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The Patient Speaks: a Phenomenological Exploration of the Patient's Experience of Psychoanalysis

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LOYOLA UNIVERSITY CHICAGO

THE PATIENT SPEAKS: A PHENOMENOLOGICAL EXPLORATION
OF THE PATIENT'S EXPERIENCE OF PSYCHOANALYSIS

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN THE CANDIDACY OF THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN SOCIAL WORK

BY

KATHERINE M. WILLIAMS

CHICAGO, IL

MAY 2020

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My graduate education was conducted as a dual student at two institutions simultaneously, at Loyola University Chicago School of Social Work where I was a doctoral student and at the Chicago Psychoanalytic Institute where I am training to be a psychoanalyst. These years of training have been the most arduous but the also the most vitalizing of my life. My deep desire to train as an analyst while working on a dissertation become a reality on a cold November morning as I sat in David Terman's M.D. office discussing my future. David with clarity and enthusiasm suggested I pursue my professional goals. His enthusiasm soon combined with a commitment to support me in my training process. On the long journey of training David has been my mentor, clinical supervisor and member of my dissertation committee. When I think of David my heart overflows with gratitude and deep affection when I think of the many ways in which he always believed I could complete the task and was always ready to support me.

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Dedicated to my husband, Dr. Steven Timm and to my analyst, Scott Davis, M.D.

In offering a contrasting viewpoint that regards experiencing as the key to human existence, psychoanalysis becomes an alternative worldview that places the highest value not on any measurable outcome, but on the realization of potential on awareness and expansion of experience. That is the psychoanalytic vision.

Frank Summers, *The Psychoanalytic Vision: The Experiencing Subject, Transcendence, and the Therapeutic Process*

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ABSTRACT

The goal of this study was to conduct a qualitatively based clinical outcome study of the patient's experience of a psychoanalytic treatment and to explore how the analysis impacted the patient's life post treatment. Much of what is known about analytic treatments comes from analysts in the form of case reports or journal articles. The goal of this study was to directly obtain patient's views of their analysis. In order to do this a heuristic phenomenological research design was used. The phenomenological approach puts a focus on the experience of the participant of a particular phenomenon in the case of this study psychoanalysis. In addition, by utilizing a heuristic research approach meant both the participant and researcher needed to be immersed in the experience of an analysis.

By means of snowball sampling a purposeful sample was recruited of ten adult former patients (N=10) who had completed an analytic treatment. Three in-depth interviews were conducted of which the last interview functioned, in part, as a member checking process to verify the emergent research themes. In the data analysis individual portraits were created for each participant followed by composite depictions, exemplary portraits and finally a synthesis was formed of the research findings. The goal in keeping with the heuristic research method was to maintain a balance between the experience of individual participants and to also focus on the themes that emerged from the group as a whole.

The data indicates that patients who report high levels of satisfaction with their treatments stated that the relationship that developed with the analyst was of paramount

importance. Participants who reported having high levels of satisfaction with their analysis also described having a corrective emotional experience with the analyst over the course of the treatment. Patients who experienced low levels of satisfaction with the analysis report that the analyst was not able to successfully negotiate cycles of rupture and repair in the treatment. In addition, the analyst displayed a sense of clinical inflexibility and tended to not be able to acknowledge having made errors in the analysis.

CHAPTER ONE

INTRODUCTION

In 1938, the psychoanalyst Smiley Blanton travelled to London for what would be the last of his psychoanalytic sessions with Sigmund Freud. Blanton (1971) had been crossing the Atlantic since 1929 on a semi-regular basis to engage in analysis with Freud. In the course of the final session Freud inquired of Blanton whether the analysis had contributed to his personal happiness. Blanton responded that indeed the analysis had positively impacted his personal happiness. It could be suggested that Freud's inquiry of Blanton was one of the first attempts at a single-case study in the effectiveness of psychoanalysis. Since the time of Freud, psychoanalysts have grappled with the question: does psychoanalysis work? And if analysis works, how does it work? A number of attempts have been made to answer these questions most often using quantitative research methods. However, the experience of an analysis is uniquely individual for each patient. This suggests that studying the outcome of analysis by using quantitative methods might not be the most effective research design to answer these questions. It is worth considering that by using a qualitative methodology that allows for the deeper exploration of the experience of the patient, we are more likely to be able to start answering the above questions.

Why This Study?

A number of years ago I was in the self psychology class at the Chicago Psychoanalytic Institute studying the case of Mr. I in the self psychology case book (Goldberg, 1978). There was a sense of restlessness and frustration growing inside me. The casebook contained an extensive description of the analysis of Mr. I as written by his analyst. The case write-up was sensitive and thoughtful and even contained direct quotes from Mr. I as reported by his analyst. In my years of analytic training I had read and heard countless cases presented in case conferences, or had published cases assigned as class reading. As a trainee I have written case reports on my clinical work and presented at case conferences at my institute and at conferences. I therefore fully appreciate how important it is for trainees and professionals in the field to be learning from cases. In addition, I regard case write-ups to be an importance source of possible data for clinical outcome researchers. However, my restlessness in class that Friday morning stemmed from a growing realization that I had been trained exclusively on cases that were written and presented from the perspective of the analyst. Nowhere in my training, outside of my own clinical work, had there been instances of learning directly from the unvarnished words and thoughts of the patient. I wondered if Mr. I were given an opportunity to tell his story, unfiltered through the perceptions of his analyst, what would he say?

In the case book, Mr. I's analyst states that: "he latched onto the analyst and the analysis with an addiction-like intensity" (Goldberg, 1978, p. 18). The analyst goes on to recount a turbulent, lengthy but ultimately, from the analyst's point of view, successful analysis of Mr. I. At termination the analyst reports that: "he got off the couch, turned around, smiled, and said 'Thank you very much. I appreciated it.' He shook hands with a firm handshake. The analyst smiled too and wished him good luck. Mr. I turned around and left quickly" (p. 114). I wondered

reflecting on the contents of the self psychology case book, how if interviewed Mr. I might have directly recounted the events of that termination session from his perspective and how might he, years later after the completion of the analysis, think and feel about the treatment? I also wondered how clinical training and practice might change if we were to hear directly from the patient?

Study Purpose

Shortly after that fateful Friday self psychology class, I wrote the following in an email to my analyst:

Psychoanalysis has historically shown a lack of interest in studying treatment outcomes from the perspective of the analysand, so Mr. I remains silent about whether his treatment was useful in his life while the analyst's voice is privileged and is viewed as the ultimate authority to be studied as evidence of treatment efficacy. (Williams, K. personal communication, March 25, 2016)

And so it was after an extensive journey of trying to find a useful way of studying the analytic process, finally my research agenda seemed clear to me: to give voice to the analytic patient. The goal of this study is therefore to establish the patient as the authority on treatment outcomes by engaging the patient directly in outcomes study rather than to filter the patient's voice through the analyst.

In this study a heuristic phenomenological approach was used. The word heuristic comes from the Greek root to "find" or to "discover" (Moustakas, 1990). The heuristic research method was first used by the late American psychologist Clark Moustakas (1923-2012) in his groundbreaking research on loneliness. Moustakas describes the heuristic research method in the following way:

It refers to the process of internal search through which one discovers the nature and meaning of experience and develops methods and procedures for further investigation and analysis. The self of the researcher is present throughout the process and, while

understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge. (p. 9)

Psychoanalysis at its core is about the patient's experience of the process of treatment (Summers, 2013). It is that experience that this research aims to study by engaging directly with the experiencing subject, i.e. the patient. An essential component to heuristic research is the involvement of the researcher with the phenomena being studied by a process of engagement and emergence in the phenomena being studied. As a patient of analysis and a candidate at a psychoanalytic institute, I regard myself to be fully immersed in the phenomena.

Research Questions

The central research question is how the participant experienced the process of the analysis and how this experience influenced their subsequent lives. An analysis varies in length anywhere from one year to a decade or more with a frequency of three to five days of treatment for the patient. The patient is therefore investing a considerable amount of time and money in the treatment process. The questions therefore are: what expectations do patients bring to an analysis and to what extent are those expectations met by the treatment? In addition, when patients reflect on the treatment after a passage of time, how do they view their analysis and the impact it has had on their lives?

In order to attempt to answer the central question of the the patients experience of the analysis it is important to remain open to that which participants wish to share with the researcher. Therefore, an open-ended research tool was used, that while providing some structure to the interview process, facilitated an environment of openness in which the participant could share information with the researcher.

Significance to Social Work

Social work as a discipline is well positioned to ask questions relevant to this study. As an interdisciplinary field, social work has the flexibility to draw on the theories most suited to answer the questions of this study. In addition, social work as a clinical practice has a long history of empowerment with respect to the people social workers serve (Simon, 1994). An integral part of empowerment is both recognizing that people are experts on their own lives and the social worker facilitating a process whereby the person is able to speak for themselves. Much of clinical outcome research, including psychoanalytic outcome research, is conducted by individuals who are perceived to be “experts”. Analysts in reporting on their cases and in engaging in research have framed the questions and have certain assumptions about what a successful treatment would be comprised of. In this way patients’ voices are unintentionally filtered out of the process of determining treatment outcomes. Essentially analysts have to date controlled the dialogue with respect to outcomes research. This is an attempt to change that and to give patients the opportunity to shape the dialogue. Social work provides the theoretical frame to engage in patient centered research.

My dual training as a social work doctoral student and as an analytic training candidate equipped me with the needed skills to engage with these research questions effectively. My analytic training provided with a clinical and theoretical foundation and most important with an immersion into the analytic process via my own personal analysis. My social work training both clinical and in training to be a social work researcher instilled in me certain skills that flowed from the philosophical base that forms the bedrock of the social work profession. One such concept is the person-in-environment concept in social work that views the person as influenced by and engaged in the social structure that surrounds the individual. This concept assisted me in

thinking about how no patient and analyst dyad operates in isolation from the rest of the world. It therefore seemed important to explore with participants how for example their analysis impacted others in their lives, how their professional lives and the analysis interacted and how they managed the economic implications of an analysis that could go on for a lengthy period of time.

In addition, my social work training encouraged me to question implicit and explicit power and authority paradigms. For some time there seems to have been an implicit understanding in psychoanalysis that the analyst is the authority on what is best for the patient and is by implication positioned to determine what is a “cure” and therefore how best to study clinical outcomes. The history of outcome studies in psychoanalysis discussed in the literature review of this dissertation demonstrate this attitude an attitude which has been somewhat changed by the relational turn toward a two-person psychology in psychoanalysis. However, my social work training positioned me professionally to question these implicit and explicit power assumptions made within American psychoanalysis and to go directly to the patient with an understanding that the patient is the ultimate expert on the outcome of their analysis.

In addition, social work doctoral training is an inherently interdisciplinary process which ideally creates social science researchers who are able to flexibly draw on findings and use research methods in other academic fields. I was therefore able to think about the research by employing an anthropological lens while using a research method, the heuristic research method, designed by the psychologist Clark Moustakas (1990).

In addition, it is important that social work as a profession engage in research with respect to psychoanalysis. There are two related reasons for this: one is the increasing influence social work has had on psychoanalysis within the past almost four decades. Philips (2009), reports overhearing a colleague say that a future member of the American Psychoanalytic

Association (APsaA) will be “a woman social worker on a second career (p. 9).” I myself would be an example of this statement and this phenomena is evident by the increasing number of social workers not only in training at American Institutes but increasingly in leadership positions such as the presidency of APsaA and directors of psychoanalytic institutes. The second reason to engage in psychoanalytic outcomes research is that clinical social workers comprise the largest group of providers of mental health services in the country (Phillips, 2009). It would therefore be in the interest of social work as a profession and the mental health field in general for social workers to be engaged in a fuller understanding of the possible benefits and potential obstacles that are part of an analytic treatment.

Scope of the Study

This study examines adult former patients who are at least 21 years old and have engaged in an analytic treatment with an analyst. The treatment needs to have been conducted at a frequency of three to five or more times a week for a length of at least one year. The analysis needs to have terminated for at least six months prior to the start of data collection.

A Word on Language

It tends to be more common in social work practice and literature to use the word “client” rather than “patient”. I have consciously elected both in my practice and writing to use the word “patient” to refer to individuals who seek clinical services from a mental health provider. There are two reasons for this. The first is that at the Chicago Psychoanalytic Institute there is a tradition in which all providers, social workers, psychiatrists and psychologists tend to use the word “patient” regardless of the mental health discipline the provider originates from.

By far the more important decision in using the word “patient” is based on a personal ideological and ethical position I take toward my clinical practice. The word “patient” comes

from the Greek word “to suffer” and in my clinical experience tends to accurately describe the majority of individuals who seek mental health services. It is the clinician’s function to assist in reducing this suffering and this is done in a relationship of trust between patient and clinician. The word “client” by contrast tends to be associated with an individual being a “customer” and both the words “client” and “customer” have a transactional feel that does not present what happens in the clinical space optimally. In addition, the word “client” also seems to imply that if the service is not satisfactory or even bad the “client” can be compensated for that. Like returning rotten produce to the store either to get a refund or replacement produce. However, mental health services do not function in the same way as the purchase of other goods and services. While patients who are victims of unsatisfactory mental health services can through litigation sometimes get financial compensation, it is not possible to return the time the patient has lost by receiving suboptimal mental health care. In addition, as is evident from some participants to this study, the psychological effects of suboptimal care for the patient continue to have a negative impact on patients lives for many years after termination. My use of the word “patient” is therefore a daily reminder to me of the full measure of my responsibility I have in relation to the individuals in my care.

Definition of Terms

Psychoanalysis. For the purposes of this study psychoanalysis is defined as a theory about human behavior founded by Sigmund Freud. Psychoanalytic theory is often defined as having three general applications: (1) a way to understand the mind, (2) psychoanalytic theory and (3) psychoanalytic treatment which is the clinical application of the theory (Burness,1990). This study focuses on the application of psychoanalysis as a clinical theory. Clinical treatment traditionally involves the use of free association, the exploration of dreams and fantasies in the

service of uncovering the unconscious of the patient (Freud, 1915). In contemporary psychoanalytic treatment approaches the goal and method of treatment is dependent on the theoretical focus of the psychoanalyst. In this study the term analysis is used interchangeably with the term psychoanalysis.

Psychoanalyst. For the purposes of this study psychoanalyst is considered to be a graduate from either an American Psychoanalytic Association (APsaA) accredited institute or a graduate from an independent institute with comparable training. Training traditionally is comprised of three components: a personal analysis, completion of didactic training and supervised clinical work. In this study, the term analyst will be used interchangeably with the term psychoanalyst.

Psychodynamic psychotherapy For the purposes of this study is a treatment conducted at a frequency of one to two sessions per week. Long-term psychodynamic psychotherapy is conducted for at least one year, frequently longer. Short term psychodynamic psychotherapy (P.P.) is conducted for less than one year with between one to two sessions per week. The goals of P.P. vary but most often involve symptom reduction and patients gaining a deeper level of understanding with respect to their unconscious motivations. Tangible treatment goals are frequently a defining feature of P.P. Working in the transference is an important part of P.P. but significant regression by the patient is avoided as the dose of the treatment i.e number of sessions per week, tends not to be sufficient to contain the patient.

Analytic Treatment. For the purposes of this study analytic treatment will be defined as treatment engaged in at a frequency of at least three times or five times per week for at least one year. The analyst conducting the treatment needs to meet the above requirements.

Study Participant. For the purposes of this study, a study participant will be defined as an adult participant that is at least 21 years old who has engaged in an analytic treatment with an analyst. The analyst conducting the treatment needs to have met the standards determined for an analysis as defined above. The treatment needs to have been conducted at a frequency of three to five or more days per week for a length of at least one year. The analysis needs to have terminated at least six months prior to data collection.

CHAPTER TWO
LITERATURE REVIEW

Introduction

In 1909 Sigmund Freud set sail for America to receive an honorary degree from Clark University in Worcester, Massachusetts. It would be the only honorary degree he would receive. Freud, while becoming increasingly known, had not yet attained the revered status he would achieve in later life. Freud had however already formulated some of the most important ideas that would form the core of psychoanalytic clinical practice and he was intentionally forming a movement to promote what he thought of as the new science of psychoanalysis. It seems that Freud was keenly aware that speaking at Clark University in America was an important moment for psychoanalysis. He would later recall that:

As I stepped onto the platform at Worcester to deliver my five lectures upon psychoanalysis it seemed like the realization of some incredible day-dream: psychoanalysis was no longer a product of delusion, it had become a valuable part of reality. (Freud, 1927)

In the Five Lectures Freud would set out the major clinical concepts that would come to form the core of psychoanalytic practice. This literature review will cover the basic concepts of classical theory while also taking note of expansions of other contemporary theory. By far the majority of the sample was drawn from participants who had analysts who identified as either ego psychologists or self psychologists and therefore the focus of this literature review will be focused on these two respective theories. The literature review will then focus on which patients have been historically considered to be “analyzable” by analysts and what the implications of

that are for psychoanalysis. The therapeutic action of psychoanalysis will then be explored and the concept of the corrective emotional experience and the implications this concept has for the outcome of an analysis. Finally, there will be a discussion of the psychoanalytic outcome studies that have been conducted within psychoanalysis.

The story of psychoanalysis starts with hysteria and Joseph Breuer's patient Anna O, the pseudonym given to Bertha Pappenheim. It is worth taking note that the first patient of psychoanalysis was a woman and a social worker. In later life she would emerge as a pioneering social worker, feminist and intellectual. Pappenheim founded schools and orphanages promoting training programs to encourage women to become self-sufficient. Pappenheim was also founder of the German Federation of Jewish Women that eventually had over 50,000 members (Swenson, 1994). However, studying the case of Anna O one gets the clear impression that Pappenheim was dealing with a serious mental health crisis in her early life.

According to Breuer and Freud, Anna O was dealing with hysteria consisting of a host of physical symptoms such as paralysis on her right side, vision and hearing problems (Breuer, 1895). Hysteria is no longer a recognized psychiatric disorder today replaced by more specific diagnostic nomenclature such as somatization disorder but in Freud's time hysteria was a disorder that confounded physicians. Freud would theorize that Anna's O physical symptoms were as a result of her inability to manage her negative emotional reaction toward her ill father who she was nursing. The cure would be what Freud termed the "talking cure" and Anna O descriptively referred to as "chimney-sweeping" (Freud, 1927). This was a process in which she would spontaneously tell Breuer whatever came to mind. Freud would later come to call this process free association. Anna O reported experiencing relief from her symptoms after talking to Breuer in this way. The psychoanalytic method provided not only a way to obtain relief from

symptoms but also a way to understand the meaning the symptoms had for the patient. It is however, part of psychoanalytic history that the Anna O case came to a dramatic end. It is told that Breuer arrived at the home of Anna O and believing herself to be pregnant with Breuer's baby was reported to say: "Dr. B's baby is coming" (Freud, 1950, pp. 409-410). Breuer unnerved by the force of Anna O's transference reaction fled the scene and would never again see his patient. Freud would go on to speculate that Anna O was engaged in an experience of a hysterical pregnancy (Breuer & Freud, 1957). However, historians have come to question the accuracy of the above events. It seems that Freud merely had a theory that Anna O might have been experiencing a hysterical pregnancy based on what Breuer had told him. Breuer himself never directly made this claim and what is more Freud was speculating 50 years after the actual events of the case (Ellenberger, 1972). What is known factually is that Breuer was indeed made uncomfortable about aspects of the Anna O free association that related to sexual matters and as a result he ended the work with his patient prematurely (Freeman, 1972), (Jackowitz, 1984). The case of Anna O would serve as an early object lesson to psychoanalysis about the power and danger of transference and countertransference reactions between analyst and patient. The analytic method held the potential for psychic relief for patients as it offered to Anna O but it also evoked deep and sometimes dangerous feelings and longings in patients that required clinical skill on the part of the analyst to manage.

Over time Freud would formulate many clinical techniques based on the Anna O case that would come to comprise the classical psychoanalytic technique. However, this single event: one person suffering speaking freely about the suffering to the analyst, who assists in bringing meaning to the distressing symptoms and understand to the suffering, would become the true genius of the psychoanalytic method. Something so simple yet at the same time so revolutionary.

Freud and Classical Theory

Freud's theories developed through two models, the early topographic model and the later structural model. The topographic model divides the mind into three parts: the unconscious containing feelings and thoughts that are not within the individual's awareness, the preconscious thoughts that are partly in the conscious but can slip in and out of the individual's consciousness and the conscious that are comprised of thoughts and feelings that the individual is conscious of. Important clinical concepts developed as a result of the topographic model among them the idea of free association which became known as the fundamental rule, transference and dreams. Additional clinical concepts of note at this point would be the neutrality of the analyst and the use of the couch in clinical practice.

Topographic Model

Free association. Freud recommended that at the beginning of treatment the patient be instructed to say whatever comes to mind over the course of the treatment. Patients were to say whatever came to mind without self-censorship regardless of how foolish or embarrassing the patient felt about the material. This process of talking in this way was referred to as free association. Freud (1913) referred to this as the "fundamental rule" because he regarded free association to be a central component of analytic treatment. In addition, Freud recognized how difficult the process of free association would be for most patients and therefore recommended the analyst provide specific instructions to the patient on how to engage in free association. In Freud's technique papers he suggested the following instruction be given to the patient:

You will notice that as you relate things various ideas will occur to you which you feel inclined to put aside with certain criticisms and objections. You will be tempted to say to yourself: 'This or that has no connection here, or it is quite unimportant, or it is nonsensical, so it cannot be necessary to mention it.' Never give in to these objections but mention it even if you feel a disinclination against it, or indeed just because of this. Later

on you will perceive and to understand the reason for this injunction, which really the only one that you have to follow. So say whatever comes through your mind. Act as though you were sitting at the window of a railway train and describing to someone behind you the changing views you see outside. Finally, never forget that you have promised absolute honesty, and never leave anything unsaid because for any reason it is unpleasant to say it. (p. 147)

It is not clear to what degree the fundamental rule is followed in contemporary treatment.

What is however clear, is that analytic treatment requires the patient to engage in the process of being able to freely speak his or her mind and that this is a process that patients are able to master with greater proficiency over time (Lear, 2015).

Transference. For analytic treatment to be successful the patient needs to engage in a transference experience with the analyst. Originally Freud (1919) conceptualized transference as an intrapsychic process of unconscious processes over the repression barrier. Later transference was viewed to be the process in which the patient unconsciously displaces parts of his or her relationships with primary figures from infancy and childhood onto the analyst. Traditionally, transference has been viewed as distortions of reality in which the patient experiences others not as they are in reality but as repetitions of past experiences. Transference occurs in everyday life but transference in the context of the treatment dyad is experienced with particular intensity by the patient. It was also generally maintained that the analyst taking a stance of anonymity and abstinence contributed to the formation of a transference neurosis. This is a process in which the patient re-enacts aspects of childhood experience in the treatment context with the analyst. It is thought that the analyst interpretations to the patient will eventually lead the patient to abandon infantile wishes directed toward the analyst.

This traditional view of transference has been challenged by contemporary analysts who maintain the view that transference cannot be unaffected by the analyst presence. Rather

contemporary analysts think of transference as an interpersonal event. Hoffman (1983) states that it is not possible for transference ever to be “uncontaminated.” He states that transference “is always evoked by some quality or activity to some developmentally preformed organizing principle.” Hoffman goes on to challenge the idea of the “interpretation without suggestion” stating that “interpretations are suggestions” reflecting the analyst theoretical orientation and particular personal biases.

Dreams. For Freud dreams were very important, he referred to dreams as the “royal road to the unconscious” (Freud, 1900). During a patient’s waking hours the defensive system keeps threatening or unacceptable thoughts and wishes out of consciousness. However, during sleep the patient’s defensive system is largely inactive and the repressed thoughts and wishes emerge.

Frequently the wish appears in a dream in a disguised form and therefore the real meaning of the dream appears in a distorted form. Dreams are considered to have latent content and manifest content. Latent content are the unconscious dream thoughts that are stimulated by the day residue and how the dream is dreamed by the patient. The manifest content is how the patient remembers the dream (Freud, 1900).

Freud developed a form of dream interpretation in which each component of the manifest content is associated to. The various associations eventually lead the patient and analyst to uncover the various meanings of the dream.

Neutrality. Freud never referred to the concept of neutrality in his writings and his reports of his own clinical work show many instances in which he was not neutral in his approach to his patients. It was Anna Freud (1936) who first suggested that the analyst needed to be neutral in approaching the patient to ensure that personal biases not interfere in the clinical work:

It is the task of the analyst to bring into consciousness that which is unconscious, no matter to which psychic institution it belongs. He directs his attention equally and objectively to the unconscious elements in all three institutions. To put it another way, when he sets about the work of enlightenment, he takes a stand at a point equidistant from the id, the ego and the superego. (p. 28)

Linked to the idea of the neutrality is the concept of the analyst as a blank screen onto which the patient projects intrapsychic conflict. This in turn led to the concept of a one-person psychology in which the neutral analyst acts as the blank screen onto which the patient projects wishes and fantasies. In contemporary analytic thinking this concept of neutrality has been challenged. In contemporary thinking the analyst is not viewed as being capable of neutrality nor is it regarded as being a desirable goal. Rather the analyst and patient are engaged in a relationship in which there is mutual influence on both members of the treatment dyad. In contemporary analytic practice a two-person psychology has emerged (Eagle, 2011).

Linked to the concept of neutrality is the concept of abstinence and anonymity. Freud (1919) conceived the concept of abstinence to mean to allow the patient to feel frustration as the feelings of longing and wishes emerge toward the analyst over the course of the treatment. Freud (1919) states that to gratify these wishes would be to reduce the patient's "instinctual energy propelling him toward a cure." Anonymity refers to the process of allowing the patients' unconscious wishes and fantasies to be projected onto the analyst. This requires that the analyst refrain from disclosing any personal details to the patient over the course of the treatment to prevent possible interference with the process of being a blank slate to the patient's projections.

In contemporary thinking both the concepts of abstinence and anonymity have been either modified or abandoned by analysts. It has been suggested by Viderman (1991) that the process of abstinence and anonymity is perhaps even harmful to the treatment process. Rather he

suggests that an environment of warmth and positive regard for the patient facilitates openness in the treatment process. Viderman states that:

Many analyses become sterile by virtue of the apparent detachment of the analyst and anxiety generated by fears of intimacy in the patient remain unanalyzed as both patient and analyst sink into a comfortable but distinct and nonproductive *modus vivendi* that not infrequently characterizes some particularly long analyses. (p. 454)

Use of the couch. Perhaps the most enduring symbol of psychoanalysis is the vision of the patient lying on a couch speaking to their analyst who is sitting out of sight. While the couch is often thought to originate with Freud it was not his original idea. Freud, in an effort to access unconscious material, had originally hypnotized his patients who would lie on the couch while being hypnotized. It however turned out that Freud was not particularly skilled at the practice of hypnosis and soon abandoned the practice. In developing the treatment of psychoanalysis Freud retained the use of the couch (Gay, 1988). It had in Freud's (1913) view the added benefit of having the patient out of sight – "I cannot bear to be gazed at for eight hours a day."

Analysts have found over time that the couch facilitates treatment in a number of ways. Lying down the patient is in the position that most promotes relaxation and frees up the patient's physical and psychic energy. The position also promotes relaxation and allows the patient to abandon western social norms such as making eye contact while talking to others (Kelman, 1954).

There are however analysts who have questioned the usefulness of the couch. The couch tends to promote regression in the patient. Salzman (1967) contends that while the promotion of regression is suitable for traditional analytic theories, contemporary theories do not necessarily value regression in the same way and the use of the couch might therefore no longer be necessary. In addition, the couch is contraindicated for patients prone to dissociation or for

patients with a psychotic core who are mostly not able to manage the regression. However, it should not be assumed that some psychotic patients cannot benefit from analysis. The work of Harry Stack Sullivan (1962) and David Garfield (1995) would indicate otherwise. Sullivan (1962) modified the use of the couch by sitting within the visual range of the patient. Garfield (1995) has successfully worked with psychotic patients by having them sit up rather than use the couch.

A related issue to the use of the couch is depriving the patient of making eye contact with the analyst. Traditionally it is thought that not making eye contact with the analyst assists the patient in free association and makes the patient less self-conscious in expressing embarrassing or shameful thoughts. In addition loss of eye contact promotes regression, which is viewed as a necessary part of the treatment process within classical theory.

However, infant researchers Stern (1985) and Beebe and Lachmann (2002) suggest that visual contact is an essential part of adult treatment. Many contemporary analysts have adapted the use of the couch – with the patient lying on the couch with the analyst sitting within visual range of the patient. The patient is then freed up to look at the analyst or to look away as he or she chooses.

Structural Model

It is important to keep in mind that Freud's theory developed in response to the growing clinical data he acquired in this work with patients. We therefore see classical theory develop and change a process that would continue for the duration of Freud's life and beyond. By the 1920's it became clear to Freud that the topographic model no longer fully explained the nature of conflict. For Freud the notion of conflict was at the core of what defined psychopathology. This meant that one part of the patient's mind was in conflict with another part of the mind and

symptoms such as the paralysis that Anna O suffered formed as a result of this conflict. Over time it became clear to Freud that the topographic model no longer adequately described the nature of the conflict he was witnessing within his patients. Freud concluded that conflict lies between the defenses and the unconscious and not between the conscious and the preconscious as the topographic model would imply. Further Freud concluded that the defenses reside in the unconscious. In Freud's view the true conflict therefore resided in the unconscious of the patient (Mitchell & Black, 1995).

A new model was needed to explain Freud's understanding of psychopathology and the structural model was developed. The structural model consists of three separate but interrelated domains of the self: the id, ego and the superego. The id consists of the raw impulses what Freud referred to as the "cauldron full of seething excitations" (Freud, 1933, p. 73). The ego is the self's regulatory system that imposes rules on the id. The superego mediates between the id and the ego and is comprised of the moral values of the self and develops as a result of socialization.

Freud was deeply influenced by Darwin's theory and held that humans are conflicted between basic animal instincts as exhibited by the id and the need to temper those instincts in order to live in community with others. In addition, humans are single-mindedly driven to seek pleasure which Freud referred to as the pleasure instinct. In order to avoid criticism from the super-ego and others the patient needs to conceal this hedonistic motive. Freud concluded that the ego and the superego work together to regulate the self and make it possible for people to live together with each other in relative harmony. The result of this function is a self that is filled with secrets and impulses not known consciously to the self (Mitchell & Black, 1995).

Other theories and the Development of a Two-Person Psychology

Much has changed theoretically in psychoanalysis since Freud, with a rich tapestry of theoretical and clinical developments. Anna Freud in Britain and Heinz Hartmann in the United States developed ego psychology. Melanie Klein and Donald Winnicott, focusing on very different strains of human experience, developed the big tent theory of object relations theory. Back in the United States, Heinz Kohut, focusing his clinical attention to disorders of the self, developed self psychology. Kohut's work opened the field of psychoanalysis to the treatment of patients who had previously been considered to be "unanalyzable". The 1980's saw the emergence of relational theory with the work of Stephen Mitchell (1988), Lewis Aron (1996) and Jessica Benjamin (1988). In addition, in the past thirty years there have been a number of attempts to link psychoanalysis and neuroscience with the work of Alan Shore (2011) and Eric Kandel (2005). More recently the analyst Mark Solms (2014) has coined the term neuropsychoanalysis which is an attempt to integrate psychoanalytic theory with neuroscience findings. For example, recently Solms and Turnbull (2002) have engaged in research that linked drive theory to the dopaminergic seeking system. In addition, infant research findings have also influenced psychoanalytic thinking through the work of Daniel Stern (1985) and the Boston Change Process Study Group (2010).

One of the biggest theoretical shifts in psychoanalysis was the move from a one-person psychology to a two-person psychology. Freud originally conceptualized psychoanalysis to be a one-person psychology in which the analyst is a blank slate onto which the patient projects his or her transferences (Freud, 1917). The idea of the analyst as a neutral party in the analytic dyad was over time largely abandoned as it became increasingly clear through clinical practice that the analyst and patient are both mutually influenced by each other (Hoffman, 1983).

Analysts have consistently been moved by the human experience of suffering and the process of developing clinical theory is in essence an attempt to alleviate that suffering. In psychoanalysis clinical theory is an outgrowth of the analyst experience in the consulting room.

Ego Psychology

Psychoanalytic theory developed and continues to develop within a social context. Freud with his structural theory was pessimistic about the nature of humans and our capacities. In essence the human is viewed as a wild untamed teeming with sexual and aggressive drives that threaten to harm self and others if not sublimated. Freud's view of human nature remained dark throughout his life so much so that there is some speculation that Freud's growing attachment to dogs in his later life was in part motivated by his growing disenchantment with human nature (Green, 2002). Viewed within the social context of the time, however, it hardly seems surprising that Freud would hold a pessimistic view of human nature when one considers that he lived through the horrors of the First World War, through the terrifying rise of the Nazis in Europe and needing to flee his beloved home of Vienna after the temporary arrest and detainment of his daughter Anna Freud by the Gestapo on the morning of March 22, 1938 (Gay, 1998).

Ego psychology would offer a somewhat more hopeful and practical approach to dealing with human nature. Ego psychologists, while remaining faithful to Freud's essential drive model, focused far more on the functions of the ego which they considered to be the most important psychological mechanism. In addition, ego psychology shifted its focus increasingly to a developmental focus which in turn started to consider how humans engage with their environment (Schamess & Shilkret, 2011).

Ego psychology originated in Vienna and England in the period between the two world wars and continued to flourish in the period after the Second World War. England would be an

important contributor to ego psychology, in particular with the work of Anna Freud (1895-1982) however the theory flourished in the United States with the contributions of emigrant analysts such as Heinz Hartmann (1894-1970), Margaret Mahler (1897-1985) and David Rapaport (1911-1960) being of special significance. Ego psychology would be the dominant psychoanalytic theory in the United States through much of the 1940's until the 1960's (Wallerstein, 2002). Ego psychology is of particular significance to this study as a number of participants had analysts who were utilizing an ego psychological clinical approach to the analysis.

Anna Freud considered herself to be the holder of her father's legacy and she spent much of her professional life both making a major contribution to ego psychology while also remaining faithful to Freud's structural theory (Young-Bruehl, 2008). Anna Freud's book, *The Ego and the Mechanisms of Defense* (1936) published before the death of her father, formed the theoretical and technical foundation for ego psychology. In the book Anna Freud theorized that the ego is engaged in a pattern of regulating and supervision of the id through a number of defenses. Therefore Anna Freud argued the task of the analyst was to pay attention to the defensive functions of the ego which can be seen in the way the patient free associates in the session. This in turn meant that the analyst needed to be highly attuned to the moment by moment process that unfolded in the session. Anna Freud placed more emphasis on interpretation on how the ego kept content out of consciousness than the exploration of and interpretation of repressed content in the mind of the patient (Freud, 1966).

Self psychology

The most significant theoretical challenge to the dominance of ego psychology came from Heinz Kohut's (1913-1981) theory of self psychology. Kohut, a faculty member of the Chicago Psychoanalytic Institute would initially tentatively and by the posthumous publication

of his book “How Does Analysis Cure” (1984) have decisively challenged the drive theory model. In the early years of Kohut’s career it was not at all obvious that he would pursue this path. Kohut was referred to as “Mr. Psychoanalysis”, a reference to both his expansive knowledge of Freud and to his clinical commitment to working in the classical frame (Strozier, 2011).

However, over time Kohut (1984) came to see how classical theory did not especially help many of his patients dealing with disorders of self, for example issues related to narcissism. Kohut came to understand that it was not Oedipal conflicts that afflicted these patients but rather a sense of not having a cohesive sense of self that troubled many patients dealing with a variety of disorders of the self. Kohut came to think that all pathology could be traced back to disturbances in the self by stating that: “all these flaws in the self are due to disturbances of selfobject relationships in childhood” (p. 53).

Kohut’s initial thoughts on self psychology can be found in his 1966 paper “Forms and Transformations of Narcissism.” Kohut would continue to develop his ideas in papers and books and like Freud he was intent on organizing a movement to mobilize his clinical thinking. The Chicago Psychoanalytic Institute became the center of an analytic revolution and Kohut was able to recruit some of the most talented analysts of the time to work with him in the development of self psychology. These analyst recruits in turn were excited at the possibility of working more effectively with patients who had not been particularly helped by classical analytic theory. It is especially important to take note of the climate of this time at the Chicago Psychoanalytic Institute as a number of the participants to this study had analysts who were part of or on the periphery of the self psychology movement in Chicago.

Empathy

Empathy is at the center of self psychology as expressed in Kohut's paper, "Introspection, Empathy, and Psychoanalysis" (1959). According to Kohut's formulation empathy was a process of "vicarious introspection" in which one person comes to understand the experience of another by using one's own subjective inner experience. This process places emphasis on the way in which two people can have similar subjective experience. Using empathy in this way is complex and often involves periods of prolonged empathic emergence on the part of the analyst (Terman, 2012).

It should be kept in mind that Kohut (1959) initially considered empathy to be primarily a clinical data collection tool. There has however been a growing understanding within self psychology that the experience of being understood through empathy is therapeutic. Indeed the experience of being understood by others is essential to our human experience in the creation of bonds between people which also have the impact of making people feel like others which in turn promotes a sense of a cohesive sense of self. In the analytic space, empathy has the added benefit of promoting a connection with the analyst which in leads to the personal growth of the patient (Terman, 2012).

Therapeutic Process of Self psychology

Kohut (1971) identifies three transferences that emerge from the analytic process: the mirror transference, the twinship transference and the idealizing transference. The mirror transference can be thought of as the need the baby has to be merged with the caretaker. In the analytic setting this is the transference in which the patient needs to have the analyst confirm his or her specialness. It is also of note that in the mirror transference the patient cannot tolerate the analyst's independent subjectivity. By contrast, in the twinship transference the patient

experiences herself as exactly like the analyst. It is this experience of similarity and a sense of belonging that promotes personal growth for the patient. The idealizing transference is when the patient experiences the analyst as a strong, secure figure worthy of admiration. For the patient, being able to idealize the analyst provides deep feelings of stability and calm (Terman, 2012).

According to Kohut (1971) the therapeutic process occurs when the selfobject needs of the mirror, twinship or idealizing transference are evoked in the course of the analytic process. Unlike many other theoretical orientations in self psychology, the analyst welcomes the transference and is empathic and responsive toward the patient as the selfobject needs emerge. It is however inevitable that the analyst would at some point disappoint the patient by being away on vacations, for example. It is in these situations that the important process of transmuting internalization occurs for the patient.

Transmuting internalization was a process that Kohut adapted from Freud's *Mourning and Melancholia* (1917) paper. It is the process in which the patient experiences the analyst as not fulfilling the need and is able to take over that function. So for example a patient might want the analyst to be available for sessions on a weekend but is able to tolerate the analyst not fulfilling that need and the patient is able to soothe himself rather than looking to the analyst to do this. This process became known as optimal frustration and it was viewed as essential in order for internalization and structural change to occur for the patient (Kohut, 1971).

A shift however occurred in self psychology when Bacal (1985) challenged the idea that frustration was needed for internalization and suggested that rather than frustration, the patient needed the developmentally appropriate optimal responsiveness from the analyst. Terman (1985) further developed this idea by stating that the pattern of continual responsive dialogue between patient and analyst is what creates structure for the patient: "The dialogue is the structure. The

repetition – not the absence or interruption – creates the pattern. This is the essential stuff of which we are made – and remade” (p. 125).

In the more than fifty years since, Kohut’s “Transformation of Narcissism,” self-psychology has developed into a big tent theory ranging from clinicians practicing in what might be described as a classical self psychology model in other words in accordance with Kohut’s original ideas to clinicians who work to integrate infant research and relational theoretical concepts into their self psychological practice.

Which Patients are Considered “Analyzable”?

The idea of analyzability, in other words which patients are considered to be capable of engaging in an analysis and ultimately benefitting from the treatment, has shifted over time. There appears to be some difference between views of who would benefit from analysis and how Freud conducted his own practice. The apparent contradiction between Freud’s own practices and that which he promoted as good practice is evident in a number of domains outside of the issue of analyzability. A possible explanation for this is that Freud grew increasingly concerned about what he termed “wild analysis” by analysts in Vienna at the time many of whom had limited training and clinical experience (Freud, 1910). As a result in the interest of promoting patient safety, Freud felt a need to provide clear and in many cases restrictive guidelines to practitioners of analysis (Schwartz, 1999).

Freud in his own practice selected patients for analysis many of whom were seriously mentally ill. Rat Man for example presented for analysis suffering from serious obsessional and neurotic features all of which significantly impairing his functioning (Freud, 1909). It would appear that Freud not only believed he could help Rat Man but at termination considered the analysis to have been a success stating in a footnote in the case: “the patient’s mental health was

restored to him ...” (p. 128). In a similar fashion Freud treated Wolf Man who entered analysis with severe depression and a number of somatically based issues (Freud, 1918). Wolf Man would later reveal his identity to the public and from Sergei Pankejeff (1886-1979) we have a sense of how the patient experienced the analysis. Pankejeff describes an analysis in which Freud felt optimistic about the recovery of his very ill patient and this positive attitude on the part of the Freud had a positive impact on Pankejeff (Gardiner, 1971).

It is against this backdrop that we need to consider Freud’s instructions on which patients he considered to be analyzable. In Freud’s 1905 paper, “On Psychotherapy,” he declared the criteria for analyzability was a patient dealing with a neurotic syndrome or later to be conceptualized as a patient able to form a transference neurosis. In addition, Freud stated the patient needed to be young but past adolescence, be intelligent, of reliable character, and “educable.” Freud stated that the patient was only to be considered analyzable if able to meet these very exact criteria and only then could the patient make use of what Freud came to call the “pure gold of analysis” (Freud, 1919, p. 167). Additional criteria emerged over time such as the patient’s ability to form a transference, capacity to form object relations, and ability for self-observation. These guidelines originated from ego psychology the dominant theoretical model of the time. This set of criteria for analyzability in turn deeply influenced institute training programs in America and largely determined for many years which patients were considered suitable for analysis (Goldberg, 2012).

However, as theoretical models expanded so did analysts’ perception of which patients were potentially analyzable. Not only did analysts’ theories start to expand and provide wider possibilities for potentially engaging with a wider group of patients but a welcome shift occurred in which analysts started to consider not whether the patient was potentially analyzable but rather

whether the analyst in question is able to work with a particular patient. Wilson (1999)

underscored this when he stated that:

psychoanalysts who locate analyzability inside an analysand rather than as wedded to the shifting tides of the contexts have made an egregious error, one that is damaging in many ways – to the patient, not to mention to the field of psychoanalysis itself. (p. 127)

There appears to be a general shift in focus on the issues of patient analyzability. The attitude of the analyst to the patient emerges as an important component to the patient being considered analyzable. Gedo (1981), made the claim to work with a broad range of patients but for a few that he found difficult. Both Rothstein (1994) and Backrach (1990) stress that the analyst's optimistic attitude toward the patients being able to succeed in an analysis was of paramount importance. Rothstein (1994) in particular takes the view that many patients need to be taught how to become analytic patients often through an initial phase of psychoanalytic psychotherapy.

In thinking about Freud's own practice we can speculate that he was optimistic and what analysis could offer patients who are dealing with deep suffering. It seems that analysts are increasingly following the practices of Freud on analyzability of patients rather than following the written instructions of Freud on the matter.

The Therapeutic Action of Psychoanalysis

The therapeutic action of psychoanalysis consists of two related variables: first the goals of the analysis, in other words that which needs to change for the patient in order for the treatment to be successful. The second variable is what clinical technique should be used over the course of the analysis in order to facilitate the change needed (Gabbard & Western, 2003).

Goals for the Analysis/What Needs to Change for the Patient

In considering what the goals are for an analysis it is worth first considering the question: what is considered to be optimal mental health. Shedler and Western (2010), in designing the SWAP-200 assessment instrument, provide a comprehensive list of traits exhibited by people who are considered to have mental health. The list of Shedler and Western:

- Is able to use his / her talents, abilities, and energy effectively and productively.
- Enjoys challenges; takes pleasure in accomplishing things.
- Is capable of sustaining a meaningful love relationship characterized by genuine intimacy and caring.
- Finds meaning in belonging and contributing to a larger community (e.g., organization, church, neighborhood).
- Is able to find meaning and fulfillment in guiding, mentoring, or nurturing others.
- Is empathic; is sensitive and responsive to other people's needs and feelings.
- Is able to assert him/ herself effectively and appropriately when necessary.
- Appreciates and responds to humor.
- Is capable of hearing information that is emotionally threatening (i.e., that challenges cherished beliefs perceptions, and self-perceptions) and can use and benefit from it.
- Appears to have come to terms with painful experiences from the past; has found meaning in and grown from such experiences.
- Is articulate; can express self well in words.
- Has an active and satisfying sex life.
- Appears comfortable and at ease in social situations.
- Generally finds contentment and happiness in life's activities.
- Tends to express affect appropriate in quality and intensity to the situation at hand.
- Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.
- Has moral and ethical standards and strives to live up to them.
- Is creative; is able to see things or approach problems in novel ways.
- Tends to be conscientious and responsible.
- Tends to be energetic and outgoing.
- Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways.
- Is able to find meaning and satisfaction in the pursuit of long-term goals and ambitions.
- Is able to form close and lasting friendships characterized by mutual support and sharing of experiences. (p. 106)

In contrast drawing on the recent findings of neuroscience, Gabbard and Westen (2003), identified two related goals that need to be reached in analytic treatments. The first is to work with the patient to change unconscious associational networks. This involves for example networks that trigger distressing emotional reactions or defensive reactions or problematic interpersonal patterns of relating to others. The second goal involves changing maladaptive patterns of feelings, motivations and thinking and to promote affect regulation.

Summer (2013), invoking Nietzsche states that goal of analysis is to assist the patient to be who they are meant to be. In addition, the analyst opens up new ways of being for the patient which creates within the patient a desire to do new things. The work of the analysis is to both explore the new possibilities and to assist the patient in bringing those possibilities into reality.

What techniques will facilitate the needed change? Levey (2012) contends that in an analysis a process of emotional deepening is needed in order to facilitate the work. He identifies seven goals of analytic interventions that promote the deepening the work. In addition, Levey states that the seven goals are applicable regardless of the theory used by the analyst. The goals are: first, the promotion of safe environment in the treatment where the patient feels able to engage in self-exploration. Second is to increase a patient sense of motivation to be curious about how their mind works. This is done by the analyst linking thoughts and feelings for the patient and assisting the patient in understanding that feelings have meaning. Third, once safety and curiosity are established, to uncover thoughts, feelings and motivations that create distress and anxiety for the patient. Fourth is to create an environment in which the patient is able to engage in a new experience and tolerate the affects generated as a result of the new experience. Fifth is to assist the patient in integrating new experiences and in reflecting and accepting conflicting parts of the self. Sixth is to assist the patient in new action and to develop a realist view of self

and the world. The seventh goal would be for the analyst to assist with symptom relief and character change.

The Corrective Emotional Experience

Few clinical concepts have caused more controversy or been more misunderstood in psychoanalysis than the corrective emotional experience. The founder of the Chicago Psychoanalytic Institute Franz Alexander (1891-1964) is credited with the concept but to fully understand the concept of the corrective emotional experience it is necessary to consider the contribution of Sandor Ferenczi (1873-1933) to the concept. In the book *The Development of Psycho-analysis* Rank and Ferenczi (1924) were critical of the idea that favors interpretation as the primary curative factor in treatment. The authors contended that treatment need consist not of remembering but rather repeating the distressing emotional from early life that brings the patient to treatment. Ferenczi further promoted the concept of an active technique which via the assistance of the analyst promoted emotional activation of the patient in the treatment process. The goal of this technique was to favor a process of learning by the patient rather than a process of insight through interpretation. This approach was a significant departure from Freud's technique which favored interpretation (Freud, 1958).

Franz Alexander (1935) took the idea of emotional activation in treatment a step further when he contended that treatment needed to consist of three components: (1) emotional abreaction which is the release of previously unexpressed emotion, (2) recollection of repressed infantile memories and (3) intellectual insight. Alexander (1935) stressed the importance of the emotional experience stating that: "without emotional abreaction, intellectual insight remains theoretical and ineffective" (p. 595) and stating that "every analysis should be conducted on as high an emotional level as the patient's Ego can stand" (p. 30).

In the book *Psychoanalytic Therapy: Principles and Applications*, Alexander (1946) and French formulated the concept of the corrective emotional experience by initially stating that: “only a corrective experience can undo the effect of the old” (p. 22). They then went on to define the corrective emotional experience in the following way:

To re-expose the patient, under more favorable circumstances, to emotional situations which he could not handle in the past. The patient must undergo a corrective emotional experience to repair the traumatic influence of previous experiences. Because the therapist’s attitude is different from that of the authoritative person of the past, he gives the patient an opportunity to face again and again, under situations that was formerly unbearable and to deal with them in a manner different from the old. This can be accomplished only through actual experience in the patient’s relationship to the therapist; intellectual insight alone is not sufficient. (pp. 66-67)

The concept of the corrective emotional experience was controversial from the very beginning, but somehow the idea has not lost its currency as is evidenced by the fact that the journal *Psychoanalytic Inquiry* dedicated an entire edition to the topic in 1990. The frequently cited criticism is the notion that the analyst needs to engage in role playing (Miller, 1990), by being deliberately taking an emotional posture that is different from the one the traumatic figure took from the patient’s past. So if for example the patient had a cold and distant father the analyst might deliberately aim to be warm and engaged with the patient. Opponents of the corrective emotional experience sized on this idea of role-playing denouncing it as bad practice. However, a close reading of Alexander shows a great deal of ambiguity in his writing about the degree or the desirability of the analyst engaging in this type of role playing to create the corrective emotional experience. Towards the end of his life it was clear that Alexander (1961) had abandoned the notion of role playing when he said: “I fully recognize the fact that the analyst cannot change himself ...” (p. 376). It could be argued that the analyst role playing is not an essential component to the corrective emotional experience. Rather it could be viewed that if

the analyst employs and maintains an optimal empathic and response to the patient, in whatever way is natural for the analyst, then the conditions are met to provide the patient with a corrective emotional experience. The self psychologist, Marian Tolpin, famously quipped: “if an analysis is not a corrective emotional experience then what is it?” (1983).

It is worth considering more carefully the opinions of major psychoanalytic thinkers in *Psychoanalytic Inquiry* almost 45 years after Alexander promulgated the idea. Wallerstein (1990) found little use for the concept and concluded with a revealing remark when he wrote that the corrective emotional experience should be thought of “as a specifically psychotherapeutic rather than psychoanalytic concept” (p. 321). The Kleinian analyst Hannah Segal (1991) stated that analytic neutrality was not attainable, and that intellectual insight is not sufficient for a successful treatment. However, Segal too questioned the desirability of the analyst engaging in any form of role playing with the patient. She contended this ignored the reality of the patient engaging in a defensive splitting. She contended that it is necessary for the patient to relive the split aspects of the object in the transference in order to discover what is a real attitude to the object and what is a childlike projection. For Segal, this is the true corrective emotional experience.

Miller (1991) speculates that the opposition to the corrective emotional experience originated due to opposition to Alexander’s initial suggestion that the length of analytic treatment should be shortened. He also points to the dominance of Ego psychology at the time and the stress the theory places on interpretation and insight. However, Miller maintains that stripped of any notions of role playing, the corrective emotional experience has clinical value stating that it: “evokes what we are trying to do – to correct, to repair, to cure the effects of deleterious experiences during the formative years, thereby increasing psychological health and

facilitating further development” (p. 381). In addition, Miller notes that not infrequently an analysis terminates successfully but with a patient obtaining minimal insight in the treatment process and conversely an analysis can terminate unsuccessfully but with a patient having insight. Miller theorizes that the concept of corrective emotional experience might explain this phenomena. In addition, he suggests that this might also explain how different analytic theories can produce successful treatments thereby implying that for an analysis to be successful some sort of corrective emotional experience is needed by the patient regardless of the theory used by the analyst.

Jacobs (1990) states that the analyst-patient relationship is more complex that would be suggested by the concept of the corrective emotional experience. He states that only part of the patient’s experience is to experience the analyst as a new object. Other effects of the relationship are internalizations of the analyst’s skills of ego, attributes and values. Jacobs concludes that insight and a corrective experience in the treatment are complementary experiences for the patients.

According to Woolf (1990), the term corrective emotional experience became a negative concept as in the 1950’s and 1960’s when it was viewed as “certainly not psychoanalysis and probably not even good psychotherapy.” This points to the unfortunate devaluing of psychotherapy with psychoanalysis being viewed as the superior treatment. Aron and Star (2013) point to the way in which psychoanalysis historically has been viewed as the masculine and by implication desirable treatment and psychotherapy the feminine and by implication the inferior form of treatment. It would therefore seem that the concept of the corrective emotional experience fell victim to this particular prejudice.

Psychoanalytic Outcome Studies

Historically there has been ambivalence expressed with respect to clinical outcome studies. In particular, during the so-called golden years of psychoanalysis in America during the fifties to the seventies there was a certain arrogance that dominated psychoanalysis where the prevailing view seemed to be that the benefits of analysis were self-evident and therefore outcome studies were not needed. This view is captured by Schlesinger (1974) when he states:

Anyone foolhardy enough to have proposed that what psychoanalysis needed was research into the psychoanalytic process would in all likelihood have been met by an effort to understand, sympathetically, the reasons for his “doubts about psychoanalysis,” for which that sovereign remedy “more analysis,” was probably needed.

Fortunately, not all analysts shared the misguided notion that psychoanalysis should be a type of faith-based enterprise and there were a number of attempts on the part of practicing analysts to engage in clinical outcome research. Pfeffer (1959), designed the first outcome studies based on a case study model. The majority of subsequent outcome studies in America followed the methodology developed by Pfeffer.

The methodology of the study Pfeffer (1959) can be described in four sequential steps: first cases were identified by requesting successful terminated cases from senior analysts. This had the effect of excluding failed cases out of the sample which is problematic. The treating analyst and follow-up analyst then met to examine the patient history and other relevant information on the case. Second, the former patient having terminated a number of years before was requested to be interviewed by the follow-up analyst. The interview was conducted in an analytic manner by requesting the former patient to free associate and speak about their analysis. The follow-up analyst would ask follow-up questions to clarify issues as needed. The third step was to examine the data with a view to current challenges experienced by the patient in particular

to determine if those challenges are similar to the challenges that originally brought the patient to analysis. The data was also examined for the transference between the follow-up analyst and the patient to determine if it was a replication of the transference with the treating analyst.

Additionally, the data was examined to determine the level of functioning of the patient. The fourth and final step in the methodology was for the treating analyst and the follow-up analyst to meet and discuss and evaluate the data. Pfeffer (1961, 1963) would continue to use this method in a series of follow-up studies.

There are a number of issues of note with regard to these outcome studies. It was Pfeffer (1959) who first identified that former patients frequently replicated the transference from the analysis with the interviewer in the follow-up study. Schlessinger and Robbins' (1983) research would also identify the some phenomena in their research decades later. A further finding by Pfeffer (1959) was the ability of the former patients to be able to distinguish between problems that had been resolved and those that had only partially being resolved. It was also noted by Pfeffer that former patients expressed enthusiasm about participating in the follow-up studies and were grateful for the opportunity to talk about ongoing lingering problems post termination. However, it should be noted that former patients were directly contacted by their analyst to request participation in the study. It is of interest to note that it appears that Pfeffer did not consider the transference implications of having an analyst requesting a former patient to participate in a follow-up study. While it is important to take note that the context of these studies: conducted in the 1950's by individuals, by medical doctors many of whom had limited training as researchers. While keeping the context of these studies in mind it is nonetheless important to take note of this serious limitation in theses research. By current research standards it would generally not be considered acceptable for a researcher to conduct research with a

population where there was an unequal power relationship. It could be argued that even after termination there is at the very least a residue of unequal power between a former patient and the analyst.

In Pfeffer's research there are a number of findings related to analysts that are of interest with respect to outcome research. Pfeffer (1959) contends that many analysts, in particular those in the early part of their career, tended to underestimate the extent of positive analytic results. This finding should be considered alongside that of Glover (1959) who commented on the difficulty of persuading analysts to consent to engage in outcome studies. Given the deeply personal nature of the analytic work it is understandable that analysts are narcissistically invested in their work and want to protect both their patients and themselves. It does suggest that analytic outcome research is best done without needing to involve the former analyst directly.

In addition, Pfeffer (1959) notes that a shortcoming in the research design is the lack of a control which would not of course be practical or ethical. However, this is only a shortcoming in quantitatively based research and Pfeffer was engaging in case study analysis which as a qualitative method would not make use of a control group. A more relevant shortcoming to consider that Pfeffer and his analytic researcher colleagues were all viewing the data from an ego psychology perspective. This had the effect that the analyst was determining the criteria for a successful analysis. While analyst clinical judgment is, of course, relevant it does seem overall more useful to request that the former patient set the criteria for what constitutes a successful treatment.

One final note is needed with respect to Pfeffer's (1959) research in the selection of the first "successful" case for study. According to the case write-up a 23 year old woman presented for an analysis and it was determined that "her homosexuality seems to be her main disturbance"

(p. 421). The follow-up was done four years after the termination of the analysis where it was determined that the analysis was a success as the former patient was married to a man, had a child and, “she had occasional vaginal orgasms” and it was further noted that “...she spoke about her fear of the responsibilities of marriage and also her puzzlement that she did not experience the same thrill when her fiancé touched her hand as when her homosexual partner had” (p. 423). This case is not only the first outcome study of American psychoanalysis but also considered a success by the analyst researchers. For the historical record it needs to be noted that this misguided attempt at analytic conversion therapy is part of the history of outcome research for psychoanalysis and this case cannot be considered a success.

It is especially important to consider this unfortunate case in light of the public apology issued to the LGBTQ community at the 109th Annual Meeting of the American Psychoanalytic Association (APsaA) in San Diego on June 21, 2019. Dr. Lee Jaffe the then president of APsaA stated in part that:

The American Psychoanalytic Association is apologizing for their past views pathologizing homosexuality and transgender identities. ... In 1969, homosexuality was considered a mental illness and sexual orientation was conflated with gender identity by the mental health field. This led many being coerced, either by force or choice, into traumatic and harmful methods to “cure” homosexual desires and non-conforming gender identities. Regrettable some of that era’s understanding of homosexuality and gender identity can be attributed to the American psychoanalytic establishment. It is long past time to recognize and apologize for our role in the discrimination and trauma caused by our profession. ... While APsaA is now proud to be advocating for sexual and gender diversity, we all know that hearing the words “we are sorry” is important to healing past trauma. (APsaA, 2019)

The next significant set of significant analytic outcome studies were conducted by Schlessinger and Robbins (1983) in Chicago. Schlessinger and Robbins followed the case study methodology of Pfeffer with some minor modifications. Like with previous outcome studies only cases deemed to be successful were selected for study. The methodology was as follows: to

study the first few hours of the analysis, the sessions when it is decided to engage in a termination process and the last hours of the analysis. These sessions were studied via process recordings and the follow-up interviews were conducted two to five years after termination. Schlessinger and Robbins also used an ego psychological criteria by which to determine success of the analysis. The criteria used was: (1) the nature of the alliance with the patient, (2) the special configuration of the Oedipus complex, (3) the defense transference, and (4) dreams. It is of note that the concept of a defense transference, while mentioned in the work of Fenichel (1941) and Gitelson (1944), emerged as something of a Chicago clinical concept. The defense transference is in reference to the way in which a transference could emerge between the patient and the analyst which serves as a shield against the development of the transference neurosis which is viewed as an essential development in an analytic process from the perspective of ego psychologists. The transference neurosis is the patient re-experiencing psychic conflicts and modes of defense via fantasies about the analyst. This in turn is a re-experiencing of the fantasies of important objects, of the parents, from the patient's childhood. The defense transference then is a mechanism of the patient's ego to avoid engaging in the transference neurosis.

The findings of Schlessinger and Robbins (1983) replicated those of Pfeffer (1959) in a number of important respects, for example that former patients were aware of which problems were dealt with in their analysis and which problems persisted post termination. Schlessinger and Robbins (1983) also found that original transference the patient experienced in the analysis was replicated often in modified form in the follow-up interview process. This has implications as ego psychologist Helene Deutsch (1959) stated: "What we conquer are only parts of psychogenesis: expressions of conflicts, developmental failures. We do not eliminate the original

sources of neurosis; we only help to achieve better ability to change neurotic frustrations into valid compensations” (p. 458).

Further the research of Schlessinger and Robbins (1983) indicate that while ego functions are often significantly altered by an analysis the work of the analysis is never entirely complete even after a successful analysis. In addition, in a successful analysis post-termination the patient has gained self-analytic functions. This implies that the analysis is never actually over as humans we are always in the process of change and in the process of collecting data in outcome studies the researcher is both a participant via the replicated transference and an observer of the change in the former patient. Schlessinger and Robbins (1974) speaks to this when they state that: “perhaps the most vivid experience for researcher is that he is observing, not a still photo at each assessment, but a panorama that changes as he looks at it and interacts with it” (p. 564).

A further quantitatively based study of note is the Menninger Foundation Psychotherapy Research Project started in 1954 and conducted under the leadership of Lewis Robbins and Robert Wallerstein. This is to date the largest longitudinal study of psychoanalysis. The study (N= 42) looked at both psychoanalysis and psychotherapy with half of the participants engaged in psychotherapy and half in analysis. For the purposes of the literature review only the findings pertaining to analysis will be considered. Participants to the study were randomly selected and engaged in extensive psychiatric evaluations including interviewing family members of the participant. Data was collected at the time of termination and evaluated by senior clinicians. Evaluations were again conducted at two years post-termination and continued for nearly thirty years (Wallerstein, 1989).

A significant flaw in this otherwise impressive study was in the recruitment of the participants. Due to Menninger Clinic’s reputation as the treatment facility of last resort a

number of the analytic patients in the sample are considered to be more ill that is generally the case for patients seeking analysis. These analyses were conducted as a last resort and by student-analysts (Galatzer-Levy et al., 2000). These factors possibly skewed the sample and the findings. Wallerstein (1986) reports that out of the sample (N=22), six patients needed to be transferred to psychotherapy due to “unmanageable transferences,” six patients were counted as failed treatments and four patients were evaluated as having moderately successful treatments and six were counted as successful treatments. Again it bears mention that the determination of what constitutes a successful treatment was left to the analysts and psychiatrists rather than to the patients.

Two potentially interesting findings that emerge from the Menninger Foundation report pertain: (1) to the so-called turning point in the treatment, and (2) the issue of insight and change. Wallerstein (1986) noted that frequently in case presentations and in case write-ups there appeared to be a turning point, a stage in treatment when something happen that then results in the treatment changing in some way. Wallerstein theorized that perhaps clinicians for rhetorical reasons felt need to present a type of turning point in a case. However, the Menninger Foundation study findings indicate that change work in an analysis is seldom accompanied by so-called turning points in the work. The second important finding is that therapeutic change did not appear necessarily coincide with interpretation by the analyst. This would suggest that for some patients it is possible to have significant gains in the analysis without insight (Galatzer-Levy et al., 2000).

There have been a number of studies that to some degree or another have attempted to replicate the central findings of Pfeffer (1959). Oremland, Blacker, and Norman (1975) and Gillman (1982) conducted outcomes studies on the termination phase of the analysis. Both

studies determined that analytic work on unresolved issues continue post-termination. In addition, Luborosky and Crits-Christoph (1988) and Kantatrowitz, Katz and Paolitto (1990) engaged in case study outcomes studies that focused on the former patient's capacity for self-analysis post termination. Finally, Schachter (2005) edited a book in which he invited eight analysts to write disguised accounts of analytic treatments. In some cases the patients were involved in the writing process and in other cases not. Newell Fischer (2011) published an accounts of nine of his analytic cases.

It is clear that in the past 60 years American psychoanalysis has made an attempt to study clinical outcomes. The case study method used by Pfeffer and many of the other researchers shows promise but tends to become problematic when combined with a desire to engage in quantitatively based method in search of empirical findings. Psychoanalysis is inherently subjective, and our research efforts are best focused when we use methods, like the heuristic research method used in this study, that are able to capture the unique individual experience of patient's experience of their analysis. As Summers (2013) states in describing the shift in psychoanalysis from a positivist science as conceived originally by Freud to a science of the subjective experience of the patient:

And so it is that a field that began with the positivist mission to make the psyche into a natural science achieves its full potential and makes its greatest contribution on a social as well as individual level as a science of the subjective. (p. 189)

CHAPTER THREE

METHODOLOGY

Research Design

The purpose of this study is to explore the patient's experience of analysis in particular how patients view their experience post treatment. A related question is how do patients view the experience of analysis impacting their lives post treatment. These questions were answered by using a qualitative research design, which involved engaging in a series of unstructured interviews with participants.

The methodology that guided this study was a phenomenological approach in particular a heuristic research design (Moustakas, 1990). A phenomenological approach focuses on the experience of participants of a particular phenomenon (Padgett, 2008). This study focuses on the patient's experience of psychoanalysis making the phenomenological method best suited to answer the research questions. In a phenomenological study it is the phenomenon that is the unit of analysis and not the participant (Vagle, 2014).

Qualitative Research Method

A qualitative research design is radically different from a traditional quantitative design. The way in which qualitative research produces knowledge is unique. Unlike quantitatively based research which often takes place in a lab setting the qualitative researcher does research in the natural setting of the participant e.g. home or work setting. Being in a natural setting with the participant promotes understanding and insight in the research process (Rossman & Rallis,

1998). In this research the participants determined where it would be best for them to meet with the option of meeting in the researcher's professional office. By doing this the participants could determine where they would feel most secure and comfortable in the data collection process.

The majority of participants elected to meet in the researcher's office.

Qualitative research is also interactive which means the researcher welcomes and encourages the participant's involvement in the data collection procedure. Most often the researcher does not impose a pre-set interview guide onto the participant. The interview guide is used as a guide rather than as a research instrument to be followed with precision. It is the process of engagement between the participant and researcher that produces the knowledge for qualitative research (Patton, 2002).

An additional important quality of qualitative research is the way the method takes an emergent stance to the creation of knowledge. In general, the qualitative researcher does not set out to test a hypothesis. Rather the researcher is open to the data shaping and altering the research questions under consideration (Patton, 2002). In particular, with heuristic research both the participant and researcher are open to the creation of knowledge through the process of dialogue about the phenomena under investigation. For this process to work optimally the researcher needs to be sufficiently flexible to allow questions to emerge through the dialogue and to use the interview guide as guide rather than as a prescription for how the research should be shaped (Sultan, 2019).

Qualitative research is a process of interpretation. Over the course of data analysis, the researcher looks for themes that emerge and ultimately makes interpretations and draws conclusions from these themes (Wolcott, 1994). These interpretations and conclusions are impacted by the researcher's own history – by her complex identities and social and political

stance to the world. In qualitative research, there is no attempt to separate the person of the researcher from the phenomena being researched. The personal interpretation is viewed as part of the process of research (Creswell & Miller, 2000). This is particularly the case with heuristic research that requires the researcher to be immersed in the phenomena being studied (Moustakas, 1994).

Heuristic Research

The heuristic research approach is a particular form of phenomenological research first used by the psychologist Clark Moustakas (1961) in his research on loneliness. The heuristic approach in particular focuses on intense human experiences or phenomena making this approach ideal for studying an experience like psychoanalysis.

There are two major components to the heuristic research method that work in tandem: (1) the research must have his or her own experience of the phenomena under study and (2) participants shape the direction of the research through dialogue with the researcher and are viewed as co-researchers (Moustakas, 1990). In this approach the researcher and participant work in close collaboration with each other to explore the phenomena under investigation. This is an approach that focuses on the depth of human experience rather than statistical measures. Douglass and Moustakas (1985) express this best when stating that: “Heuristics is concerned with meanings, not measures; with essence, not appearance; with quantity; with experience, not behavior” (p. 42).

Role of the Researcher

In a heuristic research design the researcher is an essential part of the process of acquiring insights with regard to studying the phenomena in question. In addressing the role of the researcher Moustakas (1990) states the following:

If I am investigating the meaning of delight, then delight hovers nearby and follows me around. It takes me fully into its confidence and I take it into mine. Delight becomes a lingering presence; for a while, there is only delight. It opens me to the world in a joyous way and takes me into a richness, playfulness and childlikeness that move freely and effortlessly. I am ready to see, feel, touch, or hear whatever open me to a fuller knowledge and understanding of the experience of delight. (p. 11)

Sample Selection

This sample consisted of 10 (N=10) adult participants all who have engaged in an analytic treatment. The sample for this study is a purposeful sample. Participants were chosen based on their experience of analytic treatment (Padgett, 2008).

The inclusion criteria for his study were: (1) participants who have engaged in an analytic treatment with an analyst (2) the participant engaged in the treatment with a frequency of between three to more times per week, (3) the participant has terminated the treatment at least six months before engaging in interviews for this project. The major selection criteria are for the participant to have fully engaged with the phenomena of analytic treatment.

The exclusion criteria for this study were (1) patients who are still actively engaged in analytic treatment, (2) candidates who are engaged in a training analysis and (3) analysts who are either still clinically practicing or who have retired from practice. Practicing or retired psychotherapists who had engaged in an analysis are not excluded from this study provided the prospective participant is not in training to be an analyst and is not planning at the time of data collection for this study to train as an analyst.

Sample Size

Sample size is based on a number of considerations. The choice of ten participants was based on the data collection method of in-depth sampling, and the time frame within which the study needs to be complete (Padgett, 2008).

In qualitative research the focus is on depth rather than on breadth (Patton, 2002). Three considerations were taken into account in the decision-making process of sample size: (1) a smaller sample size than is generally used in quantitative research, facilitates depth in the data collecting process, (2) smaller sample sizes are generally used when collecting data with a homogenous population and (3) participants provided a large volume of information and the researcher elected depth of interviews over breadth (Padgett, 2008).

Moustakas (1990) notes that in theory it is possible to conduct a heuristic study with just one participant however the research would “achieve richer, deeper, more profound and more varied meaning” with a larger sample size (pp. 46-47). Moustakas recommends a sample size of between 10-15 participants. This study recruited and interviewed ten participants.

Recruitment

A purposeful sampling method of snowball sampling was used to collect the data. Snowball sampling provides researcher with a method of identifying participants who will be potential good interviewees (Patton, 2002). In this study participants were asked to refer to the research, other potential participants who might be interested in participating in the study.

A number of interview participants were known to the researcher and were invited via email to participate in the study. The researcher had no prior or existing relationships of authority over any of the participants. The email contained basic details of the study and the expected length of the in-depth interviews. Three interviews were conducted on three different days. The first two interviews lasted on average one and half hour each and the third interview, which was the member checking interview, lasted on average one hour. Prospective participants were asked to respond to the email if they wished to participate in the study. A maximum of two emails were sent to participants in the process of recruitment.

Once a participant responded to the email indicating that they wished to participate in the study an, interview was scheduled. Interviews took place either in a private location of the participant's choice or in researcher's professional office. The majority of participants made the choice to meet in the researcher's office. At the end of the final interview participants were asked if they knew of other prospective participants who might be interested in being interviewed for the study.

Protection of Human Subjects

The proposal was sent to the Institutional Review Board (IRB) of Loyola University Chicago for a full review. The IRB approved the proposal and granted permission for data collection to begin.

Ten participants who had completed analytic treatment at least six months prior to the study were included in the research. All participants were adults and had the intellectual capacity to consent to participate in the study. No participant below the age of twenty-one was interviewed.

It was anticipated that risks to participation in the study would be minimal. It was further anticipated that participants could potentially experience a degree of emotional distress as they recall aspects of their treatment experience and that as a trained and experienced therapist, I would assist participants in managing their emotional reactions. Participants were informed that referral could be provided should they deem it necessary to see a therapist. Both analytically based referrals as well as non-analytically based e.g., CBT were available to participants.

Over the course of the data collection, participants did exhibit a range of emotions from joy to sadness and many participants become tearful or outright cried while talking about their analytic experience. However, without exception each participant expressed feeling positive

about talking about their experience. None of the participants requested or in my professional opinion required follow-up mental health service after the completion of the interviews. One participant expressed wanting a referral to an analyst, so she could have a “tune up” – stating that her analytic experience had been so positive, but she felt there were still issues to be dealt with and wanted to talk to an analysis. I provided the participant with an analytic referral.

Participants were also informed that they had the right to end the interview at any time should they wish to do so or to drop out of the study without providing the researcher with a reason should they wish. Answering questions was also optional, and participants could elect to not answer any question that they wished not to answer. None of the participants dropped out of the study and all the participants elected to answer all questions.

Confidentiality was maintained by requesting participants to pick a pseudonym. The pseudonym was used in all written records related to this research. All information related to participants, name, address, phone numbers were kept secure in a locked filing cabinet. This information will be destroyed five years after the completion of data collection.

Participants did not receive monetary rewards for participating in the study. It was anticipated that participants would benefit from sharing their story with a researcher who, has a high degree of interest in an important experience in their life. It was also anticipated that participants would derive benefit from knowing that they have contributed to knowledge in the field of psychotherapy outcome research.

Over the course of the interviews a large number of the participants expressed feeling positive about talking about their analytic experience and expressed that they hoped the research would contribute to the field of psychotherapy in particular analysis.

Data Collection

In heuristic research, the data is generally collected via in-depth interviews. The goal of these interviews is to create a climate in which the participants is open to tell his or her story. Ideally the dialogue only ends once the participant feels fully heard. One the unique features of the heuristic research method is the way in which the researcher and participant engage in a process of collaborative dialogue with regard to the phenomena under investigation (Moustakas, 1990).

In this study the data collection consisted of one close- ended questionnaire which asked basic informational questions such as frequency of sessions and length of treatment (see Appendix A). The questionnaire took on average five minutes to complete. The bulk of the research was conducted by doing a series of two in-depth interviews, ninety minutes in length each. An interview guide was used to facilitate dialogue, but participants were encouraged to lead the dialogue in whichever direction they felt wished it to go. The third interview was a member checking interview for one hour. Member checking is the process of asking participants for their feedback on themes that emerge in the process of data analysis. All the interviews were audio recorded. Participants engaged in interviews on three separate days. Time between interviews facilitate reflection by both the participant and researcher on themes emerging in the interviews (Moustakas, 1994).

Self-disclosure was used by the researcher as part of the data collection process. It was found by Jourard (1968) that self-disclosure facilitates participant disclosure. In order to obtain useful data in the heuristic method it is essential to create an environment in which the participants are able to be flexible in their thinking. Judicious self-disclosure by the researcher promotes mutual exploration of the phenomena. Buber (1965) states that, “dialogue is like

mutual unveiling, where each seeks to be experienced and confirmed by the other ... Such dialogue is likely to occur when two people believe each is trustworthy and of good will” (p. 21).

Interview Questions

The closed ended questionnaire was used to collect data on the general conditions of the treatment. Questions such as the length of the treatment, frequency and number of years since the termination of the treatment were asked. The goal of the questionnaire is to obtain basic information with regard to the conditions under which the treatment was conducted.

An interview guide was used for the interviews. The interview guide was used to facilitate dialogue rather than as a way to set the agenda for the direction of the interview. The goal of the interview guide was to facilitate a dialogue between the participant and researcher. There two interviews guides covered the following topics: how the participant went about picking their analyst, the initial phase of the analysis, the middle phase and then the termination phase of the interview and how the analysis impacted the post- analysis life of the participant.

Field Notes

After each of the three interviews, the researcher created a memo reflecting on the experience of the interview process. These memos in turn formed part of the data and were used to form the creation of the composite, exemplary depictions and the ultimate synthesis of the overall data. This interaction of responses between researcher and participant is what creates the data of the research and is one of the unique features of the heuristic research method (Moustakas, 1990).

Data Organization and Analysis

Generally, the goal of research is to generalize knowledge from the sample to the whole. Individual experience is therefore generalized. With the heuristic research method there is a

generalization of knowledge, but the individual participant is not lost in the process (Moustakas, 1990). There are four phases in the heuristic research process: (1) the creation of the individual depictions, (2) the composite depictions, (3) the exemplary portraits and the (4) creative synthesis of themes (Sultan, 2019).

Individual Depictions

The researcher starts out by working with the material from one participant at a time. In the initial phase the researcher gathers all the material related to an individual participant. All the interviews and field notes are gathered. In this study the researcher listened to and made notes on the recording multiple times. The researcher then enters into an experience of full immersion with the gathered material. The goal of this period of immersion is for the researcher to as fully as possible understand the experience of the individual participant of the phenomena under investigation (Moustakas, 1990). This phase of research is similar to the process of vicarious introspection Kohut (1984) refers to as the, “capacity to think and feel oneself into the inner life of another person” (p. 82).

The individual depictions contain the following elements: a demographic description which in this study was obtained from both the interviews and the close ended questionnaire. The depiction is taken from the raw data of the original interviews and contains verbatim excerpts from the interviews (Moustakas, 1990). The depiction focuses on the major themes that emerged in the interviews (Sultan, 2019).

Once the individual depictions were complete the researcher returned to the original data to check for accuracy. Moustakas (1990) suggests asking two questions to promote accuracy: (a) “does the individual depiction of the experience fit the data from which it was developed?” and “Does it contain the qualities and themes essential to the experience?” (p. 51). In addition, an

added level of member checking was engaged in by sending participants the depictions to further ensure accuracy.

Composite Depictions

The next phase is the creation of a composite depiction that is generated by considering the data as whole. A composite depiction emerges with themes that appear that are common to many and perhaps all the participants. This represents the shared experiences of the participants (Moustakas, 1990). Once again verbatim direct quotes from the interviews are used in the creation of the composite depiction. The composite depiction is in essence the unifying of themes that emerge from the individual depictions (Sultan, 2019). In this way the tension is maintained between representing the individual voices of the participants and finding unifying themes that generate knowledge about the phenomena being studied.

Exemplary Portraits

Exemplary portraits were created by developing three portraits that illustrate the unique experiences of participants within the gestalt of the whole group of participants (Sultan, 2019). Information that was not used in the individual or composite depictions was included in the exemplary portraits. Exemplary portraits are a way to focus both on the individual experiences of participants and to explore the collective experience of a group of participants (Sultan, 2019).

Creative Synthesis of Themes

The final stage of the research is the creative synthesis of the data. This is a process in which the researcher uses all the knowledge acquired over months of data collection and immersion in the data to develop a comprehensive understanding the phenomena under investigation. The researcher once again returns to the data, consults the exemplary portraits created but also relies on the intuition that the researcher incubated over the course of the data

collection and analysis phase of the research. Moustakas (1994) states of this final phase of the research:

The researcher as scientist-artist develops an aesthetic rendition of the themes and essential meanings of the phenomenon. The researcher taps into imaginative and contemplative sources of knowledge and insight in synthesizing the experience, in presenting the discovery of essence ... In the creative synthesis, there is a free reign of thought and feeling that supports the researcher's knowledge, passion, and presence; this infuses the work with a personal, professional, and literary value (p. 52)

Strategies for Rigor

In this study, four methods will be used to promote rigor: member checking, debriefing and the use of expert opinion and prolonged engagement. All these methods are considered to be reliable methods of ensuring rigor in the research design (Padgett, 2008).

Member checking is the process of asking participants for their feedback on themes that emerge in the process of data analysis. In this way the researcher is able to assess if the emergent themes resonate with participants and the degree to which the emerging interpretations are valid. In addition, the heuristic research method the participants are regarded as co-researchers and members checking therefore becomes an important way to include the participants in the data analysis process.

Debriefing and the use of expert opinion is not only to support the research but as a method to encourage rigor in the research process (Padgett, 2008). In this research committee members were consulted to discuss the process of the interviews and the themes that are emerged from the interviews.

The final strategy to promote rigor was repeated engagement with participants. This was accomplished by engaging in three interviews with participants on three different days. In

addition, the member checking process as part of the creation of the individual depictions further involved engagement between the research and participants.

CHAPTER FOUR

RESEARCH FINDINGS

The findings for this study will be reported using the heuristic research model. Following this model the following steps were used to organize the research findings. First, individual depictions were created for each of the participants interviewed for this study. The goal in creating the individual depiction is to understand each participants individual experience of their analytic treatment and to focus on the major themes that emerged from each of the individual interviews (Moustakas, 1990). The second is reporting the findings and the creation of a composite depiction that emerges from themes that are common to a number of the participants. This represents the shared experience of the participants. In the heuristic research model there is an attempt to maintain a balance between both the experience of the individual and many ways in which an individual experiences the phenomena under investigation (Moustakas, 1990).

The third step is the research process is the creation of three exemplary portraits. Exemplary portraits are a way to focus both the individual experiences of participants and the collective experience of a group of participants (Sultan, 2019). The final stage of reporting the findings is the creation of synthesis of the data. That data synthesis will be contained in Chapter Five.

Description of the Participants

Ten participants, three men and seven women, were recruited for this study. The majority of the participants (N=7) engaged in an analysis in Chicago with a minority of participants

engaging in an analysis in cities outside Chicago (N=3). The age of participants at the time of the start of the analysis ranged from 24 years old to 47 years old. Seven participants had male analyst and four had female analysts. One participant engaged in two separate analyses a number of years apart, one with a female analyst and one with a male analyst. One participant engaged in two analyses, one as a child and the other as an adult, with the same male analyst.

The number of days the participants spent in analysis each week ranged from three days to five days. The length of the treatment ranged from two to 15 years. All but one of the participants ended treatment with a mutually agreed upon termination between patient and analyst. One participant had her analysis unilaterally terminated by the analyst. The number of years since participants' termination of the analysis ranged from five years since termination to 45 years since termination. Four of the participants reported that they knew the theoretical orientation of their analyst at the start of the treatment and six of the participants stated that they did not know the theoretical orientation of their analyst at the start of the treatment.

Table 1. Characteristics of Participants (N=10)

	Age at start of analysis	Previous Psychotherapy	Analysis Conversion*	Gender of Analyst	Analysis Frequency (days)	Length of Analysis (years)	Years since termination (years)
Brenda	35	Yes	Yes	M	4	2	40
Debbie	28	Yes	No	M	3	4	36
Paul	21	Yes	No	M	4	7	5
Pearl	24	Child Analysis	No	M	3	10	34
Ruby	47	Yes	No	M	4	5	27
Sally	27	Yes	No	F	4	5	43
Shelley	20 27	Yes	Yes No	F M	4 4	7 7	32
Jennifer	29	No	No	M	4	4	25
Jim	46	Yes	No	F	4	3	18
John	30	No	No	F	5	15	15

*The patient first engaged in a psychotherapy with the analyst before converting the treatment into an analysis.

Individual Depictions

Brenda

Brenda entered analysis after a period of psychotherapy with her analyst wishing to deal with issues in her life at a deeper level. Practical goals were foremost in Brenda's mind. She wanted to change a pattern of unsuccessful relationships with men and she wanted to get married. Simultaneously Brenda was aware that her father's suicide, when she was three years old, "informed my whole life." An analysis Brenda felt would provide an opportunity to understand how her father's suicide had impacted her life.

Brenda expressed having a strong and lasting bond with her analyst: "I was immediately comfortable with him." The core of the analysis appears to have been the relationship and the way Brenda felt when she was with her analyst. She states that: "I felt safe and cared for, every time I walked out of his office, I felt a lightness in my step." In addition, she felt understood by the analyst stating that, "in the first session he said, 'there are a lot of "shoulds" in your life' and that nailed me." Brenda frequently felt compelled to act according to certain expectations, or she felt she would risk self-destruction. The analysis Brenda feels "freed me of this. I am still not a major risk taker, but I don't live in fear."

Brenda reports no impasses or ruptures in the treatment: "we just kept rolling along." She states that in her opinion the success of an analysis is in part dependent on the analysands willingness to work on difficult issues. She was aware of a "cold dark space" inside related to her father's suicide. Brenda feels that the issues related to her father's suicide were actively and successfully engaged in her analysis: "I got rid of a lot of demons in my analysis." In addition, other gains followed as a result of her analytic work including a fulfilling marriage and

continued professional success. There was a strong sense that Brenda could take what she learnt in the analysis and apply it to her life.

Brenda initiated a termination when she felt that “I had talked enough, and it was time to go and do.” She felt that her analyst had “opened my heart” and at the last termination session her analyst said to Brenda: “I learnt a lot from you, and you are a wonderful person.” The analyst also indicated to Brenda that she was free to return to treatment whenever she wished to. Brenda did in fact take up her analyst on this offer and returned periodically to sessions with him to discuss the various challenges in her life. Brenda’s analyst died some year later:

That is maybe the closest we came to an impasse. I would say to him if anything happens to you, I need to know what to do who to go to. He would never respond and that made me a little angry I needed a plan B. We never talked about my anxiety about his future death. He just said he was not going to die and then he did, but I forgive him. Everybody does the best they can.

Debbie

Debbie started an analysis as a graduate student. Her primary reasons for engaging in an analysis was to deal with longstanding issues. In particular, issues around power as they related to her relationship with her father and how these patterns replicated in her adult relationships. Debbie had engaged in previous psychotherapy but had not achieved as much as she had hoped for and sensed that analysis might be a form of treatment that would more comprehensively deal with issues she wished to resolve. In addition, as a graduate student Debbie was surrounded by people who expressed positive sentiments towards psychoanalysis, and this resulted in feeling intrigued by the prospect of an analysis and a “sense that it was the elite form of therapy.”

Debbie felt that her analyst was compassionate, and he had an innate sense of gentleness which was helpful to her. There were some initial adjustments to analysis such as not having eye contact and “sorting through the ambiguity of the process,” but Debbie settled into analysis and

found that she had a lot to say. At times she found the frequency of sessions to be challenging. Over the course of the treatment there were no major disruptions. She stated, that she felt the relationship with the “analysis was very positive warm and non-judgmental.”

Significant gains were made over the course of the treatment. Debbie was able to work through her feelings toward her father and accept his limitations: “the analysis helped me put things in perspective and having a male analyst was a corrective experience.” In addition, the analysis helped Debbie to be aware of situations that triggered her and to respond more constructively than she might have in the past. This was particularly helpful in Debbie’s professional life where she was able to more successfully navigate conflictual encounters with others while also still maintaining her self-regulation.

Debbie initiated the termination of the analysis and states that “I think we ended it before he felt like I was ready, but I felt ready and in hindsight I made the right choice for me.” Post analysis Debbie married, had children, and continued to have a productive relationship with her father. Reflecting on her analysis Debbie states that “I think back on my analysis with very fond feelings.”

Paul

Paul entered analysis on the advice of his family: “doing an analysis is just what we do in my family.” His grandfather offered and paid John’s analytic fees. John picked a prominent analyst in the city in which he lived: “everyone in the analytic community knows his name. He wrote a ton of books I thought I was getting the best.” Paul entered analysis feeling he was depressed and with an “aching sense of isolation and loneliness.” The loneliness was further aggravated by the analysis: “here I was lying week in and week out talking to a largely silent analyst. I tried to feel something but all I felt was alone.”

Things reached a crisis point in the analysis when Paul started to become more depressed and feared he would fail a professional credentialing exam. On the advice of Paul's internist he considered going on an anti-depressant and his analyst strenuously objected: "he said no patient of his was taking medication. How dare I even suggest something so ludicrous. I felt mocked by my analyst and that is when the wheels really came off the treatment." Paul decided to follow the dictates of his analyst and not to take the anti-depressant: "I felt like I had no choice but to try really hard to work with my analyst and see if maybe I could feel better." Paul did manage to pass his credentialing exam and he attributes the success to his analyst's support: "I felt he did want me to succeed even if only because that meant at some level he was succeeding as an analyst." However, Paul felt that the core of his issues with depression and loneliness was never addressed in the analysis.

The analyst initiated termination after seven years: "it seems there is a thing about seven years in this city with analysts and frankly I was relieved that we were done." Paul speculates that perhaps he was not ready for analysis when he entered treatment: "I am older now maybe I could be a better patient at this point in my life. But I would pick another analyst someone who could be kind who would really listen to me maybe someone like you."

Pearl

Pearl engaged in two separate analyses with the same analyst, first as a child and then at age 24 as an adult. As a child her parents felt that she needed help with school performance issues and sent her to a respected child analyst. Pearl's father, a physician was well informed about psychoanalysis. In fact father and daughter were in analysis at the same times each with their own analyst. This was a major financial commitment on the part of the young family and

Pearl states that: “my father was only just starting out professionally and I later got the sense that our respective analyses almost broke the bank.”

Pearl’s memories of her child analysis are vivid: on important dates such as her birthdays or Hanukkah her analyst would send her to the toy store instructing her to pick out a present for herself. He would also bring presents back from trips and they would eat popcorn in his office together. Pearl feels the analyst was an essential support during her childhood and real progress was evident through her improved school performance and a general sense of wellbeing.

At age 24 while training as a clinical social worker, Pearl decided to engage in an adult analysis. She commented that it never occurred to her to go to any other analyst but her previous child analyst. Pearl states that: “his sweetness and his ongoing support bonded us.” The adult analysis differed significantly from the child analysis, there was no sharing popcorn or present buying by the analyst, as Pearl put it, “there was no gratification.” Asked how she felt about the change from the child to the adult analysis Pearl stated: “I came to the analysis wanting to do the work and this was how it was done.” Pearl stated that the issues that motivated her to engage in an analysis were largely dealt with over the course of the treatment. For example, she managed to work through the death of her father and a troubled relationship with her mother, “lots of forgiving of what she could not give me.” In addition the analysis prepared Pearl to be a parent, “I did a lot better at listening to my own child than I might have without the analysis.”

Pearl knew she was ready for termination as a result of the gains she had made in the treatment. There were also tangible results in the analysis such as sustained weight loss were evident. In addition, she had gained a sense of self awareness that helped Pearl engage more effectively with her clinical work as a social worker. A termination date was set, and six months

later Pearl and her analyst terminated treatment. For years until the death of the analyst Pearl returned from time to time for psychotherapy sessions with her analyst.

Ruby

Ruby's immediate reasons for engaging in an analysis was as a result of a crisis in her private life but also indicated that she had a longstanding interest in doing an analysis: "I was kind of drawn to the whole thing." It was important to Ruby that her analyst was a self psychologist as she had read some of Kohut's (1971) writings and felt drawn to the theory. After interviewing several analysts Ruby choose a male analyst who she felt comfortable with: "other analysts were too aggressive, challenging what I was saying. He was not."

Ruby states that a deeply meaningful and transformative treatment developed over the course of the analysis. For her the relationship with her analyst was of utmost importance: "the relationship is the whole thing." She stated that it felt like "he knew and liked me" and "I told him everything including the worse stuff." Ruby went on to state that, "the curative part of the analysis was and is to this day that he never saw me as bad. I had to love and respect him enough that it mattered that he thought I was not bad." As a result of the analysis Ruby feels that she came to understand herself and how her mind works. "To understand who I am is the central part of living for me." Ruby further states that: "there was a time that I thought I would lose the analysis if I could not hold onto the idealized image of him. That has not happened. I don't question the validity of the work we did."

After five years, Ruby and her analysis engage in a termination process which took 18 months to complete. She states that: "I was in grief at termination, he was very dear with me and we liked each other a lot." The termination was a traditional termination in the sense that it was

agreed upon between the analyst and patient that no further contact would take place after termination.

Sally

Sally entered a four times a week analysis at age 27 to deal with “paralyzing anxiety I want to emphasize how bad that was for me. I was very afraid.” She had previously engaged in psychotherapy but felt she needed to “talk more in depth.” She requested a referral from the Chicago Institute and the intake coordinator recommended a female analyst. Sally vividly remembers the first day of her analysis: “I remember her saying what is on your mind? I thought that was a good way to start.” A transference quickly developed: “I immediately connected, and I had great respect for Dr. T. She had real warmth and I was very curious about her.”

Sally states that she had a keen awareness that the analysis was essential to her life: “it was crucial to my life I was troubled. I really needed analysis so there was no question of if I had the time, I made the time.” It seems that Dr. T had a strong sense that she could help Sally saying: “people will look back on these symptoms and not even remember what it was like” and Sally went on to state, “that has proved to be true.” In addition, the analysis provided Sally with a strengthened sense of self over time: “it was slow going at first, but the analysis was good for my career it was good for relationships.” A significant idealizing transference developed in the treatment in which Dr. T modeled for her patient a sense of professional competency. Sally states that, “I look back at my analysis with a kind of wonder.”

At the five year mark of the analysis, Sally was pregnant and there was an active discussion in the analysis to start the termination process. It was during this time that Sally arrived one day for her session: “I came and knocked on the door and there was no answer.” Sadly, Dr. T had died the previous night after emergency surgery. Mourning Dr. T was

complicated for Sally as she was dealing with multiple stressors in her life at the time and not much support was available. However, for Sally the gains of the analysis remain unequivocal and she states that: “tears well up when I think about our meaningful experiences. I was lucky to have her for as long as I did.”

Shelley

Shelley engaged in two separate analysis one with a female analyst and another some years later with a male analyst. She picked the male analyst in part due to his reputation and thought he was “on the side of being a jerk like my father and the guys I dated. I thought this is perfect I will work it through. That did not happen.” Shelley said she entered analysis because she thought of analysis as “having the Good Housekeeping seal of approval” and states that was perhaps not the right reason to start an analysis but goes on to say “my family was a mess” and states that she had significant problems engaging in intimate relationships.

Shelley feels that the issues that motivated her to enter into analysis were not engaged or worked through in any significant manner in the treatment. “The analysis allowed me to put depression into a box, but it kept coming back and the analysis did not teach me to have relationships.” There was however a sense in which she believed in the process of the analysis while also experiencing the treatment as largely ineffective in dealing with the issues that brought her into analysis: “I think he thought he was giving me a good treatment and I thought I was getting a good treatment but it was a folie a Deux.”

Shelley does however state that there was a sense of “goodness” in the analyst: “I was really lost, and it gave me a sense of meaning and purpose.” For Shelley the most curative part of the analysis came years after the termination when she ran into her former analyst at a professional meeting: “what really helped me was running into him at a meeting and I went up to

him and he touched my cheek and looked into my eyes and that was lovely. He had been such an asshole during the treatment.”

Shelley terminated after seven years believing that was the standard time her analyst conducted treatment: “I thought he was bored and wanted someone else for seven years.” In the last dream of her analysis Shelley had a dream of a beautiful apartment with hardwood floors but there was no bedroom in the apartment. The analyst had little to say about the dream, but Shelley interpreted it as the failure of the analysis to provide her with a pathway to engage successfully in intimate relationships.

Jennifer

Jennifer entered analysis to deal with panic attacks and challenges in early motherhood. She was overwhelmed with sad, fatalistic feelings about her children’s future. In addition, Jennifer had a growing awareness of sexual abuse in her childhood and felt she could benefit from talking to an analyst: “I wanted to believe in analysis.” She was aware that her analyst was on the “cutting edge” and considered to be one of the group of analysts practicing in the early days of self psychology.

There was an immediate sense of connection for Jennifer with her analyst, “there was a pleasure in someone listening.” It felt to her that an intense special relationship was developing. Jennifer would feel upset about weekend separations and her analyst would say to her “you need me to know that partings are difficult for you.” It felt to Jennifer as if the analyst at times talked to her as if she were his lover. He never actually engaged in a boundary crossing with her rather in hindsight it seemed to Jennifer that he was talking to her through his self psychology theory which was based on a developmental model: “he wasn’t talking to me he was talking to his theory.” As a result it seemed the analyst was unaware of the extent to which the treatment had

been eroticized. When Jennifer years into the treatment talked with her analyst about her erotic feelings, he unilaterally terminated the analysis and referred her to a colleague for a consultation. The analyst refused to have further contact with Jennifer: “I was on my own with this, he took no responsibility for his part in the treatment.”

Jennifer stated that, “I was very disappointed, and I left my treatment angry.” In addition, there had been a general lack of progress in the treatment in terms of Jennifer’s depression. Her analyst had opposed the use of psychotropic medication. In subsequent psychotherapy after Jennifer’ elected to use medication in conjunction with psychodynamic psychotherapy which resulted in significant relief from depressive symptoms. Recovering from the abrupt ending of her analysis would however be a much more complex process for Jennifer and required extensive psychotherapy for many years.

Jim

Jim started an analysis when his then therapist suggested he try is: “I really knew nothing about it just that you lie on a couch.” He was dealing with significant trauma due to the loss of his family in a divorce going from being the primary caretaker of his children to living in another state without his children. Jim was dealing with significant issues of loss which was underscored by a dream in which he dreamt that he had murdered his children. “There were things I could not figure out for myself and thought analysis could help.” Shortly after the suggestion that he try analysis from his, therapist Jim relocated for a job. In his new stated Jim called the local psychoanalytic institute requesting a referral for an analysis. Jim states that he had no idea of what qualities his prospective analyst needed to have other than he wanted a female analyst who practiced somewhere within his zip code. Jim assumes he felt drawn to the idea of a female analyst as a result of having a positive working relationship with his previous female therapist.

The opening phase of the analysis was characterized by Jim feeling that he was “floundering” in the treatment. Initially he told no one about the analysis feeling that “if you need to go see your shrink four times a week there is something fucked up about that” but he kept going back for the next session. In spite of feeling that his analyst was “like a ghost,” silently listening to him, Jim also felt at times that he was getting at something and he was dealing with the trauma of being separated from his children. He was however also drinking heavily in “an alcoholic manner” several times a week over the course of the analysis. The analyst was aware of Jim’s problems with drugs and alcohol but did not address his substance use in any way.

Over the course of the treatment Jim feels he did significant work on his feelings with respect to his children and finally concluded that “there is no such thing as time or space when it comes to love.” However, Jim’s substance abuse problems become more serious over time while in the analysis. The analyst was aware of Jim’s problems with drugs and alcohol and did not engage with this over the course of the analysis which Jim feels in hindsight was a mistake in the treatment.

Jim terminated the treatment when he married and moved to a city in another state. He had balance due to his analyst and made it a priority to pay the outstanding fees after termination. With the last check Jim included a note of thanks to his analyst.

John

John started an analysis when his marriage started to breakdown in large part as a result of his emotional difficulties: “I felt myself coming apart I urgently needed help.” His wife wanted children and John felt terrified to start a family due the extensive emotional and physical abuse in his own childhood. The abuse John suffered was a secret: “I felt shame like I

deserved the abuse I was so messed up and desperately needed to tell someone.” A colleague of John’s had been in analysis and suggested that he might be helped by the treatment.

The first session John remembers shaking uncontrollably physically: “she (the analyst) first got me a hot cup of tea then talked to me softly telling me I was safe.” Within the first week he told the analyst about the abuse inflicted on him as a child. A powerful connection developed between John and his analyst: “she become my lifeline there were years where I could not imagine living without her.” Many of those years were painful for John as he systematically worked through his childhood abuse. There was also the loss of his first marriage: “the marriage needed to end I was not ready for marriage my then wife needed more than I could give at that time.” John expresses a deep sense of commitment to the work of the analysis: “I knew the only way I would ever have a life would be through the analysis.” In addition, it was very important to John that his analyst remained optimistic in being able to help him. “I felt like she never stopped believing that I could be helped. I held onto that at painful times in the work.”

After an analysis of 15 years, John felt ready to terminate provided he could keep connected with his analyst: “I told my analyst that she had given birth to me, the real me. I wanted her to see me succeed in my life.” The patient and the analyst agreed to yearly “check-ups” in which they would meet and talk about John’s progress in his life. Shortly after the termination of the analysis, John re-married. The couple went on to have a baby girl which the couple agreed to name after John’s analyst: “my precious baby girl would not have existed without my analyst.”

Composite Depiction

Each participant engaged in a highly individual experience in their analysis. There are however a number of themes that run through the data that apply to a number of participants.

These themes form the composite depiction of this research. The heuristic research design is committed to maintaining a balance between individual experience of analysis and the shared experience of the participants (Sultan, 2019).

The first theme was organizing around the patient's perception of the reason they entered treatment. Some patients felt that they had an insurmountable obstacle that significantly interfered with the quality of their lives, while other patients had milder motivations, such as curiosity about the process of analysis. A number of participants expressed knowing that they were dealing with significant problems in their lives that were impacting not only daily functioning but also their overall quality of life. One participant emphasized this point by stating: "I was very afraid and had paralyzing anxiety. I want to stress how bad that was for me." A large number of participants were dealing with significant developmental traumas such as the suicide of a father or extensive childhood physical or emotional abuse. The majority of the participants had tried psychodynamic psychotherapy before engaging in an analysis but came to understand that a deeper or comprehensive treatment was needed. One participant had a therapist recommended analysis as a more appropriate treatment to deal with her deep anxiety. The majority of participants came to an understanding within themselves that an analysis was needed to potentially deal in a more comprehensive fashion with emotional issues that caused them distress. One participant stated that:

I was aware that there was something very wrong inside me. Something was not working for me. I would look at other people and they would seem happy at least some of the time. I never one time in my life experienced that feeling. I hoped analysis would help me feel happy even if only one time it would be worth all the effort analysis takes. I am pleased to say that my analysis has helped me be happy a lot of the time.

The second theme was organized around the patient's experience of the relationship with the analyst. Some patients found that being listened to, gave them a sense of value and sense of

being cared for by the analyst. Participants in this study engaged in analytic treatment at a frequency between three and five days a week. This frequency in combination with being listened to by an attentive analyst had the impact of eliciting powerful feelings in participants.

One participants stated that:

For the first time in my life I had someone, my analyst, who was really listening to me and wanted to hear everything I had to say. Never before or since my analysis has someone been so interested in listening to me. That alone would have made my analysis worthwhile.” Another participant stated that: “I became aware of how carefully my analyst was listening to me by the interpretations he was making. His ability to listen really impressed me and made me feel special.

A third theme was the patient’s awareness of learning a way of understanding themselves a kind of self- analysis which occurred after the analysis. This is the ability of the patient post treatment to continue the work of the analysis and to do for themselves what the analyst was doing for the patient in the analysis. A number of participants expressed an ability to continue to use the insight gained in their analysis i.e. to engage in self-analysis. Examples of this were, a large number of participants who stated that they were able to more successfully engage in their professional lives as a result of the analysis and how they continued to think and behave professionally in ways they recognize as being psychoanalytic. One participant stated that she was able to parent more effectively due to her analysis and another expressed enjoying having the ability to be able to analyze her own dreams.

A final theme was the patient’s experience of the analyst’s flexibility in his or her treatment approach. This was a significant variable that impacted both successful and unsuccessful treatments. In unsuccessful treatments the analyst frequently displayed a marked sense of inflexibility in manner of working with the patient which in turn led to dissatisfaction for the patient. This can be seen in participants where for example the analyst would not consider

the use of psychotropic medication to assist with symptom reduction. One participant stated that her analysis was “lost years” and not helpful but that the one time her analysis was helpful was years after the analysis. She accidentally ran into her analyst at a professional meeting and he reacted to her in a spontaneous and caring manner and she had felt helped by encounter.

Conversely analysts who displayed flexibility in their treatment approach appear to have patient who made gains as a result of this approach. Flexibility was perhaps most evident in treatments where the analyst proverbially left a door open for the patient post termination. A surprising number of analysts in this sample either explicitly or implicitly let their patient know that they were welcome to return to treatment if they needed to post-termination. Four participants had ongoing psychotherapy with their analyst periodically after the termination of the analysis. All four these participants report high levels of satisfaction with their analysis.

Exemplary Portraits

In this study, three exemplary portraits have been created to illustrate the range of experiences participants had of the analytic process. The three portraits are titled: The Analysis That Saved My Life, The Good Enough Analysis, and The Analysis that Went Off the Rails.

The Analysis that Saved My Life

The portrait of this analysis is one of a transformative experience that forever changes the patient’s life. The patient seeks the treatment most often due to one or more developmental traumas that have significantly impacted the patient’s functioning and ability to live a meaningful life. Life before the analysis was difficult for this group of patient’s and a transformative treatment was an absolute necessity in order to survive.

These patients went in pursuit of an analysis often interviewing a number of analysts and asking many questions of the prospective analyst. The relationship between patient and analyst is

of paramount importance to this group of patients: “the relationship is everything” and it was almost as if the analyst re-birthed the patient “without her I would not have a life.” The process of getting to the point of having a life was challenging for patient and involved years of intensive analytic work. There is a high level of commitment to the work displayed by both the patient and the analyst and frequently the analyst worked outside what could be considered the traditional analytic frame. The patient felt the analyst as a felt presence in their lives and were aware of the caring of the analyst. Patients repeatedly expressed a sense that they sensed that their progress was important to their analyst: “she expressed feeling proud of me when I would report feeling better and I would want to work harder in analysis to hear that pride in her voice.”

Life for participants after their analyses is rich, fulfilling and vibrant: “I wake up in the morning with a sense of expectation and wonder at the life I have today.” The memory of the analysis and the relationship with their analyst remains important to the patient: “I remember him with sense of tenderness he remains very special to me.” There is a sense that the investment of time and money into the analysis was worthwhile: “the analysis was an expression of my commitment to myself and to be the best person I can be for me and others.”

The Good Enough Analysis

The portrait of this analysis is one in which the patient often seeks out an analysis due to “being intrigued by the process.” Patients in this group often tended to have problems to deal with in the analysis but on average tended not to have significant developmental traumas in their history. The relationship with the analyst tended to be marked with an expressed mutual respect between analyst and patient: one participant for example stated that his analyst “expressed admiring me for the way in which I continued to actively care for my children” after being separated from his children by living in another state. However, while the relationship with the

analyst was important it tended to be marked with less of an intensity than it was for patients in the other two portraits. This group of patients tended most often to be dealing with unresolved life issues such a troubled relationship with a parent or dealing with obstacles in their professional lives that they wanted to deal with more effectively. Patients in this group also appear to be motivated to engage in a process of learning in their analysis that frequently meant they were able to achieve certain concrete goals in the treatment. One participant stated that: “the things I learnt in my analysis helped me to achieve certain tangible professional goals.” In this way the analysis became an active learning space for the patient. Many of these skills learned in the analysis continued to be useful to the participants after termination. In this portrait participants did sometimes find practical details of the analysis such as travel, and time spent in the treatment to be burdensome and this often led to a motivation to do the work of the analysis in order to terminate.

Participants that comprise this portrait rarely reported impasses in the analysis that were of a serious nature or that significantly disrupted the treatment process. There were however at times subtle impasses that were never actually resolved. One participant expressed that her analyst expressed that he thought she was prematurely wanting to terminate her analysis. This remained an unresolved issue between them but ultimately the analyst in question respected the participants right to self-determination and engaged in a successful termination process with her.

The Analysis that Went Off the Rails

The portrait of this analysis is one in which the process fundamentally did not work for the patient and there are significant negative long-term implications that flowed out of the failed analysis. The analysis starts out in much the same way all treatments start with a patient that feels hopeful that the analysis will be helpful. Often patients enter analysis with a belief that they

have made a choice to enter a treatment is the best available treatment: “for me analysis had the housekeeping stamp of approval.” In addition, frequently, the patient is deeply committed to the process of the treatment: “I was married to the analysis and Dr. G and thought I was doing everything possible to make it work.”

Each patient has his or her own individual story to tell about why an analysis goes “off the rails” but there are certain common themes in these treatments. The relationship between patient and analyst showed early signs of problems starting often with the analytic stance the analyst took. Most often these analysts took a hierarchical stance in the analysis setting themselves up as the all-knowing expert: “he was a legend in the field, and I thought he knew everything worth knowing in life and he acted as if he knew everything.” This means that there is relatively little space in the analysis to work collaboratively with the patient. Impasses in the analysis are difficult to manage and resolve in these treatments. One of the reasons for this is the overall poor quality of the relationship between patient and analyst. Treatment impasses of one kind or another occur in virtually every analysis and many analysts would even argue that working through an impasse is an important part of the treatment. In a successful analysis patient and analyst manage to work through the impasse successfully or at least well enough. For some participants in this study the working through process of the impasse continued to occur even after termination. However, working through of the impasse is dependent, in part, on the quality of the analytic relationship. Without a secure relationship the working through of an impasse becomes impossible. In this portrait the quality of the analytic relationship was so weak that it precluded the working through process. For one participant the impasse resulted in the analyst unilaterally terminating the analysis: “he could not manage what I had told him, and he refused to talk further with me. He dropped me.”

Participants who together comprise this portrait also engaged in treatments in which analysts tended to not pay sufficient attention to symptom reduction. Frequently, participants were instructed by their analyst not to take psychotropic medication and in one notable case the analyst threatened to end the analysis if the patient elected to explore the possibility of taking an antidepressant. These actions on the part of the analysts were not only misguided based on basic standards of care but also possibly imparted a message of not caring about the daily functioning and pain of the patient.

CHAPTER FIVE

SYNTHESIS OF RESEARCH FINDINGS

This chapter contains a synthesis of the findings, which is an exploration of how participants individually and collectively experienced the analysis. While each participants experience is unique, there are common features to the experience of an analysis, the most obvious being, that each participant expressed having their lives profoundly impacted by the experience of the analysis. For some participants the experience was life-altering and positive. Statements such as “the analysis saved my life” were uttered by a number of the participants. There were however also a number of negative experiences where participants felt that their lives became more challenging as a result of the analysis and further help was sought from mental health avenues outside psychoanalysis to resolve these challenges post termination of the analysis.

This chapter is divided into the themes that formed around the open-ended questionnaire that was used for the interviews. Although the interviews were unstructured, the initial questionnaire was designed around some core themes. Stepping back from the individual interviewees, findings are analyzed here around these themes. Broadly speaking the participants spoke about the reasons for making the choice to enter analysis and the choice of the analyst in the first interview. The middle and termination phases of the analysis were covered in the second interview. The third member checking interview was intended to provide an opportunity to verify with the participants that I accurately understood the information they were attempting

to convey to me. However, frequently participants had new insights they wished to express in the third member checking interview. The interviews were not unlike the analytic process in that it was not uncommon for participants to have thoughts between interviews that they wanted to convey to me at the next interview. Participants were encouraged to flexibly use the interview time and space to fully express thoughts and feelings about their analytic experience. Frequently participants brought notes to interviews in particular the second and third interview wanting to impart very specific points to me. There was often a great deal of emotion in the room in which both the participants and I would be moved to tears or laughter. Every participant asked me about my analytic experience as a patient and were intrigued by my analytic training as a candidate at the Chicago Psychoanalytic Institute and how that in turn informs my experience in my own analysis. I took a stance of welcoming these questions from participants. This posture of deliberate disclosure in turn promoted a climate that promoted reflective dialogue and provided safety for the participants. In a number of the interviews there was a sense that the three interviews functioned as a reflection of the original analysis: with a beginning, middle and with the last member checking interview being the termination. Frequently on the last interview participants would express sadness and loss that this would be the last of the interviews. I too would share feelings of sadness at the end of the interview process and let the participant know that I had enjoyed our time together would miss speaking with them and thanked them for the contribution they were making to clinical outcomes research.

Choice of Analyst

In this sample, participants made the choice of analyst in four different ways: the largest number of participants obtained a referral from their local psychoanalytic institute. One participant consulted with several analysts before picking her analyst. Several participants made

a choice of analyst based on the reputation of the analyst and several others picked an analyst based on the recommendation of family and or professional colleagues and friends.

The majority of the participants turned to their local institute for a referral. Three of the participants obtained a referral from the Chicago Psychoanalytic Institute and one participant obtained a referral from an East Coast Institute where he lived at the time. Institutes ranged in how they went about making referrals from extensive evaluations with some participants to brief conversations with others. For example, Jim contacted his local institute and it appears that the information they gathered from him in order to make a referral was scant and of practical nature rather than attempting to make any diagnostic assessment. With other participants a good deal more information was known to the Institute before providing a referral. For example, the Chicago Psychoanalytic Institute was aware that Brenda's father had died by suicide when she was a young child made a referral to an analyst who specialized in early parental loss. At the time of Brenda's analysis, the Chicago Psychoanalytic Institute had formed a study group engaged in research on early parental loss and Brenda's analyst was part of that group. It is noteworthy that all the participants who obtained referrals from psychoanalytic institutes reported satisfaction with their respective analysis ranging from "the good enough analysis" to "the analysis saved my life."

One participant, Ruby, recounted consulting with a number of analysts before picking her eventual analyst. Initially, she had wanted to see a female analyst thinking a male analyst could not understand her experience as a woman. However, the consultation with the female analyst went badly and she moved onto the male analysts on her list. Ruby recounts the following in how she eventually chose her male analyst:

We met for three initial sessions and he explained his 'rules' to me. Things like letting him know a week ahead of time if I intended to miss a session. His rules seemed demanding to me and I called him up and expressed that and he said, 'please come back so we can talk about this'. His receptiveness was important to me.

Two participants, Shelley and Paul, picked their analyst based on the analysts' professional reputation in the field. Shelley before starting analysis had been a student in her analysts' class and thought he had "prestige and was brilliant." Paul coming from a family that had generationally engaged in analytic treatment was aware of the "big names in the field and I thought that a big name must mean a quality analysis like buying a BMW car but turns out not to work that way in analysis."

The remaining two participants, John and Jennifer, picked their analyst through recommendations from family and colleagues. Jennifer states that: "I am Irish-Catholic and we don't talk to therapists. Then I married a Jewish man and it was wonderful everyone had their personal therapist to talk to and my husband's family helped me find an analyst." John turned to a colleague and friend who had originally suggested John try analysis provided him with the name of an analyst. The analyst in question at the time had a full practice and therefore not able to take John into analysis. The analyst provided John with the name of a colleague, a female analyst, with whom he then started an analysis.

It is of note that the majority of the sample for this study was recruited in Chicago and the vast majority of participants (N= 8) engaged in an analysis with a Chicago Psychoanalytic Institute trained analyst. The majority of these treatments spanned from the 1970's to the late 1980's. This was a time in which much of the Chicago Psychoanalytic Institute was immersed in ferment of self psychology. In 1971, Heinz Kohut (1913-1981) wrote, "The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorder

(1971)” followed by “The Restoration of the Self (1977)” and posthumously with “How Does Analysis Cure (1984)” which ushered in a revolution in psychoanalytic theory and clinical practice.

Until the emergence of Kohut and his theory of self psychology the United States was largely dominated by ego psychology with a primary focus on dealing with Oedipal conflicts and defenses (Mitchell & Black, 1995). The patients considered most appropriate at that time for an analysis were patients considered to be dealing with hysteria (Anderson, 2014). Self psychology provided psychoanalysis with a workable clinical theory and technique to treat patients challenged by a variety of self-state issues such as narcissistic injuries and fragmentation.

Kohut much like Freud purposely formed a movement to promote his theory and clinical technique and Chicago became the center of a psychoanalytic revolution with analysts from across the United States traveling to Chicago to study with Kohut and to join self psychology study groups (Strozier, 2001). A number of the participants in this study were engaged in treatments with analysts who were part of the early movement of self psychology. Some participants such as Ruby, who consciously made a choice to engage in analysis with a self psychologist, felt that her analysis was greatly enhanced by her analyst being a part of this early group of self psychology practitioners. However, Jennifer expressed that she felt that her analysis was more aligned with his theory than with her clinical needs.

Relationship with Analyst

Participants in this study spoke most often and passionately about their relationship with their analyst regardless of whether the relationship was largely positive or negative. Ruby put it best when she stated, “the relationship is everything.” While there are great nuances in these relationships it can broadly be contended that when the analytic relationship was satisfying and

robust the reported patient satisfaction with the treatment was high and when the relationship was troubled the treatment outcome reported tended to be less satisfying.

Participants expressed that their analyst was an important figure in their lives often with the analyst taking on a maternal or paternal transference. Frequently the analyst was able to do for the patient what the parent had been unable to do. For example, Sally, whose father had died by suicide, stated of her analyst: “he was like my father there for me in a way my father had not been.” Shelley says of her first female analyst: “I loved her like she was my mother.” In addition, often a dependency developed in many of the treatments in particular with participants like John who had experienced significant early developmental trauma. John states that:

There was a time that I felt like I needed my analyst support for everything that was important in my life. She was very kind to me I remember many times calling her before important professional meetings and she would encourage me, tell me she believed in me. I had never had an experience like that before, of someone believing that I was competent and good person.

Freud in a letter to Jung stated that: “psychoanalysis is in essence a cure through love” (Jung, 1909). The vast majority of participants stated feeling that their analysts expressed, in a variety of ways, a sense of caring in the analysis. Pearl engaged in two separate analyses with the same analyst, one as a child and later as an adult. As a child Pearl recalls eating popcorn with her analyst in his office or at Hanukkah being sent by her analyst to a toy store to pick out a present for herself. Later in her adult analysis Pearl recounts that her analyst, who had a classical theoretical orientation, was different and they did not eat popcorn in his office anymore. Asked how she felt about this change Pearl stated: “I understood that the treatment was different being an adult.” However, she added that her analyst remained caring and considerate and when she wrote to him during his recovery from heart surgery, he would write back providing her with updates on his progress. Asked why she chose to return for an adult analysis to her child analyst

Pearl stated: “what bonded us was his sweetness and ongoing caring support, I did not feel like I could go to anyone else.” Another participant, Ruby suggested that loving in an analysis needed to go both ways. She reports saying to her analyst: “I thought I was coming here so you can love me and now I realize that I must learn to love you.” John stated that in his opinion a successful analysis teaches the patient how to love. He relates that: “I grew up feeling not loved by anyone and did not know I was supposed to or how to love myself either. I had to learn all that in my analysis.”

For a number of the participants the analyst, through the idealizing transference, became an important role model. Sally a school teacher related that her physician female analyst helped her to view herself as a competent professional. Sally relates the following:

Sally: Women in my generation tended to fall into two groups we either became nurses or school teachers. It was as if we set the stage for people who do important things in the world. In my thinking back then important women like Dr. T became physicians. That is what I thought of myself. I told Dr. T that if she ever met me at a party, she would not find me interesting enough to talk to. She said that was not true she would want to talk with me.

Katherine: Did you believe Dr. T when she said that to you?

Sally: Not at the time she said it. But I believe that now. Think I did important work in my career as a teacher. I came to see that after the analysis, but it took Dr. T to start me on the path of viewing myself differently.

The role model function facilitated through the idealized transference can occur even when there is a significant difference such as gender between analyst and patient. For example, John reports starting to consider the possibility that he might want to be a parent like his analyst:

She (the analyst) had a picture of her twin boys on her desk and one day I asked about them. She had this look of pure joy on her face when she talked about them. A while after that I started to think I wanted to eventually have a child someone to talk about and to feel that kind of joy about. My analyst opened up the possibility for me to think about wanting to be a father. It took a long time for me to think I was emotionally well enough to parent but that also came eventually after much work in the analysis.

Difficulties Experienced Over the Course of Analysis

The degree to which participants experienced difficulties or impasses over the course of the analysis differed greatly among participants. The data does however suggest that there are three broad groups of difficult experiences in an analysis: one group of participants reported few if any difficulties and not surprisingly this group of participants also report high levels of satisfaction with their analysis. The second group of participants, report having at times significant impasses with their analysis, but the issues were either dealt with in the analysis or the participant found ways to deal with the impasses post analysis. This group of participants also report high degrees of satisfaction with their analysis. The data from this group would suggest that an analysis need not be conducted perfectly, at best unrealistic goal, in order to be of use to the patient. The third group of participants had treatments in which the impasses were not dealt with at all and not surprisingly the participants in this group report high levels of dissatisfaction with the analysis.

Few if Any Impasses in Analysis

Brenda reports no impasses in her analysis and states of the analyst that: “we just kept rolling along.” She expresses high degrees of idealization toward her analyst and he never seemed to have disappointed her. Rather she says of her analyst that: “I really do think he was quite special” and “he opened my heart.” With Brenda’s history of early parental loss, with the suicide of her father when she was three, it makes sense that Brenda was in search of and found a corrective experience with an analyst that she describes as warm, caring and consistent. Unlike her father who left her the analyst stayed even beyond termination by having an open-door policy toward Brenda should she wish to return for psychotherapy which she did until shortly before his death.

Debbie also reported having few if any impasse with her analysis: “there were times of feeling stuck and analysis can be slow and laborious. I sometimes felt like saying ‘can we not accelerate this’ but there were no actual ruptures in the analysis.” Debbie commented that at times it felt like her analyst could be rigid with respect to personal disclosure in the treatment, but she assumed this was due to his classical theoretical stance. It seems that the closest this analytic dyad got to an impasse was when Debbie wanted to terminate before her analyst thought she should. However, even with this she stresses that there was a sense that he trusted Debbie to act in her own best interest. Overall Debbie describes a “very positive relationship” and felt that her analyst was “warm and non-judgmental.”

Pearl also reports an overwhelmingly positive relationship with her analyst with no major impasse. She had two analyses with the same analyst, one as a child and one as an adult. The child analysis is filled with warm delightful memories for Pearl: eating popcorn with him, being sent to a toy store to pick out Hanukkah gift for herself etc. It was this warm relationship that brought her back to him for an adult analysis. Yet Pearl says: “if I were to do the analysis again, I would talk more about the relationship.” She feels that there was a maternal transference at work in the analysis and feared that he would criticize her in the way her mother had. Overall, she stresses that the relationship was positive: “nothing that he did made me angry.” Pearl suffered a relatively early paternal loss of her father who died unexpectedly of a heart attack on a business trip when she was a junior in college. Like with Brenda it could be considered that the analysis for Pearl was a way to work through the loss of a parent and the analyst served as a surrogate parent to the patient.

Impasses that were Somewhat Worked Through

Within this group there was a diversity of experience. Some participants like Sally and John experienced impasses with their analyst which were fully and successfully worked through in the analysis with the analyst. On the other hand, Jim experienced not so much an actual impasse rather the failure of the analyst to engage with a very significant issue in his life, his substance abuse, that was over the course of the analysis increasingly challenging his level of functioning. Ruby in turn reports having impasses in the analysis that were successfully worked through in the analysis and issues that remained unresolved post termination.

Sally reported remembering two significant impasses and stated that the way her analyst dealt with both lead to a resolution of the respective impasses. Sally states that she was very curious about her analyst and asked an acquaintance, who she was aware knew Dr. T professionally, about her. The acquaintance had a negative view of Dr. T and shared this with Sally which left her feeling uneasy and conflicted toward her analyst. She was eventually able to tell her analyst about her conversation with the acquaintance and the resulting negative information obtained about Dr. T. Sally states that her analyst was not defensive but rather discussed with her the content of the information and her feelings about it. This act of transparency on the part of the analyst had profound meaning for Sally and deepened the analytic relationship and the sense of trust Sally felt for Dr. T.

The other impasse occurred as a result of an unexpected separation from the analyst. Dr. T became unexpectedly ill and needed to be hospitalized for a period of time during which Sally did not hear from her. Sally in turn was understandably upset and afraid as a result of this unexpected interruption of her analysis. When Dr. T returned to work, she once again non-

defensively explained to Sally why she had been away and apologized for the distress this had caused her.

John reports that the most significant impasse occurred in the analysis in the second year. At the time John was still married to his first wife and the marriage was rapidly deteriorating. While the marriage had always, in John's view, been troubled the analysis caused a further crisis:

My then wife got really jealous of the analyst and eventually this led to the marriage ending. I felt terrible about this I was already feeling guilty for having gotten married when I so clearly did not have the ability to be in a marriage with anyone. I was like this empty shell of a person which does not exactly lend itself to being a partner to another person in an intimate relationship. But for so long I could just ignore my marriage but in analysis I could no longer do that. So the marriage ended and in hindsight I can see that it was a marriage that needed to end. But at the time I was bereft about the loss and there was a time I blamed my analyst for that. We needed to work that one through and we did, but for a while maybe a year it was difficult in the analysis, while I was working through the loss of the marriage and my guilt for causing my ex-wife so much pain.

In Jim's analysis he does not report any traditional impasse but there was a lack of attention on the part of the analyst to a significant issue in Jim's life. By the time Jim had entered analysis, he was using alcohol to excess. Jim describes attempting at times not to drink on the nights before his analytic sessions, but he was often unable to abstain from use. Jim's analyst was aware of his alcoholism but never engaged with the issue in the treatment. As a result, Jim continued throughout his analysis to use alcohol in excess with the level of use steadily increasing over the course of the analysis. While Jim feels he made a number of real gains in his analysis the failure of the analyst to attend to his alcohol use remains for Jim a significant problem with the treatment. Post-analysis Jim did attend Alcoholics Anonymous (AA) and has successfully managed to maintain his sobriety.

Ruby stated that in her view, an analysis need not be perfect in order to be of value. She reported a number of impasses and a number of the impasses remained unresolved even after

termination. Ruby attributes these unresolved impasses to the analysts “reluctance throughout the treatment to admit that he was ever wrong about anything.” In the years since the analysis Ruby has managed to make peace with her analyst’s shortcomings. In addition, she attributes his attitude to the era in which he was trained. The analyst was classically trained and became one of the early self psychologists but as a result the analyst himself would not have experienced a self psychological analysis. Ruby expressed feeling that “you cannot give what you were not given” meaning that it would be difficult for an analyst to provide a patient with something he had no direct experience of in his own analysis. There were however also impasses that were successfully resolved in the treatment. Early in the analysis Ruby felt that her analyst did not understand her experience as a woman and repeated attempts on her part to discuss gender issues with her analyst were unsuccessful. Ruby states that:

Eventually I brought in a book of Catherine McKinnon [the feminist author] and would read to him from the book in session while I was on the couch. One day he called out to me ‘I get it woman are not people’ It felt like he understood. When he got it you could feel the energy in the room.”

It seems that Ruby’s ability to influence her analyst is what resolved the impasse. Further her analyst was able to empathically grasp Ruby’s lived experience.

Not Worked Through Impasses

For a number of participants, a significant number of impasses in the analysis remained unresolved and this in turn seriously compromised the results of the analysis. Shelley seems to have had a general experience in her analysis of not feeling understood. She worked hard at the analysis: “I was married to Dr. G and the process.” Shelley expressed a general sense of being misunderstood and that her analyst never fully grasping the presenting problem, which to her mind was her inability to form successful intimate relationships. The analyst failed to fully

comprehend this all the way to the end of the analysis. Shelley feels strongly that the final dream of her analysis, of the beautiful apartment with the wooden floors but without a bedroom, indicates the failure of the analysis to deal with issues of intimacy but the analyst interpreted the dream as Shelley being ready to terminate the analysis.

Jennifer had the experience of her analyst unilaterally terminating the treatment and therefore all possibilities of working through the rupture were lost to her. This in turn had a profoundly negative impact on her life as she needed extensive psychotherapy to deal with the trauma of her analysis. She had to work through the trauma with other mental health providers and that in turn led to significant progress. In addition, Jennifer stated that the experience of being interviewed for this research was helpful in particular the feeling of being heard and believed by me. In the third and concluding interview Jennifer stated that she had recommended that her adult son engage in an analysis. Asked why she had done this given her own negative analytic experience Jennifer stated that: "I knew that my experience in analysis was an outlier and my son had a very different more positive experience in analysis than I had."

How Analysis Impacted Significant Relationships

A majority of the participants focused on intimate love relationships. A number of participants were single at the time of the analysis but entered significant relationships during or shortly after the analysis. For Brenda, the stated goal of the analysis was to learn how to successfully engage in an intimate relationships and to extricate herself from relationships that were unfulfilling to her. This goal was successfully met, and Brenda married shortly after the analysis and reports high levels of satisfaction in her marriage and family life. Both Sally and Jim, while not necessarily stating that marriage was an immediate goal of their respective treatments, also married shortly after termination and went on to have children and a successful

marriage. During the course of his analysis John's first marriage painfully ended in divorce.

John remarried toward the end of his analysis and attributes the success of the marriage to his analysis:

Without the analysis there could not have been another relationship or marriage for me. I felt so guilty for the way I hurt my first wife. I had to work through that and find some sort of peace in my life before trying to have another relationship. In the analysis that eventually happened and I could reach for a life, one that provided me with a loving wife and a child. That is what my analysis did for me. And I found peace with my first wife. I wrote her a letter, before my wedding to my current wife, expressing to her my sorrow for having hurt her wishing her a good life. She wrote back saying she had forgiven me and wished me well. I got her reply the day before the wedding and I showed my fiancée and I started crying and was able to say how grateful I felt for the three women in my life: my first wife for loving me by wishing me well in my future life, my analyst for helping me create a life and now my second wife for the life we are creating together.

Debbie became engaged during the course of the analysis and attributes the engagement to one of the reasons she felt motivated to terminate the analysis. She felt that for her there developed a sense of "competing intimacies" with her fiancée feeling left out. Ruby in turn had a different experience with her partner who was also in analysis simultaneously with a different analyst. Pearl reports having a partner in analysis as being very helpful to her analysis and that there was a great deal of mutual support especially during challenging times in their respective treatments. Paul in turn states that he felt the analysis had little impact on his intimate relationships: "I thought of my analysis as separate from my lived life outside his office."

Participants also talked about the impact the analysis had on their relationships with their children. Pearl states that her analysis taught her to listen to her child in a way she thinks would not have been possible without the treatment. Brenda became a stepparent and credits her analyst with supporting her in the role of step-parenting through continued psychotherapy post termination of the analysis.

Finally, participants talked about the impact, the analysis had on their feelings toward their parents. Pearl talked about reaching a point of being able to forgive her mother for being judgmental and not emotionally available to her. Debbie was able to work through her feelings regarding her fathers perceived flaws and develop an adult relationship with her father.

Termination Process

Participants' experience of the termination process to the analysis were varied. All terminations but one was by mutual agreement between the analyst and the patient. Post termination contact also varied greatly among participants ranging from no contact to extensive contact usually continued treatment in the form of psychotherapy. One participant had the unfortunate experience of her analyst dying before the termination of the analysis and two of the participants had analysts who have died since the formal termination of their respective analyses.

A number of participants in the sample chose to maintain contact with their analyst post termination. The contact took the form of engaging in psychotherapy with the analyst. This was also the group of participants that reported exceptionally high degrees of satisfaction with the treatment experience and outcomes. The analysts in this group displayed remarkable and admirable amounts of clinical flexibility in the ways in which they negotiated the post- analytic contact with their patients. Brenda initiated termination wanting to put into practice the relationship skills she had learned in analysis. She went on to marry and to co-parent her husband's children. Brenda returned to her analyst for sessions to discuss the challenges of parenting. The process would continue between Brenda and her analyst until shortly before his death.

Pearl initiated a second termination of her analysis, the first one being when she was a child, when she felt that certain important issues in her life had been satisfactorily resolved. She

states that: “I was feeling in a good and centered place in my life, my professional life was going well.” Pearl and her analyst set a date six months ahead for termination. Post-termination Pearl returned to her analyst for sessions as she needed: “I assumed he would be fine with that and he was.”

John states that the decision to start the termination process was “a lengthy process of negotiation” with his analyst. He further states that: “I wanted to ‘graduate’ from analysis, but I wanted to do it in a way that was logical for me which meant some post analytic contact.” John was highly motivated to live a fulfilling rich life post termination and wanted his analyst to see “the fruits of her labor.” Seems the analyst shared John’s desire to have her as a presence in his life and proposed a yearly “check-in sessions.” In the 15 years post termination, John has yearly met with his former analyst at agreed upon times to “check-in.”

Another group of participants had no contact post-termination. Debbie initiated termination after four years feeling that she was ready. The analyst expressed that Debbie was not entirely ready to end analysis, but she felt that she was “and he trusted me.” Asked if her analyst suggested she could return to treatment if she wanted to at Debbie could not recall if he did make the offer and was uncertain if that was something he would be inclined to do. Debbie commented that had he offered to engage in post termination psychotherapy she might have been inclined to take him up on the offer.

Paul stated that he was aware that his analysis would end when the seven-year mark had been met. He was uncertain how exactly he knew this except to say: “everyone in my family had a seven-year analysis. I sort of thought that was just the thing to do and it seemed so did my analyst.” He states that he was relieved at the end of the analysis: “I got my time back and that

became more important to me as I had started a relationship that would eventually lead to marriage.”

Ruby initiated a termination with a date eighteen months in the future. In spite of what would seem like a good preparation for termination she states that: “I was in grief at termination.” The week following termination Ruby experienced a physical crisis that ending up needing her to visit the emergency room – “and my partner, who was also in her own analysis, said you are having a reaction to the termination and she was right.” Ruby and her analyst had both agreed not to have contact post termination – “it was the way he was how he did things” but Ruby also states that “he was very dear with me we liked each other a lot.”

Sally had a sadly traumatic termination to her analysis. She had been in the process of discussing the prospect of a termination with her analyst when one day, Sally arrived for her usual session and her analyst was not there. Sally called the Chicago Psychoanalytic Institute and was told that her analyst had died the previous night in the course of emergency surgery. She attempted to talk to the then clinic intake coordinator about the loss, but it was less than satisfying: “I talked once with the clinic intake coordinator but then that was it. I needed to talk more but more was not available.” It is indeed sad that a greater support system was not made available to Sally and further underscores the necessity for analysts to have an analytic will in which another the analyst appoints another analyst to take care of patients’ like Sally.

Sometimes life events such as marriage or a geographical move can prompt patients to terminate an analysis. That was the case for Jim who married and moved out of state to go live with his new wife. Debbie too mentioned that her engagement to her now husband was one of the factors in making the choice to engage in a termination process in the analysis.

In the sample for this study by far the most distressing termination occurred to Jennifer. She was the only participant in the study to have her analyst unilaterally terminate the treatment. Jennifer describes a process in the analysis in which her analyst spoke to her in ways that she experienced as seductive. She is clear that her analyst was objectively not in fact seducing her and he never engaged in any boundary violations with her. Rather Jennifer believes that it was her experience of the analyst based on the transference with a father who had been seductive with her. So for example before a weekend Jennifer would express to her analyst that being separated from him was difficult for her. It is not unusual for patients to have difficulty on weekends and vacations when separated from the analyst. Jennifer's analyst, using his self psychological theory which was focused on developmental model, would talk softly to Jennifer and interpret to her that the separation was difficult for her saying things like "you need me to see how it hurts for us to be apart." Jennifer's analyst was essentially talking to her as one might speak to a young child. Many patients would find this response helpful but for Jennifer, for whom an erotic transference developed over the course of the treatment, her analyst response was experienced as verbally seductive. Eventually Jennifer told her analyst how she experienced many of his interpretations and he responded by unilaterally terminating the treatment. The analyst suggested that Jennifer consult with one of his colleagues, but he insisted on ending the treatment unilaterally. It would appear as if the analyst while engaging with what was then the new exciting theory of self psychology got clinically lost and missed the signs of an erotic transference and subsequently managed the transference badly and ultimately at Jennifer's expense. Jennifer states that: "he was swept up in his idealization of Kohut and I was hurt by his use of theory. He wasn't talking to me he was talking to his theory."

Each of Shelley's two analyses terminated after seven years respectively. During the analysis phase of the first analysis, her female analyst indicated that Shelley would most likely need another analysis. Shelley interpreted that to mean that her first analyst felt that certain core issues remained unanalyzed and unresolved. While Shelley too recognizes the shortcomings of her first analysis she has fond feelings for her first analysis: "I loved her like she was my mother." However, Shelley is a lot more ambivalent about her second analysis. The analysis terminated after seven years and she had the impression that seven years was the average length of time this analyst engaged in a treatment. It seems that to the very end Shelley attempted and failed to make an emotional connection with her analyst. She related: "the last day of the analysis I shook his hand and I wanted to hold on a bit longer and he pulled his hand away. I left angry and I am still angry."

Post Termination

Participants were asked to reflect on their post termination life and the impact of the analysis. All participants regardless of the quality of the analysis indicated that the analysis had a definite impact of their lives.

Shortly after Brenda's analysis, she married a man she describes as kind and gentle who also had a number of young children from a previous marriage. With the ongoing help and guidance of her analyst she was able to navigate the challenges of being a stepparent. Professionally Brenda continued to enjoy great success in her professional life and after retirement has engaged in extensive philanthropic work. Over the course of the interviews Brenda spoke with engagement and excitement about her analysis. Recalling the memories of the treatment appeared to provide her with joy and at several points she thanked me for inviting her to be interviewed. Toward the end of the first interview Brenda reflected to me: "that consent

form you asked me to sign said that there were no direct benefits to these interviews. Well I don't agree I have already benefitted from talking." At the end of the series of interviews, Brenda summed up her thoughts and feelings referencing her analyst: "I really did think he was quite special."

Debbie was engaged at the time of the termination of her analysis and would go on to marry her fiancé and together the couple had children and later grandchildren. The process of accepting her father's limitations had a positive impact on her life and facilitated a more positive adult relationship with her father. In her professional life, Debbie was able to use the insights gained from her analysis to in particular as it pertained to dealing in more productive ways with people in authority. Debbie was able to speak about the process of her analysis with remarkable clarity in terms of talking about the ways in which the treatment had been helpful and the ways in which the analysis had been helpful to her and the aspects of analysis such as frequency of session that had been challenging for her. She also showed a keen interest in analysis wanting to know how analysis is currently practiced and we engaged in a conversation about my experiences as a patient and as a candidate. Like with many of the other participants the analyst often remains an enduring presence in the life of the analyzed. At the end of the interviews, she reflected that it had been many years since the termination of her analysis. Smiling and looking into the distance Debbie concluded saying about her analyst: "I think about him with very fond feelings."

Paul has a great deal of ambivalence about the outcome of his analysis. As a whole he did not find the analysis to be helpful leaving the analysis feeling many of the major issues such as his depression were not addressed. After the analysis, Paul did consult with a pharmacologist and went on a selective serotonin reuptake inhibitor (SSRI) which he has found "somewhat"

helpful but adds that “I still have times of darkness and the sense of loneliness is pervasive.” He does add that his analysis taught him how to “show up” and that has helped him at difficult times in his professional life. Paul married shortly after the analysis, but the marriage failed soon after and the couple divorced. He thinks the marriage might have survived had they gone to couples counseling, “but suppose one never knows with these things and I was just not up for another stint in some shrink’s office.” For the past year Paul has been involved in a relationship which he says has been “very good” and he feels positive about that. He concludes by saying:

you know I don’t want to be completely down on my analysis I most likely got things out of it I cannot even see. I do believe that at core my analyst was a good person maybe he was just not good for me.

Post analysis, Pearl married and later divorced and had one child, a boy. She feels that while her relationship with her mother remained difficult, the analysis did help her to accept her mother’s limitations. The analysis did have a profound impact on how Pearl parented her own child: “I did a lot better in listening to my own child as a result of my analysis.” Post-termination Pearl returned to her analyst periodically for psychotherapy sessions. This in turn impacted how she experienced her father who died suddenly of a heart attack when she was a junior in college and she states that: “I fantasied that my father would have been like my analyst had he aged.” Additionally, she states that the analysis “gave me the tools to be aware of myself and to do my work.” Sometime after the analysis Pearl moved out of state and shortly afterwards her analyst died. She recalls that a friend offered to drive her to the funeral of her analyst but she decided not to go feeling it would simply be too difficult for her emotionally. That was however many years ago and Pearl stated that her process of mourning has shifted and that at this point in her life it is pleasurable to recall the memories of her analyst and to think about the many ways in which he was and continues to be important in her life.

Ruby states that she feels that the analysis was a financially expensive process and took a great deal of effort on her part to maintain in terms of travelling long distances to and from her sessions but the analysis also “felt like a necessity and I feel proud of the analysis it reflected my values.” She feels that she came to understand herself over the course of the analysis and this in turn was helpful not only in her personal life but also to her professionally and that the benefits of the analysis have increased over time. Ruby stated that: “there was a process of internalization after termination I came to own the analysis.” An example of internalization she gave was being able to engage in her process of working through issues in the way she once might not have in her analysis. Post termination Ruby learned information that portrayed the analyst in a negative light, but she states this did not alter the essential usefulness of the analysis to her. For her a process of internalization of the analysis had taken place: “after the analysis I came to feel like I owned the analysis” she no longer felt the gains of the analysis were linked to a sense of idealization toward the analyst. In addition, Ruby also talked about her analyst being very good at dream interpretation and how she is now able to conduct her own dream analysis and how this is a source of pleasure for her. Ruby states that: “the curative part of the analysis was and is to this day that he never saw me as bad and I told him the worst things about me.” She goes on to state that: “there was mutual positive regard between us, and we liked each other. He was verbally very affectionate with me.”

Sally expresses that the analysis was a transformative experience for her and that she felt very much in need of the treatment due to her levels of paralyzing anxiety and she goes on to say that: “I want to empathize how bad things were for me before analysis.” The analysis ended abruptly due the Sally’s analyst dying and mourning the loss was complicated due to the lack of avenues available to her to process the traumatic loss. However, Sally was clearly able to use the

treatment gains in her life. Shortly after the termination she married and had a baby and went on to have a very satisfying and successful career. Reflecting on her analysis Sally states that she thinks of the outcome of her analysis in three different categories: one issues that have been resolved: “I don’t wake up in the middle of the night feeling anxious anymore.” Two would be issues that Sally feels are unresolved, and she feels perhaps she still needs help with, but she adds that many of these issues rarely come up in her life. Third are unresolved issues that occur but “I have a process whereby I learned how to deal with these issues.” Sally went on to state that one of those unresolved issues emerged between us in the interviews and she wanted to share this with me as an illustration of one of the ways she learned in analysis to deal with issues i.e., to talk about issues that arise and cause her distress.

Sally recounted to me that at the end of the first interview she noticed that we ended the interview ten minutes early. She said she left wondering if maybe she was not as interesting to me as some of the other participants in the study that I had previously interviewed. I shared with Sally that after the first interview, I had two thoughts regarding ending the first interview ending ten minutes early: first that it stuck me how articulate and clear Sally was in relating her experiences of her analysis and therefore maybe it took slightly less time to obtain the information and second Sally was one of the participants toward the end of the study so I speculated that perhaps I was becoming more skilled at conducting the interviews and was therefore needing less overall time to interview participants. We talked more about this experience and she commented how these feelings of inferiority was one of the issues she worked on in her analysis. Sally went on to say that in her life before analysis she would have let her fear of being uninteresting to me remain unspoken but that analysis helped her to be able to voice those feelings and to in turn to reality test the feelings.

From a theoretical point of view, Sally was experiencing the replication of the transference she had with her analyst with me in the interview process. In the analysis she reported feeling that Dr. T would not find her interesting and not want to talk to her at a party, a perception that her analysis challenged in the treatment. This transference replicated in Sally's feeling that I ended the research interview ten minutes early because she was not as interesting as the other participants. The difference between the experience of the transference as it occurred in her analysis and post-analysis with me was her ability to recognize the transferential pattern and to talk about it by reality testing her perceptions. This would suggest an ability on Sally's part to engage in a process of continued self-analysis post treatment.

Sally's experience is not unique in this research sample. The vast majority of the participants in some way experienced a replication of the original transference in the research interviews. It is of note that similar findings regarding the replication of the transference were found in the research of Schlessinger and Robbins (1983) conducted at the Chicago Psychoanalytic Institute several decades ago.

Post termination Shelley still feels a great deal of ambiguity about her two analyses. With respect to her first analysis Shelley says of the analyst: "I loved her like she was my mother." In her second analysis the feelings are a lot more complex. In the first interview Shelley talked extensively about the analysis in negative terms, stating that the analyst was a "jerk" and stating that her years in the analysis were "lost years." At the beginning of the second interview Shelley stated that:

I was thinking that I spent so much time complaining last time we talked and maybe I was giving my analysis short shrift. I was really lost, and the analysis gave me a sense of meaning and purpose. The analysis also gave me a sense of goodness in the analyst and in me.

However, after the second termination Shelley rapidly descended into a period of instability marked by troubled relationships and engaging in excessive working in her professional life. Eventually Shelley started to attend group therapy which she ultimately found to be helpful.

After the traumatic ending of her analysis, Jennifer was left to deal with the devastation of her analytic experience. She relates that: "I wondered if it was all my fault, what happened. But the proof is in the pudding, I went to a good therapist who set boundaries and I got better." In addition, Jennifer elected to disregard the previous instruction of her analyst and decided to try medication which in turn helped for her depression. In her therapy, Jennifer states, she was able to more effectively deal with the Oedipal issues that she thinks of as being at the center of her eroticized transference with her original analyst. She states that that the years of therapy were helpful in being able to reconstruct her life. In addition, Jennifer states that in doing the research interview it was her hope that analysts could be helped to understand how important it is to take responsibility for errors in their work. In spite of her experience Jennifer states that she fundamentally believes that analysis can be useful to patients.

Jim terminated when he married and moved out of state to live with his wife. He expresses fond feelings with regard to his analyst: "when I left, I still owed her some money and it was a high priority to me to pay her in full and with the last check I included a note of thanks to her." He expresses feeling that the analyst "was on my side and had my wellbeing in mind." Jim stated that analysis for him was a unique experience that he rarely got to talk about and for that reason had looked forward to engaging in the research interviews.

After termination John married and two year later, he and his wife had a baby girl who they named after his analyst. Professionally John has enjoyed great success and says his career holds great meaning for him and the financial rewards have enabled him to "make a difference in

the world. It feels good to be able to write a check to a charity or an individual that needs money.” John states that he wanted to participate in the research to stress that it is possible to recover from extreme childhood trauma and neglect. He was keen to talk with me about ways to make analysis more readily available to the general population. “My analysis saved my life and I have this big wonderful life I just want others to have at least some of what I have.”

CHAPTER SIX

DISCUSSION OF RESULTS

In “Mad Men,” the 1960’s period drama the fictional character Roger Sterling is portrayed lying on the couch in his analyst’s office talking without pause while his analyst, sitting out of sight, stares blankly into space (Weiner, 2007). The analyst’s Park Avenue, New York office would suggest that Roger is a patient with financial resources. In a previous episode, Roger is shown recreationally using lysergic acid diethylamide (LSD) with wealthy friends, a fashionable indulgence of the 1960’s emerging counterculture. There is a certain suggestion in “Mad Men” that analysis is just another indulgence for the wealthy, another commodity to buy.

There are any number of caricatures in American culture of what psychoanalysis is and who the analytic patient is: from New Yorker Magazine cartoons that portrayed mostly male analysts in ironic situations, to more recent New Yorker Magazine cartoons displaying a certain veiled hostility toward psychoanalysis. Then there are Simon and Garfunkel who plaintively sing: “can analysis be worthwhile?” or Barbara Streisand after years of analysis expressing her ambivalence toward the value of her treatment (Holden, 1991). A more current and ironically positive image of psychoanalysis was presented by the radio shock jock Howard Stern who in a recent book disclosed his years-long analysis and wrote glowingly about the benefits of analysis (Stern, 2019). These are the type of images that have come to dominate our American cultural perception of what psychoanalysis is and who the intended analytic patient is supposed to be.

These cultural depictions would suggest that American psychoanalysis is for white, professional, wealthy, educated East Coast, in particular New York elites.

There is, however, a huge gap between the dominant cultural depiction of American psychoanalysis and how it is lived and practiced by analysts and patients. Psychoanalysis is not an East Coast undertaking; every major city in America has a psychoanalysis institute and all American Psychoanalytic Association (APsaA) affiliated institutes run low fee clinics providing sliding scale fees for patients needing either psychotherapy or analysis. The data for this study would suggest that a range of people are able to access analytic treatment.

The Patients in the Study

The majority of participants in this study identify as white and all are college educated professionals who would in their current life be considered to be middle to upper-middle class. However, at the time of the analysis the majority of the participants were early career professionals and in one case a graduate student. All the participants expressed needing to deal with some obstacles related to accessing analytic treatment and frequently these obstacles were related to money or time. It could be suggested, however, that the ability of a patient to access analytic treatment cannot simply be viewed through the patient's ability to manage the financial and time commitment needed for the treatment. In this sample the participants, while having significant differences nonetheless displayed similar approaches with respect to how they approached the analysis in practical terms.

An important factor to consider is that the participants to this study emphasized that for them engaging in an analytic treatment had felt absolutely necessary and essential. The majority of the participants had engaged in in-depth psychotherapy before seeking out an analysis. Some participants had their psychotherapist recommend analysis as a more appropriate treatment and

other participants came to this conclusion independently. Many of the participants stressed that they were dealing with significant psychological pain and distress that required a comprehensive, in-depth treatment approach that analysis provided.

In conjunction with an awareness of the psychological issues they were dealing with participants also displayed a high level of motivation to do the work of the analysis. Participants expressed being willing to endure hardships in order to engage in an analysis. These hardships included financial and extensive time commitment to the treatment. Participants were also willing to engage in the inevitable frustrations of the actual treatment that arose over the course of the treatment.

In light of these personality factors, it should be considered that there is a combination of social and personality factors that enables an individual to engage in an analysis. Having the financial resources and educational background might be somewhat helpful to individuals but it is not sufficient to ensure success in moving through analysis. Rather what is required is a combination of personality qualities outlined above in conjunction with having some ability to manage the structural difficulties imposed by the expense and time needed for an analysis.

While not the primary focus of this research it is worth considering how participants navigated the issues of paying for their analysis. It should, however, be stressed that this discussion is very particular to analysis in the United States. Other countries have different models of funding health care and this in conjunction with cultural factors that are more favorable to an analytic treatment stance in various countries has meant that analysis is available to larger groups of people in certain countries. For example, in Argentina, where psychoanalysis is part of the fabric of social life, it is often said that everyone from the garbage collector to the president engages in an analytic treatment (Romero, 2012). While it is beyond the scope of this

study to consider how analysis is practiced in countries outside the United States, it is important to keep in mind that it is worth considering whether the limitations of access to analysis are inherent in the culture rather than in the specific conditions of analytic treatment. In other words, if America engaged in true mental health parity as a social policy and if mental health care were viewed as an essential human right, analytic treatment might be available to a larger group of people in America.

Paying the Analytic Fee

For a patient to engage in an analysis requires a huge commitment on the patient's part of time and money. It is not unusual to hear people cite the lack of time and money as reasons for not being able to engage in an analysis. Historically some analysts have described people who cite these impediments as having resistance against doing an analysis. It could be contended that many of these analysts failed to take into account the external reality of people's lives by making such statements. However, the image of analysands as holders of trust funds to finance an analysis with endless amounts of free time to devote to years of an analysis is not an accurate picture of this research sample. Rather the reality is far more complex.

Participants in this study funded their analysis in a number of ways. One participant was a graduate student at the time of her analysis and she contacted her local institute for a referral. The analyst she was referred to offered a sliding scale fee. The vast majority of participants paid their analytic fees through medical insurance and some through a combination of insurance and self-pay. Participants in this group expressed that paying for an analysis often involved making significant financial sacrifices. One participant in this group smilingly stated that: "my partner and I used to joke that we put our respective analysts' children through college." She quickly added that she felt good about spending her money on an analysis and that it was an expression

of her values. Probing further for willingness to make these financial sacrifices participants would most often stress how essential the analysis was for them. There was a sense that given the significant psychological issues participants were dealing with, the analysis felt essential for their mental health in much the same way a life-saving surgery would be essential to maintain physical health.

Paul had his analytic fees paid for by a trust created for him by his grandfather. Asked about this, Paul expressed that he had thought of this payment arrangement in much the same way he had his college cost which was also paid for by the trust. Paul expressed feeling that he was fortunate to have access the financial means but did not initially think it impacted the quality of the treatment or in his case the lack of quality of the analysis. In subsequent interviews Paul stated that he had given this matter more thought and started to wonder if in fact the payment arrangement had perhaps some deleterious effects on his analysis. In particular Paul was aware that some of the pressure he felt about picking a “famous analyst” was related to wanting to impress his grandfather who was paying for the analysis. Paul also expressed feeling guilty when he felt he was not making the type of progress in analysis he felt his grandfather would expect.

Paul: It was like when I was in college and I got a C in organic chemistry. I felt so bad about that and told my grandfather. My family is wealthy but my grandfather impressed on us that money should be used well. I remember apologizing to my grandfather about the C and him reassuring me saying he knew I had tried my best. With my analysis I felt the same way like I should apologize to my grandfather for not using the money well. But I felt too much embarrassment about failing in my analysis. Here I was with one of the most reputable analyst in the business doing so poorly. And you know it just occurred to me I never told my analyst any of these things. That is sort of stunning to me to think about now how much we never talked about things. Sitting here telling you things I should have told my analyst. So yes to answer your original question having my analysis paid for by family was most likely not the best arrangement for me. In hindsight I would want to take greater responsibility for my own analysis.

There were a number of participants who self-paid for their analysis. Some of these participants experienced financial hardships with analyst making adjustments to the fee in order to maintain the treatment. Other participants expressed they were able to pay for the analysis but also had an awareness that the financial investment they were making into the treatment was substantial.

Treatment Outcomes

In terms of considering the outcome of the analysis the outcomes are grouped together in three sections: (1) factors that facilitate a positive analytic outcome, (2) factors that have minimal impact on analytic outcomes, and (3) factors that result in a negative outcome for the analysis.

Factors that Promote and Facilitate Positive Analytic Outcomes

The fit between patient and analyst. The data suggests that the way in which participants went about selecting their analyst is correlated to the level of satisfaction with the analytic process and eventual outcome. Those participants that focused on finding an analyst that was a good fit tended to have higher levels of satisfaction with the process and outcome of the analysis. In the research of the Boston Change Process Study Group (BCPSG) (2010), they refer to the important of the process of “fittedness” between analyst and patient. This is referred to as a process in which both patient and analyst have the desire and ability to move in a “directional fittedness” and that they are able to find ways of understanding each other. The BCPSG suggests that this process most often happened implicitly or stated in in other terms outside the conscious awareness of patient and analyst. However, for participants in this sample like Ruby who put a great deal of effort into seeking out a good fit in the analyst she picked, it was a good use of time and energy as it resulted in a good outcome for the treatment.

In this sample, the participants most able to secure a good fit with their analyst either interviewed a number of analysts before making a choice or requested a referral from their closest psychoanalytic institute. The participants that approached the institute for a referral engaged in an initial assessment by for example determining the presenting issue of the prospective patient. In this way, for example, Brenda dealing with the childhood death of her father was referred to an analyst known to specialize in early parental loss. It appears that institutes were committed to making informed referrals that would promote a good fit.

Participants who interviewed several analysts were aware of factors that would promote a good fit and those that would not. Ruby for example was aware that in order for an analysis to succeed she needed not to feel judged by the analyst. An initial interview with a female analyst went badly in this regard and Ruby moved on to the next name on her list. The ability to maintain a tension between being able to seek out a good fit analyst but to also be open to trying again with another analyst is important. Ruby states that she initially thought when her analyst explained his “rules” to her she found them too demanding. However, his openness to wanting to talk about this with her helped. John, in turn, expressed feeling disappointed that the first analyst he consulted did not have openings to start an analysis.

John: I first consulted with this really kind elderly male analyst but he said he could not start for six months. I wanted to wait but he said it would be best that I find someone sooner it was obvious that I was in so much pain. He said there were many good analysts who could help me. I feel grateful for his kindness in encouraging me to go find another analyst and not to wait for him. He was right. I could not wait much longer for help.

By contrast those participants that made a choice of analyst based on the reputation of the analyst tended to have lower levels of satisfaction with the analysis. For both Shelley and for Paul the professional reputation of the analyst played a big part in their reason for selecting the analyst. Shelley had some familiarity with her analyst who she had taken a professional seminar

with and she states being impressed by his intellect while also being aware that he was in her opinion interpersonally a “jerk.” Paul had not met his analyst before the first consultation but stated that, “I knew he had written a ton of books on psychoanalysis and that impressed me.” However, the apparent stellar reputation of the analysts in question did not translate into a good enough fit for the participants to feel that their analysis was successful.

Ability of patient and analyst to negotiate sequences of rupture and repair. There is a general understanding within self psychology that working through the inevitable cycles of rupture and repair that occur between patient and analyst in a treatment are what is ultimately curative about the analysis (Kohut, 1984). A number of participants related the importance of this process in their analysis. For example, Sally talked about feeling worried and angry when Dr. T failed to show up for sessions. Sally would later learn that Dr. T had become unexpectedly ill and had been hospitalized. An essential part of moving through the rupture to the repair for Sally was the non-defensive posture her analyst took. The analyst answered Sally’s questions and accepted her anger. Sally stated that: “I was finding my voice and having appropriate anger.” In the same vein Ruby stressed the importance of working through the ruptures with her analyst. She further stressed that an analysis need not be perfect to be helpful and that for her some of the working through of the ruptures with her analyst continued for her after the termination of the analysis. Sally’s analytic experience can be theoretically understood by the work of Terman (1988) who states that change occurs for the patient by understanding the old and engaging in a new experience with the analyst.

There are a number of participants who report few ruptures and in one case, Sally reports no ruptures with her analyst stating: “we just kept rolling along.” In similar fashion, Pearl and Debbie report no noteworthy ruptures and repair cycles in their respective treatments. It is

important to make an attempt to understand these analytic experiences for the following reasons. Psychoanalysis as conceived of by Freud is an inevitable conflictual encounter between patient and analyst. The process of making the unconscious conscious is to Freud's way of thinking a struggle filled with resistance and negative emotion experienced by the patient (Freud, 1914). It is therefore not surprising that many analysts would be somewhat skeptical about an analysis with no reported ruptures or impasses. Given the ingrained conflict model within psychoanalysis it is not surprising that historically positive emotion within a treatment is often viewed with suspicion by many analysts. It is not until relatively recently that researchers such as Schore (2002), have emphasized the importance of a patient's experiencing positive emotion to facilitate change. This historical position within psychoanalysis notwithstanding, how are we to understand the experience of this group of participants given that they engaged in years long analytic treatment but report remembering no actual ruptures or impasses?

In the cases of Debbie, Pearl, and Brenda, there were no recollections of ruptures or impasses in their respective analyses. It is possible to consider that this group of participants might have experienced minor ruptures with their analysis that remained outside their conscious awareness. Additionally, this group of participants enjoyed exceptionally robust relationships with their respective analysts which could have facilitated the weathering of possible microscopic ruptures. There is also a general sense that ruptures reflect the historical traumatic selfobject failures that patients bring to treatment with their own distinct structural vulnerabilities (Kohut, 1977). Therefore, a patient with the capacity for a secure attachment is able to negotiate a rupture without much distress (Beebe & Lachmann, 2014).

Clinical flexibility of analyst. With participants with high levels of satisfaction the analysts in these dyads displayed an impressive amount of clinical flexibility. This was

displayed in a number of different ways such as for example Sally's analyst encouraging her to sit up rather than use the couch until she felt completely comfortable with using the couch. A number of analysts in this sample were open to post-termination contact in the form of continued psychotherapy as needed. Brenda expressed that this was critically important to her as she navigated the transition in her life from a single woman to marriage and being a stepparent to her husbands' daughters from a previous marriage. Clinical flexibility has been held to be an important component in treatment by Bacal (2006) in his work on specificity theory that holds that treatment efficacy is determined in part by the ability of the treatment dyad, analyst and patient, to respond to the possibilities that arise within the treatment.

Corrective emotional experience. In this sample the participants who reported the most transformative analytic treatments described having an emotionally corrective experience with their analyst. At the core of the debate surrounding the corrective emotional experience is the tension between interpretation and emotional experience. For Freud (1958), analysis was essentially a process of the analyst engaging in interpretation to the patient. Ferenczi (1921) however stated that an active process of emotional activation was needed for the patient to have a new experience over the course of the analysis. Alexander and French (1946) took this concept a step further and stated that what was needed for meaningful change for the patient was a "corrective experience to undo the effect of the old" (p. 22). Further they stated that: "the patient must undergo a corrective emotional experience to repair the traumatic influence of previous experiences" (pp. 66-67). This process does not, as Alexander and French initially indicated, involve the analyst engaging in some form of role playing. Rather the analyst engages in an intersubjective experience with the patient, in which the individual subjectivities of both parties to the dyad are recognized but the analyst is able to fashion him or herself to the patient. In this

way the analytic process becomes what Sander (2002) refers to as a treatment of learning by doing. The patient is in essence learning a new way of being through the more life enhancing emotional experience with the analyst.

Brenda experienced a significant developmental trauma with the suicide of her father when she was three years old. She experienced her father's suicide as an abandonment and it left her feeling emotionally adrift. The analyst was able to provide an experience for her in which she experienced the analyst as reliable and steadfast. Brenda states that her analyst made her feel "safe and cared for" and that "he opened my heart." The analyst in essence became for Brenda the father that she needed and provided the emotional experience of a secure attachment.

In similar fashion both Pearl and Debbie experienced their respective analysts as providing them an emotional experience that was absent from their early life with a parent. Pearl experienced her analyst as listening to her and not being as critical as was her experience with her mother. Debbie had the experience of an analyst that taught her how to deal with issues of power and control and an analyst who trusted her to make decisions that were in her best interest.

John in turn also powerfully speaks to the importance of the emotional experience of his analysis. The degree of emotional physical abuse John suffered in his early life is staggering and by all accounts he spent much of his life before analysis barely being able to survive emotionally. Speaking of his analysis John states that: "emotionally speaking my analyst birthed me into life. I came into my life fully due to my analysis." It is important to note that a corrective emotional experience in an analysis does not preclude interpretation. John is able to recall interpretations his analyst made in particularly in the later years of the analysis when he was feeling secure emotionally and was more able to reflect on the circumstances of his early life. Another participant Jim stated that he found his analyst's interpretations to have emotional

resonance for him. It was indeed the interpretations that provided the grounding for the corrective emotional experience for him. Jim expressed feeling understood and cared for by his analyst and this occurred primarily through the vehicle of interpretations.

The analyst's emotional involvement in the process. In Freud's (1913) description of the clinical technique there was a sense of the analyst as a blank slate onto whom the patient projects. In this model the analyst is a neutral party, abstinent party to the analytic encounter. However, Freud was also aware that analysts were in fact emotionally influenced and impacted by the analytic process. Freud (1905) displayed this understanding when he stated that it was not possible for an analyst to "hope to come through the struggle [treatment] unscathed." As psychoanalysis moved toward a two-person psychology there was an increasing focus on how the analyst and patient are mutually influenced by the other. This was further elaborated by the focus on how the work between patient and analyst is inherently intersubjective (Stolorow & Atwood, 1989).

The participants in this sample who report having a very satisfying analysis also talked about an awareness that the analyst was emotionally involved in the treatment process and that the analyst was invested in a good outcome in the treatment. Jim's analyst expressed an active concern for the ways in which he was being treated in an intimate relationship. John talked about having a strong sense that his progress in the analysis was important to his analyst and that she cared about the quality of his daily life. Ruby talked about a strong sense of there being a mutual affection in her analysis and that they liked each other as people. Brenda felt strongly connected with her analyst and at the termination remembers her analyst expressing affection for her and stated that he had learned from her. Sally also expressed feeling that she mattered to her analyst.

Factors that Have Minimal Impact on Analytic Outcomes

Gender and the analyst. On the whole in this sample the gender of the analyst had little impact on the levels of satisfaction of the analysis. There were some exceptions to this with two participants, Brenda and Debbie, both stating that having a male analyst served as an emotionally corrective experience for them. Brenda experienced her analyst as a male role model, who unlike her father did not leave her. Debbie felt that she worked through her feeling with regard to her critical father by way of the kindness and acceptance of her male analyst. Another participant however had the converse experience, with Shelley sensing that her male analyst replicated the negative behavior of her father. She hoped for working through or corrective experience did not happen for her.

Most often however in this sample the gender of the analyst had little impact on the actual work of the analysis even in cases where the participant initially thought gender would matter. Both Ruby and John had an initial preference to work with a same gender analyst and ultimately ended up having very productive treatments with opposite gender analysts. What appears to be more important than the gender of the analyst was the way in which an analyst could engage in understanding of the patient and this depended on the willingness of the dyad to work together toward understanding. So for example Ruby feeling that her male analyst did not understand her experience, resorted to reading to him from feminist Catherine McKinnon's books. Ruby's analyst responded positively and she felt understood. It is an excellent combination of patient creativity and analyst desire to empathically understand the patient.

Theory used by the analysis. Four of the 10 participants indicated that they were aware of the theory the analyst used in the analysis. One participant consciously selected an analyst that was a self psychologist. For the participants who did not know what theory their analyst

subscribed to it was possible to identify the theory based on the description of the treatment. Theories used by analysts in this sample tended to be either ego psychology or self psychology based. A number of the analyst displayed a flexibility in the way in which they used theory. For example, a number of participants reported analysts who were anything but abstinent in their approach to the analysis; something that would have generally been considered the norm in a traditional ego psychological clinical technique. For example, a number of the analysts answered the questions of patients and were actively responsive in ways that tend not to be thought of as the analyst acting outside the treatment frame. In addition, not all analysts who subscribe to the same theory necessarily employed the same clinical techniques. A number of the ego psychologists were highly responsive to their patient whereas a number of the self psychology analysts had a marked distance in the way they interacted with their patients.

Within psychoanalysis there is a continuous debate of the role of theory and if one theory is somehow superior to another. It could be contended that every clinical interaction is dictated by a theory, whether the theory is conscious to the analyst or not. The human mind is in continuous engagement with theory seeking explanations and predictions. However, the relevant question is not if theory is important, it clearly is, but rather in what way does theory determine clinical outcomes for patients. What perhaps appears to matter more than the actual theory the analyst adheres to is the manner in which the analyst's personality and the theory interact. An added factor could be the analyst's own personal analysis. The variables of theory, personality and personal analytic experience combine to form each analyst into a unique analyst. This would account at least in part for the variation of clinical technique by different analysts claiming adherence to the same theory.

There is, however, a danger that an analyst can get lost in theory and in the process lose sight of clinical material that does not appear to fit with the theory. This is what seems to have happened to Jennifer. The analyst working within a self psychological developmental model clearly missed some rather obvious indicators of the development of an erotic transference. In Jennifer's view her analyst got lost in his theory and in the process her needs were lost to his attention. The erotic transference remained outside the analyst's view for years until Jennifer eventually spoke with him about it. It can only be concluded that this came as a big shock to the analyst as he proceeded to unilaterally terminate the analysis.

Professional reputation of the analyst. All the analysts in the sample were graduate analysts and were senior analysts with years of experience. Many participants stated that they feel they benefitted from working with an experienced analyst. Two of the participants, Shelley and Paul, chose an analyst that was both a senior experienced analyst and was well known in the field. Both participants were at least in part motivated to seek out the analysts in question due to their prominent reputation in the field. In both cases the analysis ended up being disappointing and not what the participant felt they needed.

Factors that Result in a Negative Outcome for the Analysis

Inflexibility and unwillingness to admit mistakes. Participants who engaged in treatments where the analyst displayed significant inflexibility in his or her clinical technique resulted in unsatisfying results. It became especially injuring for the patient when the inflexibility was combined with an inability to admit mistakes. Paul describes the impact of this type of treatment in the following way:

The analysis made me feel like I was always wrong and the analyst was always right and I feel he promoted that idea. It meant that I did not trust my own sense of what was good for me. That played out big time with the medication. I wanted to at least try things were

so bad for me. It was taking longer and longer to get out of bed in the morning. I told the analyst and he said 'you will get up you need be here four days a week. No medication that is not analysis'. He made me think that was the absolute rule of analysis, no medication. I now know from talking with you that is not true. That was the rigidity of my analysis not necessarily the view of all analysts.

Shelley had a similar treatment experience in which her analyst set himself up as the absolute authority and never acknowledged making a mistake as did Jennifer whose analyst ultimately abandoned the treatment rather than deal with the mistakes he made. Even in satisfying treatments, analysts appear to sometimes have problems acknowledging mistakes. Ruby who reports high levels of satisfaction with her analysis nonetheless states that issues remained for her post termination with her analyst's inability to ever acknowledge his mistakes.

Inability to negotiate patterns of rupture and repair. In the same manner when the analytic dyad is unable to work through ruptures and repairs, it has a deleterious effect and ultimately leads to treatment failure. The most dramatic example of this state of affairs occurred in Jennifer's analyst. The events of the treatment are dramatic, the patient after years of feeling verbally seduced by her analyst eventually is able to tell him and the analyst response is to unilaterally terminate the treatment leaving no possibility of making a repair. It is worth considering, however, that the rupture had been occurring for years before the dramatic events of the day of Jennifer's disclosure. The inability of the analyst to recognize and manage his patient's erotic transference over years of treatment was the actual variable that set the analysis on the road to failure. The analyst's action of sending Jennifer to consultation was the initial correct action. However, his ultimate inability to resume the analysis and work through the rupture is eerily reminiscent of Anna O and Breuer who got lost in his patient's countertransference (Breuer, 1895).

The analyst not attending to significant symptoms. A number of participants were dealing with symptoms such as depression and substance abuse issues over the course of the analysis. Jim had been steadily increasing his alcohol intake over the course of the analysis. Attempts to not use alcohol on nights before sessions were increasingly failing. His analyst was aware of his drinking habits but did not attend to the issue in the analysis. In a similar way Paul and Jennifer reported significant levels of depression over the course of the analysis, and attempts to use medication were aggressively rejected by the analysts.

The inability and or unwillingness of the analyst in question to attend to symptoms was experienced as a mistake and an empathic lapse by the participants. The symptoms in question negatively impacted the participants' ability to function in their daily lives and in Jim's case there was a progression of the disease of alcoholism.

Life After the Analysis

In the research interviews participants spoke extensively about the impact of the analysis on their lives post termination. Participants terminations ranged between five and forty years since termination. In the research the following themes emerged.

Ability to Engage in Self-Analysis

A number of participants spoke about the ability to continue to engage in a process of self-analysis after termination. This can be seen as the patient's having the ability to do for themselves what the analysis used to do. For some participants like John this entailed the ability to regulate himself. John had experienced significant levels of physical and emotional abuse as a child. This meant that John was easily triggered into fear responses in daily life as an adult. An important part of the analysis was the safe, containing environment that his analyst provided on a

near daily basis. Over time John was able to internalize these functions and was able to regulate himself and not to need to rely on his analyst to do this.

Ruby talked about how her analyst was exceptionally good at dream analysis which was both helpful and an interesting part of her analysis. She mentioned that now years after her analysis it still brings her great joy to be able to interpret her own dreams in the ways the analyst taught her. Participants like Jim and Jennifer talked about learning in analysis how to think about professional situations that were potentially conflictual and how not to be reactive but to deal with the situations productively.

The Continued Working Through Process

Related to the process of self-analysis post termination is the idea that patients post termination continue the process of working through many of the issues that initially brought them to analysis. This can most clearly be seen in the replication of the transference in the research interviews. In the research conducted by Schlessinger and Robbins (1983) in Chicago, the researchers noted the replication of the original transference in the research interviews. In this study there was a similar replication of the transference with the majority of the participants. The question is how does this finding impact the outcome of the analysis? What implications does it have for the patient that transferences continue to replicate even after an analysis?

It is important to take note of how the transference replicates. For example, Sally was aware that when I ended the research interview ten minutes early it resulted in her feeling that she was potentially not as interesting to me as she imagined the other research participants to be. This was similar to the way she felt with her analyst that she was not an interesting person. However how Sally was able to manage these feelings was different from how she might have

pre-analysis. She was able to recognize the transference and then reality test her feelings in the next interview with me.

These findings would suggest that analysis optimally provides the patient not with some miraculous “cure” in which deeply embedded transferences are resolved but rather a method for the patient to manage these transferences in a more functional way. In this way the analysis is a process of learning by doing (Sander, 2002). During the analysis the patient needs the analyst to provide scaffolding in order to engage in the “doing” and post analysis the patient is independently able to engage in the “doing.”

Post Analytic Contact in the Form of Psychotherapy

It is noteworthy that two of the participants in the sample, Brenda and Pearl, with high levels of treatment satisfaction continued to have post analytic contact with their analyst in the forms of psychotherapy. Both participants report that it seemed like a natural outcome of the analysis to return for psychotherapy as needed. The analyst in question displayed impressive levels of clinical flexibility not only in their willingness to engage in psychotherapy with their analysands post termination but with their general clinical technique. There is a sense in which these analysts were able to fashion an analysis and after care that was needed by the patient rather than relying on a set of rules or conventions in how to conduct a termination.

Death of the Analyst

A number of the participants experienced the death of their analyst after the analysis and one participant Sally had the experience of her analyst dying while she was in the final phase of her analysis. There appears to have been virtually no support available to Sally from the analytic community other than one meeting with the clinic intake coordinator at the Chicago Psychoanalytic Institute. Unfortunately, Sally’s experience is not unique and there is a long

history of the analytic community not managing the illness or death of its members well (Galtatzer-Levy, 2004). It is not clear to what extent Sally's analyst was aware of being ill or whether, as so often appears to happen, she was in denial about the state of her health (Hoffman, 2000). In addition, it appears that the analyst made no provision in the form of an analytic will to manage her patients after her death. At the time of Sally's analysis this would not have been usual, however in recent years there has been an increase in urging analysts to create an analytic will. An analytic will is a document that provides instructions information on patients under the care of the analyst and who those patients need to be referred to upon the death of the analyst (Gabbard & Peltz, 2001).

The other two participants, Brenda and Pearl, whose analysts have died since the termination spoke movingly about the process of mourning the loss of their analyst. Pearl talked about not attending the funeral as she felt it would be too difficult for her to manage her sadness. However, in the years since her analyst death feeling that she has worked through the sadness and can now focus on the happy memories of the time she spent with her analyst. Brenda also spoke about the deep sadness she felt when her analyst died but expressed feeling good about the opportunity to talk about this over the course of the research interviews.

CHAPTER SEVEN

STUDY IMPLICATIONS AND FUTURE RESEARCH

This research started as a result of my curiosity about the life of Mr. I, the patient in the self psychology casebook (Goldberg, 1978). While the ultimate fate of Mr. I's life is unknown, the curiosity he stirred in me led to the voices and treatment experiences of the extraordinary participants in this study: Brenda, Debbie, Paul, Pearl, Ruby, Sally Shelly, Jennifer, Jim and John.

The goal of this research was to listen to the patient directly. The participants of this study's willingness to talk about their analytic experiences ensured this task was accomplished. It is of note that data collection for this study was a relatively easy task to accomplish. There was a certain expectation on my part that data collection, in particular participant recruitment, would be onerous but that assumption proved to be false. It turned out that former analysands enthusiastically volunteered to participate in this study. A process of snowball sampling was utilized to recruit participants. This meant that participants were asked to refer other potential participants, who might be interested in participating in the study, to the researcher. In this study a number of participants tended to know a number of other people who had engaged in an analysis who in turn expressed enthusiasm about participating in the study.

Participants expressed that it felt useful to them to talk about their analytic experience and also a desire to contribute to research. The prospect of being able to influence how analysts practiced was an additional motivation for participants to participate in the research. It is of note

that both participants who had an overall positive experience of their analysis and those who did not expressed a desire to be interviewed. For the participants who had a negative treatment experience, being interviewed functioned as a corrective experience through the process of being heard in the interviews.

Implications of the Study

Corrective Emotional Experience

There are a number of important implications that flow from this study. It appears that the most important factor that predicted success in the analysis was the degree to which the analysis functioned as a corrective emotional experience for the patient. The corrective emotional experience did not involve the analyst pretending to be a certain way that was incongruent with the analyst's personality, rather it involved the analyst's ability to be what the patient needed in much the same way as a parent might attempt to fashion themselves according to the needs of their child. Given that each individual has his or her own unique personality structure, temperament, and genetic factors, the optimal treatment process involved the analyst having the clinical flexibility to create a unique treatment needed by the individual patient. In this study there are ample examples of analysts who worked with their patients in ways that demonstrated clinical flexibility rather than dogmatically abiding by the dictates of clinical method that the analyst's theory or training dictates. Conversely, other participants had the experience of analysts who rigidly stuck to their method and were not able to make the needed adjustments to the patient. This, in turn, led to low levels of patient satisfaction with the treatment as the patient's attempt to experience the analysis as a corrective experience was thwarted.

Psychotherapy and Psychoanalysis

A further implication of this study was the role of psychodynamic psychotherapy in patient care. There are two considerations with respect to psychotherapy. One being the psychotherapy participants engaged in before the start of their analysis. The therapy was most often conducted by a psychotherapist. Two of the participants did have treatments that were conversions meaning the patient first engaged in psychotherapy with the analyst before converting the treatment into an analysis. The majority of the participants engaged in psychotherapy with a therapist before starting an analysis. Some of these participants had therapist recommend analysis to their patients. Other participants independent of the psychotherapist felt a need to start an analysis. The most frequent reason given for ending psychotherapy in order to engage in an analysis was the need to deal with problems at a deeper level. Participants expressed the realization that they were dealing with significant challenges to their mental health that needed a higher level of care that analysis offered. Part of obtaining a higher level of care involved greater session frequency in combination with needing an intensive treatment experience that analysis offered. The study finding that patients enter analysis with the expectation that they will receive a higher level of care than provided by psychotherapy has certain implications for psychoanalysis and the mental health field as a whole.

It could be contended that psychotherapy and analysis are treatments of equal value but with somewhat different treatment goals. It also seems important that analysts have a clear clinical understanding for recommending an analysis to a particular patient as opposed to psychodynamic psychotherapy or some other form of psychotherapy. Clinicians are ethically obligated to provide the lowest dose of treatment needed for meaningful recovery by the patient. The average analysis takes many years to complete and is financially costly to the patient. It is

therefore ethically problematic for an analyst to take a patient into analysis if the same results could in the clinical judgment of the analyst be obtained from a psychotherapy.

A related issue is the qualifications needed by clinicians to conduct an analysis. All the analysts in this study were graduates of institutes affiliated with the American Psychoanalytic Association (APsaA), which at that time had centralized training requirements for candidates training to be analysts. However, psychoanalyst is generally not a protected title in most states meaning in theory anyone is free to claim to be a psychoanalyst. There are some states such as New York that require formal licensing for analysts, a welcome move toward professionalization. In the years since the analysis of the participants in this study there has been a proliferation of independent institutes not affiliated with the APsaA with unclear training standards and blurring of the lines between psychotherapy and analysis. This is a problematic state of affairs, as the sample in this study clearly illustrates, that patients come to analysis with a significant mental health issues and with an expectation of obtaining a higher level of care that analysis offers. It therefore stands to reason that the clinician providing the care be trained for this task. This is especially important when we consider the components of the average analysis: a treatment with a patient dealing with significant mental health challenges engages in a treatment spanning many years at high levels of frequency in terms of days per week in turn leading to heightened levels of transference responses and regression in the patient.

An interesting addition to the discussion of psychotherapy is that a number of participants in the study engaged in psychotherapy with their analyst post-termination. The psychotherapy ranged from booking a session with the analyst on a need to basis to regular weekly sessions with the analyst. The participants who engaged in this model of termination expressed that it was essential to them to have this continued form of contact with the analyst post-termination. It is

beyond the scope of this study to examine the conditions of the psychotherapy in depth but based on the data it does appear that the relationship between analyst and patient changed and evolved. The patient was able to tolerate less access to the analyst and could function more independently from the analyst than was possible in the analysis.

Replication of the Transference

The outcome study of Schlessinger and Robbins (1983) first identified the replication of the patient's original transference with the analyst in the researcher interviews. This study in turn replicated the original finding of Schlessinger and Robbins with regard to the transference. The replication of the transference in the research interviews has certain implications for outcomes for the participants. It implies that analysis does not necessarily provide a "cure" for the most bothersome issues a patient is challenged by, but rather the analysis teaches the patient to more functionally deal with these challenges.

Sally, for example, in spite of reporting having a successful analysis, continued post-analysis to have times of low self-esteem, like she experienced with me when thinking that I found her less interesting than other participants when ending one of the research interviews ten minutes early. However, Sally post-analysis was able to reflect on the transference, recognize the pattern, and reality check her assumptions by talking with me, all things she was unable to do before her analysis. This would imply that Sally gained an ability to engage in self-analysis in her post-analysis life. Schlessinger and Robbins speak to this in their research findings when they state: "The effect of analysis is not the obliteration of conflict but a change in the potential for coping with conflict, evidence in a greater tolerance for and improving mastery of frustration, anxiety, and depression" (p. 167).

In this way in a successful or good enough analysis the patient post continues the working through process post analysis, of many of the original issues that brought the patient to analysis. However, the patient is now able to perform many of the functions the analyst, for example regulation of affect and interpretation of which reality testing is a part, for themselves. In an unsuccessful analysis the patient remains embedded in their original organizing principles with an inability to have a new experience of previously distressing events.

Strengths of the Study

The study has numerous strengths, the greatest being the in-depth exploration of participants' experience of their analysis. The goal of this study was to privilege the voice of the patient and this was accomplished by using a heuristic method of inquiry that privileged the voice of the participant. A related strength was the importance of using a qualitative research. There has been a tendency in clinical outcome research to favor quantitative studies in particular randomly controlled trials (RCT) (Galatzer-Levy et al., 2000). This has been especially problematic approach in researching analysis as it comes in direct opposition to a general principle of research that the research question asked should determine the method employed for the research (Patton, 2002). So for example if researching the efficacy of a drug to reduce a particular symptom, a RCT research design could be considered the most effective way to pose the research question. However, the question as it regards the efficacy of psychoanalysis is a highly complex question and involves many more variables beyond symptom management. As is demonstrated by this study, participants have nuanced and complex views on their analytic experiences. Many of the participants that expressed high degrees of satisfaction with their analysis also reported times of difficulties in the analysis. Conversely participants that reported an overall negative outcome of their analysis also reported some positive aspect of the analytic

engagement. An effective research design needs to represent all these diverse patient experiences. The nuances in participant responses could not be captured by quantitative study.

This goal of this study was to optimally capture as much of the patient's experience as possible and therefore a heuristic research method was used. An important component of the heuristic research mode is the way in which both the experiences of the individual and the group are captured in the research process. The method is committed to elucidating the experience of the individual participant but simultaneously the experience of the study sample/group is captured by the creation of composite depictions, exemplary portraits and a synthesis of the findings (Sultan, 2019).

An additional strength and important part of privileging the voice of the patient was to have the participants determine what they regard as a successful analysis or a "cure". As documented in the literature review there have been a number of attempts to engage in outcome studies in qualitatively based outcome study in psychoanalysis. However, there are few clinical outcome studies of analysis where the former patient is asked to determine from their point of view what is a successful treatment. It is hoped that this study would function as one of the models of how to approach clinical outcome studies in psychoanalysis in the future where the views of the former patient is privileged.

Limitations of the Study

The primary limitation is related to the primary recruitment of participants in one geographical area. The majority of the participants engaged in an analysis in Chicago. A further complication is the time of the majority of the analyses were conducted around the time in the formative years of self psychology in Chicago. While it is hopefully true that theories are always in the process of being changed and adapted, there does seem to be a very particular climate that

developed within the Chicago Psychoanalytic Institute at that time. In his biography of Kohut, Strozier (2001) documents how the zeal to use this promising new theory of self psychology while at the same time radically challenging the drive theory, the status quo of the day, resulted in a turbulence within the ranks of the Chicago analysts. This zeal and turbulence in turn impacted the analyses of many of the participants of this study and in turn affected the type of data that was collected. The degree to which this limitation impacts the results is unclear and can only be fully assessed once additional data is collected from more diverse geographical locations.

An additional limitation was lack of complete fidelity to the heuristic research model in two respects: (1) not fully treating the participants as co-researchers in the study and (2) not collecting artifacts as part of the research process. In the heuristic design participants are viewed as co-researchers in the research process. Sultan (2019) describes this in the following manner: "... our co-researchers are our companions and collaborators on a journey that will ultimately transform each of us: research, co-researcher, and readers of the findings. It is our shared journey that renders the process of discovery possible" (p. 159). While I attempted to engage with participants in the spirit of the above quote, there was also a keen awareness that in the work I was producing, academic standards dictate that I take full responsibility for the research product in the form of a dissertation which can only have one researcher. However, my goal was to include the participants in the research process as much as was viable within the constraints imposed with a dissertation writing process, and the goal is in future research to fully engage participants as co-researchers.

The second deviation from the heuristic research method was not collecting artifacts from participants. Part of the heuristic research method is to request participants to provide the researcher with any notes, diary entries, drawings or any other works that is related to the

phenomena which is being studied (Moustakas, 1990). In this study I made a decision not to formally request artifacts from the participants. Given the very sensitive nature of the data being collected it felt too intrusive to request artifacts if any existed. The closest this study came to using artifacts was to quote words that I wrote to my analyst in an email, to indicate how my thinking evolved with respect to this study. Also it could perhaps be said that some participants created artifacts in the research process by writing notes between interview sessions. However, artifacts in the traditional sense intended by the heuristic research method were not collected or analyzed in this study.

Future Research

There are two research endeavors planned in relation to this study. First is to continue to expand the data base of collected patient stories of their analytic treatment. It is hoped that this study could serve as a pilot study to convince the American Psychoanalytic Association (APsaA) to invest research dollars in qualitatively based research projects. In addition, it would be a goal through the publication of results of this study that clinical outcome researchers in general consider engaging in research that highlights the full experience of the patient rather than to use symptom reduction as the sole determinant of a successful treatment.

The second project related to future research would be to compare accounts of treatments from the perspective of former patients and their analysts. In 2012, Arnold Goldberg published his book, "The Analysis of Failure: an Investigation of Failed Cases in Psychoanalysis and Psychotherapy." Goldberg had for decades been involved in the arduous task of collecting the accounts of analysts and psychotherapists of their failed cases. The book is a treasure as it represents one of the very few clinical works that attempts to examine the treatment failure. However, as important as Goldberg's book is, it remains an incomplete work. Until we have the

patient's perspective alongside that of the analyst it will be impossible to meaningfully determine what factors lead to treatment failure. Frequently, patient confidentiality is cited as a reason for not collecting the stories of former patients. However, this study has demonstrated that many former patients are highly motivated to talk to researchers and in fact find the research interview process to be beneficial. It seems to function as an additional form of working through of the analytic experience. This is true of both participants who report successful treatments and those that report treatment failures. It seems entirely possible to engage in this type of research in a manner that is both ethical and will protect both the patient and the clinician.

Conclusion

It seems appropriate at the end of this study to return to the first patient of psychoanalyst Bertha Pappenheim, the social worker more commonly known as Anna O. Together Anna O and her analyst Josef Breuer discovered that human suffering could be relieved by speaking to another person who in turns listens. Pappenheim's contribution as the patient was essential to the development of the psychoanalytic treatment method (Swenson, 1994). It would ultimately take the brilliance and drive of Freud to start the psychoanalytic revolution and movement that would forever alter the ways as humans we view ourselves. We would all come to live in Freud's world leaning to speak the language of psychoanalysis. Words such as the "unconscious," "ego," "projection," and "denial" now form part of the common vernacular. The genius of the psychoanalytic revolution that Freud spearheaded is simple: one person, the analyst, listening to another person, the patient, in service of reducing suffering. Psychoanalysis privileges each human's inner life and unique subjectivity. Ultimately each analyst and patient dyad is tasked with answering the question the poet Mary Oliver (1992) poses: "tell me, what is it you plan to do with your one wild and precious life?" (p. 133). It is in the process of

answering this fundamental question that the patient is vitalized and able to live a fuller life and deal with the disappointments and challenges of life more effectively. In the process the world gains a citizen more fully able to make a contribution to the world, as is evidenced by the lives of the participants in this study.

APPENDIX A
RECRUITMENT MATERIALS

Dear

Thank you for contacting me with regard to my research study titled, **The Patient Speaks: A Phenomenological Exploration of the Patient's Experience of Psychoanalysis**. This email will provide you with basic information concerning the study. The goal of this research is to explore patient's experience of analysis after the completion of treatment. To date the majority of the research concerning psychoanalysis have been formulated by analysts – who decide what questions to ask and define who define what a “cure” consists of. The major goal of this research is for patients to control the dialogue by talking freely about their treatment experience and about how the treatment impacted their lives. All information in this study is confidential. A pseudonym, which you choose, will be used in all documents related to the research: transcripts, dissertation, publications and in presentations concerning the study. Your true identity will only be known to me.

The research will consist of three interviews. In the first interview I will ask you to complete a short questionnaire with basic information regarding your treatment e.g. length of treatment, gender of analyst etc. The remainder of the interview time will be spent talking about your analytic experience during the initial phase of your treatment. The second interview will be a continuation of the first interview and will most likely focus on the termination phase of your analysis. I will be using a general interview guide for the first two interviews but this is merely a guide. I am primarily interested in your perceptions of treatment so focus will be on your reflections of the treatment process. The first two interviews are expected to last for a hour and a half each. After the interviews I will be reading through the transcripts and extracting themes. The third interview will be an opportunity for me to share with you the themes that have emerged from the interviews and for you to correct my perceptions. It is expected that the third interview will last for one hour.

I consider the interview process to be a collaborative process between participants and researcher. In the spirit of collaboration and transparency I want to provide you the following information regarding who I am. I am a doctoral student in the School of Social Work at Loyola University Chicago. I am also training to be an analyst and am a candidate at the Chicago Institute for Psychoanalysis. As part of training candidates are required to undergo a personal analysis. I am therefore in analytic treatment four times per week.

If after reading the above information you wish to participate in this research project, please email me and we can set-up a time for the first interview. The interview can take place at the location of your choice or in my office at 122 S. Michigan Avenue, Chicago.

Regards,
Katherine Williams

(The following information will be printed on a card)

Participants Needed for Dissertation Research on Psychoanalysis through Loyola University Chicago, School of Social Work

Participants must be at least 21 years old and have completed an analysis at least six months before being interviewed for this study. If interested, please call Katherine Williams (630) 299-9537 or email: kwilliams12@luc.edu.

APPENDIX B
RESEARCH INSTRUMENTS

Questionnaire

1. What is your gender?
2. What is your current age?
3. At what age did you start your analysis?
4. What was your occupation at the time of the analysis?
5. What is your current occupation?
6. Before entering analysis did you engage in psychotherapy? If yes for how long?
7. Was your analysis a conversion i.e. did you engage in psychotherapy with your analyst prior to your analysis? If yes for how long?
8. What was the gender of your analyst?
9. Did you know the theoretical orientation of your analysis prior to treatment? If no did you become aware of your analyst's theoretical orientation during the course of treatment?
10. Number of days per week in analysis?
11. How long was your analysis?
12. How long has it been since you terminated your analysis?

Interview Guide

Interview 1

1. Can you tell me how you picked your analyst?
2. Talk to me about your reasons for wanting to engage in analytic treatment?
3. Tell me about what you remember about the first day of your analysis?

Interview 2

1. Did analysis differ from your expectations prior to treatment?
2. How would you describe your relationship with your analyst during treatment?
3. How did your analysis impact the significant relationships in your life?
4. Tell me about any difficulties you experienced over the course of your analysis?

Interview 3

1. Tell me about the process of deciding to end your analysis?
2. Have you had any contact with your analyst after termination?
3. How would you say your analysis has impacted your life since you terminated treatment?

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