

# ARNOLD ROTHSTEIN

## PSYCHOANALYTIC TECHNIQUE AND THE CREATION OF ANALYTIC PATIENTS



Second Edition

ROUTLEDGE

**Psychoanalytic Technique and  
The Creation of Analytic Patients**

*Second Edition*



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# Psychoanalytic Technique and The Creation of Analytic Patients

*Second Edition*

*by*

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# *Table of Contents*

Preface to the Second Edition	ix
Introduction	xiii
I. Introductory Phase Work	
1. Beginning Analysis with a Reluctant Patient	3
2. Beginning Analysis with Patients Who Are Reluctant to Pay the Analyst's Fee	19
3. On Doing a Consultation and Making the Recommendation of Analysis to a Prospective Analysand	43
4. On Analysts' Evaluating, Diagnosing, and Prognosticating	59
5. Fantasies of Failure, Name-Calling, and the Limits of Analytic Knowledge	77
6. Couples Therapy Conducted by a Psychoanalyst: Transference and Countertransference in Resistance to Analysis	91
II. Midphase Work	
7. Who Maps Psychic Reality?	111
8. The Seduction of Money	121
9. Results and Conclusions	135
References	145
Name Index	153
Subject Index	155



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**For Leo Stone whose example has provided me with a model of an optimal analytic attitude for helping people become analysands, and for Charles Brenner, whose theoretical contributions have provided me with an evolved and elaborated Freudian paradigm for understanding and analyzing the consequences of implementing Leo Stone's example.**



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# *Preface*

## *to the Second Edition*

In the two years since the first edition of this book was published I have had the opportunity to discuss its contents with groups of colleagues around the United States. These discussions have impressed me with the importance of the subject matter of this book. Whether or not other analysts agree with some or all of my observations and proposals it is clear that most are very interested in the issues I discuss. This is so because they are concerned with the nature of their practices and in the apparently declining number of patients seeking psychoanalysis as a treatment solution for their problems.

In this edition I elaborate central premises of the book, add clinical material and a chapter on “Fantasies of Failure, Name-Calling, and the Limits of Analytic Knowledge.”

This text evolved from my growing recognition that the way candidates are taught to evaluate and select prospective analysands does not work. The model, the concrete puzzle solution, that has been part of analytic training for at least seventy-five years has failed.

Since I was a candidate that model has always seemed to me to resemble that of an exclusive club deciding whom to exclude and whom to admit, rather than a procedure based on sound clinical experience. Analytic experience has demonstrated that it is not possible in a consultation to predict accurately the outcome of an analysis. To make matters worse, it is probable that an analyst whose mind is focused on the task of evaluating a prospective analysand contributes to creating

an environment in which certain patients are experienced as sicker than they might otherwise be.

In spite of the fact that it is not possible in a consultation to predict accurately the outcome of an analysis, many experienced “senior” analysts believe an analyst can and should be evaluative and selective. In their discussions of the subject they focus primarily on characteristics of the patient rather than the match.

It is, of course, true that in a consultation there are some patients, such as most of those who are characterized by Axis I diagnoses of DSM-IV, who obviously would be better served by some other form of treatment (APA, 1994). However, for the vast majority of patients it is more a matter of the analyst’s taste than sound scientific decision making. The analyst cannot help being evaluative. In this book I emphasize that it is more useful for the analyst to consider such urges as possibly reflective of countertransference, and to concentrate his efforts on understanding patients’ difficulties in accepting the recommendation of a trial of analysis as the optimal treatment for them.

In this book I emphasize that in a consultation there are advantages in focusing on the patients’ responses to the idea of engaging in a trial of analysis. My perspective emphasizes the match. A trial of analysis evaluates the match of a particular patient with a particular analyst at a particular time in *their* lives. The analyst’s gender, age, personality, and related state of mind may be as important in effecting the outcome of a trial of analysis as any feature of the patient’s mind.

This book shifts the emphasis of the focus of inquiry in a consultation from the patient to the analytic couple. It offers a different way of teaching candidates to work with prospective collaborators.

That said, it is important to acknowledge both the realistic exigencies of the world in which we live and the fact that

this book is fundamentally a reflection of my subjectivity. For a variety of reasons, there are probably fewer potential analytic collaborators per available analyst than there were thirty or forty years ago. I have nothing to say about that exigency that might be helpful. In this book I focus on what I believe can be done to improve the likelihood that a prospective analytic collaborator can become a satisfied analysand. The model I offer for doing a consultation derives from my clinical experience and inevitably reflects my personality. I invite you to “try it on for size.” Experiment with it. Modify it in ways that suit your personality.



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## *Introduction*

The central emphasis of this book is on analysts' attitudes toward analysis and prospective analysands. I believe the ability to help people become analysands is enhanced if the analyst has a *conviction* concerning the therapeutic efficacy of psychoanalysis. In addition, I believe that a trial of analysis is the optimal treatment for *most* people who seek analysts' help regardless of the presenting manifestations of their difficulties.

Although I am writing this introduction in 1995 I have been thinking about this subject for more than a quarter century. I remember, as a candidate and then as a supervisor on the admission service of the Psychoanalytic Center for Training and Research, Columbia University, New York, being impressed by the subjectivity of the discussions of prospective patients' analyzability. It seemed to me that half the faculty found it valuable to detail a prospective analysand's hypothesized defects in ego functioning while the remainder would say, "Give it a try and see what happens." It was also striking to me that it seemed like the same people said roughly the same thing regardless of who the patient was. I was in the "give it a try group."

I vividly remember Shapiro's report in 1977 to the annual meeting of the American Psychoanalytic Association on a survey of psychoanalytic practice (Panel, 1978). In it he noted that, "A sizable group of graduated members are conducting relatively few psychoanalyses.<sup>1</sup> Twenty-two percent reported that

<sup>1</sup>Brauer (1992) reporting to the executive council of the American Psychoanalytic Association on a contemporary study of practice noted: "The recent survey on psychoanalytic practice indicates a gradual decline in the number of analytic patients being treated" (p. 613).

patients in analysis in the survey week in April 1976 made up 10 percent or less of their private office patients; 19 percent reported that they then had only one patient in analysis or none at all" (p. 619). Shapiro continued: "Two-thirds of those who experienced a decline attributed it to decreased referral of *suitable analytic patients*" (p. 619; emphasis added).

I left that meeting impressed with the statistics and wondering what these analysts meant by "a suitable analytic patient." I remember thinking that Leo Stone would probably suggest that a patient had to prove they were *not* suitable for analysis, and not analyzable after a trial of analysis. I wondered how analytic training and the engendering of an evaluative rather than analytic attitude in the perennial quest for the elusive, idealized "good case," interfered with analysts' ability to develop analytic patients.

Some time later, while chatting with a group of recent graduates at a dinner party, the question came up of how many analytic cases each person was treating. After sharing their difficulties, one person turned to me and said, "And how many cases do you have?" My answer, "ten," was met with a mixture of awe and incredulity; one fellow guest commented, "It must be because you have written some papers and a book." I said I did not think so and added, somewhat presumptuously, that I thought I knew something about how to begin an analysis. Shortly thereafter I began to collect clinical data from unusual opening phases of analyses, some of which I reported in the (1986b) unpublished paper, "On Beginning an Analysis on the Periphery of the 'Widening Scope,'" which has evolved into the first chapter of this book. My debt to Leo Stone is clear in the title of the paper. Stone's (1954) concept of "modification" (p. 575) has been very helpful to me.

I read that paper to the Canadian Psychoanalytic Society (Montreal English Branch), the Long Island Psychoanalytic

Society, the Michigan Psychoanalytic Society, and the 35th International Psychoanalytic Congress. In addition, I presented the paper to a panel on "The Opening Phase of Psychoanalysis" at the 1986 Fall Meeting of the American Psychoanalytic Association, a panel conceived and chaired by Joseph Lichtenberg. Portions of that paper are presented in chapter 1 of this book.

In all these experiences it was clear that many analysts were vitally interested in discussing clinical data that might help them more successfully begin analyses and develop analytic practices. Shortly after the panel on the "Opening Phase," Dr. Theodore Jacobs, who was also a panelist, and I decided to pursue the project of developing the book *On Beginning an Analysis*.

My interest in the subject of this book became focused by George H. Allison who asked me to join a newly formed task force on psychoanalytic practice of the American Psychoanalytic Association which he chaired. In response to hearing Lee Brauer (1991) present a "Preliminary Report on the 1990 Survey of Psychoanalytic Practice" to the task force, I wrote a paper which is chapter 6 of this book.

Brauer reported a small decline in the number of analysts in analysis with members of the American Psychoanalytic Association since Shapiro's (Panel, 1978) earlier findings: "For graduated analysts in all membership categories who had at least one patient in any treatment, the mean number of analytic cases was 4.2. The number of cases varied considerably with membership category and training analytic status. Training analysts had 5.8 cases, compared to 3.9 for certified members" (p. 1).

Brauer added:

Although there is a gradual increase in the size of practices according to membership status from 2.6 cases for affiliate members to 3.9 for certified members, *it is clear*

*that most certified members and extended associate or associate members spend only a small portion of their time doing analysis. . . . [There is a] decline in analytic cases since 1976 [the data of the last study reported by Shapiro in 1978]. . . . Studying only certified members, there is a reduction in the size of practices for both training analysts and non-training analysts. Not all cases are evenly distributed among the membership . . . almost half of all analysts who are not training analysts have two or fewer cases in analysis. One hundred seventy-two of these analysts have no cases in analysis. A higher percentage of certified and extended associate members have no cases in analysis than do associate and affiliate members, indicating that for some, practice declines with seniority. It is clear that most analysts who are not training analysts spend little of their time practicing clinical analysis. A preliminary look at geographic distribution of cases indicates some geographic variation. However, in cities with more than one institute, the number of cases tends to be the same. Also, the geographic variation is small, with only four societies having a mean of five or more cases [pp. 1–2; emphasis added].*

These findings emphasize a serious morale problem among graduate analysts related to their difficulties in developing analytic practices. This problem influences young mental health professionals as they consider the option of pursuing analytic training. Residents in psychiatry often ask teachers who are analysts how satisfied they are in their work, and often ask, “Why should I pursue analytic training and spend all that time and money if there is little hope that I will be able to practice analysis?”

Perhaps the most obvious question raised by these findings is: Why do analysts have so few analytic cases? Before

proceeding with my attempt to reflect on this question, it is important to emphasize that the most an individual analyst can hope to do, given the current state of research methodology, is to state an opinion, and an opinion is inevitably biased and subjective, deriving from one's personality, clinical experience, and training, as well as one's theoretical beliefs, convictions, and commitments. This emphasis resonates with the fact that psychoanalysis is taught by analysts who are respected authorities. Their authority is, to some extent, institutionalized.

The basic premise of this book is that the analyst's attitude toward analysis, particularly its clinical efficacy and indications, profoundly influence her or his capacity to develop an analytic practice. Success in helping patients become analysands, and in developing and sustaining an analytic practice, is enhanced if the analyst has a conviction concerning the therapeutic efficacy of psychoanalysis tempered by a realistic sense of its possibilities. This basic premise is associated with a difficult conjecture that I believe is true. The conviction concerning the efficacy of analysis is like all convictions based, in part, on unconscious bias. In a related vein, and derivatively, I suggest that those analysts who lack such conviction and who have few or no cases in analysis may have an unconscious generalized bias against analysis. Reflecting on a colleague's success with a group of difficult patients, Silber (1991) notes:

It is clear that for analytic treatment to be successful, the analyst's attitude towards patient and illness assumes the utmost significance. . . . Her flexible, imaginative approach is bound to bring out what is latently accessible in her patients. It is also her *conviction* that change is possible which may supply the needed spark to breathe life into the joint analytic endeavor [p. 370].

Throughout this book I will stress the subjective contributions of the analyst's attitude toward analysis. When I conduct a consultation I am armed with the conviction that analysis is the best treatment for most nonpsychotic patients who seek help for specific symptoms or for complaints about the quality of their personal or professional lives. My conviction generates an attitude that a trial of analysis is indicated for all such nonpsychotic patients. In addition, success is facilitated by a flexible attitude toward the structure of the analytic situation as well as toward the characteristic elements of its technique. What is essential in analytic technique is the analyst's attitude toward the patient and the patient's behavior and verbal associations. Other features of the analytic situation, such as frequency of sessions and use of the couch, though important, are not always and absolutely essential.

A secondary premise of this book is that various aspects of training in social work, psychology, psychiatry, and psychoanalysis contribute to analysts' difficulties in developing analytic practices. I suggest that analytic candidates are taught, in part, from the perspective of an idealized model. Analytic training in general and training in analyzability in particular, may also promote the search for the mythical "good" analytic case. It is noteworthy that most of the clinical teaching in the analytic process is done by senior training analysts who have had, for the most part, little concern with the problem of creating an analytic practice. Brauer's (1993) most recent survey indicates that "the practice of training analysts has declined 15 percent in the seventeen years since 1976" (p. 21). This factor may be one of the factors that has influenced institutes to begin to initiate courses on the creation of analytic practice.

An exploration of the literature on the psychoanalytic process, indications for analysis and analyzability, reveals two