

**THE BOSTON PSYCHOANALYTIC SOCIETY AND INSTITUTE, INC.**

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TECHNIQUE IV  
Fall 2015

Current Issues in Technique: How Do We Make Psychoanalysis Work?

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Beginning with Freud, there has been a longstanding debate about the relative importance of insight and interpretation versus the analytic relationship with respect to the therapeutic action of psychoanalysis. In recent decades, this debate has become less binary and increasingly complex and nuanced. In this course, we will consider the components of therapeutic action, paying particular attention to the role of the analyst as a person. We will consider how the analyst's unique involvement influences technique and colors the ongoing interaction of the particular analytic dyad. Both classical and more contemporary perspectives will be reviewed.

We will begin with Guntrip's (1975) description of his analyses with Fairbairn and Winnicott, noting their differences in technique and ways of relating, and the effect this had on Guntrip's experience. This paper will be joined by Kite's (2008) article concerned with the impact of the analyst's character on the analysis. These articles will set up our exploration of what the analyst brings to the treatment relationship, and how what the analyst brings influences what happens in the treatment. A suggested article by Bonaminio (2008) provides a contemporary clinical example of how the person of the analyst shapes the process of interpreting and not interpreting, and how the personal factors of the analyst may have a therapeutic or anti-therapeutic effect.

Next, we will move on to discuss countertransference, projective identification, intersubjectivity, enactment and self-disclosure among other topics. As we proceed, we will consider how our participation evolves, what impact it has on the analytic process, and how we work within ourselves and in the interaction with our patients. We will continually try to consider the impact on analytic process and outcome as well as the ethical implications of the differing technical choices and personal stances. In our final class, we will discuss times of difficulty or impasse in analysis, and the analyst's potential contribution to the impasse and possible resolution of that impasse.

Each week there will be two assigned articles and one suggested. The instructors will begin the discussion by presenting what they see as salient in the readings. We ask each participant to think of an anecdote each week that illustrates or addresses an issue in the reading. Also, each candidate will write up one vignette for presentation to the class.

Other than this written vignette, the anecdote does not have to involve a formal presentation and should help us work together as we grapple with the issues.

## **1. September 17: The Analyst's Character and Technique**

**The participant will identify how differences in the analyst's character, manner of relating and analytic technique affect the treatment process.**

We bring our own selves to analysis and this inevitably affects what we do as analysts and the resulting treatment process. In our first class, we will begin thinking about individual style and its impact. Guntrip recounts his two analyses with two analysts with differing personalities, ways of relating, and technique, and he describes how these differences affected his experience and the treatment outcomes. We will discuss character, what Kite sees as “the manifestation of a person's fixed, unconscious personality organization” explicitly. We will follow her as she reviews others' notions of the impact of the analyst's character on the analytic situation. It determines the analyst's style of doing analysis as well as the nature of the interaction between two people. Bonaminio speaks of the “person of the analyst” and the way in which it effects how one tells the story of the patient, and the process of interpretation. In addition, he explores the ways people from various schools have thought of the influence of the individual analyst.

Guntrip, H. (1975). My experience of analysis with Fairbairn and Winnicott. *Int. Rev. Psycho-Anal.* 2:145-156. [PEP Web Link](#)

Kite, J.V. (2008). Ideas of influence: The impact of the analyst's character on the analysis. *Psychoanal. Q.*, 77:1075-1104. [PEP Web Link](#)

Suggested

Bonaminio, V. (2008). The person of the analyst: interpreting, not interpreting, and countertransference. *Psychoanal Q.*, 77:1105-1146. [PEP Web Link](#)

As we read the articles, let us think of a clinical vignette that illustrates an aspect of our individual style and consider its impact on the analytic process

## **2. September 24: Countertransference**

**The participant will identify the various meanings of countertransference and how the concept evolved since Freud's use of the term.**

Countertransference is the particular response of the analyst to the particular patient. For a long time it was discussed with an element of shame, as though the analyst should not react emotionally to the patient. Over the years, the concept of countertransference has been reconsidered, and the potentially positive contributions of the analyst's use of his or

her countertransference have been discussed. Loewald (1986) states that both patient and analyst are subject to transference and countertransference, and focuses on the therapeutic value of the analyst's countertransference. He provides brief clinical vignettes to illustrate his points. Levine (1997), in a more recent paper, uses the term countertransference to refer to "the totality of the analyst's emotional reactions to the patient and the analysis" and contends that the countertransference "is a fundamental, inevitable, and necessary component of the analytic relationship, one that can be conceived of as potentially helpful or potentially obstructive, according to how that experience becomes manifest and is dealt with by the analyst and analyst within the analytic process". Sandler (1976), in a frequently cited article, contends that the analyst's "free-floating responsiveness" to the patient is a crucial component of the useful countertransference, and often the "irrational response" of the analyst to the patient may be regarded as "a compromise formation between his own tendencies and his reflexive acceptance of the role which the patient is forcing on him".

Loewald, H.W. (1986) Transference-countertransference. *J. Amer. Psychoanal. Assn.*, 34:275-287. [PEP Web Link](#)

Levine, H.B. (1997). The Capacity for Countertransference. *Psychoanal. Inq.*, 17:44-68. [PEP Web Link](#)

Suggested:

Sandler, J. (1976). Countertransference and role responsiveness. *Internat. Rev. Psycho-Anal.*, 3:43-47. [PEP Web Link](#)

Our examples can illustrate a countertransference reaction to a patient that was either helpful or obstructive to the analytic process.

### **3. October 1: Projective Identification**

**The participant will identify the occurrence of projective identification in clinical work.**

This week we will consider projective identification, a concept introduced by Melanie Klein in 1946 in her paper, 'Notes on some schizoid mechanisms'. Ogden, building on the ideas of Klein and Winnicott, describes projective identification as a process involving the following three steps or aspects: 1) the projector has a fantasy of projecting a part of himself and putting that aspect of himself into another in a controlling way; 2) the projector exerts pressure on the recipient of the projection via the interpersonal interaction to think, feel, and behave in a manner consistent with the projection; and 3) the recipient processes the projection and makes it available for reinternalization by the projector. Sandler, who was a member of the Contemporary Freudian group of British analysts, provides some thoughts about the history of the concept as well as giving his own view of projective identification. Feldman focuses on the patient's need for the analyst to become involved in the living out of some aspects of the patient's phantasies

reflecting internal object relations, and provides a clinical example. He contends that it is reassuring to the patient if what is experienced in the external world corresponds in some way to an unconscious internal object relationship of the patient.

Ogden, T. (1979). On projective identification. *Int. J. Psycho-Anal.*, 60:357-373. [PEP Web Link](#)

Sandler, J. (1987). The concept of projective identification. *Bulletin of the Anna Freud Centre*, 10:33-49. [PEP Web Link](#)

Suggested

Feldman, M. (1997). Projective identification: the analyst's involvement. *Int. J. Psycho-Anal.*, 78:227-241. [PEP Web Link](#)

For this week, let us identify an occurrence of projective identification in our work with a patient, and consider how we became aware that this was taking place.

#### **4. October 8: Intersubjectivity**

**The participant will identify the similarities and differences between the classical model and technique of psychoanalysis and the intersubjective model and technique.**

Until now we have largely been discussing analysis as a treatment involving two individuals interacting with each other, a classical view. Now we will go to the realm of two subjectivities influencing each other moment to moment, creating a pair that Ogden calls "the third". Dunn offers a critique of the differences and similarities between the classic and intersubjective view, recognizing the risk that idealizing any theory can lead to self-aggrandizement, in which the treatment is no longer for the sake of the patient. Aron emphasizes the importance of the analyst's subjectivity in the patient's mind.

Dunn, J. (1995). Intersubjectivity in psychoanalysis: A critical review. *Int. J. Psycho-Anal.*, 76:723-738. [PEP Web Link](#)

Ogden, T. (1994). The analytic third: Working with intersubjective clinical facts. *Int. J. Psycho-Anal.*, 75:3-20. [PEP Web Link](#)

Suggested:

Aron, L. (1991). The patient's experience of the analyst's subjectivity. *Psychoanal. Dial.*, 1:29-51. [PEP Web Link](#)

This week's example could be about a time we realized that we were caught up in something that was going on between the patient and ourselves.

## 5. October 15: Expressive Uses of Countertransference

**The participant will identify how the expressive use of the countertransference may be used in some analyses to enhance the analysand's understanding of the transference-countertransference dynamics.**

The session is about listening to our inner world as we work. Once we have some sense of our reactions, we can decide how to use that which we become aware of to understand the patient and help the patient understand her/himself. Bollas particularly sees this as a joint venture. Cooper emphasizes the ways in which his process is his own, as he tries to “continually rethink and imagine his or her patient’s affects and conflicts”. Renik feels it is more helpful to be clear about what he thinks without spending as much time wondering about his own reactions.

Bollas, C. (1983). Expressive uses of countertransference – notes to the patient from oneself. *Contemp. Psychoanal.*, 19:1-33. [PEP Web Link](#)

Cooper, S.H. (2008). Privacy, reverie, and the analyst’s ethical imagination. *Psychoanal. Q.*, 77:1045-1073. [PEP Web Link](#)

Suggested:

Renik, O. (1998). Getting real in analysis. *Psychoanal Q.*, 67:566-593. [PEP Web Link](#)

Our example could be about our musings about our own reactions and the process of deciding how to present it to the patient in order to further the aims of the treatment.

## 6. October 22: Self-disclosure

**The participant will identify the potential benefits and hazards in the utilization of self-disclosure in clinical work.**

This week we will focus on the rationale for the use of self-disclosure in an analysis and the impact of self-disclosure on the ensuing analytic process. Different theories possess different views on how change occurs in analysis and present different positions regarding analyst self-disclosure. Bromberg, writing from a postclassical perspective, asserts that self-revelation facilitates the goal of intersubjective negotiation and is a necessary component of effective treatment. Busch, writing from a modern ego psychological perspective, presents principles of modern structural theory that are relevant to considerations regarding the use of self-disclosure and its impact on analytic process. Brody provides a personal account of her deliberations regarding self-

disclosures during an illness as well as her understanding of how her disclosures affected her patients.

Bromberg, P.M. (2006). The analyst's self-revelation: Not just permissible, but necessary. In: *Awakening the Dreamer*. Hillsdale, NJ: The Analytic Press, Chapter 7, pp. 128-150. [Available in [Library](#)]

Busch, F. (1998). Self-disclosure ain't what it's cracked up to be, at least not yet. *Psychoanal. Inq.*, 18:518-529. [PEP Web Link](#)

Suggested:

Brody, S. R. (2013). Entering night country: Reflections on self-disclosure and vulnerability. *Psychoanal Dial.*, 23:45-58. [Available in [Library](#)]

For this week we can think about how self-disclosure fits into our theory of change. The clinical example could involve an instance of self-disclosure, the considerations involved in deciding to disclose, and the impact of the disclosure on the subsequent analytic process.

## 7. October 29: Pressures Towards Enactment

**The participant will identify pressures towards and susceptibilities to enactments, given that participant's particular character and ways of working in analysis.**

This week we will focus on enactments, keeping in mind the ethical as well as treatment implications of our technical choices. Casement describes a clinical sequence involving a patient's request for handholding, his initial openness to the possibility of such action, and his reconsideration after listening to the patient and reflecting on his countertransference. Jacobs focuses on the subtle forms of countertransference that can pervade our listening and responding to patients, and can impact our work in ways that are not easily recognizable. McLaughlin provides a clinical example illustrating the analyst's contributions to enactments, focusing on the reactivated conflicts and technical preferences of the analyst as factors in enactments.

Casement, P.J. (1982). Some pressures on the analyst for physical contact during the re-living of an early trauma. *Internat. Rev. Psycho-Anal.*, 9:279-286. [PEP Web Link](#)

Jacobs, T. (1986). On countertransference enactments. *J.Amer.Psychoanal.Assn.*, 34:289-307. [PEP Web Link](#)

Suggested:

McLaughlin, J.T. (1991). Clinical and theoretical aspects of enactment. *J. Am. Psychoanal Assoc.*, 39:595-614. [PEP Web Link](#)

This week's example could be about our involvement in an enactment of either the dramatic or more subtle sort.

## **8. November 5: Impasses**

### **The participant will identify the analyst's contribution to the development and resolution of impasses in analysis**

In our final class, we will focus on times of difficulty or impasses in analyses and the analyst's contribution to the development and possible resolution of the difficulty. Ferro and Basile discuss the many gradients of the analyst's functioning, focusing in particular on those times when the analyst is having difficulty and how the analyst works through those difficulties. Kantrowitz discusses the analysis and resolution of resistance and transference/counter-transference binds in situations of potential impasse. Both articles stress the importance of self-analysis, especially during periods of difficulty. O'Shaughnessy describes two possible deteriorations of the analytic situation, which she calls 'enclaves' and 'excursions', and provides clinical material to illustrate how she works with each of these potentially problematic situations.

Ferro, A.& Basile, R. (2004). The psychoanalyst as individual: self-analysis and gradients of functioning. *Psychoanal Q.*, 73:659-682. [PEP Web Link](#)

Kantrowitz, J.L. (1993). Impasses in psychoanalysis: overcoming resistance in situations of stalemate. *J. Amer. Psychoanal. Assn.* 41:1021-1050. [PEP Web Link](#)

Suggested:

O'Shaughnessy, E. (1992). Enclaves and Excursions. *Int. J. Psycho-Anal.*, 73:603-611. [PEP Web Link](#)

This week, let us think of a difficult time in a treatment, and how we might have contributed to that difficulty and its resolution or lack of resolution.