

## Psychoanalysis and Psychoanalytic Psychotherapy: Is There a Meaningful Distinction in the Process?

James L. Fosshage, PhD

*National Institute for the Psychotherapies, New York City*

The pluralism in models of development, pathogenesis, and technique and the expansion of the applicability of treatment that characterizes the current psychoanalytic scene further erode the traditional criteria for psychoanalysis and the long-standing but increasingly fragile distinction between psychoanalysis and psychoanalytic psychotherapy. The purpose of this article is to delineate general features of the psychoanalytic process that are more encompassing of contemporary theoretical models and to use these features as criteria to explore if a meaningful distinction can be made between psychoanalysis and psychoanalytic psychotherapy. Following a brief historical review of the literature, I reassess on the basis of theory, research, and practice the so-called extrinsic and intrinsic criteria for psychoanalysis, and I conclude, from today's perspective, that a meaningful distinction with psychoanalytic psychotherapy cannot be made. I then arrive at what, in my view, are the fundamental features of the psychoanalytic process that can include all psychoanalytic approaches.

The pluralism in models of development, pathogenesis, and technique and the expansion of the applicability of treatment that characterizes the current psychoanalytic scene further erode the traditional criteria for psychoanalysis and the long-standing but increasingly fragile distinction between psychoanalysis and psychoanalytic psychotherapy. The criteria for assessing a psychoanalytic process continue to change, and it has become clear that the pluralism of models can only be housed under a most general definition of psychoanalysis. As more theory-based specificity is introduced into the definition of psychoanalysis, the definition becomes more exclusive and parochial, and, therein, potentially more politicized and less useful in reflecting accurately how psychoanalysis is practiced. With an

unachieved consensus on the most general criteria for psychoanalysis, it becomes even more difficult to approach the question as to a meaningful distinction between psychoanalysis and psychoanalytic psychotherapy.

With these limitations notwithstanding, the purpose of this article is to delineate general features of the psychoanalytic process that are more encompassing of contemporary theoretical models and to use these features as criteria to explore if a meaningful distinction can be made between psychoanalysis and psychoanalytic psychotherapy. I first present a brief historical review of the literature with regard to the criteria used for differentiating psychoanalysis and psychoanalytic psychotherapy. On the basis of theory, research, and practice, I reassess, from today's perspective, the so-called extrinsic and intrinsic criteria for psychoanalysis to determine if a meaningful distinction with psychoanalytic psychotherapy can be made. I then arrive at what, in my view, are the fundamental features of the psychoanalytic process that can include all psychoanalytic approaches.

#### HISTORICAL REVIEW OF THE DISTINCTION BETWEEN PSYCHOANALYSIS AND PSYCHOANALYTIC PSYCHOTHERAPY

The distinction between psychoanalysis and psychodynamic psychotherapy, later referred to also as psychoanalytic psychotherapy, principally occurred in the United States beginning in the mid-1940s (see Wallerstein, 1989). Robert Knight (1945/1972, 1952) led the way in developing a "dynamic psychology" based on the scientific contributions of psychoanalysis. He differentiated between two groups of psychotherapy—those aimed primarily at the *support* of the patient with suppression of erupting material and those aimed at *expression*. This became a general criterion for the distinction between psychodynamic psychotherapy and psychoanalysis. Supportive psychotherapy was the treatment of choice for those patients with the more severe psychopathology, and expressive psychotherapy or psychoanalysis was utilized for the neurotic patients who had the ego strengths to undergo structural or characterological change.

As pointed out by Wallerstein (1989) in his excellent review of these developments, Gill (1954), Rangell (1954), and Stone (1951, 1954) were the principle protagonists in the 1950s in defining psychoanalysis and distinguishing it from psychoanalytic psychotherapy. It was Gill's (1954) statement that was the most often quoted: "Psychoanalysis is that technique which, employed by a neutral analyst, results in the development of a regressive transference neurosis and the ultimate resolution of this neurosis by techniques of interpretation alone" (p. 775). The treatment of choice for Gill (1951) revolved around the "gross major decision [as to] whether the defenses of the ego are to be strengthened or broken through as a preliminary toward a reintegration of the ego" (p. 63), a decision based on whether

it was necessary and safe. Supportive psychotherapy became the treatment of choice for those patients too ill for analysis (Stone, 1954) and whose egos were unable to withstand the stresses of analysis (Gill, 1951). Rangell (1954) differentiated the two approaches technically on the basis of interpretation versus interaction. Bibring (1954) delineated five distinct technical principles: suggestion, abreaction, manipulation (i.e., a redirection of the emotional systems of the patient possibly through exposing the patient to novel experiences or "learning by experience"), insight through clarification (i.e., enhancing self-awareness in the absence of resistance), and insight through interpretation. Psychotherapies, including psychoanalysis, could be classified on the basis of their relative use of these principles, individually and in combination.

Twenty-five years later, in 1979, Gill, Rangell and Stone were invited to a symposium to update their views on the topic "Psychoanalysis and Psychotherapy: Similarities and Differences: A 25-Year Perspective." Although Stone's (1982) views remained relatively unchanged, he added a new dimension involving the nature of interpretation that occurs in each treatment. In psychoanalysis, interpretation, according to Stone, is focused on the transference neurosis; in psychoanalytic psychotherapy, interpretation is focused on the patient's current conflict and the relationship of such conflict to actual objects.

Of the three, Gill (1984a) had changed the most in his views. His work on transference led to his view that the interpretation of transference is *the* criterion for psychoanalysis. What is uniquely psychoanalytic, for Gill, is the interpretation of transference in the here-and-now. Gill (1984a) reviewed the "intrinsic criteria" for psychoanalysis, the same as set forth in his 1954 article: "the centrality of the analysis of transference, a neutral analyst, the induction of a regressive transference neurosis and the resolution of that neurosis by techniques of interpretation alone, or at least mainly by interpretation" (p. 161). He then assessed the "extrinsic criteria," which are "frequent sessions, the couch, a relatively well integrated patient, that is one who is considered analyzable, and a fully trained psychoanalyst" (p. 161). He concluded that none of the extrinsic criteria can validly delimit a psychoanalytic process, for "no universal meaning of any aspect of the analytic setting may be taken for granted" (p. 174). For example, "while the couch is ordinarily considered to be conducive to regression, it may enable an isolation from the relationship which has a contrary effect" (p. 174). Addressing the meanings frequency of sessions might have, Gill (1984a) stated:

It would seem obvious that one can accomplish more with greater frequency simply because there is more time to work. But if greater frequency is frightening to a particular patient, frequent sessions may impede the work despite interpretation. One cannot simply assume that more is better. ... Some take to it like a duck to water and can work despite infrequent sessions, while others never seem to find it congenial." (p. 174)

Gill's (1984a) overall emphasis is to "sharply narrow the indications for psychoanalytic psychotherapy and primarily practice psychoanalysis" (p. 163) with its centrality on the analysis of transference. Reacting to Gill's singular emphasis on the analysis of transference, Rangell (1981) called for a more balanced perspective, emphasizing that analysis of transference, although central, was not sufficient. He stated

The analyst hovers, equidistant not only from the three psychic structures but between intrapsychic and interpersonal, the internal and external world, past and present, transference and original objects. ... If a patient relates only to the analyst, or to external objects and not the transference figure, or if he speaks of the past and not the present, or only about sex, or only the deep unconscious without the daily and trivial, the needle has become stuck and needs a tap. (p. 678)

On the basis of his experience, Rangell asserted that

there is no analysis without its share of each of the technical maneuvers noted by Bibring (1954) [i.e. suggestion, abreaction, manipulation and clarification, along with interpretation]. ... There is no analysis without some of these mechanisms, which are not inadvertent but built-in and by design. (pp. 670-671)

His distinction between psychoanalysis and psychoanalytic psychotherapy became a quantitative rather than a qualitative difference—that is, it is based on the proportionality of these technical interventions with psychoanalysis involving more interpretive interventions.

## RESEARCH FINDINGS

The most comprehensive and influential empirical study that has focused on the question of differences among treatment approaches with regard to interventions and therapeutic change is the Menninger Research Project, a longitudinal investigation of psychotherapeutic treatment along the entire expressive/supportive spectrum. Specifically, the study differentiated three treatment modalities: psychoanalysis, expressive psychoanalytic psychotherapy (what they called the "intermediate" form), and supportive psychoanalytic psychotherapy. Robert Wallerstein (1986) wrote up this project in *Forty-Two Patient Lives* (a massive volume of 800 pages), with a summary article in 1988.

In sharp contrast to prevailing psychoanalytic theory, the research team found that structural change cannot be linked to interpretation alone, for it occurred both in psychoanalysis and the more supportive therapies as well. On the basis of these findings, Wallerstein (1989) strongly questioned the usefulness of attempting "to link the kind of change so tightly to the intervention mode" (p. 587). According to

their research findings, "therapeutically induced change is at least proportional to the degree of achieved conflict resolution—though it is clear that there can be significantly more change than there is true intrapsychic conflict resolution, change brought about by all the varying supportive [measures]" (p. 587). Indeed, effective conflict resolution "turned out *not* to be necessary to therapeutic change." Many changes were brought about by the supportive therapies which in many instances were "quite indistinguishable" from the change brought about through insight. Supportive interventions tended to produce change—far more than was anticipated—and tended to be incorporated, with similar effectiveness, in the psychoanalyses and the more expressive psychotherapies. This study directly challenges the following traditional beliefs about psychoanalysis: (a) Structural change is brought about only through interpretation, working through, and insight; (b) structural change is brought about solely through conflict resolution; (c) supportive measures do not bring about structural change; (d) change brought about by supportive measures does not involve structural change and is, therefore, not as lasting; and, finally, (e) supportive measures do not occur within psychoanalysis.

These research findings support Rangell's claims that *all* of the technical measures are used in both psychoanalytic psychotherapy and psychoanalysis. Moreover, *all* of these technical measures are a source of therapeutic action in both psychoanalytic psychotherapy and psychoanalysis. These empirical findings, in conjunction with close readings of detailed clinical work (not easily found in our psychoanalytic literature, yet readily available in supervisory consultations), make it clear that our theory of technique in psychoanalysis has been far too narrow and has not included many of the facilitative interventions that occur in psychoanalysis as practiced. Indeed, I recall that, when in analytic training, I had difficulty grasping the distinction between supportive therapy and psychoanalysis, for it seemed to me that to be deeply understood—a psychoanalytic aim—was the most supportive measure of all.

#### THE CURRENT PSYCHOANALYTIC SCENE

Today psychoanalysis continues to undergo fundamental change in theory and technique. A paradigmatic transition from positivistic to relativistic science and, now for many, to hermeneutics has dethroned the analyst from a position of objectivity and a purveyor of interpretive "truth." Instead, the analyst is a co-participant in a complex interactional field, called a relational (Greenberg & Mitchell, 1983; Mitchell, 1988, 1992) or intersubjective field (Atwood & Stolorow, 1984; Stolorow & Atwood, 1992; Stolorow, Brandchaft, & Atwood, 1987). Although a fundamental psychoanalytic aim to understand the inner world of the patient remains unchanged, we now recognize that an analyst both interactionally affects the patient's experience and subjectively shapes his or her perceptions and understandings of the patient.

Early in the development of psychoanalysis, interpretation was juxtaposed with suggestion and used as a major criterion as to what was distinctly psychoanalytic (Freud, 1919; Glover, 1931, 1954; Jones, 1910/1918). All psychotherapies other than psychoanalysis were seen as entirely based on suggestion. Ironically, from today's relativistic perspective, *interpretations are essentially suggestions* (Fosshage, 1991; Gill, 1994; Stolorow, 1990)—that is, interpretations, in contrast to an "objective truth," emanate from the analyst's subjectively organized perceptions and are offered to the patient as "suggested" understandings.

From a positivistic perspective interpretation was also juxtaposed with interaction, the latter tended to be viewed as a problematic countertransferentially induced enactment. Only when it became clear from a relativistic position that interpretations are not objective statements could it be realized that they, too, are actions or responses of the analyst, or fundamentally a part of the interaction (Fosshage, 1991; Gill, 1994; Namnum, 1976; Stolorow, 1990). The emergent model that best captures the analytic situation is an interactive systems model in which all of the analyst's intended and unintended, verbal and nonverbal responses are actions that enter into the interactional system (a host of authors have contributed to an interactive systems model; see Fosshage, 1995b). Within this model, interpretation and interaction are no longer dichotomized, for interpretation is a form of interaction.

Similarly, insight and relationship, traditionally divided within our theory of technique (Friedman, 1978), can now be viewed as "two aspects of a whole—that is, in analysis insight emerges within, is made possible, is shaped by ... gains its potency from the relationship" (Fosshage, 1995b, pp. 461–462), and, in turn, shapes the relationship.

#### EXTRINSIC AND INTRINSIC CRITERIA REASSESSED

In light of this very different psychoanalytic scene, I address the extrinsic and intrinsic criteria that have been used for differentiating psychoanalysis and psychoanalytic psychotherapy, focusing particularly on transference and technique.

The extrinsic criteria can be dealt with more easily. To reiterate, they are "frequent sessions, the couch, a relatively well integrated patient, that is, one who is considered analyzable, and a fully trained psychoanalyst" (Gill, 1954, p. 161). Psychoanalysts differ as to what frequency of sessions is needed for psychoanalytic treatment. Although the International Psycho-Analytic Association stipulates a requirement of four sessions per week to call an analytic treatment psychoanalysis, many psychoanalytic institutes require three sessions per week, and some even require two. Gill (1984a, 1994) went to the heart of the matter when he addressed the *meaning* the frequency of sessions has for the patient. Certainly more sessions provide more time for the work; yet, patients are quite individual as to how

effectively they work and as to what frequency is therapeutically facilitative. Some patients take to analysis, in Gill's apt description, "like ducks to water" on a once-a-week basis. Indeed, I was initially surprised to observe both in my own practice and in supervisory sessions an in-depth analytic process occurring with remarkable change on even a once-a-week basis. For other patients, analysis four times per week proves optimal. The frequency of sessions clearly can not be used as a meaningful, hard-and-fast criterion for assessing an ongoing psychoanalytic process.

In a similar vein, the couch, as Gill suggested, cannot be used as a criterion for psychoanalysis, for it depends again on its *meaning* to the patient. Whereas the couch for some patients facilitates tuning into their affective experience and fantasies, for others the couch deprives them of the requisite visual cues to more fully experience the analyst, needed in order to feel safe and to proceed with the analysis.

A relatively well-integrated patient is also no longer a criterion for psychoanalysis, for the applicability of psychoanalytic treatment has been extended to include the widest spectrum of psychopathology. Treatment is unique to each patient and does not appear to be limited by diagnosis. In addition to expanded theory and technical innovations, the adjunctive use of the much improved psychotropic medications has contributed to the more severely disturbed patients becoming amenable to psychoanalysis. The particular patient and analyst match is likely to be the most facilitative or limiting factor. In emphasizing the importance of the intersubjective system, Stolorow (1990) stated, "While there are doubtless some patients who could be analyzed only by the most gifted of analysts, I believe that, in principle, anyone with an intact nervous system is analyzable by *someone*" (p. 129).

The last extrinsic criterion, a "fully trained psychoanalyst," is also not problem-free. The distinction between psychoanalysis and psychoanalytic psychotherapy is made on the basis of whether the therapist has undergone formal training and has been certified as a psychoanalyst. In this way we attempt to formally structure and regulate our profession, a meaningful requirement for any profession. More and more therapists, however, are supervised to do psychoanalytic work. Depending on their skill level, we all know from our supervisory experience that some therapists without formal psychoanalytic training are quite capable of working analytically at a level commensurate with certified analysts. To be a certified psychoanalyst importantly regulates the profession, yet this cannot be meaningfully used to designate psychoanalytic work.

Let us turn to the intrinsic criteria by which psychoanalysis is defined. They are, in Gill's (1984a) words, "the centrality of the analysis of transference, a neutral analyst, the induction of a regressive transference neurosis and the resolution of that neurosis by techniques of interpretation alone, or at least mainly by interpretation" (p. 161).

Although the analysis of transference is commonly seen as a central task in psychoanalysis, opinion widely diverges as to the nature of transference and, correspondingly, to the task of how to effectuate its analysis—for example, promoting or not promoting the transference, exclusiveness of transferential focus, management of extratransferential material, and disclosure of our subjective experience. It is often claimed (Miller, 1991) that whereas the transference or transference neurosis is promoted in analysis, it is avoided in psychoanalytic psychotherapy; whereas the transference is central in psychoanalysis, conflicts with others are focused on in psychoanalytic psychotherapy; and whereas transference is resolved via interpretation in psychoanalysis, it is manipulated into a so-called transference cure in psychotherapy. Whereas suggestion is viewed as a primary mode of intervention for psychotherapy, interpretation is seen as the predominant mode for psychoanalysis and is used to overcome the “contaminant” of suggestion. (This latter distinction is negated with our understanding from today’s perspective that interpretation is a form of suggestion.)

Psychoanalysis is often said to promote a regressive transference neurosis, whereas psychotherapy either avoids the transference or is not sufficiently intense to create it. Despite considerable disagreement as to how transference differs from transference neurosis, those who make the distinction commonly hold that the difference is quantitative. Transference neurosis is usually seen as entailing a patient’s more comprehensive, intense, and persistent involvement with the analyst. However, if the difference is only quantitative, as Arnold Cooper (1987) argued, we should not use a terminological distinction that connotes qualitative differences. An intrinsically different type of transference should not be posited and used to differentiate psychoanalysis from psychoanalytic psychotherapy. Moreover, clinical experience clearly reveals that the intensity of transferential experience varies more according to patient, analyst, and treatment moment rather than to the frequency of sessions or a presumed distinction between psychoanalysis and psychoanalytic psychotherapy.

The recent reconceptualization of transference (including, among others, Fosshage, 1994; Gill, 1982; Hoffman, 1983, 1992; Lichtenberg, 1990; Lichtenberg, Lachmann, & Fosshage, 1992, 1996; Stolorow & Lachmann, 1984/85; Wachtel, 1980)—what Hoffman (19XX) called the social-constructivist model and what I call the organization model of transference—identifies transference as perceptual-cognitive-affective organizing activity. Organizing patterns or schemas are established on the basis of thematic lived-experience and serve as patterned ways of organizing one’s world. Transference, within the organization model, refers to the primary organizing patterns with which the patient constructs and assimilates the analytic experience. Transference, thus, is ever present in both psychoanalysis and psychoanalytic psychotherapy. In contrast to the traditional belief of promoting a regression in psychoanalysis, from the vantage point of the organizing model, we cannot promote or set in motion a linear regression to an earlier period in one’s life