Psychotherapy with Psychotherapists

Psychoanalytic Treatment for Therapists, Residents, and Other Trainees

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PSYCHOANALYTIC TREATMENT FOR THERAPISTS, RESIDENTS, AND OTHER TRAINEES

Samuel Greenberg, M.D.
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At the outset, let us briefly explain what we mean by psychoanalytic therapy (and recommend the reader to primary sources for a full articulation of the various theoretical foundations and perspectives in *The Collected Papers of Sigmund Freud* and the writings of Jung, Adler, Horney, Sullivan, Abraham, Greenson, Lang, and other more recent theoretician-therapists). There is no official definition of psychoanalysis. Many years ago a committee was appointed by the American Psychoanalytic Association to formulate a definition for use by that group. This committee struggled for several years, but could not decide on a definition that was acceptable. Nonetheless, it is generally agreed that psychoanalysis is a form of psychotherapy that concerns itself with the analysis of resistance and transference (Brenner, 1982). Its methodology involves free association, the interpretation of dreams and slips of the tongue, and seeking to bring about the return of repressed material by making the unconscious conscious (Waelder, 1964). For followers of the classical tradition, it means four sessions per week and the use of the couch by the patient. Classical analysts do not consider any other treatment to be analysis, but rather would label it analytically oriented

psychotherapy.

For the neo-Freudians or culturalists, therapy three times a week, with the patient sitting up, also constitutes analysis. There continues to be a great deal of discussion regarding the boundary line between psychoanalysis and analytically oriented therapy. Some feel that the boundary between the two is sharp; others feel that it is blurred. A good overview of the problem was presented by Paolino (1981) in a recent article.

We believe that there is no sharp dichotomy and use the terms psychoanalysis, psychoanalytic therapy, and analytically oriented psychotherapy interchangeably. Our views are quite similar to those Portnoy articulated in the second edition of the *American Handbook of Psychiatry* (Portnoy, 1974). It is an uncovering form of therapy that takes place in the matrix of a unique and evolving relationship between the patient and the therapist. The goal is to bring about a basic and long-term change in the direction and quality of a person's life; to shift his or her energies from maintaining the neurotic system to healthy self-realization. "It is a reorientation through self-knowledge" (Horney, 1950). Overcoming resistances that prevent insight from emerging and the analysis of transference are the essential processes involved. Assessing the pattern of the patient's relationship to the analyst eventually constitutes the most important area for developing insight. The emphasis on analysis of the

relationship should be primarily on the "here and now" rather than on the patient's distant past. We agree with Gill (1982) that if this is done, "analytic technique should be applicable over a broader range of settings, whether gauged by frequency of sessions, use of couch or chair, type of patient or experience of the therapist, than is usually considered possible." It is essentially a long-term therapy, but some shorter therapies, or time-limited therapies, may use analytic principles (Kadis & Markowitz, 1972). Restructuring of the personality is frequently one of the goals.

Mental health professionals are, for the most part, consistent. They practice what they preach. When they have problems in living, significant degrees of anxiety or depression, or other neurotic symptoms, they seek help from highly respected colleagues. Some go from the role of the therapist to the role of the patient quite easily and are not obstructed by feeling that there is a stigma attached to or a weakness of character evidenced by seeking therapeutic help. Their attitude is the same as for friends and neighbors who ask what to do about crises or neurotic problems: they suggest they commence therapy. They believe in what they are doing and they perceive therapy as a constructive measure that not only relieves symptoms but also leads to personal growth. Others who are more ambivalent about their chosen profession and do not wish to risk self-disclosure to an analyst will shy away from therapy and rationalize their decision.

THE THERAPIST AS PATIENT

Mental health professionals have several advantages over lay people when they enter therapy. They know which therapists are available in the community and so can make a better choice. They are familiar with the various schools of psychoanalytic thought and can choose a therapist with a compatible frame of reference—a classical Freudian, Jungian, Sullivanian, Horneyan, or Kleinian, among others—with whom they anticipate they will be able to establish a therapeutic alliance. Another advantage is that they know what the therapy process is likely to be and are better prepared for its vicissitudes. Almost always, they are intelligent and verbal. [editor's note: See N. Kaslow and Friedman, Chapter 3, for more on the "ideal" patient.] For all these reasons, therapy is likely to start off well and end well, although there may be some precarious and despairing phases during the course of the analysis. Some know that no analysis is ever complete, and they set more reasonable goals for themselves. When these are achieved, they end with a feeling of accomplishment. Many therapists make "good" patients. Others who are perfectionistic and/or narcissistic may be chronically disgruntled and have great difficulty working through their resistance and giving up such defense mechanisms as denial, projection, and repression (A. Freud, 1971). Nothing involving human beings is simple, and analysis is indeed a complex process.

Although most clinicians probably fall in the "normal-neurotic" range, our ranks also include schizophrenics, borderline, and psychopathic personalities. These are always difficult patients to treat, and this is especially so when their clinical knowledge is used to reinforce their already formidable resistance. They may be highly manipulative, and the analyst may be especially vulnerable to their maneuvers, because he or she often tries to do even more for therapist-patients than for others. In our experience, it is valuable for the therapist to be clear about this and insist on treating them like any other patients. The therapist will have to set very firm guidelines and say to such patients, in effect, "You will be treated like all other patients, the fees will be my customary ones, and missed sessions will be paid for. I shall not intervene in any legal proceedings or appear before any boards on your behalf. If this is satisfactory then we can proceed." These patients can be quite destructive of the relationship unless dealt with firmly. Competitive strivings and boundary issues may also need to be addressed and worked through.

THE THERAPISTS' THERAPIST

In all fields there are special individuals who are sought out by their colleagues when they need help. There are lawyers' lawyers and doctors' doctors. And there are also therapists' therapists. These are people who have distinguished themselves by publications, lectures, and academic and

clinical achievements. They enjoy a fine reputation among their colleagues. They find that their colleagues make interesting and rewarding patients and are pleased to be sought out by them. They like the idea that they may be having a favorable influence, not only on their patients, but on their patients' patients.

In the treatment of other mental health professionals, an interesting issue comes up: when is it treatment and when is it education or quasi-supervision (Kaslow, 1972)? In all fields of medicine, patients are educated to deal more effectively with their illness, whatever the ailment. However, in no field of medicine is treatment of such educational value as in psychoanalysis. This has long been acknowledged, and an extensive personal analysis is a required part of the curriculum of all recognized analytic institutes. Beginning with Freud himself, all of the psychoanalytic pioneers attracted psychiatrists and other clinicians, who came for treatment. They often went on to become distinguished analysts in their own right. The reverse holds true in that the therapist may feel that some colleagues are not suitable therapists, and this creates a dilemma, which we discuss further on in this chapter.

Until fairly recently only the largest cities had psychoanalytic institutes and an abundance of well-trained therapists. New York City, for example, has six analytic institutes and also many other centers for postgraduate

education. It therefore has hundreds of outstanding therapists available to other mental health professionals. Boston, Chicago, Los Angeles, Philadelphia, and other large cities are similarly well endowed. This has not always been true for many medium-sized cities. Not so many years ago, Miami had only one qualified analyst in the city, and almost half the psychiatrists in town were analyzed by him. This condition has changed a great deal in the last decade, and there are now 400 psychiatrists and a psychoanalytic society and institute in Miami. In the past decade, the geographic distribution of analysts has improved, and even many small cities now have competent analysts.

Although some therapists like to treat their colleagues, others avoid doing so. There are often complications in treating other mental health professionals. The therapist-patient may be involved in legal proceedings, divorce and custody battles, and problems involving hospital staffs or boards of medical or psychological examiners. The analyst recognizes that such a patient will require more than treatment, that he or she wants an advocate as much as a therapist. These patients may involve the therapist in court hearings, depositions, or appearances before boards. All this is disruptive of a busy practice and may be alien to his or her concept of what an analyst should be and do.

There are many times and circumstances when prominent analysts are

under pressure to accept a colleague as a patient. For example, a psychiatric resident may begin to act in a bizarre way; this comes to the attention of the chairman of the department, who then requests a faculty colleague to see the resident. Or the president of a county medical society may request that the analyst see some practitioner who has been accused of making sexual overtures to patients. It is a wise therapist who is not pressured into accepting a patient with whom he or she is likely to be uncomfortable or to form a negative countertransference. Fortunately, there are psychiatrists who do not mind court appearances or media publicity, and they may do well with such patients, finding them particularly interesting and challenging.

THE PSYCHIATRIC RESIDENT

Unfortunately, there is some truth to the degrading joke, "You don't have to be crazy to be a psychiatrist, but it helps." There is a higher incidence of suicide among psychiatrists than among other medical specialists. It is also true that some clinicians are interested in this field because they hope that in pursuing it they will come to understand or resolve some personal problems. Many plan on psychoanalysis for therapeutic as well as educational objectives. There are, however, some psychotherapists who are not conscious of their problems, or the extent of them, until they are triggered by exposure to psychiatric patients. It is well known that medical

students and nurses are often disturbed by exposure to psychiatric patients. Some may leave the field as a result; others decide to get personal therapy and stay in the field. It is natural for some psychiatric residents to turn to a member of the attending staff or the faculty of the medical center where they are in training for assistance in exploring their inner world of fears, desires, pent up anger, sexual longings, confusion, ambivalences, etc. But others seek out someone at a distance, preferring to travel far and feel safe with an analyst not involved in their training program.

Older colleagues are usually quite sympathetic to these problems and are ready to provide help. If it is an acute disturbance, supportive therapy and not psychoanalysis is indicated at first. If, however, it is a long-standing personality disorder that has been stirred up, then psychoanalysis may well be the treatment of choice. If the medical center is in a fairly large city, there will be many analysts available. The resident will then become another regular patient. He or she will visit the analyst's private office, pay a fee that they agree upon, and in all ways become an ordinary patient. His or her privacy is safeguarded in all respects. If the medical center is in a small city, all the competent therapists may be members of the faculty, and their offices may be in the teaching hospital. It may be impossible to provide real privacy in these circumstances. It could be awkward for the patient to visit the therapist where secretaries and colleagues note the regular visits and infer that he or she is coming for treatment. To some residents this may present

no problem, but to others it may be so distressing that the therapy is terminated soon.

There are other complications when the resident is being treated by a member of the faculty. The resident may hear tales about the therapist and may know a great deal about him or her from lectures, publications, and writings. This may be a hindrance to free association and full self-disclosure and may make the course of therapy more difficult, since it complicates the transference.

The reverse side is that the therapist may find current and former patients in the audience when giving lectures or participating in seminars or conferences. We have each spoken to groups of residents that included former and current patients. When this occurs one is very conscious, during the course of the presentation, of the process of therapy with these patients, and this awareness may result in some constraint to avoid certain topics and clinical illustrations because of the effect it might have on them.

The resident in treatment with a faculty member may be concerned that some slippage will occur and that material conveyed in a therapy hour will be utilized inadvertently in the therapist's evaluation of the resident for continuing in the residency program or for candidacy for an analytic institute. This suspicion must be considered legitimate, explored fully, and

ultimately laid to rest.

CANDIDATES OF PSYCHOANALYTIC INSTITUTES

At one time only psychiatrists were accepted as candidates by most institutes. This is no longer true, and members of several disciplines in the field of mental health may now be considered for enrollment in most institutes. All recognized institutes require candidates to undergo an extensive personal analysis, called the training analysis, as part of the curriculum. Candidates are given a list of approved training analysts and must pick one acceptable to that particular institute. Usually a minimum number of hours, approximately 500-700, is required. The analysis, however, may be prolonged far beyond the minimum, when indicated. Most of the time this requirement causes no severe problem. The candidate usually picks an institute that he or she respects and looks forward, albeit ambivalently, to the experience of a training analysis with an outstanding analyst. Often he or she may be charged a reduced fee. Most of the time this arrangement works out well, and the candidate feels that he or she is getting excellent training in the field of choice. Although analysis is costly and time consuming, there is rarely any question about whether the analyst is prolonging the analysis unnecessarily.

The analyst is not only the patient's therapist but usually is also a

member of the faculty of the institute and often an important figure in the psychiatric community in which the patient may want to practice. The candidate desires the approval of this analyst since it may be extremely important to his or her career. There may come a time when the candidate feels fully analyzed, but the therapist feels that the process should continue. The analysand may not feel free to speak up. By then, he or she has made a major investment in time and money, and certification by the institute is of great importance. He or she may then feel trapped and "a captive patient" until freed by the analyst. Greenson (1967) has mentioned that some of his patients, who are candidates, do not express anger or hostility to him. Instead, however, they are often very critical and hostile to other members of the institute, and/or to certain courses. This negative transference is displaced from the therapist to other targets that are not so vital to the candidate. For the analysis to proceed, the resistance to the awareness of the transference must be dealt with, and candidate and analyst must become more fully cognizant of the subject's feelings. Well-trained analysts are aware of this; when these resistances occur, they can successfully analyze them.

TRANSFERENCE AND COUNTERTRANSFERENCE

Classical analysis proceeds best when the patient knows little about the therapist as a person. The therapist is then a neutral and objective observer,

and the patient can begin to express himself or herself freely, seeing the analyst as a blank screen on which to safely project feelings and thoughts. In so doing the patient can transfer past attitudes onto the person of the therapist (Little, 1981). It is also preferable for the therapist to start off knowing little about the patient so that the treatment can be conducted in the customary detached and rational manner. The therapist who is free of any preconceived ideas is more readily able to listen to the patient with nonjudgmental acceptance. Most therapists prefer to be personally anonymous to the patient, and they limit their contacts with patients to the office. Here the analyst can observe everything that goes on between them and conduct therapy in the accustomed way, sitting behind the head of the person lying outstretched on the couch. Illustrative of the patient's need to perceive the analyst as he or she wishes is an incident author Samuel Greenberg (S.G.) remembers when a patient saw him in the lobby of his office building. At the next session the patient said, "I never realized how short you were. In the office I see you as seven feet tall." Of course, this had to be analyzed at the appropriate time.

A special dilemma is posed when the analysand is a resident or colleague who has personal contact with the analyst, a fairly frequent occurrence in small communities with residency training programs and a paucity of analysts not affiliated with the department. When patient and therapist are in the same field, inevitably their paths will cross. They will

happen upon each other on many occasions outside the office, at conferences, seminars, lectures, parties, and concerts. There is also the likelihood that they will hear about each other through colleagues' conversation and gossip may travel far. Many therapists may prefer to be the observers and not the observed. They want to be able to control what they wish to reveal about themselves and when and to whom they choose to do this. Sometimes what the patient hears may interfere with the process of therapy. He or she may hear criticism of the "beloved" analyst at a seminar, or criticism of theories or publications. The therapist's private life may be discussed by others, and what the analysand hears may hinder the transference. Some analysts do get divorced, and some are sued by patients. They experience the gamut of difficulties that all human beings encounter. The first seminar that S.G. attended where his training analyst was serving as cochairman was somewhat disconcerting for him. For the first time, he was not listening exclusively to his analyst but to eight others as well. Also, the cochairman was not as deferential to the "great man" as S.G. thought he should have been. This had a disturbing effect on S.G. Similarly, author Florence Kaslow (F.K.) was disconcerted the first time she saw her analyst at a professional organization social event with his wife. Seeing him in his other real life-role being attentive to someone else made him seem less totally available and receptive to her.

As mentioned earlier, education and therapy overlap. A patient may, on

occasion, state that he or she was "trained" by the therapist. Although we have felt satisfied with the progress and reactions of most of our therapist-patients, there are some who caused much consternation by their misrepresentation to others of our role-relationship. There was a social worker, in treatment with S.G. rather briefly, who went around broadcasting instead that she was trained by him. She did some bizarre things in therapy, but he could not set the record straight without disclosing privileged and confidential material. Quite recently F.K. had a psychiatrist enter psychoanalytically oriented treatment with her. After three sessions, he said that since he had recently begun private practice, he had no medical insurance coverage plan, but he could deduct the sessions as "educational" if he were billed for supervision. They had to deal with the role confusion, and how this would hamper the development of the transference, as well as with the ethical dilemma he was posing for both of them as he sought to manipulate the relationship for financial gain, F.K.'s refusal to accede to the request led them into his characteristic personality style of seeking to control and getting angry when anyone, especially a woman, did not acquiesce to his charmingly presented demand. Particularly in a training environment, one must be careful to keep the lines between therapy, supervision, consultation, friendship, and mentorship clear (Kaslow, 1972; Abroms, 1977). Not to do so is to confuse and render a disservice to analyst, patient, and supervisee alike. In light of all of the foregoing, it is less

surprising to recall that Sigmund Freud would not accept Wilhelm Reich as a patient and that Reich harbored a great deal of resentment toward Freud for this.

When patients living in the same locale are mental health professionals, they are also colleagues and even competitors. Consider, for example, the case of a prominent analyst in New York City who was regularly upset whenever he heard that one of his former analysands was charging higher fees than he was. Many professors experience similar turmoil when former residents earn more or become more prominent than they. At one time, there was a psychiatric resident in treatment with S.G. who frequently asked to borrow books that the latter had in his office. If he were an ordinary patient S.G. would have been confident in assenting or refusing, depending on the appropriateness of the request. However, as he was a younger colleague, S.G. did lend him some books. The patient sensed the ambivalence and exploited it, keeping the books longer than he was supposed to, and returning them a little worse for wear. In time, both patient and analyst's behavior were analyzed.

SUMMARY AND FINAL COMMENTS

We have tried to cover some of the main benefits and pitfalls of treating one's colleagues. Many of them make interesting and stimulating patients;

others engender feelings of uneasiness and make one feel manipulated and perhaps exploited. Unethical behavior may surface, and this invariably poses a tremendous dilemma. It needs to be dealt with as part of the behavior being analyzed. Boundary issues and the kind of therapeutic alliance that can be established in the context of an often enmeshed department of psychiatry and/or psychology have been addressed.

It seems arbitrary and often unworkable when analytic societies and institutes, particularly in small communities, forbid any contact outside the therapy hour. It is not unheard of for analyst and patient to meet unintentionally at a small dinner party and have to decide which one will leave. Everyone present is likely to figure out the relationship, so that confidentiality may be more impaired by the exit than by both remaining and keeping their contact superficial. Also, the possible rudeness to the host and hostess must be considered since therapy must be part of a real life that does not go "on hold" for the duration of the treatment process. Conversely, frequent or intense contact outside the sanctuary of the analyst's office mitigates the specialness of the treatment alliance and the benefits of classical analysis to be derived from analyzing a transference relationship. Thus it may be that didactic analyses and treatment of one's own colleagues for more distinctly therapeutic reasons is simultaneously a privilege, an honor, and a relationship fraught with potential challenges and subtle difficulties.

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EDITOR'S COMMENTARY
WHEN THE THERAPIST SEEKS ANALYSIS

Florence Kaslow Ph.D.

No doubt, in some quarters, therapists feel that unless they have been analyzed, they haven't really gone through proper therapy. This attitude is likely to be most prevalent in communities that have a large psychoanalytic cadre that promulgates this version about the best of all possible therapies. Anyone who goes into brief therapy or even longer therapies that are not psychoanalytic in nature may feel pressured about not having sufficiently restructured his or her personality or not having developed adequate insight —whatever that may constitute.

Thus, students in programs with an analytic orientation are likely to gravitate toward analysis. So, too, there are graduate therapists who feel that perhaps they have missed an essential experience or that they haven't delved sufficiently into their unconscious to be able to function at their peak ability. There continues to be a realistic attitude that psychoanalysis is the treatment of choice for certain kinds of dysfunctions and as a training technique for some therapists. There is also perhaps a glamourized image of psychoanalysis as the panacea for all. In this chapter, there is agreement with the first statement and not the second.

The cost of analysis is likely to be far greater than the cost of any other

therapy. This economic issue is raised here, although it is not addressed in terms of specific figures. No price tag can be put on any therapy because there is tremendous variation in different regions and communities throughout the country and because of analysts' varying skills and reputations.

In this chapter, as in several of the others, the salient issue of dual relationships is addressed. It is important that this be considered in light of the ethical principles promulgated by some of the professions. In the American Psychological Association's 1981 revision of its Ethical Principles, Principle 6 (which deals with "welfare of the consumer") highlights a stance on this issue. It states:

> Psychologists are continually cognizant of their own needs and of their own potentially influential position vis-a-vis persons such as clients, students, and subordinates. They avoid exploiting the trust and dependency of such persons. Psychologists make every effort to avoid dual relationships which could impair their professional judgment or increase the risk of exploitation. Examples of such dual relationships include but are not limited to research with and treatment of employees, students, supervisees, close friends.

Some of the chapters indicate that actual practice is somewhat different from what is espoused in this principle. We raise here the dilemma which this points to particularly in small communities where the paucity of available resources sets up the context for dual and multiple relationships. It is perhaps easiest to pick this up where there is least contradiction to the

principle in psychoanalysis, where there is greatest clarity about keeping the relationship uncontaminated. Nonetheless, even here one could push it to the extreme and then find that the analyst must see therapist/patients at professional and staff meetings. One hopes that we can keep the roles separate without becoming so arbitrary that people can't even be in the same room at a professional meeting or social event to which they have both been invited without knowledge that the other would also be in attendance. More attention needs to be paid to where normal, overlapping relationships end and complex, unwise dual relationships begin so that therapists, supervisors, and professors do not find themselves inadvertently and with all good intention violating the above principle.