that the precipitous weaning had been a catastrophic disruption of that union. She went on to a very fruitful seven year psychoanalysis!

This is but one of innumerable experiences I have had over the years where an experience from very early life, particularly in the first days and weeks of infancy, and the patient's "baby" reaction to it, has been crucial in giving meaning, much like a Rosetta stone, to the reactions and interactions that dominate the patient's emotional climate on a daily basis.

Summary of the Early Phase of Treatment:
I would like to summarize, using slightly different words, what I have just highlighted about my approach to early phases of psychoanalytic psychotherapy.

1 – First, I am interested in helping the patient see that they have an unconscious inner world and that it is a product of their childhood, and in particular their infancy, and how they viewed and reacted to those experiences.

2 – That these experiences, especially going back to earliest infancy, typically have a far greater impact on how their mind works than common sense would allow them to recognize.

3 – That this unconscious inner world, being the only game in town, is all they know of how relationships work and will necessarily, therefore, be recreated in all intense relationships including the one with me.

4 – That this recreation with me affords us the valuable opportunity to put our heads together and compare our mutual experiences of what goes on between us.

5 – That this same baby core is the author of night time dreams, and these dreams are a valuable resource, in pure culture, of what is most important in the patient's unconscious inner world at that moment, and how at that deeply unconscious level they are choosing to deal with those emotionally significant issues.

Frequency of Sessions and Mental Pain:
During this time I am continually observing and commenting on the patient's ways of coping with the

mental pains they experience as they conduct their daily lives. This includes explorations the origins of these pains and the origins of how they adopted the methods they use to cope with these pains. Of particular interest to me is the degree to which they find our discussions helpful to them in coping with these issues. In turn, how well does this feeling of being helped to cope hold up between sessions. Can they bear to stay in contact with what we have stirred up. When the patient has not been able to sustain contact with the issue between sessions, I can then explore why they couldn't and what maneuvers they then used, almost always unconsciously, to cope. Where these coping maneuvers involve problematic defensive actions, which at times with more seriously characterologically disturbed individuals may lead to serious acting out, I am then in a position to demonstrate specifically why this is a problem that can be linked to the frequency of sessions. That, in effect, we need a frequency that is adequate to hold the patient from the previous session until the next opportunity for us to work on understanding their unconscious pains. Our goal would be to achieve the necessary frequency needed to be able to tolerate these pains without being driven to unburden themselves through action during the gap between sessions.

This is all in the context of the external reality factors of time and money, but they are probably less critical than one might imagine. How this process develops probably correlates more with such variables as:

1 – How much pain the patient experiences and how problematic their outside life is.

2 – How intensely wedded they are to manic maneuvers and omnipotent acting out to cope with mental pain.

3 – How seriously they turned away from their primary objects in infancy to form a narcissistic personality organization.

4 – How much healthy encouragement versus destructive collusion they get from those around them.

A key point for me is that none of this is mysterious, privileged information that I have and visit from my sophisticated position down to the patient. The need to increase the frequency, for example, is invariably obvious to both of us before either of us is sure how to achieve it. It becomes a shared mutual decision even though I am often the first to suggest an additional session.

Because this all tends to happen naturally over time, organically if you will, we rarely make a distinction about what to call what we are doing. Initially, the patient tends to recreate the relationships from their unconscious inner world by externalizing them with such significant figures as spouse and immediate family, relatives, people at their workplace, friends, etc. But over time, as frequency increases, I am able to demonstrate those same recreations occurring with me in the transference, and that slowly but inexorably eclipses the outside focus. A psychoanalysis is born, albeit with a long gestation and a not so dramatic delivery.

As an aside, regarding the use of the couch, I tend to bring it up whenever a patient seems to be distracted by our looking at each other. I simply point out that it is easier to focus on contacting their own thoughts and feelings if they don't have as many distractions. This might occur with a once a week patient, but is common place with three times per week.

<u>Summary of Key Points</u>:
So we now have an overview of the three main points of this paper. First that it is possible to do psychotherapy in a fashion that has as its natural extension, doing a psychoanalysis without significant modification of technique. The second point is that I don't really have a patient who believes they need treatment until they have a conviction that they have an unconscious inner world. Once they truly see that fact, and want to alter those elements that are problematic in their inner world, they will want to become intimately familiar with it.

In that process they will also become familiar with how they cope with contact with this inner world between sessions. The needed session frequency will then be a logical and obvious function of how well they can tolerate staying in touch with their inner world between sessions. This naturally leads quickly to twice a week which is always experienced as more than just a double of once a week, and fairly readily extrapolates out to three, four, and five times per week over a period typically of one to three years. I do not wish to sound like a Pollyanna who thinks this will all unfold smoothly. I have, with virtually all my patients that ended up in a four or five day per week analysis, gone through many trials and tribulations about which I would have gladly spared us both. But childhood necessarily develops unevenly, and so does the best of analytic relationships, as is self evident to anyone in this business. I do think that for patient and therapist alike, forewarned is forearmed. This I believe to be especially true of negative transference reactions.

Anticipating the Negative Transference:

I would now like to turn my attention away from therapy relationship enhancing issues to therapy destroying issues. When one gets only two referrals a year, it becomes necessary to anticipate every possible resistance that could torpedo the work. The most obvious are always money and time. With this is mind I learned never to set a fee without detailed exploration of both the external realities of the patient's finances, and a good overview of the emotional significance of the fee to the patient. I have always tried to get the patient to decide what he or she feels would be a fair fee for both of us. Not infrequently I go with a slightly lower fee in anticipation of a greater frequency sessions. I don't want to be a reasonable approximation, in the patient's unconscious phantasies, of a greedy part of the patient or a selfish internal parental figure because I appear more interested in the money than the patient.

In similar anticipation of negative transference possibilities, I have tended to analyze idealizations of me as they come up. I was taught to assume that when I'm being made "all good" that there is some scary bad stuff lurking around and I would rather get to it sooner rather than later. As I say to patients, I realize that "it is a quick, short drop from being idealized on top of the pedestal to being crushed underneath it"! So we might as well go looking for what is so bad or anxiety producing that it has to be kept out of our relationship.

Maybe even more directly to this point of negative elements that will come home to roost sooner or later, I try to actively anticipate all negative transferences long before they arrive in full bloom with their inevitable high potential for irreparable harm. Anticipating them doesn't seem to stop them, it just seems to aid in the patient's ability to more readily differentiate their bad internal version of me from the [usually less bad] real me. Nowhere is this more apparent to me than with patients who turned away from a flawed, but good enough parent, who is also the object of considerable envy for those good qualities that were not consistently available to the patient. This brings me to a graphic case example of negative transference impeding a needed frequency to adequately support the patient and diminish her regular desire to quit treatment.

A woman came to me for treatment because she was very chronically unhappy with her life despite a superficially successful marriage, two lovely teenage children, and a very successful career as an artist. She felt herself to be much too perfectionistic in her art work, unable to make use of praise, and she led me to believe for the first two or so years of treatment that this was all the fault of her out of control alcoholic mother who had ruined her childhood. This was all presented to me as historical fact and I had no reason to doubt it. In her second year of treatment, coming at a frequency of twice a week and with regular worries about the financial burdens, and what if this or that bad thing happened financially, a pattern began to develop. We would have what I often thought of as a good session, and she would come to the next session with every intention of quitting because I had been so insensitive and cruel in whatever I pointed out to her in the previous session. I would try not to be overly defensive, try to see her point of view, but would always question why she didn't confront me at the time if what I had done was so cruel or insensitive. I would also remark how everything that had ever been good in our work seemed so completely lost for her at those moments. My above mentioned bit of defensiveness was usually in the form, at least to the extent that I'm consciously aware, of reminding her that I had become all bad just like her mother was for her internally.

Our breakthrough came in that second year when she had a dream in which "a beautiful woman was giving a party and everyone in the neighborhood of her childhood was there, singing the praises of this woman, how beautiful and fun she was, etc." This watershed dream led to several sessions in which a number of facts emerged about her mother that were revelations to me. First, and most importantly, her mother had not become an alcoholic until the patient was pubertal although had always been a relatively heavy social drinker along with the patient's father. Secondly, her mother was quite beautiful when the patient was young, even though later she looked like a fairly dissipated alcoholic. Finally, her mother was by all accounts a very colorful woman in every possible way. She dressed with a flair, was the life of the party, and to add insult to injury, the patient's friends would come over to hang out with the patient's mother instead of the patient. This led to an instant association on my part as to where the patient got her artistic talent for color but could not enjoy, or at root, take any credit for it. She denied her mother any credit for teaching the patient how to put color together, and now her own work was nothing but un-attributed plagiarism. Virtually all of these attacks on her mother had gone on unconsciously, and it was a disturbing revelation for her to see how she had ruined her mother inside herself.

It also became a template for deciphering what was going wrong between us. When she would leave a session, she would find herself focused on some small slight she felt and it would grow over several days, especially weekend breaks, to the point that it would feel like a momentous injury. Completely unavailable to the patient was her feeling that I was so much more colorful as a person, and that I wouldn't want to see her more often because she would just be a drag on my happiness. From one frame of reference, the frequency of twice a week was woefully inadequate for what she needed. I was iatrogenically making matters worse, in the sense that it was my responsibility to see that the frequency was adequate to the task. I had allowed her protests of financial anxiety to put me off what I would ordinarily suggest. When I pointed all this out to her, she was able to recognize the merit of my points, that she was treating me as she treated her internal mother, never giving me the chance to become a better mother who more adequately met her needs. This of course also allowed her to evade the experience of any envious feelings toward me as I remained chronically marginal as a mother. Shortly thereafter we were able to arrange a compromise fee that allowed us to increase to three times per week. The flow of the work improved considerably, and she began to truly dissect and own what she did to her mother and me.

In this example, I hope it comes through that what I was doing was analysis of an issue, essentially no differently than I would if the patient were in five day a week analysis, but that we would never be able to get to an analytic level without work on those negative transference elements. My primary point being that it is precisely those types of elements that, unaddressed, prevent a psychotherapy from ever growing to an analysis. It is even conceivable to me that nearly every psychotherapy with a patient who has significant characterological difficulties and does not progress to analysis, is breaking down because some aspect of the patient's omnipotence and negative feelings, often an envious reaction to the treatment, is not being addressed.

Concluding Summary:

In summary, I would like to suggest that at least here in the my region of the U.S., psychoanalytic patients are made, not born. That every psychotherapy has the potential to progress to the level of a psychoanalysis. That progression is as much or more a function of the therapist's mind set and expectation as it is the patient's availability. The therapist who can demonstrate the existence of an unconscious inner world that informs and determines how the patient lives his or her life is then in a position to suggest that the patient has no choice but to learn about that inner world as it is the only game in town. Once that patient comes to the realization that they neglect that inner world at their own peril, then the therapist has a patient who can see the logic, if not necessity, for coming as frequently as is needed to do justice to exploring and modifying that inner world.