Psychotherapy and Psychoanalysis: Fifty Years Later

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Richard Fox began by reviewing the historical antecedents in American psychoanalysis regarding the differences and similarities between psychoanalysis and psychotherapy. He noted that a panel on the same subject was held fifty years ago at the Annual Meeting of the American Psychoanalytic Association (Rangell 1954a; Freud 1954; Stone 1954). A key question centered upon the defining elements of psychoanalysis.

The panelists, who included Leo Stone, Edith Jacobson, and Anna Freud, agreed that a psychoanalytic process is defined by structural change occurring after the development of a transference neurosis. They agreed also that resolution of the transference neurosis by interpretation alone is the primary contributant to therapeutic change in analysis. Because psychotherapy does not entail the resolution of a transference neurosis, its benefits were deemed more modest than those of a full psychoanalytic procedure.

Other elements that that panel viewed as definitive of psychoanalysis included significant regression and the absence of parameters. When parameters had to be employed, it was thought, they should be thoroughly analyzed by the end of the analysis. Patients in psychotherapy were believed to benefit from identification with the therapist, not from interpretation and working through of the transference. Fox underscored that in the 1950s psychoanalysis was deemed the “gold standard of treatment” by most analysts, who relegated psychotherapy to a secondary, inferior role.

Panel held at the Spring Meeting of the American Psychoanalytic Association, Seattle, June 10, 2005.
Panelists: Richard Fox (chair), Rosemary Balsam, Arnold Rothstein, Kenneth Eisold.

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Over the past fifty years significant societal change, as well as numerous developments in theory and technique, have brought changes in the practice of psychoanalysis and psychodynamic psychotherapy. Fox emphasized that analysis as practiced in the 1950s was anchored in structural theory and the metaphors and theory of ego psychology. Unconscious process, regression, and the interpretation of intrapsychic conflict through the vehicle of the transference neurosis held privileged positions in what analysts assumed led to therapeutic improvement, if not cure. At that time interpersonal aspects of the therapeutic process were rarely mentioned, other than as impediments to analytic regression. Consequently, differences rather than similarities between the two modes of treatment were accentuated in mainstream psychoanalytic practice and in the literature. Expectations about what analysis could achieve were high among both analysts and the public.

Fox went on to relate how another series of papers and a panel of the American Psychoanalytic Association (Rangell 1954b; Bibring 1954; Gill 1954; Ludwig 1954; Chassel 1955) were instrumental in joining the debate over the “curative factors” in treatment. While the panelists Leo Rangell, Edward Bibring, and Merton Gill held to the classic notion of transference neurosis, therapeutic regression, and interpretation as the cornerstones that lead ultimately to structural change and improved adaptation in life, Frieda Fromm-Reichmann (1954) and Franz Alexander (1954) challenged that view. In particular, Fromm-Reichmann believed that the interpersonal dimensions of therapeutic technique were being undervalued. She argued for a more inclusive “dynamic psychotherapy” approach that would reach greater numbers of people, including so called “widening-scope” patients. Alexander, stressing his notion of “corrective emotional experience,” joined her in arguing that dyadic aspects of treatment are instrumental in facilitating personal growth.

After this succinct historical overview, Fox elaborated on how the two panels demonstrated the influence of particular personalities who espoused differing theoretical positions that influenced the debate; even then it was hinted that what differentiates the two processes can only be sorted out empirically. Nonetheless, political ferment in the profession (beginning in the 1960s and continuing to the present), along with the introduction of a wide variety of therapeutic techniques and economic changes in the culture at large, has had a major impact on the practice patterns of psychoanalysts. Today the majority of graduates of psychoanalytic institutes report that most of their professional time is spent
practicing psychodynamic psychotherapy rather than psychoanalysis. A significant minority of psychoanalysts have no patients at all in four-to-five-times-weekly psychoanalysis. An updated understanding of what constitutes therapeutic process and cure, and of the similarities and differences between psychoanalysis and psychotherapy, is therefore timely for the field as a whole.

Underscoring that there is today considerable overlap between psychoanalysis and psychodynamic therapy as most practitioners conceive them, Fox opined that clinicians must nonetheless each arrive at their own amalgamation of what constitutes appropriate technique. In order to treat a particular patient, a practitioner must consider factors such as the needs and problems of the patient, treatment goals, and the crucial role of the dyadic relationship. Fox asked the panelists to consider to what extent they believe the similarities and differences between analysis and psychotherapy are qualitative rather than quantitative. Fox asked them also to describe their general philosophy in approaching the choice of analysis or psychotherapy for a given patient. Specifically, what problems or life issues respond more favorably to psychotherapy than to analysis? Are there fundamental differences in technique that they believe differentiate psychoanalysis from psychotherapy in the twenty-first century? Fox hoped that the panelists would be able also to shed light on how technical and theoretical developments in the field over the past half-century have affected how they practice; in the consulting room, what one does is inevitably influenced by what one believes to be the different goals and therapeutic factors in analysis and therapy.

In her presentation, Rosemary Balsam noted that despite much research and discussion, there is still ambiguity about an “evidence base” that would differentiate the efficacy of psychotherapy and psychoanalysis. Concurring with Fox's assessment of the arbitrary delineations—yet noting fifty years ago an overblown confidence in the clear superiority of psychoanalysis—she remarked that research does point to the efficacy of the constructive byproducts of psychoanalytically informed treatments (e.g., catharsis, affect regulation, unburdening the superego, reworking psychic conflict and old traumas, strengthening a resilient self).

Balsam believes that practitioners’ convictions about which form of therapy to advocate are guided consciously and unconsciously by their roots in Freud, their personal analyses, supervisors, teachers, and readings, and all of the “ghosts and ancestors” that constitute their experiences. Both psychoanalysis and therapy have in common that they are part art and craft, part humanism, and part science. The theoretical pluralism that dates from about 1970 in our field has seemingly stemmed from a division in the movement between stricter schools that have followed Freud, and less rigid schools that followed Ferenczi. Balsam compared them to the different artistic styles of craftsmen who train in different workshops, yet yield products of similar functional forms.

For Balsam, the difference between psychoanalysis and psychotherapy is quantitative, but sometimes qualitative as well. “What does psychoanalysis add to psychotherapy?” frames the question as a continuum, she said, so that we can consider the indications for and the process of “conversion” to the more intensive modality. What psychoanalysis adds to psychotherapy is a matter of degree; more time, space, and texture ultimately give the adult additional opportunities in psychoanalysis to reorganize, rework, and transform early experiences. There are subtleties of course. Balsam talked of how one may be involved in a psychoanalysis with an individual, and yet use psychotherapy techniques like psychoeducation or confrontations for ego splitting. One can be engaged in a once-a-week therapy and yet be able to craft a sophisticated interpretation with much benefit.

She also compared the analytic therapist to a portrait painter, whose final product will depend on what medium is best suited to what is commissioned. An analysis would be like a portrait in oils, whereas a therapy resembles a delicate portrait in ink. Although the clinical consideration of a patient’s level of ego integration and capacity for reflection must be taken into account in deciding on a treatment, Balsam noted the importance of pragmatic factors in the life context of the patient. Often the choice of treatment will be dictated by how much time the patient is willing to give to it, as well as by finances and geographical stability. The therapeutic work ultimately will reflect the basic components of the clinician’s flexibility and responsiveness, the patient’s wishes, and the unique style of the analyst as he or she creatively attunes to the needs of the patient in order to craft the final product and foster resumption of growth.

Returning to Fox's historical perspective, Balsam noted that treatments are now being conceived as more “patient-centered” than “treatment-centered.” Notions of “cure” are now antiquated. The clinician...
unfortunately cannot fully predict if an individual will benefit from analysis until a “trial analysis” has taken place, and some psychotherapies can deliberately be undertaken as a prelude to more intensive work. Occasionally the treatment of choice will be clear from the outset. For example, Balsam thinks that psychoanalysis is particularly apposite when patient and analyst identify frequently repeating unconscious patterns that can be unraveled and worked through only very slowly. On the other hand, from her experience working in the student health services at Yale, a short-term therapy experience can often meet strategic developmental needs. While therefore asserting a difference in the two modalities, Balsam maintains that what can be accomplished in psychoanalysis compared with psychotherapy may be subjectively assessable for an individual, but that the question is unanswerable in an objective way as yet, because there are so many variables.

Arnold Rothstein began by saying he is comfortable recommending a trial of analysis as the treatment of choice to most patients who come to him for consultation. He believes that for most human beings psychoanalysis remains the optimal form of therapy. For Rothstein, great value derives when patients are seen more frequently; however, analytic training must be revised in order to help psychoanalysts “welcome the disturbance” into the room. The more often the practitioner is able to see a severely disturbed patient, the more likely it is that the patient will get the help that is needed.

Rothstein segued to another historical change in the past fifty years: the development of the DSM classification system and a growing reliance on it in formulating treatment plans. There is an inherent difference between a psychiatric approach that values a descriptive classification system and a psychoanalytic diagnostic perspective. At the present time, clinicians of all theoretical persuasions and training backgrounds tend to evaluate the manifest contents of a patient's verbalizations. Consequently, we formulate a psychiatric diagnosis based more on our own subjectivity than we may believe. Making a diagnosis is never as “objective” as it may appear to an outsider. Rothstein takes his countertransference responses into account but tends to see them as a co-construction between the participants in the therapeutic relationship. Like Balsam, he believes it is impossible to predict, based on a brief consultative experience, who will and who will not benefit from a trial of psychoanalysis. This is so because countertransference reactions are embedded in our initial treatment recommendations.

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On the other hand, Rothstein does believe that there are some patients best served by a form of treatment other than analysis. Patients with a bona fide Axis I (DSM-IV) diagnosis and patients in the midst of a life crisis are best served, respectively, by a supportive or brief psychotherapy. In either case, once the crisis has abated, many patients can benefit from psychoanalysis if the analyst is capable of embracing the deeper levels of the patient's disturbance. According to Rothstein, more analytic patients would be available to psychoanalytic practitioners if we were more able to listen to and tolerate these deeper levels of emotional pain. In Rothstein's view, psychoanalytic education must be modified to help analysts become more able to tolerate and work through a patient's significant disturbance.

With respect to the goals of analysis, Rothstein believes that the analyst must take into account the actual traumatic events that the patient endured in childhood. These horrific childhood experiences (e.g., incest) must be assimilated by helping the survivor share what has often been denied or profoundly suppressed. Only after repeated reexperience of the actual occurrence can its meaning and the disturbing affects it gives rise to be integrated into the personality, often with profound restorative effects on the individual. Ultimately, Rothstein believes that psychoanalysis helps to reorganize brain function. The most apparent effects of neurobehavioral modulation are the patient's capacity for self-analysis and the ability to work on ongoing infantile sexual conflicts. Rothstein also cited the crucial role of helping patients sort out the influence of unconscious guilt on their lives. For the individual who has undergone significant traumatic experiences, greater frequency is not only better but essential, as it provides more time for these assimilative and integrative capacities to flourish.

Kenneth Eisold, responding to the questions that Fox raised from an historical point of view, suggested that the initial concerns arose fifty years ago as a political issue. Analysts were bent on maintaining the purity of psychoanalysis despite the public clamor at that time for a wider applicability of psychoanalytic ideas. Eisold noted that the debate itself began just a few years after the end of the Second World War. William Menninger, who had been chief psychiatrist in the U.S. Army and was the newly elected president of the American Psychoanalytic Association, proposed that membership be opened to interested physicians and social scientists and that training programs in psychoanalytic psychotherapy be established for psychiatrists and

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other mental health professionals. The association voted down his proposals. When Alexander and French (1947) published their classic text on psychoanalytic psychotherapy, much criticism was directed at the concept of the “corrective emotional experience.” In
point of fact, many psychoanalysts were concerned that psychoanalytic psychotherapy as proposed by Menninger and Alexander would undermine the very structure of psychoanalysis. The heresy continued unabated despite the fact that there was significant sub rosa agreement among psychoanalysts (which has continued to the present) regarding the great overlap of the principles used in analysis and psychodynamic psychotherapy.

Eisold concurs with Rothstein with respect to the importance of framing the issues in terms of what is needed in psychoanalytic education. The key concern driving the issue of training derives from the need of analysts to develop and maintain a practice in an era in which there is much more competition for patients. Citing Otto Kernberg's recent presentations on psychoanalytic training, Eisold noted that the teaching of psychoanalytic therapy in psychoanalytic institutes is realistic and essential for the ongoing viability of psychoanalysis. Indeed, all of the panelists concurred with Eisold's and Fox's point that practitioners from every mental health discipline now seek out psychoanalytic training upon completing of their terminal degrees, having experienced clinical deficits within their training programs. Obviously, this speaks to the continuing need for in-depth psychodynamic psychotherapeutic and psychoanalytic training within the mental health professions.

With respect to the primary goals of treatment, Eisold maintains that it is unquestionably the same for both analysis and therapy: both have the explicit target of relief of psychological suffering. Additionally, achieving insight and exploring actions and hidden motives that undermine individual potential are championed in both forms of treatment. Eisold regrets that as yet psychoanalysis has not achieved one of Freud's major aims—the application of its principles to government, communities, schools, and organizations. Aspects of psychoanalysis (e.g., the uncovering and exploring of hidden motives and actions) are relevant to many areas of a democracy, and expanding outreach of the discipline to the wider world would help its practitioners begin to answer on a more scientific basis some of the questions posed to the panel. Echoing Balsam, Eisold emphasized the lack of scientific data to help us resolve the important questions Fox had posed.

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Finally, Eisold outlined the advantages and disadvantages of greater frequency, underscoring again the political nature of the question. Admitting the paucity of empirical data on the subject, he described a patient who made profound changes that he believes would not have been possible had he not been trained in the analytic method and its requirement of more frequent meetings. For Eisold, the advantages of the method include (1) greater time for reflection and exploration as opposed to merely reporting events; (2) the development of a more meaningful relationship between patient and therapist; and (3) greater relaxation for the therapist. By raising the last point, Eisold appeared to suggest that it benefits the patient for the analyst to have sufficient emotional and cognitive space to develop interpretations and stay emotionally close to the material. The disadvantages of intensive treatment can include (1) disruption in the patient's life in terms of time and money and (2) the patient's fear of greater intimacy, which may make him feel less safe.

Eisold believes that as analysts we are on firmer ethical ground when we can make a compelling rationale for the time and expense involved in the treatment. He noted that greater pressures in our society, increasing demands for work-related travel, and the nature of an economically competitive, demanding, commodity-oriented society require that the cost of psychoanalysis in time and money be justified on both clinical and ethical grounds.

From the audience Scott Dowling commented that psychoanalysis has an etiology-based diagnostic system that needs to be taken into consideration in making treatment recommendations. The panel generally concurred with this point, while noting that the DSM system can be an impediment to understanding the patient's world. Balsam recalled Lawrence Friedman's 2004 Freud Anniversary Lecture (Friedman 2006), in which he opined that it would be a great pity to lose analysis before we know what it does or does not do. Eisold remarked that regardless of professional discipline, each analyst is a part of the medical profession because psychotherapy is a treatment procedure. We must accept that diagnosis is part of our world, even as it slices up human behaviors in ways that can be stigmatizing and limiting. He wondered about the risks and benefits of taking a stance away from a medical diagnosis to form our own, analytic diagnosis, as Rothstein suggested we do. Fox remarked that the DSM format may be inhibiting in understanding our patients more fully from a dynamic perspective.

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Norbert Freedman commented that German and Swedish studies have revealed that at one to two years after termination, there is little difference between patients who undergo psychodynamic psychotherapy or psychoanalysis. However, at three or more years after termination, differences between the two treatment methods emerge. Psychoanalytic research of this kind is essential in helping us determine which patients will have difficulties internalizing a four-times-weekly process.
Irwin Rosen recalled how William Menninger's suggestions were rejected in New York but not in Topeka. In the Menninger School of Psychiatry and Mental Health Sciences, there was instruction in psychoanalytic psychotherapy for all mental health disciplines. The watchword in the training programs was “Keep the analytic therapy as analytic as you can.”

Jane Hall mentioned her book Deepening the Treatment (1998) and opined that when we give the patient a kind of listening they have never had, they want more of it. Attitudes in the analytic profession must change. In addition to our respect for our patients, we must value our own ears so that we can listen as thoroughly and thoughtfully as possible. Balsam remarked that this point of view is in keeping with her patient-centered approach. We must always keep in mind that what the patient wants to experience may be quite different from the aims of the analyst. While the analyst wants to know how the mind works, the analysand wants lasting relief. Rothstein echoed this point, underscoring that the experience of being listened to and being with the analyst usually becomes a revolutionary experience in the life of the patient. He noted that the suicide rate is high among psychiatrists but low among analysts, perhaps reflecting the generativity through listening and understanding that is experienced by both participants in the analyst-patient dyad.

Eisold remarked that, following Wallerstein (1992), we should continue to speak of “psychoanalyses and psychotherapies,” reflecting the plurality and diversity in our field. He underscored that his analytic training has allowed him to do the work that he does, including less intensive psychotherapies, which can also be life-transforming for a given patient. Fox echoed this perspective, saying that we must always adapt ourselves to the patient's need. The therapist is a new object who corrects for an old object. Duration of treatment may be as important a subject to research as the choice between therapy or analysis.

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